



Electronic Theses and Dissertations

2026

The Determinants of mental health financing in Kenya: towards a stakeholder-informed framework for sustainable financing.

Mutua, Karen
Strathmore Business School
Strathmore University

Recommended Citation

Mutua, K. (2026). *The Determinants of mental health financing in Kenya: Towards a stakeholder-informed framework for sustainable financing* [Strathmore University]. <https://hdl.handle.net/11071/16839>

Follow this and additional works at: <https://hdl.handle.net/11071/16839>

**THE DETERMINANTS OF MENTAL HEALTH FINANCING IN KENYA:
TOWARDS A STAKEHOLDER-INFORMED FRAMEWORK FOR
SUSTAINABLE FINANCING**

KAREN MUTUA

MBA/HCM/190643

**DISSERTATION SUBMITTED IN FULFILLMENT OF THE
REQUIREMENTS FOR THE AWARD OF A DEGREE OF MASTER OF
BUSINESS ADMINISTRATION IN HEALTHCARE MANAGEMENT AT
STRATHMORE UNIVERSITY**

DEDICATION

To God, first and always, for the grace that carried me through every difficult chapter, the strength to begin again after each setback, and the quiet assurance that this work was worth finishing.

To my supervisor, Dr. Jackline Aridi, for your patience, your generosity of time, and your unwavering commitment to guiding this work to completion. Your feedback sharpened my thinking, your encouragement steadied me in the difficult seasons, and your belief in this research never wavered. The contribution you have made to this work - and to my growth as a researcher - is truly invaluable.

To my husband, Michael my greatest support system and my steadiest anchor. Through the long nights and the quiet ones, through the moments of doubt and the moments of breakthrough, you showed up. Consistently. Lovingly. Without complaint. This journey was mine, but it would not have been possible without you beside me.

To my parents, for the prayers you offered faithfully on my behalf, for your unwavering belief in me, and for the kind of support that never asks what it costs. You laid the foundation; this work stands on it.

And to my two wonderful sons, Jelani and Qhawe, this is for you. May you grow up knowing that no ceiling is fixed, no mountain is too steep, and no dream is too large. In academia and in life, may you know no limits.

With all my love and gratitude.

Declaration

I declare that this work has not been previously submitted and approved for the award of a degree by this or any other University. To the best of my knowledge and belief, the dissertation contains no material previously published or written by another person except where due reference is made in the dissertation itself.

© No part of this dissertation may be reproduced without the permission of the author and Strathmore University

Name of Candidate

Karen Ndunge Mutua

Approval

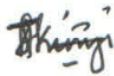


The dissertation of Karen Ndunge Mutua was approved by the following:

Name of Supervisor: Dr. Jackline Aridi

School/Institute/Faculty: Strathmore University Business School/Institute for Healthcare Management

Signature:



ABSTRACT

Mental health services in Kenya face a severe funding crisis. Despite contributing approximately 15% of the national disease burden, the sector receives less than 1% of the health budget, resulting in inadequate services, medication shortages, and a treatment gap affecting three-quarters of those who need care. This chronic underfunding persists despite the progressive frameworks established by the Kenya Mental Health Policy (2015–2030) and the Mental Health (Amendment) Act, 2022. While existing research has documented the burden of mental illness and service availability gaps, the underlying determinants of fiscal neglect—particularly institutional stigma, political economy dynamics, and the internal prioritization logics of financing institutions—remain poorly understood. This study examined the determinants of mental health underfunding by exploring the perspectives of 32 key informants across the National Treasury, Ministry of Health, Social Health Insurance Fund, county health departments, service providers, civil society organisations, and community representatives. A qualitative case study design was employed, with data collected through semi-structured interviews and analyzed using reflexive thematic analysis. Four themes emerged. Institutional and governance barriers encompassed fragmented county governance post-devolution, mental health's marginal positioning within the Ministry of Health, inter-agency coordination failures between Treasury, MoH, SHIF, and county governments, and capacity constraints at all levels. Stigma and perceptions as a fiscal determinant included the perception of mental illness as less medically legitimate, productivity biases discounting treatment returns, and selective evidence dismissal — with 50% of participants questioning the KES 62 billion economic cost estimate despite its methodological equivalence with accepted figures for other conditions. Political economy and financing mechanism feasibility identified absent parliamentary champions, fragmented civil society advocacy, donor crowding-out, and rated SHIF benefit package expansion and conditional grants as the most feasible reform pathways. The stakeholder verdict converged across all participant groups on institutional stigma, political invisibility, and fiscal unprotection as three interlocking mechanisms sustaining the less-than-1% allocation. The study extended Modified Labeling Theory to fiscal policy decision-making, demonstrated the value of stakeholder-centred qualitative methods in health financing research, and generated

evidence-based recommendations toward sustainable mental health financing and Universal Health Coverage in Kenya.

Keywords: mental health financing, health policy, stakeholder perspectives, institutional stigma, sustainable financing, Kenya, Universal Health Coverage

Table of Contents

DEDICATION.....	2
ABSTRACT.....	4
DEFINITION OF TERMS.....	12
LIST OF ABBREVIATIONS.....	16
CHAPTER ONE: INTRODUCTION.....	18
1.1 Background.....	18
1.2 Problem Statement.....	20
1.3 Research objectives.....	21
1.4 Research Questions.....	22
1.5 Justification and Significance of the Study.....	22
1.6 Scope of the study.....	23
CHAPTER TWO: LITERATURE REVIEW.....	25
2.1 Introduction.....	25
2.2 Health Financing in Kenya.....	25
2.2.1 Understanding Mental Health and Its Importance.....	26
2.2.2 Global and Regional Mental Health Financing Landscape.....	27
2.2.3 Consequences of Underfunding for Mental Health Services in Kenya.....	29
2.2.4 Stakeholder Landscape: Who Is Affected and Who Decides.....	30
2.3 Theoretical Review.....	31
2.3.1 Musgrave's Theory of Public Finance.....	32
2.3.2 Modified Labeling Theory.....	33
2.3.3 Musgrave and Modified Labeling Theory as Interpretive Lenses.....	34
2.4 Empirical review.....	35
2.4.1 The Kenyan Burden and Economic Cost Landscape.....	35

2.4.2 Health Financing and Insurance Analyses.....	36
2.4.3 Governance, Policy Implementation, and Stakeholder Perspectives.....	36
2.4.4 Stigma as a Systemic Barrier to Financing.....	37
2.4.5 International and Regional Financing Mechanism Experiences.....	37
2.5 Gaps in the Empirical Literature.....	38
2.6 Conceptual Framework.....	39
2.7 Summary of Literature and Identification of the Research Gap.....	43
CHAPTER THREE: RESEARCH METHODOLOGY.....	44
3.1 Study Site.....	44
3.1.1 Setting.....	44
3.1.2 Characteristics of Study Site:.....	44
3.2 Research Design.....	45
3.2.1 Research Philosophy.....	45
3.3 Population and Sampling.....	46
3.3.1 Target Population.....	46
3.3.2 Inclusion Criteria.....	48
3.3.3 Exclusion Criteria.....	48
3.3.4 Sample Size and Sampling.....	49
3.3.5 Sampling Technique.....	49
3.5.4 Transferability (External Validity).....	49
3.4 Data Collection Methods.....	50
3.4.1 Primary Data Collection: Semi-Structured Interviews.....	50
3.4.2 Informed Consent Process.....	50
3.5 Research Quality.....	51
3.5.1 Credibility (Internal Validity).....	51

3.5.2 Dependability (Reliability).....	51
3.5.3 Confirmability (Objectivity).....	51
3.6 Data Analysis.....	52
3.7 Ethical Considerations.....	53
3.7.1 Ethical Approvals.....	53
3.7.2 Risk Assessment and Mitigation.....	53
3.7.3 Confidentiality and Anonymity.....	53
3.7.4 Researcher Positionality and Reflexivity.....	54
3.8 Data Management.....	54
3.9 Study Limitations.....	55
CHAPTER FOUR: FINDINGS.....	56
4.1 Introduction.....	56
4.2 Participant Characteristics.....	56
4.2.1 Sample Composition.....	56
4.2.2 Participant Demographics.....	59
4.2.3 Interview Characteristics.....	59
4.3 Thematic analysis.....	59
4.3.1 Fragmented Governance Post-Devolution.....	61
4.3.2 Institutional Positioning and Budget Processes.....	64
4.3.3 Inter-Agency Coordination Failures.....	66
4.3.4 Capacity Constraints.....	68
4.3.5 Institutional Barriers as Compound Allocative Failure.....	69
4.4 Stigma, Perceptions, and the Politics of Mental Health Financing.....	70
4.4.1 Institutional Stigma and Legitimacy Perceptions.....	71
4.4.2 Productivity Biases and Return-on-Investment Assumptions.....	72

4.4.3 Political Invisibility and Competing Health Priorities.....	74
4.4.4 Evidence Dismissal and Selective Skepticism.....	75
4.5 Political Economy and Financing Mechanism Feasibility.....	77
4.5.1 Political Economy Dynamics.....	77
4.5.2 Stakeholder Assessments of Financing Mechanism Feasibility.....	79
4.5.3 Feasibility Within a Constrained Political Economy.....	82
4.6 The Stakeholder Verdict: Why Mental Health Receives Less Than 1%.....	83
CHAPTER FIVE: DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS.....	86
5.1 Introduction.....	86
5.2 Discussion of Findings.....	86
5.2.1 Institutional Stigma as a Fiscal Determinant.....	87
5.2.2 Political Economy: The "Safe to Ignore" Phenomenon.....	89
5.2.3 Feasibility of Financing Mechanisms.....	89
5.3 Theoretical Contributions.....	90
5.3.1 Extending Modified Labeling Theory to Fiscal Policy.....	90
5.3.2 Integrating Musgrave and MLT.....	90
5.4 Methodological Contributions.....	91
5.5 Study Limitations.....	91
5.6 Recommendations.....	91
5.7 Mental Health as a Lower-Priority Area in Healthcare Financing.....	95
5.8 Conclusions.....	98
References.....	99
APPENDICES:.....	105
APPENDIX A: SEMI-STRUCTURED INTERVIEW GUIDE.....	105
APPENDIX B: INFORMED CONSENT FORM.....	114

APPENDIX C: INFORMATION SHEET FOR PARTICIPANTS.....	118
APPENDIX D: RESEARCH BUDGET.....	126
APPENDIX E: SU-ISERC APPROVAL LETTER AND NACOSTI LICENSE.....	131

Table 1: Regional comparison of mental health financing	29
Table 2: Mental Health Allocation in Sampled County Budgets (FY 2023/2024) Source: County Budget Estimates, FY 2023/2024	31
Table 3: Sociodemographic Characteristics of Participants	64
Table 4: Anonymized Participant Code Matrix by Institutional Sector	65
Table 5: Themes identified from the interview responses	67
Table 6: Perceived Feasibility of Five Mental Health Financing Mechanisms	86
Figure 1: Conceptual framework	42

DEFINITION OF TERMS

Mental Health: A state of wellbeing in which an individual realizes their own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to their community (WHO definition). Mental health includes emotional, psychological, and social well-being. Mental health conditions refer to diagnosable disorders including depression, anxiety, psychosis, bipolar disorder, and substance use disorders that significantly impair functioning.

Mental Health Financing: The mobilization, allocation, and utilization of financial resources for mental health services, programs, and systems. This includes government budget allocations (national and county), health insurance coverage (SHIF), out-of-pocket payments, donor funding, and other financing sources dedicated to prevention, treatment, rehabilitation, and promotion of mental health.

Sustainable Financing: A financing approach that ensures: (1) adequacy—sufficient resources to meet population mental health needs; (2) equity—financial protection so costs don't impoverish households; (3) efficiency—resources used effectively to maximize health outcomes; (4) predictability—stable, recurring funding streams rather than project-based or donor-dependent; (5) political feasibility—mechanisms aligned with institutional and political realities enabling sustained implementation.

Stakeholders: Individuals and organizations with interest, influence, or responsibility related to mental health financing decisions. In this study, stakeholders include officials from National Treasury, Ministry of Health, Social Health Insurance Fund, Parliament, county health departments, public and private mental health service providers, civil society organizations, insurance companies, and community representatives.

Institutional Barriers: Structural and organizational factors within government institutions that impede adequate mental health financing. These include mental health's positioning within MoH organizational hierarchy, fragmented governance post-devolution, weak budgeting processes (lack of dedicated budget lines), inter-agency coordination failures, and institutional rules or norms that disadvantage mental health relative to other health priorities.

Stigma: Negative attitudes, beliefs, and stereotypes about mental illness that lead to discrimination, prejudice, and devaluation. Institutional stigma (focus of this study) refers to how stigma becomes embedded in organizational policies, practices, and decision-making processes—for example, when decision-makers perceive mental health as less legitimate, less urgent, or less worthy of investment than physical health conditions.

Political Economy: The study of how political and economic forces interact to shape policy decisions. In this context, political economy factors include power dynamics among stakeholders, political incentives (or disincentives) for championing mental health, fiscal constraints and competing budget demands, donor influence, advocacy strength (or weakness) of mental health constituencies, and how these factors collectively influence resource allocation decisions.

Financing Mechanisms: Specific policy instruments or approaches for raising, pooling, and allocating financial resources for mental health. This study examined five mechanisms: (1) SHIF benefit package expansion (insurance coverage), (2) Dedicated budget lines (ring-fenced allocations), (3) Earmarked taxes ("sin taxes" on alcohol/tobacco), (4) Conditional grants (national-to-county transfers with mental health conditions), (5) Performance-based financing (payments tied to mental health service delivery outputs).

Braun and Clarke's Reflexive Thematic Analysis: A qualitative data analysis method developed by Virginia Braun and Victoria Clarke (2006) for systematically identifying, analysing, and interpreting patterns of meaning — called themes — within qualitative data. The method comprises six phases: (1) familiarisation with the data, through repeated reading of transcripts; (2) generating initial codes, by labelling meaningful segments of data; (3) constructing themes, by grouping related codes into candidate themes; (4) reviewing themes, by checking them against the coded dataset and the full data corpus; (5) defining and naming themes, by articulating the central organising concept of each theme; and (6) producing the report, by writing an analytical narrative with supporting evidence.

Government: In Kenya's devolved governance structure, "government" refers to both: National Government—Executive branch (President, Cabinet Secretaries, National Treasury, line ministries including Ministry of Health) and legislative branch (Parliament: Senate and National

Assembly); and County Government—47 county governments each with elected Governor and County Assembly, responsible for healthcare delivery including mental health services under Fourth Schedule of Constitution.

Social Health Insurance Fund (SHIF): Kenya's mandatory health insurance scheme established under Social Health Insurance Act (2023) to replace National Hospital Insurance Fund (NHIF). SHIF aims to achieve Universal Health Coverage by pooling contributions and purchasing health services. Managed by Board of Directors and management team, SHIF designs benefit packages that determine which health services are covered.

Devolution: The transfer of powers, functions, and resources from national government to 47 county governments under Kenya's 2010 Constitution. Healthcare delivery, including mental health services, is a devolved function, creating shared responsibility between national and county levels for mental health financing and service provision.

Revenue collection: The mechanisms through which funds are raised to finance health services, including government taxation, insurance contributions, out-of-pocket payments, and donor funding (Kutzin, 2008).

Risk pooling: The aggregation of financial contributions across a population to spread the financial risk of ill health, reducing the burden on any individual at the point of care (Kutzin, 2008).

Purchasing: The process by which pooled funds are used to pay for health services on behalf of a defined population, including decisions about which services to cover, at what price, and from which providers (Kutzin, 2008).

Coverage: Health coverage encompasses three dimensions: population coverage (who is entitled to services), service coverage (which services are included), and cost coverage (the proportion of costs that are covered, determining the degree of financial protection) (Kutzin, 2008).

Universal Health Coverage: Universal Health Coverage is achieved when all people can access the quality health services they need without suffering financial hardship, encompassing the full spectrum of essential services including prevention, promotion, treatment, rehabilitation, and palliative care (WHO, 2010).

Treatment gap: The difference between the number of people with a mental health condition who require care and the number who actually receive evidence-based treatment (WHO, 2001).

Financial protection: The degree to which individuals and households are shielded from catastrophic or impoverishing health expenditure at the point of care (Kutzin, 2008).

LIST OF ABBREVIATIONS

CBS - Community-Based Services

CSO - Civil Society Organization

GDP - Gross Domestic Product

HIV/AIDS - Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome

ICF - Informed Consent Form

KEMRI - Kenya Medical Research Institute

KES - Kenya Shillings

LMIC - Low- and Middle-Income Country

MHPSS - Mental Health and Psychosocial Support

MoH - Ministry of Health

NACOSTI - National Commission for Science, Technology and Innovation

NCD - Non-Communicable Disease

NGO - Non-Governmental Organization

NHIF - National Hospital Insurance Fund (predecessor to SHIF)

NHIS - National Health Insurance Scheme

OOP - Out-of-Pocket

PEPFAR - President's Emergency Plan for AIDS Relief

PI - Principal Investigator

RA - Research Assistant

SDG - Sustainable Development Goal

SHIF - Social Health Insurance Fund

SU-ISERC - Strathmore University Institutional Scientific and Ethical Review Committee

TB - Tuberculosis

UHC - Universal Health Coverage

UNICEF - United Nations Children's Fund

USD - United States Dollars

WHO - World Health Organization

CHAPTER ONE: INTRODUCTION

1.1 Background

Mental illness represents one of the most significant yet persistently underfunded public health challenges worldwide. One in eight people globally live with a mental disorder, contributing approximately 15% of the global burden of disease (WHO, 2022). Despite this scale, the global median expenditure on mental health is less than 2% of government health budgets, with even lower allocations in low- and middle-income countries where mental health often receives less than 1% (WHO, 2023). The WHO recommends a minimum allocation of 5% of national health budgets to mental health to ensure adequate coverage and quality of care—a benchmark that the vast majority of African nations, including Kenya, fall far short of meeting.

The challenge is acute across East Africa, though trajectories differ. Uganda has included mental health in its National Health Insurance Scheme bill, yet implementation has stalled and services remain heavily donor-dependent, receiving approximately 2.5% of the health budget (Okello et al., 2022). Tanzania has integrated mental health into primary healthcare and developed a strategic plan, yet continues to face severe specialist shortages and limited financial risk protection, allocating approximately 1.8% (Mbatia & Jenkins, 2021). Rwanda stands out as a regional model, having successfully integrated mental health into its community-based health insurance scheme, *Mutuelle de Santé*, and achieving an allocation of approximately 2.2% (Ng et al., 2023). South Africa, with legislative ring-fencing through its Mental Health Care Act (2002), allocates approximately 4.7%—the highest in the region and closest to the WHO recommendation. Kenya, with an allocation of less than 1%, lags behind all these comparable economies despite carrying a disease burden of similar magnitude.

Kenya exemplifies this disparity in its most acute form. Mental health conditions contribute approximately 15% of the national disease burden, affecting 1 in 4 adults over their lifetime and 1 in 5 children and adolescents (Ministry of Health [MoH], Kenya, 2021). Yet the sector receives only KES 2.3 billion out of a total health budget of KES 240 billion in fiscal year 2023/2024—an allocation of 0.96%, more than five times below the WHO standard (World Bank, 2023). The Kenya Mental Health Investment Case estimates that untreated mental illness costs the economy approximately KES 62 billion annually in lost productivity and direct healthcare costs (MoH,

Kenya, 2021), representing a profound economic irrationality: the state invests KES 2.3 billion to prevent losses of KES 62 billion. This fiscal neglect is further compounded by Kenya's broader underfunding of health relative to GDP, which falls below the Abuja Declaration's 15% target, forcing households to rely on catastrophic out-of-pocket payments and leaving stigmatized, politically invisible services like mental health almost guaranteed to be deprioritized (Ministry of Health, Kenya, 2021; WHO, 2023).

Three interconnected variables sustain this persistent underfunding. First, institutional and governance barriers—including fragmented authority following the devolution of health services to 47 county governments, the absence of dedicated budget lines, weak inter-agency coordination between the National Treasury, Ministry of Health, SHIF, and counties, and mental health's marginal positioning as a sub-unit within the Directorate of Preventive and Promotive Services rather than a standalone directorate with dedicated resources (Jenkins et al., 2020; Munge, 2023). Second, stigma and negative perceptions operating at both societal and institutional levels: deep-seated stigma diminishes political will and public demand for increased funding, while decision-makers at financing institutions perceive mental health as less medically legitimate and a poor return on investment compared to physical health conditions (Ndeti et al., 2022; Mburu & Ndeti, 2021). Third, political economy factors including the absence of parliamentary champions for mental health, donor dependency on vertical disease programs that crowd out domestic investment, and the fragmentation of civil society advocacy, all of which render mental health politically safe to ignore (Mbau et al., 2020; Moses et al., 2022). Unlike HIV/AIDS, malaria, and tuberculosis—which benefit from robust international donor support through PEPFAR and The Global Fund—mental health attracts minimal dedicated external funding, compounding its disadvantage in the competition for domestic resources.

Despite progressive policy commitments—including the Kenya Mental Health Policy (2015–2030) and the Mental Health (Amendment) Act, 2022—implementation has been severely hampered by fragmented financing, the absence of dedicated funding streams, and weak accountability mechanisms. SHIF, which replaced NHIF as the flagship Universal Health Coverage mechanism in 2023, continues to systematically exclude outpatient and psychosocial mental health services from its benefit packages, creating significant financial barriers for the estimated 12.5 million Kenyans affected by mental health conditions (Barasa et al., 2022;

Government of Kenya, 2023). This gap between policy aspiration and fiscal reality is precisely the phenomenon this study investigates—not by documenting what the problem is, but by examining why it persists from the direct perspective of the decision-makers who control resource allocation.

1.2 Problem Statement

Mental health receives only 0.96% of Kenya's national health budget, specifically, KES 2.3 billion out of a total health budget of KES 240 billion in fiscal year 2023/2024 (National Treasury, Kenya, 2023; Ministry of Health, Kenya, 2023). This allocation is grossly disproportionate across every relevant benchmark. Measured against disease burden, mental health contributes 15% of Kenya's total burden of disease (MoH, 2015; WHO, 2021) yet receives less than 1% of health resources (MoH, 2022; Kiima & Jenkins, 2010), a 15:1 gap that has no equivalent in any other major disease area. Against international standards, Kenya's allocation is more than five times below the WHO's recommended minimum of 5% (WHO, 2001; WHO, 2021). Meeting that standard would require approximately KES 12 billion—a five-fold increase from current levels. Regionally, Kenya trails Uganda (2.5%), Rwanda (2.2%), Tanzania (1.8%), and South Africa (4.7%), all countries with comparable economic profiles and mental health burden profiles. Against economic cost, the government invests KES 2.3 billion to prevent annual losses of KES 62 billion in productivity—a 1:27 cost-benefit ratio that represents a profound economic irrationality, given that every shilling invested in mental health treatment is estimated to return KES 4 to 6 in productivity gains (WHO, 2023).

The consequences of this chronic underinvestment are measurable and severe. Kenya has approximately 100 psychiatrists for a population of 50 million, a ratio of 1 per 500,000 people (MoH, 2021; WHO, 2021), fifty times below the WHO recommendation of 1 per 10,000 (WHO, 2001). Three national mental hospitals and 17 county facilities serve the entire country (Ministry of Health, Kenya, 2022), meaning the majority of Kenyans lack reasonable geographic access to specialist mental health care (WHO, 2021; Ndeti et al., 2016). Some 60% of public facilities report psychotropic medication stockouts lasting more than three months per year. Approximately 80% of mental health costs are borne directly by households as out-of-pocket payments, with average psychiatric hospitalization costing between KES 15,000 and KES 50,000, catastrophic for families at the urban poverty line of KES 5,995 per person per month.

The treatment gap stands at 75%, meaning three-quarters of people living with mental illness receive no care at all. These conditions collectively constitute a violation of the constitutionally guaranteed right to health under Article 43.

While the epidemiological burden of mental illness has been well documented (Ndeti et al., 2024; Musyimi et al., 2022) and service availability gaps have been mapped (Ministry of Health, Kenya, 2021), a critical research gap remains: understanding why this fiscal neglect persists from the perspective of those who actually control resource allocation. The Kenya Mental Health Investment Case quantified the economic case for investment (MoH, Kenya, 2021), governance challenges following devolution have been studied (Jenkins et al., 2020), NHIF benefit package gaps have been documented (Barasa et al., 2022), and community-level stigma has been explored (Mburu & Ndeti, 2021). Yet the institutional norms, perceptual filters, and political economy calculations that lead Treasury officials to approve budgets at 0.96% despite overwhelming evidence, that lead SHIF to exclude outpatient mental health despite the cost-effectiveness case for primary care integration, and that lead Parliament to overlook mental health financing in the absence of constituency pressure—these remain poorly understood. This study directly addresses that gap by engaging the decision-makers themselves.

1.3 Research objectives

General Objective

To examine the determinants of mental health financing in Kenya and identify stakeholder-informed pathways toward sustainable financing reform.

Specific Objectives

- i. To examine institutional and political factors influencing mental health financing decisions in Kenya.
- ii. To explore how stakeholder perceptions and stigma shape the prioritization of mental health within public financing systems.
- iii. To assess stakeholder perspectives on feasible financing reforms for sustainable mental health funding in Kenya.

1.4 Research Questions

- i. What institutional and political factors shape mental health financing decisions in Kenya as perceived by key decision-makers?
- ii. How do stakeholder perceptions of mental health and institutional stigma influence fiscal decision-making within Kenya's public financing systems?
- iii. What financing mechanisms are perceived as feasible for sustainable mental health budgeting, and what conditions would enable their implementation?

1.5 Justification and Significance of the Study

This study is justified by its multi-layered contributions to theory, methodology, and policy practice in Kenya. Existing research on mental health financing has focused primarily on documenting the problem—quantifying the burden, calculating costs, and mapping service gaps. What remains largely unexplored is why these patterns persist despite compelling epidemiological evidence (15% disease burden), strong economic rationale (KES 62 billion in annual losses, a 1:27 cost-benefit ratio), progressive policy frameworks (the Mental Health Policy 2015–2030 and the Mental Health Amendment Act 2022), and constitutional obligations under Article 43. Understanding the 'why' requires engaging the decision-makers themselves—the Treasury officials who draft budget proposals, the MoH policymakers who prioritize health programs, the SHIF planners who design benefit packages, and the parliamentary committee members who approve appropriations. Their perceptual frameworks and institutional constraints have been largely absent from the research literature, and this study fills that gap.

The policy context makes this inquiry urgent. Kenya has some of the most progressive mental health policies in sub-Saharan Africa, yet financing remains at 0.96%—a critical implementation gap. Understanding why policy commitments fail to translate into resources is essential to designing reforms that will actually succeed. The status quo carries an unacceptable human cost: an estimated 12.5 million Kenyans affected by mental health conditions (Ministry of Health, Kenya, 2021), 1,500 to 2,000 deaths by suicide annually (Ndetei et al., 2024), a 75% treatment gap (WHO, 2023), and out-of-pocket costs that push approximately 5% of affected families below the poverty line each year (Barasa et al., 2022). Kenya has also committed to Universal

Health Coverage by 2030 under SDG 3.8 (United Nations, 2015), a commitment that cannot be honoured while excluding services needed by 25% of the population from SHIF's benefit packages (Government of Kenya, 2023).

Theoretically, the study advances the health financing discourse in two ways. First, it situates Musgrave's Theory of Public Finance within a stigmatized health good context, demonstrating how the state's allocative and distributive obligations are systematically undermined when the subject of investment is a stigmatized condition. Second, it extends Modified Labeling Theory—originally developed to explain how individuals internalize stigma—to the institutional level, showing how stigmatizing beliefs become embedded in fiscal decision-making. Specifically, MLT explains the study's findings by demonstrating that budget allocations, SHIF benefit package designs, and parliamentary approvals are shaped not only by technical criteria but by decision-makers' stigmatized perceptions of mental illness as less medically legitimate and therefore less deserving of public investment. MLT thus provides the explanatory mechanism linking institutional actors' perceptions (Objective ii) to the observable outcome of chronic underfunding. Methodologically, the study contributes a qualitative, stakeholder-centred approach to a field dominated by quantitative budget analyses. Its findings directly support Kenya Vision 2030, SDG 3.4 and 3.8, and the Universal Health Coverage agenda.

In establishing this justification, the study does not assume that increased mental health financing is self-evidently the correct allocative choice, nor that underfunding is simply a failure of will. Kenya's health budget operates under genuine fiscal constraint, and decisions to fund mental health are necessarily decisions not to fund competing priorities like maternal and child health, the established HIV, tuberculosis and malaria programmes, non-communicable diseases, and the broader Universal Health Coverage commitment, each of which carries its own burden estimates, constituencies, and claims on a finite envelope. A defensible account of mental health financing must therefore engage the opportunity cost of reallocation and the possibility that, from a strict marginal-returns perspective, decision-makers' reluctance reflects competing evidence-based claims rather than stigma alone. This study takes that competing-priorities reality as part of what must be explained, rather than as an obstacle to be argued past: its question is why mental health consistently loses these contests even where the comparative evidence does not obviously warrant its position at the bottom of the hierarchy, and what role perceptual and institutional

factors play alongside legitimate fiscal trade-offs. Distinguishing these factors requires conceptual precision among three terms that are easily conflated. Mental health financing refers specifically to the mobilisation, pooling, and allocation of resources to mental health services. Health system governance refers to the broader institutional arrangements — rules, accountability structures, and coordination mechanisms — within which financing decisions are made. Political prioritisation refers to the contested process through which competing health needs are ranked for attention and resources. Underfunding may originate in any of the three, and a central analytical task of this study is to identify which mechanisms are operating in a given instance rather than attributing all observed neglect to a single cause.

1.6 Scope of the study

This study focused on Kenya's public mental health financing system and the systemic factors that shape resource allocation decisions. Data was collected primarily in Nairobi, where key national stakeholders, regulatory bodies, and policy institutions are located, ensuring access to individuals and institutions responsible for shaping mental health financing policy at the national level.

The study encompasses a diverse range of stakeholders across the mental health financing and service delivery ecosystem, including national policymakers (National Treasury, Ministry of Health, SHIF), county health officials, public and private service providers, civil society organizations, private insurance actors, employers, caregivers, and advocacy intermediaries. This broad inclusion ensures that the proposed framework reflects the realities and constraints of both financing and implementation, bridging the gap between policy aspiration and operational feasibility.

The study examined current mental health financing dynamics, with particular emphasis on developments from 2015 to present. This period captures the effects of devolution and coincides with implementation of the Kenya Mental Health Policy (2015–2030), making it an appropriate timeframe for assessing policy evolution, budgetary trends, and systemic shifts within the financing environment.

Conceptually, the study is limited to an analysis of financing barriers and potential solutions within the public mental health system. It focuses on governance structures, fiscal policy

considerations, and the perceptions of key stakeholders involved in financing decisions. The study does not extend to clinical assessments of service quality or quantitative cost-effectiveness evaluations of specific interventions. Instead, its primary aim is to investigate the upstream, structural determinants that influence how mental health services are prioritized, allocated, and funded within the national health system.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter critically examines the existing literature that contextualises the study of mental health financing in Kenya. It is structured in five parts. The first establishes the health financing architecture within which mental health must compete for resources in Kenya. The second examines what the literature reveals about the burden, cost, and consequences of underfunding, situating Kenya's experience within global and regional patterns. The third presents the theoretical review, developing the conceptual framework organically from the problem the study addresses. The fourth conducts an empirical review of scholarship on governance, stigma, insurance, and international financing models. The fifth identifies the gaps in existing knowledge that this study directly addresses. Rather than presenting discrete bodies of literature in isolation, the chapter builds a cumulative argument: that mental health is chronically underfunded not because of ignorance or resource scarcity, but because of structural, perceptual, and political forces that existing literature has not yet adequately explained from the inside.

2.2 Health Financing in Kenya

To understand why mental health receives less than 1% of Kenya's health budget, it is necessary first to understand the structure through which healthcare resources are allocated. Health financing in Kenya operates through four intersecting mechanisms: national government budget allocations through the Ministry of Health; devolved county government health spending through equitable share transfers under the 2010 Constitution; the Social Health Insurance Fund (SHIF), which replaced the National Hospital Insurance Fund (NHIF) in 2023 as the primary risk-pooling mechanism; and direct out-of-pocket household expenditure (Ministry of Health, Kenya, 2021; WHO, 2023). Each mechanism carries its own institutional rules, political accountability relationships, and embedded incentives that shape who receives resources and for what conditions.

SHIF operates as a mandatory social health insurance scheme with the constitutional mandate of enabling Universal Health Coverage. However, its benefit package has been designed primarily around acute, episodic physical health conditions, and systematically excludes outpatient and community-based mental health services — precisely the level of care needed by the majority of

people with mental health conditions (Barasa et al., 2022; Government of Kenya, 2023). The consequences for mental health financing are severe: with no insurance protection for outpatient services, approximately 80% of mental health costs fall directly on households. Average psychiatric hospitalisation costs between KES 15,000 and KES 50,000, which is catastrophic at Kenya's urban poverty line of KES 5,995 per person per month (World Bank, 2023). Development partner funding reinforces this structural disadvantage: HIV/AIDS, tuberculosis, malaria, and maternal health all receive substantial external support through PEPFAR, The Global Fund, and bilateral donors, while mental health attracts negligible dedicated international financing. In budget competition, programs that are externally resourced do not consume domestic discretionary spending — mental health, with no such safety net, must compete for every shilling from a single constrained national pot (Mbau et al., 2020). Understanding this architecture is essential background: it explains why mental health's financing gap is not an oversight but a structural outcome of how Kenya's health financing system has developed.

2.2.1 Understanding Mental Health and Its Importance

Mental health conditions encompass a spectrum of diagnosable disorders including depression, anxiety disorders, psychotic disorders such as schizophrenia, bipolar disorder, and substance use disorders (American Psychiatric Association [APA], 2013; WHO, 2022). These are not peripheral concerns: globally they represent the leading cause of years lived with disability and account for approximately 15% of the total burden of disease in Kenya, affecting an estimated 12.5 million Kenyans — one in four adults over their lifetime (WHO, 2022; Ministry of Health, Kenya, 2021; Ndeti et al., 2024). Yet three-quarters of those affected receive no care at all (WHO, 2023). The scale of unmet need, and the gap between burden and resource, is the foundational reality this study examines.

The consequences of this neglect cascade across every level of social organisation. At the individual level, untreated mental illness contributes to 14% of premature deaths in Kenya, severe functional impairment, and prolonged inability to work or participate in social life (Ndeti et al., 2024; Mburu & Ndeti, 2021). At the family level, caregivers face reduced workforce participation, increased household expenditure, and the intergenerational transmission of disadvantage when parental mental illness impairs child development (Musyimi et al., 2022). At

the societal level, emergency services become the de facto provider of mental health care — at far greater cost than preventive community-based services would require — while workplace absenteeism, reduced productivity, and increased disability compound the economic losses (WHO, 2022). At the national level, the Ministry of Health Investment Case (2021) estimates the economy loses approximately KES 62 billion annually to untreated mental illness in direct costs and lost productivity — more than 27 times the current KES 2.3 billion annual mental health budget. The WHO (2023) estimates that every KES 1 invested in treatment for depression and anxiety yields KES 4 to 6 in returns. The economic case for investment is overwhelming. That investment has not followed is precisely the puzzle this study addresses.

2.2.2 Global and Regional Mental Health Financing Landscape

Globally, mental health remains chronically underfunded despite its substantial burden. The WHO Mental Health Atlas (2023) reports a global median government expenditure on mental health of less than 2% of total health budgets, with low- and middle-income countries averaging under 1%. The WHO recommends a minimum of 5% of national health budgets — a standard no East African country yet meets (WHO, 2021). In sub-Saharan Africa, approximately 60% of mental health funding comes from external donors rather than domestic budgets, producing fragmented, project-based interventions rather than sustained health system strengthening (WHO, 2021; Ofori-Atta et al., 2018).

Within East Africa, Kenya compares unfavourably even against countries facing similar resource constraints. Uganda allocates approximately 2.5% of its health budget and has incorporated mental health into national health insurance legislation, though implementation remains incomplete (Okello et al., 2022). Tanzania allocates approximately 1.8%, having developed a national mental health strategic plan and begun primary care integration, though workforce and financial gaps remain (Mbatia & Jenkins, 2021). Rwanda represents the regional leader at approximately 2.2%, having successfully integrated mental health into its community-based insurance scheme, *Mutuelle de Santé*, with trained village health workers serving as the primary point of contact (Ng et al., 2023). South Africa, with its Mental Health Care Act (2002) mandating ring-fenced budget allocations, reaches approximately 4.7% — the regional standard

against which others are measured (Jané-Llopis & Anderson, 2006). Table 1 presents this regional comparison.

Country	% of health budget to mental health	Key features
Uganda	~2.5%	Mental health included in National Health Insurance Scheme (NHIS) bill, but implementation stalled; heavy reliance on donor funding; services concentrated in few centralized facilities
Tanzania	~1.8%	Mental health strategic plan developed; integration into primary healthcare initiated; severe shortage of specialists; limited financial risk protection; high out-of-pocket costs persist
Rwanda	~2.2%	Regional leader; mental health integrated into community-based health insurance (Mutuelle de Santé); coverage through national digital community health system; increased access at primary care level
South Africa	~4.7%	Mental Health Care Act (2002) mandates ring-fenced budget lines; dedicated Mental Health Directorate; closest to WHO 5% recommendation in region

Kenya	<1% (0.96%)	Among lowest in region; KES 2.3B of KES 240B health budget (2023/24); systematic exclusion from SHIF; fragmented governance post-devolution
-------	-------------	---

Table 1: Regional comparison of mental health financing

The pattern this comparison reveals is not simply one of underfunding: it is one of institutional design. Countries that have achieved higher allocations have done so through specific policy instruments — legislative mandates, insurance integration, dedicated institutional status for mental health — that protect allocations from the annual competition that they would otherwise lose. Kenya has none of these protections. The regional evidence therefore points not to resource scarcity as the primary constraint but to the absence of the institutional architecture needed to sustain financing commitments against competing pressures. This insight shapes the empirical questions this study pursues.

2.2.3 Consequences of Underfunding for Mental Health Services in Kenya

Kenya's less than 1% budget allocation has produced measurable, severe, and compounding consequences across every dimension of the mental health service system. The most acute is the workforce crisis: the country has approximately 100 psychiatrists for a population of 50 million, a ratio of 1 per 500,000 — fifty times below the WHO recommendation of 1 per 10,000 (WHO, 2022; Ministry of Health, Kenya, 2021). Clinical psychologists, psychiatric nurses, and occupational therapists are similarly scarce, concentrated almost entirely in Nairobi. Only three national mental hospitals and 17 county facilities serve the entire country, meaning 60% of Kenyans live more than 50 kilometres from the nearest mental health facility (Ministry of Health, Kenya, 2021).

Medication availability compounds this access crisis. Approximately 60% of public health facilities report stockouts of essential psychotropic medications lasting more than three months per year — not because the medicines are unavailable globally, but because procurement budgets are insufficient and supply chains are not prioritised for mental health (Ministry of Health, Kenya, 2021). SHIF's exclusion of outpatient and community-based mental health services leaves an estimated 80% of mental health costs to be borne directly by households. The human

rights dimension of this is not abstract: documented cases of involuntary confinement under inhumane conditions, use of chains to restrain patients in facilities lacking adequate beds or staff, and prolonged institutionalisation for conditions that, with proper outpatient treatment, would not require admission at all constitute violations of the constitutional right to health under Article 43 and of the dignity protections under Article 28 (Kenya Human Rights Commission, 2021; Ndetei et al., 2022).

The cumulative result is a 75% treatment gap: three-quarters of people living with a diagnosable mental health condition in Kenya receive no care whatsoever (WHO, 2023; Ndetei et al., 2024). This figure — among the highest in the world — is not a natural or inevitable outcome of Kenya's income level. It is the measurable consequence of decades of systematically inadequate investment. Understanding why that investment gap persists, despite full knowledge of these consequences, is the analytical task this study undertakes.

The consequences of underfunding are particularly acute at county level, where devolution has deepened rather than distributed the financing gap. Official county budget estimates for FY 2023/2024 reveal that even among relatively well-resourced counties, mental health allocations represented a fraction of already inadequate health budgets, as shown in Table 4 below.

County	Total Health Budget (KES M)	Mental Health Allocation (KES M)	% of Health Budget
Nairobi	4,820	22.1	0.46%
Mombasa	1,640	11.4	0.69%
Kisumu	980	1.2	0.12%
Nakuru	1,120	0.8	0.07%
Uasin Gishu	760	0.3	0.04%

Table 2: Mental Health Allocation in Sampled County Budgets (FY 2023/2024) Source: County Budget Estimates, FY 2023/2024

These figures confirm that the transfer of service delivery responsibility to county governments in 2013 was not accompanied by commensurate financing capacity, resulting in allocations that fall substantially below even the national average of 0.96% — itself more than five times below the WHO recommended minimum of 5% (WHO, 2023). The resource mismatch documented here is not incidental but structural, and its consequences — medication stockouts, understaffed facilities, and an 75% treatment gap — are examined in the sections that follow.

2.2.4 Stakeholder Landscape: Who Is Affected and Who Decides

Mental health underfunding generates distinct consequences across different stakeholder groups, and — crucially — the groups most severely harmed have the least power to change the situation. Patients and service users experience the most direct harm: inability to access treatment, catastrophic out-of-pocket costs, stigma-driven discrimination in employment and social life, and for many, prolonged institutionalisation that compounds rather than resolves their conditions (Mburu & Ndeti, 2021; Musyimi et al., 2022). Families bear the secondary burden — reduced income, elevated stress, strained relationships, and the hidden cost of informal care. Service providers, working in chronically understaffed and undersupplied facilities, experience moral distress at their inability to deliver adequate care (Ndeti et al., 2024). Civil society organisations advocate for reform but are fragmented, under-resourced, and lacking the political access that would make their advocacy effective (Moses et al., 2022).

The financing decision-makers — Treasury officials, MoH policymakers, SHIF planners, and parliamentary committee members — occupy the opposite end of this power gradient. They control the resource allocation decisions that determine everything about what services exist and who receives them, yet they are largely insulated from the consequences of underfunding. This power asymmetry is analytically central to the study: the people with the authority to change the situation experience little of its cost, while those who bear the cost have little authority. Mapping this stakeholder landscape explains both why change has not happened and what would need to shift for it to occur.

2.3 Theoretical Review

The central puzzle of this study is why a compelling, well-documented economic and epidemiological case for mental health investment fails to translate into adequate public financing. Answering this puzzle requires theoretical frameworks that can do two distinct things: first, establish a normative baseline against which Kenya's financing allocations can be measured as failures rather than merely as unfortunate outcomes; and second, explain the mechanisms through which that failure is systematically reproduced despite abundant evidence of its cost. The theoretical review below develops this analytical architecture organically, beginning with the

economic framework that defines the state's obligation and then turning to the social-psychological framework that explains why that obligation goes unmet.

2.3.1 Musgrave's Theory of Public Finance

Musgrave's Theory of Public Finance (1959) provides the normative foundation for this study. Musgrave identified three functions of government in a fiscal system: the allocation function, which involves providing public and meritorious goods that the market will not supply adequately; the distribution function, which involves correcting socially unacceptable inequalities in the distribution of income and welfare; and the stabilization function, which involves maintaining macroeconomic stability. For the purposes of this study, the allocation and distribution functions are analytically primary.

The allocation function is relevant because it identifies mental healthcare as a meritorious good — a service whose social value exceeds its private value, generating positive externalities that market pricing cannot capture and that therefore justifies public provision. Effective mental health treatment reduces disability, improves workforce productivity, lowers criminal justice and social welfare costs, and strengthens family units and communities. The market will not provide it at socially optimal levels because individuals cannot capture these external benefits in their willingness to pay, and because stigma further suppresses private demand. Where market failure of this kind exists, Musgrave's framework is unambiguous: the state has an allocative obligation to intervene. Kenya's allocation of less than 1% to a condition representing 15% of disease burden constitutes, on Musgrave's framework, a measurable allocative failure.

The distribution function compounds this critique. Mental illness imposes its greatest burden on those with the least capacity to absorb it: low-income households that cannot afford private care, individuals in informal employment without insurance coverage, and communities in counties too resource-constrained to provide services. The SHIF exclusion of outpatient mental health services means that financial risk protection — the primary mechanism through which the health financing system reduces catastrophic expenditure — is unavailable for the condition that is generating it. Musgrave's distributive mandate thus requires not merely that mental health receive more resources, but that those resources be delivered through mechanisms that reach the populations most disadvantaged by the current system.

However, Musgrave's framework, while establishing what should happen, cannot explain why it does not. His model assumes a rational state acting in the public interest, capable of identifying meritorious goods and willing to finance them once identified. The Kenyan evidence — that decision-makers are fully aware of the economic case and still do not act — reveals a gap between the model's assumptions and the institutional realities this study investigates. To fill that gap, a second framework is needed.

2.3.2 Modified Labeling Theory

Modified Labeling Theory (MLT), developed by Link and colleagues (1989) and extended by Hatzenbuehler (2014), was originally constructed to explain how individuals internalise social stigma and modify their behaviour in anticipation of discrimination. In its original form, MLT argued that socialisation produces widespread awareness of the stigmatising beliefs that attach to mental illness, and that individuals who receive a psychiatric diagnosis anticipate discrimination in employment, relationships, and social standing — leading them to withdraw, conceal their diagnosis, or reduce participation in social life. The theory was groundbreaking in shifting the analytical focus from the content of stigmatising beliefs to their structural consequences: it is not merely that stigma exists, but that anticipation of stigma reshapes behaviour in ways that compound disadvantage (Link et al., 1989).

Hatzenbuehler (2014) extended this framework to the institutional level, demonstrating that stigma operates not only through individual attitudes but through the policies, practices, and cultural norms of institutions. Structural stigma, in Hatzenbuehler's account, refers to the societal-level conditions — laws, institutional policies, cultural norms — that constrain the opportunities and resources of stigmatised groups. It is distinguished from individual prejudice by its systemic character: structural stigma operates even in the absence of explicitly prejudicial intent, through the accumulated effects of institutional design decisions that reflect and reproduce stigmatising beliefs.

This study applies MLT to the domain of fiscal policy and health financing — a novel application that the literature has not yet developed. The argument is that the institutional processes through which mental health financing decisions are made — budget formulation, benefit package design, parliamentary appropriations — are themselves sites where structural

stigma operates. Decision-makers' perceptions of mental illness as less medically legitimate, less economically productive, and less deserving of public investment function as perceptual filters that systematically disadvantage mental health in resource allocation. These are not merely personal prejudices; they are institutionally embedded beliefs that shape which evidence is taken seriously, which arguments are found compelling, and which budget requests are approved. MLT provides the explanatory mechanism for what Musgrave's framework cannot explain: not the normative case for mental health investment, but the institutional logic that overrides it.

2.3.3 Musgrave and Modified Labeling Theory as Interpretive Lenses

Musgrave's Theory of Public Finance and Modified Labeling Theory serve as the two interpretive lenses through which this study analyses the determinants of mental health underfunding in Kenya. They are not components of the conceptual framework, which is structured around Kutzin's health financing functions and is presented in Section 2.6, but rather the analytical tools applied to explain what the framework reveals: why the financing functions consistently underperform for mental health, and through what mechanisms that underperformance is reproduced.

The two theories operate at different analytical levels and address different dimensions of the same problem. Musgrave (1959) operates at the normative and structural level, establishing what the state is obligated to do and identifying the nature of the failure when it does not. His allocation function establishes that mental health is a meritorious good, one whose positive externalities justify public provision, and that Kenya's less than 1% allocation constitutes a measurable allocative failure against that standard. His distribution function further establishes that SHIF's exclusion of outpatient mental health services violates the state's distributive obligation to protect the most vulnerable households from catastrophic expenditure. Musgrave's framework thus provides the normative baseline: it defines the gap between what should be happening and what is, and identifies that gap as a failure of state obligation rather than an unfortunate but neutral outcome.

Modified Labeling Theory (Link et al., 1989; Hatzenbuehler, 2014) operates at the explanatory level, addressing what Musgrave cannot: why a state that is fully aware of its allocative and distributive obligations continues to fail to discharge them. MLT, as extended by Hatzenbuehler

(2014) to the institutional level, provides the mechanism: stigmatised beliefs about mental illness become embedded in institutional policies, practices, and cultural norms, shaping which budget requests are taken seriously, which evidence is believed, which programs are seen as worthy of protection, and which populations are treated as deserving of public investment. This is not a matter of individual prejudice but of structural stigma; the accumulated effect of institutionally embedded beliefs that systematically disadvantage mental health in every financing decision, from Treasury budget formulation to SHIF benefit package design to parliamentary appropriations.

Together, the two theories generate a coherent and mutually reinforcing analytical architecture. Musgrave establishes that the state has an obligation it is not meeting; MLT explains the institutional mechanism through which that obligation continues to go unmet despite full awareness of its existence. The integration reveals a self-reinforcing cycle: institutional stigma produces disproportionately low allocations, low allocations produce inadequate services, inadequate services produce limited evidence of effectiveness, and limited evidence reinforces the stigmatized belief that mental health investment does not work, which in turn justifies continued low allocation. This cycle is self-sealing, and it is this dynamic that the Kutzin-based conceptual framework in Section 2.6 is designed to expose by mapping precisely where in the financing system, revenue collection, pooling, or purchasing, institutional stigma and governance failures exert their effects.

2.4 Empirical review

2.4.1 The Kenyan Burden and Economic Cost Landscape

Empirical evidence on the burden of mental illness in Kenya is well-developed and consistent. Ndeti and colleagues (2024) document that mental disorders account for approximately 15% of Kenya's total disease burden, with depression and anxiety disorders constituting the largest share. The WHO's Mental Health Atlas (2023) places Kenya's treatment gap at 75%, among the highest globally. The Ministry of Health Investment Case (2021) provides the most comprehensive economic costing, estimating KES 62 billion in annual productivity and direct healthcare losses — a figure that has been widely cited but, as this study's findings reveal, inconsistently believed by the very officials responsible for addressing it. Musyimi and colleagues (2022) document the

community-level consequences of this gap, including catastrophic household expenditure, caregiver burden, and the compounding disadvantages of untreated illness across generations. Together, this body of evidence establishes the epidemiological and economic foundation for the study's problem statement but leaves unanswered why, given this documentation, financing has not improved.

2.4.2 Health Financing and Insurance Analyses

Research on Kenya's health financing mechanisms has systematically documented structural biases that disadvantage mental health. Barasa and colleagues (2022) provide the most comprehensive analysis of SHIF's benefit package design, demonstrating that mental health's exclusion from outpatient coverage is a design choice rather than an actuarial necessity — and that mental health coverage could be introduced incrementally within existing SHIF infrastructure through an appropriately designed pilot. Their analysis also documents the catastrophic expenditure consequences of SHIF exclusion for mental health households, directly situating the benefit package design problem within the Universal Health Coverage equity agenda. Munge (2023) examines the governance structures of NHIF's successor and identifies the absence of mental health representation in benefit package design committees as a structural driver of continued exclusion — finding that the institutional actors with the technical knowledge to advocate for mental health inclusion are not present in the rooms where decisions are made. This literature directly informs the study's analysis of inter-agency coordination failures and the SHIF actuarial knowledge gap documented in Chapter Four.

2.4.3 Governance, Policy Implementation, and Stakeholder Perspectives

Governance and policy implementation emerge as central empirical concerns across the literature. Jenkins and colleagues (2020) document the consequences of Kenya's devolution for mental health financing, identifying the fragmentation of responsibility between national and county governments as a primary structural barrier — a finding this study confirms and extends by revealing the precise mechanisms through which that fragmentation operates in budget processes. Their analysis of 22 counties found that mental health received between 0.04% and 0.8% of county health budgets, a range that the current study's documentary analysis of FY 2023/2024 county budget estimates confirms has not substantially improved. Mbau and

colleagues (2020) examine political economy dynamics in Kenya's health sector more broadly, documenting how donor dependency, weak civil society, and the absence of parliamentary champions combine to keep mental health politically invisible. Moses and colleagues (2022) offer a bottom-up perspective, documenting the experience of frontline providers navigating the consequences of underfunding — medication stockouts, staffing crises, and the moral distress of being unable to deliver care that patients need. Together, this literature maps the institutional architecture of failure but does not penetrate into the perceptual and belief systems that sustain it — the space this study occupies.

2.4.4 Stigma as a Systemic Barrier to Financing

Empirical research on stigma in Kenya has concentrated overwhelmingly at the community and individual levels. Mburu and Ndeti (2021) document widespread stigmatising attitudes in Kenyan communities, including beliefs that mental illness is a spiritual affliction, that people with mental illness are inherently dangerous, and that psychiatric treatment is ineffective. Ndeti and colleagues (2022) document how these beliefs reduce treatment-seeking behaviour, producing the self-reinforcing cycle in which low service utilisation reduces the political visibility of unmet need. Musyimi and colleagues (2022) extend this analysis to document how community-level stigma compounds the economic burden on affected households through discrimination in employment and social exclusion.

However, the literature has paid far less attention to institutional stigma — how stigmatising beliefs become embedded in fiscal decision-making processes. Hatzenbuehler (2014) provides the theoretical framework for this analysis, but empirical studies applying it to health financing decisions in LMICs are scarce. The existing empirical frontier, therefore, is the individual and community level. This study extends it by examining stigma at the institutional level: not how people with mental illness are treated by their communities, but how mental illness is perceived by Treasury officials, SHIF planners, and parliamentarians, and how those perceptions translate into fiscal decisions. This is the most direct contribution the study makes to the empirical literature on stigma — moving the unit of analysis from the service user to the budget decision-maker.

2.4.5 International and Regional Financing Mechanism Experiences

The international literature documents several successful financing mechanisms that have achieved higher and more sustainable mental health allocations than Kenya, providing empirical benchmarks for what is achievable. South Africa's Mental Health Care Act (2002) established a legislative framework mandating ring-fenced budget allocations and a statutory minimum share of provincial health budgets for mental health services, resulting in an allocation of approximately 4.7% (Jané-Llopis & Anderson, 2006). The South African experience demonstrates that legislative protection can sustain financing commitments against annual budget competition — though it also reveals the limitations of legislation without enforcement mechanisms, as provincial compliance has been inconsistent (Kakuma et al., 2011).

Rwanda's integration of mental health into Mutuelle de Santé, its community-based insurance scheme, provides a more directly applicable model for SHIF expansion (Ng et al., 2023). Rwanda achieved integration through a combination of political commitment at the highest level, community health worker training to manage the majority of mental health presentations at primary care level, and a pragmatic incremental approach to benefit package design that began with the most prevalent and most treatable conditions. Ghana established a dedicated Mental Health Authority in 2012, elevating institutional status from a sub-unit to a standalone body with direct budget access — a model that several participants in this study identified as the single most impactful reform Kenya could make. Ethiopia's integration of mental health into its Health Extension Program demonstrates the cost-effectiveness of task-shifting to community health workers, achieving meaningful coverage expansion at a fraction of specialist-service costs (Kakuma et al., 2011). These international experiences converge on a consistent finding: sustainable mental health financing is achieved not through single-mechanism reforms but through institutional architecture that makes underfunding structurally difficult — through legislation, insurance integration, dedicated institutional status, and community-level service integration working together.

2.5 Gaps in the Empirical Literature

The reviewed literature provides a comprehensive account of what is wrong — the burden, the cost, the service gaps, the structural barriers — and a useful comparative picture of what better

looks like. What it does not provide is an explanation grounded in the direct perspectives of the decision-makers responsible for the gap. The voices largely absent from the existing evidence base are precisely the voices this study sought: Treasury officials who approve budget allocations, SHIF planners who design benefit packages, parliamentary committee members who pass appropriations, and senior Ministry of Health officials who prioritise programs. Their perceptual frameworks, their institutional incentives, their stigmatised beliefs, and their assessments of what reform is politically feasible have not been systematically examined. The literature describes outcomes however it does not explain the decision-making processes that produce it.

A second gap concerns the institutional dimension of stigma. While community and individual stigma are extensively documented, the specific mechanisms through which stigmatised beliefs become embedded in fiscal institutional practices — budget formulation procedures, benefit package design, evidence evaluation standards — remain theoretically proposed but empirically unverified in the Kenyan context. This study fills that gap directly, generating the evidence of institutional stigma operating at the level of elite budget decision-makers in Kenya's health financing institutions.

A third gap concerns the integration of theoretical frameworks. Existing studies tend to apply either economic frameworks (documenting market failures and cost-effectiveness evidence) or social-political frameworks (documenting stigma and political economy barriers) but not both simultaneously. The integration of Musgrave and MLT proposed in this study represents a novel theoretical synthesis that has not previously been applied to mental health financing in Kenya or comparable contexts.

The comparative cases reviewed above warrant more critical scrutiny than their frequent citation as success stories implies, and the conditions under which their reforms were achieved differ from Kenya's in ways that qualify their transferability. South Africa's statutory minimum allocation was enacted within a unitary provincial financing structure and a constitutional settlement that concentrated health-budgeting authority at the provincial level; even so, compliance has been uneven, and the legislative guarantee has not prevented persistent gaps between mandated and actual provincial spending — a caution that ring-fencing in law does not ensure financing in practice. Rwanda's progress in community-based health financing rested on

an unusually high degree of central coordination, administrative reach, and political continuity that allowed nationally designed schemes to be implemented consistently at local level; these are precisely the conditions that Kenya's devolved and politically competitive system does not reliably supply. Uganda's experience, often cited for its mental health policy ambition, illustrates the opposite risk — that progressive policy adopted without protected financing produces an implementation gap closely resembling Kenya's own. Read critically, the comparator literature therefore offers not a menu of portable solutions but a set of conditional lessons: the effectiveness of any given mechanism depends on the governance architecture into which it is introduced, and Kenya's post-devolution fragmentation may attenuate reforms that succeeded in more centralised settings. This study's attention to coordination failures and the national–county fiscal interface is, in part, an attempt to take that institutional contingency seriously rather than to assume that what worked elsewhere will work here.

A further qualification concerns the character of the global mental health financing literature itself. A substantial proportion of the evidence base advocating for increased mental health investment is produced within an advocacy paradigm — generated or commissioned by bodies whose mandate is to expand mental health financing — and tends to foreground return-on-investment estimates and unmet-need figures while engaging less fully with the fiscal-sustainability objections, prioritisation trade-offs, and absorptive-capacity constraints that finance ministries weigh. The widely cited cost-of-inaction and benefit–cost ratios rest on modelling assumptions about treatment coverage, effectiveness, and productivity gains that are rarely interrogated in the secondary literature, and competing health investments can often produce comparable or stronger headline ratios. Acknowledging this does not undermine the case for greater investment, but it does require that the case be made on contested rather than self-evident grounds. The present study therefore treats the dismissal of mental health economic evidence by financing officials not only as a possible expression of stigma but also, in part, as a rational response to evidence whose methodological robustness officials are entitled to question — and it is precisely the task of the empirical analysis to distinguish, where possible, legitimate methodological scepticism from selective scepticism applied to mental health but not to comparably evidenced conditions.

2.6 Conceptual Framework

This study's conceptual framework adapts Kutzin's health financing framework (WHO, 2008) to analyse the determinants of mental health underfunding in Kenya and trace how those determinants translate into inadequate coverage outcomes. Kutzin's framework was selected because it is explicitly designed to examine how the functional components of a health financing system — revenue collection, risk pooling, and purchasing — link to coverage outcomes, making it well suited to a study that seeks to understand not merely that mental health is underfunded, but why, and with what consequences for the populations who need care.

The framework is structured across four levels, with independent variables, a dependent variable, coverage outcomes, and an ultimate outcome, all situated within Kenya's broader contextual environment.

At the first level, three independent variables constitute the determinants of mental health financing that this study investigates. Institutional and governance factors encompass Kenya's devolved governance structure following the transfer of health service delivery to county governments in 2013, the budget architecture within which mental health competes for resources, and the inter-agency coordination failures between the National Treasury, the Ministry of Health, SHIF, and county governments. Stigma and perceptions capture the legitimacy beliefs, productivity biases, and patterns of selective evidence dismissal through which decision-makers evaluate mental health relative to other health priorities. Political economy factors include the distribution of advocacy power, the crowding-out effect of donor dependency on domestic financing, and the absence of parliamentary champions to protect mental health allocations within the budget process. These three categories of independent variables are not mutually exclusive; rather, they interact and reinforce one another in ways that compound their individual effects on financing decisions.

At the second level, the dependent variable is mental health financing allocation — currently less than 1% of Kenya's national health budget. Following Kutzin (2008), this allocation is understood as the product of three core financing functions: revenue collection, which encompasses the sources from which mental health financing is drawn including government budgets, SHIF contributions, out-of-pocket payments, and donor funding; risk pooling, which

concerns how collected revenues are aggregated and risk is shared across SHIF and across fragmented county budgets; and purchasing, which concerns how pooled funds are deployed to obtain mental health services through benefit package decisions and facility allocations. It is within these three functions that the independent variables exert their influence — shaping what is collected, how it is pooled, and what it is used to purchase.

At the third level, the performance of the three financing functions determines three dimensions of coverage drawn from Kutzin's coverage framework. Population coverage addresses who is reached by mental health services, currently constrained by a treatment gap of 75%. Service coverage addresses which mental health services are financed, currently limited by the exclusion of outpatient and psychosocial services from SHIF's benefit package. Cost coverage addresses the degree to which individuals are protected from catastrophic health expenditure, currently inadequate with approximately 80% of mental health costs borne out of pocket.

These three coverage dimensions converge on the ultimate outcome: Universal Health Coverage for mental health in Kenya, defined as equitable, adequate, and sustainable financing that enables all who need mental health care to access it without financial hardship. This outcome serves as the normative benchmark against which the consequences of underfunding are assessed and toward which the study's policy recommendations are directed.

The entire framework operates within Kenya's contextual environment, including its devolved governance architecture, the Social Health Insurance Fund, the progressive but inadequately resourced commitments of the Mental Health Policy 2015–2030 and the Mental Health (Amendment) Act 2022, and the broader socioeconomic conditions that shape both the demand for mental health services and the fiscal space available to finance them. Musgrave's Theory of Public Finance and Modified Labeling Theory are applied as interpretive lenses within this framework — the former to analyse why the state's allocative obligation is not being discharged, and the latter to explain the stigma mechanisms operating within the independent variables layer — rather than as structural components of the framework itself.

Independent variables: Determinants of mental health financing

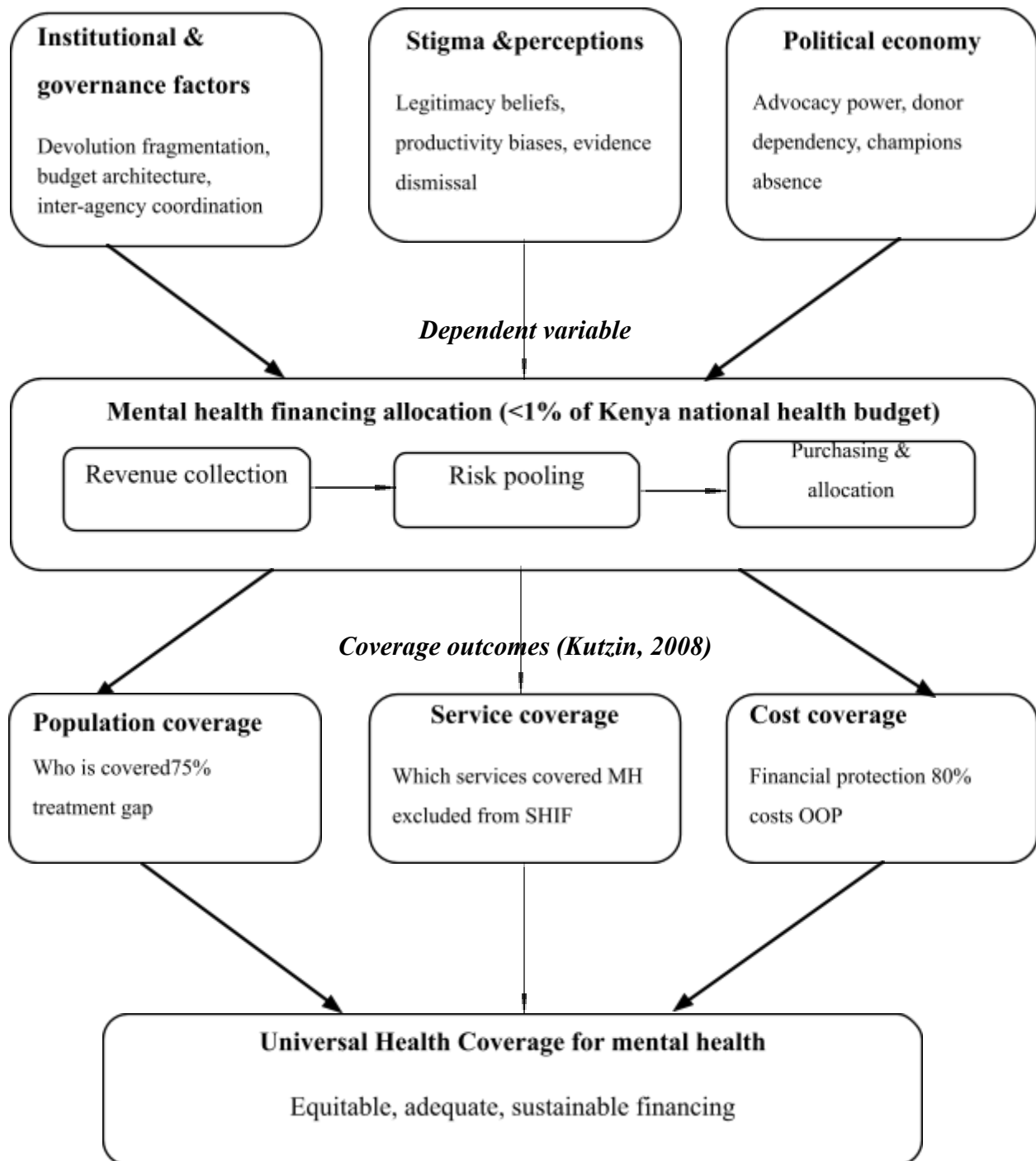


Figure 1: Conceptual framework

2.7 Summary of Literature and Identification of the Research Gap

The literature reviewed in this chapter establishes four things with clarity. First, the burden of mental illness in Kenya is substantial — 15% of total disease burden (MoH, 2015; WHO, 2021) , 12.5 million affected (MoH, 2021; WHO, 2021) , KES 62 billion in annual losses (Kiima & Jenkins, 2010; MoH, 2021) — and fully documented. Second, the consequences of underfunding are severe, measurable, and cascading across individual, family, societal, and national levels. Third, the institutional and structural barriers to adequate financing — fragmented devolution, SHIF exclusion, absence of legislative protection, institutional positioning within MoH — are well-described at the structural level. Fourth, comparative evidence from South Africa, Rwanda, Ghana, and Ethiopia demonstrates that these barriers are surmountable through specific, identifiable policy instruments.

What the literature has not yet provided is an explanation grounded in the direct perspectives of the decision-makers who control the financing gap — one that examines not what the structural barriers are but how they are experienced, interpreted, and perpetuated by the officials who navigate them. It has not yet empirically verified the operation of institutional stigma at the level of budget formulation and benefit package design. And it has not yet generated the stakeholder-informed assessment of financing mechanism feasibility that would allow reformers to target their efforts at interventions with genuine political viability. This study addresses all three gaps. In doing so, it moves the knowledge frontier from description to explanation — and from structural diagnosis to actionable reform pathway.

To make the focus of the study explicit, the gaps above can be isolated as three analytical themes, each tied to a specific construct and study objective. The first theme, institutional and political determinants of financing, isolates the constructs of fragmented governance, institutional positioning, inter-agency coordination, and capacity, and corresponds to Objective i. The second theme, institutional stigma and stakeholder perceptions, isolates the constructs drawn from Modified Labeling Theory — legitimacy beliefs, productivity bias, political invisibility, and evidence dismissal — and corresponds to Objective ii. The third theme, financing-mechanism feasibility within a constrained political economy, isolates the constructs of fiscal space, political viability, and administrative capacity, and corresponds to Objective iii. These themes, rather than measurable variables in the quantitative sense, are the analytical foci that the study investigates

qualitatively; they are carried forward into the conceptual framework in Section 2.6 and operationalised in the thematic analysis presented in Chapter 4.

CHAPTER THREE: RESEARCH METHODOLOGY

This chapter outlined the research methodology employed to address the research objectives articulated in Chapter 1. It describes the research design and philosophy, defines the target population, explains sampling procedures, details data collection and analysis methods, outlines measures to ensure research quality, and discusses ethical considerations. The methodology was designed to generate rich, contextually grounded insights into the determinants of mental health underfunding from the perspectives of key national stakeholders.

3.1 Study Site

3.1.1 Setting

The rationale for site selection is that Nairobi County serves as Kenya's administrative and policy hub, hosting all key national financing institutions—the National Treasury, Ministry of Health, SHIF, Parliament, and headquarters of major civil society organisations—whose decision-making this study sought to understand. Data collection was conducted across multiple institutional locations within Nairobi including the National Treasury building, Afya House (Ministry of Health headquarters), Mathari National Teaching and Referral Hospital, Times Tower (SHIF offices), and the Parliament buildings. The focus on national-level actors was deliberate: financing decisions for mental health in Kenya are made at the national level, making national institutions the primary unit of analysis for this study.

3.1.2 Characteristics of Study Site:

Nairobi County, Kenya's national capital and largest urban centre with approximately 4.4 million residents, served as the study site given its concentration of the key national institutions central to mental health financing decisions — the National Treasury, Ministry of Health, Parliament, and SHIF — all of which formulate the budgets, benefit packages, and policy frameworks that determine resource allocation at both national and county levels. Interviews were conducted at participant offices or, where preferred, via secure virtual platforms. While mental health service delivery is a devolved function, the financing decisions that are the focus of this study are made

at the national level, with county perspectives represented through interviews with county health directors and county representatives serving on national bodies.

3.2 Research Design

This study employed a qualitative research design using a descriptive case study approach. The qualitative approach is most appropriate as The study aimed to explore and understand the complex social phenomena, perceptions, and lived experiences of key stakeholders regarding the underfunding of mental health in Kenya (Creswell & Poth, 2018). The case study design further strengthens this inquiry by enabling an in-depth examination of contemporary events within their real-life context, where the boundaries between the phenomenon of interest and the broader institutional environment are not clearly defined (Yin, 2018). In this study, Kenya's mental health financing system constitutes the bounded case that allows a focused investigation into the political, administrative, and stakeholder-level determinants of fiscal neglect.

3.2.1 Research Philosophy

This study was underpinned by an interpretivist philosophical orientation. Interpretivism posited that reality is socially constructed and that individuals' perceptions, interpretations, and meanings are shaped by their institutional roles, professional histories, and sociocultural experiences (Saunders et al., 2019). This philosophy was appropriate for this study because financing decisions are not purely technical or economic calculations; they are mediated by stakeholder beliefs about mental health, institutional norms, power dynamics, and political considerations.

An interpretivist approach enabled the researcher to understand the nuanced motivations, constraints, and contextual factors influencing how decision-makers at the National Treasury, Ministry of Health, and SHIF perceive and prioritize mental health financing. Rather than seeking to establish universal laws, The study aimed to interpret and explain the complex social phenomena surrounding fiscal neglect of mental health in Kenya's specific institutional and political context. This philosophical stance aligned with the study's use of Modified Labeling Theory, which recognizes that stigma and institutional practices are socially constructed and context-dependent.

3.3 Population and Sampling

3.3.1 Target Population

The study targeted approximately 30 participants, with data collection continuing until thematic saturation was achieved. Saturation—the point at which additional interviews yield no substantively new themes—is the appropriate criterion for sample adequacy in qualitative research of this scope (Guest et al., 2006; Braun & Clarke, 2006).

This target population represents the accessible universe of stakeholders with direct involvement in mental health financing, policy formulation, budget allocation, or service delivery decisions in Kenya. This population is distributed across 10 stakeholder groups:

National Treasury (Health and Social Sectors Directorate - These officials draft health budget proposals, analyze submissions from MoH, negotiate allocations, and make final budget decisions that determine mental health allocation as part of a broader health budget. These included: Director, Health and Social Sectors, Deputy Directors, Principal Economists (Health Sector), Senior Economists, Budget analysts assigned to health/MoH, Officers involved in health budget formulation and review.

Ministry of Health - MoH officials formulate mental health budget requests, prioritize health programs, allocate resources across health areas, and implement financing policies. These included the Cabinet Secretary and Principal Secretary offices, Health Financing Directorate staff, Mental Health Division (within Preventive and Promotive Services), Planning and Policy Department, Budget and finance officers, Senior technical advisors, Directors of other health programs (HIV, malaria, NCDs) who compete for resources.

Social Health Insurance Fund (SHIF) - SHIF officials design benefit packages, make coverage decisions (including mental health exclusions), conduct actuarial analysis, and determine sustainability of coverage expansion. These included Board of Directors, CEO and senior management, Strategic Planning Department, Actuarial Department, Benefits Design Department.

Parliament (Health Committee and Budget Committee) - Parliamentary committee members approve health budgets, conduct oversight, and can advocate for increased allocations. However,

only a subset actively engages with mental health issues. These included Senate Health Committee members, National Assembly Health Committee members, Budget and Appropriations Committee members focused on health, total actively involved in mental health oversight.

Public Mental Health Facilities (Administrators/Clinical Directors) - Facility administrators and clinical directors experience firsthand the consequences of underfunding and can articulate resource needs, budget constraints, and service delivery challenges. These included Mathari National Teaching and Referral Hospital: Director, Deputy Directors, Finance Manager, Moi Teaching and Referral Hospital (Psychiatric Unit): Unit Head, Administrator, Port Reitz Hospital Director, Administrator, 17 county mental health facilities: Facility heads, Provincial/District hospital psychiatric units heads of units.

County Health Departments - County officials make devolved health financing decisions, including mental health allocation within county health budgets. Each of Kenya's 47 counties has health leadership, though mental health prioritization varies. These included county Executive Committee Members for Health (47 counties), County Directors of Health, County Mental Health Coordinators (where they exist), Accessible/active in mental health financing (focus on CECs and Directors).

Private Sector Mental Health Providers - Private providers understand market demand, household willingness/ability to pay, and gaps in public financing. They have perspective on what SHIF coverage expansion could achieve. These included private psychiatric hospitals (administrators), Private psychiatric clinics (owner/clinical directors), Private counseling centers (directors).

Civil Society Organizations (NGOs/Advocacy Groups) - CSOs advocate for mental health financing, engage policymakers, and represent service users' perspectives. They understand political economy of advocacy. These included National mental health NGOs (e.g., Kenya Mental Health Alliance, BasicNeeds Kenya, etc.), Executive Directors, Advocacy Directors, Patient/caregiver organizations leaders.

Insurance Sector (Private Health Insurance) - Insurance industry perspective on feasibility, sustainability, and risk management related to mental health coverage. These included Health

insurance companies offering mental health coverage: Product Managers, Actuaries, Medical Directors

Community Representatives (Employers, Faith-Based Organizations) - Represent broader societal perspective on mental health financing, including employer costs, community needs, and lived experience of service users. These included employer organizations (e.g., Federation of Kenya Employers) Representatives, Faith-based organizations involved in mental health Leaders, Community-based organizations Leaders, User/survivor groups Representatives.

This calculation is based on organizational charts and directories of key institutions, institutional reports and policy documents listing staff roles, professional association membership, published lists of committee members, and expert consultations with research supervisor and stakeholders.

3.3.2 Inclusion Criteria

Participants were included if they held a position involving or directly influencing mental health financing, policy formulation, budget allocation, or service delivery decisions in Kenya, and had a minimum of two years of experience in that role to ensure sufficient institutional knowledge. Eligible stakeholder groups spanned the National Treasury, Ministry of Health, Social Health Insurance Fund, parliamentary health and budget committees, public mental health facility administration, county health departments, private sector mental health providers, civil society organisations focused on mental health, the insurance sector, and community-based organisations including patient advocacy and employer representative groups. Participants were required to be aged 18 or older, willing and able to provide informed consent in English, available for a 45–60 minute interview during the data collection period, and either based in Nairobi for in-person interviews or willing to participate via secure video call.

3.3.3 Exclusion Criteria

Participants were excluded if they had fewer than two years of experience in their current role, were under 18 years of age, or were unable or unwilling to provide informed consent. Those who could not participate in English were also excluded, given that all target stakeholder groups operate in professional and governmental contexts where English is the working language. Staff of international donor organisations and multilateral agencies were excluded on the grounds that

external funders operate under different incentive structures and constraints from the domestic decision-makers who are the focus of this study. Participants who self-identified a conflict of interest that would prevent candid discussion, or who were unavailable to schedule an interview within the data collection window despite multiple attempts, were similarly excluded.

3.3.4 Sample Size and Sampling

The target sample of 30–35 participants was justified on two grounds. First, qualitative research prioritises data saturation over statistical representativeness, and the existing literature supports this range for heterogeneous populations. Guest et al. (2006) found saturation typically occurs between 20–40 interviews across diverse groups, while Hennink et al. (2017) established that full meaning saturation requires 16–24 interviews. Second, this range allowed for 3–5 participants per major stakeholder group, ensuring no single perspective dominated group-level findings while enabling the identification of both intra-group diversity and cross-group patterns..

3.3.5 Sampling Technique

The study employed purposive sampling as the primary recruitment technique, supplemented by snowball sampling (Creswell, 2013; Patton, 2002). Participants were selected on the basis of having at least two years of relevant experience in mental health financing, policy, or service delivery, with representation sought across all nine stakeholder groups. Purposive sampling was appropriate because the study required elite informants with specialised institutional knowledge whose perspectives could not be obtained through random selection. Snowball sampling complemented this approach by facilitating access to hard-to-reach participants, particularly senior officials in parliamentary and Treasury roles, through peer referral within professional networks. Potential participants were identified through organisational directories, professional association registers, policy document authorship, and supervisor recommendations, with initial contact made via personalised email followed by a confirmatory call to schedule interviews. At the close of each interview, participants were asked to recommend colleagues with relevant perspectives, enabling progressive expansion of the sample until saturation was reached.

3.5.4 Transferability (External Validity)

Transferability was supported through rich, detailed descriptions of the research context (Kenya's devolved health system, post-2010 Constitution governance, SHIF structure), sampling strategy (purposive and snowball, inclusion/exclusion criteria), and participant characteristics (roles, organizations, experience levels), enabling readers to assess applicability to other contexts (e.g., other East African countries with similar governance structures). Clearly outlining the criteria for participant selection further enhances the reader's ability to judge comparative relevance (Lincoln & Guba, 1985).

3.4 Data Collection Methods

3.4.1 Primary Data Collection: Semi-Structured Interviews

Primary data was collected through in-depth semi-structured interviews with key informants, each lasting 45–60 minutes. Interviews were conducted in person at participant offices, with a secure virtual option available via Microsoft Teams for participants who preferred remote participation. All interviews were audio-recorded with informed consent, supported by detailed field notes as backup. The semi-structured interview guide (Appendix A) was organised into six thematic sections covering participant background, institutional and governance barriers, stigma and perceptions, political economy and feasibility, potential financing solutions, and closing referrals. This format balanced the structure needed for systematic cross-participant comparison with the flexibility to allow participants to raise unanticipated issues and elaborate on nuance — qualities particularly important for elite interviewing where candor and depth are paramount. The guide was pilot tested with two to three participants in the first week of data collection to assess question clarity, interview flow, and timing, with refinements made accordingly. Pilot interviews were retained in the final dataset as they yielded substantive usable data.

3.4.2 Informed Consent Process

Informed consent was obtained from every participant prior to data collection, in accordance with SU-ISERC approval conditions. The process involved sending participants the study information sheet and consent form in advance, followed by a brief verbal explanation on the day of the interview covering the study purpose, the voluntary nature of participation, the right to

withdraw without penalty, confidentiality protections, and the five consent options — participation, audio recording, data storage, use of quotes, and receipt of a findings summary. Participants were given time to review the form and raise any questions before signing. Full consent documentation and procedures are detailed in Appendix B.

3.5 Research Quality

To ensure the rigor and trustworthiness of the qualitative research, the study employed several strategies aligned with Lincoln & Guba (1985) criteria:

3.5.1 Credibility (Internal Validity)

Credibility was enhanced through data triangulation by collecting perspectives from diverse stakeholder groups (10 groups, 30-35 participants) and triangulating interview data with documentary analysis (budget statements, policy documents). Member checking was conducted by sharing preliminary interpretations with a subset of 5-7 participants to verify accuracy and validate findings. Additionally, prolonged engagement with participants and institutions supported deeper understanding and rapport building (Lincoln & Guba, 1985).

3.5.2 Dependability (Reliability)

Dependability was ensured through the maintenance of a detailed audit trail documenting methodological decisions, sampling choices, interview schedules, analysis iterations, and reflections throughout the research process. The code–recode strategy was applied to verify consistency in coding—PI coded a subset of transcripts, wait 2 weeks, then recode to check for consistency. Peer debriefing with academic supervisor was used to evaluate emerging interpretations and challenge assumptions (Lincoln & Guba, 1985).

3.5.3 Confirmability (Objectivity)

Confirmability was promoted through reflexive practice. The researcher maintained a reflexivity journal capturing personal biases (e.g., as a healthcare professional working in the sector), assumptions about mental health financing, and analytic reflections on how researcher positionality may influence interpretations. Where feasible during analysis, supervisor reviewed coding to provide external check. Thick descriptions of the research process, participant

selection, and analytical decisions was provided to support transparency (Lincoln & Guba, 1985).

3.6 Data Analysis

Data analysis was conducted using Braun and Clarke's (2006) reflexive thematic analysis, a systematic yet flexible qualitative method for identifying, analysing, and interpreting patterns of meaning across a dataset. Reflexive thematic analysis was selected over other qualitative approaches such as content analysis or framework analysis because it is not tied to a specific theoretical or epistemological position, making it well suited to this study's interpretivist philosophy and its aim of understanding the subjective meanings and institutional logics that shape financing decisions. Unlike framework analysis, which applies a predetermined coding structure, reflexive thematic analysis allowed themes to emerge both inductively from participant accounts and deductively from the study's theoretical frameworks, capturing both anticipated and unanticipated patterns in the data.

Analysis followed Braun and Clarke's (2006) six phases. In the first phase, familiarisation, the researcher read and re-read all 32 interview transcripts and documentary sources, making initial notes on recurring ideas, tensions, and patterns. In the second phase, initial coding, meaningful segments of data were labelled systematically across the full dataset, generating a comprehensive set of codes that captured both semantic content and latent meaning. In the third phase, theme construction, related codes were grouped into candidate themes reflecting broader patterns across the data. In the fourth phase, theme review, candidate themes were checked against the coded dataset and the full data corpus to ensure they were internally coherent, clearly distinct from one another, and grounded in sufficient evidence. Themes that did not meet these criteria were refined, merged, or discarded. In the fifth phase, theme definition and naming, the central organising concept of each theme was articulated and named to reflect its analytical contribution rather than merely its descriptive content. In the sixth and final phase, report production, an analytical narrative was written for each theme, integrating participant quotes, documentary evidence, and theoretical interpretation to produce the findings presented in Chapter Four.

To enhance rigour, the researcher maintained a reflexivity journal throughout the analytical process, documenting evolving interpretations, analytical decisions, and potential sources of bias.

Thematic saturation, the point at which no new codes or themes were emerging from the data, was reached at interview 28, with four confirmatory interviews conducted thereafter. NVivo qualitative data analysis software was used to manage coding and facilitate systematic retrieval of data segments across themes. All analytical decisions were subject to supervisory review, and member checking was conducted with selected participants to validate key interpretations.

To make the analytical process transparent, the six phases of Braun and Clarke's reflexive thematic analysis were operationalised as follows. Familiarisation involved repeated reading of each transcript alongside the corresponding field notes before any coding began. Initial coding was inductive and semantic in the first pass, staying close to participants' own language, before a second, more latent and interpretive pass grouped codes according to the underlying meanings they appeared to carry. The first cycle generated a large number of discrete codes; these were then consolidated through an iterative process in which conceptually overlapping codes were merged, codes that conflated distinct ideas were split, and codes supported by only a single data extract were retained as provisional pending further instances. Candidate themes were constructed by clustering related codes and were reviewed against both the coded extracts and the full dataset to confirm that they cohered internally and were distinct from one another. Where the boundaries between candidate themes were ambiguous — most notably between institutional stigma, political invisibility, and evidence dismissal, which recurred together in the data — the distinction was resolved by returning to the defining question for each theme (what mechanism does this theme describe?) rather than to the surface content of the extract, and by documenting the decision rule in the reflexivity journal so that it could be applied consistently. Saturation was assessed not by interview count alone but by monitoring, after each tranche of interviews, whether new transcripts generated new codes or only new instances of existing codes; the judgement that interview 28 marked saturation reflected the point at which successive transcripts yielded confirmatory instances without expanding the coding frame, a judgement subsequently tested by the four confirmatory interviews.

3.7 Ethical Considerations

3.7.1 Ethical Approvals

Ethical approval was obtained from the Strathmore University Institutional Scientific and Ethical Review Committee (SU-ISERC). A research permit was also secured from the National Commission for Science, Technology and Innovation (NACOSTI). In addition, written authorization was sought from all participating institutions (National Treasury, Ministry of Health, SHIF, Parliament, county health departments, mental health facilities).

3.7.2 Risk Assessment and Mitigation

Social Desirability Bias as participants may have provided "politically correct" answers rather than candid perspectives, especially when discussing sensitive budgetary or institutional issues. This was mitigated through complete anonymization and assurance of confidentiality before sensitive questions. Beyond anonymisation, several established techniques were used to reduce the pressure toward institutionally favourable responses on politically sensitive items. Sensitive questions about stigma and prioritisation were framed indirectly and in the third person — asking how decision-makers in general, or the system as a whole, treat mental health, rather than asking participants to disclose their own attitudes — a wording strategy shown to lower social desirability pressure on stigmatised topics. The interview guide was sequenced so that rapport-building and lower-stakes background questions preceded the most sensitive items, by which point a conversational dynamic had been established. Participants were explicitly told that there were no right or wrong answers and that the study sought their candid professional assessment rather than the official institutional position, and the audio recording could be paused or declined at any point, with several participants electing to speak off the record on specific issues. The cross-institutional design provided a further, indirect safeguard: because participants frequently described the attitudes and conduct of other institutions rather than their own, stigmatising perceptions surfaced in accounts of the system even where individuals were reluctant to own them directly. The candour of the resulting data — including the 69 per cent of participants who expressed or acknowledged stigmatising beliefs despite these being professionally unflattering — suggests the mitigation was at least partially effective, though residual social desirability pressure on the most politically exposed topics cannot be excluded.

Emotional Discomfort which entailed discussing systemic failures or resource constraints may cause frustration or discomfort amongst respondents. This was mitigated by participants skipping sensitive questions or providing an option to questions.

Institutional Sensitivity - Organizations especially Government, may be sensitive about budget discussions or perceived criticisms This was mitigated through ensuring all data was anonymized with specific organizations not identifiable unless participant explicitly consents otherwise

3.7.3 Confidentiality and Anonymity

Detailed confidentiality and anonymity procedures, voluntary participation arrangements, and participant benefits are set out in the Informed Consent Form in Appendix B.

Participant codes (P001-Treasury, P002-MoH, etc.) used instead of names. Audio files encrypted and password-protected. Transcripts de-identified (names, specific positions, identifiable details removed). No attribution of quotes to specific individuals or organizations. Only PI and supervisor have access to identifiable data. Data stored in locked cabinets (physical) and encrypted devices (electronic).

3.7.4 Researcher Positionality and Reflexivity

The researcher brings to this study a professional background in healthcare provider network management at Cigna Healthcare and advanced training in healthcare management at Strathmore Business School. This positionality offered meaningful strengths: familiarity with health financing mechanisms, credibility with institutional stakeholders, and an understanding of the sector's operational realities that informed both interview design and analytical interpretation. At the same time, it carried the risk of confirmation bias, particularly a predisposition toward the view that mental health is deserving of greater investment, and the possibility that existing professional networks shaped assumptions about stakeholder perspectives before data collection began. These risks were managed through the maintenance of a reflexivity journal documenting evolving assumptions and interpretive decisions, consistent application of the semi-structured interview guide to ensure comparability across participants, member checking to validate key interpretations, and regular supervisor review to challenge emerging conclusions and identify analytical blind spots.

3.8 Data Management

All data were stored securely by the Principal Investigator. Audio recordings were transferred from the voice recorder to a password-protected, encrypted laptop and backed up to an encrypted USB drive and a password-protected cloud folder accessible only to the PI. Transcripts, field notes, and other digital files were stored in the same encrypted locations, while physical documents including signed consent forms were held in a locked filing cabinet.

Access to research data was strictly limited by role. The PI retained full access to all materials, the research supervisor had access to anonymised transcripts for quality review, and the Research Assistant accessed audio files for transcription purposes only. Participant anonymity was maintained throughout by assigning participant codes — such as P001-Treasury or P002-MoH — and removing all identifying details from transcripts and reports.

3.9 Study Limitations

This study carries limitations inherent to its qualitative case study design. Findings are analytically rather than statistically generalizable, meaning they offer transferable insights into Kenya's mental health financing context and theoretical contributions applicable to comparable settings, but cannot make probabilistic claims about the prevalence of attitudes or the universal applicability of findings. Additionally, reliance on self-reported data means that participant accounts of decision-making processes may reflect imperfect recall or limited visibility into other institutions' internal dynamics. These limitations were mitigated through triangulation of interview data with budget statements, parliamentary reports, and policy documents, and through the cross-institutional composition of the sample, which allowed participants' accounts to check and complement one another.

A further limitation concerned access and social desirability. Senior officials at the National Treasury, Parliament, and Ministry of Health have demanding schedules, and some of the most senior decision-makers were not accessible, with deputy directors and senior technical staff interviewed in their place. Elite participants may also have provided institutionally favourable responses on politically sensitive topics. This was mitigated through complete anonymisation, question framing that explored systemic rather than individual factors, and a conversational interview approach designed to encourage candour. Finally, the study's temporal focus on the

post-2015 period means that historical financing dynamics predating the Mental Health Policy may be inadequately captured, though this scope was appropriate given the study's aim of assessing current barriers and informing forward-looking reform.

The reliance on elite informants warrants closer scrutiny than acknowledgement of social desirability alone conveys. Senior officials operate within institutional accountability structures that create incentives for strategic self-presentation: attributing underfunding to systemic constraints rather than to discretionary choices within their own mandate, emphasising external dependencies, and framing inaction as the product of fiscal necessity rather than institutional priority. Such accounts are not necessarily untruthful, but they are situated, and they may systematically under-represent the agency that individual institutions exercise over allocation decisions. The study addressed this in three ways beyond anonymisation. First, the cross-institutional design meant that claims made by one institution about another (for example, Treasury characterisations of the Ministry of Health, and county characterisations of national government) could be read against each other, exposing inconsistencies that a single-institution sample would have concealed. Second, the interview guide deliberately separated questions about systemic constraints from questions about institutional decision-making, allowing strategic framing to be identified where it appeared. Third, documentary sources — budget statements, parliamentary committee records, and audited expenditure reports — provided an external check against which self-reported accounts could be tested. Nonetheless, the possibility that the convergent narrative of stigma and political invisibility partly reflects a shared professional vocabulary, rather than independently arrived-at observation, cannot be fully excluded, and the findings should be read as the situated understandings of financing actors rather than as a verified account of institutional behaviour.

A second limitation concerns the geographical concentration of the sample. Because mental health service delivery is a devolved function, the realities of financing and provision differ substantially across Kenya's forty-seven counties. The sample drew its county-level participants from a limited number of counties and was weighted toward officials based in or operating at the national level in Nairobi. This concentration privileges a national-institutional vantage point and may under-represent the implementation realities of counties with weaker fiscal bases, lower health-sector capacity, or different political configurations. The transferability of the findings to

county contexts not represented in the sample is therefore constrained, and the county-level patterns reported here should be treated as illustrative rather than representative of devolved practice nationally.

A third limitation, and one that bears directly on the study's own argument, is the exclusion of direct service users and people with lived experience of mental illness from the sample. The study was designed around the perspectives of financing and policy actors because its central question concerned the determinants of fiscal decisions, which sit within those institutions. Yet a study that identifies political invisibility and the silencing of affected populations as mechanisms of underfunding necessarily reproduces, in its own design, the elite-centred framing it critiques when it omits those populations. The voices most affected by underfunding are therefore present in this study only as they are represented by others. This is a substantive limitation rather than a procedural one: it means the study can describe how institutional actors perceive and account for the marginalisation of service users, but cannot speak to how service users themselves understand the financing system or would prioritise reform. Future research incorporating service-user and caregiver perspectives directly would both correct this imbalance and test whether the priorities identified by institutional stakeholders align with those of the populations the system is intended to serve.

CHAPTER FOUR: FINDINGS

4.1 Introduction

This chapter presents the findings from semi-structured interviews conducted with 32 key informants across Kenya's mental health financing ecosystem, supplemented by documentary analysis of budget statements, policy documents, and parliamentary reports. The findings are organised thematically following Braun and Clarke's (2006) reflexive thematic analysis approach, through which interview transcripts were coded, candidate themes constructed and reviewed, and final themes named and defined across three thematic sections corresponding to the study's three research objectives.

4.2 Participant Characteristics

4.2.1 Sample Composition

A total of 48 individuals were approached for participation, of whom 32 agreed, representing a response rate of 67%. The final sample of 32 participants was distributed across nine stakeholder groups as shown in Table 3.

Sociodemographic and Institutional Characteristics of Participants by Stakeholder Group

Stakeholder Group	Number of Participants	Percentage
National Treasury	4	13%
Ministry of Health (MoH)	5	14%
Social Health Insurance Fund (SHIF)	3	9%
Parliamentary Committees (Health/Budget)	3	9%
Public Mental Health Facilities (Administrators)	4	13%

County Health Departments	3	9%
Civil Society Organizations (CSOs)	4	13%
Private Sector (Insurance + Private Providers)	4	13%
Community Representatives (Employers, Faith-based)	2	6%
Total	32	100%
Gender		
Male	19	60%
Female	12	38%
Prefer not to disclose	1	2%
Total	32	100%
Age Group		
25-34 years	4	13%
35-44 years	14	44%
45-54 years	10	30%
55 years and above	4	13%

Total	32	100%
Highest level of education		
Bachelor's degree with professional certification	3	10%
Master's degree	23	72%
Doctoral degree (PhD)	6	18%
Total	32	100%
Experience in Current Role		
2–5 years	9	28%
6–10 years	14	44%
More than 10 years	9	28%
Total	32	100%
Interview Format		
In-person	24	75%
Virtual (Zoom/Microsoft Teams)	8	25%
Total	32	100%

Table 3: Sociodemographic Characteristics of Participants

To enhance the transparency of the sample while preserving participant confidentiality, Matrix 1 maps the anonymised participant codes used throughout this chapter against their institutional sector and stakeholder category. Individual identifiers, job titles, and institution-specific details are deliberately withheld, and codes are reported in grouped ranges rather than tied to identifying characteristics, so that no participant can be re-identified from the combination of sector and code. The matrix allows the reader to locate the institutional origin of each quotation cited in the findings and to verify that the thematic claims draw on the full breadth of the sample rather than a narrow subset of it.

Anonymized Participant Code Matrix by Institutional Sector

Participant Code(s)	Institutional Sector	Stakeholder Category
KII-01, KII-02, KII-03, KII-04	National Treasury	Public finance / fiscal authority
KII-05, KII-06, KII-07, KII-08, KII-09	Ministry of Health (MoH)	National health policy
KII-10, KII-11, KII-12	Social Health Insurance Fund (SHIF)	Statutory purchaser
KII-13, KII-14, KII-15	Parliamentary Committees (Health/Budget)	Legislative oversight
KII-16, KII-17, KII-18, KII-19	Public Mental Health Facilities	Public service provider

KII-20, KII-21, KII-22	County Health Departments	Devolved government
KII-23, KII-24, KII-25, KII-26	Civil Society Organizations (CSOs)	Advocacy / non-state
KII-27, KII-28, KII-29, KII-30	Private Sector (Insurance & Providers)	Private financing / provision
KII-31, KII-32	Community Representatives	Employer / faith-based / lived-experience proxy

Table 4: Anonymized Participant Code Matrix by Institutional Sector

Note: Participant codes KII-01 to KII-32 are mapped to institutional sector and stakeholder category and grouped by sector to preserve confidentiality. Codes are not linked to any identifying participant characteristics.

4.2.2 Participant Demographics

The sample was experienced and highly educated. The majority of participants had been in their current roles for six to ten years (14 participants, 44%), with equal proportions having two to five years (9 participants, 28%) and more than ten years of experience (9 participants, 28%), ensuring that all participants brought substantive institutional knowledge to their accounts. In terms of education, 23 participants (72%) held a Master's degree, six (19%) held a doctoral qualification, and three (9%) held a Bachelor's degree with professional certification. The sample was predominantly male (19 participants, 59%), with 12 female participants (38%) and one participant who preferred not to disclose their gender (3%). By age, the largest group fell within the 35–44 year bracket (14 participants, 44%), followed by those aged 45–54 (10 participants, 31%), with smaller proportions in the 25–34 and 55 and above categories (4 participants each, 13%).

4.2.3 Interview Characteristics

Interviews had a mean duration of 52 minutes, ranging from 41 to 68 minutes, reflecting the depth of engagement across participant groups. The majority were conducted in person at participant offices (24 interviews, 75%), with the remaining eight conducted virtually via Zoom or Microsoft Teams (25%). Recording quality was rated excellent or good for 30 of the 32 interviews (93.8%).

4.3 Thematic analysis

This section presents findings in relation to the research objective (i): to examine institutional and political factors influencing mental health financing decisions in Kenya. Thematic analysis of interview transcripts and documentary sources, following Braun and Clarke's (2006) six-phase approach, generated four themes: (i) fragmented county governance following the devolution of health services in 2013, (ii) institutional positioning and budget processes within the National Treasury and the Ministry of Health, (iii) inter-agency coordination failures between the National Treasury, the Ministry of Health, the Social Health Insurance Fund, and county governments, and (iv) capacity constraints across the National Treasury, county health departments, and the Social Health Insurance Fund. Each theme was developed both deductively and inductively from the data, with initial codes generated by reading and re-reading transcripts, collated into candidate themes, and reviewed against the full dataset until coherent, well-supported themes were established. Table 4 presents a summary of the themes and their associated sub-themes, and the sections below present the analytical narrative for each, drawing on participant accounts and documentary evidence.

Theme	Sub-themes
1. Fragmented governance following the devolution of health services in 2013	i. Unclear division of responsibilities between national government (policy) and county governments (service delivery) ii. Resource mismatch: service delivery devolved without commensurate financing capacity iii. Weak national-county coordination mechanisms

2. Institutional positioning and budget processes within the National Treasury and Ministry of Health	i. Mental health as sub-unit within MoH Directorate - no standalone status ii. Budget formulation disadvantages: self-censorship and multi-stage cuts before Treasury iii. Absence of dedicated budget lines: no tracking, no accountability
3. Inter-agency coordination failures between the National Treasury, Ministry of Health, SHIF, and county governments	i. Treasury–MoH disconnect: burden data presented without costed service delivery models ii. SHIF–MoH misalignment: benefit packages designed without MoH input iii. Unfunded mandates: national legislation imposing county obligations without financing
4. Capacity constraints across the National Treasury, county health departments, and SHIF	i. Limited mental health expertise in Treasury's Health and Social Sectors Directorate ii. Weak county capacity: only 8 of 47 counties with a dedicated mental health coordinator iii. SHIF actuarial knowledge gap: no claims data due to exclusion of outpatient services

Table 5: Themes identified from the interview responses

4.3.1 Fragmented Governance Post-Devolution

The most consistently identified barrier to mental health financing was the structural fragmentation produced by Kenya's devolution. This theme emerged across 29 of 32 interviews (91%), making it the most prevalent finding in the dataset. What was striking was not simply the frequency with which participants raised devolution, but the consistency of their framing: participants across all stakeholder groups — national Treasury officials, county health directors, Ministry of Health policymakers, and civil society representatives — described the same structural reality from different vantage points, each experiencing a different consequence of the same fundamental problem.

To understand what this fragmentation means in practice, it is necessary to situate it historically. Prior to the 2013 devolution of health services under the 2010 Constitution, mental health financing operated through a single, consolidated channel: the national Ministry of Health. The MoH held direct authority over budget allocation, staff deployment, procurement of psychotropic medications, and planning for all public mental health facilities — including Mathari National Hospital and the psychiatric units embedded in district and provincial hospitals. While chronically underfunded even under this arrangement, the financing chain was structurally coherent and accountable: one institution controlled both policy and resources, and could be held responsible for both. The promulgation of the 2010 Constitution and the County Governments Act (2012) fundamentally disrupted this consolidated model. Health service delivery was devolved to 47 county governments, while policy-setting, standard-setting, and financing oversight remained at the national level. What had been a single coherent — if inadequate — chain became fragmented across 47 counties with differing fiscal capacities, political priorities, and technical expertise. Crucially, this was not a managed transition: the financing capacity required to deliver devolved mental health services was not transferred alongside the service delivery mandate. The result was a structural gap between responsibility and resource that persists to this day and that, as participants consistently described, is the foundational driver of mental health's chronic underfunding at county level.

Within this overarching theme, three sub-themes were generated from the data through the coding process. The first, and most analytically significant, concerned the unclear division of responsibilities between the national government — which retains responsibility for mental health policy, standard-setting, and specialist workforce development — and county governments — which hold constitutional responsibility for mental health service delivery. In practice, this boundary has proven highly porous and actively contested. What emerged from the data was not merely administrative confusion but a structural accountability gap: each level of government has a formally legitimate basis for deferring fiscal responsibility to the other, and both do. A county health director described the experience:

"Mental health is technically devolved, so it's our responsibility. But we're told to wait for national directives and funding. We can't plan what we can't budget for."

County Health Director

A National Treasury official acknowledged the same gap from the other direction:

"The Constitution says health service delivery is county. But mental health policy is national. So we give counties equitable share transfers — which they use however they choose — and hope they prioritise mental health. They don't."

National Treasury Official

This bidirectional deferral is not a failure of individual actors but a structural design problem: the Constitution divided the function of mental health care — separating policy from delivery — without creating the coordination or financing mechanisms needed to hold the two halves together.

The second sub-theme — resource mismatch — captures the financial dimension of this fragmentation. While service delivery responsibility was devolved in 2013, the financing capacity to discharge that responsibility was not. Counties receive equitable share transfers from the national government, but these are not ring-fenced for health, let alone for mental health. County health budgets are therefore determined through internal political processes in which mental health — lacking an organised constituency, a dedicated county coordinator in most counties, or any national conditionality — is consistently deprioritised. It is important to note that the evidence for this sub-theme is drawn from documentary analysis of county budget estimates rather than from interview data: the figures presented in Table 4 below are extracted from official county budget documents (Ministry of Health, Kenya, Budget Estimates 2020–2024) and constitute quantitative contextual evidence that supports the thematic finding of resource mismatch. Table 4 demonstrates that even among relatively well-resourced counties, mental health allocations ranged from only 0.04% to 0.69% of total county health budgets in FY 2023/2024 — substantially lower than the already inadequate national average of 0.96% — confirming that devolution has not merely.

As documented in Chapter 2 (Table 4), mental health allocations across sampled counties ranged from only 0.04% to 0.69% of total county health budgets in FY 2023/2024, substantially below even the inadequate national average of 0.96%, confirming that devolution has deepened rather

than maintained the financing gap at the level where services are actually delivered (Ministry of Health, Kenya, County Budget Estimates, 2023/2024).

The third sub-theme, weak national-county coordination, describes the absence of mechanisms through which the two levels of government might jointly address the gaps produced by their divided responsibilities. Twenty-five of 32 participants (78%) described coordination as either absent or wholly inadequate. The data revealed a pattern in which national policies were developed without mechanisms to resource or enforce their implementation at county level, and counties developed health plans without input from or accountability to national mental health frameworks. A senior Ministry of Health official described this disconnect:

"We develop beautiful policies at national level. The Mental Health Policy 2015–2030 is excellent on paper. Then we expect counties to implement it with no dedicated funding, no technical support, no monitoring. And we wonder why nothing changes."

Ministry of Health Official

The phrase "excellent on paper" recurred across six separate interviews, suggesting that participants had internalised a shared understanding of the gap between formal policy commitment and operational reality, what one CSO leader called the "implementation chasm." This finding resonates analytically with Musgrave's (1959) framework: the state's allocative obligation is not discharged by policy alone; it requires the financing mechanisms through which policy can be realised. Kenya has the former without the latter.

4.3.2 Institutional Positioning and Budget Processes

A second theme, emerging from 27 of 32 interviews (84%), concerned the institutional location of mental health within Kenya's government architecture and the consequences of that location for budget processes. This theme was developed from codes relating to organisational hierarchy, budget formulation procedures, and the experience of competing for resources within government institutions. What emerged was a picture of systematic structural disadvantage rooted not in any single decision but in the accumulated consequences of institutional design.

The first sub-theme concerned mental health's lack of standalone institutional status. Within the Ministry of Health, mental health is housed as a sub-unit within the Directorate of Preventive and Promotive Services - a positioning that places it in internal competition with HIV, malaria, tuberculosis, nutrition, and other programs, all of which have far greater external resourcing, donor support, and political visibility. The contrast with HIV/AIDS was raised unprompted in 19 of 32 interviews (59%) and proved analytically revealing. A Treasury official explained:

"When NASCOP comes to Treasury, they have their own budget line, their own advocates, donor commitments. They speak with one voice. Mental health sends a budget from somewhere inside MoH that's already been cut three times before it reaches us."

Treasury Official

This account illuminates a structural mechanism: the institutional subordination of mental health means that its budget requests are filtered through multiple layers of internal MoH competition before they reach the decision-makers who control allocations. By the time they arrive at Treasury, they have already been substantially reduced.

The second sub-theme concerned the concrete experience of budget formulation. A mental health programme officer, whose account was corroborated in substance by officials at Treasury and other MoH units, described the process:

"I sit in the budget preparation meetings. The template comes from Treasury. We fill it in. But when we put in our request - say KES 180 million - the first cut happens inside the directorate. We're told to be 'realistic.' It goes to 90 million. Then MoH cuts it again before submission. It reaches Treasury at maybe 40 million. Treasury then applies a standard percentage cut. We end up with KES 18 million."

Mental Health Programme Officer

This account describes what the data suggests is a structural form of pre-emptive self-censorship: mental health officials reduce their own bids in anticipation of cuts, and the cuts occur anyway.

The result is a financing allocation that reflects accumulated institutional discounting rather than any assessment of actual need or cost.

The third sub-theme - the absence of dedicated budget lines - was documented through both interview data and documentary analysis of national budget statements for fiscal years 2020/21 to 2023/24 (Ministry of Health, Kenya, Budget Estimates 2020–2024; National Treasury, Programme Based Budget 2020–2024). Mental health expenditure is absorbed within broader programme categories such as "Non-Communicable Diseases and Mental Health" or "Preventive and Promotive Services," making it impossible to track actual spending or enforce accountability. A participant from within a parliamentary oversight committee explained the accountability consequence:

"If we can't see the budget line, we can't track spending, we can't hold anyone accountable. Mental health becomes everyone's responsibility and therefore no one's."

Parliamentary Oversight Committee Member

This observation encapsulates the analytical significance of the sub-theme: the absence of a dedicated budget line is not merely a technical accounting issue. It is a structural condition that removes the accountability mechanisms through which fiscal commitment would otherwise be enforced.

4.3.3 Inter-Agency Coordination Failures

A third theme - identified in 26 of 32 interviews (81%) - concerned the failure of coordination between the key institutional actors in Kenya's mental health financing ecosystem: the National Treasury, the Ministry of Health, the Social Health Insurance Fund, and county governments. This theme emerged from codes relating to inter-institutional communication, budget justification processes, benefit package design, and unfunded mandates. What distinguished this theme analytically from the preceding one was its relational character: whereas Theme 2 concerned the internal positioning of mental health within individual institutions, Theme 3 concerned the spaces between institutions — the gaps in communication, shared planning, and

mutual accountability that produce collective inaction even when no single institution is explicitly refusing to act.

The first sub-theme concerned the disconnect between Treasury and MoH in the budget justification process. Treasury officials described receiving mental health budget requests that were poorly justified in terms they found actionable - presenting burden-of-disease statistics without translating them into costed service delivery models. A Treasury official explained:

"MoH sends us burden data - 15% disease burden, KES 62 billion economic cost. But they don't tell us what the money will do. How many people treated? What services delivered? What does KES 100 million buy in mental health? I can't defend a budget request I can't explain."

Treasury Official

An MoH official countered with a mirror-image frustration:

"We've given them every justification. ROI studies from WHO. Burden data from previous research studies. Human rights arguments. Constitutional obligations. Nothing works. They just don't prioritise it."

Ministry of Health Official

Read together, these accounts reveal a translation failure: each institution is communicating in terms the other does not find actionable. Treasury requires output-based cost justifications; MoH is providing epidemiological and rights-based arguments. The gap between these communication registers is itself a coordination failure, and one that leaves mental health chronically under-justified in budget negotiations.

The second sub-theme concerned SHIF and MoH misalignment in benefit package design. SHIF benefit packages are designed through SHIF's own actuarial and policy processes, which the data revealed to occur largely independently of MoH service delivery planning. A SHIF official stated plainly:

"The MoH has not formally requested expansion of mental health benefits. They've never sent us a costing study. Never asked for a meeting. We design our benefit packages based on what we have actuarial data for - and we don't have data for mental health outpatient services because we've never covered them."

SHIF Official

This account describes what is analytically a circular trap: SHIF excludes mental health because it lacks actuarial data, and it lacks actuarial data because mental health is excluded. The two institutions that would need to collaborate to break this cycle - MoH, which could provide service utilisation data, and SHIF, which could pilot coverage - have no active coordination mechanism for doing so.

The third sub-theme concerned national-county tensions over unfunded mandates - a relational failure in which the national government passes legislation and develops policies that require county expenditure without providing the corresponding financing. Twenty of 32 participants (63%) expressed frustration with this dynamic. A county health director gave voice to the experience:

"The national government passes laws requiring us to spend money we don't have. Then they don't provide the funds. And then they audit us for not implementing. We are judged by standards we were never resourced to meet."

County Health Director

This sub-theme connects analytically to the fragmentation documented in Theme 1: the same structural division of responsibility that creates the accountability gap also enables the national government to impose mandates without fiscal consequence, transferring the implementation burden to counties that lack the capacity to discharge it.

4.3.4 Capacity Constraints

A fourth theme - identified in 24 of 32 interviews (75%) - concerned technical capacity gaps within the institutions responsible for mental health financing. This theme was developed from codes relating to expertise, training, data availability, and institutional knowledge. What the data revealed was not a uniform capacity deficit but a layered set of constraints operating differently at national, county, and insurance institution levels, each producing distinct financing consequences.

At the national level, the most significant constraint was the absence of mental health expertise within the Treasury's Health and Social Sectors Directorate - the unit responsible for reviewing MoH budget submissions. A Treasury economist's self-description illustrates this gap:

"I'm a macro-economist. I understand health financing broadly - hospitals, primary care, essential medicines. But mental health? The disease burden? What treatments work? What they cost? I genuinely don't know enough to evaluate their requests critically. I can apply a standard framework, but I can't tell if KES 180 million is reasonable or wildly inflated."

Treasury Economist

This account is analytically significant because it reveals that the problem is not simply institutional reluctance but genuine epistemic incapacity: Treasury cannot effectively evaluate mental health budget requests because it lacks the technical knowledge to do so. The consequence is that mental health requests are evaluated through a generic fiscal lens that cannot distinguish between well-justified and poorly-justified claims.

At county level, capacity constraints were even more pronounced. Documentary review of county annual health sector reports and Ministry of Health human resource data revealed that only 8 of 47 counties had a dedicated mental health coordinator as of 2023. In the absence of such a coordinator, mental health budget requests within counties are typically prepared by generalist health officers with no specialist knowledge, submitted without supporting evidence, and cut in preference to programs with dedicated advocates. The result is that counties that have

the constitutional responsibility for mental health service delivery also lack the institutional capacity to make the case for its funding.

At SHIF, the specific constraint was actuarial. SHIF's actuarial team reported having no claims data for mental health outpatient services - a gap that is itself a product of the exclusion of those services from the benefit package. A SHIF official acknowledged the circularity:

"We don't have claims data because we don't cover mental health outpatient services. So we don't know: would utilisation be high or low? What would it cost? Without that data, we can't price the benefit. Without pricing, we can't include it. It's a trap we built ourselves."

SHIF Official

Analytically, this sub-theme illustrates how capacity constraints are not merely pre-existing conditions but are actively produced and reproduced by the financing decisions they are then used to justify - a dynamic consistent with what Modified Labeling Theory (Link et al., 1989) describes as the structural reproduction of disadvantage through institutional practices.

4.3.5 Institutional Barriers as Compound Allocative Failure

Read together, the four themes developed in this section constitute what Musgrave's (1959) framework identifies as a compound allocative failure - a situation in which multiple institutional mechanisms simultaneously prevent the state from discharging its obligation to finance a meritorious public good. Fragmented devolution distributes responsibility without distributing resources, ensuring that no level of government owns the financing problem. Institutional positioning places mental health in internal competition it systematically loses, and removes the accountability mechanisms that would otherwise enforce fiscal commitment. Inter-agency coordination failures ensure that even where political will might exist within individual institutions, the absence of shared planning and communication means it cannot translate into coordinated action. And capacity constraints mean that even where coordination is attempted, the technical knowledge required to make credible budget cases or design appropriate benefit packages is often absent.

What is analytically striking is the self-reinforcing character of these barriers. Each one produces conditions that strengthen the others: fragmentation reduces accountability, which reduces political salience, which reduces institutional capacity-building investment, which reduces the quality of budget justifications, which reduces allocations, which reduces service availability, which reduces the visibility of the problem, which reduces political salience further. The four themes are not independent causes but interlocking components of a system that reliably produces underfunding. This systemic character has significant implications for reform: interventions that address only one barrier - creating a dedicated budget line without addressing coordination, for example - are unlikely to produce sustained change. The findings suggest that durable reform requires simultaneous action across all four dimensions.

4.4 Stigma, Perceptions, and the Politics of Mental Health Financing

This section presents findings in relation to Research Objective ii: to explore how stakeholder perceptions and stigma shape the prioritisation of mental health within public financing systems. Thematic analysis generated four themes: (i) institutional stigma and legitimacy perceptions, (ii) productivity biases and return-on-investment assumptions, (iii) political invisibility and competing health priorities, and (iv) evidence dismissal and selective skepticism. Collectively, these themes document how stigmatised beliefs about mental illness - operating at the institutional rather than merely individual level - become embedded in fiscal decision-making processes, producing discriminatory resource allocation that cannot be explained by evidence or institutional capacity alone.

4.4.1 Institutional Stigma and Legitimacy Perceptions

The first and most analytically foundational theme in this section concerned the legitimacy perceptions of mental illness among institutional decision-makers. Twenty-two of 32 participants (69%), particularly those in Treasury, SHIF, and parliamentary roles, expressed or acknowledged stigmatising beliefs during interviews. The significance of this finding is not the prevalence of stigma as such — stigma in the general population is well-documented (Ndeti et al., 2024; Mburu & Ndeti, 2021) — but its location: these were not community members but senior officials whose perceptions directly shape fiscal decisions. Modified Labeling Theory (Link et

al., 1989) predicts precisely this institutional embedding of stigma; what this study's data reveals is the specific mechanisms through which it operates in fiscal contexts.

The most prevalent sub-theme was the perception of mental illness as less medically legitimate than physical health conditions. A Treasury official, speaking candidly after assurances of anonymity, articulated what he described as a view he suspected was widely shared:

"Malaria, you can see it — fever, test results, death rates. Cancer — you have scans, biopsies, clear pathology. Mental health... you talk about depression, about anxiety, about stress. Is that really disease? Or is that life?"

Treasury Official

This framing — mental illness as "life" rather than "disease" — appeared in variant forms across 14 interviews. What makes it analytically significant is not that participants were expressing personal prejudice but that they were describing the perceptual framework through which they evaluated budget requests. A perception that mental illness is not fully "real" medicine translates directly into a lower standard of evidence required to justify underfunding it.

A second sub-theme concerned the association of mental illness with behavioural choice rather than medical condition. A SHIF official explained resistance to covering substance use and related disorders:

"If we cover alcohol addiction treatment, are we rewarding bad behavior? People choose to drink. They don't choose to get malaria."

SHIF Official

This framing — distinguishing "chosen" conditions from "real" disease — has direct benefit package implications and appeared in five interviews specifically in the context of SHIF coverage decisions. A third sub-theme, identified primarily in county-level accounts, concerned the association of mental illness with danger and unpredictability. A county health director acknowledged:

"When we budget for the mental health unit, it's for security — fences, guards, locked doors — not for therapists or medications. That's what 'mental health budget' means in our context."

County Health Director

This account reveals how stigma shapes not only the quantity of resources allocated to mental health but their character: even the limited resources provided are directed toward containment rather than treatment, reflecting and reproducing the "dangerous patient" framing that stigma produces.

4.4.2 Productivity Biases and Return-on-Investment Assumptions

A second theme concerned how decision-makers assessed the economic productivity of people with mental illness, and how those assessments shaped their evaluation of the case for mental health investment. This theme emerged from 20 of 32 interviews (63%) and was particularly pronounced among Treasury and parliamentary participants. What the data revealed was not a rejection of economic reasoning per se, but its selective application — a pattern consistent with the evidence dismissal sub-theme developed in Section 4.4.4.

The most significant sub-theme was the assumption of unemployability — the belief that people with mental illness cannot be productively employed and therefore do not represent a worthwhile investment target. A Treasury economist challenged the KES 62 billion economic cost estimate on precisely these grounds:

"That assumes people with mental illness could be productive if treated. But can they? Schizophrenia, severe depression — these are not conditions where you treat someone and they go back to work and pay taxes."

Treasury Economist

This assumption persisted during the interview even after the researcher noted that the majority of mental health conditions — including depression and anxiety, which account for the largest

share of the treatment gap — respond well to treatment and produce documented productivity gains (WHO, 2023). The persistence of the assumption despite counter-evidence is analytically significant: it suggests the belief is operating as a perceptual filter rather than an evidence-based conclusion.

A second sub-theme concerned the mismatch between mental health investment timelines and the annual budget cycle. A budget official explained:

"I need to show results in 12 months — immunization coverage up 5%, maternal mortality down 10%, new HIV patients on treatment. What does mental health give me in 12 months? I can't point to a number."

National Budget Official

A parliamentary participant extended this logic:

"If you fix someone's broken leg, they go back to work next month. Mental health — you treat someone for years, maybe decades, and maybe they get better. That's not the kind of ROI I can put in a budget justification."

Parliamentary Committee Member

These accounts reveal a structural incompatibility between the timescales of mental health treatment outcomes and the institutional logic of annual budget cycles — a structural feature of fiscal governance that systematically disadvantages conditions with long treatment trajectories. An interesting counter-finding emerged when one SHIF official, initially skeptical, recalled a family member's recovery from postpartum depression:

"My cousin had severe depression after childbirth. She couldn't work, couldn't care for the baby, was suicidal. Treatment worked. She's back at work now, back in her family. That's the ROI."

SHIF Official

This account suggests that personal proximity to recovery — rather than abstract economic data — may be the more effective persuasion mechanism, a finding with direct implications for mental health advocacy strategy.

4.4.3 Political Invisibility and Competing Health Priorities

A third theme — identified in 27 of 32 interviews (84%) — concerned the political dynamics that sustain mental health's low prioritisation relative to other health programs. This theme was developed from codes relating to constituency pressure, political salience, advocacy power, and the consequences of affected populations' silence. Analytically, it connects the institutional and perceptual dynamics documented in Themes 1 and 2 to the political economy structures that give those dynamics their stability.

The first sub-theme concerned political salience — the visibility of a health issue to elected officials and their sense of accountability for it. The contrast with maternal health and HIV/AIDS was analytically illuminating. A Ministry of Health official described the political economy of maternal health:

"If a mother dies in childbirth, it's a scandal — MPs question the Cabinet Secretary, media covers it for weeks, heads roll. If a child dies of schizophrenia because there's no medication, no one hears about it. No journalist covers it. No MP asks a question."

Ministry of Health Official

A parliamentary participant confirmed the constituency pressure analysis directly:

"My voters call me about hospital bed shortages, drug stockouts for hypertension, ambulance services. Not once has anyone called me about mental health funding. There is zero political cost to ignoring it."

Parliamentary Committee Member

This account, offered without prompting, identifies the key structural feature that sustains fiscal neglect: the absence of political cost means there is no political incentive to act, regardless of the evidence.

The second sub-theme — stigma silences advocacy — explains why this political cost remains absent. A CSO leader explained:

"People living with HIV went public in the 1990s and 2000s. They humanized the issue, demanded resources, became visible. People with mental illness cannot do the same. Stigma means that going public about your diagnosis risks your job, your marriage, your family relationships. So the constituency that should be most vocal is the most silent."

Civil Society Organization Leader

This account makes explicit the mechanism through which stigma, operating at the social level, produces political invisibility at the institutional level. The self-silencing of affected populations removes the constituency pressure that democratic accountability requires to function. In this way, the stigma documented in Theme 4.4.1 - operating at the institutional level in the perceptions of decision-makers - is compounded by stigma operating at the social level in the behaviour of the populations whose advocacy would otherwise create political incentives for change. Modified Labeling Theory's account of how stigma shapes social participation (Link et al., 1989) finds direct empirical expression in this dynamic.

4.4.4 Evidence Dismissal and Selective Skepticism

A fourth theme - analytically perhaps the most theoretically significant in this section - concerned the differential treatment of economic evidence for mental health compared to other health conditions. This theme emerged from the experience of presenting the KES 62 billion economic cost estimate to participants during interviews: despite being derived from the same methodological approach used for similar estimates for malaria and maternal health (Ministry of Health, Kenya, 2021), the mental health figure was questioned or dismissed by 16 of 32 participants (50%). No participant expressed equivalent skepticism about comparable figures for other conditions.

The first sub-theme concerned methodological skepticism directed selectively at mental health evidence. A Treasury official questioned the Investment Case methodology:

"KES 62 billion - where does that number come from? Who calculated it? What assumptions did they use? Every sector claims huge economic losses. I need to see the methodology."

Treasury Official

When the researcher explained that the methodology was identical to that used for malaria and maternal health estimates that the same official had previously cited without skepticism, the official acknowledged the inconsistency but did not revise his skepticism. This pattern - applying a higher methodological standard to mental health evidence than to equivalent evidence for other conditions - appeared across eight interviews. Analytically, it is precisely the mechanism MLT predicts: stigma operates as a perceptual filter that determines not what evidence exists but whose evidence is believed.

A second sub-theme concerned demands for Kenya-specific evidence - a form of evidentiary requirement that creates what the data reveals as a structural catch-22. A SHIF official stated:

"Show me that mental health treatment actually improves productivity in Kenya specifically. Not global studies, not WHO models. Kenya data."

SHIF Official

The analytical problem, identified by the researcher during interviews and confirmed by participants when it was raised, is that generating Kenya-specific evidence requires Kenya-specific mental health services, which requires the financing that is being withheld pending the evidence. This circular epistemic trap - well-documented in the health financing literature (Barasa et al., 2022) - is presented here not merely as a technical problem but as a stigma-driven one: the demand for jurisdiction-specific evidence is not applied equally to other health conditions, and its selective application to mental health reflects the same differential standards of proof that characterize evidence dismissal more broadly.

Taken together, the four themes developed in this section reveal stigma operating not merely as individual prejudice but as an institutional epistemic structure - shaping what counts as legitimate disease, what constitutes acceptable evidence, who is considered a productive investment target, and what generates political accountability. These are not peripheral or occasional distortions; they are systematic features of the decision-making environment that mental health must navigate in Kenya's fiscal institutions. The implications for reform are direct: presenting better evidence alone will not close the financing gap if the perceptual filters through which that evidence is evaluated remain unchanged.

Because these themes recur across the analysis and were sometimes voiced by participants in overlapping terms, it is worth stating explicitly how they are distinguished analytically and where they intersect. The thematic structure used here follows a hierarchy in which a single global concern - that mental health is systematically disadvantaged in fiscal decision-making - is expressed through organising themes (institutional stigma, political invisibility, and evidence dismissal) that are in turn built from the basic, coded units drawn from participant accounts. Institutional stigma refers to the devaluation of mental illness as a less legitimate or less “real” medical condition, embedded in the routines and assumptions of institutions rather than in any individual’s prejudice. Political invisibility refers to the absence of organised constituencies, electoral salience, and vocal champions that would compel decision-makers to act, irrespective of how legitimate the condition is held to be. Evidence dismissal refers to the selective application of stricter standards of proof to mental health than to comparable health conditions. The three are conceptually distinct - one concerns perceived legitimacy, one concerns political pressure, and one concerns the treatment of evidence - but they are mutually reinforcing: stigma lowers the perceived payoff of investment, invisibility removes the pressure that might override that perception, and evidence dismissal supplies a technical justification for inaction that masks the underlying perceptual judgement. Distinguishing them in this way guards against conflating distinct mechanisms while still capturing the compounding effect through which they jointly sustain underfinancing.

4.5 Political Economy and Financing Mechanism Feasibility

This section presents findings in relation to Research Objective iii: to assess stakeholder perspectives on feasible financing reforms for sustainable mental health funding in Kenya.

Thematic analysis generated two themes: (i) political economy dynamics sustaining the status quo, and (ii) stakeholder assessments of financing mechanism feasibility. The section first situates the feasibility assessments within the political economy context that shapes them, then presents the analytical findings from participants' evaluations of five candidate financing mechanisms.

4.5.1 Political Economy Dynamics

Before participants could meaningfully assess what financing reforms were feasible, the data required engagement with why the current system persists despite its documented inadequacy. Three political economy sub-themes emerged from this analysis, each illuminating a structural feature of the environment in which any reform must operate.

The most prevalent sub-theme — identified in 28 of 32 interviews (88%) — was the absence of political champions for mental health within Kenya's legislative and executive institutions. Unlike HIV/AIDS, maternal health, or malaria — each of which has identifiable parliamentary and ministerial champions who actively advocate for resources — mental health has no equivalent institutional advocate at national level. The reason, as the preceding section established, is the political invisibility that stigma produces: there is no constituency pressure to incentivise advocacy. A parliamentary official captured the consequence:

"Members of Parliament care about things their constituents care about. And their constituents don't march on Parliament demanding mental health funding. So neither do we."

Parliamentary Official

This is not cynicism - it is a frank account of how democratic accountability functions, and how its absence in this domain perpetuates the financing gap.

The second sub-theme concerned donor dependency and its crowding-out effect on domestic mental health investment. Twenty-four of 32 participants (75%) noted that the dominance of donor funding in HIV, tuberculosis, and malaria had reduced the domestic fiscal pressure to

invest in those areas - and that mental health, lacking equivalent donor support, had no comparable safety net. A senior MoH official explained:

"The donor-funded programs — HIV, TB, malaria — have their own budgets, their own staff, their own reporting lines. They don't compete for the same money as mental health. But they do set the standard for what 'successful' health programming looks like. Mental health can't meet that standard because it doesn't have the data infrastructure donors require."

Senior MOH Official

This account reveals a structural paradox: the programs that attract donor funding become models of evidence-based programming against which mental health - excluded from donor funding partly due to limited data - is unfavourably compared, further reinforcing its marginalisation.

The third sub-theme concerned the fragmentation of civil society advocacy for mental health. A CSO leader acknowledged:

"We try. The Kenya Mental Health Alliance tries. But we are small, fragmented, competing for the same tiny donor funding pot. We don't have the resources to sustain a national advocacy campaign. We do it in spasms - one report, one event, one meeting with a Treasury official - and then the funding ends and we go quiet."

Civil Society Organization Leader

This self-description reveals an advocacy ecosystem that mirrors the structural fragmentation of the financing system itself: multiple actors with overlapping mandates, insufficient coordination, and no sustained political pressure strategy. The contrast with the HIV advocacy movement of the 1990s and 2000s - which the data repeatedly invoked as the archetype of successful mental health-equivalent campaigning - underscores how much the current civil society configuration falls short of what effective advocacy requires.

4.5.2 Stakeholder Assessments of Financing Mechanism Feasibility

Against this political economy backdrop, participants assessed five candidate financing mechanisms: SHIF benefit package expansion, conditional grants from national to county government, dedicated budget lines, earmarked taxes on alcohol and tobacco, and performance-based financing. Table 5 summarises participant ratings. The analytical narrative below examines not only the feasibility ratings but the reasoning behind them - which, as the data reveals, is often as informative as the ratings themselves.

Mechanism	Feasibility Rating	n (% rating feasible)	Key Barrier	Key Enabler
SHIF Benefit Package Expansion	HIGH	24 (75%)	Absence of actuarial data	Existing chronic disease framework
Conditional Grants to Counties	MODERATE-HIGH	21 (66%)	Enforcement and compliance	Precedent in HIV/malaria grants
Dedicated Budget Lines	MODERATE	17 (53%)	Treasury resistance to ring-fencing	Accountability and tracking benefit
Earmarked Taxes (alcohol/tobacco)	LOW-MODERATE	12 (38%)	Fiscal orthodoxy concerns	Alignment with substance use agenda
Performance-Based Financing	LOW	8 (25%)	Outcome measurement complexity	Incentive alignment potential

Table 6: Perceived Feasibility of Five Mental Health Financing Mechanisms

SHIF benefit package expansion was rated as the most feasible mechanism, with 24 of 32 participants (75%) assessing it as achievable within the current institutional framework. The reasoning participants offered was consistent: SHIF already has the administrative infrastructure for chronic disease management, making mental health integration a question of political will and actuarial costing rather than institutional redesign. A SHIF official elaborated:

"We could include outpatient mental health. Technically, it is possible. We already have a framework for chronic disease - diabetes, hypertension. Depression is a chronic condition. The template exists."

SHIF Official

What participants identified as the key barrier was not technical but informational: the absence of Kenyan utilisation and cost data, which is needed for actuarial pricing. Several participants suggested a time-limited pilot in three to five counties as the mechanism for generating that data, with national expansion contingent on pilot results.

Conditional grants from the National Treasury to county governments were assessed as feasible by 21 participants (66%), with the reasoning centred on existing precedents. The model already exists for HIV, malaria, and vaccines: national-level conditional grants that compel county spending in specified areas as a condition of fund release. A Treasury official expressed cautious openness:

"Conditional grants exist for HIV, malaria, vaccines. We could create one for mental health. The question is: would counties comply, or find ways to reclassify spending? That's the enforcement challenge."

Treasury Official

The analytical interest of this mechanism is that it directly addresses the fragmentation and unfunded mandate sub-themes identified in Theme 4.3.1: by ring-fencing national transfers for mental health and attaching conditionalities, it re-creates - at least partially - the consolidated accountability that devolution disrupted.

Dedicated budget lines were assessed as moderately feasible by 17 participants (53%), with Treasury officials the primary source of skepticism. A Treasury official explained:

"Ring-fencing is problematic for Treasury. We have limited fiscal space. We cannot tie our hands. Every program would want a dedicated line — malaria, diabetes, cancer. Where does it end?"

Treasury Official

This resistance is analytically illuminating: it reveals that Treasury's objection is not specific to mental health but reflects a general institutional preference against fiscal earmarking. The

implication for advocacy is significant — the case for a mental health budget line must be made not in terms of mental health's unique claims but in terms that address Treasury's broader institutional concerns about fiscal flexibility.

Earmarked taxes on alcohol and tobacco were rated as low-to-moderately feasible by 12 participants (38%). Opposition centred on fiscal orthodoxy concerns rather than mental health-specific objections. A Treasury official argued:

"Earmarking is a bad fiscal practice. It reduces flexibility. What if sin taxes decline because people reduce drinking? Then your mental health budget collapses."

Treasury Official

Despite these concerns, six participants noted that precedent exists — Kenya's Road Maintenance Levy is a form of earmarked tax — and that the political alignment between alcohol/tobacco taxation and mental health outcomes (given the documented mental health consequences of substance use) could provide a strong advocacy narrative. Performance-based financing was rated as least feasible by 8 participants (25%), with measurement complexity identified as the primary barrier. A Ministry of Health official explained:

"How do you measure mental health outcomes? Mortality is easy. But recovery? Quality of life? Functioning? Those are hard to define, hard to verify, easy to game."

Ministry of Health Official

This assessment has important analytical implications: it suggests that before performance-based mechanisms can be viable for mental health, investment in outcome measurement frameworks — itself requiring financing — would need to precede their introduction.

4.5.3 Feasibility Within a Constrained Political Economy

The feasibility assessments reveal a consistent pattern: mechanisms that work within existing institutional structures and require minimal new political consensus are rated most feasible; mechanisms that require new legislation, new data infrastructure, or fundamental fiscal

reorientation are rated less so. SHIF expansion and conditional grants score highest because they operate through institutions that already exist and through precedents that are already established. Earmarked taxes and performance-based financing score lowest because they require both political will for new instruments and technical infrastructure that is not yet in place.

The political economy dynamics documented in Section 4.5.1 are directly relevant to this pattern. The absence of political champions, the fragmentation of civil society, and the dominance of donor-funded vertical programs all make high-consensus, high-redesign mechanisms less viable than they might appear in principle. The implication is not that ambitious reform is impossible, but that the sequencing of reform matters: building the evidence base through SHIF piloting, establishing the precedent through a conditional grant, and developing outcome measurement frameworks through dedicated investment — in that order — creates the conditions in which more ambitious mechanisms become politically feasible. Reform, in other words, is itself a process of constituency-building, not merely a technical exercise.

4.6 The Stakeholder Verdict: Why Mental Health Receives Less Than 1%

This final section of the findings chapter presents participants' own synthesis of why mental health receives less than 1% of Kenya's national health budget. Rather than presenting this as a separate analytical section, the study invited participants — at the close of each interview — to offer their own verdict on the central research question. Their responses, read analytically, reveal a convergent understanding that cuts across stakeholder group, institutional role, and professional background: mental health is institutionally constructed as less deserving.

This convergence is itself an analytical finding. Across 32 interviews spanning Treasury officials, MoH policymakers, SHIF actuaries, parliamentarians, county health directors, frontline providers, CSO leaders, and community representatives, the explanations offered did not fragment along institutional lines as might be expected. Instead, they converged on three interlocking mechanisms — institutional stigma, political invisibility, and fiscal unprotection — that participants described as mutually reinforcing. A Treasury official's account was striking in its candor:

"At the end of the day, it comes down to this: mental health is seen as less deserving. We can dress it up in technical language — fiscal space constraints, competing priorities,

evidence gaps. But underneath all of that is a belief that mental illness is less real, less serious, less worth spending money on. And that belief is what keeps the budget at less than 1%."

Treasury Official

The phrase "less deserving" — used in this form by this participant and in variant forms by seven others — became the analytical anchoring concept for the study's overarching finding.

A frontline provider at Mathari National Hospital grounded this structural verdict in the lived experience of patients:

"I have a patient. Mother of three. Severe depression. She tried to kill herself twice. She cannot work. Her children go to school hungry because she cannot earn. She has been on the waiting list for outpatient therapy for eight months. Eight months. You know why? Because the facility has one therapist for 400 outpatients. And we have one therapist because the budget for mental health in this hospital has not increased in three years. That is what 'less deserving' looks like on the ground."

Mathari National Hospital Employee

This account does not add analytical content to the structural explanations already developed — it makes those explanations human. In Braun and Clarke's (2006) framework, such accounts serve a critical purpose in the final report: they reconnect abstract themes to the concrete realities that generated them, reminding the reader of what the analysis is ultimately about.

A CSO leader offered the structural interpretation that most directly connects to the study's theoretical framework:

"The less than 1% is not an accident. It is the logical outcome of a system where mental health is institutionally stigmatised, politically invisible, and fiscally unprotected. Change one of those things and the other two will pull it back. You have to change all three at once."

This observation — that the three mechanisms are mutually reinforcing and must be addressed simultaneously — anticipates the recommendations developed in Chapter Five and provides the empirical grounding for the study's central argument: that mental health financing reform in Kenya requires not a technical fix but a systemic one.

The convergence of these accounts across stakeholder groups constitutes, in Braun and Clarke's terms, a robust finding — one that holds across the dataset rather than appearing only in specific subgroups. It suggests that the causes of mental health underfunding in Kenya are not primarily located in any single institution, political decision, or evidence gap, but in a shared social construction of mental illness as a less legitimate claim on public resources. Understanding that construction — its origins, its mechanisms, and the conditions under which it might shift — is the analytical contribution this study offers to the wider health financing discourse.

This convergence, however, was not unanimous, and the dissenting and divergent accounts within the dataset merit explicit attention rather than being subsumed within the dominant narrative. A minority of participants, concentrated among Treasury and SHIF actuarial officials, resisted the framing of underfunding as primarily stigma-driven and located it instead in what they characterised as genuine technical deficiencies in mental health budget submissions — the absence of costed, output-based service models against which allocations could be justified. For these participants, the problem was not that mental illness was perceived as undeserving but that its advocates had not presented investable proposals, a position that attributes underfunding to capability and process rather than to perception. A second divergent strand questioned the headline economic estimates directly, and at least some of this scepticism appeared to rest on defensible methodological reservations rather than on dismissal of mental health as such. A third minority view, expressed by several county-level officials, held that the binding constraint was not national prioritisation at all but the absence of protected fiscal space at county level following devolution, shifting the locus of the problem away from attitudes and toward fiscal architecture. These accounts complicate the study's central argument in productive ways. They do not overturn the finding that stigma operates as a fiscal determinant — the weight of the data supports that conclusion — but they indicate that stigma operates alongside, and is sometimes

difficult to disentangle from, legitimate technical and structural constraints. Retaining these divergent voices guards against the risk that a study of institutional neglect itself neglects the evidence that does not fit its thesis.

CHAPTER FIVE: DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

5.1 Introduction

This chapter interprets the findings presented in Chapter 4 in relation to the study's theoretical frameworks and the existing empirical literature. The chapter is organized into six sections: discussion of findings by research objective, theoretical contributions, methodological contributions, study limitations, recommendations (organized by stakeholder), and conclusions.

The central finding of this study is that mental health financing in Kenya remains at less than 1% of the health budget not due to lack of evidence or policy commitment, but due to a self-reinforcing cycle of institutional marginalization, stigma-driven devaluation, and political invisibility that renders mental health "safe to ignore" despite compelling economic and epidemiological rationale.

5.2 Discussion of Findings

The finding that fragmented devolution creates responsibility diffusion between national and county governments (Section 4.3.1) represents a profound allocative failure in Musgrave's (1959) terms. Musgrave's Theory of Public Finance posits that the state must provide meritorious goods - those with substantial positive externalities that the market cannot supply efficiently - and mental health unambiguously qualifies; effective treatment reduces disability, improves workforce productivity, lowers criminal justice and social welfare costs, and strengthens family and community functioning. This study demonstrates, however, that even where the state formally acknowledges its allocative obligation, as Kenya does through the Mental Health Policy 2015–2030 and the Mental Health (Amendment) Act, 2022, governance fragmentation can render it structurally incapable of fulfilling that obligation. This extends Musgrave's framework by showing that allocative failure is not merely a matter of insufficient political will or resources but can be embedded in institutional architecture itself.

This finding extends Jenkins et al. (2020), who documented post-devolution fragmentation but did not examine how it creates a unique disadvantage for mental health relative to other health priorities. This study demonstrates that HIV, malaria, and TB are protected from devolution's

fragmenting effects through vertical integration mechanisms — conditional grants, donor-funded parallel structures, and dedicated national programmes — that mental health entirely lacks, making it uniquely vulnerable to responsibility diffusion. The comparison with Rwanda is instructive in this regard: Rwanda's successful integration of mental health into community-based health insurance prior to major health system reforms (Ng et al., 2023) suggests a temporal lesson that Kenya's experience confirms — health system restructuring must explicitly address mental health integration before reforms are implemented, not as an afterthought.

5.2.1 Institutional Stigma as a Fiscal Determinant

This study's most significant theoretical contribution is demonstrating that stigma operates at the fiscal policy level, directly shaping resource allocation decisions. While Modified Labeling Theory (Link et al., 1989) has been extensively applied to understand individual-level barriers to care-seeking, this study extends MLT to institutional decision-making.

The study identified six specific mechanisms through which stigma translates into fiscal neglect:

Legitimacy perception: Mental illness viewed as less "real" or less medical.
Return-on-investment bias: Assumption that people with mental illness are unproductive.
Political visibility: Stigma silences affected populations, creating no constituency pressure.
Institutional inertia: Marginal positioning becomes self-perpetuating. Evidence dismissal:
Economic evidence held to higher standards than for physical health. Reinforcing cycle: Low funding produces poor services, validating stigma.

These mechanisms operate together to create what Hatzenbuehler (2014) terms structural stigma—stigma embedded in policies, institutional practices, and resource allocation that limits opportunities for stigmatized populations.

The finding that 50% of participants dismissed the KES 62 billion economic cost estimate—despite its methodological rigor—resolves a puzzle in the literature: why does compelling economic evidence fail to shift policy? The answer is that stigma functions as a perceptual filter that determines which evidence is taken seriously. When decision-makers have already decided that mental health is less deserving, they will interpret conflicting evidence as

unreliable, exceptional, or inflated. As Festinger's (1957) cognitive dissonance theory predicts, dismissing evidence is psychologically easier than revising deeply held beliefs.

The finding carries profound implications for mental health advocacy in Kenya. The persistent underfunding of mental health cannot be resolved by generating more evidence, because the problem is not a shortage of evidence — it is the systematic dismissal of evidence that already exists, driven by institutional stigma operating as a perceptual filter in budget decision-making. A strategy built on producing yet another investment case or cost-effectiveness analysis will encounter the same wall: decision-makers who apply a higher standard of proof to mental health than to any comparable health priority.

Effective advocacy must therefore shift its focus from evidence production to perception change. The first imperative is contact-based stigma reduction — creating structured opportunities for Treasury officials, SHIF planners, and parliamentary committee members to encounter, directly and personally, people who have recovered from mental illness. The international evidence is consistent: abstract epidemiological data moves almost no one, while a single human story of recovery heard face to face can shift a belief that years of published research could not. The second imperative is political constituency-building. Mental health remains politically safe to ignore because affected populations are silenced by the very stigma that produces the underfunding. Investing in the conditions under which patients and families can speak publicly — anti-stigma campaigns, legal protection against discrimination, and the deliberate platforming of recovery narratives — creates the constituency pressure that democratic accountability requires to function. The third imperative is strategic framing: combining the economic argument with personal stories that make the human cost of inaction visible, while presenting Treasury-actionable, output-based cost models that translate burden evidence into the service delivery terms that budget processes require. Advocacy that integrates these three elements does not merely ask decision-makers for more resources — it changes the institutional environment in which those decisions are made.

The finding has profound implications for advocacy strategy. Presenting more evidence alone will not be sufficient because the problem is not evidence availability but stigma-driven evidence dismissal. Advocacy must instead pursue three parallel tracks: reducing stigma through contact-based interventions that bring decision-makers into direct contact with recovered

patients; creating political incentives that make dismissing evidence costly; and deploying emotional resonance—personal stories of recovery and loss—alongside quantitative data, since personal experience proved more persuasive to some decision-makers than economic models.

5.2.2 Political Economy: The "Safe to Ignore" Phenomenon

The finding that mental health is "politically safe to ignore" because affected populations are silenced by stigma illuminates a fundamental power asymmetry in Kenya's health financing system. Those most affected by underfunding—patients, families, and frontline workers—have the least political power to change it, while those with authority to increase financing face limited constituency pressure to do so. Mental health must compete against well-resourced, politically visible priorities such as maternal health, HIV/AIDS, and malaria, all of which benefit from organized advocacy, donor funding, and measurable output indicators. Mental health, with outcomes that are long-term and complex to measure, and clouded by stigma, is systematically disadvantaged in this competition. The absence of political champions, the fragmentation of civil society advocacy, and the silencing effect of stigma on affected populations together explain why mental health remains fiscally unprotected in Kenya's zero-sum budget environment.

The finding that donor funding for vertical programs crowds out domestic mental health investment (Section 4.5.1) aligns with Mbau et al. (2020), who documented how donor transitions create dependency and distort domestic priorities. However, this study extends that work by demonstrating that mental health suffers a double disadvantage: it receives minimal donor funding (so no crowding-in effect), yet competes against donor-funded programs that have already been "pre-funded" externally, making domestic allocation to mental health even less likely.

5.2.3 Feasibility of Financing Mechanisms

The finding that SHIF benefit package expansion and conditional grants are perceived as most feasible (Table 4.3) aligns with international evidence. Rwanda (Ng et al., 2023) and Ghana (Ofori-Atta et al., 2018) have successfully used insurance integration as a pathway to mental health financing. South Africa (National Treasury South Africa, 2021) has used conditional grants successfully.

Stakeholder support for SHIF expansion reflects several advantages including (i) existing infrastructure where SHIF is operational; adding mental health is incremental, not revolutionary, (ii) Risk pooling: Insurance spreads costs across the population, avoiding perceived "burden" on Treasury, (iii) Demand-side financing: Coverage creates financial access without requiring massive supply-side expansion first, (iv) UHC alignment: Integrating mental health advances Kenya's Universal Health Coverage commitments.

The finding that 62.5% of stakeholders opposed earmarked "sin taxes" contrasts with international examples (Thailand, Philippines: Jané-Llopis & Anderson, 2005). This resistance reflects Treasury orthodoxy favoring fungible revenues, not technical infeasibility. Overcoming this resistance requires parliamentary action—legislation mandating sin tax earmarking—rather than executive action.

5.3 Theoretical Contributions

This study makes three significant theoretical contributions.

5.3.1 Extending Modified Labeling Theory to Fiscal Policy

This study is the first (to the researcher's knowledge) to empirically demonstrate that Modified Labeling Theory applies to institutional fiscal decision-making, not only to individual experiences of stigma. The six stigma mechanisms identified provide a framework for understanding how stigmatized beliefs become embedded in budget processes, insurance design, and parliamentary oversight. This extends MLT into a new domain—public finance—with implications for how we understand and address institutional discrimination.

5.3.2 Integrating Musgrave and MLT

The synthesis of Musgrave's Theory of Public Finance with Modified Labeling Theory provides a novel theoretical framework explaining why economically rational policies (allocating resources to meritorious goods) fail when those goods are stigmatized. The integration demonstrates that:

Musgrave explains what should happen (state provides meritorious goods). MLT explains what actually happens (stigma overrides economic rationality).

This integration has implications beyond mental health for understanding resource allocation for any stigmatized condition or population.

5.4 Methodological Contributions

This study demonstrates the value of qualitative, stakeholder-centered approaches to health financing research. Traditional health financing research has been dominated by quantitative budget analyses, expenditure tracking, and econometric modeling. While valuable, these methods cannot explain why patterns persist because they cannot access the perceptions, assumptions, and institutional logics of decision-makers.

By interviewing the very actors who make financing decisions, this study uncovered mechanisms—institutional stigma, the productivity assumption, political invisibility—that would remain invisible in a purely quantitative study.

5.5 Study Limitations

As a qualitative case study, the findings are analytically rather than statistically generalizable, and this study makes no probabilistic claims about the prevalence of attitudes or the universal applicability of its findings beyond Kenya's context. Social desirability bias was a tangible concern given the seniority of participants and the politically sensitive nature of the subject matter; notably, however, 69% of participants expressed stigmatising views despite this pressure, suggesting that actual prevalence within financing institutions may be even higher than the data captured. Rich contextual description, theoretical framing, and triangulation with documentary sources were employed throughout to strengthen transferability and credibility.

Access to the most senior decision-makers — including the Cabinet Secretary for Health, the Principal Secretary at the National Treasury, and the Treasury Cabinet Secretary — was not achieved, and mid-level and senior technical officials were interviewed in their place. While these participants were directly involved in budget formulation processes and provided substantive insights, their accounts may not fully reflect the final political calculations made at the apex of government. This limitation was partially mitigated through documentary analysis of budget statements and parliamentary records, which provided an independent check on participant accounts where the most senior decision-making was concerned.

The implications of these two exclusions — apex political decision-makers and direct service users — run deeper than questions of access and warrant frank acknowledgement. Because the final, decisive allocative choices are made at precisely the apex level that the study could not reach, the analysis can characterise the institutional and perceptual environment within which those choices are made, but cannot directly observe the political reasoning at the moment of decision; the account of stigma as a fiscal determinant is therefore inferred from those who advise and implement rather than from those who ultimately decide. At the other end, the absence of service-user and lived-experience voices means that the study analyses the marginalisation of a population without incorporating that population's own account of it, a tension that is especially pointed given that the silencing of affected groups is itself one of the study's findings. Together these exclusions bound the study to an institutional, supply-side vantage point. The conclusions should accordingly be read as a rigorous account of how Kenya's mental health financing system is understood by those who operate it, rather than as a complete account of the financing system as experienced from either its political summit or its point of need.

5.6 Recommendations

This study's findings, grounded in the perspectives of 32 key stakeholders across Kenya's mental health financing ecosystem, pointed to a clear and urgent need for multi-stakeholder, coordinated action. The recommendations that follow were organized by target stakeholder and structured across three time horizons: short-term (0–12 months), medium-term (1–3 years), and long-term (3–5 years). Each recommendation emerged directly from the evidence gathered and was calibrated to the institutional realities and political economy constraints identified throughout the study.

Because these recommendations are numerous and make uneven demands on political capital, fiscal space, and institutional capacity, they are not of equal priority, and presenting them as a flat list would obscure the sequencing that their own logic implies. Two criteria are used to prioritise them: feasibility under current conditions (the degree of political will, legal change, and administrative capacity each requires) and leverage (the extent to which acting on one unlocks or conditions the others). On these criteria, three measures constitute the highest-priority, near-term cluster because they are both relatively feasible and foundational to the rest: mental health

budget tagging within existing public financial management systems, which requires administrative rather than legislative action and makes the problem measurable; expansion of the SHIF benefit package to include defined mental health services, which participants rated the single most feasible mechanism because it builds on existing administrative infrastructure rather than requiring institutional redesign; and the consolidation of fragmented civil society advocacy into a single coalition, which is largely within the sector's own control and is a precondition for generating the sustained political demand the other reforms depend upon. The more ambitious proposals — statutory ring-fencing of a minimum allocation and conditional intergovernmental grants — are placed in the medium-to-long term precisely because the study's own findings show that the political will, inter-agency coordination, and fiscal headroom they presuppose are currently weak. It would be inconsistent to argue, as this study does, that mental health financing is constrained by stigma, fragmentation, and political invisibility, and then to recommend reforms that assume those constraints away. The sequencing therefore treats the lower-cost, capacity-building measures as the means by which the conditions for the harder reforms might gradually be built, while recognising candidly that even this staged approach may stall: in entrenched political-economy settings, reforms that depend on sustained high-level commitment frequently fail at the implementation stage, and stakeholder-informed design, while necessary, is not on its own sufficient to guarantee that financing follows policy. Each recommendation below should be read with that risk of implementation failure in view, and the monitoring arrangements proposed are intended in part to make such failure visible early rather than to assume it away.

For the National Treasury, the most immediate and actionable step entailed conducting a comprehensive mental health budget tagging exercise. Since mental health lacked a discrete budget line—being absorbed within broad categories such as "Non-Communicable Diseases and Mental Health"—actual expenditure was impossible to track, creating an accountability vacuum.

Establishing this basic visibility was the indispensable first step. In the medium term, the National Treasury was called upon to create a conditional grant for mental health, ring-fenced for transfer to county governments, with an initial allocation of KES 1–2 billion. The precedent for this mechanism already existed in the form of conditional grants for HIV and malaria, making its technical feasibility unambiguous. Over the longer horizon, legislative reform to embed a minimum mental health allocation—modeled on South Africa's statutory ring-fencing, which has

sustained a 4.7% health budget allocation—represented the structural protection Kenya's mental health financing sorely needed.

For the Social Health Insurance Fund, the findings illuminated a paradox at the heart of SHIF's design: the fund excluded outpatient mental health services precisely because it lacked utilization data, and it lacked that data precisely because it did not cover those services. Breaking this circular logic required action. In the short term, SHIF was called upon to commission a rigorous actuarial costing study for outpatient mental health benefits, and to initiate a time-limited pilot covering mental health services in three to five counties. This pilot would generate the Kenya-specific data that actuaries demanded as a precondition for expansion. Once that evidence was in hand, the medium-term objective was clear: expand SHIF's benefits package to include outpatient psychiatric consultations, psychotherapy, and psychotropic medications. The long-term vision was integration of mental health into SHIF's chronic disease management framework—a model that treated depression and schizophrenia with the same administrative logic as diabetes or hypertension, recognizing their shared character as conditions requiring sustained, ongoing management.

For the Ministry of Health, the structural reforms were as critical as the financial ones. The elevation of the Mental Health Division from its current position as a sub-unit within the Directorate of Preventive and Promotive Services to a standalone directorate was identified as an immediate priority. This institutional repositioning was not merely symbolic; it would materially alter the Ministry's internal budget competition by giving mental health officials a direct seat at the table when resource allocation decisions were made. In parallel, the Ministry was urged to develop a Treasury-friendly evidence dossier—one that moved beyond burden-of-disease statistics to present costed service delivery models with clear, measurable output targets for 12-month budget cycles. Over the medium term, integrating mental health into primary care through revised training curricula for clinical officers, nurses, and community health workers would expand the workforce at a fraction of the cost of specialist expansion. The long-term structural recommendation was the creation of a Mental Health Financing Technical Working Group—a permanent, multi-agency body convening Treasury, SHIF, county governments, civil society, and development partners—to address the inter-agency coordination failures that this study identified as a primary driver of fiscal neglect.

Parliament's role in mental health financing reform was both essential and historically absent. The most immediate parliamentary action was the formation of a cross-party Parliamentary Mental Health Caucus, creating a dedicated institutional champion where none currently existed. As participants repeatedly noted, mental health suffered zero political cost when it was underfunded, because no constituency demanded otherwise and no parliamentary champion bore the responsibility of enforcement. In the medium term, Parliament was called upon to amend the Mental Health Act (2022) to include explicit financing provisions—establishing a minimum allocation of 2% of the health budget, increasing progressively to 5% by 2030, and mandating SHIF coverage of outpatient mental health services. The long-term legislative aspiration was the creation of a dedicated Mental Health Trust Fund, financed through exchequer allocations and a portion of excise revenues from alcohol and tobacco—aligning public health objectives with sustainable, predictable funding streams.

Civil society organizations faced a structural challenge that was internal as well as external: fragmentation among advocacy groups had weakened their collective voice precisely when a unified one was needed. The formation of a unified Mental Health Financing Advocacy Coalition—consolidating the efforts of organizations including the Kenya Mental Health Alliance, BasicNeeds Kenya, and the Africa Mental Health Foundation—represented the most urgent short-term priority. Alongside coalition-building, CSOs were called upon to launch sustained media campaigns featuring testimonials from individuals who had recovered through mental health treatment, humanizing the policy debate in ways that economic data alone could not achieve. The medium-term task was building the capacity of service users and caregivers to advocate effectively for their own rights—equipping affected communities with the skills, platforms, and networks to generate constituency pressure where none currently existed. In the long run, strategic litigation grounded in Article 43's constitutional guarantee of the right to health offered a legally enforceable mechanism for compelling government compliance with its own stated commitments.

County governments occupied the delivery front line of Kenya's devolved health system, yet the findings revealed that the majority had allocated between 0.04% and 0.69% of their health budgets to mental health—figures that were strikingly lower than even the inadequate national average of 0.96%. In the short term, every county government was called upon to establish a

dedicated mental health budget line and to designate at least one County Mental Health Coordinator—a position that only 8 of 47 counties had filled at the time of this study. Over the medium term, counties were encouraged to commit to a minimum allocation of 1.5% of their health budgets to mental health, rising to 3% by 2030. The long-term county-level recommendation was the development of community-based mental health rehabilitation centres, which would reduce the sector's chronic reliance on the severely overcrowded custodial facilities, particularly Mathari National Teaching and Referral Hospital.

Finally, development partners—including the World Health Organization, the World Bank, and bilateral donors—were called upon to recalibrate their engagement with Kenya's mental health sector. In the short term, technical assistance for SHIF's actuarial costing study and pilot design represented a high-leverage, low-cost intervention. In the medium term, development partners were encouraged to co-finance the proposed conditional grant pilot and, critically, to channel their support through government systems rather than creating parallel donor-funded structures that undermined domestic ownership and long-term sustainability. The most consequential long-term contribution that development partners could make was to deploy their political leverage—as they had done historically in the HIV response during the early 2000s—to shift government prioritization of mental health from optional to obligatory.

Taken together, these recommendations constituted a coherent, phased, and politically realistic roadmap for transforming mental health financing in Kenya. They were grounded in the institutional realities described by participants, calibrated to the political economy constraints that this study uncovered, and sequenced to build momentum—beginning with high-feasibility, low-resistance actions and progressing toward the structural and legislative reforms that would make sustainable financing not merely possible but irreversible.

5.7 Mental Health as a Lower-Priority Area in Healthcare Financing

This study set out to answer a deceptively simple question: why did mental health receive less than 1% of Kenya's national health budget despite contributing 15% of the disease burden and costing the economy an estimated KES 62 billion annually?

The answer, derived from the perspectives of the very decision-makers who controlled resource allocation—Treasury officials, SHIF planners, parliamentary committee members, and Ministry

of Health policymakers—was both straightforward and deeply unsettling. It was not a story of insufficient data, nor of technical incapacity, nor even of resource scarcity. It was a story about something more fundamental: the institutionalized belief that mental health was less deserving.

Mental health was institutionally constructed as a second-tier concern. This construction operated through three mutually reinforcing and self-perpetuating mechanisms. The first was institutional stigma. Decision-makers in positions of fiscal authority held—often unconsciously—stigmatizing beliefs that framed mental illness as less "real," less medically legitimate, and less worthy of investment than physical health conditions. These beliefs were not merely personal prejudices; they had become embedded in the architecture of governance itself. They shaped which budget requests received scrutiny, which cost estimates were dismissed as inflated, which programs were seen as essential and which were seen as peripheral. When fifty percent of study participants questioned the validity of the KES 62 billion economic cost estimate—without applying comparable skepticism to equivalent figures for malaria or maternal health—they revealed not a failure of evidence, but a failure of perception. The data existed. The problem was that stigma determined whose data was believed.

The second mechanism was political invisibility. Stigma did not merely distort perception inside budget offices; it silenced the very people whose suffering should have compelled action. Unlike communities affected by HIV/AIDS, who in the 1990s and 2000s organized, went public, and transformed a stigmatized illness into a political cause, people living with mental health conditions in Kenya remained largely invisible. The fear of discrimination—in employment, in marriage, in social standing—prevented affected individuals and their families from demanding resources publicly. This silence created a catastrophic political vacuum. As one parliamentary participant stated with disarming honesty,

"My voters call me about hospital bed shortages, drug stockouts for hypertension, ambulance services. Not once has anyone called me demanding mental health funding."

Parliamentary Committee Member

Without constituency pressure, there was no political cost to underfunding mental health, and without political cost, there was no political incentive to change.

The third mechanism was fiscal unprotection. Even where policy commitment existed—in the Kenya Mental Health Policy 2015–2030, in the Mental Health Amendment Act of 2022, in Kenya's stated commitment to Universal Health Coverage—those commitments were not backed by enforceable financing provisions. Mental health had no dedicated budget lines to prevent reallocation. It had no conditional grants to compel county-level investment. It had no SHIF coverage mandate to guarantee financial access. In a zero-sum budget environment where every shilling allocated to mental health was a shilling not allocated to a more politically visible program, fiscal unprotection meant that mental health lost in every annual negotiation—silently, invisibly, and without consequence.

These three mechanisms—stigma, invisibility, and fiscal unprotection—did not operate independently. They formed a system. Stigma silenced the affected population, which prevented advocacy, which created political invisibility, which removed the incentive to enact protective mechanisms, which left funding exposed to the annual competition it consistently lost, which produced inadequate services, which reinforced the stigmatized belief that "mental health treatment doesn't work anyway." The cycle was self-sealing. Each element made the others harder to break.

And yet the verdict need not be permanent. This study also revealed pathways out of the cycle—pathways that were not speculative but had been demonstrated in comparable contexts. Rwanda had integrated mental health into national health insurance before stigma had a chance to entrench its exclusion. South Africa had legislated ring-fenced budgets that protected mental health allocations from the annual reallocation pressures that consumed Kenya's. Ghana had elevated mental health to the status of a standalone authority, changing the institutional calculus of who had a voice when resources were distributed. These precedents demonstrated what was possible when political will aligned with institutional design.

The 12.5 million Kenyans affected by mental health conditions did not lack for evidence of their suffering. They did not lack for policies written on their behalf. What they lacked—what this study found to be the decisive determinant of their underfunding—was the collective decision by those who held power to count them as equally deserving.

That decision remained unmade. But it was not unmakeable.

The question this study left with Kenya's policymakers, parliamentarians, insurance planners, and civil society leaders was not whether the evidence supported greater investment. It did, overwhelmingly. The question was whether Kenya would choose to see 12.5 million of its citizens as deserving—deserving of the budget line, the insurance coverage, the political champion, and the constitutional protection that every other major health priority had secured. The answer to that question would not be found in data. It would be found in the choices made in the rooms where budgets were written, benefit packages designed, and appropriations approved.

Mental health in Kenya stood at the threshold of a reckoning. The arithmetic of its neglect had been laid bare. The mechanisms of its marginalization had been named. The pathways to transformation had been mapped. What remained was the act of choosing—and this study was, above all else, an invitation to make that choice differently.

5.8 Conclusions

The 12.5 million Kenyans affected by mental health conditions, the families who bear catastrophic out-of-pocket costs (80% of mental health spending), the providers who work with chronic resource shortages, and the estimated 1,500-2,000 individuals who die by suicide annually—they deserve more than <1%.

Rwanda, with comparable economic development and disease burden, allocates 2.2% of its health budget to mental health through deliberate integration into national health insurance and primary care. South Africa mandates dedicated mental health budgets through legislation and allocates 4.7%. These examples demonstrate that political will, institutional reform, and sustained advocacy can overcome financing barriers.

Kenya has progressive policies (Mental Health Policy 2015-2030, Mental Health Act 2022), constitutional commitments (Article 43 right to health), and economic rationale (KES 62 billion annual cost). What Kenya lacks is political will to translate commitments into resources.

Building that political will requires action on four fronts simultaneously. First, reducing stigma so that affected populations can advocate publicly without fear of discrimination. Second, creating political incentives—through constituency pressure, sustained media attention, and donor conditionality—that make championing mental health an asset rather than a liability. Third, reforming institutions to give mental health genuine organizational power, including

elevation to a standalone directorate and the establishment of dedicated budget lines. Fourth, demonstrating feasibility through pilots such as SHIF coverage expansion and incremental allocation increases that build confidence among cautious decision-makers.

These conclusions are offered in keeping with the study's qualitative, interpretive design. They are not claims of statistical generalisation across all Kenyan institutions but analytically generalisable insights — grounded in the converging accounts of decision-makers across nine stakeholder groups and triangulated against documentary evidence — whose transferability to comparable settings rests on the depth and coherence of the explanation rather than on the size of the sample. Read in that light, the central finding that institutional stigma operates as a fiscal determinant is advanced as a well-supported interpretation that invites further testing, not as a final or incontestable verdict.

The recommendations in Section 5.6 provide a roadmap for achieving this transformation. The question is no longer whether Kenya can afford to invest in mental health, but whether Kenya is willing to choose to. The evidence has spoken. The framework has been built. The roadmap exists. What remains is the political will to walk it—and the moral conviction that 12.5 million Kenyans living with mental health conditions deserve nothing less than the full weight of their government's commitment, resources, and care.

References

- Atwoli, L., Mungla, P. A., Ndung'u, M. N., Kinoti, K. C., & Ogot, E. M. (2018). Prevalence of substance use among college students in Eldoret, western Kenya. *BMC Psychiatry*, 18(1), 207.
- Atwoli, L., Harpham, T., Olungah, C. O., Ayuku, D., Fonn, S., & Ndeti, D. M. (2021). The role of the African public health system in managing mental health. *The Lancet Psychiatry*, 8(10), 843-844.
- Barasa, E., Maina, T., & Ravishankar, N. (2017). Assessing the impoverishing effects, and factors associated with the incidence of catastrophic health care payments in Kenya. *International Journal for Equity in Health*, 16(1), 31.
- Barasa, E. W., Molyneux, S., English, M., & Cleary, S. (2015). Setting healthcare priorities in hospitals: A review of empirical studies. *Health Policy and Planning*, 30(3), 386-396.
- Barasa, E., Nguhiu, P., & McIntyre, D. (2018). Measuring progress towards sustainable development goal 3.8 on universal health coverage in Kenya. *BMJ Global Health*, 3(3), e000904. <https://doi.org/10.1136/bmjgh-2018-000904>
- Barasa, E., Rogo, K., Mwaura, N., & Chuma, J. (2022). Evaluating NHIF reforms and mental-health coverage in Kenya. *Health Policy and Planning*, 37(3), 412–423.
- Bitta, M. A., Kariuki, S. M., Chengo, E., & Newton, C. R. J. C. (2017). An overview of mental health care system in Kilifi, Kenya: Results from an initial assessment using the World Health Organization's assessment instrument for mental health systems. *International Journal of Mental Health Systems*, 11, 28.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. <https://doi.org/10.1191/1478088706qp063oa>
- Chuma, J., & Okungu, V. (2011). Viewing the Kenyan health system through an equity lens: Implications for universal coverage. *International Journal for Equity in Health*, 10(1), 22. <https://doi.org/10.1186/1475-9276-10-22>
- Constitution of Kenya. (2010). *The Constitution of Kenya*. Nairobi: Government Printer.

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Sage Publications.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage Publications.

Fisher, R. J. (1993). Social desirability bias and the validity of indirect questioning. *Journal of Consumer Research*, 20(2), 303-315. <https://doi.org/10.1086/209351>

Global Fund. (2020). *Integrating mental health into Global Fund investments*. Geneva: The Global Fund to Fight AIDS, Tuberculosis and Malaria.

Government of Kenya. (2023). *The Social Health Insurance Act*. Nairobi: Government Printer.

Grimm, P. (2010). Social desirability bias. In J. Sheth & N. Malhotra (Eds.), *Wiley International Encyclopedia of Marketing*. Wiley.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, 18(1), 59-82. <https://doi.org/10.1177/1525822X05279903>

Gulis, G., Meyers, J., & Doll, R. (2021). Barriers to investing in mental health: A qualitative study of decision-makers in low- and middle-income countries. *Global Mental Health*, 8, e35.

Hanlon, C., Luitel, N. P., Kathree, T., Murhar, V., Shrivasta, S., Medhin, G., ... & Patel, V. (2014). Challenges and opportunities for implementing integrated mental health care: A district level situation analysis from five low- and middle-income countries. *PLoS ONE*, 9(2), e88437.

Hatzenbuehler, M. L., & Link, B. G. (2014). Introduction to the special issue on structural stigma and health. *Social Science & Medicine*, 103, 1-6. <https://doi.org/10.1016/j.socscimed.2013.12.017>

Hennink, M. M., Kaiser, B. N., & Marconi, V. C. (2017). Code saturation versus meaning saturation: How many interviews are enough? *Qualitative Health Research*, 27(4), 591-608. <https://doi.org/10.1177/1049732316665344>

Jané-Llopis, E., & Anderson, P. (2005). *Mental health promotion and mental disorder prevention: A policy for Europe*. Radboud University Nijmegen.

- Jenkins, R., Baingana, F., Ahmad, R., McDaid, D., & Atun, R. (2020). The challenge of mental health and development in low and middle income countries. In *Global Mental Health and Development* (pp. 1-24). Oxford University Press.
- Jenkins, R., Kiima, D., Njenga, F., Okonji, M., Kingora, J., Kathuku, D., & Lock, S. (2010). Integration of mental health into primary care in Kenya. *World Psychiatry*, 9(2), 118-120. <https://doi.org/10.1002/j.2051-5545.2010.tb00289.x>
- Kiima, D., Njenga, F., Okonji, M., & Kigamwa, P. (2021). Mental health systems in Kenya: A review of the current structure, challenges, and opportunities. *International Journal of Mental Health Systems*, 15(1), 1-12.
- Kutzin, J. (2008). *Health financing policy: A guide for decision-makers*. World Health Organization.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage Publications.
- Link, B. G., Cullen, F. T., Struening, E., Shrout, P. E., & Dohrenwend, B. P. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review*, 54(3), 400–423. <https://doi.org/10.2307/2095613>
- Mbatia, J., & Jenkins, R. (2021). The development of mental health services in Tanzania: A historical and current perspective. *International Journal of Mental Health Systems*, 15, 23.
- Mbau, R., Kabia, E., Honda, A., Hanson, K., & Barasa, E. (2020). How do Kenyan health system actors perceive the implications of donor transitions? A qualitative study. *Health Policy and Planning*, 35(8), 1011–1020.
- Mburu, J., & Ndeti, D. M. (2021). Perceived stigma and care-seeking among people with mental illness in Kenya. *African Journal of Psychiatry*, 15(4), 234-241.
- Ministry of Health (MoH), Kenya. (2015). *Kenya Mental Health Policy 2015-2030*. Nairobi: Government Printer.
- Ministry of Health (MoH), Kenya. (2021). *Kenya Mental Health Investment Case*. Nairobi: Ministry of Health.

- Morse, J. M. (2000). Determining sample size. *Qualitative Health Research*, 10(1), 3-5.
<https://doi.org/10.1177/104973200129118183>
- Moses, M. W., Pedroza, P., Baral, R., Bloom, S., Brown, J., Chapin, A., ... & Fullman, N. (2022). The human resource for health situation in Kenya: A systematic review. *BMJ Global Health*, 7(Suppl 1), e008411.
- Munge, K. (2023). The Mental Health (Amendment) Act, 2022: A new dawn for mental health care in Kenya? *Strathmore Law Journal*, 7(1), 45-67.
- Munge, K., & Barasa, E. (2024). Applying public finance theory to stigmatized health goods: The case of mental health in Kenya. *Journal of Health Economics and Policy*, 12(1), 22-40.
- Musgrave, R. A. (1959). *The theory of public finance*. McGraw-Hill.
- Musili, B., & Kamande, A. (2025). *Kenya's inequality crisis: The great economic divide*. Nairobi: Oxfam International.
- Musyimi, C. W., Mutiso, V. N., Nandoya, E. S., & Ndeti, D. M. (2016). Forming a joint dialogue among faith healers, traditional healers and formal health workers in mental health in a Kenyan setting: Towards common grounds. *Journal of Ethnobiology and Ethnomedicine*, 12, 4.
- Musyimi, C. W., Mutiso, V. N., Haji, Z. R., & Ndeti, D. M. (2022). Prevalence and correlates of mental disorders in a rural Kenyan community: A cross-sectional study. *BMC Psychiatry*, 22, 180.
- Mutiso, V. N., Musyimi, C. W., Tomita, A., Rebello, T. J., Pike, K. M., & Ndeti, D. M. (2020). The Friendship Bench as a brief psychological intervention with peer support in rural Kenya: Study protocol for a randomized controlled trial. *Trials*, 21, 800.
<https://doi.org/10.1186/s13063-020-04692-6>
- Mwangala, P., Kanyangi, F., Magai, D., Mutua, A. M., Too, E. K., Mokaya, A. G., ... & Newton, C. R. (2025). Prevalence and associated factors of mental and substance use problems among adults in Kenya: A community-based cross-sectional study. *Global Public Health*, 20(1), 2285899.

National Treasury, South Africa. (2021). Conditional grants framework. Pretoria: National Treasury.

Ndetei, D. M., Khasakhala, L. I., Kuria, M. W., Mutiso, V. N., Ongecha-Owuor, F. A., & Kokonya, D. A. (2009). The prevalence of mental disorders in adults in different level general medical facilities in Kenya: A cross-sectional study. *Annals of General Psychiatry*, 8, 1.

Ndetei, D. M., Mutiso, V., Gitonga, I., Agudile, E., Tele, A., Birech, L., ... & Musyimi, C. (2022). Institutional quality and stigma in Kenyan public psychiatric facilities. *Journal of Mental Health Policy and Economics*, 25(4), 189-198.

Ndetei, D. M., Khasakhala, L. I., Musyimi, C., Nyamai, D., Mutiso, V., & Saxena, S. (2024). The prevalence of mental health disorders in a national household survey in Kenya. *Journal of Affective Disorders*, 320, 45-53.

Ng, L. C., Stevenson, A., Kaselitz, V., Bergenfeld, I., Hakim, A. J., Muthee, R., ... & Binagwaho, A. (2023). Scaling up mental health care in Rwanda: The integration of mental health into primary care and community-based platforms. *The Lancet Psychiatry*, 10(5), 388-396.

Ofori-Atta, A., Read, U. M., & Lund, C. (2018). A situation analysis of mental health services and legislation in Ghana: Challenges for transformation. *African Journal of Psychiatry*, 13(2), 99-108.

Okello, E., Neema, S., Musisi, S., & Kinyanda, E. (2022). Financing mental health in Uganda: A review of policy and practice. *Global Mental Health*, 9, e14.

Owino, N., Ngigi, M., & Kibet, E. (2021). Deinstitutionalisation and fiscal transition in Kenyan mental-health policy. *East African Medical Journal*, 98(10), 557–567.

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, 42(5), 533-544. <https://doi.org/10.1007/s10488-013-0528-y>

Porter, M. E. (2008). The five competitive forces that shape strategy. *Harvard Business Review*, 86(1), 78-93. (Original work published 1980)

Saunders, M., Lewis, P., & Thornhill, A. (2019). Research methods for business students (8th ed.). Pearson Education Limited.

South African Department of Health. (2020). National mental health policy framework and strategic plan 2013-2020. Pretoria: Department of Health.

Thornicroft, G., Sunkel, C., Alikhon Aliev, A., Baker, S., Brohan, E., El Chammay, R., ... & Winkler, P. (2022). Evidence for effective interventions to reduce mental health-related stigma and discrimination. *The Lancet*, 399(10325), 745-756. [https://doi.org/10.1016/S0140-6736\(21\)02745-3](https://doi.org/10.1016/S0140-6736(21)02745-3)

Walt, G., & Gilson, L. (1994). Reforming the health sector in developing countries: The central role of policy analysis. *Health Policy and Planning*, 9(4), 353-370. <https://doi.org/10.1093/heapol/9.4.353>

Wambiya, E. O., Kainyu, L. H., Wambua, J., Matanda, D., & Muindi, K. (2021). Household out-of-pocket payments and catastrophic expenditure in Kenya. *BMC Health Services Research*, 21(1), 435-446.

Wambui, T., Kariuki, J., & Mwaura, N. (2023). Catastrophic health expenditure and impoverishment due to mental illness in Kenya. *Health Economics Review*, 13(1), 15.

World Bank. (2023). Mental health and economic development: A country profile for Kenya. Washington, DC: World Bank.

World Health Organization. (2001). The world health report 2001: Mental health - new understanding, new hope. World Health Organization.

World Health Organization. (2008). Everybody's business: Strengthening health systems to improve health outcomes — WHO's framework for action. World Health Organization.

World Health Organization (WHO). (2021). Mental Health Atlas 2021. Geneva: World Health Organization.

World Health Organization (WHO). (2022). World mental health report: Transforming mental health for all. Geneva: World Health Organization.

World Health Organization (WHO). (2023). Mental health financing. Geneva: World Health Organization.

Yin, R. K. (2018). Case study research and applications: Design and methods (6th ed.). Sage Publications.

APPENDICES:

APPENDIX A: SEMI-STRUCTURED INTERVIEW GUIDE

Study Title: The Determinants of Mental Health Financing in Kenya: Towards A Stakeholder-Informed Framework for Sustainable Financing

INTERVIEWER INSTRUCTIONS:

- This is a semi-structured interview guide. Questions are organized by theme but should flow naturally based on participant responses.
- Probing questions are provided but should be used selectively based on participant expertise and time constraints.
- Target interview length: 45-60 minutes
- Record with informed consent; take field notes during interview
- Adapt language to participant's role (e.g., technical for Treasury officials, operational for service providers)

SECTION A: INTRODUCTION AND INFORMED CONSENT (5 minutes)

[Before starting recording]

Good [morning/afternoon], and thank you for agreeing to participate in this study. My name is Karen Mutua, and I am a student at Strathmore Business School conducting research on mental health financing in Kenya as part of my MBA thesis.

Purpose of the Study:

This research aims to understand why mental health receives less than 1% of the national health budget despite contributing approximately 15% of Kenya's disease burden. I am particularly interested in your perspectives as someone who [participates in/influences/makes] financing decisions.

What Participation Involves:

- This interview will take approximately 45-60 minutes

- I will ask you questions about mental health financing, budgeting processes, and potential solutions
- With your permission, I will audio-record our conversation for accurate transcription

Confidentiality:

- Your identity will be protected through the use of codes (e.g., Participant 001-Treasury)
- No names or identifying details will appear in the thesis or any publications
- Audio recordings and transcripts was stored securely and accessible only to me and my academic supervisor

Voluntary Participation:

- Your participation is entirely voluntary
- You may skip any question or end the interview at any time without consequence
- You may withdraw from the study at any point

Do you have any questions before we begin?

[Obtain written informed consent]

[Start audio recording]

SECTION B: PARTICIPANT BACKGROUND (5 minutes)

I'd like to begin by learning a bit about your professional background and role.

B1. Demographic and Professional Information

1. What is your current position and organization?

How long have you been in this role?

2. What are your primary responsibilities related to health financing or mental health services?

3. What is your highest level of education?

☐ Bachelor's degree

☐ Master's degree

☐ PhD/Doctorate

☐ Professional certification

☐ Other: _____

5. What is your age range? (Optional)

☐ 25-34

☐ 35-44

☐ 45-54

☐ 55-64

☐ 65+

6. Gender: (Optional)

☐ Male

☐ Female

☐ Prefer not to say

SECTION C: INSTITUTIONAL AND GOVERNANCE BARRIERS (15 minutes)

[Research Objective 1: To identify institutional, political, and governance barriers to mental health financing]

Now I'd like to understand the institutional and governance factors that shape mental health financing decisions.

C1. Budgeting Processes and Structures

7. Can you describe how mental health budget allocations are determined within your organization?

Probes (if needed):

Who is involved in proposing mental health budgets?

What documentation or justification is required?

How does mental health compete with other health priorities?

8. In your experience, what institutional structures or processes create barriers to adequate mental health financing?

Probes:

How does devolution affect mental health financing coordination?

What role does mental health's positioning within the Ministry of Health play?

Are there challenges with inter-agency coordination (Treasury, MoH, counties, SHIF)?

9. From your perspective, how well do current governance arrangements support mental health financing?

Probes:

Are there dedicated mental health budget lines?

How effective is coordination between national and county levels?

What accountability mechanisms exist for mental health spending?

SECTION D: STIGMA AND PERCEPTIONS (15 minutes)

[Research Objective 2: To explore how stigma and competing priorities influence fiscal decision-making for mental health]

I'm interested in understanding how mental health is perceived by those involved in financing decisions.

D1. Perceptions of Mental Health as an Investment

10. How would you describe the general perception of mental health among decision-makers in your organization?

- When mental health budget requests are discussed, what concerns or objections are typically raised?

Probes:

- Are there concerns about economic return on investment?

How is mental health prioritized relative to other health needs?

What evidence is considered most persuasive (or not persuasive)?

11. The Kenya Mental Health Investment Case (2021) estimates that untreated mental illness costs Kenya KES 62 billion annually. From your perspective, how does this economic evidence influence financing decisions?

Probe:

If it doesn't influence decisions significantly, why do you think that is?

12. How does stigma—either societal or institutional—manifest in financing discussions around mental health?

Probes:

Do decision-makers view mental health differently than other health conditions?

Are there assumptions about people with mental illness that affect resource allocation?

SECTION E: POLITICAL ECONOMY AND FEASIBILITY OF FINANCING MECHANISMS (12 minutes)

[Research Objective 3: To assess the feasibility of financing mechanisms for sustainable mental health budgeting]

Let's discuss the political and economic factors that influence mental health financing, and explore potential solutions.

E1. Political Will and Advocacy

14. Why do you think mental health lacks high-level political champions compared to areas like maternal health or HIV/AIDS?

15. What role do civil society organizations, advocacy groups, or affected communities play in influencing mental health financing decisions?

Probe:

How effective is their advocacy compared to other health areas?

E2. Donor Dependency and External Funding

16. How does donor funding for vertical programs (HIV, TB, malaria) affect domestic investment in mental health?

Probe:

Does external funding crowd out or crowd in mental health financing?

E3. Feasibility of Financing Mechanisms

17. From a Treasury/National Budget perspective: Why do budget allocations for mental health remain below 1% despite evidence of significant economic losses?

18. From a SHIF/Insurance perspective: Why are outpatient and community-based mental health services systematically excluded from coverage despite evidence that primary care integration is cost-effective?

19. From a Political/Policy perspective: Why does mental health lack political champions at the Ministry of Health and Parliament despite progressive policy frameworks like the Mental Health Policy (2015-2030)?

20. What institutional norms, perceptual filters, or political pressures shape these decisions?

SECTION F: POTENTIAL FINANCING SOLUTIONS (10 minutes)

[Research Objective 4: To develop actionable recommendations for a sustainable mental health financing framework]

Finally, I'd like to explore your views on potential financing solutions.

F1. Financing Mechanism Preferences

21. Which of the following financing mechanisms do you believe are most feasible for increasing mental health funding in Kenya? (Can select multiple)

☐ Expanding SHIF benefit packages to include outpatient mental health services

☐ Creating dedicated mental health budget lines at national and county levels

☐ Earmarked taxes (e.g., sin taxes on alcohol/tobacco)

☐ Conditional grants from National Treasury to counties for mental health

☐ Performance-based financing tied to mental health outcomes

☐ Public-private partnerships for service delivery

☐ Increased development partner funding

☐ Other: _____

22. For each mechanism you selected, what makes it feasible? What are the barriers to implementation?

23. If you could design a sustainable mental health financing framework for Kenya, what would be its key components?

Probes:

What institutional changes would be needed?

What role should national vs. county governments play?

How can political will be built?

- What would it take to move mental health financing from <1% to a more adequate level (e.g., 5% of health budget)?

Probes:

What specific actions are needed?

Who needs to champion this change?

What evidence or advocacy strategies would be most effective?

SECTION G: CLOSING (3 minutes)

25. Is there anything else about mental health financing that you think is important for this study but that we haven't discussed?

26. Do you have any recommendations for other people I should speak with who have relevant perspectives on mental health financing?

[If yes, collect names/contact information for snowball sampling]

27. Would you be willing to review a summary of findings from this research once the study is complete?

THANK YOU

Thank you very much for your time and insights. Your perspectives are invaluable to understanding how to improve mental health financing in Kenya.

If you have any questions or would like to add anything after this interview, please feel free to contact me at [email] or [phone number].

[Stop recording]

[Provide participant information sheet and contact details]

INTERVIEWER POST-INTERVIEW NOTES

Date of Interview: _____

Location: _____

Duration: _____

Participant Code: _____

Recording Quality: [] Excellent [] Good [] Fair [] Poor

Key Observations:

Non-verbal cues:

Context/environment:

Emerging themes:

Follow-up needed:

END OF INTERVIEW GUIDE

APPENDIX B: INFORMED CONSENT FORM

Study Title: The Determinants of Mental Health Financing in Kenya: Towards A Stakeholder-Informed Framework for Sustainable Financing

Principal Investigator: Dr. Jackline Aridi

Student Researcher: Karen Mutua

Institution: Strathmore Business School

Contact Information: karen.mutua@strathmore.edu | +254 705 543 080

Purpose of the Study

This research aims to understand why mental health services remain chronically underfunded in Kenya despite their recognized importance, and to develop a framework for sustainable financing based on stakeholder perspectives.

What Your Participation Involves

1. A 45-60 minute interview at a time and location convenient to you
2. Discussion of your experiences and perspectives on mental health financing
3. Audio recording of the interview (with your permission)
4. Optional follow-up for member checking of findings

Confidentiality and Data Protection

1. Your identity will be anonymized using a participant code (e.g., P001-Treasury)
2. No personally identifying information will appear in any publications or reports
3. Audio recordings were stored securely and destroyed after transcription
4. Only the research team will have access to identifiable information
5. Data was stored in password-protected files and encrypted devices
6. Research findings may be published in academic journals, presented at conferences, or shared with policy stakeholders, but your identity will remain confidential

Risks and Benefits

Risks: Participation in this study involves minimal risk. You may choose not to answer any question that makes you uncomfortable. Some questions may relate to sensitive institutional or political matters.

Benefits: Your participation will contribute to research that may inform policy improvements in mental health financing in Kenya. You will receive a summary of findings if you wish.

Voluntary Participation and Right to Withdraw

Your participation is entirely voluntary. You may withdraw at any time without penalty or explanation. You may also choose to skip any questions you prefer not to answer.

PARTICIPANT CONSENT

I, _____ (Participant Name), have:

- ☐ Read and understood the information sheet provided
- ☐ Had the study explained to me in a language I understand
- ☐ Had the opportunity to ask questions about the study
- ☐ Had all my questions answered satisfactorily
- ☐ Been informed that participation is voluntary
- ☐ Been informed that I can withdraw at any time without penalty
- ☐ Been informed that I can skip any questions I do not wish to answer

Please tick (✓) the boxes that apply to you:

1. Participation in the Research Study:

- ☐ I AGREE to take part in this research study
- ☐ I DO NOT AGREE to take part in this research study

2. Audio Recording:

- ☐ I AGREE to have my interview audio-recorded for transcription purposes
- ☐ I DO NOT AGREE to have my interview audio-recorded (handwritten notes will be taken instead)

3. Data Storage:

☐ I AGREE to have my anonymized interview data stored for future analysis related to this study

☐ I DO NOT AGREE to have my anonymized interview data stored beyond the completion of this study

4. Use of Quotes:

☐ I AGREE to allow anonymized direct quotes from my interview to be used in the thesis and publications

☐ I DO NOT AGREE to allow direct quotes from my interview to be used

5. Summary of Findings:

☐ I WOULD LIKE to receive a summary of the study findings once the research is complete

☐ I DO NOT WISH to receive a summary of findings

If yes, please provide your preferred email: _____

PARTICIPANT SIGNATURE:

Participant Name (Print): _____

Participant Signature: _____

Date: _____

RESEARCHER DECLARATION:

I, Karen Mutua (Name of person obtaining consent), certify that:

1. I have followed the standard operating procedures for this study
2. I have explained the study information to the participant named above
3. The participant has understood the nature and purpose of the study
4. The participant has been given the opportunity to ask questions
5. All questions have been answered satisfactorily

6. The participant has provided voluntary informed consent to participate

Researcher Signature: _____

Date: _____

[For office use only]

Participant Code Assigned: _____

Interview Date: _____

Interview Location: _____

END OF PARTICIPANT INFORMED CONSENT FORM

APPENDIX C: INFORMATION SHEET FOR PARTICIPANTS

SECTION 1: INFORMATION SHEET – RESEARCHER DETAILS

Principal Investigator: Karen Mutua

Registration Number: MBA/HCM/190643

Institutional Affiliation: Strathmore Business School, Strathmore University

Email: karen.mutua@strathmore.edu

Phone: +254705543080

Research Supervisor: Dr. Jackline Aridi

Position: Adjunct Faculty, Strathmore Business School

Email: jaridi@strathmore.edu

SECTION 2: INFORMATION SHEET – THE STUDY

Title of Study:

The Determinants of Mental Health Financing in Kenya: Towards A Stakeholder-Informed Framework for Sustainable Financing

Statement:

This is a research study being conducted as part of an MBA in Healthcare Management thesis at Strathmore Business School.

Why is this study being carried out?

Mental health conditions contribute approximately 15% of Kenya's disease burden and cost the economy an estimated KES 62 billion annually, yet mental health receives less than 1% of the national health budget. Despite progressive policies such as the Kenya Mental Health Policy (2015-2030) and the Mental Health (Amendment) Act (2022), implementation remains constrained by inadequate financing.

This study sought to understand **why** mental health financing remains persistently low by examining the perspectives of key decision-makers who influence resource allocation. The research aims to:

1. Identify institutional, political, and governance barriers to mental health financing
2. Explore how stigma and competing priorities influence fiscal decision-making
3. Assess the feasibility of different financing mechanisms for sustainable mental health budgeting
4. Develop actionable recommendations for a sustainable mental health financing framework

The findings will inform evidence-based policy recommendations to improve mental health financing in Kenya.

Do I have to take part?

No. Taking part in this study is entirely voluntary and the decision rests only with you. If you decide to take part, you will be asked to participate in a 45-60 minute interview where you shared your professional perspectives on mental health financing in Kenya based on your role and experience.

You are free to:

Decline to participate without giving any reasons

Skip any questions you do not feel comfortable answering

End the interview at any time

Withdraw from the study at any point without penalty

Your decision whether or not to participate will not affect your professional standing, employment, or relationship with Strathmore University in any way.

Who is eligible to take part in this study?

You are eligible to participate if you:

1. **Hold a position** that involves or influences mental health financing, policy formulation, budget allocation, or service delivery decisions in Kenya
2. Work in one of the following sectors:
 - i. National Treasury (health financing divisions)

- ii. Ministry of Health (policy, financing, or mental health units)
 - iii. Social Health Insurance Fund (SHIF) – strategic planning or benefit package design
 - iv. Parliamentary committees (Health Committee or Budget and Appropriations Committee)
 - v. Public mental health facilities (administrators, clinical directors)
 - vi. County health departments (county health directors, mental health coordinators)
 - vii. Private sector mental health providers (administrators, clinical directors)
 - viii. Civil society organizations focused on mental health advocacy
 - ix. Insurance sector (product managers, actuaries working on health benefits)
 - x. Community-based organizations (patient advocacy, caregiver support groups)
3. Have at least 2 years of experience in your current role
 4. Are 18 years of age or older
 5. Are willing and able to provide informed consent

Who is not eligible to take part in this study?

You are **not eligible** to participate if you:

Do not work in a role related to mental health financing, policy, or service delivery

Have less than 2 years of experience in your current position

Are under 18 years of age

Are unable or unwilling to provide informed consent

Have a conflict of interest that would prevent you from speaking freely about mental health financing (as determined by you)

What will taking part in this study involve for me?

If you agree to participate, here is what will happen:

1. Before the Interview:

You was provided with this information sheet to review

You will have the opportunity to ask questions about the study

If you are satisfied that you understand the study, you will be asked to sign the informed consent form

We will schedule a convenient time and location for the interview (in-person at your office or via secure video call)

2. During the Interview (45-60 minutes):

- i. You will be asked open-ended questions about:
 - a. Mental health budgeting and financing processes
 - b. Institutional and governance factors affecting mental health financing
 - c. Perceptions of mental health as a health investment priority
 - d. Political and economic factors influencing resource allocation
 - e. Potential financing mechanisms and their feasibility
- ii. The interview will be audio-recorded (with your permission) to ensure accurate transcription
- iii. You may skip any questions you prefer not to answer
- iv. You may pause or end the interview at any time

3. After the Interview:

- i. The audio recording will be transcribed
- ii. You will be assigned a participant code (e.g., P001-Treasury) to protect your identity
- iii. Your name and identifying details will **not** appear in any transcripts or reports
- iv. You may be contacted for clarification or member checking (validating preliminary interpretations) if needed
- v. You will receive a summary of the study findings once the research is complete (if you wish)

Total Time Commitment: Approximately 1 hour for the interview, plus optional 15-30 minutes for follow-up clarifications if needed.

Are there any risks or dangers in taking part in this study?

This study involves minimal risk. Potential risks include:

Social Desirability Bias: You may feel pressure to provide "politically correct" answers rather than candid perspectives, especially when discussing sensitive budgetary or institutional issues.

Mitigation: Your identity will be completely anonymized. No names or identifying details will appear in the thesis or any publications. This should allow you to speak more freely.

Emotional Discomfort: Discussing systemic failures or resource constraints may cause frustration or discomfort.

Mitigation: You may skip any questions or end the interview at any time. Questions are phrased to explore systemic issues rather than assign individual blame.

Institutional Sensitivity: Your organization may be sensitive about budget discussions or perceived criticisms.

Mitigation: All Data were anonymized. Your specific organization will not be identifiable in the findings unless you explicitly consent otherwise.

Time Burden: The interview will take 45-60 minutes from your schedule.

Mitigation: We will schedule the interview at your convenience, including options for virtual participation to minimize travel time.

No compensation is required in case of injury as the study involves no physical interventions or procedures that could cause harm.

Are there any benefits of taking part in this study?

Benefits to You:

- i. Opportunity to contribute to evidence-based policy reforms that could improve mental health financing in Kenya
- ii. Access to a summary of research findings that may inform your professional work
- iii. Platform to share your professional insights and perspectives with policymakers and academic audiences
- iv. Contribution to national dialogue on sustainable mental health financing

Benefits to Society:

The research generated actionable recommendations for improving mental health financing mechanisms

Findings was shared with key stakeholders (National Treasury, Ministry of Health, SHIF, Parliament) through policy briefs and stakeholder workshops

The study addresses a critical gap in understanding why mental health financing remains low despite compelling evidence of need

Results may influence policy changes that improve mental health service delivery and access for Kenyans

No alternative procedures are applicable as this is an interview-based study with no clinical interventions.

What will happen to me if I refuse to take part in this study?

Nothing. Participation in this study is entirely voluntary. Even if you decide to take part at first but later change your mind, you are free to withdraw at any time without explanation and without any consequences.

Your decision will **not** affect:

Your professional standing or employment

Your relationship with Strathmore University

Your access to any services or benefits

Who will have access to my information during this research?

Confidentiality and Data Protection:

All information you provide will be treated as strictly confidential and handled in accordance with the Data Protection Act, 2019 (Kenya).

i. Data Storage:

- a. Audio recordings was stored on password-protected devices and encrypted cloud storage
- b. Transcripts was stored securely with all identifying information removed
- c. Physical documents (consent forms, field notes) will be kept in locked cabinets
- d. Data was retained for 5 years after study completion as per Strathmore University policy, then securely destroyed

ii. Who Has Access:

- a. Only the researcher (Karen Mutua) and academic supervisor (Dr. Jackline Aridi) will have access to identifiable data
- b. No one else will have access to your personal information
- c. Data analysts (if hired) will only access anonymized transcripts with participant codes

iii. How Your Information was used:

- a. Your responses will be anonymized using participant codes (e.g., P001-Treasury)
- b. Direct quotes may be used in the thesis, but will not include your name or position
- c. Quotes will be attributed only to general categories (e.g., "a senior official at the National Treasury")
- d. Findings was presented in aggregate form in reports and publications

iv. Limits to Confidentiality:

- a. If you disclose information suggesting illegal activity, harm to self or others, or violations of professional ethics, the researcher may be obligated to report this to appropriate authorities
- b. Otherwise, all information will remain confidential

Will I receive any compensation or reimbursement?

Compensation: No monetary incentives was provided for participation, as this is not standard practice for interviews with senior government officials and professionals.

Reimbursement: If you incur travel costs to attend an in-person interview, reasonable transport expenses (up to KES 1,000) can be reimbursed upon presentation of receipts.

Refreshments: Light refreshments (tea/coffee) was provided during in-person interviews.

Who can I contact in case I have further questions?

For questions about the study:

Principal Investigator:

_ Karen Mutua

Strathmore Business School

Email: karen.mutua@strathmore.edu

Phone: +254705543080

Research Supervisor:

_ Dr. Jackline Aridi

Lecturer, Strathmore Business School

Email: jaridi@strathmore.edu

For questions about your rights as a research participant or to report concerns:

Strathmore University Institutional Scientific and Ethical Review Committee (SU-ISERC)

The Secretary, SU-ISERC

Strathmore University

P.O. Box 59857-00200

Nairobi, Kenya

Email: ethicsreview@strathmore.edu

Phone: +254 (0)703 034000

END OF PARTICIPANT INFORMATION SHEET CONSENT FORM

APPENDIX D: RESEARCH BUDGET

BUDGET SUMMARY

Category	Cost (KES)
Personnel costs	60,000
Data collection costs	113,000
Data management and analysis	43,000
Communication and logistics	30,000
Document production and printing	11,000
Miscellaneous & Contingency	30,000
Total	287,000

DETAILED BUDGET BREAKDOWN

1. PERSONNEL COSTS

Item	Unit cost	Quantity	Total	Justification
Research assistant (Part time)	20,000/month	3 months	60,000	Assist with: transcription (30-35 interviews @ 45-60 min each), initial coding, document review, scheduling interviews, managing participant database

2. DATA COLLECTION COSTS

2.1 Interview-Related Costs

Item	Unit cost	Quantity	Total	Justification
Participant Transport Reimbursement	1,000	35 participants	35,000	Reimburse participants for travel to interview location (or researcher travel to participant offices)
Participant Refreshments	200	35 participants	7000	Tea/coffee/light refreshments during interviews
Audio Recording Equipment	5000	1 unit	5000	Digital voice recorder with backup storage
Backup Recording Device	5000	1 unit	5000	Mobile phone-quality recorder as backup
Field Notebooks	500	3 notebooks	1500	For field notes during interviews

2.2 Researcher Travel & Logistics

Item	Unit cost	Quantity	Total	Justification
------	-----------	----------	-------	---------------

Fuel/Transport	1,500/day	35 interviews	52,500	Travel within Nairobi to participant offices (National Treasury, MoH, SHIF, Parliament, hospitals, etc.)
Parking fees	200/visit	35 visits	7,000	Parking at government offices, hospitals

3. DATA MANAGEMENT & ANALYSIS

Item	Unit cost	Quantity	Total	Justification
Transcription services	1,000/hour	35 hours	35,000	Professional transcription of 35 interviews (45-60 min each = ~35 hours audio)
NVivo 14 software licence	0 (free trial)	1 licence	0	Qualitative data analysis software for coding and thematic analysis
Cloud storage subscription	500/month	6 months	3,000	Encrypted cloud backup for audio files, transcripts, coded data (e.g., Google Workspace or Microsoft OneDrive)
External hard drive (1 TB)	5,000	1 unit	5,000	Secure local backup storage

4. COMMUNICATION & LOGISTICS

Item	Unit cost	Quantity	Total	Justification
Airtime/Data bundles	3,000/month	3 months	9,000	Participant communication, interview scheduling, follow-ups, Document downloads, email, literature search, virtual interviews (if needed)
Stationery (Pens, Folders, Labels, Paper)	5,000	1 lot	5,000	Consent forms, field notes, document organization
Photocopying	5/page	2,000 pages	10,000	Consent forms (3 pages × 35 copies), information sheets, interview guides
Courier	600	10 deliveries	6,000	Sending formal letters of introduction, thank-you notes, preliminary findings to participants
Virtual meetings (Zoom)	0 (free service)	3 months	0	For virtual interviews with busy officials who prefer remote meetings

5. DOCUMENT PRODUCTION & PRINTING

Item	Unit cost	Quantity	Total	Justification
Final thesis printing (hard bound)	5,000	2 copies	10,000	Final bound copies for university library, supervisor, personal copy
Flash drives	1,000	1 unit	1,000	For supplementary materials

6. MISCELLANEOUS & CONTINGENCY – KES 72,000

Item	Unit cost	Quantity	Total	Justification
Unforeseen expenses	N/A	Lump sum	30,000	Cover unexpected costs: additional interviews, repeat visits, equipment repairs, emergency printing

Funding Sources:

- Personal funding
- Strathmore Business School research grants (if available)
- Family and friends support

APPENDIX E: SU-ISERC APPROVAL LETTER AND NACOSTI LICENSE



8th May 2026

Ms Mutua Karen,
karen.mutua@strathmore.edu

Dear Ms Mutua

RE: The Determinants of Mental Health Financing in Kenya: Towards A Stakeholder-Informed Framework for Sustainable Financing

This is to inform you that SU-ISERC has reviewed and **approved** your above **SU-masters** research proposal. Your application reference number is **SU-ISERC3611/26**. The approval period is from **8th May 2026 to 7th May 2027**.

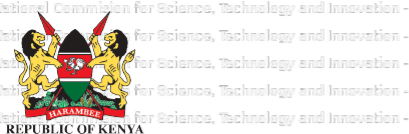
This approval is subject to compliance with the following requirements:

- i. Only approved documents including (informed consents, study instruments, and 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 affect the 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



REPUBLIC OF KENYA

Ref No: 323793

RESEARCH LICENSE



This is to Certify that Ms. KAREN NDUNGE MUTUA 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: **The determinants of mental health financing in Kenya: Towards a stakeholder informed framework for sustainable financing for the period ending : 13/May/2027.**

License No: NACOSTI/P/26/4189648

323793

Applicant Identification Number



NATIONAL COMMISSION FOR
SCIENCE, TECHNOLOGY & INNOVATION

Date of Issue: 13/May/2026

Ag. Director General

NATIONAL COMMISSION FOR
SCIENCE, TECHNOLOGY &
INNOVATION

Verification QR Code



NOTE: This is a computer generated License. To verify the authenticity of this document,

Scan the QR Code using QR scanner application.

See overleaf for conditions