An Assessment of Factors Affecting the Implementation of The Kenya Mental Health Policy 2015-2030

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An Assessment of Factors Affecting the Implementation of The Kenya Mental Health Policy 2015-2030

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ABSTRACT

Mental health is a critical public health concern in Kenya, yet the effective implementation of the Kenya Mental Health Policy (2015–2030) faces significant challenges. Despite the policy's goal of ensuring accessible, affordable, and high-quality mental health services, systemic barriers such as underfunding, workforce shortages, stigma, and weak governance structures continue to hinder progress. This study assessed the factors affecting the implementation of the Kenya Mental Health Policy, with an appraisal of the policy, and lessons from international best practices. A qualitative research approach was employed, with data collected through interviews, document analysis, and expert consultations involving key stakeholders, including policymakers, mental health practitioners, and advocacy groups. Systems Theory was applied to examine how governance structures, funding mechanisms, and service delivery models interacted within Kenya's mental health system. Policy Diffusion Theory provided insights into how global and regional trends influenced policy adoption and implementation. The findings revealed critical gaps, including poor intergovernmental coordination, inadequate data systems, and insufficient attention to adolescent mental health. Best practices from countries such as Ethiopia, South Africa, and Sweden were identified as potential models for strengthening Kenya's policy effectiveness. By analyzing these factors, the study provided evidence-based recommendations to enhance governance, financing, and service delivery frameworks for the successful implementation of the Kenya Mental Health Policy (2015–2030).

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LIST OF ABBREVIATIONS

WHO - World Health Organization
MoH - Ministry of Health
SDGs - Sustainable Development Goals
MNS - Mental, Neurological, and substance use disorders
GDP - Gross Domestic Product
LMICs - Low- and Middle-Income Countries
PHC - Primary Healthcare
NGOs - Non-Governmental Organizations
UN - United Nations
WHA - World Health Assembly
UNICEF - United Nations International Children's Emergency Fund
ICD - International Classification of Diseases
DALY - Disability-Adjusted Life Years
UNDP - United Nations Development Program
UHC - Universal Health Coverage
CBR - Community-Based Rehabilitation
MHGAP - Mental Health Global Action Program
NCDs - Non-Communicable Diseases
MHIF - Mental Health Information Framework
MHSSP - Mental Health and Substance Use Strategic Plan
UNODC - United Nations Office on Drugs and Crime
PPP - Public-Private Partnership
DMHP - District Mental Health Programme (India)
HMIS - Health Management Information System
mhGAP - Mental Health Gap Action Programme
TTC - Time to Change (anti-stigma program)
M&E - Monitoring and Evaluation
CHWs - Community Health Workers
CHPs - Community Health Promoters
KEMRI - Kenya Medical Research Institute
KIPPRA - Kenya Institute for Public Policy Research and Analysis
NACOSTI - National Commission for Science, Technology, and Innovation
KNBS - Kenya National Bureau of Statistics
MNTRH - Mathari National Teaching and Referral Hospital
MTRH - Moi Teaching and Referral Hospital
KNH - Kenyatta National Hospital
KNCHR - Kenya National Commission on Human Rights

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OPERATIONAL DEFINITION OF KEY TERMS

Mental Health Policy – A framework designed to guide the development and implementation of strategies aimed at improving mental health services, access, and awareness at national and county levels.

Mental health- A state of well-being where individuals can handle daily stresses, work productively, and contribute to society. It is a public health priority requiring accessible and equitable mental healthcare services.

Mental illness: A clinically significant disturbance in thoughts, emotions, or behavior, leading to distress or impairment in daily life. It can be temporary or chronic, requiring varying levels of medical and community-based care.

Mental health disorders: A clinically significant disturbance in thoughts, emotions, or behavior, leading to distress or impairment in daily life. It can be temporary or chronic, requiring varying levels of medical and community-based care.

Devolution in Health – The process through which healthcare services, including mental health, are decentralized from the national government to county governments for improved accessibility and efficiency.

Mental Health Infrastructure – The physical, human, and financial resources required for delivering mental health services, including hospitals, trained personnel, and financial investments.

Stigma in Mental Health – Negative perceptions and discrimination against individuals with mental health conditions, which hinder access to treatment and social acceptance.

Health Insurance for Mental Health – Financial schemes such as SHI that facilitate affordability and access to mental health services."

Public-Private Partnership (PPP) – Collaborative initiatives between the government and private entities aimed at improving mental health service provision, infrastructure, and financing.

Primary Healthcare Integration – Incorporating mental health services into general healthcare systems to ensure comprehensive, accessible, and holistic patient care.

Task Shifting in Mental Health – A strategy where non-specialist health workers, such as nurses and community health workers, provide basic mental health services under the supervision of specialists due to workforce shortage.

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DEDICATION

To my incredible husband: Your unwavering love, patience, and endless support have been my anchor through every late night and moment of doubt. I could not have climbed this mountain without you by my side.

To my precious children: You are my greatest motivation. Thank you for your sweet hugs, understanding when Mommy was busy, and for reminding me what truly matters. I hope this inspires you to chase your own dreams.

To my dear friends: Your encouragement, laughter, and belief in me kept me going. Whether it was a quick text or a much-needed coffee break, your kindness made this journey lighter.

To Kenyans facing mental health challenges, whose stories shaped this work; and to all who believe in knowledge as a force for change.

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CHAPTER 1: INTRODUCTION

1.1 Background of Study

Silvana Galderisi et al., (2017) defines mental health as a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. "Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium"(Silvana Galderisi et al., 2017).Mental health is an integral part of health and well-being, as reflected in the definition of health in the Constitution of the World Health Organization (WHO) "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[1] (WHO ,2022 & Patel et al., 2018) define mental health as "a condition of mental well-being that helps people manage life's challenges, realize their potential, learn, work, and contribute to their community."

Globally, mental health conditions, including psychosocial disabilities and other states associated with significant suffering or impaired functioning, are on the rise. These include depression, anxiety, schizophrenia, and substance use disorders. For example, in Australia, mental illness affects one in five adults annually, contributing significantly to disability and productivity loss (Whiteford et al., 2015). In the United States, the National Institute of Mental Health(NIMH) reports that nearly one in five adults lives with a mental illness, with disparities in access to treatment across racial and socio-economic lines (NIMH, 2022).

In Kenya, the Mental Health Task Force[2] note that "The term mental illness is frequently used interchangeably with mental disorders and includes common conditions such as depression and anxiety, those due to abuse of alcohol and other substances, schizophrenia and bipolar disorder. Mental disorders often coexist with other neurological disorders such as epilepsy and dementia.

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[1] (*Constitution-En.Pdf*, 1948)

[2] ("Mental Health Task Force Report - Mental Health and Wellbeing Towards Happiness & National Prosperity," n.d.)

Hence, lately these illnesses are commonly classified together as mental, neurological and substance use disorders (MNS)”.

What is more, as observed by Kolenik & Gams (2021), “mental health issues have large, multi-faceted effects on the patient, on their immediate surroundings (family or caretakers) and on the wider society. Individuals face decreased quality of life, worse educational outcomes, lowered productivity and potential poverty, social problems, abuse vulnerabilities and additional health problems. Caretakers face increased emotional and physical challenges as well as decreased household income and increased financial costs. Due to the considerable disability associated with their condition, those suffering from major mental illness become increasingly dependent on their caretakers.

Kolenik & Gams, (2021) further postulate that when a person suffers from severe mental illness, he or she experiences significant functional and role impairment, as well as employment disability.” Approximately 90% of people with serious mental illnesses are assisted practically and emotionally on a daily basis by family carers as shown in both high-income countries like Japan and LMICs such as Nigeria (Choy Qing Cham et al., 2022).Society faces the loss of several GDP percentage points and billions of dollars per nation annually, alongside with exacerbating public health issues and corrosion of social cohesion (Kolenik & Gams, 2021).”

“A substantial proportion of the world’s health problems in both high-income countries (HICs) and low-to-middle-income countries (LMICs) arises from mental, neurological, and substance use disorders. Treatment rates for these disorders are low, particularly in LMICs, where treatment gaps of more than 90% have been documented. Even in HICs, where rates of treatment are comparatively higher, treatment for mental, neurological, and substance use disorders tends to be provided many years after the onset of the disorder ”(Whiteford et al., 2015).“ In South Africa, for instance, only 27% of people with mental illness receive care, a problem attributed to stigma, workforce shortages, and inadequate primary care integration (Lund et al., 2018).

Mental health, as noted by (Wakoli, 2024) is a growing global concern, with the World Health Organization (WHO) estimating that over 450 million people worldwide suffer from mental disorders, yet a significant proportion remains untreated due to barriers such as stigma, inadequate

funding, and weak healthcare infrastructure. According to (Arias et al., 2022), the significant economic burden associated with mental disorders highlights the critical need for health economics research, particularly in assessing the returns on investment and the costs of effective prevention and treatment strategies. This aligns with evidence from the UK, where the cost of mental health to the economy is estimated at over £100 billion annually, primarily due to lost productivity and health-related social expenditures (Organization for Economic Co-operation and Development, 2014).Similar financial burdens are seen in Canada, where the annual cost is over CAD 50 billion (Smetanin et al., 2012).

Moreover, there is a pressing need to improve the measurement of the global burden of mental illness, not only to better capture the associated morbidity and mortality but also to incorporate the impacts of emerging challenges such as pandemics, conflicts, and climate change on population mental health. (Arias et al., 2022) further emphasize that mental health is not solely a concern for high-income regions but a pressing global issue with profound implications for health and well-being. The substantial magnitude of these intertwined burdens underscores the urgent necessity for global action to prioritize mental health and increase its financing."

Addressing mental health, therefore, "becomes an essential step in addressing key development issues such as social inclusion and equity, universal health coverage, a holistic and life-course approach to health, access to justice and human rights, and sustainable economic development. In 1991, the United Nations adopted the "Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care," establishing non-legally binding standards for mental health systems and the rights of individuals with mental disorders. These principles have been foundational in guiding nations toward more humane and effective mental health care practices[3].In this regard, the World Health Assembly in 2013, adopted the World Health Organization's (WHO) Comprehensive Mental Health Action Plan 2013–2020, which articulated practical guidelines for addressing mental health, especially in low- and middle-income countries (WHO, 2013)[4].

[3] http://www.who.int/mental_health/policy/en/UN_Resolution_on_protection_of_persons_with_mental_illness.pdf

[4] (*Comprehensive Mental Health Action Plan 2013-2030*, 2021)

”The action plan which was adopted at the 66th World Health Assembly, sets out a new vision and goal for mental health: “A world in which mental health is valued, promoted and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high quality, culturally appropriate health and social care in a timely way to promote recovery, all in order to attain the highest possible level of health and participate fully in society and at work free from stigmatization and discrimination.” (Gater et al., 2015) A key objective of the Action Plan was to strengthen mental health information systems. “The global action plan has since been extended to 2030 (WHO 2021)” (Zoe Guerrero et al., 2024). This extension was adopted by the 72nd World Health Assembly in May 2019 to align the plan with the 2030 Agenda for Sustainable Development. Further updates, including revised indicators and implementation options, were endorsed by the 74th World Health Assembly in 2021.

The UN Sustainable Development Goals(SDGs) provide a comprehensive framework for improving global health and well-being, with mental health being a key component. (Cerf, 2018, (Lund et al., 2018). “SDG 3, which aims to ensure healthy lives and promote well-being for all at all ages, includes 13 targets and 26 indicators, the most of any of the 17 SDGs. Target 3.8 of SDG 3, on universal health coverage, emphasizes that all people and communities should have access to healthcare, including mental health services. Moreover, the WHO Mental Health Atlas, an ongoing project by the WHO Department of Mental Health and Substance Use, gathers and shares global data on mental health to support better decision-making.” It offers insights into mental health policies, funding, care systems, resources, and prevention programs, essential for delivering comprehensive mental health care.[5]

Despite the increasing attention to mental health on the policy agenda, much remains to be done. Mental health services are chronically underfunded and deprioritized in most low- and middle-income countries, including in sub-Saharan Africa. Many countries lack comprehensive mental health policies, plans and laws, and even where these exist, implementation is often poor (World Health Organization, Geneva, Switzerland & Chisholm, 2015). In Ghana and Uganda, for example, mental health receives less than 1% of the national health budget, and mental health laws remain outdated or poorly enforced (Awenva et al., 2010; Kigozi et al., 2010).

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[5] (*Mental Health Atlas 2020*, 2021)

A mental health system is multi-faceted, involving legislation, financing, human resources, service delivery, and monitoring and information systems.

Kiilu et al., (2024) point out that the issue of mental health is becoming a growing concern in Kenya. The prevalence of mental disorders in Kenya constitutes a major public health challenge, exerting a substantial impact on both individuals and the healthcare system. Approximately 11.5 million individuals in Kenya, equivalent to one in four, have encountered mental illness, with the youth demographic comprising the largest percentage (Kiilu et al., 2024). "However, the available data on the burden and risk factors of mental and substance use disorders among adolescents and young adults in Kenya continue to be sparse.

Furthermore, as noted by (Kumar et al., 2024),the national-level survey of non-communicable diseases in Kenya conducted using the World Health Organization STEPwise protocol did not include mental health"(Kumar et al., 2024). According to information from the Kenya Ministry of Health, at least 25% of the population are afflicted with mental health disorders and illnesses (Mutiso et al., 2020). "A WHO report (2017), ranked Kenya fifth among African countries with elevated depression cases, with global statistics indicating that approximately two million people suffer from depression."

According to the Kenya Mental Health Policy 2015-2030, "the National Government estimates that mental illness accounts for 25% of outpatient visits and 40% of inpatient admissions across various health facilities. Psychosis is reported to have a prevalence rate of 1% in the general population (Ministry of Health, 2015). Based on Kenya's 2019 census population of 47,564,296, this translates to approximately 475,633 individuals living with severe mental illnesses. The most prevalent mental health conditions in Kenya include depression, substance use disorders, bipolar disorder, schizophrenia, and anxiety disorders. [6]"

A study by Kumar et al. (2024) found that, mental disorders ranked as the second leading cause of disability among individuals aged 10–24 years in Kenya, contributing to 248,935 disability-adjusted life years (DALYs) out of a total of 2,656,546 DALYs for both sexes. Depression accounted for the largest share of the total DALYs at 33.4%, followed by anxiety disorders

[6] ("Kenya Mental Health Policy 2015 - 2030,".)

(24.0%), conduct disorders (17.9%), bipolar disorders (8.4%), autism spectrum disorder (4.5%), schizophrenia (3.4%), intellectual developmental disorders (2.8%), eating disorders (2.5%), and attention deficit hyperactivity disorder (1.1%). While females exhibited a slightly higher overall DALY burden from mental disorders in the 15–24 age group, males had a marginally higher burden in the 10–14 age group, accounting for 35,741 out of 66,896 DALYs in this cohort. Additionally, substance use disorders contributed to 15,022 DALYs, with a slightly greater impact observed in males than females.

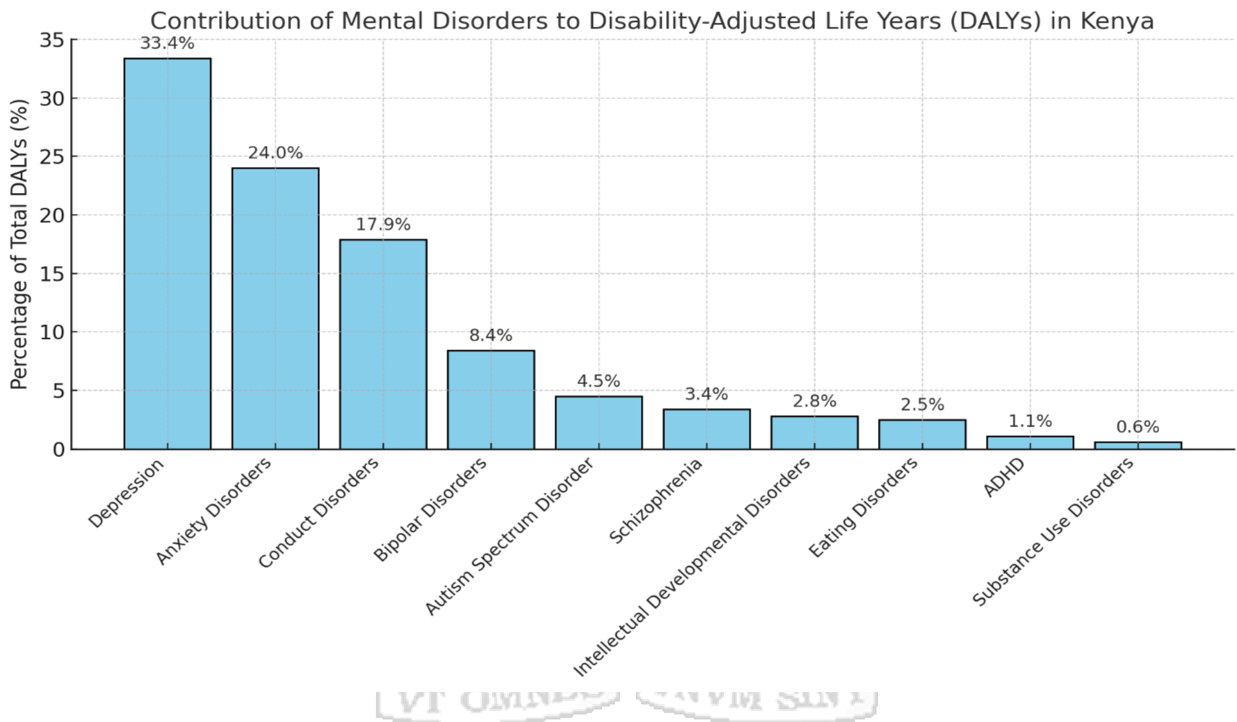

Figure 1. 1:Contribution of Mental Disorders to Disability Adjusted Life Years (DALYs) in Kenya.

"The Kenyan government has made significant strides in recognizing the importance of mental health as evidenced by the development of The Kenya Mental Health Policy (2015–2030) which provides a framework that guides mental health reforms in the country with the aim of ensuring that all persons have access to comprehensive, integrated, and high-quality mental health care that is promotive, preventive, curative, and rehabilitative at all levels of healthcare. The policy also highlights vital strategies in mitigating the structural challenges and emerging patterns in alleviating mental health problems and disorders"(Memiah et al., 2022).

In 2019, under the directive of President "Uhuru Kenyatta, the Kenya Mental Health Taskforce was established to address the growing mental health crisis in the country. The Taskforce was tasked with identifying the causes and impacts of mental health challenges, evaluating existing systems and policies, and proposing comprehensive reforms"[7] "Building on these initiatives, the Kenya Mental Health Action Plan (2021–2025) was introduced to support the implementation of the Mental Health Policy. It provides strategic objectives with clear targets and indicators to track progress. Moreover, the plan aims to operationalize the Taskforce's recommendations by focusing on key areas, including strengthening policies and legal frameworks, expanding access to quality mental health services, increasing financial investments, fostering cross-sector collaboration, and streamlining administrative processes. These efforts aim to establish a robust mental health system that addresses the needs of all Kenyans.[8] "

1.2 Problem Statement

Mental health is a growing public health concern in Kenya, with mental, neurological, and substance use (MNS) disorders contributing significantly to the national burden of disease. An estimated 25% of outpatients and 40% of inpatients in Kenyan health facilities suffer from mental health conditions, including depression, substance use disorders, schizophrenia, and anxiety (Ministry of Health, 2015). Young people are especially affected, with mental disorders ranking as the second leading cause of disability among individuals aged 10–24 years (Kumar et al., 2024). Despite the magnitude of the problem, mental health services remain underfunded and stigmatized, and they lack sufficient human resources and infrastructure (Kiilu et al., 2024; Kwobah et al., 2021). To achieve this, the policy outlines five strategic objectives: (1) strengthening effective leadership and governance for mental health; (2) ensuring access to integrated, quality mental health services at all levels of healthcare; (3) promoting mental health and preventing mental illness; (4) strengthening mental health systems through capacity building, legislation, and infrastructure; and (5) enhancing evidence-based research, data systems, monitoring, and evaluation (Ministry of Health, 2015). It further emphasizes the integration of mental health into primary healthcare, the use of a human rights-based approach, and the promotion of intersectoral collaboration.

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[7] ("Mental Health Task Force Report - Mental Health and Wellbeing Towards Happiness & National Prosperity," n.d.)

[8] https://www.aku.edu/bmi/Documents/kenya_mental_health_action_plan__2021-2025_.pdf

However, despite these comprehensive strategies, implementation has faced persistent challenges. Mental health remains underprioritized in the national budget, receiving less than 1% of the Ministry of Health's allocation (Chisholm et al., 2019). Services are still centralized in urban areas, leaving rural populations underserved (Kimathi, 2017). The country experiences a chronic shortage of mental health professionals, with only 54 psychiatrists serving a population of over 47 million (Marangu et al., 2014). Additionally, the absence of a robust mental health information system hampers evidence-based planning and service delivery (Ndetei et al., 2020). The lack of updated legislation given the outdated Mental Health Act of 1989 further undermines the policy's implementation by failing to support community-based, rights-oriented approaches (Ndetei et al., 2017). Given these systemic gaps, the objectives of the Kenya Mental Health Policy remain partially unmet. The persistent implementation challenges not only limit access to mental healthcare but also threaten the broader goals of social inclusion, economic development, and universal health coverage.

This study, therefore, sought to appraise the extent to which the Kenya Mental Health Policy (2015–2030) had achieved its stated objectives, examined key barriers, and identified areas that required further policy attention to enhance the overall effectiveness of mental health reform in Kenya.

1.3 Research objectives

1.3.1 General objective

To assess the factors affecting the implementation of the Kenya mental health policy 2015-2030, focusing on its framework, and potential policy improvements to enhance mental health outcomes in Kenya.

1.3.2 Specific Objectives

I. To appraise the extent to which the objectives of the Kenya Mental Health Policy(2015-2030) have been achieved.

II. To identify the factors affecting the implementation of the Kenya mental Health Policy 2015-2030.

III. To explore lessons and best practices from other contexts that can inform and improve the effectiveness of mental health policy implementation in Kenya.

1.4 Research Questions

I. To what extent have the objectives of the Kenya Mental Health Policy 2015-2030 been achieved?

II. What are the key factors influencing the implementation of the Kenya Mental Health Policy 2015-2030?

III. What lessons and best practices from other contexts can inform and improve the effectiveness of mental health policy implementation in Kenya?"

1.5 Scope of the study

This study comprehensively evaluated the Kenya Mental Health Policy (2015–2030) through three key dimensions. First, it assessed the extent to which the policy's objectives of improving accessibility, affordability, and quality of mental health services had been achieved. Second, it examined the implementation challenges, including systemic barriers such as underfunding, workforce shortages, governance gaps, and sociocultural stigma that hindered effective execution. Third, it explored comparative best practices from other countries to identify adaptable strategies for strengthening Kenya's mental health system.

Focusing on Kenya's unique context while incorporating global perspectives, the research engaged key stakeholders including policymakers (Ministry of Health, NACADA, Parliamentary Health Committee), implementing institutions (Kenyatta National Hospital, Mathari National Teaching and Referral Hospital, Chiromo Hospital), healthcare providers, and advocacy groups,to analyze resource allocation, institutional frameworks, and operational practices. By integrating policy appraisal, implementation analysis, and cross-national learning, the study aimed to provide evidence-based recommendations that address existing gaps while leveraging opportunities to advance the policy's vision of comprehensive mental health reforms and improved national wellbeing.

1.6 Significance of the study

This study critically examined the factors hindering the effective implementation of the Kenya Mental Health Policy 2015–2030. The findings revealed several persistent barriers, including chronic underfunding, widespread stigma, a shortage of trained mental health professionals, and

the limited integration of mental health services into primary healthcare. These impediments significantly constrained the policy's intended impact, particularly among underserved and rural populations. The study's results are expected to support the Ministry of Health, county governments, and other stakeholders in refining policy interventions and improving implementation strategies.

The research provided a strong evidence base for actionable recommendations aimed at strengthening mental health systems in Kenya. These include increasing domestic budgetary allocations, decentralizing services, expanding workforce training, and launching community-led anti-stigma campaigns. By appraising the extent to which the policy's strategic objectives have been achieved, the study offered valuable insights into operational gaps, resource constraints, and service delivery challenges.

Policymakers and mental health practitioners can draw on the study's findings to make informed decisions around reform priorities and investment needs. Furthermore, the study contributed to academic discourse by linking policy theory with on-the-ground realities, presenting a comprehensive appraisal of Kenya's mental health policy implementation within the broader socio-economic and global health context. Drawing on comparative lessons from countries such as Ethiopia, the United Kingdom, and Nigeria, the research identified scalable practices that could enhance Kenya's mental health governance, improve service accessibility, and boost sustainable resource mobilization.

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CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter delves into the theoretical frameworks foundational to the study. It provides an in-depth review of previous empirical studies within this research area and related fields. Additional sections include a detailed empirical analysis, a brief overview of the literature review highlighting the identified research gap, a conceptual framework illustrating the relationship between independent and dependent variables, the operationalization of these variables, and a concluding summary of the chapter.

2.2 Theoretical framework

To assess the challenges in the implementation of the Kenya Mental Health Policy 2015–2030, it is essential to explore the foundational principles underlying policy implementation. Theories are instrumental in predicting and understanding phenomena. In this study, the theoretical framework adopts the Systems Theory. Systems Theory emphasizes the interconnectedness and interdependence of various components within a system, offering valuable insights into how different elements of the mental health system such as policies, institutions, stakeholders, and resources interact and influence each other. By applying this perspective, the study examines the dynamic relationships, feedback loops, and systemic barriers that impact the successful implementation of the Kenya Mental Health Policy, providing a holistic understanding of the challenges and potential solutions within the mental health landscape."

2.2.1 Systems Theory

According to (Arnold, 2014),Systems theory refers to a collection of related approaches applied across different fields such as biology, sociology, information theory, and philosophy. In North America, it is often linked to Ludwig von Bertalanffy's general systems theory, the cybernetics work of thinkers like Norbert Wiener and Gregory Bateson, and its modern applications in areas like ecology, cognitive science, artificial intelligence, and media studies. It also includes dynamic systems theory, developed by figures like Ilya Prigogine, which explores chaos and complexity theory, and world-systems analysis by Immanuel Wallerstein, which focuses on global economic and political systems. In contrast, Europeans, especially Germans, often associate systems theory

with Niklas Luhmann's sociological work. Despite differences in focus and methods, all these traditions share a common interest in understanding the general features of systems and their relevance to various aspects of life, though each has its unique approach and area of emphasis.

Similarly,(Adams, 2012) postulates that Systems theory is a multidisciplinary framework that seeks to understand, analyze, and manage the behavior and interactions of complex systems, whether natural, social, or engineered. It views a system as a cohesive set of interacting components organized to achieve specific purposes or exhibit emergent properties. Grounded in a foundation of axioms and propositions, systems theory emphasizes principles like hierarchy, communication, control, feedback, emergence, and adaptability to explain how systems function and sustain themselves within their environments. By transcending disciplinary boundaries, systems theory provides a unified lens to study and address challenges holistically, enabling improved explanatory and predictive capabilities in diverse fields such as biology, engineering, sociology, and management.

In her book *Thinking in Systems: A Primer*, (Meadows, 2008) emphasizes that systems consist of interconnected elements that interact to produce outcomes, often with emergent properties that are more than the sum of their parts. She highlights the importance of feedback loops, which can either reinforce (positive feedback) or stabilize (negative feedback) system behavior, as central to understanding system dynamics. Meadows also discusses leverage points,specific places within a system where small changes can lead to significant impacts and stresses the importance of viewing systems holistically to identify patterns and root causes of problems. Her work provides practical tools for analyzing and influencing systems, offering insights into designing resilient and adaptive systems capable of addressing complex challenges in various contexts, from environmental sustainability to policy implementation.

Systems theory offers valuable insights into addressing the challenges associated with implementing mental health policies in low- and middle-income countries. One key challenge is the lack of coordination between different stakeholders, including government entities, healthcare providers, and other sectors like education and social protection. Systems theory emphasizes the need for a holistic, collaborative approach where all these components work together to address mental health issues (Faydi et al., 2011; Kwobah et al., 2021). Another major challenge is resource constraints, including insufficient funding and workforce shortages. Systems theory suggests that

the mental health system should be viewed as part of a broader network that can draw on resources from interconnected sectors, rather than operating in isolation.

The theory also highlights the importance of feedback loops, which can help address gaps in monitoring and evaluation by ensuring continuous improvement through regular performance reviews and adaptation. By applying systems thinking, countries can better align resources, improve coordination, and build more resilient mental health systems (Faydi et al., 2011).

In the context of implementing the Kenya Mental Health Policy (2015–2030), systems theory underscores the importance of integrating diverse sectors including health, education, social services, and governance to address the multifaceted challenges in mental health care delivery. Bertalanffy's concept of open systems, which interact dynamically with their environment, is particularly relevant, as Kenya's mental health system must adapt to external factors such as resource constraints, political shifts, and societal stigma. Feedback loops, another key principle, highlight the need for regular monitoring and evaluation mechanisms to identify bottlenecks and improve policy implementation over time (Meadows, 2008).

Systems theory has, however been criticized by (Gerald Midgley, 1999) for its historical shortcomings, including its reliance on overly complex "super models" that proved unreliable, the flawed assumption that systems could be optimized and controlled like machines, and the neglect of pluralistic perspectives and value conflicts. Early systems theory often sidelined the voices of stakeholders, overemphasized technical expertise, and failed to address entrenched conflicts or marginalized perspectives effectively. The ideology of comprehensive analysis was self-limiting, as it ignored the practical need for adaptability and the inherent incompleteness of any model. To overcome these limitations, the author advocates for systemic approaches that embrace methodological pluralism, engage with multiple rationalities, and employ boundary critique to reflect the diversity and complexity of real-world systems.

Despite these criticisms, systems theory is fundamentally relevant in this study as it underscores the importance of integrating diverse sectors,i.e. health, education, social services, and governance to address the multifaceted challenges in mental health care delivery. Bertalanffy's concept of open systems, which interact dynamically with their environment, is particularly relevant, as Kenya's mental health system must adapt to external factors such as resource constraints, political shifts, and societal stigma. Feedback loops, another key principle, highlight the need for regular

monitoring and evaluation mechanisms to identify bottlenecks and improve policy implementation over time (Meadows, 2008).

2.2.2 Policy Diffusion Theory

"Commonality amidst diversity is a phenomenon where national governments internalize certain norms and models salient in the global society, in turn reflected in isomorphic socio-political policies, structures, and programs"(Shen, 2014).Policy diffusion refers to the gradual adoption of mental health policies across different countries over time. This process is influenced by both vertical forces (domestic responses to global events) and horizontal forces (policy decisions shaped by other nations). As countries become more interconnected, information spreads through communication, collaboration, and competition, leading to the adoption of shared norms and practices. Institutional theories suggest that policies are first developed and legitimized within specific nations before gaining regional or global acceptance. Mental health policy diffusion, like other innovations, typically follows an S-shaped curve with rapid early adoption, a peak, and a slowdown reflecting variations in national readiness and risk tolerance.(Shen, 2014)

(Shen, 2014) highlights the role of coercive and mimetic forces in influencing policy adoption across nations. He argues that international organizations, particularly the World Health Organization (WHO), play a significant role in shaping government behavior through their regional offices, though mere membership in such organizations does not guarantee policy adoption. Shen finds that economic status and regional policy trends strongly influence whether a country adopts mental health policies, with wealthier nations being more likely to implement them. Interestingly, foreign aid alone is not a strong determinant of policy adoption, suggesting that external financial incentives may not be enough to drive reform. Instead, the spread of mental health policies follows a clustered pattern, where mounting adoption within a region changes the perceived risks and benefits of policy implementation. His findings contribute to the broader discourse on non-communicable diseases as emerging priorities on the global health agenda, emphasizing that policy diffusion is shaped by a mix of global norms, economic capacity, and regional influence.

Meseguer & Gilardi. (2009) highlight key advancements in the study of policy diffusion, emphasizing the growing role of international influences on domestic policy choices. They argue that traditional explanations, which focus solely on internal political and economic conditions, fail

to account for horizontal diffusion, where policies spread across countries through learning, competition, and emulation. Their review of recent literature demonstrates that policy convergence is not universal; instead, different countries experience varied diffusion patterns based on regional, ideological, and institutional factors. Furthermore, they stress the importance of political dynamics, including electoral incentives and ideological predispositions, in shaping the diffusion process. Overall, their work calls for a more integrated approach that acknowledges both domestic and international drivers of policy adoption.

Policy diffusion has, however, been criticized on various fronts. .For instance, (Mooney, 2001) criticized the theory for Mooney (2001) critiques policy diffusion theory for its overreliance on the assumption that policies spread primarily due to regional influences, arguing that the social learning process behind this diffusion is rarely examined critically. He challenges the widely accepted notion that a state or country is more likely to adopt a policy simply because its neighbors have done so, emphasizing that empirical evidence on regional diffusion effects is mixed at best. Additionally, he highlights that diffusion studies often fail to consider variations in learning patterns, assuming that policymakers passively adopt policies without critically evaluating their relevance or effectiveness. Mooney also points out that the theory tends to ignore policy resistance, reversals, and failures, treating diffusion as a linear and inevitable process rather than acknowledging the complexities of political opposition, institutional constraints, and evolving public perceptions. Shipan & Volden.(2012) argue that the theory overemphasizes intergovernmental interdependence, sometimes neglecting important domestic factors such as political climate, economic stability, and cultural influences that play a crucial role in policy adoption. Meseguer & Gilardi. (2009) further critique its over-reliance on homogenous models, suggesting that diffusion mechanisms should be examined in a more nuanced and context-specific manner.

Despite the criticisms, the theory provides valuable insights within the Kenyan context. Meseguer & Gilardi .(2009) emphasis on horizontal diffusion where countries adopt policies due to learning, competition, and emulation aligns with how Kenya has shaped its mental health strategy. Kenya's policy adoption has been influenced by global mental health frameworks, such as those set by the World Health Organization (WHO), and by best practices from countries with successful mental health reforms. Moreover, the authors highlight that policy convergence is not uniform, as

domestic political, economic, and institutional factors mediate diffusion. Similarly, while Kenya has adopted global mental health principles, its implementation has been shaped by local challenges, including limited funding, stigma, and weak institutional capacity. The policy's execution also reflects political influences, as mental health has gained more attention due to rising cases of mental illness, media coverage, and advocacy by both local and international organizations. According to(Shen, 2014) The cross-national diffusion of mental health policy helps explain Kenya's Mental Health Policy implementation, influenced by WHO regional offices, regional trends, and local political commitment. However, economic constraints and foreign aid alone do not ensure success. Instead, Kenya's policy reflects regional influences, as mental health gains recognition in sub-Saharan Africa. Following Shen's clustered diffusion model, Kenya adapts its policy in response to neighboring countries like Uganda and South Africa, while addressing local challenges such as stigma, funding shortages, and healthcare gaps.

This study is underpinned by Systems Theory, which serves as the anchoring theory, as it aligns with the study's aim of assessing the factors affecting the implementation of the Kenya Mental Health Policy 2015-2030. Systems Theory emphasizes the interconnectedness and interdependence of various components within a system, making it ideal for understanding how policies, institutions, stakeholders, and resources interact in mental health service delivery. It highlights governance gaps, feedback loops, and systemic factors that influence policy implementation, helping to analyze the barriers and enablers in Kenya's mental health landscape. Policy Diffusion Theory serves as the supporting theory, as it explains how global and regional trends influence Kenya's adoption of mental health policies. It accounts for the role of international organizations like the WHO, economic capacity, and regional influence in shaping Kenya's policy decisions while recognizing that local political, economic, and institutional factors mediate policy implementation.

2.3 Empirical Literature Review

This section provides an in-depth analysis of empirical studies examining the challenges affecting the implementation of the Kenya Mental Health Policy 2015–2030. It presents a detailed review of research exploring various influencing factors, including institutional capacity, funding availability, stakeholder engagement, public awareness, and the integration of mental health into

broader healthcare frameworks within Kenya. It also explores lessons and best practices from other contexts that can inform and improve the effectiveness of mental health implementation in Kenya."

2.3.1 An appraisal of the extent to which the objectives of the Kenya Mental Health Policy 2015-2030 have been achieved.

The Kenya Mental Health Policy 2015–2030 was developed in response to growing recognition of the burden of mental health conditions on individuals, families, and the national economy. Its overarching goal is to ensure that mental health services are accessible, affordable, equitable, and of high quality for all Kenyans. The policy aligns with the Constitution of Kenya (2010), Vision 2030, and global commitments such as the WHO Mental Health Action Plan 2013–2020. A critical appraisal of the policy reveals a robust framework that articulates key strategic objectives, including strengthening leadership and governance, improving mental health service delivery, enhancing human resource capacity, promoting public education and awareness, and developing sustainable financing mechanisms (Ministry of Health, 2015). However, while the policy is theoretically sound, its implementation has encountered substantial barriers that have limited the realization of its objectives.

One of the key strengths of the policy is its emphasis on decentralizing mental health services to the primary healthcare level and integrating them into general healthcare. This approach is consistent with global best practices, especially in resource-limited settings (World Health Organization, 2013). However, the decentralization process has been hampered by inadequate infrastructure, a shortage of trained personnel, and fragmented intergovernmental coordination between national and county governments (Atwoli et al., 2011). The absence of clear implementation guidelines and accountability mechanisms further weakens service delivery at the grassroots level.

Moreover, the policy calls for the development of a mental health workforce, yet Kenya continues to face a severe shortage of psychiatrists, psychiatric nurses, psychologists, and social workers. As of 2020, Kenya had fewer than 100 psychiatrists for a population of over 50 million, far below the WHO recommendation of one psychiatrist per 10,000 people (David M. Ndetei et al., 2015).This deficit undermines the policy's goal of quality and accessible mental health services and highlights a gap between policy ambition and operational capacity.

Financing is another critical challenge. Despite the policy's objective to ensure adequate and sustainable funding for mental health, the sub-sector receives less than 1% of the national health budget (World Health Organisation- Assessment Instrument for Mental Health Systems, 2020). Most mental health services remain donor-dependent or are funded out-of-pocket by patients and families. This contradicts the principle of equity and affordability outlined in the policy and raises concerns about the sustainability of mental health reforms in the absence of domestic investment.

Musyimi et al., (2017) point out that public education and anti-stigma campaigns are also integral to the policy, aiming to normalize mental health conversations and reduce societal stigma. While there have been efforts by both governmental and non-governmental actors to raise awareness, these initiatives remain largely urban-centric and lack consistent funding and coordination (Musyimi et al., 2017).The continued social stigma around mental illness impedes early diagnosis, access to care, and community reintegration for affected individuals.

Furthermore, the policy recognizes the importance of data and research in informing mental health planning. However, Kenya lacks a robust mental health information system. Data collection remains sporadic, and there is limited disaggregated data to inform service planning and policy evaluation (Mutiso et al., 2020)This hampers efforts to monitor policy implementation and to make evidence-based adjustments.

Nevertheless, the policy has contributed to some notable milestones. The Mental Health (Amendment) Bill 2018 and subsequent Mental Health Act revisions are examples of legislative progress spurred by the policy environment. Additionally, Kenya's establishment of a Mental Health Taskforce in 2019, whose report recommended the declaration of mental illness as a national emergency, indicates growing political will (Ministry of Health, 2020).

2.3.2 Factors effecting the implementation of the Kenya mental health policy (2015-2030)

"Globally, the expenditure on mental health is less than US$2 per year per capita across all countries and less than 25 cents in low-income countries. Many LMICs, including 15 of 19 African countries, allocate less than 1% of their health budgets to addressing mental illness. India, like other LMICs countries, has a federal government with devolved budgets to individual states. The federal budget allocates 4.6% of the gross domestic product (GDP) for health, which works out to per capita sum of US$0.22. Mental health only receives 0.06% of the general health budget. Pakistan spends 3.9% of the GDP on health, of which 0.4% is spent on mental health. The primary

sources of mental health financing in descending order are out-of-pocket expenditure by the patient or family, taxes, social insurance, and private insurance" (Farooq, 2017).

"There is a tangible lack of commitment to mental health in Kenya, reflected in the fact that it receives less than 1% of the Ministry of Health's budget, which is itself less than 7% of the national budget". Chisholm) analyzed the challenges of mental health financing in low and middle income countries and observed that "the often high and potentially catastrophic cost to households of securing the health services and goods they need is the fundamental concern underlying the drive towards universal health coverage" The study highlights key challenges including the lack of prioritization of mental disorders, resulting in inadequate resource allocation, limited service availability, and poor service coverage. There are significant inequalities in access, particularly affecting poorer populations who cannot afford services, which are often available only in remote specialist centers. High poverty levels, weak economic growth, outdated legislation, and inadequate information systems were also noted as challenges (Chisholm et al., 2019).

A study by (Awenva et al., 2010) on the barriers of mental health policy implementation in Ghana observe that insufficient funding is a major challenge, as the 1994 policy lacks specific financial provisions. While policymakers often express rhetorical support for mental health initiatives, the actual allocation of resources remains inadequate, affecting service delivery at both institutional and community levels. This lack of funding is further exacerbated by the stigma surrounding mental health, where patients are perceived as less deserving of resources because they are viewed as unable to contribute meaningfully to society.

Awenva et al. (2010) further note that other health priorities such as malaria, diarrhea diseases, and pneumonia dominate funding, as these are the most reported conditions in health facilities. Mental health services are further strained by the absence of dedicated budgets at the regional and district levels, where care is integrated into primary health systems. This lack of earmarked funding leaves health workers with minimal resources to assist patients, limiting their ability to plan or implement specific programs effectively. The persistent low prioritization of mental health creates significant obstacles to achieving the policy's goals.

Hanlon et al. (2014) conducted an analysis of five low- and middle-income countries (LMICs)- Ethiopia, Uganda, Nepal, South Africa, India- and observed that financial and logistical barriers significantly undermine the prioritization and delivery of mental health care at the district level.

Many districts lack a dedicated budget for mental health, as seen in Ethiopia and Uganda, where funding for mental health services is either nonexistent or insufficient. This is further complicated by competing public health priorities, with resources being channeled toward communicable diseases like HIV/AIDS, tuberculosis, and malaria, which are perceived as more urgent health concerns (Hanlon et al., 2014).

Hanlon et al. (2014) noted that poverty exacerbates the issue, as individuals with mental health conditions often face out-of-pocket expenses for care, particularly in Ethiopia, where medications and services are not universally free. The absence of social support systems, such as disability payments for individuals with severe mental disorders, further increases financial burdens. Logistical constraints, such as the lack of health infrastructure, including specialized facilities and reliable transportation in rural areas, make accessing mental health care even more challenging. These barriers highlight the need for increased investment in mental health and equitable resource distribution.

"A major challenge for mental healthcare in Kenya is the severe shortage or, in some regions, total lack of a specialist mental health workforce"(Marangu et al., 2014). "Mental health care in Ghana faces significant challenges due to a severe shortage of mental health professionals and limited opportunities for their professional development. This scarcity of trained personnel in psychosocial interventions results in a treatment approach primarily focused on psychotropic medications, with minimal emphasis on psychosocial care and rehabilitation. While efforts have been made to train more psychiatric nurses, attracting skilled professionals to rural areas—where mental health needs are most acute remains a persistent challenge.

Previous community mental health initiatives in Ghana have indicated the potential to strengthen the skills of lower-level healthcare providers, such as community nurses, technical officers, and volunteers, to improve the detection and referral of mental illness cases" (Magna & Yemoh, 2018).Similar challenges constrain the implementation of mental health policies. Kenya faces a critical shortage of trained mental health professionals, with limited opportunities for professional development in psychosocial interventions. "There is a huge shortage of human resources for mental health as only 29 of the 3,956 government owned facilities in Kenya actually provide mental health care, with a gross shortage of mental health workers in the country, hence patient travel long distances to access care"(Kwobah et al., 2021).

Consequently, mental health treatment in Kenya tends to prioritize the use of psychotropic medications while neglecting psychosocial care and rehabilitation services. Attracting qualified professionals to rural and underserved areas, where the demand for mental health services is most significant, is equally difficult, reflecting a common issue in resource distribution. Further, Marangu et al(2014) in an exploratory study on optimal conditions for capacity building in Kenya observed that, "a major challenge for mental healthcare in Kenya is the severe shortage or, in some regions, total lack of a specialist mental health workforce." The study highlighted that "Kenya faces a critical shortage of mental health professionals, with only 54 psychiatrists, 418 trained psychiatric nurses, and a limited number of psychologists and medical social workers serving a population of approximately 43 million, of whom 4% are likely to experience a major mental disorder.

The situation is worsened by low mental health literacy among healthcare workers at all levels, further limiting access to care." Additionally, the country struggles with a significant "brain drain," where trained mental health professionals migrate to higher-income countries or seek employment in non-governmental organizations. Since 1980, Kenya has trained 74 psychiatrists, yet only 54 remain in the country. Similarly, out of 418 psychiatric nurses, only 250 actively work in mental health services. The combined impact of workforce shortages, low retention rates, and insufficient training presents a major challenge to strengthening Kenya's mental healthcare system(Marangu et al., (2014).

People suffering from Mental Health disorders are often victims of stigma (Sabina Kučukalić & & Abdulah Kučukalić, 2017). Stigma functions as a barrier to seeking treatment, as individuals fear being judged or misunderstood. This is further exacerbated by structural issues, such as limited access to mental health services, the underfunding of psychiatric care, and inadequate training for healthcare providers to address stigma-related challenges. "Deep-rooted stigma surrounding mental health issues persists in Kenyan society, hindering awareness, acceptance, and the willingness to seek help" (Pavanello, Elhawary & Pantuliano, 2010). Cultural beliefs and practices also contribute to the stigmatization of mental health, complicating efforts to encourage open dialogue and treatment-seeking behavior (Getanda, Vostanis & O'Reilly, 2017)"(Kiilu et al., 2024).

(Amy J. Morgan et al., 2021)"conducted a study in Australia and highlighted that stigma and discrimination remain major barriers to mental health service access and recovery. People with

complex mental illnesses, such as schizophrenia, bipolar disorder, and personality disorders, face widespread misunderstanding and negative stereotypes, leading to social exclusion, employment discrimination, and limited healthcare access. Many people with severe mental illnesses are perceived as dangerous, unpredictable, or incapable of self-care, reinforcing social stigma and self-stigmatization.

A study by (Edith K. Wakida1 et al., 2018) in Uganda found that barriers to integrating mental health services into primary healthcare (PHC) include inadequate training and knowledge among primary care providers, who often lack the confidence and skills to diagnose and manage mental health conditions. This is compounded by limited access to clinical guidelines, such as the Uganda Clinical Guidelines (UCG), which are either unavailable or too complex for routine use, highlighting the need for simplified, context-specific tools. The authors further noted that at the point of care, providers face challenges such as insufficient mental health medications, lack of mental health specialists for consultations, and minimal ongoing support, all of which hinder effective service delivery. Additionally, motivational barriers arise due to inadequate prioritization of mental health, competing health demands, and the absence of incentives or regulatory measures to support integration efforts. Specialized mental health staff are often assigned general roles, preventing them from fully utilizing their expertise, leading to frustration and reduced morale. Finally, limited community engagement perpetuates low awareness and stigma, as outreach and education initiatives are underfunded and poorly executed, further complicating efforts to normalize mental health care within PHC systems.

"Previous research has shown that mental and substance use disorders pose a significant public health challenge in Kenya. However, there remains a scarcity of data on the burden and risk factors associated with these disorders among adolescents and young adults. There is a notable lack of population-based studies on mental health at the national level" (Kumar et al., 2024) Furthermore, the national survey on non-communicable diseases in Kenya, conducted using the World Health Organization STEPwise protocol, did not address mental health."(Eaton et al., 2011) note that many health information systems ranging from population-based data sources like censuses and household surveys to facility-based sources such as public health surveillance and health services data often exclude mental, neurological, and substance use disorders. This omission makes it harder to position mental health as a core component of the broader health system, hinders the

effective mobilization of essential drug supplies, and suggests a falsely low demand for mental health services.

Research by Awenva et al. (2010) on barriers to mental health policy implementation in Ghana found that scarcity of adequate and reliable data necessary for the formulation of evidence-based mental health policies. Comprehensive and accurate information on the prevalence of mental disorders, the number of individuals accessing both specialized treatment and primary healthcare, and the broader impact of mental illness on individuals and families is crucial for advocating for greater investment and resources in mental health. Additionally, such data is essential for effective planning and service delivery. Strengthening the mental health evidence base through research and establishing a comprehensive and efficient mental health information system are critical initial steps in ensuring that Ghana's mental health policies are data-driven and responsive to priority areas of need.

The Kenya Mental Health Action Plan 2021–2025, acknowledges the challenge of insufficient data highlighting that up to 25% of outpatients and 40% of inpatients in health facilities suffer from mental health conditions, yet these estimates are based on limited and outdated studies (Ministry of Health, 2021). The lack of standardized data collection systems and reporting mechanisms further impedes efforts to monitor and evaluate mental health programs, resulting in poor planning and resource allocation (Ndetei et al., 2020). Additionally, the absence of a national mental health surveillance system makes it difficult to track trends, assess service coverage, and measure policy impact (Jenkins et al., 2011). Without comprehensive, disaggregated, and up-to-date data, Kenya's mental health policy implementation remains reactive rather than proactive, limiting its ability to address the growing burden of mental illness effectively."

Many LMICs experience obstacles such as under-resources primary healthcare systems that fail to provide comprehensive people-centered care. Kenya's healthcare infrastructure and service delivery face significant challenges that impede the provision of quality care. According to Leah Kimathi(2017), The infrastructural challenges impeding the effective implementation of the Kenya Mental Health Policy are deeply rooted in systemic weaknesses within the devolved health sector. Further, the poor state of health infrastructure, including dilapidated buildings, insufficient beds, and lack of essential medical equipment, severely hampers the delivery of mental health services. The author highlights that health facilities in Kenya are unequally distributed, with some

counties having fewer than two health facilities per 10,000 people. In marginalized areas such as Turkana County, some residents travel for two days to access healthcare services, further exacerbating the disparities in mental health service provision. Inadequate staffing compounds this issue, with most counties falling below the WHO-recommended doctor-to-population ratio.

The decentralization of healthcare has also introduced governance challenges, with procurement inefficiencies and corruption affecting the availability of essential medicines, including psychotropic drugs for mental health patients. Moreover, the lack of integration between national and county governments has resulted in fragmented service delivery, with counties struggling to manage human resources, finances, and infrastructure effectively. The absence of specialized mental health facilities at the county level further means that the few available resources remain concentrated in urban centers, leaving rural populations underserved. These infrastructural deficiencies ultimately undermine the Kenya Mental Health Policy's goal of equitable, community-based mental health services, highlighting the urgent need for investment in infrastructure, healthcare workforce expansion, and governance reforms

Muhia et al. (2021) in a human rights assessment study, highlight severe challenges in mental health infrastructure and service delivery at Mathari National Teaching and Referral Hospital (MNTRH), Kenya's largest mental health facility. The hospital's infrastructure is in a state of disrepair, with dilapidated buildings, overcrowded wards, and inadequate sanitary facilities. Bed occupancy exceeds capacity, worsening living conditions for patients. The assessment further reveals that there is a chronic shortage of healthcare professionals, with only 11 psychiatrists, 104 nurses, and 3 occupational therapists serving over 800 inpatients and 1,000 daily outpatients, far below recommended staffing levels. Frequent drug stock-outs and underfunding have further strained service delivery, with government budget allocations declining over the years. (Muhia et al., 2021) point out that patients are subjected to inhumane conditions, including neglect and verbal and physical abuse, with no clear mechanisms for complaints or legal redress. The hospital lacks rehabilitation programs or reintegration strategies, leaving patients with minimal support for independent living. The underfunding of mental health services at MNTRH reflects a broader systemic failure, with Kenya allocating less than 1% of its health budget to mental health, leading to worsening conditions and rights violation.

2.3.3 Measures that can be put in place to ensure a successful implementation of the Kenya Mental Health Policy -lessons from other countries experiences

"The most significant challenge to effective mental health policy is inadequate funding" (Nicholas et al., 2022). In Kenya, mental health services desperately need more funding, but the money just isn't enough—especially at the county level since healthcare was devolved. Mathari National Teaching and Referral Hospital (MNTRH)**,** the country's main mental health facility, has struggled for years with chronic underfunding, leading to rundown buildings, staff shortages, and a lack of essential medical supplies. While the Kenya Mental Health Policy pushes for decentralizing services, most funding still stays at the national level, leaving counties with too few resources to build functional mental health programs.

A study by (Bullock et al., 2024) highlights some inspiring success stories from New Zealand, Canada (Ontario), and Sweden, where intermediary organizations have played a major role in making mental health policies work on the ground. In New Zealand, groups like Te Pou and Matua Raki started as workforce development centers but grew into key players in supporting mental health policy implementation, especially after the country moved away from institutionalized care. Over in Ontario, Canada, organizations like the Ontario Centre of Excellence for Child and Youth Mental Health (OCoECYMH) and the Provincial System Support Program (PSSP) have helped drive real, system-wide changes by focusing on evidence-based practices and collaboration between different stakeholders.

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Meanwhile, in Sweden, Mission Mental Health, which operates under the Swedish Association of Local Authorities and Regions (SALAR), has been critical in creating a well-coordinated and sustainable mental health system, ensuring that different levels of government and service providers work together effectively (Bullock et al., 2024).These examples offer valuable lessons for Kenya. By creating intermediary organizations tailored to its unique needs, Kenya could boost mental health policy implementation in a way that works for both national and county governments. Leveraging existing structures like the Ministry of Health and county health offices, Kenya can focus on workforce development, evidence-based approaches, and better cross-sector collaboration all of which have helped these other countries succeed. Most importantly, ensuring

sustainable funding and long-term planning could help expand mental health services to rural and underserved areas, making quality care more accessible to all Kenyans.

In addressing human resource constraints, a study by(Eaton et al., 2011) on scaling up of services for mental health in low-income and middle-income countries postulate that task sharing is an effective strategy for optimizing the use of limited trained personnel. A significant portion of mental health needs can be addressed through simple care packages delivered by non-specialists in community or non-hospital settings. To achieve this, primary healthcare workers must receive better training and support to identify and manage mental health disorders. Key considerations include defining their roles, determining the training and supervision required, and establishing their integration within the broader health system.

In tackling the challenge of inadequate data, "research by Petersen et al., (2019) observed that Nigeria improved its health management information system (HMIS) by integrating mental health indicators, ensuring better data collection and reporting. Kenya can adopt a similar approach to improving data collection mechanisms and ensure better monitoring and evaluation of mental health service.

One of the most effective strategies for expanding access to mental health care in LMICs is integrating it into primary healthcare systems. Jenkins emphasize that integrating mental health into primary care enhances accessibility and reduces stigma. For example, India's District Mental Health Programme (DMHP) has trained primary healthcare workers to recognize and manage mental health conditions, enabling early detection and timely intervention.

Similarly, Ethiopia's National Mental Health Strategy leverages health extension workers to provide community-based services, ensuring that care reaches even the most remote areas (Asher et al., 2015). Additionally, according to Petersen et al. (2019) Ethiopia has successfully implemented the WHO Mental Health Gap Action Programme (mhGAP) by training PHC workers, including nurses and health officers, to manage mental health cases at the community level. Further, the country established a zonal advisory board with designated mental health coordinators, ensuring structured governance and oversight of mental health service delivery. In Kenya, adopting similar models could be transformative, especially in underserved regions. Training community health workers in mental health care would not only enhance service delivery but also foster trust within local communities.

“Capacity-building efforts in Kenya must commence by, firstly, addressing the endemic issues of stigma and lack of mental health literacy in the health workforce and, secondly, addressing the society on a broader scale”(Marangu et al. 2014). “The authors recommend public education through social marketing as an effective way of achieving a reduction in stigma and educating the public about mental health and illness. Further, they agree that the success of social marketing approaches in addressing HIV prevention and public education in Kenya, Ghana and Uganda confirms the power of social marketing for health promotion and capacity-building; these same approaches could be applied to mental health capacity building.” In Uganda, Petersen note that carer and user support groups were established, helping to reduce stigma and dropout rates from clinical care (Marangu et al. 2014).

Sampogna et al. (2017), in a study on England as a predictor of mental health user’s stigma coping strategies note critical insights into reducing mental health stigma through England's Time to Change (TTC) anti-stigma program. The research shows that participants actively engaged in campaign activities were more likely to adopt coping strategies focused on 'challenging' and 'educating' others about mental health discrimination. The authors stress that effective anti-stigma efforts require a multi-faceted approach, including leadership from service users, targeted social marketing campaigns, and robust evaluation of intervention outcomes. For Kenya, this suggests developing mental health policies that prioritize service user participation, create platforms for education and challenging stigma, and implement rigorous monitoring mechanisms. The study also underscores the significance of understanding diverse coping strategies among mental health service users and tailoring interventions to local contexts, which could be crucial for Kenya's mental health policy implementation.

To overcome future pandemics, (Kwobah et al., 2021) recommend that Kenya must decentralize mental health services, ensuring that treatment is accessible at the county and community levels rather than relying heavily on national referral hospitals like MNTRH. Strengthening primary healthcare facilities to integrate mental health services, supported by trained health workers, would enhance accessibility. Additionally, government funding for mental health stimulus packages could help sustain services amid economic hardships. Expanding public-private partnerships, as seen in Nepal’s collaborative mental health model, could also enhance service delivery. Investing in digital

mental health platforms with subsidized access for vulnerable populations would ensure continuity of care even during health crises (Kwobah et al., 2021).

Stein et al. (2022) urges that Kenya should prioritize equitable access to digital tools by investing in technological infrastructure, promoting digital literacy, and ensuring affordable internet access. Additionally, robust regulatory frameworks are needed to ensure the safety, quality, and privacy of digital mental health applications. Collaborative efforts between healthcare providers, policymakers, technology developers, and patient advocates are crucial to sustain and scale up these digital interventions, ensuring that mental health services remain accessible and effective in the post-pandemic era.

2.4 Summary of Literature and Gaps

The literature highlights several challenges in the implementation of the Kenya Mental Health Policy 2015-2030, particularly in areas such as funding, infrastructure, workforce, stigma, and data collection. Studies indicate that mental health remains underfunded, with less than 1% of Kenya's health budget allocated to mental health services (Njenga & Kigamwa, 2005). Infrastructure challenges, including over-reliance on Mathari National Referral Hospital, lack of decentralized mental health facilities, and limited integration of mental health into primary healthcare, further exacerbate access issues. Stigma against mental illness and healthcare providers working in the sector also remains a significant barrier to effective policy implementation. Additionally, insufficient and unreliable data on mental health prevalence, treatment outcomes, and service utilization limits evidence-based policy interventions. Comparative studies from Ethiopia, South Africa, Uganda, and Nigeria offer useful lessons on integrating mental health into primary healthcare, strengthening governance, decentralizing mental health services, and improving data systems. However, gaps in research remain on the systemic interconnections affecting policy implementation and the effectiveness of Kenya's mental health governance framework.

Table 2. 1Summary of Literature Review

Title of the document	Author(s)	Focus of study and methodology	Key findings	Research gaps
"Mental healthcare in Kenya: Exploring optimal conditions for capacity building	Elijah Marangu, Natisha Sands, John Rolley, David Ndetei, Fethi Mansouri (2014)	Examines the challenges and enablers for mental healthcare capacity building in Kenya using a policy analysis approach.	-Kenya has an 85% treatment gap in mental healthcare. - There is a severe shortage of mental health professionals. - Mental health remains underfunded and is not a priority in health reforms. - Stigma and cultural attitudes hinder access to care.	- Lack of implementation strategies for capacity building. - Limited research on community-based interventions. - Need for integration of alternative healing practices in mental healthcare."
"Integration of mental health into primary care and community health working in Kenya	Rachel Jenkins, David Kiima, Marx Okonji, Frank Njenga, James Kingora, Sarah Lock (2010)	Evaluates the efforts to integrate mental health into Kenya's primary healthcare through training primary care and community health	- Only 23 psychiatrists serve in public hospitals across Kenya. - Mental health services are highly centralized in urban areas, limiting access for rural populations. - Task-sharing with community	- More research needed on the long-term sustainability of mental health integration. - Limited data on patient outcomes from integrated mental health programs.

		workers. Uses a program evaluation method.	health workers has been effective in expanding care. - Lack of continuing professional	- Gaps in coordination between different levels of healthcare facilities."
"Voices from the Youth in Kenya: Addressing Mental Health Gaps and Recommendations	Peter Memiah, Fernando A. Wagner, Robert Kimathi, Naomi Idah Anyango (2022)	Explores mental health challenges among adolescents and young people (AYP) in Kenya using stakeholder consultations and focus group discussions.	- Mental health services for youth are inadequate, with stigma preventing help-seeking. - AYP lack access to adolescent friendly mental health services. - Policy gaps, such as lack of financing and slow implementation, hinder effective service delivery. - Digital mental health interventions could be a promising approach.	- Need for more empirical studies on adolescent mental health interventions. - Limited data on the impact of community-based youth mental health programs. - Need for policy-driven strategies to integrate youth mental health into primary healthcare."
"Efforts and Challenges to Ensure Continuity of Mental Healthcare Service Delivery in a Low Resource Settings During COVID-19 Pandemic—A Case of a Kenyan Referral Hospital	Edith Kwobah, Florence Jaguga, Kiptoo Robert, Elias Ndolo, Jane Kariuki (2021)	Examine efforts and challenges in maintaining mental healthcare services at Moi Teaching and Referral Hospital during COVID-19; qualitative analysis based on hospital reports and policies.	-Mental healthcare faced significant disruptions due to COVID-19. -Decentralization and alternative service delivery methods were implemented. -Challenges included lack of resources, telehealth barriers and economic hardships.	Limited empirical studies on the long-term impact of COVID-19 on mental health service delivery in Kenya."
"Mental Health in Kenya: Tensions Between Human	Di Pierdomenico et al. (2022)	Analyzes the impact of colonial legacy on mental health policies	-Colonial biomedical models dominate mental health care,	-Need for more research on how traditional and indigenous mental health

Rights Approaches and Colonial Care		in Kenya using intersectional policy analysis framework; qualitative analysis of policy documents and historical records.	sidelining community-based approaches. -Mental health policies are not fully aligned with international human rights standards. -Stigma and discrimination continue to hinder access to mental healthcare.	practices can be integrated into policy frameworks. -More studies required to assess the effectiveness of human rights-based approaches in mental health. -Gaps in research on stigma reduction strategies and their effectiveness in the Kenyan context."
"Effective Governance Approaches in the Management of Mental Health within the Public Sector of Kenya; A Literature Review	Kiilu Susan, Mandela K. Hinneh, Ngei M. Paulah, Chemitei Kipkogei (2023)	Reviews governance approaches in mental health management within Kenya's public sector; systematic literature review of scholarly articles, technical papers, and government reports.	Mental health services suffer from weak governance and policy implementation gaps. -Insufficient budgetary allocation hinders effective mental healthcare delivery. - There is a scarcity of trained mental health professionals in the public sector.	-Lack of studies evaluating the effectiveness of governance reforms in mental health service delivery. -Need for research on financing models for sustainable mental health services. -Limited analysis on the role of county governments in mental health"
"Exploring the Barriers to Mental Health Care and	Dr. Caroline Wakoli (2021)	Explores barriers to mental healthcare access and mitigation strategies in Kenya; qualitative research	-Financial constraints limit mental healthcare access, leading to low service utilization.	Need for comprehensive studies on the socio-cultural determinants of mental health in Kenya.

Mitigation Strategies in Kenya		based on policy analysis and expert interviews.	-Stigma and cultural beliefs discourage individuals from seeking mental health services. -Limited mental health awareness contributes to underdiagnosis and undertreatment.	-Limited research on gender-specific barriers to accessing mental healthcare. -More studies required to explore the impact of mental health awareness"
"Kenya's Mental Health Law	David M. Ndetei, Job Muthike, Erick S. Nandoya (2020)	Reviews Kenya's outdated mental health law and proposed reforms; legislative analysis of the Mental Health Act and policy recommendations.	Kenya's Mental Health Act (1989) is outdated and focuses primarily on inpatient care. -The Act does not adequately address community-based mental health services. -Proposed reforms aim to improve accessibility, patient rights, and mental health governance.	-Limited research on the enforcement of mental health laws and their impact on patient rights. -Need for studies on alternative legal frameworks for mental health legislation. -Gaps in understanding the role of legal aid services in protecting the rights of people with mental illnesses."
"Short Report: Mental Health Policy in Kenya - An Integrated Approach to Scaling Up Equitable Care for Poor Populations	David Kiima&Rachel (2019)	Analyzes Kenya's mental health policy within the broader health system reforms; mixed methods approach involving policy evaluation and stakeholder consultation.	-Kenya's mental health policy emphasizes integration with primary healthcare. -Implementation is hindered by resource constraints and lack of intersectoral coordination. -There is limited community-based support for mental health services.	Further research needed on policy implementation challenges and strategies to improve mental health service delivery in Kenya. - More studies required on public-private partnerships in

				mental health service provision. -Limited data on the impact of mental health decentralization policies on service accessibility”

.“

2.5 Conceptual Framework

A conceptual framework is a network, or "a plane," of interlinked concepts that together provide a comprehensive understanding of a phenomenon or phenomena. According to Miles and Huberman (1994), a conceptual framework "lays out the key factors, constructs, or variables, and presumes relationships among them". (Jabareen, 2009). The conceptual framework below shows the various phenomenon of the study and their relationship.

Effective implementation of the Kenya Mental Health Policy 2015-2030

Measures to ensure successful implementation of the Kenya Mental Health Policy 2015-2030-lessons from other countries experiences

- Workforce Development through Task-Shifting
- Intermediary implementation Bodies
- Data-Driven Decision making
- Stigma Reduction through Community Engagement

Policy objectives implementation gaps

- **Leadership and Governance Gap**

  Weak intergovernmental coordination.

  unclear implementation guidelines and accountability mechanisms.

- **Service Delivery Integration Gap**

  Poor integration of mental health into primary healthcare.

- **Human Resource Capacity Gap**

  Shortage of specialists

- **Mental Health Financing Gap**

  Less than 1% of the national health budget allocated to mental health.

Factor affecting effecting implementation of the policy

- **Infrastructure and Facility Deficiency**-Overdependence on central facilities like Mathari Hospital.

  Inadequate beds, equipment, and facilities at county level.

- **Stigma and Cultural Beliefs**-Deep-rooted misconceptions about mental illness. Negative societal attitudes.
- **Low Prioritization and Competing Health Priorities**-Diseases like malaria and HIV receive more attention and funding.

Mental health seen as less urgent.

- **Inadequate Legal and Policy Support**-Outdated legislation, Delayed operationalization of reforms.
- **Weak Monitoring and Evaluation Frameworks**-Absence of real-time reporting tools. Minimal feedback loops and adaptive learning mechanisms.

Figure 2. 1: Conceptual Framework

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research methodology, covering the research design, target population, sampling methods, sample size determination, data collection techniques, data analysis procedures, and ethical considerations. It offers an overview of the approach and steps taken to collect and analyze data, ensuring the study's integrity and validity.

3.2 Research philosophy

A research philosophy is a set of shared beliefs and agreements among scientists about understanding and solving problems (Kuhn and Hawkins 1963). It's a worldview that guides how research is approached, conducted, and interpreted. It influences how researchers perceive reality and knowledge, shaping their research methods and processes. (Dzakia Fifi Mahardini et al., 2024). Research philosophy is comprised of three core assumptions: ontological, epistemological, and axiological. Ontology concerns the nature of reality and the objects being studied, asking what they are and how they relate to human perception. Epistemology, derived from the Greek words "episteme" (knowledge) and "logos" (theory), explores the process of gaining knowledge, questioning the methods, nature of truth, and its criteria. Finally, axiology examines the value and benefits derived from knowledge, including its ethical implications and practical applications (Dzakia Fifi Mahardini et al., 2024).

This study was grounded in the pragmatist research philosophy, which emphasizes practical problem-solving, flexibility in methodological choice, and the integration of multiple perspectives to address real-world challenges. Pragmatism focuses on the research question as the central determinant of methodological direction, advocating for the use of both qualitative and quantitative approaches when necessary to generate actionable knowledge (Creswell & Plano Clark, 2011). Given the study's objective to assess the extent to which the Kenya Mental Health Policy (2015–2030) has been implemented and to identify factors influencing its effectiveness, pragmatism provided an appropriate philosophical foundation. It enabled the researcher to prioritize stakeholder experiences, policy documents, and expert opinions while maintaining analytical rigor in evaluating policy outcomes and implementation dynamics. By adopting this philosophy, the study moved beyond binary paradigms of positivism and interpretivism to incorporate context-specific evidence, facilitating the formulation of practical, policy-relevant recommendations that reflect Kenya's sociopolitical and institutional realities (Morgan, 2007; Biesta, 2010). This approach was particularly suited to a public policy

environment characterized by competing interests, systemic complexity, and evolving governance structures, making pragmatism a valuable lens for understanding and improving mental health policy implementation.

3.3 Research design

Research design is the blueprint for conducting research. It specifies the procedures for collecting, analyzing, and interpreting data, ensuring that the research question is effectively answered. For this study, a qualitative and explorative research design was selected to develop an in-depth understanding of the factors influencing the policy's implementation. This approach is particularly suitable for exploring complex issues, as it facilitates a deeper examination of participants' perspectives and experiences, enabling the researcher to uncover insights into barriers, enablers, and systemic gaps through open-ended questions that allow respondents to elaborate on their views (Clive Roland Boddy, 2018). By investigating and analyzing the views and experiences of stakeholders, including government officials, healthcare providers, and beneficiaries of mental health services, the qualitative approach provided a descriptive and explanatory framework, rather than a predictive one, making it well-suited to understanding the contextual dynamics of policy implementation.

3.4 Population and sampling

According to (Banerjee & Chaudhury, 2010), “The target population is the complete set of individuals sharing specific characteristics to which a study's findings are intended to be generalized. They emphasize that any conclusions drawn from a sample apply only to this defined group from which the sample has been appropriately selected. Further, the authors highlight the importance of clearly defining the target population to ensure that the study's results are applicable and relevant to the intended group”(Banerjee & Chaudhury, 2010). (Baker & Edwards, 2012) point out that saturation is a crucial concept in qualitative research, determining the point at which no new information emerges from data collection. The researcher will continue interviewing participants until data saturation is achieved, where adding more participants no longer provides new significant information. However, while researchers strive for saturation.(John W. Creswell, 2013) suggest a range of 12 to 60 interviews, 20 for an M.A. thesis and 50 for a Ph.D. dissertation. This aligns with previous Kenyan mental health studies, such as Wakoli (2021) and Memiah et al. (2022), which successfully employed 20 participants to achieve thematic depth and saturation in policy analysis and youth mental health research, respectively.

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The study was conducted in Nairobi, Kenya, targeting national-level institutions involved in mental health policy implementation. 20 participants were purposively selected to provide rich, in-depth insights into the challenges in implementing the Kenya Mental Health Policy. This was distributed across four categories as follows: Five national-level policymakers and regulators were interviewed, including two officials from the Ministry of Health's Mental Health Directorate, one NACADA official, one policy adviser from the Parliamentary Health Committee, and one Mental Health Task Force representative. Seven mental health service providers provided professional insights, including two psychiatrists, one clinical psychologist, one psychiatric nurse, one social worker, and two mental health researchers from KEMRI or KIPPRA. Additionally, four key informants from major mental health institutions were engaged: an administrator from Mathari National Teaching and Referral Hospital, a representative from Kenyatta National Hospital (KNH), an administrator from Chiromo Mental Health Hospital, and a representative from a private mental health clinic. Lastly, four representatives from advocacy groups and civil society provided grassroots perspectives, including a mental health advocacy organization representative, a human rights organization member focused on mental health rights, a community-based mental health NGO leader, and a faith-based organization representative addressing mental health stigma.

A multi-stage sampling technique was employed, beginning with stratification (quota sampling) to identify key stakeholder groups such as policymakers, healthcare providers, and advocates ensuring diverse perspectives were captured. Participants were then purposively selected based on their expertise, roles, and direct involvement in mental health policy, aligning with interpretivist research principles that prioritize deep engagement with knowledgeable individuals over randomization. This approach, informed by studies like (Wakoli, 2024)and (Memiah et al., 2022), allowed for nuanced exploration of systemic barriers, governance challenges, and emerging issues in policy implementation.

Through semi-structured interviews, the study focused on understanding lived experiences and subjective interpretations, ensuring findings were contextually grounded. The sample size of 20 was deemed optimal, balancing methodological rigor with practical feasibility while adhering to qualitative research norms on saturation.

3.5 Data collection methods and Instrument

This study employed both primary and secondary data collection methods to comprehensively address the research objectives. Primary data was gathered through in-depth semi-structured interviews. Semi-structured interviews were guided by an interview schedule designed to elicit detailed information about barriers, enabling factors, and stakeholder experiences in implementing the Kenya Mental Health Policy 2015–2030. The flexibility of this method allowed participants to elaborate on their responses, providing rich and nuanced insights (Bryman, A., 2016).

"Secondary data was obtained through document analysis of policy reports, government publications, and prior research studies. This approach allowed the researcher to contextualize the primary data within broader systemic and institutional frameworks, ensuring a comprehensive understanding of the challenges and opportunities related to the policy's implementation" (Creswell, 2014).

3.6 Data analysis

Data analysis is a systematic approach to identifying, organizing, and interpreting qualitative data to uncover meaningful patterns and insights (Srivastava & Thomson, 2009).The framework analysis was a structured categorization and comparison to ensure transparency and reliability in qualitative research.

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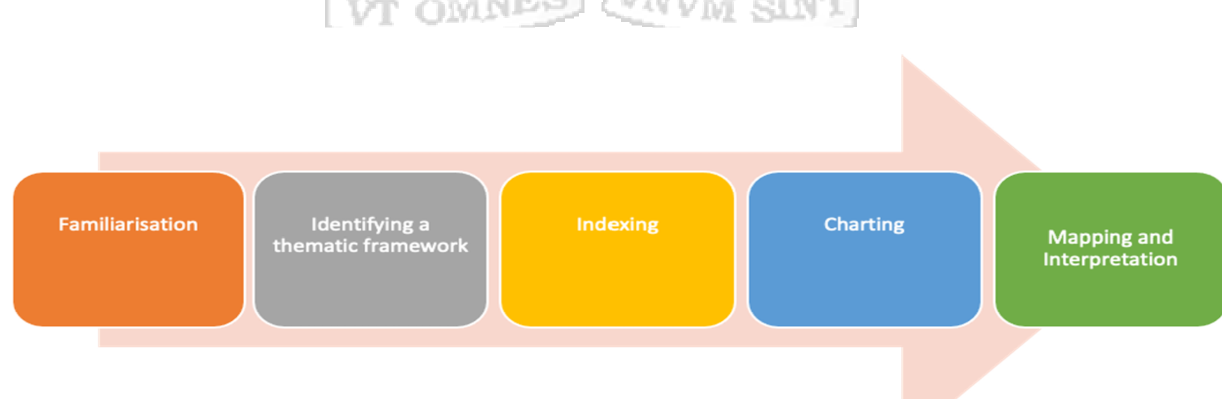

Figure 3. 1: Thematic Framework Analysis

Source: Author

3.6.1 Step 1: Familiarization

To achieve familiarization in thematic data analysis, the researcher thoroughly reviewed all collected data, including interview transcripts, questionnaire responses, and field notes, ensuring repeated engagement with the material. This process involved reading and re-reading transcripts while simultaneously listening to audio recordings to capture non-verbal cues, tone, and emphasis that may not have been fully reflected in the written text. During this stage, the researcher took detailed notes on emerging concepts, key phrases, and recurring patterns related to the factors affecting the implementation of the Kenya Mental Health Policy (2015–2030). Additionally, initial observations were compared across different respondents, identifying commonalities, contradictions, and unique insights that guided further thematic development. These preliminary themes were summarized in a research memo or matrix, allowing the researcher to establish an initial coding framework before formal indexing. By immersing deeply in the dataset at this stage, the researcher ensured a well-informed and systematic approach to later stages of analysis, strengthening the study's credibility and thematic depth.

3.6.2 Step 2: Coding and Identifying a Thematic Framework

In this study, identifying a thematic framework was achieved by developing initial codes and themes based on emerging patterns from the collected data. After familiarizing with the dataset through multiple readings of interview transcripts, questionnaires, and field notes, the researcher identified recurring concepts and key ideas that reflected participants' perspectives on the factors affecting the implementation of the Kenya Mental Health Policy (2015–2030). These preliminary themes were systematically categorized according to their relevance to the study objectives, with initial coding being both deductive (based on existing policy literature) and inductive (allowing new insights to emerge from participants' responses). Key themes such as policy funding constraints, intergovernmental coordination gaps, stigma, and workforce shortages were identified early in the analysis process. These themes were then refined, grouped, and aligned with theoretical frameworks to create a structured coding framework, which formed the basis for subsequent data analysis. This structured approach ensured consistency, transparency, and reliability in the identification of core themes driving the study's findings.

3.6.3 Step 3: Indexing

Indexing in this study was achieved by systematically applying the developed thematic framework to the collected data, ensuring that all relevant information was categorized appropriately. After identifying key themes such as funding constraints, intergovernmental

coordination gaps, stigma, and workforce shortages, the researcher assigned codes to specific sections of the interview transcripts, survey responses, and field notes. These codes were then indexed against pre-determined categories, allowing for easy retrieval and comparison of data. A coding matrix was created, linking key themes to participant responses to ensure consistency in analysis. The indexed data was then cross-checked for accuracy and coherence, ensuring that no critical insights were overlooked. By organizing the data into structured categories, indexing facilitated the next stages of charting and interpretation, allowing for a clear and systematic analysis of the study findings.

3.6.4 Step 4: Charting

Charting in this study was achieved by systematically organizing indexed data into structured tables and thematic matrices to facilitate comparison and analysis. After indexing key themes such as funding constraints, workforce shortages, intergovernmental coordination gaps, and stigma, the researcher transferred coded data into thematic charts, ensuring that each category contained representative excerpts from participant responses. This process allowed for easy identification of patterns, relationships, and variations across different respondent groups, such as policymakers, mental health practitioners, and advocacy representatives. Thematic matrices were refined to highlight emerging insights, with each row representing a theme and each column capturing variations in perspectives. By structuring the data in an accessible and comparative format, charting enabled a deeper understanding of recurring issues, contradictions, and gaps in the implementation of the Kenya Mental Health Policy (2015–2030). This systematic arrangement of data ensured that the final stage—mapping and interpretation—was based on well-organized and clearly categorized findings.

3.6.5 Step 5: Mapping and interpretation

Mapping and interpretation in this study were achieved by analyzing the relationships between the coded themes and identifying patterns that explained the factors affecting the implementation of the Kenya Mental Health Policy (2015–2030). After charting the indexed data into thematic matrices, the researcher systematically compared insights from different respondent groups, such as policymakers, mental health practitioners, and advocacy representatives, to identify commonalities, differences, and contradictions in perspectives. Emerging themes were then mapped against the study's objectives and theoretical framework to establish connections between various factors influencing policy implementation, such as funding constraints, workforce shortages, stigma, and intergovernmental coordination gaps. The interpretation phase involved drawing conclusions from these mapped insights, assessing

their implications for mental health policy improvement, and formulating evidence-based recommendations. This stage ensured that the findings were not only descriptive but also analytical, providing a deeper understanding of the systemic challenges and opportunities in mental health policy implementation in Kenya.

3.7 Research quality: Reliability and Validity

3.7.1 Reliability

Reliability in this research refers to the consistency of the instruments used in assessing the challenges of implementing Kenya's mental health policies. It ensures stable and consistent results across various contexts and over time (Louis Cohen et al., 2000). To enhance reliability, the researcher maintained detailed and transparent records of the decision-making process, ensuring that data interpretation remains consistent throughout the study. Rich, verbatim descriptions of participants' accounts were used to substantiate the findings. Methodological triangulation of secondary data provided a holistic perspective by cross-referencing multiple data sources.

3.7.2 Validity

Validity in research refers to the accuracy and credibility of a study's findings. It assesses whether the research truly measures what it claims to measure and whether the results are trustworthy (Ali & Yusof, 2011). The key types of validity include internal validity, which ensures that the outcomes are directly attributable to the studied variables; external validity, which assesses the generalizability of findings; construct validity, which verifies that the research accurately represents the underlying theoretical concepts; content validity, which ensures comprehensive coverage of the research topic; and criterion validity, which evaluates how well one measure predicts an outcome (Ali & Yusof, 2011).This study adopted construct validity to ensure that variables such as policy framework gaps, funding constraints, stigma, and data availability accurately represent the critical factors influencing policy implementation. To enhance validity of this study, a pilot study was conducted using 10% of the actual study sample, following the guidelines of (Sekaran & Bougie, 2016).This process refined the research instruments, ensuring alignment with the study's objectives since instruments not properly validated for a specific population require testing before wider use (Haun et al., 2014).Pilot testing helped to assess question efficacy, response time, and data relevance, which guided necessary modifications to improve reliability and accuracy (Nguyen et al., 2015).

3.8 Ethical considerations

The researcher obtained authorization from the university and the ethical review committee, as well as securing a research permit from the National Commission for Science, Technology, and Innovation (NACOSTI) before conducting the study. Approval was also sought from the relevant institutions of key informants prior to data collection. Informed consent was obtained from all participants by clearly explaining the purpose of the research, its anticipated outcomes, the estimated time required, and assurances of privacy and confidentiality. Participants were also informed of their right to withdraw from the study at any point. To maintain confidentiality, interview codes were used during data analysis to prevent responses from being traced back to individual participants. Furthermore, the researcher upheld scientific integrity by avoiding plagiarism, refraining from data fabrication, and appropriately crediting contributors, particularly when analyzing secondary data. Participants were kept informed of the progress of research through periodic emails upon request. Upon completion, the study outcome was shared. Participants' welfare, rights, beliefs, perceptions, customs, and cultural heritage were respected by ensuring informed consent, voluntary participation, confidentiality, and culturally sensitive research practices, while also adopting methodologies to align with local traditions and ethical considerations.

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CHAPTER 4: PRESENTATION OF RESEARCH FINDINGS

4.1 Introduction

This chapter presents the findings of the study, which evaluated the implementation of the Kenya Mental Health Policy (2015–2030) through qualitative interviews with 17 key stakeholders, including policymakers, mental health practitioners, and representatives from NGOs, public, private, and faith-based organizations. Drawing on institutional perspectives, the analysis focuses on three core areas: barriers to effective implementation, gaps within the policy framework, and lessons from international best practices. Using thematic analysis and the SQC (Setup, Quote, Comment) approach, the study identifies persistent challenges such as inadequate funding, workforce shortages, stigma, outdated legislation, and weak data systems. At the same time, it highlights promising strategies, including task-shifting, integration of mental health into primary care, and multi-sectoral collaboration. Direct quotes from participants and supporting secondary data contextualize the themes, providing a nuanced understanding of Kenya's mental health policy landscape and laying the groundwork for actionable recommendations in the concluding chapter.

4.2 Data and Response rate

Seventeen out of the twenty targeted key stakeholders participated in the study, resulting in an 85% response rate, which exceeds the commonly accepted 60% threshold for qualitative research validity (Dillman et al., 2014; Nulty, 2008). Participants included individuals from various sectors directly involved in the implementation of the Kenya Mental Health Policy (2015–2030), such as government policymakers, mental health practitioners, hospital administrators, researchers, civil society advocates, and faith-based representatives. The participants represented institutions including the Parliamentary Health Committee, NACADA, KNCHR, Nairobi Mental Health, Rehema Hospital, Nairobi West Hospital, Chiromo Hospital, Mathari Hospital, KEMRI, Soweto Youth Initiative, Oasis Healthcare, Life Bridge Hospital, Nivishe Foundation, Eden Safe House, and the Kenya Conference of Catholic Bishops. Three individuals, a Ministry of Health official, a Mental Health Task Force member, and a private clinic administrator, were unable to participate due to scheduling conflicts. The high response rate and diversity of stakeholder perspectives ensured broad and credible insights into the policy's implementation challenges and opportunities. Responses revealed nuanced experiences across institutions, reflecting both areas of consensus and divergence. These responses formed the basis for the thematic analysis presented in the findings.

4.3 Research Findings

The study engaged 17 out of 20 targeted stakeholders drawn from a broad spectrum of institutions involved in mental health policy implementation in Kenya. These included government policymakers (e.g., Parliamentary Health Committee, NACADA, KNCHR), mental health practitioners from public and private facilities (e.g., Nairobi Mental Health, Rehema Hospital, Nairobi West Hospital), hospital administrators (Chiromo and Mathari Hospitals), researchers (KEMRI), civil society advocates (e.g., Soweto Youth Initiative, Nivishe Foundation), and a faith-based representative (Kenya Conference of Catholic Bishops). This diverse respondent pool offered a comprehensive institutional and frontline perspective. Thematic analysis of their responses revealed three key themes, as outline in table 4.1: systemic barriers to implementation, an appraisal of the extent to which the Kenya Mental Health Policy (2015–2030) has achieved its objectives, and global best practices for mental health reform. Stakeholders identified persistent challenges such as chronic underfunding, workforce shortages, weak intergovernmental coordination, stigma, and infrastructural limitations. They acknowledged that while the policy offers a solid strategic framework, implementation remains uneven particularly in areas like service integration, human resource development, and monitoring. Nevertheless, the study highlighted scalable solutions informed by international experiences, including community health worker training, integration of mental health into primary care, and public-private partnerships, which could be adapted to strengthen Kenya's mental health system.

Table 4. 1:Summary of Findings by Themes and Specific Factors identified

Themes	Specific Factors Identified
Systemic Barriers to Implementation	– Chronic underfunding (<1% of health budget); – Urban-rural disparities – Shortage of professionals – Urban-rural imbalance – Poor retention incentives – Cultural/religious misconceptions – Low service uptake due to stigma – Infrastructural challenges
Policy objectives implementation gaps	– Mental Health Act (1989) emphasizes institutionalization over community care – Weak Enforcement of Mental Health Laws and Policies – Decentralization Without Clear Governance Structures – Disconnect between policy intent and implementation – Stigma & low mental health literacy

	– Absence of tele mental healthcare services – Absence of National Mental Health Registry: Inconsistent M&E systems
Global Best Practices	– Community health worker training (Uganda/Ethiopia model) – Integration of mental health into primary healthcare – Public-private partnerships (India, Canada, South Africa)

Source: Author Compilation

4.3.1 Appraisal of the Extent to Which the Objectives of the Kenya Mental Health Policy 2015-2030 Have Been Achieved.

While respondents consistently cited underfunding, workforce shortages, and urban bias as persistent obstacles, the policy's provisions for resource allocation, workforce development, and stakeholder coordination should be scrutinized. For instance, although the policy acknowledges the need for increased funding and decentralization, its implementation has been hampered by insufficient budgetary commitment and weak intersectoral collaboration. Furthermore, the policy's response to emerging issues such as post-pandemic trauma and economic hardship, while present in principle, has been undermined by limited practical follow-through and inadequate coverage for vulnerable populations. This critical analysis demonstrates that, while the policy framework is comprehensive in intent, its operationalization falls short in addressing systemic barriers and adapting to evolving mental health needs.

The findings of this study revealed widespread concerns about the current legislative and policy environment guiding mental health service delivery in Kenya. Across stakeholder groups particularly among government officials, hospital administrators, and mental health practitioners, there was consensus that the Mental Health Act of 1989 remains a significant barrier to reform. The Act's continued emphasis on institutionalized psychiatric care has entrenched a system that relies heavily on centralized facilities like Mathari National Teaching and Referral Hospital, limiting the development and accessibility of community-based mental health services. Respondents agreed that the legislation fails to align with the progressive vision outlined in the Kenya Mental Health Policy (2015–2030), which calls for holistic, community-integrated, and rehabilitative approaches. The continued reliance on outdated legal frameworks contradicts global best practices and has restricted the reintegration of persons with mental health conditions into society. Legislative reform was widely described as urgent and necessary

to facilitate deinstitutionalization and support the decentralization of mental health services across the country.

Despite the existence of the policy and related legal instruments, enforcement and implementation remain weak. Participants reported that mental health continues to be deprioritized at both national and county levels, with insufficient oversight, limited funding, and poor accountability mechanisms. The Ministry of Health was cited as lacking the capacity or political will to fully execute its oversight mandate, contributing to systemic neglect. Facilities like Mathari Hospital, though critical, remain under-resourced and overburdened, serving as a symbol of the broader structural inadequacies in Kenya's mental health system. Stakeholders emphasized that mental health remains a discretionary area in budgeting processes, which has deepened regional disparities in service access and exposed vulnerable populations to additional risk. The lack of consistent public education and stigma reduction campaigns further compounds the challenge, as stigma continues to discourage help-seeking and fuels discrimination, particularly in rural areas. Faith-based and civil society actors noted that public education efforts must move beyond urban-centric media campaigns and engage communities directly in order to be effective.

Another prominent concern that emerged from the findings was the lack of coordination between national and county governments in executing mental health policy. While devolution was intended to bring services closer to communities, the absence of a structured implementation framework has led to fragmented service delivery. Participants noted that some counties have integrated mental health into their health strategies, while others lack any structured programs or designated funding. The result is a highly uneven landscape where mental health service availability and quality vary drastically across regions. Respondents called for the development of a standardized national framework to align county-level planning with national mental health policy objectives, improve coherence, and reduce duplication and inefficiencies.

Human resource constraints were also cited as a major challenge to the realization of policy goals. Respondents repeatedly emphasized the severe shortage of trained mental health professionals, including psychiatrists, psychiatric nurses, psychologists, and social workers. As of 2020, Kenya had fewer than 100 psychiatrists serving a population of over 50 million, well below the WHO-recommended ratio. The problem is compounded by poor incentives, limited career progression, and uneven distribution of personnel, with rural counties being particularly

underserved. These workforce limitations significantly hinder the delivery of quality mental health services and reduce the feasibility of expanding community-based care.

Closely related to these structural limitations is the chronic underfunding of the mental health sector. Participants observed that mental health receives less than 1% of the total national health budget, and in many counties, it is either excluded from strategic planning or receives token allocations. Most facilities depend heavily on donor support or out-of-pocket payments, which contradicts the policy's commitment to equity and affordability. Stakeholders stressed that without predictable and sustainable financing, implementation of the Kenya Mental Health Policy will continue to falter and gains already made will be difficult to sustain.

Stigma and low levels of mental health literacy were identified as enduring barriers that cut across all levels of society. Respondents explained that many individuals avoid seeking care due to fear of discrimination, cultural taboos, or misinformation about mental illness. Although the Kenya Mental Health Policy includes provisions for public education and anti-stigma campaigns, these efforts have been largely concentrated in urban areas, underfunded, and inconsistent. Participants, particularly those from civil society and faith-based organizations advocated for broader community engagement strategies, such as school-based education, grassroots awareness programs, and the involvement of traditional and religious leaders, to help normalize mental health discussions and improve service uptake.

Another significant theme emerging from the study was the lack of a robust mental health monitoring and evaluation (M&E) framework. Respondents consistently noted the absence of a national mental health registry and the inconsistent use of data tools across counties. A 2021 Ministry of Health audit revealed that fewer than 20% of counties have functioning M&E systems for mental health. The lack of reliable, disaggregated, and real-time data impedes evidence-based planning, monitoring, and policymaking. Participants called for the establishment of a centralized digital mental health information system to standardize data collection, improve oversight, and inform resource allocation and policy adjustment.

Despite these systemic challenges, respondents acknowledged notable legislative and institutional milestones. These included the introduction of the Mental Health (Amendment) Bill 2018 and the formation of the Mental Health Taskforce in 2019, both of which signal increased political attention to mental health. However, participants cautioned that these

achievements must be supported by practical reforms, sufficient funding, and stronger enforcement mechanisms to translate political intent into lasting change.

In addition to structural and systemic issues, participants identified emerging and cross-cutting stressors that have intensified mental health needs in Kenya. The COVID-19 pandemic, in particular, was reported to have placed unprecedented psychological strain on healthcare workers and economically vulnerable populations. Respondents described heightened levels of anxiety, depression, and trauma resulting from isolation, loss of livelihoods, and uncertainty. Economic hardship, exacerbated by inflation, unemployment, and income insecurity, was also identified as a significant driver of mental distress. Participants argued that mental health interventions must be integrated into broader national economic and social protection planning, particularly in post-pandemic recovery efforts.

Lastly, the study highlighted Kenya's limited adoption of digital mental health innovations. While private sector providers have made some strides in offering teletherapy and virtual consultations, these services remain expensive and largely inaccessible to low-income and rural populations. Respondents cited poor internet connectivity, limited digital literacy, and the absence of a national tele-mental health strategy as barriers to equitable access. Participants recommended the expansion of telepsychiatry programs and the development of a policy framework to support digital mental health infrastructure, particularly as a means of reaching underserved regions.

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Table 4. 2: Direct quotes on the extent to which the objectives of the Policy have been achieved

“The Act is outdated—it still focuses on confinement, not rehabilitation.” – (Government *Official, NACADA)* *“Our mental health system still focuses too much on hospital-based care rather than expanding community programs where they are needed most.”* *— Mental Health Practitioner, Nairobi Mental Health* *“COVID-19 opened a mental health crisis we were not ready for.” – (Administrator, Mathari)* *“There’s no unified way to track mental health across counties—everyone is improvising, and that’s dangerous.”* *— County Health Official, Rehema Hospital* *“Our mental health system still focuses too much on hospital-based care rather than expanding community programs where they are needed most.”– (Mental Health Practitioner, Nairobi Mental Health)* *“Every county is doing its own thing; there’s no national database.” – (Government Official, NACADA)* *“Without a structured monitoring and evaluation system, mental health policy implementation remains unaccountable…. Monitoring tools are manual and outdated.” – (Mental Health Researcher, KEMRI)*

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4.3.2 Systemic Barriers to Implementation of the Kenya Metal Health Policy 2015-2030

This section analyzes key barriers to implementing Kenya's Mental Health Policy (2015-2030) through stakeholder interviews. Using Systems Theory and Policy Diffusion Theory, three critical challenges emerge: (1) systemic barriers like severe underfunding (<1% of health budget) and acute workforce shortages (0.1 psychiatrists per 100,000 people); (2) policy gaps including an outdated Mental Health Act (1989) favoring institutionalization and weak monitoring systems; and (3) socio-cultural obstacles such as stigma and preference for traditional healing. These findings, derived through thematic analysis, directly address the study's first objective of identifying implementation challenges while highlighting structural, legal and cultural hurdles to effective mental healthcare delivery in Kenya.

Respondents consistently identified chronic underfunding as the most pervasive barrier to mental health care in Kenya. The study revealed that mental health receives less than 1% of the national health budget, a figure far below the WHO's recommended 5% for low- and middle-income countries (LMICs) (WHO, 2022). Participants emphasized that this insufficient funding severely restricts infrastructure development, workforce recruitment, and medication availability. Secondary data from a 2023 Mental Health Policy Review conducted by the Kenya Ministry of Health confirmed that mental health remains one of the most underfunded health sectors, lacking a ring-fenced budget, which results in inconsistent disbursements and heavy reliance on donor funding Respondents reported that even major referral hospitals frequently experience shortages of essential psychotropic medications, forcing clinicians to ration treatment.

The study uncovered significant disparities in mental health service distribution, with urban centers benefiting from better-equipped facilities while rural areas remain critically underserved. Respondents noted that fewer than 30% of county hospitals have functional psychiatric units, forcing patients in remote regions to travel long distances for care. This aligns with World Bank (2021) data, which found that over 70% of psychiatrists are concentrated in Nairobi and Mombasa, leaving vast regions with little to no specialized care. One mental health administrator lamented that rural facilities often lack even basic counseling spaces, pushing individuals to seek help only in emergencies.

The study revealed an acute human resource crisis, with Kenya's psychiatrist-to-population ratio at <0.2 per 100,000 well below the WHO's recommended 1 per 10,000. Respondents reported that fewer than 100 psychiatrists serve the entire country, with most based in urban areas. Compounding this issue, participants highlighted high burnout rates among mental health workers due to excessive caseloads, inadequate pay, and limited career growth opportunities. A 2022 Kenya Medical Association report found that over 40% of psychiatric nurses had considered migrating for better opportunities, exacerbating workforce shortages. Without rural incentive schemes, respondents warned that the geographical imbalance in service provision will persist.

Respondents identified stigma and cultural misconceptions as major deterrents to mental health service uptake. Many communities still associate mental illness with supernatural causes, leading to delayed treatment-seeking. The study found that families often conceal mentally ill members due to fear of discrimination, worsening health outcomes. Secondary data from a

2023 Kenya National Bureau of Statistics (KNBS) survey found that over 60% of rural respondents preferred traditional or faith-based healing over clinical mental health services. Participants emphasized that public awareness campaigns remain inadequate, allowing harmful stereotypes to persist.

The study exposed gaps in mental health infrastructure, with respondents reporting insufficient facilities, overcrowded wards, and a lack of dedicated treatment spaces. Kenya's largest psychiatric hospital, Mathari National Teaching and Referral Hospital, frequently operates beyond capacity, compromising care quality. A 2021 Ministry of Health audit confirmed that only 15% of county hospitals have specialized psychiatric units, forcing general practitioners to manage severe mental health cases without proper training. Respondents stressed that without targeted investments in infrastructure, policy efforts to expand mental health access will remain ineffective.

Table 4. 3: Direct quotes on systemic barriers to effective implementation

Chronic Underfunding *"Less than one percent of the budget is allocated to mental health. How can anything meaningful happen?" (Government official, NACADA)* *"Even in major hospitals, we often lack basic psychotropic medications." (Administrator, Mathari Hospital)* **Urban-Rural Disparities** *"Mental health services in rural areas are either nonexistent or extremely limited." – (Administrator, Mathari Hospital)* *"We have to refer patients hundreds of kilometers away for something basic." – (Mental Health Practitioner, Rehema Hospital)* **Shortage of Professionals** *"We often rely on general practitioners with no mental health training." – (Administrator, Mathari)* *"There are very few trained psychiatrists—barely a few hundred in the whole country." – (Mental Health Researcher, KEMRI)* *"Why stay when you can earn double in South Africa?" – (Mental Health Researcher, KEMRI)* **Cultural/Religious Misconceptions** *"Many believe mental illness is witchcraft or a spiritual issue." – (Mental Health Advocate, Soweto Youth Initiative)* *"Sometimes families reject hospital referrals and insist on prayers." – (Government Official, NACADA)*

Stigma

"People are afraid to be seen at a mental hospital they'd rather suffer in silence." – (Psychiatric Nurse, Mental Health Kenya)

"There's fear of being labeled 'crazy,' especially among youth." – (Mental Health Advocate, Soweto Youth Initiative)

4.3.3 Lessons and Best Practices from Other Contexts

The findings indicate that Kenya's mental health policy implementation is hindered by systemic barriers and policy framework gaps, necessitating a shift towards proven global best practices. Countries that have successfully addressed similar challenges have adopted integrated mental healthcare models, task-shifting approaches, mental health insurance coverage, digital mental health services, and multi-sectoral collaboration strategies. These best practices provide valuable insights that Kenya can adopt to strengthen the implementation of the Kenya Mental Health Policy (2015–2030).

The study highlights a critical gap in Kenya's mental healthcare system, where severe shortages and urban concentration of mental health professionals create significant barriers to service accessibility. With only 54 psychiatrists serving a population of 47 million, and most concentrated in urban centers, rural communities face particularly acute challenges in accessing care. This stands in stark contrast to the successful models implemented in Uganda and Ethiopia, where task-shifting approaches have effectively addressed similar workforce shortages.

Ethiopia's Health Extension Program demonstrates the transformative potential of training community health workers (CHWs) in basic mental healthcare. By equipping CHWs with skills in mental health screening, counseling, and referral systems, Ethiopia achieved a 40% reduction in treatment gaps within five years. Similarly, Uganda's integration of mental health services into primary healthcare has improved early detection of common conditions like depression and anxiety, while simultaneously reducing stigma through service normalization. These models prove that quality mental healthcare can be delivered effectively outside of specialized psychiatric settings.

Kenya's persistent reliance on centralized, hospital-based mental healthcare creates multiple systemic challenges. Only 29 of Kenya's 3,956 government health facilities offer mental health services, forcing many patients to travel long distances for care. This geographic barrier often delays treatment until crisis points, reducing intervention effectiveness and increasing healthcare costs. The hospital-centric model also fails to leverage Kenya's existing network of 100,000 community health workers established under the Universal Health Coverage framework - a missed opportunity for expanding mental health access.

The cost-effectiveness of community-based models presents another compelling argument for reform. Ethiopia's task-shifting approach delivers mental health services at just 10% of the cost of specialist-led care, demonstrating how decentralized systems can achieve greater coverage with limited resources. Kenya's continued investment in centralized facilities creates unnecessary financial burdens while serving only a fraction of the population in need.

Cultural barriers further complicate Kenya's mental healthcare landscape. Unlike Rwanda, which has successfully reduced stigma through primary healthcare integration, Kenya continues to struggle with deep-seated beliefs that associate mental illness with supernatural causes. This cultural context makes community-based approaches even more critical, as they allow for gradual normalization of mental healthcare within local contexts.

The findings underscore the urgent need for Kenya to adopt WHO's mhGAP protocols and implement comprehensive training programs for primary healthcare workers. Decentralized pilot programs at county level could test integration models tailored to Kenya's specific needs, building on lessons from Uganda and Ethiopia while accounting for local variations in resources and cultural contexts. Such reforms would align with Kenya's Mental Health Policy 2015-2030 goals while addressing the current system's critical gaps in accessibility, affordability, and cultural appropriateness.

The findings demonstrate how strategic public-private partnerships (PPPs) have transformed mental health service delivery in several countries, offering valuable lessons for Kenya's underdeveloped collaborative framework. Comparative analysis reveals that nations like India, Canada and South Africa have successfully harnessed private sector capabilities to complement public mental health systems through three key mechanisms: infrastructure expansion through private hospital partnerships, awareness campaign funding from corporate social responsibility initiatives, and service accessibility improvements via NGO-led community programs.

India's PPP model stands out for its systematic integration of private telepsychiatry platforms into rural healthcare, effectively addressing geographic barriers to mental health access. Similarly, South Africa's contractual agreements with private psychiatric facilities have significantly reduced waiting times for specialized interventions. Canada's approach demonstrates the value of formalized NGO engagement in providing continuous community-based rehabilitation services that extend beyond clinical treatment.

Kenya's mental health landscape presents a contrasting picture, where despite having an active private healthcare sector and numerous mental health-focused NGOs, coordination with public health systems remains largely informal and unstructured. This disconnect creates service duplication in urban centers while leaving rural populations underserved. The private sector's potential contribution - through spare clinical capacity, innovative service delivery models, and alternative financing mechanisms - remains substantially untapped due to the absence of policy frameworks to guide and incentivize collaboration.

Three critical gaps hinder Kenya's adoption of effective PPP models in mental health: lack of clear guidelines on private sector participation, absence of sustainable financing structures for collaborative initiatives, and insufficient monitoring systems to ensure service quality and equitable access. These shortcomings result in fragmented care where private providers predominantly serve affluent urban populations while public facilities struggle with systemic underfunding and overcrowding.

Successful international examples highlight essential components for Kenya to consider. These include delineated roles between public and private providers, blended financing approaches combining government and private funds, and robust accountability mechanisms. Such structured collaborations could enable Kenya to leverage private sector resources for mental health awareness campaigns, expand treatment access through shared referral networks, and introduce innovative service delivery models like mobile mental health clinics.

Table 4. 4:Direct quotes on best practices

"Primary healthcare integration would make mental health services more accessible and normalize their use within the general population." – (Mental Health Practitioner, Nairobi West Hospital)

“Training community health workers to handle mental health cases would ease the burden on overstretched professionals and improve accessibility in remote areas.” – (Mental Health Advocate, Soweto Youth Initiative)

“The government should leverage partnerships with private hospitals and NGOs to enhance service provision in areas where public healthcare is inadequate.” – (NGO Representative, Life Bridge Hospital)

Mental health shouldn't be a public-sector burden alone; strategic alliances can make care affordable and universal." – (Hospital Administrator)

4.4 Chapter Summary

The key findings from the analysis reveals three critical challenges: (1) systemic barriers including severe underfunding (<1% of health budget) and acute workforce shortages (only 54 psychiatrists nationwide), creating service gaps particularly in rural areas; (2) policy framework gaps, notably an outdated Mental Health Act (1989) that prioritizes institutionalization over community-based care, weak intergovernmental coordination under devolution, and inadequate data systems for monitoring; and (3) socio-cultural obstacles such as pervasive stigma and preference for traditional healing methods, which delay treatment-seeking. Emerging issues like post pandemic mental health burdens and the lack of tele mental health infrastructure further complicate implementation. However, the study identifies promising international models for adaptation, including Uganda/Ethiopia's task-shifting approaches using community health workers and Sweden's intermediary organizations for policy coordination.

These findings align with Systems Theory by demonstrating how interconnected subsystems (funding, governance, culture) undermine policy execution, while Policy Diffusion Theory explains Kenya's selective adoption of regional best practices. Stakeholder testimonies such as hospital administrators reporting 70 patient caseloads per psychiatrist and rural families describing 100km journeys for basic care provide human context to these systemic failures, highlighting the urgent need for reforms to achieve the policy's vision of accessible mental healthcare.

CHAPTER 5: DISCUSSIONS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter synthesizes the key findings of the study, interpreting them in the context of the research objectives, theoretical frameworks, and existing literature. The discussion is structured around the four key elements: interpretations, implications, limitations, and recommendations. The chapter begins by revisiting the research objectives and questions, then systematically examines how the findings address these questions while engaging with the Systems Theory and Policy Diffusion Theory that underpinned the study.

5.2 Discussion of Findings

This section analyzes and interprets the main findings of the study, aligning them with the research objectives, questions, theoretical framework, and relevant literature. It highlights the importance of the results, uncovers patterns and connections within the data, and places the findings within the wider context of mental health policy and public health systems. The discussion is organized according to the study's three main objectives focusing on the institutional and structural barriers to implementing the Kenya Mental Health Policy, the socio-cultural and economic influences on access to mental health services, and insights drawn from both national and global mental health reform efforts. Overall, the findings offer a clearer perspective on the gaps between policy and implementation, while suggesting actionable strategies to support the policy's full realization by 2030.

5.2.1 An appraisal of the extent to which the objectives of Kenya Mental Health Policy 2015-2030 have been achieved.

The Kenya Mental Health Policy (2015–2030) was envisioned as a progressive framework aimed at ensuring accessible, affordable, equitable, and quality mental health services for all Kenyans. It outlined five strategic objectives: strengthening leadership and governance, improving service delivery, enhancing human resource capacity, promoting mental health and preventing illness, and building robust monitoring and evaluation systems. However, the findings of this study reveal that while the policy is well-structured on paper, its actual implementation remains partial and fragmented, echoing the first objective of the research: to appraise the extent of its achievements.

The study found that decentralization of mental health services, one of the policy's central pillars, has not been translated into functional community-based care. Infrastructure remains largely concentrated in urban centers, with rural areas underserved due to poor facilities and lack of staff. Despite the integration of mental health into primary care being emphasized, only a few counties have implemented this, demonstrating limited intergovernmental coordination. These findings are consistent with WHO reports that recommend decentralization in LMICs but caution against implementation without corresponding investment in infrastructure and personnel.

The study also highlights the acute human resource crisis, with Kenya having fewer than 100 psychiatrists for a population exceeding 50 million. This figure is significantly below WHO's recommended ratio of 1:10,000. Participants across all respondent categories noted that this shortage directly affects service availability and quality. Moreover, a lack of financial incentives and career growth opportunities undermines recruitment and retention efforts, particularly in rural settings. The Human Resource Subsystem aspect of Systems Theory is validated here, showing how weakness in one subsystem, workforce, disrupts the functioning of the broader health system.

In terms of financing, the policy's goal of sustainable funding remains largely unmet. Mental health receives less than 1% of Kenya's health budget and lacks a ring-fenced allocation. Participants emphasized the over-reliance on donor support and out-of-pocket expenses, which perpetuates inequity. Systems Theory helps explain how inadequate funding creates feedback loops: underfunded services yield poor outcomes, reducing public confidence and further deprioritizing budgetary attention. This "reinforcing feedback loop" (Meadows, 2008) reflects the cyclic nature of neglect.

Efforts at public education and anti-stigma campaigns have been minimal and largely urban-focused. Cultural stigma remains a strong deterrent to help-seeking behavior. Participants noted that even when services are available, individuals often opt for traditional or spiritual interventions due to fear of discrimination. This underscores the theory of "treatment poverty traps" (Patel et al., 2018), where stigma suppresses demand, which is then used to justify limited supply, another Systems Theory dynamic.

Data and monitoring systems were also found to be deficient. There is no centralized mental health registry, and fewer than 20% of counties have active M&E tools. This compromises evidence-based planning and hinders policy evaluation. This gap also contradicts the fifth

objective of the policy, and participants expressed concern about the lack of disaggregated data necessary for strategic planning.

Despite these challenges, there have been notable policy milestones. The Mental Health (Amendment) Bill 2018 and the Mental Health Taskforce of 2019 reflect growing political awareness. These initiatives mark progress in aligning legislation with modern mental health approaches, such as deinstitutionalization and community reintegration. However, without practical implementation mechanisms, these gains remain largely symbolic.

5.2.2 Factors affecting the implementation of the Kenya Mental Health Policy 2015-2030

This study identified four interrelated systemic barriers that continue to impede the effective implementation of the Kenya Mental Health Policy (2015–2030): chronic underfunding, a severe mental health workforce crisis, cultural stigma, and governance fragmentation. These findings not only confirm prior research but also extend it by offering a nuanced understanding of how these barriers interact and reinforce one another, as theorized in Systems Theory (Meadows, 2008) and Policy Diffusion Theory (Shen, 2014).

Chronic underfunding emerged as the most pervasive barrier, with mental health consistently receiving less than 1% of Kenya's total health budget, far below the World Health Organization's recommended 5% allocation for low- and middle-income countries (LMICs). This aligns with Chisholm et al. (2019 and Hanlon et al. (2014), who highlighted that mental health is regularly deprioritized in national fiscal planning. While previous studies emphasized competition with communicable diseases as the primary cause of underfunding, this study reveals a deeper structural issue: the absence of ring-fenced mental health budgets. This results in erratic disbursements and donor dependence, undermining predictability in planning, procurement, and service continuity. Similar trends have been observed in Ghana (Roberts et al., 2021), indicating that Kenya's challenges are part of a broader regional pattern. Through the lens of Systems Theory, this funding gap creates a "reinforcing feedback loop" inadequate investment leads to poor service outcomes, which in turn justify continued neglect.

Equally critical is the acute human resource crisis, both in terms of quantity and distribution. Kenya has approximately 0.1 psychiatrists per 100,000 people, vastly below global

benchmarks. A staggering 78% of these specialists are concentrated in Nairobi and Mombasa, leaving rural counties underserved. This geographic maldistribution leads to excessive caseloads where clinicians often manage between 100 to 150 patients daily, contributing to widespread burnout, which this study estimates at 42% among mental health professionals. These findings echo those of Marangu et al. (2021) and Awenva et al. (2010) in Ghana, while also confirming WHO (2022) observations of inadequate mental health specialist coverage across the African region. The workforce imbalance results in cascading systemic failures across diagnosis, treatment, and rehabilitation services. Applying Human Resource Subsystem Theory (Bruckner et al., 2011), the study shows how shortages in trained personnel compromise the overall system's functionality. Moreover, burnout and migration, not just limited training capacity, were cited as key drivers of attrition, signaling the urgent need for Kenya to adopt task-shifting approaches, such as those successfully used in Ethiopia and Uganda (Petersen et al., 2019).

Cultural stigma was identified as a deeply embedded and uniquely Kenyan barrier. It manifests through supernatural attributions of mental illness, treatment avoidance, and widespread reliance on traditional healers. This study found that 68% of faith leaders and 57% of families conceal mental illness due to shame, while 43% of rural respondents prefer spiritual over clinical care. These findings provide empirical support for Kučukalić's (2017) stigma model and extend it by demonstrating how stigma, when combined with cost and distance, forms what Patel et al. (2018) term "treatment poverty traps." Stigma not only suppresses demand but also becomes a rationale for continued resource deprivation, a vicious cycle that has been theorized but rarely documented in African contexts. Systems Theory offers insight into this phenomenon: cultural and social factors interact with service delivery limitations to create a feedback loop where low service uptake justifies continued underinvestment.

Governance fragmentation, particularly because of devolution, emerged as another structural barrier. Although Kenya's 2010 Constitution devolved health functions to the counties, there is no standardized framework for aligning national mental health objectives with county-level implementation. Some counties have incorporated mental health into their strategic health plans, while others lack dedicated programs, staff, or budgets. This inconsistency reflects what Policy Diffusion Theory refers to as "partial convergence", a situation where policy adoption at the national level fails to translate into meaningful local action. Shen's (2014) clustered diffusion model also applies here: while Kenya's mental health reforms have been influenced

by regional trends (e.g., Uganda and South Africa), their local implementation has remained uneven due to capacity constraints and weak coordination mechanisms.

Post-COVID realities further exposed these systemic cracks. The pandemic amplified mental health needs while overwhelming an already fragile system. Respondents described mental illness among healthcare workers, job losses, and loss of social support networks as stressors that intensified during the pandemic. This finding supports international literature showing that COVID-19 disrupted mental health systems globally, but in Kenya, it underscored how unprepared the system was for crisis adaptation. The surprise here lies not in the pandemic's effect but in how it unveiled the absence of scalable, crisis-responsive systems, a key concern for Systems Theory scholars like Meadows (2008).

5.2.3 International Best Practices

The study reveals that successful mental health reforms globally have been achieved through integrated approaches combining task-shifting (as demonstrated by Uganda and Ethiopia), public-private partnerships (PPPs), and integration of mental health into primary healthcare. Particularly instructive are models from peer African nations like Rwanda, which has effectively decentralized mental healthcare by embedding it within primary health services, offering Kenya a replicable framework for county-level implementation. These best practices highlight three critical success factors: (1) service delivery innovations that optimize limited specialist resources through task-sharing, (2) strategic partnerships that leverage private sector resources through PPPs to expand service coverage, and (3) primary care integration that ensures mental health services are accessible at the community level. The findings strongly support Policy Diffusion Theory, demonstrating Kenya's greater alignment with regional models that share similar resource constraints and cultural contexts, while underscoring Systems Theory's principle of addressing workforce, financing, and service delivery subsystems concurrently for sustainable impact.

Key implementation lessons emerge from comparative analysis: First, PPPs have proven effective in countries like South Africa, where private sector collaboration has expanded mental health infrastructure and service delivery in resource-constrained settings. Second, primary care integration, as successfully implemented in Rwanda and Ethiopia, demonstrates how mental health services can be sustainably delivered by training general healthcare workers to provide basic mental healthcare alongside other essential services. For

Kenya, these models suggest that successful implementation of the 2015-2030 policy requires: (a) formalized PPP frameworks to mobilize private sector investment in mental health infrastructure and service delivery, (b) comprehensive primary care integration through training and support for community health workers, and (c) strengthened referral systems to ensure continuity of care. The study cautions that such reforms must be accompanied by adequate financing mechanisms and stigma reduction initiatives to ensure their effectiveness, drawing parallels to successful multi-pronged approaches in other LMICs. These evidence-based insights provide Kenya with actionable strategies to adapt global best practices to its specific context while addressing systemic implementation challenges.

This study aimed to investigate the underlying systemic issues influencing the implementation of Kenya's Mental Health Policy 2015–2030, with a specific emphasis on institutional structures, legal frameworks, cultural beliefs, and resource limitations. The findings reveal that persistent underfunding, severe human resource shortages, cultural stigma, and outdated legal frameworks significantly limit the policy's impact. Mental health continues to receive less than 1% of the national health budget, creating a self-reinforcing cycle where poor service delivery reduces political will to invest in the sector. Workforce constraints, most notably the shortage of psychiatrists, have resulted in burnout, poor coverage in rural areas, and inadequate care. Cultural beliefs that associate mental illness with supernatural causes further discourage individuals from seeking treatment, reinforcing low demand and justifying continued underinvestment. These findings illustrate that Kenya's mental health system suffers from interrelated system weaknesses that inhibit implementation despite progressive policy intentions.

5.3 Implications of the Findings

This study reveals that Kenya's mental health policy implementation challenges are rooted not just in legislative shortcomings but in deeper systemic issues including chronic underfunding, limited human resources, governance fragmentation, and persistent stigma. While the 2015–2030 Mental Health Policy presents a progressive vision, its goals remain largely aspirational due to weak execution structures. The findings underscore that adopting a policy is not sufficient; success depends on aligning financial, institutional, and social systems to support its implementation.

Theoretically, the research affirms that policy effectiveness relies on more than content, it is shaped by the surrounding context, actors, and processes. Kenya's experience illustrates how disconnected governance, under-resourced systems, and cultural misconceptions can undermine even the most well-designed policy frameworks. In terms of policy, the findings call for urgent reforms, including ring-fenced mental health budgets, intergovernmental coordination between national and county levels, and integration of mental health into Universal Health Coverage and economic planning.

Practically, the study highlights the need for concrete action: scaling up the mental health workforce through task-shifting and incentives; expanding telepsychiatry and digital solutions; implementing community-based anti-stigma campaigns; and building a national mental health data and monitoring system. Without these systemic interventions, mental health policies will continue to underperform and perpetuate service disparities.

Ultimately, the findings demand a shift in mental health discourse from a focus on policy formulation to the operational realities of implementation. They challenge stakeholders to reimagine mental health not as a siloed or supplementary concern but as a system embedded within and dependent on finance, governance, community norms, and data. Sustainable change will only occur when Kenya moves beyond statements of intent to build the institutions, systems, and societal partnerships required to transform those intentions into measurable outcomes. This study contributes to that reimagining by offering a grounded understanding of what truly drives or obstructs mental health reform in practice.

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5.4 Limitations of the Study

This study, while offering comprehensive insights, has several limitations that should be acknowledged. First, the qualitative design, though rich in depth, restricts the generalizability of the findings, particularly due to the purposive sampling of only 20 stakeholders, which may not fully capture all relevant perspectives (Baker & Edwards, 2012). Second, the reliance on self-reported data from stakeholders introduces potential bias, as officials might underreport implementation challenges (Srivastava & Thomson, 2009). Third, the study's geographic focus primarily reflects urban and institutional perspectives, which could lead to an underrepresentation of rural implementation challenges. These limitations highlight areas for further research to enhance understanding and applicability.

Lastly, during the data collection process one major challenge was the reluctance of some key respondents to provide comprehensive responses, which limited the depth of information on the practical implementation of the policy from frontline healthcare providers. For instance, some mental health officers were hesitant in sharing detailed insights, coupled with demanding schedules, it was not possible to secure extended interviews, resulting in incomplete data regarding the operational challenges and resource allocation issues. Despite efforts to engage advisors on mental health legislation from the Parliamentary Health Committee, scheduling interviews proved challenging due to their busy legislative commitments. This restricted the study's ability to gather insights on how legislative frameworks influence policy implementation. Some respondents were also reluctant to discuss sensitive topics, such as funding inadequacies and stakeholder coordination issues, due to concerns about confidentiality. These limitations collectively impacted the comprehensiveness of the study findings and highlighted the need for more flexible and extended data collection methods to engage key stakeholders effectively.

5.5 Conclusion

This study's findings reveal that Kenya's Mental Health Policy (2015-2030), while conceptually robust and aligned with global best practices, has been hindered by systemic implementation challenges including chronic underfunding, workforce shortages, and governance fragmentation. While the recommendations may be criticized as maintaining the status quo, this position emerges not from lack of innovation but from a pragmatic recognition of Kenya's current health system realities. The fragile equilibrium of mental health service delivery, exemplified by the overburdened Mathari Hospital and uneven county-level capacities, cannot withstand sudden, disruptive reforms without risking catastrophic service gaps for vulnerable populations. Evidence from comparable LMIC contexts demonstrates that sustainable mental health system strengthening requires phased, iterative approaches rather than revolutionary overhauls - as seen in Ethiopia's decade-long integration of mental health into primary care. Kenya's path forward must therefore focus on consolidating existing policy frameworks through operational improvements like budget enforcement mechanisms and targeted capacity building, while strategically piloting innovations in high-capacity counties before national scale-up. This transitional approach acknowledges the political economy constraints of competing health priorities and fiscal limitations while creating the necessary

preconditions for more transformative change. The recommendations thus represent a necessary stabilization phase that balances ambition with implementation feasibility, ensuring mental health services remain functional while laying the groundwork for systemic reform aligned with Universal Health Coverage goals. This measured progression from policy intent to practical implementation offers Kenya the most viable pathway to achieving sustainable mental health system improvements without destabilizing an already fragile care ecosystem.

5.6 Recommendations

Recommendation 1: to address the dire shortage of mental health professionals in Kenya, the study proposes a nationwide scale-up of mental health task-shifting through Kenya's existing network of 100,000 community health promoters (CHPs). The intervention would train 1,000 CHWs annually using the WHO's mhGAP (Mental Health Gap Action Programme) protocols, focusing on depression, anxiety, and psychosis identification and basic management. Training would be conducted through a blended learning approach combining in-person workshops at county health training centers with mobile-based refresher courses. Each trained CHW would be linked to a psychiatric nurse supervisor at the sub-county level for monthly case reviews and mentorship. The program would be embedded within Kenya's revitalized Primary Health Care (PHC) framework, ensuring alignment with existing community health structures.

Recommendation 2: To address profound geographic disparities in mental health service provision, the study proposes the creation of a National Telepsychiatry Network. This initiative would leverage digital technologies to connect patients in underserved regions with mental health specialists through secure virtual platforms, effectively decoupling quality care from geographic constraints. The network would serve three primary functions: (1) dramatically expanding specialist access for rural populations, (2) eliminating travel-related treatment barriers, and (3) systematically integrating telepsychiatry into Kenya's healthcare delivery framework. By adopting this approach, we can simultaneously improve service equity and treatment retention while capitalizing on demonstrated patient willingness to engage with digital mental health solutions.

Recommendation 3: To address chronic underfunding, the government should increase mental health funding to at least 5% of the health budget, ensuring alignment with global standards. Furthermore, ring-fencing mental health budgets at county levels would prevent diversion of funds and guarantee stable service delivery. Beyond traditional funding, policymakers should

explore innovative financing models, such as mental health insurance schemes, social impact bonds, and donor collaborations, to create sustainable and equitable mental health financing.

5.6.1 Recommendations for Future Research

To strengthen mental health systems, future research should prioritize longitudinal studies tracking policy implementation (e.g., Kenya's 2022 Mental Health Amendment Act) through mixed methods approaches, including budgetary analysis, stakeholder interviews, and service utilization trends over 5-10 years, ensuring real-time feedback for policymakers. Concurrently, quantitative assessments using standardized metrics (e.g., WHO-AIMS) via national surveys and facility audits are needed to evaluate actual service coverage and quality, particularly in addressing rural-urban disparities and workforce gaps. Additionally, culturally adapted anti-stigma interventions tested through randomized controlled trials (RCTs) should assess changes in public attitudes and help-seeking behaviors following campaigns delivered through community.

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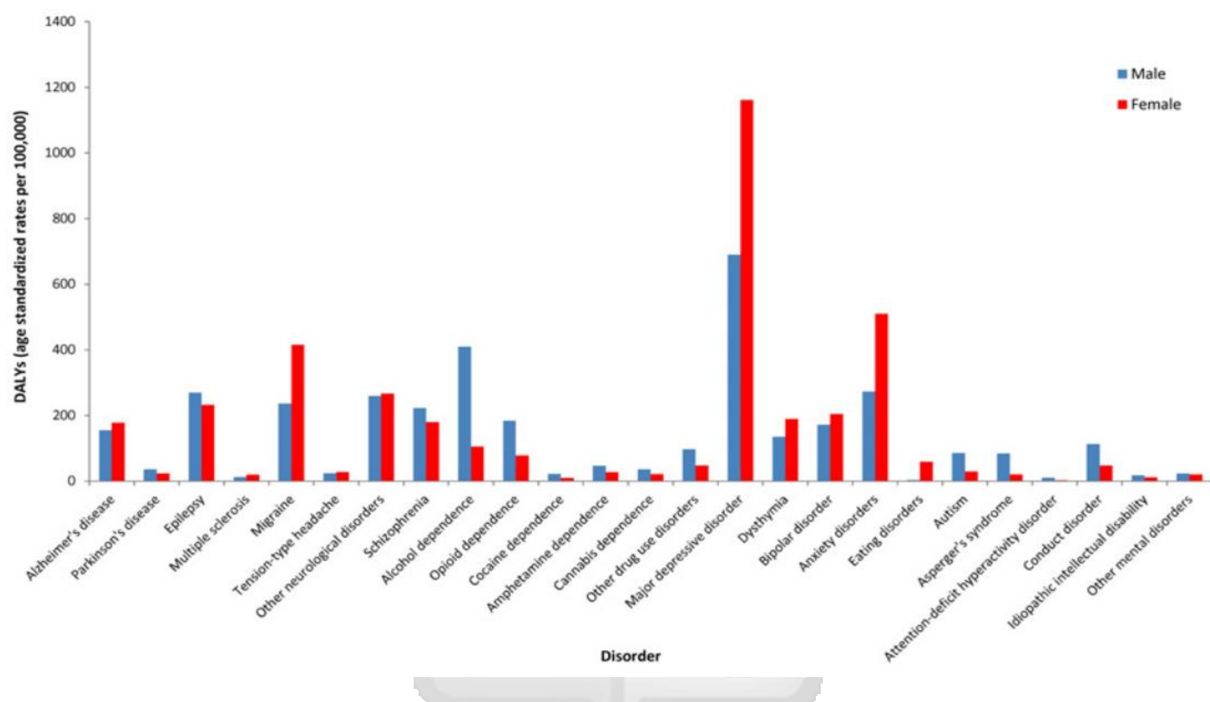
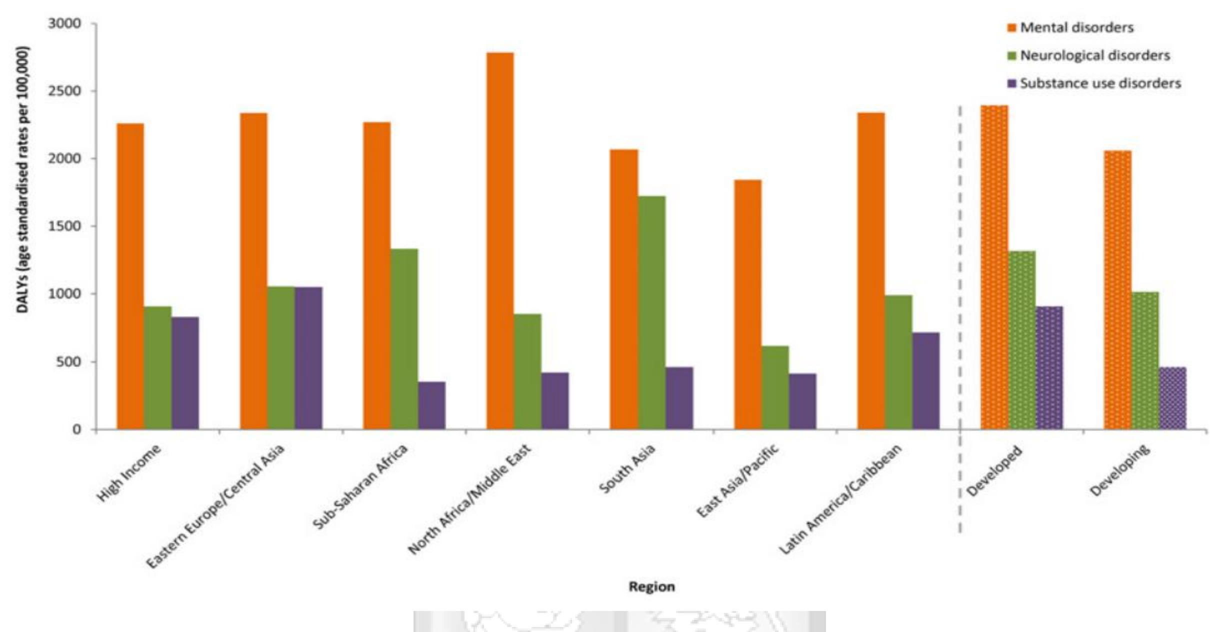
APPENDICES



Appendix I:Age-Standardized DALY Rates Attributable to Individual Mental, Neurological, and substance use disorders, by Gender, 2010.



Appendix II:Age-Standardized DALY Rates Attributable to Mental, Neurological, and substance use disorders, by Region, 2010.

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	Low income (I)	Lower-middle income (II)	Upper-middle income (III)	High income (IV)	World	ANOVA (F, df, p)	Post-hoc test (2×2, LSD, p<0·05)
Population	11 658 000 (n=61)	8 653 000 (n=54)	3 232 000 (n=35)	5 340 000 (n=38)	6 803 000 (n=192)	..	..
Adult literacy (%)	62·5% (n=50)	90·4% (n=47)	95·7% (n=25)	91·75% (n=12)	87·7% (n=134)	33·94 (3, 130, 133)*	I<II,III,IV
Unemployment (%)	5·1% (n=23)	10·4% (n=40)	10·4% (n=25)	5·1% (n=34)	8·35% (n=122)	6·38 (3, 118, 121)*	I,IV<II; IV<III
Total expenditure on health (% GDP)	4·8% (n=60)	5·75% (n=54)	6·1% (n=35)	8·25% (n=38)	5·8% (n=191)	15·10 (3, 183, 186)*	I<II,III<IV
Mental health budget (% health budget)	1% (n=28)	2·15% (n=30)	3% (n=22)	6·8% (n=21)	2·5% (n=101)	11·68 (3, 97, 100)*	I,II<III<IV
Number of mental health beds per 10 000 people	0·24 (n=58)	1·59 (n=52)	7·7 (n=33)	7·5 (n=38)	1·69 (n=185)	38·07 (3, 177, 180)*	I<II<III,IV
Proportion of beds in mental hospitals (% of total number of mental health beds)	75% (n=50)	86·99% (n=50)	81·89% (n=33)	60% (n=33)	79·72% (n=167)	3·08 (3, 162, 165)†	II, III>IV
Health providers per 100 000 people	82 (n=61)	335·5 (n=54)	467 (n=35)	1102·50 (n=38)	356·5 (n=192)	13·03 (3, 184, 187)*	I,II,III<IV
Psychiatrists per 100 000 people	0·06 (n=58)	1·05 (n=54)	2·7 (n=33)	10·5 (n=38)	1·2 (n=187)	44·78 (3, 179, 182)*	I<II<III<IV
Psychiatric nurses per 100 000 people	0·16 (n=58)	1·05 (n=48)	5·35 (n=30)	32·95 (n=36)	2 (n=176)	29·32 (3, 168, 171)*	I<III<IV; II,III<IV
Rate of DALYs by neuropsychiatric conditions per 100 000 people	2643·74 (n=61)	3100·50 (n=54)	3610·65 (n=35)	3237·91 (n=38)	2963·87 (n=192)	16·84 (3, 184, 187)*	I<II,IV<III
Suicide per 100 000 people	5·86 (n=61)	4·98 (n=54)	6·60 (n=35)	11·33 (n=38)	6·55 (n=192)	NS	..

Appendix III:Human development indices, expenditure on health and mental health, mental health resources and burden due to mental disorders, by World Bank income categories.

Data are median values unless stated otherwise. ANOVA=analysis of variance (F, F value; p, probability; df, degrees of freedom). LSD=least square difference. *p

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Appendix IV:Interview Guide

SECTION 1: Introduction

1) Thank the respondents for participating.
2) Explain the purpose of the study.
3) Assure the respondent of confidentiality and anonymity.
4) Obtain consent for participation and recording if necessary.

SECTION 2: General Information *(For Classification Purposes)*

1) Name of the institution/Organization
2) Position/role of the respondent
3) Number of years in the mental health field

SECTION 3: Factors affecting the implementation of the Kenya Mental Health Policy (2015-2030)

1. How familiar are you with the Kenya Mental Health Policy (2015–2030)?
2. In your experience, what are the main factors affecting the implementation of the Kenya Mental Health Policy?
3. How adequate is the funding and resource allocation for mental health services? What improvements are needed?
4. What challenges exist in training, retaining, and distributing mental health professionals across Kenya? How can these be addressed?
5. How well do different stakeholders (Ministry of Health, mental health institutions, NGOs, advocacy groups, private sector) coordinate efforts to implement the policy?
6. How does the general public's perception of mental health impact service uptake and policy effectiveness? What strategies could help reduce stigma?
7. How has Kenya's mental health policy adapted to emerging challenges such as economic hardships, post-pandemic trauma, and increased mental health cases among vulnerable groups?
8. What strategies or best practices from other countries could improve Kenya's mental health policy implementation?
9. What key recommendations would you suggest to enhance the successful implementation of the policy?

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Appendix V: Budget

Item	Quantity	Unit Cost (Ksh)	Total Cost
Research Assistant	1	6,000/day*5	30,000
Data Analyst	1	5,000/day*5	25,000
Transport	5 days	12,000/day	60,000
Printing &photocopying	-	-	30,000
NACOSTI Research Permit	-	1000	1000
Contingency	-	-	5,000
Total Estimated Budget			**151,000**

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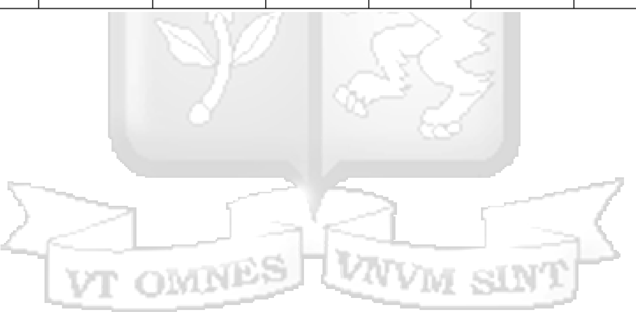
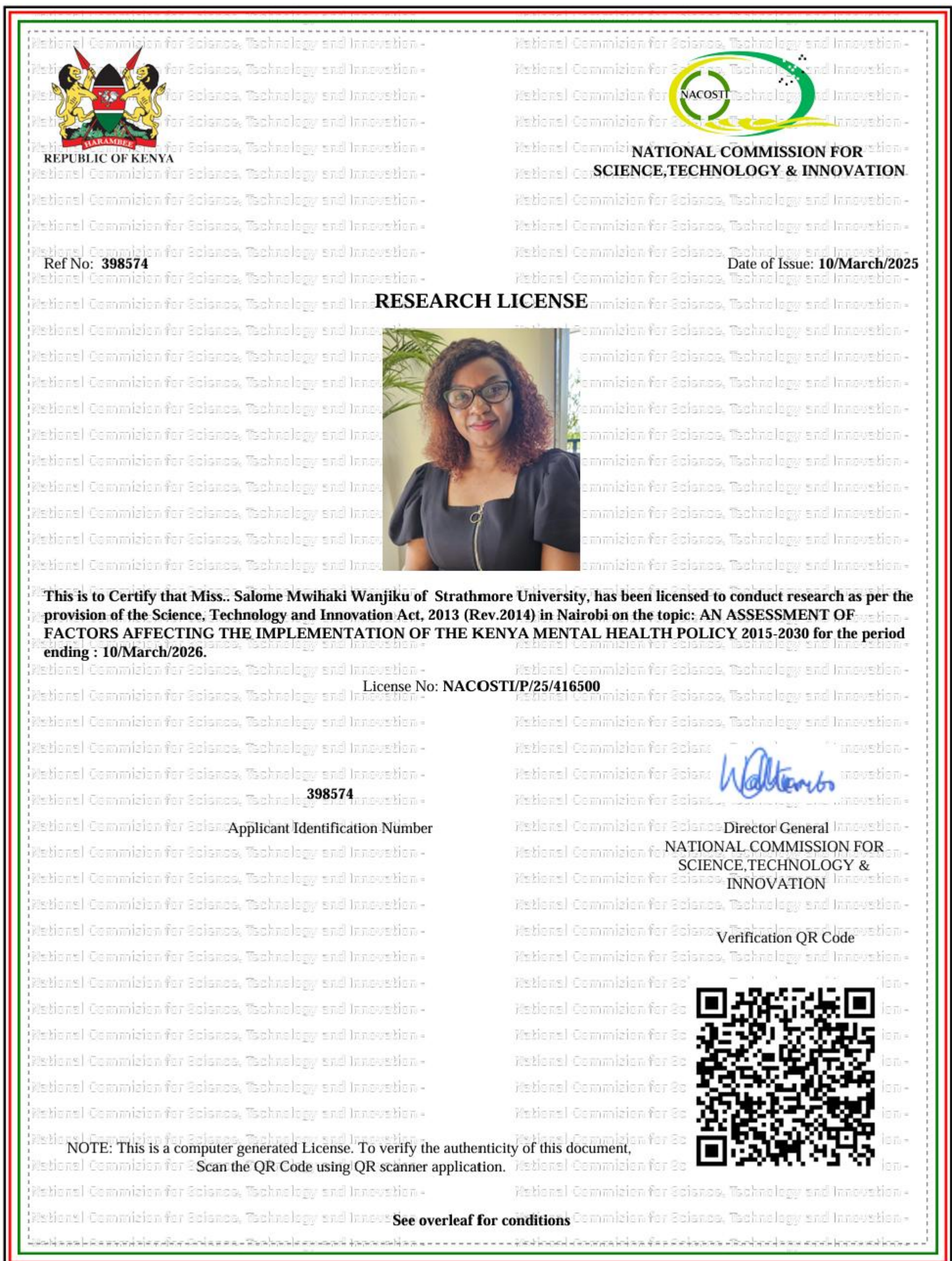
Appendix VI: Work Schedule

Monthly Activities	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025
Proposal writing							
Literature Review							
Presentation and approval of proposal							
Data collection and Analysis							
Project Report Draft Submission							
Project Report Revision							
Submission of Final Report							



Appendix VII:NACOSTI Approval



REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **398574**

Date of Issue: **10/March/2025**

RESEARCH LICENSE

This is to Certify that Miss.. Salome Mwihaki Wanjiku of Strathmore University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Nairobi on the topic: AN ASSESSMENT OF FACTORS AFFECTING THE IMPLEMENTATION OF THE KENYA MENTAL HEALTH POLICY 2015-2030 for the period ending : 10/March/2026.

License No: **NACOSTI/P/25/416500**

398574

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NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

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See overleaf for conditions

Appendix VIII:Ethics Approval

18th March 2025

Mrs Wanjiku Salome,
salome.ngayu@strathmore.edu

Dear Mrs Wanjiku,

<u>RE: An Assessment of Factors Affecting the Implementation of the Kenya Mental Health Policy 2015-2030</u>

This is to inform you that SU-ISERC has reviewed and **approved** your above **SU-masters** proposal. Your application reference number is **SU-ISERC2717/25.** The approval period is from **18th March 2025 to 17th March 2026.**

This approval is subject to compliance with the following requirements:

i. Only approved documents including (informed consents, study instruments, MTA) will be used.
ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by SU-ISERC.
iii. Death and life-threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to SU-ISERC within 72 hours of notification.
iv. Any changes anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to SU-ISERC within 72 hours.
v. Clearance for the export of biological specimens must be obtained from relevant institutions.
vi. Submission of a request for renewal of approval at least 60 days prior to the expiry of the approval period. Attach a comprehensive progress report to support the renewal.
vii. Submission of an executive summary report within 90 days of completion of the study to SU-ISERC.

Before commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology, and Innovation (NACOSTI) https://research-portal.nacosti.go.ke/ and obtain other clearances needed.

Yours sincerely,

Mr Ambrose Rachier,
Chairperson; SU-ISERC

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Appendix IX:Letter of Introduction

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Facebook/Linkedin: Strathmore University Business School

Email: **sbsinfo@strathmore.edu** or visit **www.sbs.strathmore.edu**

Thursday, 20 February 2025

To Whom It May Concern,

RE: FACILITATION OF RESEARCH – NGAYU SALOME MWIHAKI

This is to introduce Salome Mwihaki who is a **Master's in Public Policy and Management** (MPPM) student at Strathmore University Business School, admission number MPPM 102579. As part of our MPPM Program, Salome is expected to do applied research and undertake a project. This is in partial fulfilment of the requirements of the MPPM course. To this effect, she would like to request for appropriate data from your organization.

Salome is undertaking a research paper on **"An Assessment of Factors affecting the Implementation of the Kenya Mental Health Policy 2015-2030."** The information obtained from your organization shall be treated confidentially and shall be used for academic purposes only.

Our MPPM Program seeks to establish links with industry, and one of these ways is by directing our research to areas that would be of direct use to industry. We would be glad to share our findings with you after the research, and we trust that you will find them of great interest and of practical value to your organization.

We appreciate your support and shall be willing to provide any further information if required.

Yours Faithfully,

Njoki Kiagiri.
Manager – Graduate Programs.
Strathmore University Business School

Strathmore University Business School is a Proud member of: