Kenya

INTERSECTORAL CASE STUDY
LEARNING FROM HOLISTIC THINKING IN MENTAL HEALTH PROGRAMMES IN KENYA

Dr Rene Loewenson,
Training and Research Support Centre
Produced for WHO AFRO, May 2013

CONTENTS

SUMMARY

This case study describes three levels of intervention on mental health in Kenya that reflect a paradigm shift towards more holistic community centred thinking on mental health and associated intersectoral collaboration. The three levels are a (i) multi-faceted and intersectoral process for national policy development and implementation on mental health, (ii) a co-ordinated district programme on mental health and (iii) locally driven social action on mental health. Using a desk review of (limited) available literature, the case study describes the context for, inception, processes used, outcomes and impact of and lessons learned from each level. Each level was informed by collaborative situation appraisal to inform planning. The appraisal at local level was implemented using a participatory reflection and action approach to support communication and shared understanding across diverse actors, including those directly affected. A national policy process using various forums for dialogue and operational tools supported the integration of mental health into health management systems and guided intersectoral action and liaison with police, prisons and schools, and public education. The district and local level processes linked with economic actors and resources to link health responses and caring with economic and production services to strengthen the social inclusion, incomes and wellbeing of people with mental ill health and that of their households. These economic sectors may need more profile in national level policies. The role of community based workers, social networks of people with mental illhealth and their carers, of communication across actors and of embedding and building capacities in existing institutions is described as contributing to a sustainable intersectoral patient centred approach to mental health. Key informant interviews, surveys and costing studies are proposed to obtain information on the interface between levels, including in terms of resource flows.

1. Introduction

This case study focuses on the challenge of addressing mental health in a low income country. It draws on documentation of responses to mental health in Kenya at different level to show how, in the decade of the 2000s, comprehensive, intersectoral and decentralised approaches were being advanced in national policy , district programming and community centred action on mental health in Kenya. This case study explores how a paradigm shift in mental health towards a decentralised, comprehensive and community centred approach, and attention to meeting underserved needs of the most disadvantaged groups in Kenya was implemented. It uses documentation of the three levels in Kenya in the 2000s, viz (i) the national policy process on mental health (ii) an intersectoral mental health programme at district level operating in nine districts with high poverty levels, and a community level intervention in Kariobangi, a low income informal settlement in Nairobi. The case study presents the methods used, the context for the work on mental health in Kenya, and outlines the evidence on the inception, process and features of the three examples of levels of action on mental health. The case study explores the achievements, impacts, facilitators and barriers to the work, and the learning from the experience for processes that use a more comprehensive socially centred paradigm to drive intersectoral action. The conclusions note also the lack of evidence on the interface between the three levels and identify areas for follow up through more direct measures than desk review.

2. Methodology

The case study is based on a review of documented literature. The case study work was initiated by a review of the background documents for the work, ie the WHO analytic framework on Health in All Policies and the Scoping review on status of implementation of intersectoral action in the African Region. From these documents, the case study database made available by WHO and the guidance for the case studies, three papers on specific case study areas were selected. The three cases were selected to reflect work in different regions of the continent (west, east and southern) and to work that met one or more of the inclusion criteria of collaboration (work) between more than one government sector; improvements to equity as a target outcome of intersectoral action, either implicitly or explicitly; or intervention to prevent inequities in health as an entry point of ISA. A source paper was used for the case. Published and grey literature on the case were then sourced through internet search of internet libraries and google using as key words the country and theme of the case study, in this case Kenya, mental health with (using 'and' and 'or') intersectoral, and health equity. Further information was sourced by following up on references cited in the publications sourced. The case study work was contracted and drafted in May 2013. Key informant interviews were not included in the TORs due to short time frames. The case studies face the limitation of and information gaps from using publicly available documentation. This case study deliberately brings together and explores literature on three levels of intervention- at national policy, district co-ordination and programming and community level empowerment and action, given the nature of mental health and a policy recognition of the need for decentralized, locally driven intersectoral approaches. There was however no literature that documented the links between the three levels and this would need to be explored through more direct survey or methods.

3. Context

Kenya is a low income country and multiparty democracy in East Africa, with a population of 34 million, wide ethnic diversity and a life expectancy at birth in 2010 of 54 years. Kenya's gross domestic product (GDP) per capita in of $580 in 2007 was lower than the average for Africa. Economic growth between 2000 and 2007 was associated with a reduction in poverty rates from 56% to 46%, especially in urban areas (KEMRI Welcome Trust et al 2012; Kilma and Jenkins 2010). However post 2008, the post-election violence and a decline in growth, a rise in inflation and increases in food, fuel and fertilizer

process, combined with conflict on the border with Sudan and Somalia was associated with a rise in poverty and displacement. Climate change, falling rainfall and rising food prices were associated with food insecurity in some parts of the country (Kilma and Jenkins 2010; KEMRI Welcome Trust et al 2012). Inequality In rural areas, poverty, unemployment and land scarcity limit access to benefit from periods of economic growth livelihoods (ADB 2008). Kenya's Gini coefficient of 0.51 in 2005/06 (up from 0.45 in 1994) is only lower than that of South Africa and Namibia in the region (ADB 2008).

Kenya undertook a major constitutional reform in 2010. This and the policy statements in the National health sector strategic plan 2005–2010 establish a strong legal and policy basis for the right to health and health care and for equity in health in Kenya. There has been significant progress towards closing geographical, rural–urban, wealth and other social disparities in some health outcomes, such as in immunisation coverage, access to primary education, contraceptive use, access to anti-retrovirals and access to safe sanitation. Nevertheless, other areas have made less progress or now have wider differentials. Inequalities by wealth, gender or area have persisted or even widened in maternal mortality, in antenatal care coverage and access to skilled birth attendants, in child and infant mortality, and in access to safe water (KEMRI Welcome Trust et al 2012). More than 1 in 10 children die before the age of 5, and four women out of every 1,000 die in child birth. HIV and sexual and reproductive health are major public health issues (Kiima and Jenkins 2010).

The health system is broadly structured into six levels, from volunteer community health workers (level 1) to national referral hospitals (level 6). While there are strong policy commitments to universal coverage, of the eastern and southern African countries, Kenya spends the least share of government expenditure on health and public spending on health has fallen. Improved funding of the health system would need to be accompanied by measures to enhance capacities to effectively use resources at the different levels of the system (KEMRI Welcome Trust et al 2012). In 2008, as part of the establishment of the new coalition government, the Ministry of Health split into two ministries, the Ministry of Medical Services responsible for health delivery at national, provincial and district level, and the ministry of public health and sanitation responsible for health centres, dispensaries and the community. Further the initial 72 districts have now been divided into 250. These changes have strained the resources of the system. Wealthier, urban groups continue to have higher coverage and uptake of services and provinces with highest level of poverty, such as North Eastern, Nyanza and Coast provinces, also have poorer health and health care,

While attention is commonly focussed on communicable diseases in Kenya, there is increasing concern with rising levels of non-communicable diseases including mental health and mental illness. Cultural beliefs attribute mental health disorders to spiritual causes, but there is also a growing social understanding of the physical and social causes of mental health and mental disorders (Kiima et al 2004). People living in poverty are at increased risk of developing mental health problems through the stress of living in conditions of deprivation, increased risk for trauma and other negative life events, increased obstetric risks, social exclusion and food insecurity. Mental disorders have in turn been associated with increased health expenditure, loss of employment, reduced productivity, stigma and a drift into poverty. These patterns, termed the 'vicious cycle' of poverty and mental ill-health, call for measures that address the disorders themselves, their determinants and the social exclusion they generate (Lund et al 2013). Mental ill-health, as both driver of deprivation and exclusion and a consequence of deprivation and exclusion is thus an important concern for both equity and action across sectors.

While mental health specialists and services in Kenya are sparse, those present have raised the profile of mental health. Non health sectors such as education, prisons, police, community development, gender and children, regional administration and local government have raised concerns about mental health, although general health programmes have been slow to appreciate the significance of mental

health for physical health targets (Kiima and Jenkins 2010). The budget allocation to mental health is below 1% in most African countries, and most of this is spent in large, custodial psychiatric institutions, contrary to growing evidence for cost-effective community-based interventions (Lund 2010). The majority of psychatrists are in Nairobi, with one psychiatrist per province of 3-5 million people outside Nairobi and less than one psychiatric nurse per new district. Common mental disorders of depression and anxiety are rarely diagnosed, and when diagnosed rarely treated appropriately (Kilma and Jenkins 2010). Patients in need of inpatient psychiatric care are often referred to district or provincial hospitals, but these are unable to cope with the projected loads. For example if all clients with mental disorders identified at Levels 1, 2 and 3 were referred to the district hospital at Level 4, a district hospital with a catchment population of 500 000 would have to deal with 25 000 cases of severe depression and 5000 cases of longterm psychosis per year –identified to be an unsustainable case-load (Jenkin et al 2010). While some primary health care staff have received training in mental health care, they are reported to lack time to devote substantial time to mental health services (Lund et al 2013).

4. Initiation of the programme in kenya

Mental health was recognised but not given significant profile in National Health Sector Strategic plans before 2004 and development of a National Mental Health Strategic Plan was proposed in 2004 to raise the profile of mental health needs and responses in the future national health sector strategic plans (Kiima 2004). As a reflection of changes in thinking and practice the Mental Health Act of 1983 was amended in 2007, and further a new Mental Health Bill was drafted 2013 (Kiima et al 2004; Korste 2013). The 2007 Mental Health Act recognised some elements of the intersectoral nature of mental health, and established a Kenya Board of Mental Health that included health personnel, but also representatives from education, social services and from provinces (Kiima et al 2004).

The context described in the earlier section of rising need; vicious cycles of deprivation and mental ill health; significant shortfalls in services and demand for new approaches to address the mismatch between need and responses generated a demand for new thinking on policy and practice on mental health in Kenya. This section describes the initiation of a national policy process on mental health and also gives examples of similar processes of reflection and dialogue within other sectors and levels of practice on mental health that contributed to the changes in policy and practice outlined in the next section. The national policy process was directed at the affected population and the institutions that play a role in mental health, while the local processes involved more directly communities and frontline service workers. In both cases the processes involved other sectors that contribute to mental health responses, such as education, social welfare and resource organisations such as government livestock and agriculture departments, gender and social departments and children and youth departments.

An evidence led process was used to initiate the national policy process. In 2004 the Kenya Ministry of Health and DFID UK implemented a situation appraisal by identifying and analysing national and local data, and ministry and other documents and by making site visits to relevant sectors, including health, education, social welfare, police, prisons and non government organisations (NGOs) at national, regional, district and primary care levels. This appraisal was accompanied by detailed consultation and discussion with professionals, clients, families and other stakeholders. Stakeholder workshops were held to discuss the current situation, spearheaded by the Ministry of Health. The information collected from all of these processes was used to construct a mental health profile for Kenya. Further a number of surveys were implemented: a small pilot epidemiological survey; a small survey of knowledge and attitudes to mental disorder in primary care and a focus group with traditional health practitioners . This evidence was used to feed into a sustained policy dialogue on mental health with the Ministry of Health, Ministry of Social Welfare, Ministry of Education, Police, Prisons and Child Protection about the issues raised, including the policy and institutional needs, and the integration of mental health into generic health sector reforms (Kilma and Jenkins 2010).

While this national process took place, there were also independent processes taking place at other levels. For example, BasicNeeds Kenya (www.basicneeds.org/kenya/) collaborated with NGOs in the districts to hold community engagement meetings in local villages of nine districts, starting with an informal settlement in Nairobi, to raise community awareness about mental health. The meetings raised the options for using the local primary care clinic, and the role of self-help support groups for individuals with mental health problems and carers. The engagement with the community and primary care services triggered a range of supporting programmes described further later in the case study, including the training of community-based health workers (CBWs) (recognised in the current Kenya National Health Sector Strategic Plan), the integration of mental health within comprehensive primary health care services and measures to support people with mental illness to carry out productive tasks and contribute economically to their family income (Lund et al 2013; Basic Needs Kenya 2013).

In one low income informal settlement of Nairobi, Kariobangi, the community reported high levels of mental ill health, with poverty a major contributing factor. The major mental disorders identified were depression, stress, drugs/substance abuse and epilepsy, with poverty an underlying factor, as well as lack of essential services. The University of Nairobi facilitated a participatory reflection and action (PRA) process in 2007 to bring family members of people with mental illness, community leaders - village headman, local school teachers, religious leaders- and local health workers and community based health workers to draw out local perceptions and experiences on mental health and its management and identify priorities and areas for action to organise a community based response to mental health priorities that would be evaluated and reviewed by community members and health workers (Othieno et al 2008). The response is described later.

These three inception processes indicate how a context in the 2000s of perceived need, and a range of institutional leadership stimulated processes and involved new actors at community, district and national level to raise new and cross sectoral thinking, policy and practice on mental health.

5. Mental health policy and programme in Kenya

This case study describes associated processes of national policy making and local policy implementation on the specific issue of mental health.

5.1 Policy roles, processes and capacities at national level

The situation appraisal described at national level in the previous section informed a locally tailored and integrated mental health policy and strategic action plan and a multifaceted and comprehensive mental health programme that aimed to use locally available resources and integrate into local systems. The policy process from first discussions and investment in capacities took place over ten years. As one basis for more comprehensive approaches, and to support service outreach to disadvantaged groups the health sector 'got its own house in order'. Mental health was integrated into the health sector reform plans and general health policy and as an integral component of health care at all levels, with defined interventions from primary care to tertiary hospitals (Kilma and Jenkins 2010). In 2005-10, with Nuffield support, integration of mental health into primary care was supported by training of 3000 primary care health workers in mental health. Advocacy was promoted to prioritise mental health in district and provincial budgets (Kilma and Jenkins 2010).

The policy process was led by Ministry of Health, which made linkages with other relevant ministries, including the government departments responsible for police, prisons, schools, child protection, and social welfare. These were sectors with major interests expressed in contributing to mental health policy. They were participants in the policy development process and all represented on the Kenya Board of Mental Health (Kilma and Jenkins 2010).

Reopening national level dialogue on mental health legislation and a code of practice on its implementation triggered wider involvement in the issue, drawing on constitutional reforms, with the National Board Kenya Board of Mental Health coordinating intersectoral liaison on mental health at national level (Kilma and Jenkins 2010). The process has involved innovative interactions with social media and culture, including to reach young people. For example, artist, poet and mental health activist Sitawa Wafula, a mental health activist, was appointed in 2010 as a Mental Health Youth Ambassador because she was very vocal about her own bipolar condition. She is part of the Mental Health Stakeholder's Legislation Review committee and is using culture and social media to reach and involve youth in the legal debate as an affected target group and also as agents of change (Korste 2013).

A key element of the national process was developing and widening the capacities to implement changes in mental health policy. A wide range of training activities were held to address this. While some courses were run for other sectors, such as dedicated training courses on mental health run for prison nurses, the majority of the training targeted building capacities within the heath sector as part of the 'get your own house in order', with further training for 1677 primary care workers (levels 2 and 3), 133 senior district psychiatric nurses (Level 4), 10 provincial psychiatrists (level 5), 52 district public health nurses and development of weekly mental health training for CHWs as part of the normal regular weekly education sessions for CHWs attached to clinics (Kilma and Jenkins 2010).

Beyond widening professional capacities of health workers at all levels, specific inputs were made after 2007 to strengthen capacities for organising and implementing intersectoral action for mental health. Organisational and operational interventions were designed in collaboration with stakeholders and iteratively modified during stakeholder consultation workshops, together with guidelines for roles and responsibilities on mental health within the different tiers of the health service that delineated the potential contributions of key sectors outside health. Capacity building workshops were held to establish and strengthen district mental health coordination and to ensure the inclusion of mental health in district annual operational planning (Kilma and Jenkins 2010). There is limited discussion of the budget resources used for the work, although it is stated that to support sustainability implementation of policies was done through existing services and using regular ministry budgets (Kilma and Jenkins 2010). The monitoring tools and impact are discussed in the next section.

(Note: *No online information could be found on the specific tools or guidelines cited*).

5.2 Local level processes and programmes

Resonating with and feeding into the dialogue on policy and law was the emergence of new practice decentralising services, setting up community based mental health and mental health service user and family groups and engaging NGO and other resources to support livelihoods. There are a number of examples of this, such as the work of the Users and Survivors of Psychiatry Kenya; or the Africa Mental Health Foundation Kenya Integrated Intervention Model for Dialogue and Screening to Promote Children's Mental Wellbeing (KIDS) that involves children, education managers, teachers and parents as well (Korste 2013).

The BasicNeeds 'mental health and development' model, introduced earlier, is described here as it is relatively widespread and implemented in areas of high levels of poverty. It comprised five separate but interlinked modules, namely: capacity building, community mental health, sustainable livelihoods, research, and management and administration. The programme aims to improve the mental health of participants and reduce their deprivation and exclusion. Locally established user self-help support groups involving people with mental disorders and carers from within the same area were set up as a vehicle for the inputs of different sectors and actors, involving also carers (typically a family member) and facilitated by community based workers (CBWs). CBWs thus not only raised awareness for early uptake of services, but facilitated the self-help support groups and their links to key supporting sectors.

The training provided for CBWs took this role into account and covered not only key knowledge in mental health, debunking myths and misconceptions, but also techniques for facilitation, referral and counselling, for group formation and development (Lund et al 2013). The user self-help groups supported improved service uptake, and were a vehicle for support from government livestock and agriculture departments, gender and social departments and children and youth departments for various production activities, such as poultry and pig rearing, egg selling, farming dairy goats, soap making and the production of craft and bead products (Basic Needs 2013; Lund et al 2013). These economic activities positioned employment and incomes as part of long-term recovery given their role in securing treatment, building self-esteem and combatting exclusion and stigma.

The participatory work in the low income community in Kariobangi, cited earlier, through social mapping revealed both community and health service barriers to responses to common mental health problems. These barriers included poor family and community support, cost barriers, inaccessible or limited services, and social factors such as alcohol and substance abuse. While the community preferred using local primary care services there were limited services available at this level and while a range of organisations existed in the community that were potentially able to deal with these conditions, these organisations did not perceive that they had a role in mental health, and the mental health services had poor linkages with these organisations. Reflecting on these findings, community members and local organisations planned and implemented actions that they could take with local resources. A multidisciplinary team including community members in schools, religious leaders, and health workers, carried out public education, set up an additional community clinic point and self-help groups in the community, discussed with authorities to reduce the outlets selling alcohol and limit the opening hours, and with negotiated with local non-governmental organisations to extend their community centres to provide support to children with mental disabilities (Othieno et al 2008). There is no documentation of how these local initiatives linked to district co-ordination mechanisms or national policy processes.

6. Impact and lessons learnt?

6.1 Achievement of objectives and impacts

The ten year programme of work on the national policy and capacities described in this paper has achieved, with relatively limited resources, a detailed situation appraisal, epidemiological needs assessment, inclusion of mental health into the health sector reform plan and the essential package of health interventions, mental health policy guidelines to accompany the general health policy, adaptation of the WHO primary care guidelines, primary care training, construction of a system of roles and responsibilities, intersectoral liaison with police, prisons and schools, public education about mental health, and a research programme to inform future developments. The implementation was integrated within the Kenyan system through ministry of heath and other relevant ministries making it sustainable without external funding so that the system can continue to function irrespective of donor funding or of personalities (Kilma and Jenkins 2010). There is no documentation on the impact of the process on longer term intersectoral collaboration.

The district and community level initiatives described in this paper involved local communities and health workers in locating national policy within their own cultural concepts and community and sectoral processes. They set up mechanisms to make links between people with mental illness, their family and community members and the services to support their health and livelihoods. Mental health services that are based on western concepts of mental health and illness have been identified as largely ineffective in responding to the needs of local people, discouraging service uptake. Even when such services are accessed, approximately one-half of the clients are reported to drop out (Blas et al 2011). The BasicNeeds programme provided access to psychotropic medication, but also engaged wider actors to enroll participants in self-help support groups and build a network of support for productive work (Lund et al 2013). The initial participatory processes, establishment of support groups and

facilitation of community based workers achieved were key to setting up a different framework for local implementation of national policy goals, and to build the network of support, skills and interactions to address social exclusion and support economic activities in the group.

An evaluation was implemented of the BasicNeeds' Mental Health and Development programme in rural Kenya through a cohort of people living with severe mental illness in circumstances of poverty who participated in the programme. The findings on a series of outcome measures obtained from survey and from self-reported attributions of participants present evidence of the feasibility of such programmes, and of their positive impact on mental health, quality of life, social functioning and economic activity (Lund et al 2013). The benefits were found to extend to the household, with increases in median family income over the course of the programme. This is reported to be consistent with other findings regarding household economic benefits of mental health interventions in low and middle-income countries, attributed to the a improved economic functioning of participants and reduced time of family members spent in caring roles (Lund et al 2013).

In the participatory review of the community level intervention in Kariobangi, a post intervention questionnaire provided evidence of perceived improvements by both health workers and community members in the understanding of mental health (which went from low to very high rating), in community, police, NGO and chiefs support for people with mental illness, and in the management of mental health problems in the community. The participatory reflection and action process was seen to have facilitated communication across key actors in the response to mental illness, but that had had weak prior communication or shared understanding. The increased awareness of the possibilities and shortfalls of the current management of mental health in health services, and the demand for stronger links with community organisations generated a dissatisfaction with the current response. The post intervention survey indicated that the process provided an opening for communities to express their needs, plan and overcome the poor coordination and communication affecting the response to mental illness (Othieno et al 2008).

6.2 Opportunities and facilitating factors

The strengths of the national policy and capacity building process, which may be useful in planning similar policy processes elsewhere, are reported to have been an integrated and coordinated set of activities at multiple levels and across sectors; planning for the sustainability right from the beginning through domestic systems and funding; intensive policy dialogue throughout; and evaluation to assess impact. All training materials were widely disseminated to the workforce, local academic centres, and incorporated into curricula. The long term relationship with external partners and work through local institutions and budgets is noted to have achieved more sustainable impacts than might have been achievable in a shorter time period. (Kilma and Jenkins 2010). While the collection of evidence was a strong feature of the work it is implicit but less clear what role it played in leveraging support for the work.

The findings in the BasicNeeds district programme suggest that at district level, an intersectoral approach that supports the whole household and social networks for people with mental illness can have positive impact, particularly through a strong beneficial influence of income generation and productive work on mental health, social inclusion and poverty reduction, not only for those with mental illness, but also for their household carers. The facilitation by community based workers and establishment of social networks appears to be a key strength in facilitating a link between district services and resources and those in the community with mental illness and their carers. This suggests that mental health programmes need to organise people with mental illness into local networks and make strong links between them and their households and economic actors and services (Lund et al 2013).

At community level, a process using participatory reflection and action appears to have played an important role in supporting the shared understanding and analysis between local actors that was key to building a more co-ordinated and empowering response. From worlds apart at the beginning of the intervention, there was evidence of improvements in shared understanding and action between health workers, communities and other local actors and this was seen to be critical to leveraging a sustained and co-ordinated response (Othieno et al 2008).

At all levels, there is a strong consistency in the finding that intersectoral policy, service and community responses to mental health need to be driven by communication across actors, supported by people with capacity to facilitate such communication, and to be embedded in existing systems and structures or to strengthen such structures (such as networks of people with mental illness) for the effectiveness and sustainability of the response. What is less evident are the vertical links between these local community, district and national level processes. This is further discussed later in the case study.

6.3 Challenges and barriers

Limitations and barriers are described at all three levels in the literature, albeit rather briefly. This would be an area to further explore through more direct interview. At the national level in the policy process limitations included limited financing, frequent changes in senior ministry personnel and changes in ministry structures. An international and national focus on communicable disease was seen to reduce both profile and resources for this area within the ministry of health and thus to reduce its own leadership in the process, despite the active interest of other sectors to integrate mental health into their work (Kiima and Jenkins 2010). The programme is however described to have largely overcome these constraints with limited resources, including by providing support to co-ordination, dialogue and capacity building within existing systems. Central level facilities are recognized to be too understaffed and under-resourced to offer adequate quality care (and have received negative media attention for this), and the decentralization of care to smaller facilities in every county and more cooperation with, and implementation of, community based mental health and mental health service user and family groups is seen to be vital to address this and to improve access in low income communities (Korste 2013).

Much clearer evidence is needed than available in the literature on whether decentralization of responsibilities and capacities for care is being implemented with similar decentralization of resources. At district and community level, resource constraints, capacity shortfalls, stigma and competing agendas were observed as challenges to be overcome (Kilma and Jenkins 2010; Othieno et al 2008). Many of these challenges are likely to be greater for lowest income districts and households and individuals with highest levels of poverty, although this was not specifically commented on. There wasn't any systematic or disaggregated reporting of fallout from the community or district programmes. There was also no direct evidence of how the capacity building processes described at national level had filtered to local level. The BasicNeeds approach worked with personnel within the district with support from an NGO, while the community level work in Kariobangi worked with local level personnel with support from the University, and skills inputs for facilitators from a regional process in EQUINET (Othieno et al 2008). While national, district and local processes all recognised and supported the role of community based workers, the additional role of the overall 'broker' (University, NGO, DFID and Ministry personnel) was less explicitly identified and institutionalised, although it seems to be equally critical.

At community level the process encountered difficulties with explaining mental health concepts in local languages. The use of an approach that built more bottom up processes was also reported as challenging. Participants were reported to be initially surprised that they were expected to share and reflect on their own experience to come up with solutions to their problems, but it was also noted that their expectation of a passive role diminished through the process (Othieno et al 2008).

Across all three levels the challenges raised suggest that changing the culture of management of mental health towards more inclusive, community driven and intersectoral processes demands time, responsiveness to local community, district and national processes and systems, and with inputs and positive outcomes that reinforce initiative.

7. Conclusions and recommendations

The national process has demonstrated positive use of a multi-faceted and comprehensive approach to policy dialogue and development as an input to sustainable system change and to encourage intersectoral liaison. Starting with a demanding context of rising need, a crowding out of the problem of mental health and low policy attention in the lead Ministry (health) despite concern from other sectors and resource scarcity, the case study describes a process of policy dialogue across sectors and measures for capacity support that developed momentum in the late 2000s (Kiima and Jenkins 2010). The district and community level processes show how the same context has also driven bottom up intersectoral approaches to address mental ill health centred around networks of individuals and their carers, linking services and resources within and beyond the health sector and facilitated by local actors.

In all cases the work was informed by a paradigm shift. All elements described in this case study recognised the 'vicious cycle' of poverty and mental ill-health that call for measures that address the disorders themselves, their determinants and the social exclusion they generate. There was shared recognition of the need for co-ordinated medical, psychosocial, economic and, for stigmatised conditions, rights-based support. The case study indicates from all three levels that the scaling up of mental health services in low and middle-income countries needs to include improved leadership and capacities within Ministries of health at primary care and district level, to include an economic empowerment and social inclusion component, to strengthen social networking of people with mental illness, including as a vehicle for support by other sectors, and to invest on the role of institutional and community based facilitators.

Individuals (including social activists) and institutions played a key role in leveraging a change in process, supported by evidence, such as from the situation assessment at national level, by information from social media and by a new and rights based legal framework generated in the constitutional reform. At community level more participatory approaches facilitated information sharing across groups and were key to building a shared understanding between those affected and services that support their wellbeing.

For its leadership of an intersectoral response at national level the Ministry of Health had to get its own house in order through measures (policy, guidelines, training) to strengthen primary and district level services for mental health integrated within health system planning and budgets. At district and local level facilitation from non state actors seemed to be key to lever new processes, but this may also be due to the fact that processes within the state at district level are not systematically documented in the literature.

At national level sectors involved in policy dialogue and operationalizing policy included police, prisons, schools, child protection, and social welfare. This focus appears to have been due to their links with the referral system of Ministry of health, for forensic purposes, such as for crimes committed by people with mental illness, or for social welfare support of people with mental illness. The district and community level approaches linked with these sectors, but also with other sectors, including government livestock and agriculture departments, gender and social departments and children and youth departments for various production activities. It appears that guidelines for roles and responsibilities on mental health that delineate the potential contributions of key sectors outside health

developed at national level would need to include the role of these economic sectors, given their key role in positive outcomes identified at local and district level.

The case study provides a consistency of evidence across three different levels that intersectoral policy, service and community responses to mental health need to be driven by communication across actors, supported by people with capacity to facilitate such communication, and to be embedded in existing systems and structures or to strengthen such structures (such as networks of people with mental illness) for the effectiveness and sustainability of the response. At all levels, building an intersectoral, supportive culture and system for management of mental health demands time, responsiveness to local community, district and national processes and systems, and need to generate positive outcomes that reinforce initiative. While embedding the process in local community networks, local and national systems improves sustainability, these communities and systems are under-resourced and the costs for ensuring adequate support to all levels would need to be estimated to ensure that responsibilities are decentralised along with resources. While the literature provides useful evidence of changes and outcomes within different levels (community, district, national) no documentation was found of the vertical interface and resource flows between these levels. This would need to be assessed through follow up survey and interview.

Adopting an integrated approach to provision of care, recovery and economic empowerment appears from the case study to be possible in low resource settings, as is the development of an intersectoral policy and process supporting this at national level. It is possible to evaluate such change in low resource settings, and suggested that such evaluation be integrated routinely into programmes and services (Lund et al 2013).

Acknowledgments

References

1. African Development Bank. Kenya 2008-2012 Country Strategy Paper Kenya African Development Bank 2013
2. Blas E, Sommerfeld J and Sivasankara Kurup A (eds) Social determinants approaches to public health: from concept to practice, Geneva, WHO, TDR, HRP, AHPSR 2011
3. Jenkins R, Kiima D, Okonji M, Njenga F, Kingora J, Lock S. Integration of mental health into primary care and community health working in Kenya: context, rationale, coverage and sustainability, Mental Health in Family Medicine 2010;7:37–47
4. KEMRI-Wellcome Trust Research Programme, Mustang Management Consultants, Ministry of Public Health and Sanitation, Training and Research Support Centre (2011) Equity Watch: Assessing Progress towards Equity in Health in Kenya, KEMRI, EQUINET, Nairobi and Harare
5. Kiima DM, Njenga F, Okonji M and & Kigamwa P. Kenya mental health country profile International Review of Psychiatry 2004; 16; 1–2: 48–53
6. Kiima DM and Jenkins R, Mental health policy in Kenya –an integrated approach to scaling up equitable care for poor populations International Journal of Mental Health Systems 2010, 4:19
7. Korste R. Eight encounters with Mental Health care Kenya, in2mentalhealth, 2013 at http://in2mentalhealth.wordpress.com/2013/02/14/eight-encounters-with-mental-health-care-kenya/ accessed May 2013

8. Lund C, Warugurub M, Kingorib J, Kippen-Wood S, Breuera E, Mannarathd S and Rajad S. Outcomes of the mental health and development model in rural Kenya: a 2-year prospective cohort intervention study Int Health 2013; 5: 43–50 doi:10.1093/inthealth/ihs037

9. Lund C. Mental health in Africa: Findings from the Mental Health and Poverty

10. Project, International Review of Psychiatry, 2010; 22; 6: 547–549

11. Othieno C, Kitazi N, Mburu J, Obondo A, Mathai M (2008) Community participation in the management of mental disorders in Kariobangi, Kenya, EQUINET PRA paper, EQUINET, Harare

12. Skeen S, Kleintjes S, Lund C, Petersen I, Bhana A, Flisher A, and The Mental Health And Poverty Research Programme Consortium 'Mental health is everybody's business': Roles for an intersectoral approach in South Africa; International Review of Psychiatry, 2010; 22(6): 611–623

13. WHO AFRO. Scoping review on status of implementation of intersectoral action in the African Region, Brazzaville, WHO AFRO, 2013

World Health Organization

REGIONAL OFFICE FOR Africa