MENTAL HEALTH CHALLENGES AND PROSPECTS IN KENYA

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Today Kenya has 77 psychiatrists, 418 mental health nurses and 30 clinical psychologists and a much bigger number of counseling psychologists for a population of just below 40 million. Kenya has been lucky in that for more than 20 years there has hardly been any external immigration of psychiatrists but internal migration has led to inequitable distribution of the psychiatrists, with the majority in urban areas. Nearly all of these psychiatrists except 7 have been trained at the Department of Psychiatry, University of Nairobi, the only institution that trains psychiatrists in Kenya. The number of psychiatrists currently being trained is just under 20 and a similar number of clinical psychologists; also postgraduate diploma in substance use, psychiatric social work and Psychotrauma, all at the same Department. The same Department has trained and continues to train psychiatrists and mental health personnel for Rwanda, Tanzania, Zambia, Namibia, Southern Sudan and Somalia. There are several institutions, both public and private that are training on Counseling Psychology at undergraduate and Masters Level.

There are 2 fully developed public medical schools (and several others at various stages of development) with a yearly turn over of about 500 doctors who had to pass a University Examination in Psychiatry before graduation. There is a mid-level college that trains psychiatric nurses but it is facing challenge of attracting

students because increasingly more students are opting for University level education. We have no training in the equivalent of clinical officers in psychiatry although talk about this has been on the offing for sometime.

At policy level, Kenya has a Director of Mental Health who sits at the Ministry of Health Headquarters, with the title of a Deputy Director of Medical Services. He has a Deputy who is a Psychiatrist and also a Psychiatrist nurse and occupational therapists to assist him. Although there is a Mental Health Act, there is no mental health policy but there are attempts to fast-track and finalize it. The budgetary allocation for mental health is inadequate (about 0.02% of the total medical services budget). The rest of the mental health aspects in Kenya can be obtained from the now outdated WHO Mental Health Atlas (2005).

Apart from Human Resource development and the move toward mental health policy in Kenya there is a past emerging mental health research and advocacy. This is mainly through the civil society in collaboration with international bodies (civil and universities) with very strong Government support and good will. A few examples will suffice. The BasicNeed UK in Kenya has been involved in Advocacy and Governance in relation to mental health. It advocates for people with all kinds of mental disability including intellectual abilities and epilepsy. It is functional in several areas of Kenya. The User Movement in Kenya is nationally and internationally recognized for its advocacy for people with mental illness. The Kenya Association of people With Epilepsy (KAWE) is involved at community level to support people with epilepsy. The Alzheimer's Association of Kenya, a movement of caregivers for relatives with Alzheimer's disease under the auspices of Africa Mental Health Foundation (AMHF) is fast gaining influence. The Samaritans Kenya group under the auspices AMHF seeks to reach out for people who are suicidal. There is a vibrant medical Board at Mathari Hospital that has over the last 20 years transformed Mathari Hospital so that same of wards parallel and compete for patients with some of the private beds in the city of Nairobi. Other aspects aimed at de-stigmatization of mental illness include the

yearly observances of mental health day at all levels of medical services culminating in National observance, mental health radio and TV shows and various publications.

There is active research going on several aspects of mental health led mainly by AMHF in collaboration with various Government Departments and several research organizations both locally and internationally. Of note is the community based Task Shifting aimed at addressing amongst others stigma towards mental illness and delivering services beyond the health centre to the family level.

Like most LMIC countries all over the world, we still have a long way to go in reducing the treatment gap. This will have to be done through innovative ways that cannot afford to adopt the model being applied in the resource rich Western countries, but a model that seeks to map out and mobilize the resources that we already have and provide appropriate skills. It is possible that taking this approach, it should be possible, in the very near future, to significantly reduce the treatment of gap.