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# Assessment of Organizational Capacity in Implementation of the Kenya Mental Health Policy [2015-2030] in Kisumu County

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## Abstract

**Purpose:** This study was conducted to assess organizational capacity in the implementation of KMHP 2015-2030, in Kisumu County, Kenya, focusing on the availability of mental health services, financial resource allocation, and human resource capacity at public level 4 and 5 facilities.

**Methodology:** The study utilized a mixed-method design with data from administrative representatives. Census sampling included 22 facilities, and 12 key interviews provided qualitative data. Quantitative analysis included frequency count, percentage scores, multiple response crosstabs, and Fisher's Exact test at a 0.05 significance level while qualitative data employed thematic analysis.

**Findings:** Reveals substantial shortcomings in the organizational capacity of level 4 and 5 public health facilities to provide adequate mental health services. Only 4.5% of level 5 facilities offered child mental health services, with 13.6% providing care for adolescents. Rehabilitation services for substance use disorders are available in 6.9% of level 5 facilities, while a concerning 41.4% of level 4 facilities do not offer any mental health services at all. Financially, 22.7% of facilities had allocated budgets for mental healthcare while 77.3% had no dedicated funds. Availability of specialized mental health professionals is notably limited.

**Contribution to Theory, Policy and Practice:** The current study recommends expanding mental healthcare services to fill gaps in specialized care, increase financial allocation for mental healthcare, investing in the recruitment and retention of mental healthcare professionals as well as prioritize ongoing training and professional development of staff involved in mental healthcare delivery. This will improve the effective translation of KMHP [2015-2030] actions into practice.

**Keywords:** *Mental Healthcare, Policy Implementation, Organizational Capacity*

## 1.0 INTRODUCTION

Implementing mental health policies, like any other policies, is challenging, especially in low-resource settings where there is a significant gap between the need for mental health care and the actual access to it (Tennyson et al., 2016). According to the World Health Organization report (World Health Organization, 2022) mental disorders are the leading cause of years lived with disability (YLDs), accounting for one in every six YLDs globally. The World Mental Health Survey by WHO shows that mental disorders are prevalent and significantly impair individuals in many parts of the world. The burden of mental disorders is expected to rise by 15% by 2030 (Murray et al., 2012). This projection is based on indicators such as prevalence rates, global disease burden reports, risk factors associated with mental health, health system data, epidemiological studies, and social factors. The Mental Health Atlas, a tool for monitoring progress by WHO member states towards the objectives and targets of mental health plans, shows unsatisfactory progress against the target (*Mental Health Atlas 2014*) (*Mental Health ATLAS 2017*) (*Mental Health ATLAS, 2020*). There are still major gaps and imbalances in mental health systems globally. Some key highlights from the *Mental Health ATLAS (2020*) report include gaps globally between the existence of policies, plans, and laws and their implementation and resource allocation. There are also gaps in the implementation of mental health services at the primary healthcare level and limited human and financial resources allocated for policy implementation, resulting in low public expenditures on mental health.

The Kenya Mental Health Policy 2015-2030 represents a strategic framework designed to catalyze substantial reforms within the country's mental health systems. Aligned with foundational documents such as the Constitution of Kenya 2010 and Vision 2030. The policy is a dedication of the national commitment to ensuring the highest attainable standard of health for all (Bukusi, 2015). The Kenya Mental Health Policy outlines comprehensive actions to enhance mental healthcare through improved mental health services, human resource development, management, and financial resources. The policy on mental health services aims to create an accessible, high-quality, and integrated system. It mandates that mental health services be affordable, equitable, sustainable, and responsive to ensure dignity and respect for all users. Adopting the WHO model, mental health services will be integrated with general healthcare, providing comprehensive care that includes promotion, prevention, treatment, and rehabilitation of mental, neurological, and substance use (MNS) disorders at all healthcare levels. Strengthening the referral system is essential for effective and cost-efficient service delivery. Treatment of MNS disorders will be universally accessible, with programs for screening, early identification, and continuous quality improvement. Integrating mental health services with care for chronic conditions is essential due to the strong link between mental and physical health, aiming to improve quality of life and health outcomes while reducing economic costs. Rehabilitation services will be provided at all levels, strengthening evidence-based residential and community reintegration programs in emergencies, mental health services will be coordinated by national and county governments, integrating disaster management teams and ensuring the protection of vulnerable groups. Emergency mental health care will include pre-

hospital and hospital services and psychosocial support, with referral guidelines integrated into the existing system. To ensure an adequate and qualified mental health workforce, mental health training will be integrated into the curricula of all health workers, with sufficient content and time allocated. To address the current workforce shortfall, the government will provide in-service training for existing service providers, establish complete mental health teams at all healthcare levels, support and finance the training of more mental health workers at national and county levels, and train and recruit community mental health workers. To help address this shortage, the Mental Health Action Plan 2021–2025 (MoH, n.d.-a) is aiming to provide mental health training to 5% of health care providers in each county by 2025. Financial resources will be bolstered by increasing the budget for mental health services to meet WHO standards at both national and county levels.

### 1.1 Problem Statement

The quest to achieve mental healthcare objectives has been marked by capacity-expectation gap given the nature and adaptation of organizations to implement the mental healthcare policy plans. Successful implementation of policy depends not only on its design and formulation but also on its successful execution and delivery of intended outcomes (Cerna, 2013). Implementation, as noted by Bullock *et al.,* (2021) receives less attention compared to other policy-making stages and is often isolated from the broader policy process. The implementation process is significantly impacted by organizational capacity and readiness such as the availability of financial resources, and the human resources required to achieve the desired level of service delivery. To understand the current status of adoption and implementation commitments at the county level, it is essential to assess the progress made in operationalizing the policy on the ground. This involves examining the integration of mental healthcare into the formal health system and identifying potential bottlenecks and facilitators encountered during the policy implementation. Continuous gathering of evidence is crucial to establish the progress in mental health care provision nationwide and the efforts made towards achieving the goal of making mental health care accessible and affordable to all by 2030, as envisioned by WHO. The study assessed the availability of mental health services, financial resource allocation and collaboration, and human resource capacity at public level 4 and 5 facilities in Kisumu County, focusing on their organizational capacity to operationalize the Kenya Mental Health Policy (KMHP) 2015-2030.

## 2.0 LITERATURE REVIEW

### 2.1 Organizational Capacity in Implementing Mental Health Policies

Organizational capacity (Ting, 2011) is crucial for the successful implementation of mental health policies, encompassing various elements that ensure effective execution, monitoring, and sustainability of initiatives. Abd Rahim et al., (2021) states strong leadership and governance provide a vision and commitment, along with clear policy frameworks and stakeholder engagement, setting the foundation for prioritizing mental health (Szabo et al., 2017). Human resources are vital, requiring continuous education, adequate staffing, and regular support to

prevent burnout (Miseda et al., 2017). Financial resources, including sustained funding and resource mobilization, are necessary to support these programs(Chisholm et al., 2019). Service delivery must incorporate evidence-based practices, ensuring accessibility and inclusivity, while continuous improvement through regular evaluation is essential (Abd Rahim et al., 2021). Monitoring and evaluation systems, with robust data collection and performance indicators, ensure accountability (Bukusi, 2015). Building and sustaining organizational capacity requires integrating all these components to ensure the successful implementation of mental health policies. Research and studies on organizational capacities for implementing mental health policies emphasize various critical components for success. The World Health Organization (WHO) has highlighted the importance of strong governance, adequate funding, trained human resources, and integrated service delivery systems, as seen in their comprehensive "Mental Health Atlas" series example the (*Mental Health ATLAS, 2020*).

Implementation science, review identifies leadership, staff training, interagency collaboration, and evidence-based practices as vital, with an emphasis on ongoing evaluation and adaptation to local contexts(Gotham et al., 2022). Financial sustainability, as discussed by (Patel et al., 2018) is crucial, highlighting the necessity of sustained funding and resource mobilization. Workforce development, detailed by (Hoge et al., 2016) points to the need for continuous training, support, and staff retention strategies. Collectively, these studies underscore the multifaceted nature of organizational capacity, emphasizing leadership, resources, continuous evaluation, and cultural competence as essential for effective and sustainable mental health policy implementation. Research on the implementation of the Kenya Mental Health Policy 2015-2030 and the Kenya Mental Health Action Plan 2021-2025 highlights several challenges and mixed progress. Studies conducted in counties such as Makueni, Kwale, and regions in Western Kenya reveal key issues. There is a notable lack of awareness among healthcare providers about the existence and specifics of mental health policies, with a significant percentage of facility in-charges unaware of these policies and not incorporating mental health considerations into their budgets. This lack of awareness extends to the general population and other healthcare workers (Mutiso et al., 2020). Additionally, mental health services are severely under-resourced, particularly in terms of human resources and medication. Many facilities have few or no staff specifically trained in mental health, and the availability of medications is inconsistent. Services are primarily available at higher-level healthcare facilities, limiting accessibility for many patients, especially in rural areas. Lower-level facilities are often under-equipped and lack the capacity to provide comprehensive mental health services (Kwobah et al., 2023; Mutiso et al., 2020). The implementation and monitoring of mental health policies are also problematic, with inconsistent data collection and reporting, and little coordination between different levels of healthcare providers. In Kwale County, the lack of a structured approach to implementing the Kenya Mental Health Policy has led to minimal progress since its inception (*Report_mental_health_study-Kwale, 2019*).

### 2.1.1 Availability of services for mental healthcare

Mental healthcare systems all over especially in low- and middle-income countries are characterized by deficiencies and weaknesses. There are significant difference in mental health systems between the high and low- income countries (Rathod *et al.*, 2017) . Mental health care for people in LMICs has been descried as inadequate, inefficient and inequitable (J Alonso, 2018) (Keynejad *et al.*, 2018). Mental healthcare in Kenya is inadequate, ineffective, inequitable, and has suffered from decades of systematic neglect, resulting in a treatment gap. These significant gaps in mental health care do affect the availability, quality, and affordability of services. Only 13% of health facilities, both private and government-run, offer any mental health services. The majority of mental health care is concentrated in one specialized mental hospital (Mathari National Teaching and Referral Hospital) and general hospitals in major cities. Integrating mental health care into primary care remains a challenge, as an audit reported no mental health services available at primary care facilities (level 2 and 3). Moreover, facilities lack modern evidence-based treatment options and often face shortages of essential mental health medicines, including psychotropic drugs (Bitta *et al.,* 2020) (Kasanga Sylvia, 2019; Musyimi *et al.,* 2017)

### 1.2 Financial Resource Allocation for Mental Healthcare

Mental health conditions contribute significantly to global burden. yet mental health spending remains disproportionately low compared to other health issues. The WHO report *(Global Shortfall in Investment in Mental Health*, 2021) highlights significant gaps in mental health spending worldwide, only small fraction of countries meeting recommended expenditure targets. In 2020, only 13 out of 85 countries met expenditure targets outlined by Lancet, with most falling short(Patel *et al.*, 2018). International donors currently fund a small portion of mental health activities, leaving the bulk of financial responsibility on developing country governments and individual households. Despite this, many country governments allocate minimal resources to mental health, often less than 1% of their national health budgets(Mahomed, 2020). Financing of Mental Health, 2024 highlight domestic advocacy and prioritization of mental health are crucial for sustainable change, as external donors alone cannot bring about lasting policies or funding. Additionally, the economic burden on households due to mental health expenses is significant, particularly for vulnerable populations, although the exact figures are still being established. Concerns on mental health funding, particularly the prevalence of short-term contracts is the uncertainty in funding continuity which poses challenges for service planning and often leads to program terminations, affecting the health and well-being of service users(Gilbert *et al.*, 2015). There is need for emphasizes for increased funding alongside a shift towards longer-term certainty to support frontline service providers effectively and ensure stability for service users Kenya's expenditure on mental health is notably low, with a per capita government mental health expenditure of only US$ 0.0015 annually. This is considerably lower than the global median mental health expenditure per capita, which is US$ 2.5 per year (Mental Health ATLAS 2017,). In the financial year 2021–22, only 2% of the government health budget was allocated to mental health

at the national level, showing a slight increase from the previous year (Health-Sector-Report, 2021). Chronic under funding has led to a poorly equipped mental health care system, with a severe shortage of mental health professionals and inadequate facilities(*Provision-of-Mental-Healthcare-Services-in-Kenya-2017.Pdf*, n.d.). On recent report a gathering of over 100 experts convened by Kenya's Ministry of Health discussed the urgent need for increased investment in mental health on May 17, 2021. Despite the absence of a specific budget for mental health, recent reforms and the establishment of a Mental Health Task-force demonstrate Kenya's commitment to addressing this issue(*Experts Join Forces for Mental Health in Kenya*, 2021). There's lack of documentation at the county level regarding mental health budget allocations at local facilities. While reports on the budget exist at the national level, there's a gap in understanding the county-level efforts in allocating funds for mental healthcare within comprehensive health services.

### 2.1.3 Capacity of human resources for mental healthcare

World Health Organization, (2008) indicate mental health personnel are the most valuable resource when it comes to mental healthcare as they play a significance role to promote metal health, prevent disorders and provide care for the people. The density of health professionals is closely related to the service coverage and health outcomes. Unfortunately there are shortage of mental health professionals globally (Boniol *et al.*, 2022) (Endale *et al.*, 2020). According to the World Health Organization (2013), there is a severe shortage of psychiatrists in low-income countries, with only one psychiatrist for every two million inhabitants, compared to one for every 12,000 inhabitants in high-income countries.

Kenya has a shortage of qualified personnel in all mental health specialties within the public sector. Specialized mental health providers remain a scarce even with the counties, several counties reported to critically have low numbers of health professions. We have 1382 mental health professions working under the 47 counties and 354 employed by the National Government (MoH, n.d.-b). The Kisumu Mental Health Stakeholder forum highlighted key concerns in a memorandum to the Mental Health Taskforce in January 2020 (Mental Health task force-Kisumu, 2020). Among these concerns were the lack of a recognized coordination structure for mental health services and the shortage of financial and human resources to support essential mental health activities. To ensure an adequate and qualified mental health workforce the Kenya Mental Health Policy 2015-2030 recommends, mental health training will be integrated into the curricula of all health workers, with sufficient content and time allocated. To address the current workforce shortfall, the government will provide in-service training for existing service providers, establish complete mental health teams at all healthcare levels, support and finance the training of more mental health workers at national and county levels, and train and recruit community mental health workers (Bukusi, 2015). To help address this shortage, the Mental Health Action Plan 2021–2025 is aiming to provide mental health training to 5% of health care providers in each county by 2025.

## 2.1 Theoretical Review

Organizational Capacity Theory, rooted in the broader field of organizational theory, evolved through contributions from several key scholars who sought to understand why some organizations are more effective than others in achieving their goals. The origin of this theory can be traced back to Edith Penrose's seminal work in 1959, "The Theory of the Growth of the Firm," which introduced the resource-based view, emphasizing the importance of internal resources in driving firm performance(Penrose, 1995). In 1963, Richard M. Cyert and James G. March's "A Behavioral Theory of the Firm" contributed a behavioral approach, focusing on decision-making processes and organizational routines(*Behavioral_theory_of_firm,2012*). Jeffrey Pfeffer and Gerald R. Salancik, in their 1978 work "The External Control of Organizations: A Resource Dependence Perspective," highlighted the impact of external environments on organizational behavior(Dill, 1981). Jay B. Barney expanded the resource-based view in his 1986 and 1991 papers, detailing how resources and capabilities contribute to sustained competitive advantage(*Barney 1991*). Paul C. Light, through his 1998 and 2002 works, focused on organizational capacity in the public and non-profit sectors, exploring capacity-building initiatives(Noble, 2004.).

Central to Organizational Capacity Theory are several key tenets: the resource-based view, emphasizing internal resources and capabilities; human capital, focusing on employees' skills and abilities; structural and procedural elements that facilitate effective operations; adaptability and learning, stressing organizational flexibility; and stakeholder engagement, recognizing the influence of external relationships(Ting, 2011). Peter F. Drucker, although not explicitly part of Organizational Capacity Theory, significantly influenced its development through his concepts of Management by Objectives (1954), decentralization, innovation, the importance of human capital, and knowledge work, enhancing organizational adaptability and performance(*Drucker - Management By Objective*.).

Applying Organizational Capacity Theory to assess policy implementation involves evaluating several dimensions: human resources, ensuring skilled personnel and adequate staffing; financial resources, assessing funding availability and management; physical and technological resources, ensuring adequate infrastructure and tools; organizational structure, promoting efficient decision-making and communication; leadership and governance, ensuring strategic direction and oversight; program and service delivery, evaluating design and execution; and the external environment, analyzing stakeholder relationships and regulatory impact. By systematically assessing these components, policymakers can identify strengths and weaknesses, ensuring that implementing agencies are well-equipped to achieve policy objectives effectively. This comprehensive approach helps organizations navigate challenges, adapt to changes, and achieve sustained success.

### 2.2 Research Gaps

The integration of mental health into primary care is a global challenge, but the progress in Kenyan counties remains understudied. There is lack of detailed documentation regarding mental health policy guidelines at primary and secondary healthcare levels as well as limited data on the financial aspects of mental health care, particularly in devolved health systems. A better understanding of

investment and expenditure can inform resource allocation. Investigating this can guide more effective service delivery. Addressing these knowledge gaps is crucial for advancing mental health policy implementation, financial resource allocation, and integration into primary care in Kenya and globally.

## 3.0 MATERIAL AND METHODS

The study was conducted in Kisumu County. Kisumu County is one of the 47 counties in the Republic of Kenya. Geographically, it is located between longitudes 35″ 28″ and 35″ 36″, and latitudes 0″12″ and 1″10″ South. Kisumu County faces numerous challenges with mental health (TiYO, 2019) such as stigma and discrimination. Statistics from NACADA 2022 report (*Abridged Version_National Survey on the Status of Drugs and Substance Use in Kenya 2022*) significantly higher rates of substance abuse in Nyanza recording (53.2%). Highlighting it as a priority area for broader mental health intervention and policy implementation. The study employed mixed-method design. The sequential mixed-method design involved a quantitative phase then followed by a qualitative phase. The sequential progression of this mixed-method design triangulated research findings and enhanced comprehension of the research questions. The study population comprised all 23 level 4 and 5 public health facilities in Kisumu County mandated to provide mental health services. Using a census approach, data was collected from 22 out of the 23 facilities. These level 4 and 5 facilities are mandated to be primary centers for mental health services through their psychiatric units, also acting as referral facilities for lower-level health facilities. Two adequately trained research assistants comprised the data collection team briefed on the study's nature before commencing. Structured questionnaires and a Key Informant Interview Guide facilitated data collection. Questionnaires were administered to facility in-charges or their assistants, chosen purposefully to ensure respondents in authoritative positions could address organizational aspects of mental health effectively within the health facilities. The questionnaire elicited information on availability of services for mental health patients, adequacy for financial resource allocation and collaboration for mental healthcare and the capacity of human resource in addressing the mental health needs of mental health patients within these public health facilities. They key informant interviews were used to facilitate a nuanced exploration, enhancing the depth and richness of the data collected. Prior to use, the data collection tools underwent validation, incorporating feedback from supervisors and practitioners. Their comments and recommendations were thoroughly reviewed and integrated to enhance the tools quality. Data obtained from this study was entered into Microsoft Excel, cleaned and transferred to SPSS IBM (version 23) for analysis. Descriptive statistics of frequency count and percentage scores were performed to summarize the demographic characteristics. Multiple response cross tabs analysis was used to establish the association between level of availability of mental health services and level of facility. Frequency, percentage scores and Fisher's Exact test analysis at 0.05 level of significance to established the adequacy of financial resource allocation and collaboration for mental health in the facilities. Multiple response cross tabs analysis and percentage count to establish the association between the level of capacity of

human resource for mental health and level of facility. Drawing the decision rule for the analysis, items that score 1-39% were regarded as very low (VL), 40-49% as low (L), 50-69% as high (H) and 70-100% as very high (VH). For the Fisher's Exact test analysis, if the p-value is less than or equal to 0.05, we reject the null hypothesis, but if the p-value is greater than 0.05 will accept the null hypothesis. Thematic approach was utilized to analyse qualitative data from key in-depth interviews. The process started with transcribing the audio-recorded interviews, followed by cleaning and reviewing the transcripts to understand the data. During coding, patterns and associations were identified, and a manual codebook was developed and refined to capture all relevant aspects. Some identified codes were budget constraints, partner dependency, mental healthcare challenges, and progress in mental health implementation. Data was then categorized into themes and sub-themes using the software tool Dedoose. This thematic approach helped extract themes from responses, explaining the reasons behind the quantitative findings. Examples of these themes included human resource capacity in policy implementation, financial resource allocation, and overall policy implementation. Excerpts from the interviews were included where necessary to highlight participants' perspectives in line with the study objectives.

## 4.0 FINDINGS

Out of the 22 facilities from which data was collected, 20 (91%) were County Level 4 facilities, and 2 (9%) were Referral Hospital Level 5 facilities. Figure 1, shows the number of mental health patients (MHP) seen per month by level 4 and level 5 facilities. Three out of 20 County level 4 facilities do see over 15 MHP, while the two level 5 facilities also see over 15 MHP per month. Underscore the need for evaluation to ensure both levels are at capacity to continue to meet patient needs effectively and efficiently. All the others ranging from up to 5 to 15 MHP, including those not sure of their number of MHP, are seen by County level 4 facilities.

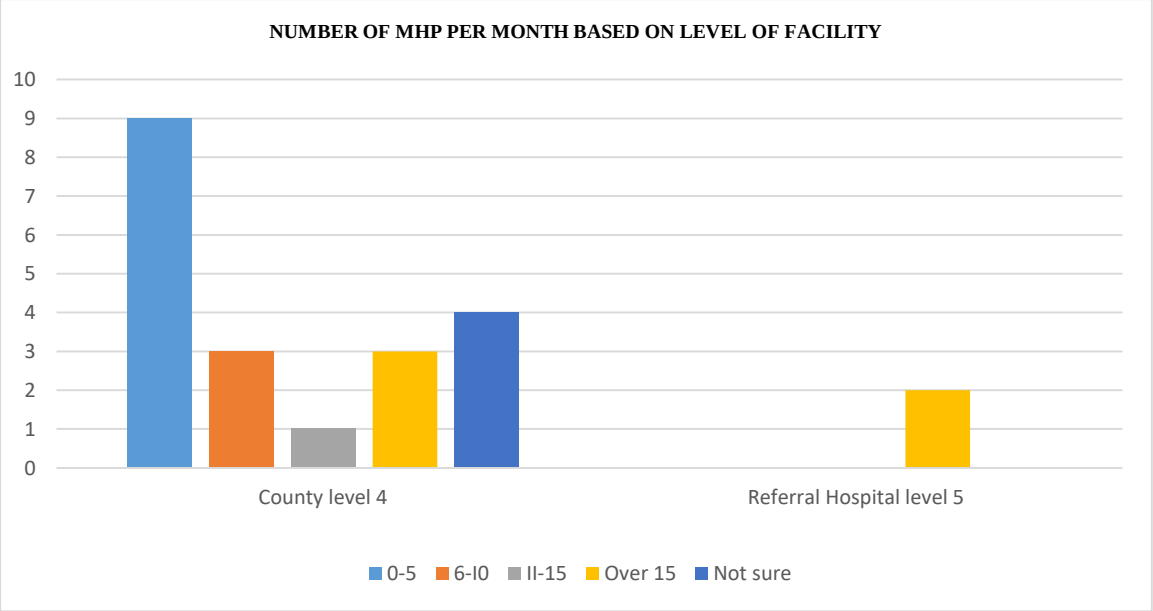

**Figure 1: Number (MHP) seen per month by level 4 and level 5 facilities.**

Significant gaps exist in mental health service availability at Level 4 and Level 5 facilities. Despite the KMHP [2015-2030] mandate for affordable, equitable, accessible, sustainable, and quality mental health services with adequate infrastructure, access remains limited, especially at Level 4 facilities. These predominantly offer outpatient services, focusing on less intensive care, while Level 5 facilities provide a broader range of specialized services. Children and adolescents face particularly significant service gaps, and there are disparities in service distribution and intensity across the two levels. A significant portion 12 (41.4%) of county level 4 facilities do not offer any mental health services, highlighting a gap in mental healthcare provision at this level. These findings highlight a critical gap in the capacity of these facilities to effectively avail mental healthcare services. Challenges related to medication availability impact the ability to provide treatment and support for mental health conditions. There are also limitations in diagnostic capabilities, which can hinder accurate assessment and treatment for lack of testing equipment. And the lack of admission commodities impedes the ability of facilities to admit and care for mental health patients appropriately. These gaps from our study are supported by previous studies and reports service gaps (Ndetei *et al.,* 2023) (Timothy Okatta: et al., n.d.) (Mental Health Task force, 2020) indicating mental health care in Kenya to be inadequate and ineffective. The policy calls for a strengthened referral system, but inefficiencies arise from high referral rates due to lack of expertise (81.8%) and resource shortages at lower levels. Most referrals are to Kisumu County Referral Hospital. Despite the mandate to include essential psychotropic drugs in the Kenya Essential Drug List, many facilities, particularly county Level 4 facilities (51.1%), report significant shortages of essential drugs and testing equipment, impacting care quality and comprehensive treatment. The disparities in service provision are also documented in a study conducted in Western Kenya (Kwobah et al., 2023b), as well as in an audit report (*Provision-of-Mental-Healthcare-Services-in-Kenya., 2017*) on mental health provision in Kenya. Both sources highlight the absence of services and the inadequate functioning in the delivery of mental health services across different facility levels. The audit report conducted on mental health provision in Kenya (*Provision-of-Mental-Healthcare-Services-in-Kenya., 2017*)echoed similar concerns about facilities lacking the capacity to effectively deliver mental healthcare.

**Table 1. Multiple Response Analysis of Level of Availability of Services for Mental Health Patients in Level 4 and Level 5 Facilities in Kisumu County**

| | Level of Availability of Services for MHP | Responses n (% of cases) | Level of Facilities | |
|---|---|---|---|---|
| | | | County Level 4 | Referral Hospital Level 5 |
| **Category 1 Mental Health Services** | Child mental services | 1 (4.5) | 0 | 1 |
| | Adolescent mental services | 3 (13.6) | 2 | 1 |
| | Drug rehabilitation services | 2 (6.9) | 1 | 1 |
| | Community psychotherapy disaster response team services | 2 (6.9) | 1 | 1 |
| | Outpatient MNS services | 7(24.1) | 6 | 1 |
| | Treatment and rehabilitation services for substance use disorders | 2 (6.9) | 0 | 2 |
| | None | 12 (41.4) | 12 | 0 |
| | **Total** | **29 (131.8%)** | | |
| **Category 2 Management of Mental Health Patients** | Give medication | 9 (40.9) | 7 | 2 |
| | Give psychotherapy | 9 (40.9) | 7 | 2 |
| | Refer them after giving them some treatment | 16 (72.7) | 15 | 1 |
| | Refer them without any treatment | 1 (4.5) | 1 | 0 |
| | Admit them if they are severely ill | 2 (9.1) | 0 | 2 |
| | **Total** | **37 (168.2%)** | | |
| **Category 3 Where Mental Health Patients are Referred** | To a national hospital | 7 (31.8) | 5 | 2 |
| | A specialist private Mental Hospital/clinic | 2 (9.1) | 1 | 1 |
| | To a CAM (Complementary and Alternative Medicine) practitioner | 1 (4.5) | 1 | 0 |
| | Kisumu County Referral Hospital (KCRH) | 20 (90.9) | 19 | 1 |
| | **Total** | **30 (136.4%)** | | |
| **Category 4 Reasons for Referral** | Lack of expertise in mental health | 18 (81.8) | 18 | 0 |
| | Lack of drugs for mental health | 13 (51.1) | 13 | 0 |
| | Lack of testing equipment | 11 (50.0) | 10 | 1 |
| | Lack of admission commodities | 15 (68.2) | 14 | 1 |
| | Other special procedures | 2 (9.1) | 0 | 2 |
| | **Total** | **59(268.2%)** | | |

A predominant theme that consistently surfaced pertained to the sustainability of services. The majority of mental health care services and programs heavily rely on support from donors and partners. An emerging obstacle impacting service availability was scarcity of necessary resources, including adequate rooms and facilities essential for delivering these crucial services.

*"Majority of the programmes & personnel offering mental health services in the county are paid and in supported projects from donor fundings. When funding is not there, it means our services are stopped." (Interview 12)*

*"I would not say the facility itself has the capacity to still run and sustain minus the support from the partner. They are still going to be a lot of gaps, and for now this is still running because the partner is still maintaining. The bigger question how long the facility will be able to sustain it, that is the services and even the facilities without the partners." (Interview 6)*

As shown in table 2, study assessed the adequacy of financial resource allocation and collaboration for mental health care. The findings reveal the allocation and collaboration for mental healthcare is very low (VL). Among the facilities, 29.5% responded yes to adequate financial resource allocation and collaboration, while 70.5% said no to adequate financial resource allocation and collaboration. However, the difference in level of allocation of financial resources and collaboration for mental healthcare among level 4 and level 5 facilities in Kisumu County did not reach statistical significance (p-value = 0.418).

**Table 2: Frequency Distribution of Financial Resource Allocation Mental Healthcare among Level 4 and Level 5 Facilities in Kisumu County.**

| S/N | Items | Yes | No | Dec | p-value |
|---|---|---|---|---|---|
| | **Financial Resource Allocation** | **F %** | **F %** | | |
| **1** | In the facility budget, is there financial allocation that support mental health? | 5 (22.7) | 17 (77.3) | VL | 0.411 |
| **2** | Given that the current mental health policy covers the period 2015 up to 2030; has there been any observable difference in mental health services since 2015, as compared to the period before in this facility, in terms of Mental Health Budgetary Allocation? | 9 (40.9) | 13 (59.1) | L | 1.000 |
| **3** | Has the proportion of the budget allocated to mental healthcare in this facility been sufficient? | 1 (4.5) | 21 (95.5) | VL | 0.091 |
| | **Average Scores** | **5 (22.7%)** | **17(77.3%)** | **VL** | **0.501** |

*n = 22 facilities, statistically significant at p≤ 0.05*

Facilities suffer considerable shortage of financial resources. A dependence on external partners is evident, currently majority of mental healthcare services are majorly supported by external partners and donors, this however, is not sustainable. The county is unable to sustain mental health services independently

> *"While partners have played a significant role, it's important to acknowledge that but there are still considerable gaps in meeting the county's needs. Partners assess their capacity to support specific events or activities based on their budget constraints. If their budget allows, they contribute; otherwise, they are unable to support the county fully. This situation is not sustainable, and it emphasizes the need for the county to explore alternative solutions. As mentioned earlier, the limited allocation of funds for mental health in their budgets poses a significant challenge that requires strategic resolution." (Interview 3)*

The policy advocates for increased budgetary allocation to mental health services to meet WHO standards. However, in Kisumu County, only 22.7% of Level 4 and Level 5 facilities have a mental health budget, with 77.3% lacking one. Of these, 29.5% find the allocation adequate, while 70.5% do not. Limited budgets are mainly used for procuring drugs and paying practitioners, leading to a shortage of resources for sustaining broader mental health services. Our findings aligns with reports from the World Health Organization (WHO) and other studies (Chisholm *et al.,* 2019) (*WHO Report Highlights Global Shortfall in Investment in Mental Health*) indicating a severe underfunding of mental healthcare in Low- and Middle-Income Countries (LMICs).In Kenya, funding sources should ideally come from both the national and county levels (*Kenya-Mental-Health-Policy*) Many mental health services in these facilities rely on external partners and donors due to inadequate internal funding, creating uncertainty and sustainability concerns. This dependency can lead to inconsistent service provision. Therefore, there is an urgent need for Kisumu County to shift from short-term donor support to more sustainable funding sources for mental healthcare. This viewpoint is echoed in reports by (Mackenzie & Kesner, n.d.) and (Gilbert *et al.,* 2015) both advocating for dedicated funding for mental health services and encouraging investment by the governments of developing countries. Inadequate financial resources in Kisumu County's Level 4 and Level 5 facilities hinder the implementation of the Kenya Mental Health Policy [2015-2030]. Insufficient budgets affect the availability and quality of mental health services, leading to unmet needs and inadequate care. Heavy reliance on donor funding is unsustainable and uncertain. Without clear and adequate budgets, strategic planning and execution of mental health programs are impeded, slowing policy progress. The lack of mental healthcare budgets in most facilities deviates from policy recommendations to meet WHO standards. To bridge this gap, significant efforts are needed to increase budgetary allocations for mental health care in the county.

**Table 3: Multiple Response Crosstabs Analysis on Capacity of Human Resource for Mental Health Patients among Level 4 and Level 5 Facilities**

| | Human Resource Capacity for MHP | Responses - n (% of cases) | Level of Facilities | |
|---|---|---|---|---|
| | | | County Level 4 | Referral Hospital Level 5 |
| **Category 1** | Psychiatrists | 5 (22.7) | 3 | 2 |
| | Psychologist | 2 (9.1) | 0 | 2 |
| | Mental health nurses | 5 (22.7) | 4 | 1 |
| **Categories of Healthcare Providers** | Occupational therapists | 9 (40.9) | 7 | 2 |
| | General medical officers but attending to mental patients | 5 (22.7) | 4 | 1 |
| | General clinical officers but attending to mental patients | 16 (72.2) | 15 | 1 |
| | General nurses but attending to mental patients | 13 (59.1) | 11 | 2 |
| | None | 3 (13.6) | 3 | 0 |
| | **Total** | **58 (263.6%)** | | |
| **Category 2** | Psychiatrists | 5 (22.7) | 3 | 2 |
| | Psychologists | 2 (9.1) | 0 | 2 |
| **Staff that receive 2 days fresher training on mental health in the past 1year** | Mental health nurses | 4 (18.2) | 3 | 1 |
| | Occupational therapists | 4 (18.2) | 2 | 2 |
| | General medical officers but attending to mental patients | 1 (4.5) | 0 | 1 |
| | General clinical officers but attending to mental patients | 11 (50.0) | 10 | 1 |
| | General nurses but attending to mental patients | 9 (40.9) | 7 | 2 |
| | None | 5 (22.7) | 5 | 0 |
| | **Total** | **41(186.4%)** | | |
| | | **Yes (%)** | **No (%)** | **Dec** |
| **Category 3** | Given that the current mental health policy covers the period 2015 up to 2030; has there been any observable difference in mental health services since 2015, as compared to the period before in this facility, in terms of Number of trainings on mental health | 7 (31.8) | 15(68.2) | VL |
| **Progress in Training** | Are there any Continuous Professional Training in Mental Health organized within the facility? | **8 (36.4)** | 14 (63.6) | VL |

The study reveals a shortage of mental healthcare professionals. Resulting in a heavy reliance on general medical staff who often lack specialized training in mental health care. A challenge in

sustaining mental health personnel due to donor dependency means the risk of interruptions in mental health services.

*"Majority of the personnel offering mental health services in the county are paid and supported projects from donor fundings. When funding is not there, it means our services are stopped and we can only but volunteer to give these services which is not sustainable" (Interview 9)*

*"The personnel, the number for those needing these services is too high and sometimes what we have is unable to meet this. What we are still fighting for is for every facility to have a psychiatric and a psychologist, social workers. This will help have the patients receive the services in their areas if the personnel is improved down to the sub counties, not having them travel for long distance to get these services at KCRH or JOORTH" (Interview 7)*

The WHO highlights mental health personnel as crucial for effective care. The Kenya Mental Health Policy [2015-2030] advocates integrating mental health training into all health workers' curricula, yet discrepancies persist. Many facilities lack trained mental health professionals, with some having none, and no Level 4 facilities have psychologists, revealing significant service gaps. The county's failure to employ diverse mental health professionals and provide specialized training to general medical officers and nurses limits care quality. This uneven distribution and inadequate training hinder the policy's implementation and compromise mental health service quality and coverage. The shortage of specialized mental health providers within the public sector mirrors the challenges documented in various studies conducted in the country (Miseda *et al.,* 2017) (Okoroafor *et al.,* 2022), as well as in Kilifi (Bitta et al., 2017), a study encompassing four counties in western Kenya (Kwobah et al., 2023b), and another conducted in Makueni County (Mutiso *et al.,* 2020). All these studies consistently highlight a scarcity of human resources for mental health service provision. Underscoring the systemic nature of the issue of mental health (Kakuma *et al.,* 2011).

The policy calls for in-service mental health training and more mental health worker recruitment. However, coverage is inadequate, with only 50% of general clinical officers and 40.9% of nurses receiving brief training. Since 2015, only 31.8% of facilities report improvements in mental health services, and 36.4% report ongoing professional training, indicating the policy's goals are unmet. Investing in continuous education is essential for improving mental healthcare quality and patient outcomes, as it ensures healthcare professionals stay updated on best practices and advancements in the field. This is supported by previous studies as a key to reducing treatment gap and achieving universal health coverage (Koly *et al.,* 2021) (Kakuma et al., 2011).

The county has initiated the adoption of task shifting in many of its sub-counties for mental healthcare provision. Task shifting initiatives have been implemented with psychiatrists training other health providers to offer mental health services. Clinicians at sub-county hospitals, particularly in Comprehensive Care Centers (CCCs), have been trained to provide treatment for mental conditions, alongside HIV care.

> *With task shifting, psychiatrists are now training other health providers to offer mental health services. Our service provision structure ensures accessibility within residential areas. In Seme County, we've extended training to community health volunteers (CHVs). They conduct screenings and refer individuals to nearby health facilities within their designated catchment areas. (interview 2)*

In low and middle-income countries (LMICs), with very few of the world's mental health resources task shifting has emerged as a prevalent approach to tackling the scarcity of mental health professionals, aiming to narrow the disparity in mental healthcare provision. This method entails deploying individuals without specialized mental health training or experience to provide care, although under supervision(Patel *et al.,* 2007) (Patel, 2009). Recent studies, including the Cochrane review (Ginneken *et al.,* 2013), provide evidence supporting its efficacy as a strategy to bridge the gap in mental health treatment. While task shifting shows promise, Kisumu County must strengthen human resources in Level 4 and 5 facilities. Many mental healthcare providers are employed through partner-supported projects, which is unsustainable. There is a need to extend training and follow-up beyond Comprehensive Care Centers to ensure broader service coverage. Limited evaluation of this approach has occurred, necessitating rigorous expansion and supervision to maximize impact. This aligns with policy recommendations for monitoring and evaluation to ensure quality outcomes (Kinuthia *et al.,* 2022). Increasing county staffing, especially for low-cadre roles like counselors, alongside training and resource allocation, could enhance comprehensive mental healthcare services in these facilities.

## 5.0 CONCLUSION AND RECOMMENDATIONS

### 5.1 Conclusion

This study was conducted to assess organizational capacity in the implementation of KMHP 2015-2030, in Kisumu County, Kenya, focusing on the availability of mental health services, financial resource allocation, and human resource capacity at public level 4 and 5 facilities. The study uncovers significant gaps in mental healthcare services in Kisumu County's Level 4 and 5 facilities, hindering access to equitable, high-quality care. These gaps stem from inadequate financial resources, a lack of specialized professionals, and limited training opportunities, compromising the facilities' ability to implement policy effectively. To bridge these gaps, increased financial investment, enhanced infrastructure, and comprehensive training and retention strategies for mental health professionals are essential. Addressing these barriers is crucial for aligning with the Kenya Mental Health Policy [2015-2030] and ensuring equitable access to high-quality mental healthcare across the county.

### 5.2 Recommendations

To improve mental healthcare, it is essential to expand service support to cover specialized care, drug rehabilitation, and community psychotherapy while enhancing management at facility levels to reduce reliance on referrals. Increasing financial resource allocation is crucial for comprehensive

care provision. Investing in the recruitment and retention of mental healthcare professionals, alongside ongoing training and professional development, is vital for enhancing staff capabilities. Future studies should evaluate the effectiveness of task shifting initiatives in bridging gaps in mental healthcare and explore alternative funding mechanisms to reduce dependency on external donors. These steps aim to improve access, service quality, and the overall performance of the mental health system.

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