

**KENYA NATIONAL COMMISSION ON HUMAN RIGHTS**

**SILENCED MINDS: THE SYSTEMIC NEGLECT OF THE  
MENTAL HEALTH SYSTEM IN KENYA**

**A Human Rights Audit of the Mental Health System in Kenya**

**November, 2011**

Silenced Minds: the systemic neglect of the mental health system in Kenya

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## Preface

It is with great pleasure that I introduce this report, *Silenced Minds: the systemic neglect of the mental health system in Kenya*, which present the findings of a human rights-focused audit of the mental health system undertaken by the Kenya National Commission on Human Rights (KNCHR). Based on consultations with key stakeholders and visits to a number of psychiatric wards around the country, the report makes the argument that, as a result of stigma and discrimination against mental illness and persons with mental disorder, the policies and practices of the Government of Kenya have been inadequate and resulted in a mental health system that is woefully under-resourced and unable to offer quality inpatient and outpatient care to the majority of Kenyans who need it.

It is our sincere hope that the report will build momentum for reforms long overdue in the sector. Without concrete and targeted action to this end, the country will not succeed in creating a just and cohesive society that enjoys equitable social development as set out in *Vision 2030*, the country's development blueprint. Mental ill health impedes the achievement of other health and development outcomes and exacerbates to poverty; placing colossal economic and social burdens on an individual, their family, the community and society at large. Treating mental disorders is affordable and cost effective when integrated into primary care; complemented by secondary care; and linked to informal community-based services and self care. Reducing the treatment gap for mental health means that more Kenyans will be able to lead healthy, productive lives; a significant step towards overcoming social inequalities in the country.

Without an entrenched practice of institutionalisation to dismantle, Kenya has the potential to be a regional leader in terms of developing community-based mental health care services. A vibrant civil society movement—of self-help groups, carers groups, community-based service providers—engaged in mental health advocacy puts the country in a strong position improve mental health in the country. Involving these groups in the development and implementation of law, policy, plans and programmes for mental health will to ensure that the focus on mental health is from a human rights perspective; enhancing respect for patients' rights and promoting accountability in the sector and emphasising de-institutionalisation and community integration as guiding principles of care.

Article 43(1)(a) of the Constitution of Kenya enshrines the right to the highest attainable standard of health. This right—an inclusive right that encompasses the

freedom to control one's health and body, as well as entitlements; to facilities, goods, services and conditions conducive to the realisation of the highest attainable standard of health—reminds us that persons with mental disorders should not be viewed as objects of pity and charity, but as subjects of human rights with capacity for self-determination. The adoption of the Constitution in 2010 has spurred a period of rapid reform in Kenya, including in the health sector, and it is crucial that we do not miss this opportunity to ensure that mental health is placed irrevocably on the reform agenda. KNCHR is committed to doing its part to ensure that we don't.

**Commissioner Anne M. Ngugi**  
**Kenya National Commission on Human Rights**

## Acknowledgments

The Kenya National Commission on Human Rights (KNCHR) wishes to thank all those who contributed towards this report, which was the result of many months of consultation with stakeholders in the mental health sector.

First, our gratitude goes to the practitioners, academics and civil society groups who shared their time, knowledge and expertise and who provided invaluable and thought provoking contributions to the draft report of the audit. In addition to those listed in Appendix II, Professor David Ndeti from the Africa Mental Health Foundation and Victoria de Menil from the London School of Economics deserve special mention for reviewing the draft report.

We are equally grateful to the staff and administrators at Mathari Hospital in Nairobi, Moi Teaching and Referral Hospital in Eldoret, Rift Valley Provincial General Hospital in Nakuru and Port Reitz Hospital in Mombasa for their hospitality, and for their openness and candour in discussing the challenges facing psychiatric institutions in Kenya.

KNCHR would like to especially thank the Ministry of Medical Services, in particular the Division of Mental Health, for their receptive and constructive engagement during the audit, and also for their stated commitment to improving the mental health system in Kenya.

KNCHR acknowledges the efforts of the investigations team; Commissioner Anne Ngugi; Dona Anyona, Judy Lema, Dan Okoth, Allison Corkery (from the Centre for Economic and Social Rights, New York) and Winfridah Moraa, who was the lead author of the report. We particularly appreciate Commissioners Anne Ngugi and Wambui Kimathi for their invaluable guidance in compiling and reviewing the report.

Finally, KNCHR wishes to acknowledge Allison Corkery, who was instrumental in the compiling of the report and provided guidance on socio-economic rights principles that helped to inform the structure and content of the report.



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## List of Abbreviations

ACPHR	African Charter on Human and Peoples' Rights
ACRWC	African Charter on the Rights and Welfare of the Child
AOPs	Annual Operations Plans
CAT	Convention Against Torture
CDC	Centres for Disease Control and Prevention
CESCR	Committee on Economic Social and Cultural Rights
CNN	Cable News Network
CORP	Community Owned Resource Person
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
DMH	Director of Mental Health
ECT	Electro Convulsive Therapy
GoK	Government of Kenya
HIV/AIDS	Human immunodeficiency virus (HIV) /Acquired immunodeficiency syndrome (AIDS)
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICCPR	International Covenant on Civil and Political Rights
IDPs	Internally Displaced Persons
KEMSA	Kenya Medical Supplies Agency
KEPH	Kenya Essential Package for Health
KNCHR	Kenya National Commission on Human Rights
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MS	Medical Superintendent
MTEF	Medium-Term Expenditure Framework
MTRH	Moi Teaching and Referral Hospital
NASCOP	National HIV & STI Control Programme
NHSSP	National Health Sector Strategic Plan
PWD	Persons with Disability
PLWHA	Persons living with HIV/AIDS
PTSD	Post Traumatic Stress Disorder
RVPGH	Rift Valley Provincial General Hospital, Nakuru
UDHR	Universal Declaration of Human Rights
WHO	World Health Organization

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# Executive Summary

## Key Messages of this Report

- There is entrenched stigma and discrimination against mental illness and persons with mental disorders and low level of awareness on mental health.
- The mental health sector has been severely neglected and persons with mental disorders have been neglected and abandoned in mental health facilities, by their family, relatives, friends, and in the community.
- The legislative, policy, programmatic and budgetary steps the Government has taken have been ineffective in realising the right to the highest attainable standard of mental health.
- Basic mental health services, facilities and goods are unavailable or inaccessible to the majority of the Kenyan population.
- A failure to effectively integrate mental health in community and primary health care has led to huge gaps in the standards of care for mental health compared to physical health.
- Compliance with constitutional and international human rights obligations requires that the Government prioritise the improvement of the mental health sector in its social and economic policies as a matter of urgency.

1. In response to a documentary on Kenya’s decaying mental health infrastructure aired by the Cable News Network (CNN) in February 2011, the Kenya National Commission on Human Rights (KNCHR) initiated an ‘audit’ of mental health care in Kenya from a human rights perspective, pursuant to its powers under Section 16(1) of the KNCHR Act (2002) and Article 59(2)(f) of the Constitution. To this end, KNCHR consulted with key stakeholders in the mental health sector, including the Ministry of Medical Services (MOMS), psychiatrists in practice and academia, non-government organisations providing services to people with mental disorders and staff and administrators at a number of mental health facilities around the country, which KNCHR also inspected.<sup>1</sup> This report presents the findings of the Commission’s

<sup>1</sup> Mathari Hospital in Nairobi; Moi Teaching and Referral Hospital (MTRH) in Eldoret; Rift Valley Provincial General Hospital (RVPGH) in Nakuru; and Port Reitz Hospital in Mombasa.

audit. While recognising the limitations of this consultative methodology, KNCHR hopes that the findings it makes prompt discussion on and build momentum for reforms in the sector.

### **The Human Rights Framework**

2. Reflecting numerous international and regional treaties that Kenya has ratified, Article 43(1)(a) of the Kenyan Constitution enshrines the right to the highest attainable standard of health. Defined in line with international law, this includes both physical and mental health. The right to health is an inclusive right that encompasses the freedom to control one's health and body, as well as entitlements; to facilities, goods, services and conditions conducive to the realisation of the highest attainable standard of health. These freedoms and entitlements place corresponding obligations on the Government to respect, protect and fulfil the right to health, as reflected in Article 21(1) of the Constitution. The United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care elaborate on such entitlements in the context of mental health and include the rights: to the best available care; to be treated with humanity and respect; to protection from exploitation, abuse and degrading treatment; to the same level of care as for physical illness; to community integration; to periodic review of treatment; to liberty; and to access information.

3. Although the rights in Article 43 may be achieved 'progressively', depending on the availability of resources, Article 20(5)(b) enshrines the principle that when allocating the resources, the Government should make it a priority to ensure the right to health is enjoyed as widely as possible "having regard to prevailing circumstances, including the vulnerability of particular groups or individuals". Further, the Government has some immediate duties, for example to ensure that conditions in hospitals do not amount to inhumane or degrading treatment.

### **Findings of the Audit**

4. The audit revealed that the policies and practices of Government of Kenya have to a great extent marginalized mental health, in effect discriminating against persons sufferings from mental disorders. For this reason, the Government needs to significantly enhance its efforts to provide quality mental health care across the country in order to meet its human rights obligations.

5. Mental health conditions contribute significantly to the disease burden in Kenya and already vulnerable groups are more likely to have higher rates of mental disorders. Although there is no data on the prevalence of mental disorders in Kenya, it has been estimated that up to 25 percent of out-patients and up to 40 percent of in-patients in health facilities will suffer from some form of mental health condition.<sup>2</sup> Nevertheless, a low clinician detection rate for mental disorders means that most psychiatric disorders remain undiagnosed and thus unmanaged.

6. The Government has not taken sufficient steps to address the burden of mental health in Kenya. Legislation governing the mental health sector is outdated and narrowly focused on in-patient admission. Regulations envisaged under the Mental Health Act to oversee the equipment, administration, control and management of mental hospitals; the care, treatment and rehabilitation of persons suffering from mental disorder; and the procedure for admitting out-patients have never been enacted. Similarly, the Act vests functions in a Board of Mental Health, but these are not being effectively performed. While a specific mental health policy was drafted in 2003, it has still not been finalised and adopted. At the same time, the broader health sector strategic plan says little on mental health. Although the Ministry has introduced some commendable initiatives to encourage hospitals to improve mental health services, their effectiveness appears to have been limited by the policy vacuum in the sector.

7. In the absence of an effective legal and policy framework, the mental health sector in Kenya has lagged behind physical health. The availability of in-patient and out-patient services—including rehabilitation services like halfway houses—is extremely limited due to underfunding and lack of personnel, which particularly affects groups such as children and youth, as well as criminal offenders. Kenya has approximately 77 consultant psychiatrists, 418 psychiatric nurses and 30 clinical psychologists to serve a population of slightly below 40 million.<sup>3</sup> The availability of psychotropic drugs supplied by the Kenya Medical Supplies Agency (KEMSA) was also criticised by some of the hospitals visited.

8. Further, the services that are available are overly centralised. Almost 70 percent of in-patient beds are in Nairobi, for example. This limits accessibility as many patients have to travel long distances to seek treatment. Of the 46 psychiatrists

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2 Ndetei, DM and Muhangi, J 1979, 'The prevalence and clinical presentation of psychiatric illness in a rural setting in Kenya', *British Journal of Psychiatry*, Vol.135, pp. 269-272.

3 Ndetei, D 2010, 'Mental Health Challenges and Prospects in Kenya', *Quarterly Newsletter of the Royal College of Psychiatrists—African International Division*, pp.2-4.

in the public service, 28 are based in Nairobi; leaving the effective ratio outside the capital one psychiatrist per province of 3-5 million people. North Eastern Province has neither a psychiatrist nor a psychiatric nurse.<sup>4</sup>

9. Also of concern is the fact that available services are not of sufficient quality. Crowded, understaffed wards hinder effective service delivery. Although the hospitals visited were on track in some areas, such as providing sufficient food, infrastructure was generally not conducive to recovery, with patients housed in isolated, poorly ventilated and dilapidated buildings. Sanitary conditions were similarly problematic, with wards and patients' clothing appearing unclean.

10. There are limited opportunities for broad stakeholder engagement in the development of policies and programmes in the mental health sector. Further, there is a lack of transparency and independent oversight of service providers. Channels for patients to make complaints also appear to be limited and it is a serious concern that the Board of Mental Health is not playing its mandated watchdog role.

11. There is universal agreement that the major reason for poor mental health care is gross underfunding. In the past five years, the recurrent expenditure allocation for mental health has remained at around 1 percent of the budget of the MOMS and mental health has not received any allocation for development expenditure. Funding from other sources, such as donors or ministries that have responsibility for criminal offenders has not been forthcoming. There were also questions raised about how well existing allocations are being spent.

12. Additionally, unresolved underlying socio-economic factors hinder people's ability to enjoy their mental health; the biggest of these being stigma and discrimination against people with mental health conditions, which is rampant among the public, politicians and even medical professionals. There is little community awareness about mental health, leading to confusion about what constitutes mental disorder, mental illness, personality disorder, intellectual disability etc. This results in the specific needs of each of these groups being overlooked. The interrelationship between mental health and other issues such as HIV/AIDS, poverty and conflict-related trauma have similarly been overlooked.

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<sup>4</sup> Kiima, D and Jenkins, R 2010, 'Mental health policy in Kenya: an integrated approach to scaling up equitable care for poor populations', *International Journal of Mental Health Systems*, vol.4, p.19.

13. Finally, a number of structural issues hamper progress in the mental health sector. For example, despite the clear human resource challenges there do not appear to be any incentive schemes to attract and retain mental health professionals. The Division of Mental Health (DMH) is housed in the Ministry of Medical Services (MOMS), which limits its ability to reach the community level. Planning in the sector is not evidenced-based, as there is limited epidemiological and development research on mental health.

### Conclusion and Recommendations

14. While to date action on mental health has not been enough to meet the Government’s obligation to fulfil the right to health, Kenya has the potential to be a regional leader in terms of developing a human rights-based approach to mental health. With few large psychiatric institutions, there is no system to dismantle. There is a vibrant civil society movement—of self-help groups, carers groups, community-based service providers—who are engaged in mental health advocacy. This puts the country in a strong position to effectively establish community-based mental health care services.

15. To this end, KNCHR makes a number of recommendations that need to be taken by various stakeholders so as to progressively fulfil the right to health and the right of people with mental disorder to treatment and care centred on five broad themes: strengthening the legal and policy framework; integrating mental health into primary health care; reducing stigma and discrimination; expanding financial and human resources; and advancing research. Specifically, the audit makes suggestions for action that stakeholders can take to achieve the following objectives:

Stakeholder	Objective
<b>Ministries responsible for health</b>	<ul style="list-style-type: none"> <li>• Develop a clear roadmap for mental health in Kenya by reviewing the Mental Health Act and finalizing the Mental Health Policy.</li> <li>• Prioritise the integration of mental health within the community and in primary care</li> <li>• Develop human resources for the mental health sector</li> <li>• Increase access to information about mental health care services</li> <li>• Support research on mental health</li> <li>• Support initiatives to combat stigma and raise awareness about mental disorders</li> </ul>

<b>Government of Kenya</b>	<ul style="list-style-type: none"> <li>• Increase the budgetary allocation to mental health</li> <li>• Mobilise resources for the mental health sector</li> <li>• Support initiatives to combat stigma and raise awareness about mental disorders</li> <li>• Support research on mental health</li> <li>• Ensure oversight and regulation of the mental health sector</li> <li>• Improve the coordination of stakeholders to ensure effective advocacy on mental health</li> </ul>
<b>Health care facilities</b>	<ul style="list-style-type: none"> <li>• Respect patients' rights and promote accountability</li> <li>• Promote public awareness about mental health and mental disorders</li> </ul>
<b>NGOs and community groups</b>	<ul style="list-style-type: none"> <li>• Document and report cases of violations of the rights of people with mental disorders</li> <li>• Promote public awareness about mental health and mental disorders</li> <li>• Gather information for policy development</li> <li>• Support research on mental health</li> </ul>
<b>Insurance industry</b>	<ul style="list-style-type: none"> <li>• End the practice of limiting benefits for mental health care services</li> </ul>
<b>Institutions of higher learning</b>	<ul style="list-style-type: none"> <li>• Increase opportunities for education and training on mental health</li> <li>• Support research on mental health</li> </ul>
<b>Professional Associations</b>	<ul style="list-style-type: none"> <li>• Promote public awareness about mental health and mental disorder</li> </ul>
<b>Donor community</b>	<ul style="list-style-type: none"> <li>• Scale up support for the mental health sector</li> </ul>

# CHAPTER ONE |

## Introduction

### 1.1 Background

1. In February 2011 Cable News Network (CNN) aired a documentary titled “Locked Up and Forgotten” on the decaying mental health infrastructure in Kenya, particularly in Mathari Hospital, Nairobi.<sup>5</sup> The documentary reported that persons with mental disorders were being held in inhumane and degrading conditions. Alleged human rights abuses highlighted included: forced medication; crowded wards; and rape and sodomy by other patients. The CNN crew also filmed a deceased patient lying in an isolation cell in one of the male wards, reportedly having passed away the night before. Another patient could be seen lying next to him. At around the same time, the Kenya National Commission on Human Rights (KNCHR) received a petition lodged by a relative of a patient at the hospital regarding the condition under which patients are kept. The petitioner’s specific complaints, expressed through their legal guardian, included lack of food, forced medication, physical assaults, and poor hygiene standards.

2. In this context, KNCHR—an independent body established under the Kenya National Commission for Human Rights Act (2011) and enshrined in Article 59 of the Constitution with the core mandate of protecting and promoting human rights in Kenya—initiated an

#### NOTE ON TERMINOLOGY

**Mental Disorder:** This report uses the term ‘mental disorder’ to capture conditions including mental illness, neurological disorders or alcohol and substance abuse. These conditions range from serious cases such as schizophrenia and bipolar to more minor mental ill health, often called psychosocial problems, such as mild anxiety disorder.

Mental disorders affect feelings and behaviour. Few mental illnesses can be prevented; nearly all can be successfully managed and treated. The cause s of disorders are complex and are influenced by a person’s heredity, life experiences, family background, and physical illness.

#### Difference between mental illness and intellectual disability

Intellectual disabilities are significant limitations caused by, among others, chromosomal abnormalities, brain damage before, during or after birth, and malnutrition during early childhood. Intellectual disability may be genetic or caused by environmental factors during pregnancy.

#### Mental disorders may amount to a disability

Mental illness may lead to mental disability if it has a substantial or long term effect on an individual’s ability to carry out ordinary day-to-day activities (**Article 260, Constitution of Kenya, 2010**).

<sup>5</sup> The documentary video is available at: <http://edition.cnn.com/video/?/video/international/2011/02/24/wus.kenya.hospital.cnn>.

investigation into the status of mental health care in Kenya from a human rights perspective with the aim of making recommendations to improve the functioning of state organs as pertains to mental health, pursuant to its powers under Article 59(2)(f) of the Constitution and sections 8 (d) and (e) of the KNCHR Act (2011). These provisions empower the Commission to investigate or research human rights issues on its own initiative or on the basis of complaints.

3. After concluding an investigation, section 42 of the constitutive Act mandates KNCHR to make a report to the state organ, public office or organization to which the investigation relates. The report is expected to include the findings of the investigations and the recommendations made by KNCHR. The Act further states that KNCHR may require the state organ, public office or organization that was subject of the investigation to submit a report to KNCHR within a specified period of time on the steps taken to implement the recommendations by KNCHR. Failure or refusal to implement the recommendations by the requisite institution, KNCHR shall prepare and submit to the National Assembly a report, detailing the failure or refusal to implement the recommendations. The National Assembly is then expected to take appropriate action.

## 1.2 Rationale

4. In responding to the allegations raised about Mathari, KNCHR decided to undertake a broader review of the mental health system in Kenya. First, the issues raised by both the CNN documentary and the petition about how care is provided to people with mental disorders are systemic and widespread and affect people across the country. Additionally, the right to health generally, in this instance

*‘Currently there is a very big gap existing between the mental health needs of kenyans and the existing mental health services at all levels of the health care services delivery system.’*

**Professor Anyang’ Nyong’o,  
Minister of Medical Services (Letter  
to KNCHR, 23 june 2011)**

mental health has just in recent times gained recognition with the introduction of a strong bill of rights under the recently promulgated Constitution (2010).

5. It has been estimated that in Kenya 20-25 percent of out-patients seeking medical attention suffer from mental disorders.<sup>6</sup> While the majority of these are minor, most are misdiagnosed because the patients present predominantly

<sup>6</sup> Ndetei & Muhangi 1979, *supra* note 2. See also, Dhadphale, M 1984, *Psychiatric morbidity among patients attending the district hospital outpatient clinics in Kenya*. MD thesis Nairobi, Kenya: University of Nairobi, Department of Psychiatry.

physical symptoms. What's more, other sectors such as education, prisons, police, community development, gender, children and others have considerable apprehension about mental health conversely as noted by Kiima and Jenkins, the general health programmes have been slow to appreciate the importance of mental health for physical health targets.<sup>7</sup>

6. Further, mental ill health impedes the achievement of other health and development outcomes and contributes to poverty and vulnerability; placing colossal economic and social burdens on an individual, their family, the community and society at large. As the World Health Organisation (WHO) highlights, not only are vulnerable groups more likely to have higher rates of mental health conditions, people with mental disorders meet the major criteria for vulnerability:<sup>8</sup>

“They are subjected to stigma and discrimination on a daily basis, and they experience extremely high rates of physical and sexual victimization. Frequently, people with mental disorders encounter restrictions in the exercise of their political and civil rights...They also are restricted in their ability to access essential health and social care, including emergency relief services. Most people with mental disorders face disproportionate barriers... As a result ... [they] are much more likely to experience disability and die prematurely, compared with the general population.”

7. With the entrenchment of economic, social and cultural rights in the new constitutional dispensation, the Government has committed to progressively realizing the right to health of all persons. The Constitution moreover places considerable emphasis on the protection of minorities and marginalised groups. For all of these reasons, it is an opportune time to review existing practices and to make recommendations for broad ranging reform in the mental health sector.

### 1.3 Report Methodology

8. The aim of the Commission's investigation was to 'audit' the state of mental health in Kenya from a human rights perspective and to make recommendations to improve the situation thereof. To this end, KNCHR consulted with key stakeholders in the sector. This included:

<sup>7</sup> Kiima and Jenkins, *supra* note 4.

<sup>8</sup> World Health Organisation 2010, *Mental Health and Development: targeting people with mental health conditions as a vulnerable group*, p.XXV.  
Available at: [http://whqlibdoc.who.int/publications/2010/9789241563949\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241563949_eng.pdf)

- contacting the CNN reporter who produced the documentary;
- meeting the Medical Superintendent (MS) and other senior officers at Mathari Hospital on 18 March 2011;
- consulting psychiatrists in practice and academia, as well as
- consulting representatives from civil society organisations and community groups providing services to people with mental disorders, including holding a stakeholder's forum at KNCHR's offices on 6 April 2011 (participants' list at Annex I) and a validation workshop of the draft report on 13 October 2011;
- meeting with the Director of Mental Health on 8 April 2011; and
- meeting with the Minister of Medical Services on 12 April 2011.

9. KNCHR also visited a number of mental health facilities around the country in order to provide case studies of type of care available in Kenya. These included: Mathari Hospital in Nairobi; Moi Teaching and Referral Hospital (MTRH) in Eldoret; Rift Valley Provincial General Hospital (RVPGH) in Nakuru; and Port Reitz Hospital in Mombasa. During the visits, KNCHR also inspected the hospital's facilities except MTRH, which was not inspected owing to time constraints.

10. In conducting its inquiry, the Commission relied heavily on information from the stakeholders it consulted with, observations made during the inspection visits and the secondary data available on mental health in the country. Unfortunately, however, there is very little literature and data on mental health care services in Kenya readily available, which was a limitation in conducting the investigation. However, the Commission benefited greatly from the open and constructive engagement it had from all stakeholders, in particular the Ministry of Medical Services, for which we extend our sincere gratitude. Consequently, this report is a snapshot view of the mental health system in the country shaped by information from key mental health institutions and stakeholders.

#### **1.4 Outline of the Report**

11. This report presents the findings of the Commission's human rights audit of mental health in Kenya. Part I begins with an overview of the international and constitutional human rights framework relevant to mental health. Part II presents the findings of the audit by looking at the burden of mental health disorders in

Kenya; the steps the Government has taken to address this burden; the resources dedicated to such efforts; and the socio-economic, cultural and structural factors that influence mental health in Kenya. Recognising the limitations in its methodology, the report makes a preliminary conclusion that the policies and practices of the Government have to a great extent marginalized mental health, in effect discriminating against persons sufferings from mental disorders. For this reason, as a matter of urgency, the Government needs to significantly scale up its efforts to provide quality mental health care across the country in order to meet its human rights obligations. The report offers a number of recommendations in this regard, with the aim of promoting discussion on and building momentum for action on reforms in the mental health sector in Kenya.

## CHAPTER TWO |

### The Human Rights Framework for Mental Health

1. Adopting a human rights based approach to mental health is important because it grants entitlements that give rise to legal obligations on the government. By placing people at the centre of an issue, a rights perspective empowers individuals and groups so that they can take more control over decisions concerning their mental health. Importantly, obligations demand accountability. This means that mechanisms must be put in place to hold government to account for its actions in relation to mental health. A rights perspective also prohibits non-discrimination and prioritizes the needs of poor and vulnerable people. By imposing obligations on the government to take action, a rights perspective strengthens the ability of poor and vulnerable groups to demand and use services and information. It also puts an emphasis on equitable access to services. Finally, a rights perspective emphasizes participation, a fundamental democratic principle. Individuals and groups have the right to active and informed participation in the formulation, implementation and monitoring of policies relevant to mental health. This includes the rights to information, to education, to association and to be heard. This chapter introduces the relevant constitutional and international standards that give effect to these principles in the Kenyan context.

#### 2.1 The Constitution of Kenya

2. One notable feature of the Constitution of Kenya 2010 is its preamble, which recognizes the aspirations of Kenyans for a government based on equality and other essential values of human rights. These human rights principles, as set out in Chapter four on the Bill of Rights, are incorporated in the entire Constitution and are the foundational basis of governance in Kenya. As the cornerstone of the Constitution, the Bill of Rights introduces a new genre of rights not previously recognized in the old Constitution; economic, social and cultural rights. These rights are protected under Article 43.

##### 2.1.1 *The right to the highest attainable standard of health*

3. Article 43(1)(a) of the Constitution provides that every person is entitled to the “highest attainable standard of health including the right to health care services,” which, as discussed further below, includes mental health. The right to health intimately relates to human dignity, the concept underlying all human

rights. Article 28 provides that every person has the right to have his or her dignity respected and protected. Having due regard to the importance of health information in the realization of the right to health, Article 35 gives all persons the right to access information held by the State or by any person when required to exercise or protect any right or freedom.

### **2.1.2 The rights of persons with mental disorders**

4. Apart from introducing economic, social and cultural rights, the Constitution entrenches equality by providing for the protection and promotion of the rights of the most vulnerable members of society. Article 27(4) specifically prohibits direct or indirect discrimination by the state on the basis of health status and disability, amongst others. Though the Constitution does not define 'health status', given that the internationally accepted definition of health includes physical, mental and social well being, mental health status would be included as a prohibited ground of discrimination. Arguably, the systemic neglect of the mental health sector, compared to physical health, amounts to indirect discrimination on the grounds of health status and the Government must be vigilant to overcome this.

5. Further, the Constitution contains a number of provisions that protect the rights of persons with special needs. Under part three of the Bill of Rights (Articles 52- 57), the Constitution provides for the special application of rights with the aim of ensuring equality in the enjoyment of rights and fundamental freedoms by all. The Constitution does this by requiring that affirmative action programmes be set up to ensure that these groups enjoy their rights and fundamental freedoms without discrimination. As already noted, vulnerable groups are more likely to suffer from mental health conditions. This mental health dimension of their vulnerability must be addressed in affirmative action measures.

6. For example, in some cases, persons suffering from mental disorders that result in either substantial or long-term effects fall within the category of persons with a disability. The Constitution's definition of disability explains that mental disorders can have a substantial or long-term effect on an individual's ability to carry out ordinary day-to-day activities.<sup>9</sup> The rights of persons with a disability are stipulated in Article 54. Notably, under sub-article (1)(a) persons with disability are entitled "to be treated with dignity and respect and to be addressed and

<sup>9</sup> Article 260 defines 'disability' to include "any physical, sensory, mental, psychological or other impairment, condition or illness that has, or is perceived by significant sectors of the community to have a substantial or long-term effect on an individual's ability to carry out ordinary day-to-day activities."

referred to in a manner that is not demeaning”. Sub-article (1)(b) entitles such persons to “access educational institutions and facilities that are integrated into society to the extent compatible with the interests of the person”.

7. Finally, with respect to persons with mental disorders receiving in-patient care in health facilities, Article 29(a) enshrines the right of every person not to be deprived of freedom arbitrarily or without just cause. In cases of admission, Article 29(f) protects every person with mental illness from being treated or punished in a cruel, inhumane and degrading manner.

## **2.2 International and Regional Law**

8. Articles 2(5) and (6) of the Constitution recognize that the general rules of international law and any treaty and convention ratified by Kenya form part of the law of Kenya. For this reason, the protection of the right to health in Article 43 should be interpreted to include the right to mental health; which is safeguarded in a number of the major international and regional human rights instruments that Kenya has ratified including the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Rights of Persons with Disabilities (CRPD), the Convention on the Rights of the Child (CRC), the African Charter on Human and Peoples’ Rights (ACPHR) and the African Charter on the Rights and Welfare of the Child. The rights of persons with a mental disorder are further protected in instruments such as International Covenant on Civil and Political Rights (ICCPR), the Convention Against Torture (CAT).

9. In September, 2011 the General Assembly in conceding that the global burden and threat of non-communicable diseases constitutes one of the major challenges for development in the twenty-first century adopted the Political Declaration on the Prevention and Control of Non-communicable Diseases.<sup>10</sup> The Declaration in paragraph 18 recognizes that mental and neurological disorders, including Alzheimer’s disease, are an important cause of morbidity and contribute to the global non-communicable disease burden. In response to the challenges occasioned by non-communicable diseases, the high level meeting resolved in the declaration that the government and the society should enhance their efforts towards: reducing risk factors and creating health-promoting environments, strengthening national policies and health systems; strengthening international cooperation in support of national, regional, and global plans for

<sup>10</sup> *Political Declaration of the High Level Meeting High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases*, 16 September 2011, UN Doc. A/66/L.1.

the prevention and control of non-communicable diseases; promoting national and international investments and strengthening national capacity for quality research and development; and strengthening country-level surveillance and monitoring systems, including surveys that are integrated into existing national health information systems.

### 2.2.1 *Right to the highest attainable standard of mental health*

10. The right to the highest attainable standard of physical and mental health has been proclaimed in several international human rights instruments, including Article 12 of the ICESCR and Article 16 of the ACPHR. For children, Article 24 of the CRC and Article 14 of the African Charter on the Rights and Welfare of the Child articulate the right of the child to enjoy the highest attainable standard of health. The right to health is an inclusive right that encompasses both freedoms and entitlements. Freedoms include the right to control one's health and body, the right to be free from torture and from non-consensual medical treatment. Entitlements include the right to facilities, goods, services and conditions that are conducive to the realization of the highest attainable standard of physical and mental health.<sup>11</sup>

*Facilities, goods and services for mental health include:*

- *Community mental health services, including halfway houses;*
- *In-patient treatment at psychiatric hospitals and psychiatric wards in general hospitals ; and*
- *Out-patient treatment at local primary care services (such as provision of mental health services in the local clinics)*

11. The Committee on Economic, Social and Cultural Rights—the body mandated to monitor governments' compliance with ICESCR—has identified criteria for judging the adequacy of such facilities, goods and services: <sup>12</sup>

- **Availability:** functioning public health and health care facilities, goods, services and programmes must be available in sufficient quantities, though those precise quantities are contingent on various factors, mainly the State's development level. Underlying determinants of health such as safe drinking water, adequate sanitation, trained medical and professional personnel and essential drugs must also be available.

11 Hunt, P 2005, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health to the 61<sup>st</sup> Session of the Commission on Human Rights*, U.N.Doc. E/CN.4/2005/51.

12 United Nations Committee on Economic Social and Cultural Rights 2000, *General Comment No. 14 on the Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C.12/2000/4.

- **Accessibility:** health facilities, goods and services must be accessible to everyone. Accessibility covers four overlapping dimensions:
  - o **Non-discrimination:** health facilities, goods and services must be accessible to all especially the most vulnerable and marginalized.
  - o **Physical Accessibility:** health facilities, goods and services must be within safe reach for all sections of the populations, especially the most vulnerable and marginalized.
  - o **Economic Accessibility:** health facilities, goods and services must be affordable to all. Poorer households should not be disproportionately burdened with health expenses as compared to the richer households.
  - o **Information Accessibility:** this includes the right to seek, receive and impart information and ideas concerning health issues, as long as it does not impair the right to have personal data treated confidentially.
- **Acceptability:** all health facilities, goods and services must be respectful of medical ethics, culturally appropriate, and sensitive to gender and life cycle requirements.
- **Quality:** requires, *inter alia*, skilled personnel, scientifically approved and up-to-date drugs and hospital equipment, safe and potable water and adequate sanitation.

*Access to services related to the underlying determinants of health.*

*Determinants of mental health include social exclusion, HIV/AIDS, poverty and violence, among others. According to the World Health Organisation between a third and a half of those affected by conflict suffer mental distress, including post-traumatic stress disorder (PTSD), depressive and anxiety disorders.*

*Measures to prevent violence and social exclusion, especially of the most vulnerable and marginalized group such as persons living with HIV/AIDS, are important to address these mental determinants of health.*

*Measures to promote access to information relating to mental health and measures to cushion the community from the harsh effects of poverty are also mechanisms of ensuring access to underlying determinants of mental health.*

### 2.2.2 Rights of Persons with Mental Disorders

12. The requirement that quality health facilities, goods and services must be available and accessible to all has been elaborated in the specific context of mental disorder in the Principles for the Protection of Persons with Mental

Illness and the Improvement of Mental Health Care<sup>13</sup> (hereinafter “Mental Illness Principles”). The Principles contain detailed minimum standards concerning the rights of every person in a mental health care facility. A selection of these rights includes:

a) *Right to the best available care*

This is recognized in Principle 1. Principle 14(2) further instructs that every mental health facility be inspected by competent authorities with sufficient frequency to ensure that the conditions, treatment and care of patients comply with the standard of care in the Principles. Principle 13 recognizes every patient’s right within the mental facility, including; to recognition as a person before the law, to privacy, and freedom of communication and freedom of religion and belief. The principle also provides that the environment and living conditions in mental health facilities “shall be as close as possible to those of the normal life of persons of similar age”.

b) *Right to be treated with humanity and respect*

This principle emphasizes the inherent dignity of a person with a mental disorder as a human person.

c). *Right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment*

Article 7 of the ICCPR, Article 16 of CAT and Articles 5 and 6 of the ACHRP apply to medical institutions especially those providing psychiatric care. Principle 9 recognizes the right of persons with mental disorders to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient’s health needs and the need to protect the physical

*Conditions that may amount inhuman or degrading treatment include:*

- *unchanged beddings;*
- *excessive force used to restrain patients;*
- *routinely ignoring calls for help by patients;*
- *washing or dressing patients without regard to their dignity;*
- *neglect or abusive treatment.*

<sup>13</sup> Adopted by General Assembly Resolution 46/119 of December 1991. These principles were developed after the General Assembly, in its resolution 33/53 of December 14, 1978, requested the Commission on Human Rights to urge the Sub-Commission on Human Rights on Prevention of Discrimination and Protection of Minorities to undertake a study of the question of the protection of those detained on the grounds of mental ill health, with a view of formulating guidelines.

safety of others. Treatment without consent including forced medication may in some circumstances amount to inhuman or degrading treatment, unless it can be demonstrated to be medically necessary. Principle 10 prohibits administering medication as punishment.

*d). Freedom from discrimination on grounds of mental illness*

Principle 3 requires special measures be taken to the rights of, or secure the advancement of persons with mental disorders. Principle 8 stipulates that every mentally ill person has the right to receive such health and social care appropriate to his or her health needs. The person is similarly entitled to care and treatment in accordance with the same standards as other ill persons.

*e). The right to the same level of care as for physical illness*

Principle 14 requires that mental health facilities should have access to the same level of resources as any other health establishment, in particular, quality and sufficient medical personnel and professional staff, diagnostic and therapeutic equipments, medical supplies, and adequate, regular and comprehensive treatment. Principle 15(2) specifies that access to mental health facility be administered in the same way as access for any other illness.

*f). The right to community integration*

The Principles take a strong and positive position with regards to community integration, recognizing, inter alia, the right of every person with a mental disorder to be treated and cared for, as far as possible, in the community in which he or she lives. In so doing, the principles acknowledge the role of community and culture in enhancing mental health.

*g). The right to legal representation*

A person suffering from mental disorder whose legal capacity is in question is entitled to be represented by a counsel. If the person fails to secure such representation, the principle notes that such representation shall be made available without payment to the extent that the person does not have sufficient means to pay for it. The decisions regarding capacity and the need for a personal representative are required to be reviewed at reasonable intervals prescribed by domestic law.

*h) The right of confidentiality*

Principle 6 requires that the confidentiality of information concerning all persons suffering from mental disorders be respected.

*i). The right to periodic review of treatment*

An involuntary patient, that is a patient admitted in a mental health facility without consent, shall have the right to have their case periodically reviewed at reasonable intervals as specified by domestic law. The review body must be a judicial or other independent and impartial body established according to domestic law and functioning in accordance with procedures laid down by domestic law. In the case of children, Article 25 of the CRC recognizes the right to periodic review of treatment provided to children who are placed in institutions for care, protection or treatment of physical or mental health.

*j). The right to liberty of persons suffering from mental illness*

According to the Principles, involuntary admission can only be lawful if a qualified mental health practitioner authorized by law for that purpose determines, in accordance with laid down procedures on determination of mental illness, that the person has a mental illness and considers that there is a serious likelihood of immediate or imminent harm to his or herself or to other persons; or in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.

*k). The right to access information*

A patient is entitled to access the information concerning his or her health and personal records maintained by a mental health facility. This right may be subject to restrictions in order to prevent serious harm to the patient's health and avoid putting at risk the safety of others. These restrictions have to be prescribed by domestic law and have to be in the best interest of the patient.

### **2.3 Nature and Scope of State Obligations**

13. Human rights impose three levels of obligations on states; categorized as duties to respect, to protect, and to fulfil the rights concerned. The obligation to respect means refraining from interfering, directly or indirectly, with the enjoyment of the right. The obligation to protect means preventing third parties from interfering with the right. Lastly, the obligation to fulfil means adopting

legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right. This formulation is reflected in Article 21(1) of the Constitution, which makes it a ‘fundamental duty’ of the state and every state organ to ‘observe, respect, protect, promote and fulfil’ the rights and fundamental freedoms that are contained in the Bill of Rights.

### **2.3.1 Applying the “respect, protect and fulfil” framework to mental health**

14. **Obligation to respect:** States should refrain from denying or limiting equal access to preventive and curative health services; adopting discriminatory practices relating to persons suffering from mental disorders; marketing unsafe drugs; adopting coercive medical treatments, unless on an exceptional basis and respecting best practices and applicable international standards; or limiting people’s participation in mental health-related matters.

15. **Obligation to protect:** States must take action to ensure that third parties providing mental health-related services do not limit access to particular groups; that the privatization of the health sector does not threaten the availability, accessibility, acceptability and quality of mental health facilities, goods and services; that medical practitioners and other health professionals meet appropriate standards; that harmful social practices do not interfere with access to mental health services; and that third parties do not limit people’s access to mental health-related information.

16. **Obligation to fulfil:** States must adequately recognise to the right to mental health in national, political and legal systems; ensure appropriate training of medical personnel; ensure sufficient equitably distributed facilities offering mental health services; ensure mental health services are culturally appropriate and that staff are trained to recognize and respond to the specific needs of vulnerable groups; promote medical research and health education, as well as information campaigns; undertake promotional actions that create, maintain and restore the health of the population.

### **2.3.2 Immediate and progressive obligations**

17. As seen in the discussion above, the right to the highest attainable standard of mental health and the rights of persons with mental disorders are underpinned by a range of rights; both economic and social, like the right to health, and civil and political rights, like the right to information. Mirroring the ICESCR, Article

21 (2) of the Constitution provides that economic, social and cultural rights may be fulfilled ‘progressively’ over time, recognising the constraints on the state due to limited available resources. Nevertheless, the Committee on Economic, Social and Cultural Rights has identified various ‘immediate’ obligations. In the Committee’s interpretation of Article 12 of the ICESCR, immediate obligations on the right to health include:

- To guarantee that the right to health will be exercised without discrimination of any kind.
- To take deliberate, concrete and targeted steps to move as expeditiously and effectively as possible towards the full realization of this right.

18. In addition, States have an immediate obligation to ensure the satisfaction of, at the very least, the “minimum essential levels” of each of the rights enunciated in the Covenant, including essential primary health care. This is called the “minimum core obligation”. The minimum core of the right to health, with specific reference to mental health, is outlined below:<sup>14</sup>

- To ensure access to the underlying determinants of health, including the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone. basic shelter, housing and sanitation, and an adequate supply of safe and potable water.
- To provide essential drugs, as defined, from time to time, under the WHO Action Programme on Essential Drugs.
- To ensure equitable distribution of all mental health facilities, goods and services.
- To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the mental health concerns of the whole population; which should be devised and periodically reviewed through a participatory and transparent process.
- Of comparable priority with respect to mental health are the obligations to:
  - o provide education and access to information concerning the main mental health problems in the community, including methods of preventing and controlling them; and

<sup>14</sup> As drawn from the Committee on Economic, Social and Cultural Rights General Comment No. 3 on the nature of States parties obligations, read together with the Programme of Action of the International Conference on Population Development and the Alma-Ata Declaration. See Hunt, *supra* note 11.

- o provide appropriate training for mental health personnel, including education on mental health and human rights.

19. Article 20(5) of the Constitution provides that if the Government claims it cannot implement a right enshrined in Article 43, it must show that “in allocating resources, the State shall give priority to ensuring the widest possible enjoyment of the right or fundamental freedom having regard to prevailing circumstances, including the vulnerability of particular groups or individuals”. This reflects the international principle that failure to meet minimum essential levels of a right amounts to a *prima facie* presumption the state has violated its obligations to fulfil the rights enshrined in the Covenant; a presumption that can only be discharged if the state demonstrates every effort has been made to use all resources at its disposal to satisfy those minimum obligations as a matter of priority.

## CHAPTER THREE |

### Findings of the Human Rights Audit

1. As outlined in Chapter Two, the Government has an obligation to respect, protect and fulfil the right to the highest attainable standard of health, as well as the rights of persons with mental disorders. In conducting its audit, KNCHR focused primarily on determining the extent to which the Government is meeting its obligation to progressively fulfil the right of persons with mental disorders to treatment and care. In this context, stakeholders raised a number of barriers to the provision and utilisation of mental health care services. In some instances, these barriers may themselves amount to human rights violations. For example, stakeholders referred to cases where individuals are taken to traditional healers against their will, where they are mistreated. Although the audit does not make specific findings on all of these barriers, they are noted as issues on which further action is needed.

#### 3.1 High prevalence and low detection of mental disorders

2. Mental disorders are a major public health concern. Global estimates are that 25 percent of people will experience a mental health disorder in their lifetime; with approximately 10 percent of the general adult population and 20 percent of patients seeking primary care presenting with symptoms at any one time.<sup>15</sup> These included unipolar depressive disorders, bipolar affective disorder, schizophrenia, epilepsy, alcohol and selected drug use disorders, Alzheimer's and other dementias, post traumatic stress disorder, obsessive and compulsive disorder, and panic disorder, and primary insomnia. This works out to around one in four families having at least one member suffering from a mental disorder at any point in time.<sup>16</sup>

3. Further, children and adolescents experience specific disorders, generally classified as either disorders of psychological development, characterized by impairment or delay in the development of specific functions such as speech and language (dyslexia) or overall pervasive development (e.g. autism); or behavioural and emotional disorders, including attention deficit or hyperactivity disorder, conduct disorders and emotional disorders. Though the prevalence figures vary

15 WHO 2001, *The World Health Report 2001—Mental Health: new understanding, new hope*, p.25.

16 Above, at p.24

considerably between studies, it seems that 10–20 percent of all children have one or more mental or behavioural problem.

4. Not only are mental disorders highly prevalent, they are also highly disabling. Mental disorders contribute to poverty and vulnerability; placing colossal economic and social burdens on an individual, their family, the community and society at large. WHO estimates that mental disorders account for four of the 10 leading causes of disability worldwide, which amounts to a huge cost in terms of human misery, disability and economic loss.<sup>17</sup> In disability-adjusted life years (DALYs), a metric used to quantify the burden of disease that can be thought of as the lost years of 'healthy' life, it was estimated that mental disorders accounted for 12.3 percent of the total DALYs lost due to diseases or injury and is predicted to rise to 15 percent in 2020.<sup>18</sup> Additionally, there is an over-representation of people with mental disorders in prisons; in a number of cases because their behaviour is seen as disorderly and because of other factors such as drug-related crime and driving under the influence of alcohol.<sup>19</sup> Further, the prison context, characterised by overcrowding, lack of privacy, enforced isolation and violence, tends to exacerbate mental disorders.<sup>20</sup>

5. Psychiatrists consulted during the audit confirmed that rates in Kenya reflect this global trend. Research suggests that up to 25 percent of out-patients seeking care in health facilities will suffer from some kind of mental health condition, such as depression, post traumatic stress disorder (PTSD), panic disorder, generalised anxiety disorder, alcohol dependence or obsessive compulsive disorder.<sup>21</sup> For in-patients this estimate leaps to 40 percent.<sup>22</sup> Already vulnerable groups, such as people with serious or chronic physical illnesses, children and adolescents with disrupted upbringing, people living in poverty or difficult conditions, the unemployed, survivors of violence, and elderly persons, are more likely to have higher rates of mental health conditions. Substance abuse in Kenya is also widespread and cuts across all social strata. Rates of alcohol and substance abuse disorders have been estimated at around 25 percent among patients in general health facilities in Kenya.<sup>23</sup>

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17 Above, at p.3.

18 Above, at p.25.

19 Above, at p.103.

20 Hunt, *supra* note 11, at para.11

21 Ndetei & Muhangi, *supra* note 2.

22 Above.

23 Ndetei D et al 2009, 'Prevalence of Substance Abuse Among Patients in General Medical Facilities in Kenya', *Journal of Substance Abuse*, 30 (1), 182-190.

6. However, there is generally a very low detection rate for mental disorders, including alcohol and substance abuse disorders. In one study, only 4.1 percent of patients had been diagnosed with a mental health condition, while the researchers' diagnoses showed a prevalence rate of 42.3 percent for depressive symptoms.<sup>24</sup> Similarly, the study on substance abuse referred to above showed a 0.1 percent clinicians' pick up rate for alcohol use.<sup>25</sup>

### **3.2 Inadequate legal and policy framework**

7. That a significant percentage of people in Kenya will experience some form of mental disorder in their lifetime and that approximately 4 million people suffer from a mental disorder at a given time—most of whom will not ever be properly diagnosed—indicates that a significant proportion of the population does not enjoy their right to the highest attainable standard of health. To respond to this high burden of mental disorder, the Government is obliged to 'take steps', to enable people to enjoy their right to mental health, including appropriate legislative, administrative, budgetary, judicial and other measures, as explained in Chapter Two. However, as the discussion in this section shows, there have been minimal efforts to that end. While some positive measures have been put in place, there is a long way to go to effect the progressive realisation of the right to health and to health care.

#### **3.2.1 Shortcomings in the Mental Health Act**

8. The current Mental Health Act came into operation in 1989. Its introduction marked a significant change in the care of people with mental disorders. Whereas the former Mental Treatment Act of 1959 only covered the handling of patients (e.g. their hospitalisation, discharge, repatriation and the management of their property) the new legislation made some attempts to de-stigmatise mental disorders by making mental health care less centralised; allowing any hospital to be gazetted as a mental hospital; simplifying admissions procedures; integrating mental health services within the nation's general governmental services; and protecting the right of people to request treatment.

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24 Above.

25 Above.

9. Nevertheless, while the Act was progressive when it was developed in 1989, it has not been amended since 1991. As a result, some of its provisions are outdated or are not in line with international standards and the Constitution of Kenya.

Particular issues raised during the audit included:

- **Unclear definition of mental disorder:** Section 2 of the Act defines a person suffering from mental disorder, as ‘a person who has been found to be so suffering under this Act and including a person diagnosed as a psychopathic person with mental illness’ and a person ‘suffering from mental impairment due to alcohol or substance abuse’. As a participant at the stakeholders’ meeting explained, this unsuccessful attempt to differentiate between mental illness and mental disability is the cause of its shortcomings. In their view, a clearer understanding of mental disorder is needed and so the Act must be sorted out before a policy is adopted on the issue.

- **Narrow focus of the Act:**

The Act is focused primarily on in-patient admission and says very little from a human rights perspective. While there are some limited protections for persons with mental disorders (e.g. on the administration of their estate, prohibition of ill-treatment in hospital, examination of females), issues such as consent to treatment, confidentiality, access to information, and conditions in mental health facilities are not addressed.

- **Treatment model out of date:** With its focus on in-patient treatment, the Act does not promote access to interventions such as counselling, psychotherapies, aftercare and rehabilitation services. In this sense, it does not reflect the WHO model for an optimum mix of mental health care

***Mental health care law: ten basic principles (WHO, 1996)***

1. *Promotion of mental health and prevention of mental disorders*
2. *Access to basic mental health care*
3. *Mental health assessment in accordance with internationally accepted principles*
4. *Provision of the least restrictive type of mental health care*
5. *Self-determination*
6. *Right to be assisted in the exercise of self-determination*
7. *Availability of review procedures*
8. *Automatic periodic review mechanism*
9. *Qualified decision-makers*
10. *Respect for the rule of law*

services, which prioritises the integration of mental health services with general health care within the community and at the primary care level.

- **Broad criterion for involuntary admission:** Section 14(1) of the Act provides for involuntary admission when a patient is ‘suffering from a mental disorder and is likely to benefit by treatment’, upon application by a spouse, relative or other person connected to the patient and with a recommendation signed by a medical practitioner. This criterion gives much more scope for admitting involuntary patients than the criteria in the UN Principles for the Protection of Persons with Mental Illness.
- **No procedural safeguards for involuntary treatment:** Under section 13(1) of the Act a voluntary patient who becomes ‘incapable of expressing himself as willing or unwilling to continue to receive treatment’ can be retained for up to, but not exceeding, 42 days. But the Act is silent on the procedure for providing treatment to such a patient during this time.
- **Other issues not addressed:** There are a number of issues completely left out of the Act, for example, the role of carers of people with mental disorders and the regulation of traditional healers. As a participant in the stakeholders’ forum noted, people tend to mix faith healers with contemporary treatment, but this can be harmful in more serious cases if it delays care. The promotion of mental health and prevention of mental disorder is another core principle of mental health care that is not addressed in the Act.
- **Outdated provisions:** some provisions have not kept up to date with technological advances, for example, section 40 giving the person in charge of a mental health facility the discretion to retain communications to a patient is restricted to letters.

10. The Director of Mental Health agreed that the Act was outdated and needed to be revised. Similarly, the Minister of Medical Services reported that the Act is on the list of laws to be reviewed and aligned with the Constitution. He also noted that a draft bill on counsellors, psychotherapists and psychologists is currently being reviewed with a view to regulating the training, registration, curricula and practice of individuals and organizations offering counselling and psychosocial interventions.

11. Furthermore, the Act has not been properly implemented. Specifically, section 4 of the Act provides for the establishment of the Kenya Board of Mental Health, while section 7 enables the Minister to appoint district mental health

councils to which some of the Board's functions may be delegated. However, while the Board has been gazetted, it has not received a vote in Parliament for its expenses as it should under section 8(1) of the Act. Stakeholders informed KNCHR that it has been largely inactive for this reason. Section 5 of the Act sets out a number of important functions the Board is expected to perform, including to approve the establishment of mental hospitals; consult with the Minister on rules for the control and proper management of mental hospitals; inspect mental hospitals; receive and investigate matters referred by patients or their relatives concerning treatment and recommend remedial action; order the discharge of patients; coordinate mental health care activities in Kenya; advise the Government on the state of mental health; and organise community-based programmes. The fact that these functions are not being performed is a matter of serious concern. The Mathari administration confirmed that the Board has visited the facility only once; an indication that the Board may exist on paper, but is latent in practice.

12. The Director of Mental Health attributed the lack of implementation of the Act to the inactive role played by the Mental Health Board in promoting mental health; in turn caused by lack of funding. He said that the Board has rarely been meeting (on average once a year) and is not performing its functions. To be specific, the current allocation for the board for each financial year is 500,000 Ksh. The Director noted that for the first half of the financial year, the Board received 250,000 Ksh, which he said was not enough to even hold a board meeting. Similarly, district mental health councils have not been appointed because of lack of funds.

13. Further, provisions of the Act that set out offences under the Act have not been enforced. Specifically, section 46(2) provides that an insurance company that expressively excludes or 'puts restrictions on' the treatment of a person suffering from mental disorder shall be guilty of an offence. However, a participant at the validation workshop reported that the insurance industry is flouting this provision by imposing caps on the benefits payable for mental health care services.

14. Operationalizing the Act has been further delayed as the Minister has not enacted regulations, which he is empowered to do, in consultation with the Board, under the section 54 of the Act. Such regulations should govern the equipment, administration, control and management of mental hospitals; the care, treatment and rehabilitation of persons suffering from mental disorder, the procedure for admitting out-patients; the better carrying out of the provisions of the Act. The

Minister noted that he had not promulgated such regulations, because he is focused on improving the Act itself.

### **3.2.2 No policy framework on mental health**

15. Further, Kenya does not have a mental health policy in place; leaving a serious policy vacuum in the area. Although a National Mental Health Policy has been drafted, it is yet to be finalised; over seven years after it was first drawn up. The draft policy was prepared in 2003 but not adopted. It was then revised in 2007 and several stakeholder meetings were held in an attempt to fast track its finalisation. This draft of the policy, according to the Director of Mental Health, was derived from Vision 2030, the Constitution and the National Health Sector Strategic Plan. Although the policy was reportedly finalised, the process again stalled because of lack of finances.

16. With the entry into force of the new Constitution, the process has stalled even further as relevant policy makers argue that the policy now has to be aligned with the Constitution. In particular, devolution of the health sector is being discussed, with 25 bills related to health expected to soon be tabled before parliament. However, one participant in the stakeholders' forum argued that devolution is an excuse. Kenya does not lack a legal framework, but rather lacks political will. Thus, the real question is how to advance advocacy and ownership about mental health to ensure that when the bills aligning the health sector to the new Constitution are tabled, mental health is not forgotten. According to the Director of Mental Health, the current approach is to have a final national stakeholder's forum, after which it is expected that a Sessional Paper will be prepared for approval by the Cabinet. However, lack of funds has continued to weigh down these efforts.

17. The primary goal of the policy, as currently drafted, is to reduce inequalities in the allocation of health resources and improve access to mental health services to all Kenyans, especially to the poor and vulnerable groups. A number of strategies are proposed to achieve this goal, including to: develop a national mental health plan; review and revise the Mental Health Act and develop rules and regulations for the implementation of the Act; develop national guidelines and standards on prevention, care, treatment and rehabilitation of persons with mental disorders and with substance-related disorders; and to develop a national mental health management information system. While these strategies would

make a significant contribution to advancing mental health in Kenya, the draft lacks a clear roadmap to effect their implementation, which is essential to ensure the policy is not merely an aspirational document.

### **3.2.3 Health sector policy silent on mental health**

18. In Kenya health care services are centred on the Kenya Essential Package for Health (KEPH), a single package that focuses its interventions toward the improvement of health at different phases of the human development cycle. These services are provided at each of the six levels:

- Level 1, the community level, allows the community to define its own priorities so as to develop ownership and commitment to health services and focuses on empowering communities with health information and skills.
- Levels 2 and 3 are, respectively, the dispensaries and health centres and maternity/ nursing homes, which primarily handle primary and preventive care, but also some curative services.
- Levels 4–6 are the primary (district), secondary (provincial) and tertiary (national) hospitals, which focus mainly on the curative and rehabilitative aspects of the service delivery package.

19. In the view of the Director of Mental Health, mental health is already encompassed in various policies, plans and programs that govern the health sector generally. It is clear that improvements in the health sector generally can positively impact on the mental health sector. Vision 2030, for example, prioritises a number of interventions that could benefit mental health, such as de-linking the ministry of health from service delivery; rehabilitating rural health facilities to offer integrated care; and training community health workers. However, a trickle down benefit cannot be assumed and a clear articulation of how mental health will be integrated in these initiatives is needed.

20. The Second National Health Sector Strategic Plan 2005-2010 (NHSSP II), for example, sets the following targets in relation to mental health to be achieved by 2010:

- At least one community-owned resource person (CORP) in each village trained in the identification, referral and follow-up of mental illness in 10 districts.
- All hospitals integrate mental health into their services.

21. It is not clear that these targets have been met. Further, a quick review of the annual operations plans (AOPs)—prepared by the Ministry of Medical Services (MOMS) and the Ministry of Public Health and Sanitation (MOPHS) to translate the NHSSP II into the year’s priorities, targets, activities and resources—suggests that rather than scaling up activities to achieve these policy targets, prioritized outputs are becoming less ambitious over the years and are merely repeating outputs that had not been achieved the year before, as shown in the table below.

AOP4 (Jul-08 to Jun-09)	AOP5 (Jul-09 to Jun-10)	
<ul style="list-style-type: none"> <li>• National psychosocial disaster coordinating committee formed.</li> <li>• National mental health policy document reviewed and adopted.</li> <li>• Public educated on mental health issues through the mass media.</li> <li>• 5,000 copies of the national guidelines printed and distributed to the health workers.</li> <li>• Mental Health Act rules and regulations developed.</li> <li>• District mental health councils appointed in line with the Mental Health Act section 7.</li> <li>• Two additional psychiatric units established and equipped.</li> <li>• 2 ECT machines and 2 anaesthetic machines procured.</li> <li>• 150 health workers per province and stakeholders trained on psychosocial interventions.</li> <li>• Trainings carried out: 2 staff trained in MMed, 4 nurses in higher diploma in psychiatric nursing, 1 psychiatric nurse trained in master’s in psychiatric nursing and 2 social workers trained in master’s in medical social work.</li> <li>• Quarterly supportive supervision carried out in health facilities.</li> <li>• 2008 World Mental Health Day observed.</li> <li>• Quarterly Board of Mental Health meetings held.</li> <li>• Quarterly Board of Mental Health inspection tours held.</li> </ul>	<ul style="list-style-type: none"> <li>• National mental health policy document finalized</li> <li>• National mental health policy disseminated</li> <li>• Quarterly support monitoring and evaluation of mental health services conducted.</li> <li>• Quarterly Kenya Board of Mental Health meetings held and board inspection visit done</li> <li>• World mental health day observance planned and commemorated countrywide</li> </ul>	
	<th data-bbox="736 1110 1153 1161">AOP6 (Jul-10 to Jun-11)</th>	AOP6 (Jul-10 to Jun-11)
	<ul style="list-style-type: none"> <li>• Mental health strategy developed</li> <li>• Substance use disorder treatment protocol developed</li> <li>• Mental health policy finalized</li> <li>• Public and health care providers sensitized on mental health</li> <li>• 500 service providers trained in drug treatment and rehabilitation</li> <li>• World Mental Health Day observed</li> <li>• 150 hospitals equipped with mental health equipment</li> </ul>	

**Figure 1: selected outputs from the fourth, fifth and sixth Annual Operations Plans**

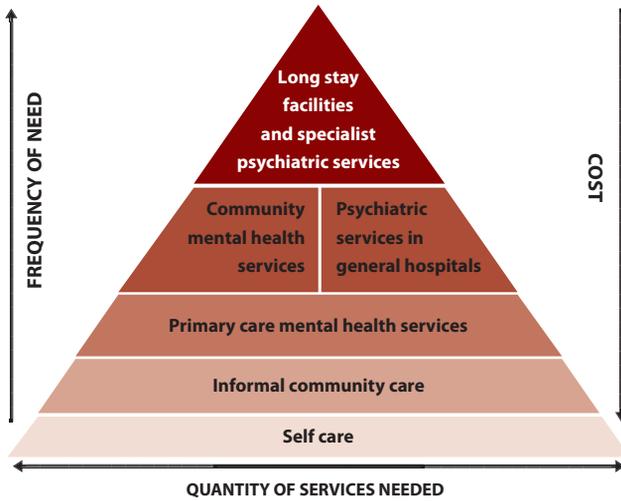
22. Participants at the stakeholders' forum were also of the view that the current health sector policy framework is basically silent on mental health. At the same time, participants also felt that there are too many documents in the health sector: policies run out every five years; hospital staff are not privy to documents; and there are certain guidelines (e.g. on public/private partnerships) that even ministry staff do not know about. The 'Mental Health Strategic Action Plan' that was adopted under the framework in 2004 was basically a short list of bullet points put together by the director at the time. Progress on other strategies, such as the Five Year Plan for Mathari Hospital, has not been consistently reported on.

23. The Minister of Medical Services indicated in his letter to KNCHR dated 23 June 2011 that the Ministry is committed to ensuring that mental health is adequately included in the formulation of Kenya's Health Sector Policy Framework (2011—2030). He also outlined a number of administrative measures that the Ministry has taken or plans to take: for example to grant Mathari Hospital a status and level equivalent to Kenyatta National Hospital and MRTH, as a national referral health facility belonging to the National Government as per Fourth Schedule Part 1 No.23 of the Constitution. The Ministry has also instructed all Provincial Directors of Medical Services and Medical Superintendents to ensure all hospitals provide quality and equitable mental health services by:-

- Including both male and female psychiatric wards in all hospital master plans where they have been excluded.
- Including mental health services in health plans and implementation plans.
- Including mental health plans in hospital master plans.
- Including mental health services in the medium-term expenditure framework (MTEF) budgeting process.
- Building capacity to provide in-patient, out-patient and outreach mental health services.

24. While such an instruction would significantly improve the provision of mental health care services, it is unlikely to be achieved without additional support from MOMS headquarters. As a participant at the stakeholders' forum explained, part of the reason that mental health is being neglected by provincial and district hospitals is that there are competing interests from other health issues. Because partners are not interested in mental health (instead they are overly focused on HIV/AIDS), hospitals are only treating in areas that they know will attract funding.

### 3.3 Deficiencies in the delivery of mental health care in Kenya



**Figure 2: Optimal mix of mental health care services**  
Source: WHO

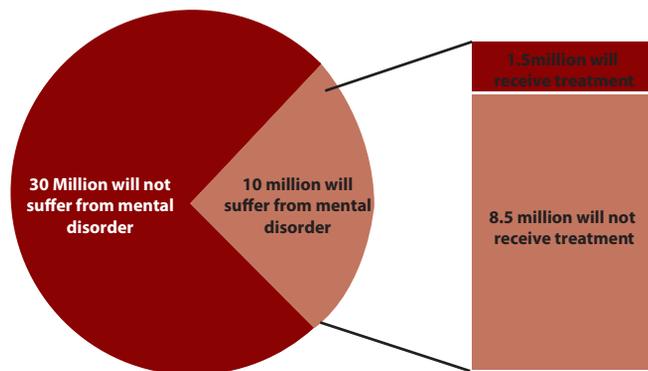
25. In the words of the Minister for Medical Services, ‘currently there is a very big gap existing between the mental health needs of Kenyans and the existing mental health services at all levels of the health care services delivery system’. As shown in the diagram to the left, WHO has developed a model describing the optimal mix of mental health care services. The model emphasizes integrated

primary mental health care, supported by other levels of promotion, prevention, treatment and care within the community and in hospitals. This section assess the extent to which these services are available, accessible, acceptable and of adequate quality. As outlined in Chapter 2, the steps a government takes to fulfil the right to health should be designed to improve services against these criteria. It concludes that the legal and policy framework governing mental health in Kenya, as it is currently, has not enabled the provision of effective service delivery on the ground.

#### 3.3.1 Limited availability of services create a high treatment gap

26. Around the world, the proportion of those who require mental health care services but do not receive them remains very high. This “treatment gap” is estimated to be between 75 to 85 percent for low and lower middle income countries.<sup>26</sup> Given the percentage of the population likely to suffer from a mental disorder in the course of their lifetime is estimated at 25 percent, this equates to approximately 8.5 million people in Kenya that are not receiving the care they need. Another gap highlighted by a participant at the validation workshop is for carers and families who may require counselling to cope with the disorder of a relative.

<sup>26</sup> See WHO 2008, *Scaling up care for mental, neurological, and substance use disorders*, at p.4.



**Figure 3: Estimated Treatment Gap in Kenya**

**Source: own calculation based on WHO global estimates**

27. The lack of mental health care services in the community and in primary care facilities was raised during the stakeholders' forum. According to BasicNeeds, a community mental health strategy in Kenya is "yet to take off". As a result, mental health care in the public sector is provided from the district level (four) upwards.<sup>27</sup> A baseline study conducted by BasicNeeds in Laikipia, Meru South, Nyeri and Nyandarau, found that mental health services were generally only provided in sub-district and district hospitals, with lower level public facilities referring suspected cases. The capacity of these higher level facilities to provide out-patient care at the community level is extremely stretched. At RVPGH, for example, the psychiatric ward has two out-patient clinics: one at the hospital and the other at Langalanga. However, the catchment area is extremely large, according to staff interviewed.

28. Further, the in-patient capacity of psychiatric wards at the district and provincial levels is extremely limited. Although the Mental Health Act specifies what a mental hospital is—all hospitals above district level can admit psychiatric patients and are considered mental hospitals for the purpose of the Act, several private hospitals too—one spot check referenced during the stakeholder forum reported that less than 80 districts were offering mental health services.

29. The availability of psychotropic drugs is another issue. In the case of Mathari Hospital, for example, the supply of drugs by the Kenya Medical Supplies Agency (KEMSA) was reportedly erratic, making it necessary for the administration to procure drugs privately. To complement KEMSA's supply, the hospital sets aside 1 million

<sup>27</sup> BasicNeeds 2011, *Respecting the Rights and Needs of Persons with Mental Illness*, Baseline Study Report, p.5.

Ksh per quarter from funds collected in the private wing and other out-patient services. Participants in the stakeholders' forum also noted the availability of drugs for out-patients was major challenge; a concern reflected in the BasicNeeds baseline study.<sup>28</sup> Patients might wait in line for a whole day, only to be told that there are then no drugs available. For out-patients, antidepressants have been available at the primary care level in the essential medicine list since 2008. However, the historical lack of antidepressants at level 2 and 3 facilities has reportedly led to the widespread but inaccurate prescription of diazepam.<sup>29</sup>

30. Participants at the stakeholders' forum highlighted the fact that vulnerable groups are being denied care. Participants agreed that 'virtually nothing' has been done for children and youth. For example, there are children who have been experiencing seizures since infancy, who still have not received treatment as teenagers. There are very few child psychiatrists in Kenya (only two fully-specialised) and paediatricians are not well-trained in mental health. At RVPGH, for example, the psychiatric ward only admits patients over 13 years and these patients are accommodated together with adults. Minors below 13 are normally admitted in the general wards, but cases have been few.

31. Criminal offenders are another vulnerable group denied appropriate care. This is because of a shortage of nurses, which means medication is not administered properly in prisons; slow transfer times to Mathari Hospital, especially when prisoners are on remand and yet to be tried; and rejection by family or community once in custody, leaving them without support after release.

32. The lack of rehabilitation and reintegration services, such as halfway houses, was also raised as an issue by staff at the hospitals visited, as well as during the stakeholders' forum. Rehabilitation services are crucial to avoid rejection and relapse, especially in cases such as RVPGH, where most patients, especially the youth, suffer from substance abuse. However, halfway houses are virtually non-existent and when they are available they are provided by well wishers. The MS at Mathari Hospital was a particularly strong advocate for the establishment of government-provided halfway houses across the country.

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28 Above, at p.34.

29 Above.

### 3.3.2 *Inaccessible services*

33. As noted above, mental health care services have not been prioritized at health centres and dispensaries which make up the primary levels of care. These services are provided at the district, provincial and national referral levels which are not easily accessible to people in the communities. Concentration of such services at these 'higher level' facilities has left a huge gap in mental health service provision at the lower levels, denying users of mental health services benefit from the much publicized 'Community Strategy for Delivery of Health Services' initiated by the Ministry of Public Health and Sanitation (MPHS).

34. Further, while in-patient services are supposed to be decentralised to the district level, almost 70 percent of beds available in public facilities are located in Nairobi. So many patients still travel long distances to Nairobi to seek treatment. The total number of public hospital beds for a population of over 38 million is 1114: 750 beds at Mathari; 40 beds at MTRH; 100 beds at Gil Gill; 6 provincial units of 22 beds each at Nakuru (Rift Valley), Kisumu (Nyanza), Nyere (Central), Embu (Eastern), Port Reitz (Coast), and Kakamega (Western); and only 5 district units (Machakos, 22 beds; Isiolo, 10 beds; Kerugoya, 20 beds; Muranga, 20 beds; Meru, 12 beds; and Siaya, 8 beds). This means there are only 22 public beds per 4 million population in most provinces, which calculates to 1 bed per 200,000 population.<sup>30</sup> So while overall, Kenya has considerably more beds available than the regional average, outside of Nairobi, it is lagging behind.

35. Over-centralisation is also an issue with mental health personnel. In 2009 there were 46 psychiatrists in the public service, of which 28 were based in Nairobi.<sup>31</sup> This means that the effective psychiatrist to population ratio outside Nairobi is 1 per province of 3-5 million. North Eastern Province currently has no psychiatrist. This means that while Kenya compares favourably to the regional average of 5 psychiatrists per 10 million population, at 12 psychiatrists per 10 million population,<sup>32</sup> outside Nairobi it lags behind with only 2-3 per 10 million.

*At the current rate of production it will take about 100 years to produce enough psychiatrist to have one in each district or county as recently demarcated in the devolved government system.*

30 Kiima and Jenkins, *supra* note 4.

31 Above.

32 WHO 2011, *Mental Health Atlas 2011*, at p.56

According to Kiima and Jenkins, ‘at the current rate of production it will take about 100 years to produce enough psychiatrists to have one in each district, taking account of retirement, and assuming no further brain drain’. The situation is similar for psychiatric nurses. Of the 418 trained psychiatric nurses in Kenya, only 250 are deployed in psychiatry. Of these, 70 are based in Mathari, leaving only 180 in the districts and provinces. This equates to less than one psychiatric nurse per district. Again, North Eastern Province is without a nurse.

36. In addition to physical inaccessibility, problems with the affordability of mental health services were also raised by stakeholders. At Mathari, for example, there are low NHIF collections and a high number of waivers granted by the hospital, which will accept anything patients can pay. While in-patients are charged 200 Ksh, 400 Ksh or 1,800 Ksh per day, depending on the level of accommodation, it costs the hospital 1,000 Ksh per patient per day. A participant at the validation workshop flagged that the coverage for psychiatric treatment offered by private health insurance is capped at a certain amount per year, which is not enough to cover all expenses.

37. Participants at the stakeholders’ forum also commented that a lack of information for patients about mental health services inhibits accessibility. For example, the Government’s eHealth website does not list facilities offering mental health services. Mathari’s notoriety and lack of awareness about alternatives means that many patients will still travel there, rather than seek treatment in facilities near their homes. The BasicNeeds study similarly found that while rehabilitation services and development services might be available, potential beneficiaries have not been able to access them due to a lack of proper sensitization by the Government.<sup>33</sup>

### **3.3.3 Poor quality services**

38. Stakeholders also raised concerns about the quality of mental health care provided in facilities in Kenya. Regarding in-patient care, for example, a high bed occupancy rates hinder effective service delivery. At Mathari Hospital the average bed occupancy is 85 percent for the Maximum Security Unit and 105 percent for the civil units. At present, two wards are under renovation and during its visit KNCHR staff observed some beds did not have mattresses, causing more overcrowding in wards. MTRH, on the other hand, had the highest bed occupancy rate, at over 200 percent.

<sup>33</sup> BasicNeeds, *supra* note 27, at p.35.

39. Staff at Mathari Hospital also noted challenges caused by poor physical infrastructure, which undermine its effectiveness as mental health facility focused on rehabilitating patients. Originally built as a small pox isolation ward in the 1900s, the buildings at Mathari Hospital are now dilapidated. Their 'prison like' design makes them difficult to administer and not conducive to the objectives of institution. Further, internal roads do not have tarmac, ventilation in the buildings is poor, there is insufficient internal and external lighting, and sewerage blockages are common. In the view of the MS, the hospital's buildings should be demolished and rebuilt. RVPGH faces similar infrastructure challenges, such as an inaccessible layout and lack of proper lighting and ventilation, as its buildings were originally constructed as military barracks in 1912. By contrast, Port Reitz is a new and well built facility.

*Originally built as a small pox isolation ward in the 1900s, the buildings at Mathari Hospital are now dilapidated. Their 'prison like' design makes them difficult to administer and not conducive to the objectives of institution.*

40. Sanitation conditions are also poor. During its visit to RVPGH, KNCHR observed that accommodation at the psychiatric ward was unclean and unhygienic, with some rooms smelling and covered in urine. The team was also reliably informed, though this is subject to further interrogation, that the ward is not regularly cleaned and that it is, in fact, the patients who are made to clean the ward. This environment is not conducive to the quick recovery of the patients. In the case of Port Reitz where there was a cleaning agency that conducted regular cleaning, it was unclear why patient were wearing soiled clothing and the toilets and bathrooms released bad odour. The ward suffered from erratic water supply that was dependent on the water pressure (it was the most affected ward in the hospital); a fact that made the sanitation levels at the facility uncertain when there was no water.

41. Infrastructure challenges are compounded by fact that mental health facilities are under-equipped. For example, Mathari Hospital only has one ambulance. On grounds where buildings are spread out across 70 hectares of land, the ambulance is needed to transfer bodies to the mortuary, take referral patients to Kenyatta and assist the workers in their patrol of the hospital. At MTRH, patients seeking Electro Convulsive Therapy (ECT) are currently being referred to Kenyatta National Referral hospital since the ECT machine has broken down. At RVPGH, staff reported that they depended on the families of patients to provide supplies like soap, toothpaste and tissue and warm clothing.

42. Lack of food was a specific allegation raised against Mathari Hospital. However, at all facilities inspected staff confidently reported that the patients had food in sufficient quantities. The MS at Mathari explained that the psychotropic drugs commonly used to treat mental illness significantly increase the appetite of a patient so their dietary needs are high. The quality of the food also appeared reasonable. In light of the complaint, however, this issue should be regularly assessed to ensure that food quantity and quality are constant, rather than an “effect” prompted by the knowledge of an impending visit.

43. Lack of staff also hinders the quality of services offered in mental health facilities around the country. There are high patient to staff ratios in mental health facilities, as shown in the table below. The staff at Mathari Hospital, the Medical Superintendent (MS) narrated, are stressed and need better working conditions to do their best in service delivery.

	<b>MTRH</b>	<b>Mathari</b>	<b>RVPGH</b>	<b>Port Reitz</b>
In-patient bed capacity	25	700	26 (13 M; 13 F)	72
Bed occupancy rate	200%	105%	160%	117% for the male ward
No. of psychiatrists	8 (2 in admin)	5 (2 in admin)	1	0
No. of clinical officers			n/a	0
No. of nurses		200 (23 male)	14 (psychiatric)	5 (Psychiatric)
No. of other staff			3 social workers	4
Staff-to-patient ratio		80:1		
No. of out-patients (p.w.)	80			

**Figure 4: Capacity of selected mental hospitals<sup>34</sup>**

44. Insecurity at the hospitals is another issue. At Mathari Hospital, for example, the grounds do not have a full perimeter fence, and are only patrolled by three government guards. The maximum security unit lacks guards. There have been cases of robberies by slum residents neighbouring the hospital, and both patients and staff have been attacked by other patients. Staff members are not insured for harm occasioned by these attacks, nor do they receive compensation. The MS at RVPGH noted that incidences of patient aggression have been nominal, as aggression decreases when patients are medicated, but noted that when such isolated incidences of violence do occur, they are normally meted out against staff.

<sup>34</sup> Figures given by hospital administration as of the day of the visits.

### Key findings on the quality of in-patient care

- All three facilities inspected were overcrowded
- All the three facilities were understaffed
- Buildings at Mathari and RVPGH were dilapidated, isolated and poorly ventilated.
- Sanitation in all the three facilities was poor, especially the bathrooms smelt foul.
- Hygiene at Port Reitz and RVPGH was low with patients wearing soiled uniforms.
- Quantity and quality of food at all the three facilities was reasonable.

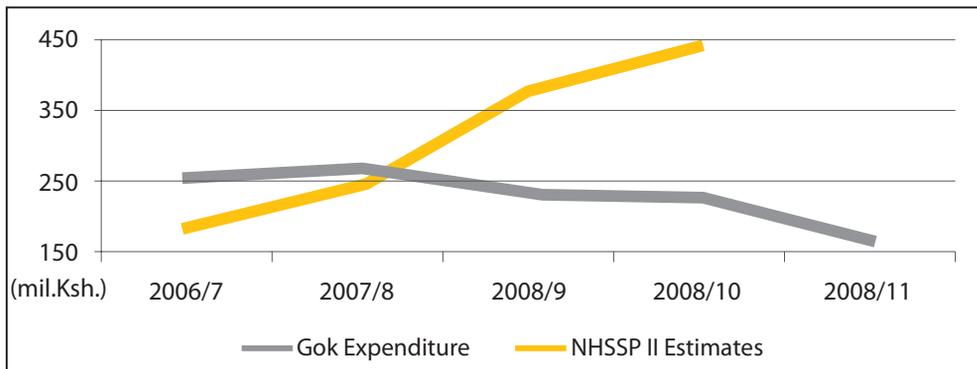
45. The quality of counselling services was also questioned by participants at the stakeholders' forum, as most of the counsellors engaged by the Ministry to counsel persons living with HIV/AIDS or even persons displaced during the post election violence are unqualified to offer these services. Their efforts are counterproductive. They cannot handle the aftermath of their counselling especially when a patient sinks further from trauma for instance due to post traumatic disorder.

#### **3.3.4 Lack of transparency in policy development and implementation**

46. Participants at the stakeholders' forum reported that there are limited opportunities for broad stakeholder engagement in the mental health sector and that there is a lack of honesty, transparency and independent oversight and there are no channels of complaint. For example, allegations of abuse go to the person in charge of hospital (who is to organise an examination). KNCHR observed that staff at Mathari Hospital appeared to brush off patients' concerns as resulting from their illnesses. They noted, for example, that while patients frequently claim to be 'wrongfully treated', this is because they rarely accept they are sick. While this is of course a legitimate fact, it may be problematic if such an attitude leads staff to 'write off' valid issues raised by patients. The MS at RVPGH reported that the hospital has a quality assessment committee that takes account of client satisfaction. This kind of assessment is done quarterly and all patients are given an opportunity to participate. The patients are interviewed and their feedback reviewed by the hospital management. This policy was affected in 2011 upon the insistence of the Ministry of Medical Services. As discussed above, the fact that the Board is not playing its mandated oversight role is a serious concern.

### 3.4 Negligible budgetary resources for mental health

47. There was universal agreement from all stakeholders consulted that one of the major reasons for poor mental health care services in Kenya is gross underfunding. The budgetary allocation for mental health is negligible compared to the immensity of the problem. In the past five years, allocation for recurrent expenditure for mental health services has remained at around 0.25 percent of the budget of the MOMS. When indexed to inflation, this allocation has in fact decreased in real terms over this period, as shown in the figure below. Further, mental health services have not received any allocation for development expenditure and mental health services do not receive a specific budget line in the budget of the MPHS. This means the allocation for mental health calculates to around 0.1 percent of the total health budget. In the past three years, the Division of Mental Health has been receiving an additional allocation of roughly 10 mil Ksh. But the bulk of this, around 70 percent, goes to salaries and allowances for staff at Afya House.



**Figure 5: GoK Expenditure on mental health services (in real value) compared to NHSSP II estimates<sup>35</sup>**

48. Poor funding to mental health reflects the trend regionally and internationally. According to the 2011 Mental Health Atlas, in Africa an average of 0.6 percent of the health budget is spent on mental health.<sup>36</sup> In monetary terms, an average of \$0.20 USD per person is spent on mental health in low income countries and \$0.60 USD in lower middle income countries.<sup>37</sup>

35 GoK, Printed Budget Estimates 2006/7- 2010/11. NB: figures indexed to inflation at 2006 CPI.

36 WHO 2011, *supra* note 32, at p.27.

37 Above, at p.25.

49. A participant at the stakeholders' forum noted that countries like Uganda and Tanzania doing much better, even with fewer resources, so the Government should not claim it has insufficient funds. The Minister of Medical Services in his letter to KNCHR dated 23 June 2011 reported that the Ministry plans to increase funding for mental health in its budgetary allocation as well as to promote public private sector partnerships in mental health; an important boost to the sector, if achieved.

50. Further, the Minister for Medical Services noted that other ministries, specifically the Ministry of Home Affairs and the Attorney General's Department, are also responsible for mentally ill prisoners held in hospitals, such as Mathari's maximum security unit. However, they rarely provide budgetary allocations to it. The MS at RVPGH similarly noted that the most recent government policy is that prisoners should be treated free whether in-patients or out-patients. Historically, the Ministry of Home Affairs would cover these costs, but this policy has since been altered. According to Deputy MS at RVPGH, this is interfering with the budget of the Ministry of Medical Services. However, there are plans underway by the Ministry of Home Affairs to construct facilities within prisons where such patients can be treated.

51. In addition to low budgetary allocations from the Government, mental health services have failed to attract the kind of donor support that other areas in the health sector have; although Port Reitz, which received funding by the Danish International Development Agency (DANIDA) to construct its building, appears to be an exception. Most often donor funding has been 'short-term, uni-sectoral and focused on vertically implemented projects, with inadequate attention to sustainability'.<sup>38</sup> At Mathari, for example, staff reported that while the United Nations rebuilt the drug and alcohol unit and conducted some training, and that donors have supplied equipment from time to time, this is irregular. Not enough donors have shown interest in assisting the reconstruction and running of the health facility. Similarly, pharmaceutical companies do not often donate medicine (unless it is stock that is about to expire). The Director of Mental Health agreed that development partners have shown no interest in mental health and suggested that this could be attributed to lack of international advocates leaving mental health in the shadows.

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38 Kiima and Jenkins, *supra* note 4.

52. Stakeholders also raised concerns about how effectively allocated funds are being spent. At Mathari Hospital for instance, a facility improvement fund was established with which the hospital developed a few private units that would assist in the generation of income, to enable the hospital to care for all the other patients. However, participants at the stakeholders' forum were of the view that nothing tangible was achieved with this fund. The Minister reported that MOMS had dedicated 60 mil Ksh. towards the rehabilitation of Mathari Hospital, although further clarification is needed on when this allocation was made and for what it was earmarked. As the only hospital funded by the Government specifically to offer mental health services, robust oversight mechanisms are crucial to ensure such funding is well spent.

53. As outlined in Chapter 2, the Government is obligated to use the 'maximum of its available resources' to progressively realise the right to health and to health care. The extremely low allocation to mental health, which is out of line with the level of disease burden of mental disorders and has in fact declined in recent years, indicates that the Government is failing to meet this obligation.

### **3.5 Social factors affecting mental health**

54. Wide ranging factors influence individual mental health; from social to biological and from economic to cultural factors. All stakeholders stressed that political, social and economical conditions, especially stigma and discrimination against persons with mental disorders, hindered individuals' ability to enjoy their right to mental health in Kenya. Understanding and addressing these factors is essential in designing strategies for preventing violations of the rights of individuals to mental health.

*The general causes of poor mental health have been identified to include; rapid social change, stressful work conditions, gender discrimination, social exclusion, and unhealthy lifestyle, risks of violence, physical ill-health, particularly infection with HIV and human rights violations especially stigma and discrimination.*

#### **3.5.1 Stigma and discrimination widespread**

55. All stakeholders consulted identified stigma and discrimination against, not only the illness, but people with mental disorders, as the major impediment to the realization of the right to mental health. In their view, persistent stigmatization and discrimination against people with mental disorders permeates the medical profession, as well as the community. This results in social marginalisation of

persons with mental disorders; poor quality of mental health services by the health practitioners; and low and inequitable distribution of resources for mental health services.

56. Because of stigma in the community, patients are often 'denied the empathy and understanding traditionally bestowed on the sick in the African society'.<sup>39</sup> They are referred to far off facilities to keep the information about their health from being known in the community. Similarly, those who have undergone treatment are frequently abandoned upon discharge. The three mental health facilities visited complained that families and relatives of the patients abandoned them; burdening the institutions financially. The average length of stay for patients varied from one facility to the other. At RVPGH and Port Reitz the average length of stay was two weeks whereas in Mathari the average length of stay was longer; 45 days for patients on the civil side and from 60 days to 40 years for patients at the maximum security unit. Some patients stay longer in the facilities because of abandonment by their families. Moreover, some patients were reported to volunteer admission at the mental health facilities because of mistreatment at home from their family members or relatives. Stigmatization of mental disorders was identified as the critical factor that led to the rebranding of Mathari Mental Hospital to Mathari Hospital. The word 'mental' itself was considered stigmatizing.

57. Participants at the validation workshop stressed that stigma and discrimination within the community is generally caused by lack of awareness and understanding about the nature of mental disorders. As Professor Ndetei explains, many people believe that mental disorders result from either a familial defect or the 'handiwork of evil machinations'.<sup>40</sup> Researchers have also suggested that one in every 20 Kenyans would rather take a mentally-ill patient to a faith healer to be prayed for or to a witchdoctor than to a hospital.<sup>41</sup> When a mental disorder relates to alcohol or substance abuse, another common societal belief is that psychiatric patients are responsible for their illness. Such ignorance perpetuates the view of people with a mental disorder as being persons are dangerous and unpredictable, less competent and unable to live productive lives.<sup>42</sup> While NGOs and civil society groups have done much to educate communities about mental health, a systematic and government-supported programme is needed.

39 Ndetei, D et al 2011, 'Knowledge, attitude and practice (KAP) of mental illness among staff in general medical facilities in Kenya: practice and policy implications', *African Journal of Psychiatry*, vol.14, 225-235, at p.226.

40 Above.

41 Karanja, J 2011, 'Why Kenyans would rather take the mentally ill to a faith healer', *Daily Nation* (11 March 2011)

42 Ndetei et al 2011, *supra* note 39, at p.226.

58. Further, stigma and discrimination perpetuated by doctors and medical officers was reportedly a great hindrance to pursuance of psychiatry studies by medical students. Additionally, because of stigmatization, psychiatry is not emphasized as a course in the training of medical personnel in the country. Psychiatry, in comparison to other courses taught in medical school, is ridiculed and not taken seriously leading to little interest among students to pursue the subject.

59. Finally, stigma and discrimination against mental disorders among politicians and decision makers also explains the poor funding allocated for mental health in the country. Participants at the stakeholders' and facility administrators felt strongly that poor perceptions of what mental health is and its causes contributed to a widespread misunderstanding of mental health by political leaders; hence the meagre budgetary allocation. The other common misconception that has led to poor funding is that mental disorders are not fatal and therefore less of a priority. Participants at the stakeholders' forum stressed that people with mental disorders die more from other health complications than people with physical illness.

### **3.5.2 Mental health impact of HIV/AIDS not addressed**

60. Consultant psychiatrists have found a complex causal relationship between HIV and mental health.<sup>43</sup> The mental health consequences of the HIV/AIDS epidemic are substantial. HIV is neurotropic and invades the brain. For this reason, more than half of people living with HIV will develop psychiatric problems as a result of their infection. In one study 65 percent of people living with HIV/AIDS demonstrated symptoms of mild to severe depression.<sup>44</sup> In addition, the result of intense stigma and discrimination against persons living with HIV/AIDS plays a major role in psychological stress.<sup>45</sup> Family members also suffer the consequences of stigma and of the premature deaths of their infected family members.

61. People with mental disorders and infected with HIV and/or suffering from the effects of AIDS are especially at risk of 'double marginalization' in access to health services.<sup>46</sup> Again, persons suffering from mental disorders such as

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43 This causal relationship between HIV/AIDS and mental health is the subject of ongoing research by the Department of Mental Health at MTRH, working collaboratively with Physicians for Health Rights.

44 Ndeti, D et al 2009, 'The Prevalence of Mental Disorders in Adults in Different Level General Medical Facilities in Kenya: A Cross-Sectional Study', *Annals of General Psychiatry*, vol.8, issue.1

45 WHO 2001, *supra* note 15.

46 BasicNeeds, *supra* note 15

depression and schizophrenia are at a higher risk of HIV infection.<sup>47</sup> HIV care cannot be merely physical. In the views of psychiatrists consulted during the audit, to win the fight against the scourge, the mental health component is vital. It has been noted by psychiatrists that mental disorders are one of the initial signs of HIV infection. Therefore, mental health issues have to be addressed to lower the HIV prevalence rate. The gap in the management of HIV/AIDS is mental health. Once this is addressed, it is expected that the HIV prevalence rates will begin to go down in the country.

### **3.5.3 Relationship between poverty and mental health not addressed**

62. Poverty causes mental disorders directly or indirectly as a result of poor environment, poor nutrition, inadequate healthcare, low education and lesser ability to negotiate for safe sex. Mental health is thus a cause and consequence of poverty. It causes poverty through lowering the productive levels of individuals; resulting in unemployment or low income and high spending on treatment. Data from cross-national surveys show that common mental disorders are about twice as frequent among the poor as among the rich. Depression is more common in the poor than in the rich. Research on the nexus between mental health and poverty in Kenya should be undertaken to determine this relationship to guide policy and practice.

### **3.5.4 No systems for addressing trauma caused by conflicts and disasters**

63. According to WHO, between a third and a half of those affected by conflict suffer mental distress, including post-traumatic stress disorder (PTSD), depressive and anxiety disorders. The post election violence witnessed after the 2007 general elections left many psychological scars on both the urban and rural population in Kenya. The worst impact was meted on internally displaced persons (IDPs) who lost relatives, friends, homes, dignity and sources of livelihood. The Ministry of Special Programmes created a psychosocial support department that dealt specifically with counselling. During the Operation Rudi Nyumbani exercise, the Ministry contracted a team of counsellors who attended to 120277 IDPs with psychosocial needs country wide. The team referred several cases of persons suffering from mental disorders as a result of the conflict to psychiatrists but could not pin out them in numbers.<sup>48</sup> It is not clear if there were many more IDPs suffering from mental disorders that did not get psychiatric help since a number

<sup>47</sup> Interview with Dr. Atwoli, consultant psychiatrist at MTRH.

<sup>48</sup> Interview with Nazi Mwaburi, Head of Psychosocial Support Programme, Ministry of Special Programmes.

of counsellors, especially from other organizations dispatched to the camps, were unqualified and could not diagnose mental health needs of the people.<sup>49</sup>

### **3.6 Structural challenges in reforming the mental health sector**

64. In addition to limitations of the current legal, policy and fiscal framework, additional challenges facing the mental health sector were raised by stakeholders that also need to be addressed to offer accessible quality mental health services. This section highlights some of these issues.

#### **3.6.1 Insufficient training opportunities for health personnel**

65. Despite the clear human resource challenges there do not appear to be any incentive schemes to attract and retain mental health professionals. Interviews with staff at the mental health facilities revealed that personnel in the mental health sector—unlike their counterparts in the other sectors of health—do not benefit from regular professional training or continuous professional development to upgrade their knowledge in the area and share good practice. They also lamented that despite psychiatry being a specialization in medicine and nursing (for example, it is necessary to undergo further training to qualify as a psychiatric nurse) their pay remained equal to other medical personnel without specialized training. They noted that this was a dissuading factor compounding the poor and insecure working environment they were exposed to. As noted above, there is a serious shortage of psychiatric nurses. Dwindling applications for mental health nurse training are therefore worrying.<sup>50</sup>

66. In light of the fact that psychiatric disorders are often diagnosed and managed by non-psychiatrist health workers in general health facilities, training for general health personnel in mental health competencies also needs to be strengthened. While the mental health project, supported by MOMS, DfID and WHO, to expose 3000 health workers to mental health training has been a significant achievement, it needs to be sustained. This issue reflects a regional trend; few countries in Africa have trained a majority (over 50 percent) of their primary health doctors and nurses on mental health only 23 percent and 24 percent respectively have been trained. Only 25 percent of countries in the region have manuals on the management and treatment of mental disorders available in the majority of primary health care settings.<sup>51</sup>

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49 Above.

50 Kiima and Jenkins, *supra* note 4.

51 WHO 2011, *supra* note 32, at pp.33, 35.

### **3.6.2 Weak governance, coordination and regulatory systems**

67. Statistics in the health sector show that almost two thirds of facilities are operated by the private sector; either by NGOs, faith-based organisations or for-profit enterprises. While almost three quarters of doctors and almost two-thirds of nurses and clinical officers work in the private sector.<sup>52</sup> Although specific information was not gathered on the extent to which the private sector is providing mental health care services, participants at the stakeholders forum and validation workshop highlighted that it is common for families to take a mentally ill patient to herbalists and traditional healers. The standard of care in these settings varies wildly and some, it was reported, abuse their patients. During the validation workshop, the Division of Mental Health reported that it does not currently have a mandate to play a strong regulatory function to oversee these service providers. As a result, referrals between unregulated mental health service providers and out-patient mental health services located in primary care and district hospitals is weak; poorer patients consume large amounts of low-quality mental health care; and patients are vulnerable to financial exploitation and ineffective or even abusive treatment.<sup>53</sup>

68. In addition to its mandate, the capacity of the Division of Mental Health to engage with service providers at the community level is limited by virtue of both its low staff numbers and institutional positing. The division, which sits within the MOMS headquarters, is led by a deputy director of Medical Services, assisted by four public officers; a psychiatrist, a psychiatrist nurse and an occupational therapist. Stakeholders commented on the need for the division to diversify its staff and build strong relationships with colleagues at MPHS, who are more directly mandated to engage at the community and primary levels.

### **3.6.3 Lack of data and information on mental health**

69. Finally, but significantly, mental health practice and interventions in Kenya are not evidence-based owing to the huge gap created by lack of national data. There is limited epidemiological and development research on mental health at both the national and household level. In particular there is no sufficient data to show the extent and type of mental disorders in the community; the broad psychosocial determinants of mental problems; or the causal relationship between

52 See, e.g. Barnes, J et al 2009, *Kenya Private Health Sector Assessment*, pp.5-10

53 WHO 2001, *supra* note 15, at p.94

mental health and other socio-economic factors such as poverty, HIV/AIDS, conflicts and disasters and stigma and discrimination. Data collection systems to capture mental health issues at the primary care level are particularly weak, with mental disorders generally being recorded as “other illnesses”.

## CHAPTER FOUR |

### Conclusions and Recommendations

#### 4.1 Conclusions

1. From the findings of the mental health human rights audit it emerges that deeply entrenched stigma, discrimination and the misconception that mental disorders are non-fatal have severely hindered the realisation of the right to the highest attainable standard of mental health. As a consequence of stigma and discrimination, mental health has been given a low priority by politicians and policy makers. The government has failed to take deliberate, concrete and targeted steps to realise the right to mental health. As a result of inaction the mental health sector is grossly underfunded. The legislation governing the sector is outdated and has not been properly implemented. Mental health is not prioritised in a specific policy or in general health sector policies and operational plans. In addition, programming is not based on epidemiological and development research.

2. In the absence of clear policy direction, the sector has suffered from lack of both human and physical resources. Staffing numbers are woefully inadequate and personnel in the sector are overworked and de-motivated by poor pay and an insecure working environment. The lack of psychiatrists in the country means that mental health care is, for the most part, delivered by psychiatric nurses, who are themselves in short supply. Worryingly, the number of students enrolling in psychiatry is reportedly declining. The infrastructure in psychiatric wards is characterised by isolated, poorly ventilated, poorly lit and dilapidated buildings that do not provide the right environment for successful management of mental health problems.

3. The inequitable distribution of mental health facilities has limited the availability of in-patient and out-patient services at the district and community levels outside Nairobi. Of the 1114 beds in psychiatric wards the country, 70 percent are in Nairobi. Out-patient mental health services are not generally integrated in primary health care at clinics and dispensaries, limiting their accessibility for the community. Moreover, there are no rehabilitative centres to prepare discharged patients for community integration. Services that are available are of poor quality. As evidenced during the inspections conducted by KNCHR, in-patients live in crowded and unhygienic conditions.

4. Despite being an integral component of health, mental health in Kenya remains relegated compared to physical health. The government's systemic neglect of and inaction on mental health has indirectly discriminated against people with mental disorders on the basis of their health status, who, at present, cannot generally access even a minimum level of health care services. In line with the Constitution and to comply with its international obligations, the Government is duty-bound to take urgent legislative, policy-based, programmatic and budgetary measures designed to ensure that people with mental disorders have access to mental health care services, which should be firmly rooted in community and primary levels of care.

## 4.2 Recommendations

5. Having concluded that sufficient steps have not been taken to progressively fulfil the right to health and the right of people with mental disorder to treatment and care, KNCHR makes a number of recommendations to this end. The recommendations centre on five broad themes: strengthening the legal and policy framework; integrating mental health into primary health care; reducing stigma and discrimination; expanding financial and human resources; and advancing research.

6. Kenya has the potential to be a regional leader in terms of developing community-based mental health care services. With few large psychiatric institutions, there is no system to dismantle.<sup>54</sup> There is a vibrant civil society movement—of self-help groups, carers groups, community-based service providers—who are engaged in mental health advocacy. This puts the country in a strong position to achieve a human rights-based approach to mental health in the country.

7. The recommendations are based upon the findings of the audit and benefited from input by participants at the stakeholders' forum and validation workshop. They were formulated with a view to promoting discussion on and building momentum for action on reforms in the mental health sector in Kenya. Recognising the need for more detailed conceptual development, costing and prioritisation of the recommendations, KNCHR calls on all stakeholders to reflect on how best to implement them.

<sup>54</sup> See Klein J 2011, 'The Other Side of "Kenya's Terrible Secret"', at: <http://blog.soros.org/2011/03/the-other-side-of-kenyas-terrible-secret/>

## To the Ministries responsible for health

### **1. *Develop a clear roadmap for mental health in Kenya by reviewing the Mental Health Act and finalizing the Mental Health Policy.***

- Adopt a human rights based approach to the development and implementation of law, policy, plans and programmes on mental health that provides for the meaningful and active participation of people with mental disorders and their carers.
- Initiate a consultative process to review the Mental Health Act so that its focus on mental health will be from a human rights perspective (e.g. emphasising de-institutionalisation and community integration as guiding principles of care, ensuring the criminal justice system is supportive of the rights of people with mental disorders).
- To the same end, review related bills and acts that affect mental health and the rights of people with mental disorder (e.g. the Children's Act, the Prisons Act).
- Finalise the draft mental health policy with input from all relevant community and professional stakeholders and transmit it to Cabinet for adoption.
- Develop a plan of action for implementing the mental health policy, which clearly spells out strategies and timeframes; achievable indicators and targets; major activities; costs and resources; and monitoring and evaluation.
- In the interim, consider enacting rules and regulations under the Mental Health Act to oversee the equipment, administration, control and management of mental hospitals; the care, treatment and rehabilitation of persons suffering from mental disorder; and the procedure for admitting out-patients after consultation with stakeholders.

### **2. *Prioritise the integration of mental health services in the community and in primary care***

- Ensure that mental health is comprehensively integrated into Kenya's Health Sector Policy Framework (2011 – 2030).

- Ensure that county health management teams have the capacity to effectively implement mental health services into their plans and budgets.
- Scale up programmes to train community health workers and general staff at primary health care levels in mental health competencies so they are able to recognise, manage and make appropriate referrals for patients.
- Coordinate with KEMSA to ensure that essential psychotropic drugs are regularly available at all facilities, especially level two and three.
- Collaborate with NGOs and civil society organisations that can facilitate access to remote or underserved areas.

### **3. *Develop human resources for the mental health sector***

- Conduct a situational analysis and needs assessment of human resources for mental health.
- Review incentive schemes (e.g. scholarship schemes, salary reviews) to encourage more students and general health personnel to pursue continuing education and training on, or additional qualifications in, mental health.
- Prioritise improving the working conditions of mental health personnel (e.g. physical security, working hours, and staffing levels) and establish incentive schemes (financial, educational etc.) for mental health personnel willing to take posts in remote or underserved areas.

### **4. *Increase access to information about mental health care services***

- For example, list facilities offering mental health services on the ministries' eHealth website.
- Disseminate IEC materials through online and offline channels so that individuals can learn about their mental health status and make a decision about treatment.

### **5. *Support research on mental health***

- Complete the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) country-wide and publish the results of the assessment.

- Collect data on the prevalence and detection of psychiatric disorders in health facilities all levels. Specifically, revise facility disease surveillance sheets at lower level facilities so that they record mental disorders, rather than listing them as ‘other illnesses’.
- Establish a mental health information system to collect, process, analyse, disseminate, and use information about mental health care services and the needs of the population they serve.
- Strengthen the capacity of Mathari Hospital to carry out its research mandate.

#### **6. *Support initiatives to combat stigma and raise awareness about mental disorders***

- In collaboration with other relevant ministries, establish public education and awareness raising programs at the community level that promote good mental health and the prevention of mental disorders.
- Provide psycho-social support for carers and families on coping with mental disorders.
- Collect and disseminate good practice on awareness raising campaigns conducted by civil society organisations.

### **To the Government of Kenya**

#### **1. *Increase the budgetary allocation to mental health***

- As a matter of urgency, source funds to ensure that the Kenya Board of Mental Health is able to perform its mandated functions and. In the longer time, provide the Board with vote in the budget, as required by the Mental Health Act.
- Set benchmarks for progressively increasing the allocation to mental health services, for example, commit to increasing the allocation to 2% of the health budget in the next five years.
- Allocate a budget line for development expenditure for mental health services.

- Ensure the Ministry of Home Affairs and the Attorney General's Department provide adequate funds to facilitate care and treatment for criminal offenders with mental disorders.

## **2. Mobilise resources for the mental health sector**

- Identify existing funding sources that can be mobilized for mental health or for addressing the mental health dimension of other health conditions, for example through CDC or NASCOP.
- Encourage the insurance sector to create more low cost health insurance products to for people with mental disorders.

## **7. Support initiatives to combat stigma and raise awareness about mental disorders**

- Utilise state media to educate the public and raise awareness about good mental health and the prevention of mental disorder.
- Strengthen the infrastructure that supports good mental health at the community level, for example community centres and recreational facilities.

## **3. Support research on mental health**

- Collect information about mental health care services in subsequent Kenya Service Provision Assessment Surveys (KSPAS).
- Collect data on the prevalence of mental health conditions in subsequent Demographic and Health Surveys (KDHS).
- Facilitate a national study on mental health in Kenya through the Kenya Medical Research Institute (KEMRI), with a particular focus on the co-morbidity of mental disorders with other conditions such as HIV/AIDS.

## **4. Ensure oversight and regulation of the mental health sector**

- Provide human and financial resources for the Kenya Board of Mental Health to act as a regular inspector of public and private mental health facilities.
- Ensure that the draft bill or bills regulating counsellors, psychotherapists and psychologists provides for a coherent and comprehensive regulatory framework.

## **5. *Improve the coordination of all stakeholders to ensure effective advocacy on mental health***

- Establish an inter-sectoral coordination mechanism for mental health or build the capacity of the Kenya Board of Mental Health to play this role. NACADA and NACC are useful models to follow in this regard.
- Mandate such a mechanism to mainstream human rights within mental health and to mainstream mental health in all sectors.
- Ensure that such a mechanism provides channels for the participation of all stakeholders, especially people with mental disorders and their carers and families, community groups and civil society organisations, and the private sector.

### **To all public and private health care facilities**

#### **1. *Respect patients' rights and promote accountability***

- Adopt rights-based approach to the delivery of treatment and care.
- Ensure that all patients are informed about their rights.
- Establish impartial complaints mechanisms for patients not satisfied with their care.

#### **2. *Promote public awareness about mental health and mental disorders***

- Provide staff with training on mental health and mental disorder.
- Include mental health and the mental health aspects of other health conditions (e.g. nutrition or HIV/AIDS) in health talks offered to patients.
- Pursue programmes and initiatives that de-stigmatise mental disorders (e.g. hospital re-branding, integrating other services with mental health services).

## **To civil society, non-government organizations and community groups**

### **1. Document and report cases of violations of the rights of people with mental disorders**

- Collaborate with the police, KNCHR, community leaders and other regulatory bodies to identify and address violations of the rights of people with mental disorders.

### **2. Promote public awareness about mental health and mental disorders**

- Continue education programmes on mental health and mental disorders targeted to stakeholders such as the community, health workers, law enforcement, and policy makers.

### **3. Gather information for policy development**

- Collect and share information about the mental health needs of the population, as well as the current mental health system and services.
- Share experiences with other countries to learn about advances and effective mental health interventions that should be incorporated into policy.

### **4. Support research on mental health**

- Facilitate community tribunals on mental health that would give a perspective from the community.

## **To the insurance industry**

### **1. End the practice of limiting benefits for mental health care services**

- Review standard policy covers to ensure their compliance with the Mental Health Act.

## **To institutions of higher learning**

### **1. Increase opportunities for education and training on mental health**

- Adopt policies that encourage enrolments in mental health-related programmes, e.g. allowing students to enrol in post-graduate studies in psychiatry without the two-year waiting period.

- Ensure that a rigorously mental health curriculum is part of the training for all medical and nursing students.
- Collaborate with NGOs to provide continuing education and training opportunities for health personnel (e.g. eLearning course for nurses).

## **2. *Support research on mental health***

- Adopt policies that encourage students and academics to pursue research in mental health.
- Increase coordination on mental health research, for example by different universities focusing on specific regions.

## **To associations of mental health care professionals in Kenya**

### **1. *Promote public awareness about mental health and mental disorders***

- Include mental health and the mental health aspects of other health topics (e.g. nutrition or HIV/AIDS) in health talks offered to patients.

## **To the international donor community**

### **1. *Scale up support for the mental health sector***

- Identify projects and programmes to support that contribute to reforming the mental health sector based on optimal mix of mental health care services.
- Address the mental health dimension of existing projects and programmes in the health sector.
- Establish indicators for evaluating these projects, based on the criteria of efficiency, quality and respect for human rights

## Appendix I | Stakeholders' Forum Participants

<b>Name</b>	<b>Organisation</b>
Victoria Mutiso	Africa Mental Health Foundation
Anne Mbwayo	Africa Mental Health Foundation
Joyce Kingori	BasicNeeds, Kenya
Fr. Boniface Mwangi	Caritas Nyeri
Helen Wangui Karimi	Caritas Nyeri
Emma Wanyonyi	Institute for Legislative Affairs
Rosemary Gathara	Kenya Assoc. for the Welfare of People with Epilepsy
Dr. Susan Hinga	Kenyatta University
Irene Maina	Legal Resources Foundation Trust
Dr. Lukoye Atwoli	Moi University
Kibacia Gatu	Schizophrenia Foundation of Kenya
Kanyi Gikonyo	Users and Survivors of Psychiatry (USP) Kenya
Dr. Caleb Othieno	University of Nairobi
Charles Imbova	Legal Resource Foundation
Irene Maina	Legal Resource Foundation

## Appendix II | Validation Workshop Participants

<b>Name</b>	<b>Organisation</b>
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Milka Waruguru	BasicNeeds
Joyce Kingori	BasicNeeds
Eric Bosire	Health Rights Advocacy Forum (HERAF)
Hillary Biwott	Institute for Legislative Affairs
Vincent Kimosop	Institute for Legislative Affairs
Tiberry Nyakwana	Joint Epilepsy Foundation
Rosemary Gathara	Kenya Assoc. for the Welfare of People with Epilepsy
Dr. Susan Hinga	Kenyatta University
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Kibacia Gatu	Schizophrenia Foundation of Kenya
Mary Wahome	Schizophrenia Foundation of Kenya
Moses Wareru	Students Campaign Against Drugs
Caleb Othieno	University of Nairobi

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MPHS & MOMS, *Fourth, Fifth and Sixth Annual Operational Plans*

### **International Instruments**

International Convention on Civil and Political Rights

International Convention on Economic, Social and Cultural Rights

Convention Against Torture

African Charter on Human and Peoples' Rights

Convention on the Rights of the Child

Convention on the Rights of Persons with Disabilities

UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, 1991

Political Declaration of the High Level Meeting High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, 2011