

Integration of mental health into primary care in Kenya

RACHEL JENKINS¹, DAVID KIIMA², FRANK NJENGA³, MARX OKONJI³, JAMES KINGORA⁴, DAMMAS KATHUKU⁵, SARAH LOCK⁶

¹WHO Collaborating Centre, Institute of Psychiatry, Kings College, London, UK; ²Ministry of Medical Services, Kenya;

³Kenya Psychiatric Association; ⁴Kenya Medical Training College; ⁵University of Nairobi, Kenya; ⁶Nuffield Foundation, London, UK

Integration of mental health into primary care is essential in Kenya, where there are only 75 psychiatrists for 38 million population, of whom 21 are in the universities and 28 in private practice. A partnership between the Ministry of Health, the Kenya Psychiatric Association and the World Health Organization (WHO) Collaborating Centre, Institute of Psychiatry, Kings College London was funded by Nuffield Foundation to train 3,000 of the 5,000 primary health care staff in the public health system across Kenya, using a sustainable general health system approach. The content of training was closely aligned to the generic tasks of the health workers. The training delivery was integrated into the normal national training delivery system, and accompanied by capacity building courses for district and provincial level staff to encourage the inclusion of mental health in the district and provincial annual operational plans, and to promote the coordination and supervision of mental health services in primary care by district psychiatric nurses and district public health nurses. The project trained 41 trainers, who have so far trained 1671 primary care staff, achieving a mean change in knowledge score of 42% to 77%. Qualitative observations of subsequent clinical practice have demonstrated improvements in assessment, diagnosis, management, record keeping, medicine supply, intersectoral liaison and public education. Around 200 supervisors (psychiatrists, psychiatric nurses and district public health nurses) have also been trained. The project experience may be useful for other countries also wishing to conduct similar sustainable training and supervision programmes.

Key words: Kenya, primary care, training, supervision, mental health

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Kenya is one of the poorest countries in the world, ranked 144 out of 177 countries in the United Nations Human Development Report for 2007. Gross national income per capita was 520 USD in 2005, and 770 USD in 2008. The population is estimated to be 38 million and life expectancy is 54 years. More than 1 in 10 children die before the age of 5, and 4 women out of every 1,000 die in child birth. The prevalence of HIV is 7.7% in women and 4% in men.

Kenya had been assumed to have more political stability than many African states but, in the context of unemployment, economic disparities and widespread concerns about access to ancestral lands, there was widespread violence immediately after the 2007 general election, leading to ethnic division, displacement of around 500,000 people and more than 1,300 deaths. The conflict damaged the tourist industry, aggravating economic problems and poverty, while climate change is affecting rainfall, aggravating famine in various parts of the country.

Kenya spends only around 10 USD per capita per year on health. Investment in health largely focuses on communicable diseases, especially HIV and malaria. Population access to health care remains very restricted, with only 1-2 nurses and clinical officers for each 10-20,000 population, and no doctors at primary care level in the public system.

The Kenya general health system is broadly structured into six levels: the national general and national specialist referral hospitals (level 6), provincial general hospitals (level 5), district and subdistrict general hospitals (level 4), health centres, maternity and nursing homes (level 3), dispensaries (level 2) and the community (level 1). The community level comprises families and households. For every 100 households there is supposed to be a community health worker,

selected by the community for the role, and given relatively short but frequent training by level 2 and 3 staff. Community health workers are trained in prevention, promotion, and identification of health problems, and in appropriate interventions including referral to the dispensary. They are coordinated by community health extension workers, who are health workers at level 2 and 3.

Kenya has 75 psychiatrists, of whom 21 are in the university system and 28 in private practice. It has around 500 psychiatric nurses, of whom only 250 work in mental health, deployed at the national, provincial and district levels, so that each district of around 150,000 will have only one or rarely two psychiatric nurses. Since the global prevalence of mental disorders is around 1% for psychosis and 10% for common mental disorders, this means that each district will have 1,500 people with psychosis and 15,000 people with common mental disorders. Therefore, unless mental health is integrated into the levels 1, 2 and 3 of the health system, population access to mental health care will be very severely restricted to the case load which can be borne by one mental health worker in each district.

The only way the system can deliver mental health care to the population is if primary care is strengthened to be a key stage in the pathway between the community and the district level. Indeed, people with mental disorders are already attending primary care, but apart from those with psychosis, which is relatively easy even for lay people to diagnose, those with depression, anxiety and other common mental disorders are usually misdiagnosed as having a physical illness.

The integration of mental health into primary care has been a policy objective in Kenya for two/three decades (1), but there was no specific allocation of resources to imple-

ment this, and no continuing professional development for staff on mental health in levels 1-4. Appreciating this dilemma, the Kenya Ministry of Health (MOH) entered into a partnership with the World Health Organization (WHO) Collaborating Centre at the Institute of Psychiatry of London, the Kenya Medical Training College (KMTC) and the Kenya Psychiatric Association, which was funded by Nuffield Foundation, to establish a national programme to integrate mental health into primary care.

The project aimed to train 3,000 of the 5,000 primary health care staff in the public health system across Kenya, using a sustainable general health system approach, with the content of training closely aligned to the generic tasks of the health workers, and the training delivery integrated into the normal national training delivery system. The primary care training programme was accompanied by capacity building workshops and courses aimed at level 4 and 5 staff. These were designed to encourage the inclusion of mental health in the district and provincial annual operational plans, and to promote the coordination and supervision of mental health services in primary care by district psychiatric nurses and district public health nurses.

THE PROGRAMME AND ITS OUTCOME

The project started in May 2005. Curriculum and teaching materials were developed by the WHO Collaborating Center in dialogue with Kenya partners, based on the Kenya adaptation of the WHO primary care guidelines. The training was piloted in three courses delivered in 2005 to 20 senior KMTC and MOH staff, and 41 selected trainers from KMTC in Nairobi, its provincial medical training colleges and MOH rural health training centres. Following the training of trainers, the training has been rolled out across the country, firstly at the national KMTC, then at six selected provincial training centres during the last four years. All nurses and clinical officers working in dispensaries and health centres are eligible for the training. They are called up in turn via their district medical officer of health. The teachers are trained teaching staff (nurses and clinical officers), who themselves experienced the course delivered by the project leaders.

The training programme for primary care is a five day course, and consists of five modules, the first covering core concepts (mental health and mental disorders, and their contribution to physical health, economic and social outcomes); the second core skills (communication skills, assessment, mental state examination, diagnosis, management, managing difficult cases, management of violence, breaking bad news); the third common neurological disorders (epilepsy, Parkinson's disease, headache, dementia, toxic confusional states), the fourth psychiatric disorders (content based on the WHO primary care guidelines for mental health, Kenya adaptation) and the fifth health and other sector system issues of policy; legislation; links between mental health and child health, reproductive health, HIV and malaria; roles and responsibili-

ties; health management information systems; working with community health workers and with traditional healers; and integration of mental health into annual operational plans.

The course is conducted through multi-method teaching of theory, discussion, role plays and videos, with a major emphasis on acquisition of practical skills and competencies for assessment, diagnosis and management. The role plays, videos, discussions and theoretical slides are accompanied by the WHO primary care guidelines. Each participant has to complete over 25 supervised role plays on different topics in the course of the week, and to observe and comment on 25 role-plays conducted by colleagues. The WPA videos on depression, psychosis and somatization were also used in the training (2).

Phase 1 testing of the training intervention included: a) iterative improvement of the course, based on feedback from teachers and students on the early courses; b) detailed collated written feedback from participants, regularly scrutinized by teachers and by the project manager; c) pre- and post-test evaluation of the first 1000 trained; d) examination of routine data collected before and after training in two districts; e) supervision observations of clinical practice in 15 health facilities across three districts, which were visited at the request of the Ministry of Health, in order to appraise how efficient and effective was the working of the level 2 and 3 service providers in mental health management following their participation in the training course. A phase 2 exploratory cluster randomized controlled trial will be conducted later this year.

A total of 1,673 primary care staff have been trained to date. The mean change in knowledge score for the first 1,000 participants was 42% to 77%. In addition, four special courses have been run for the 8 provincial psychiatrists and around 200 district psychiatric nurses and district public health nurses to give routine support and supervision to primary care.

Fifteen health facilities across two districts were visited by a senior psychiatric nurse to audit practice. The observer found that, where staff had been trained, they were knowledgeable about mental disorders. Their communication skills and therapeutic relationships with patients and relatives were well above average, their ability to take a history and assess mental state was good, and they were all actively engaged in the delivery of mental health care. The trained health professionals were much more aware of the relationship between mental disorders and communicable diseases such as malaria, amoebiasis, and typhoid fever; and between mental disorders and non-communicable diseases such as musculoskeletal disorders, diabetes, and asthma.

Almost all the health facilities where staff had been trained have started intersectoral networking liaison with community chiefs, spiritual leaders, traditional health practitioners, community health workers and any local non-governmental organizations. Many of the centres visited have set up a special locked cupboard for their psychotropic drugs. The trained staff have managed to establish good and consistent



supplies of the commonly used drugs, in collaboration with the district pharmacist and the district mental health nurse. Most of the facilities visited maintain a clinic register for people with continuing mental disorder. The facilities are organizing close links between the patients' relatives, resulting in active community involvement in the management of people with mental disorder.

The course is approved for 40 hours of continuing professional development and will now be run on a long-term basis by KMTC as one of their programme of short courses.

A cluster randomized controlled trial of the training course has been conducted in Malawi and will report shortly. A multi-component evaluation is also being carried out in Iraq. The course has been also conducted in Nigeria (3) and is going to be carried out in Sri Lanka, as part of the WPA Action Plan 2008-2011 (4).

DISCUSSION

This project has demonstrated that it is possible to train front line health workers with a short five day interactive course in mental health, using relatively small scale funds, local trainers, and a project management system embedded in a local training system, and to achieve effective outcomes of improved knowledge and practice, and skills transfer to others. The course is a complex balanced interdependent combination of skills, competencies and knowledge, which takes an intersectoral and health systems approach.

We recommend that similar efforts to train front line health workers should work in partnership with the Ministry of

Health, and in the context of the country's health policy and mental health policy. Such projects should agree with the Ministry of Health the appropriate local training institution for primary care, and work through that organization to train local trainers who are likely to remain in post for a long time. Call up of participants should be through the Ministry of Health to ensure that appropriate people attend for training. Such projects should also organize reinforcement of training by the provision of locally tailored good practice guidelines which the participants can then use for years after the training; by course handouts; and by regular supervision from the district level. Thus, supervisors also need to be trained, so that they have a good understanding of their supervisory role and skills.

Progress of such projects needs to be carefully monitored, and action taken as soon as possible to keep projects on track. Flexible funding to enable projects to weather unpredictable events such as conflict and rampant inflation, and to respond to changing health sector reforms, greatly assists long-term sustainability after such project funding has ended.

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