Kwale County
Department of Health Services

# MENTAL HEALTH STRATEGIC ACTION PLAN

## 2026 - 2030

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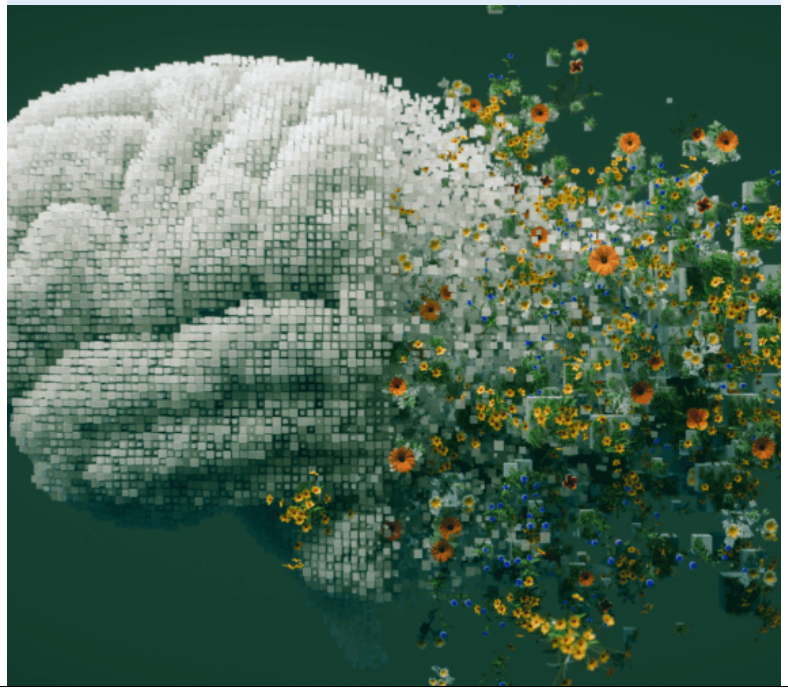
# List of Acronyms

| | | | |
|---|---|---|---|
| **ADHD** | Attention-Deficit Hyperactivity Disorder | **M&E** | Monitoring and Evaluation |
| **ADP** | Annual Development Plan | **LMICs** | Lower Middle-Income Countries |
| **AWP** | Annual Work Plan | **MH** | Mental Health |
| **ASD** | Autism Spectrum Disorder | **MHSAP** | Mental Health Strategic Action Plan |
| **APHRC** | African Population and Health Research Center | **MNS** | Mental Health, Neurological, and Substance use |
| **CECM** | County Executive Committee Member | **MNTRH** | Mathari National Teaching and Referral Hospital |
| **CHAs** | Community Health Assistants | **MOE** | Ministry of Education |
| **CHC** | Community Health Committee | **MSCC** | Multi-sectoral Coordinating Committee |
| **CHD** | County Health Department | **MSM** | Men who have sex with men |
| **CHU** | Community Health Unit | **NACADA** | National Campaign Against Drug Abuse Authority |
| **CHMT** | County Health Management Team | **NCPWD** | National Council for Persons with Disability |
| **CHPs** | Community Health Promotors | **NGOs** | Nongovernmental Organizations |
| **CHVs** | Community Health Volunteers | **PCN** | Primary Care Network |
| **CIDP** | County Integrated Development Plans | **PSS** | Psychosocial Support |
| **CME** | Continuous Medical Education | **PTSD** | post-traumatic stress disorder |
| **COP** | Community of Practice | **PWDs** | People with Disabilities |
| **CSOs** | Civil Society Organizations | **PWID** | People who Inject Drugs |
| **CTRH** | County Teaching and Referral Hospital | **PWUD** | People who use Drugs |
| **ECT** | Electroconvulsive Therapy | **QITs** | Quality Improvement Teams |
| **EEG** | Electroencephalogram | **SAP** | Strategic Action Plan |
| **EPSE** | Extrapyramidal Side Effect | **SCH** | Sub-county Hospital |
| **FSW** | Female Sex Workers | **SDG** | Sustainable Development Goal |
| **GDP** | Gross Domestic Product | **SGBV** | Sexual Gender Based Violence |
| **IEC** | Information, Education, and Communication | **SHA** | Social Health Authority |
| **ICT** | Information, Communication, and Technology | **SHP** | Self-Help Group |
| **KCDF** | Kenya Community Development Programme | **SOP** | Standard Operating Procedures |
| **KEPH** | Kenya Essential Package for Health | **SSA** | Sub Saharan Africa |
| **KES** | Kenya Shilling | **TOR** | Terms of Reference |
| **KHIS** | Kenya Health Information System | **TOTs** | Trainer of Trainers |
| **KVPs** | Key and Vulnerable Populations | **TWG** | Technical Working Group |
| **HC** | Health Center | **UHC** | Universal Health Coverage |
| **HCW** | Health Care Worker | **UN** | United Nations |
| **HERAF** | Health Rights Advocacy Forum | **WHO** | World Health Organization |
| **HIS** | Health Information System | **WMWPs** | Workplace Mental Wellness Programs |
| **K-NAMHS** | Kenya National Adolescent Mental Health Survey | | |
| **MAT** | Medication Assistant Treatment | **YLD** | Years Lived with Disability |

# Beneath the Surface



## Partners

HERAF Transforming Health System

KCDF people, giving and working together

KCP KWALE . COMMUNITY . OF . PRACTICE

APHRC African Population and Health Research Center
Transforming lives in Africa through research

# Foreword

The Kwale County Mental Health Strategic Action Plan (MHSAP) 2026–2030 is the first comprehensive strategy developed to guide the health sector in the implementation of mental health interventions within the county. This Action Plan reflects our collective commitment to pursuing strategies that promote and safeguard the optimal mental health of every individual in Kwale County.

Developed under the leadership of the County Department of Health, through a broad consultative process with key stakeholders, the plan acknowledges the existing resource gaps that have hindered the provision of quality and comprehensive mental health services at all levels of care.

Anchored on the Constitution of Kenya 2010, Kenya Vision 2030, the Kenya Mental Health Policy (2015–2030), and the Kenya Mental Health Action Plan 2021–2025, this SAP aspires to ensure the attainment of the highest possible standard of mental health across all levels of healthcare. It envisions a county where every resident enjoys optimal mental well-being.

**Guided by the county's mental health priorities, the Action Plan seeks to achieve four strategic objectives:**

1. Strengthening effective leadership and governance for mental health.
2. Implementing strategies for the promotion of mental health and the prevention of substance use and related disorders.
3. Ensuring equitable access to comprehensive, integrated, and high-quality promotive, preventive, curative, palliative, and rehabilitative mental health services.
4. Strengthening mental health systems, including information management and research.

To realize these objectives, the Action Plan emphasizes evidence-based interventions and the adoption of a multi-sectoral approach. Under the stewardship of the County Department of Health, all actors in the mental health space—state and non-state—will have opportunities to meaningfully engage at county, sub-county, and community levels. Mechanisms for coordination and collaboration with non-state actors will also be established to ensure inclusivity and sustainability.

It is my firm conviction that, working together in unity and with shared purpose, we can transform the mental health landscape in Kwale County. For effectiveness and efficiency, let us all embrace the multi-sectoral approach in addressing mental health and substance use disorders in our communities.

**Dr. Mwatsahu Francis Gwama, PhD**

**CECM – HEALTH SERVICES**

# Acknowledgment

The Kwale County Mental Health Strategic Action Plan 2026–2030 has been developed through a consultative and inclusive process involving the County Department of Health, the Department of Social Services and Talent Development, the State Department for Social Services and Senior Citizens, the Ministry of Education, the Ministry of Interior and National Administration, the National Council for Persons with Disabilities, the Court Users Committee (Judiciary), and several civil society organizations and community groups.

We gratefully acknowledge the financial and technical assistance provided by the Health Rights Advocacy Forum (HERAF) with support from Kenya Community Development Foundation (KCDF) and the African Population and Health Research Center (APHRC) in the development of this Strategic Action Plan. Special appreciation goes to the County Department of Health, whose leadership and guidance ensured that all the necessary resources and technical inputs were made available for effective planning and development.

We also extend our sincere gratitude to the technical team under the leadership of the County Director in the Department of Health. We acknowledge the dedication, commitment, and technical contributions of the various units within the health department, as well as representatives from health facilities, who played an active role in the development of this Action Plan.

The valuable contributions from the Kwale County Community of Practice, G for Girls, Diani Cerebral Palsy, Haki Yetu, Kenya Red Cross and organizations representing persons with mental health conditions: Maa-Swabrina, Mazingira Yetu SHP, and Neema Mwachindafu; are highly appreciated. Their partnership has enriched the Strategic Action Plan and reinforced the principle of inclusivity through a strong multi-sectoral approach.

We call upon all stakeholders and partners to continue embracing collaboration as they engage in the implementation of this Strategic Action Plan. Their investment, participation, and collective commitment will be instrumental in achieving the strategic objectives outlined herein by the year 2030.

**Dr. Kitsao Mjimba**
CHIEF OFFICER – CURATIVE AND REHABILITATIVE HEALTH SERVICES

**Athman Mwashando**
CHIEF OFFICER – PREVENTIVE AND PROMOTIVE HEALTH SERVICES

# Executive Summary

The Kwale County Mental Health Strategic Action Plan 2026–2030 (MHSAP 2026 – 2030) provides a comprehensive framework to guide coordination, planning, implementation, and monitoring of mental health interventions across the county. It represents the county's collective commitment to promoting mental well-being, preventing and managing mental, neurological, and substance use disorders, and strengthening systems to ensure that every resident of Kwale County can attain the highest standard of mental health. The plan was developed under the leadership of the County Department of Health through a consultative and participatory process that engaged health professionals, county officials, civil society organizations, community representatives, persons with mental health lived experience, and national partners.

Anchored in the Constitution of Kenya (2010), the Kenya Mental Health Policy (2015–2030), the Kenya Mental Health Action Plan (2021–2025), and Vision 2030, the Strategic Action Plan aligns with global frameworks such as the WHO Comprehensive Mental Health Action Plan (2013–2030) and the Sustainable Development Goals, particularly SDG 3 on good health and well-being. The plan builds on lessons from national reforms and leverages momentum toward Universal Health Coverage (UHC) to position mental health as a central pillar of the health system.

Globally, one in every eight people is affected by a mental disorder, which significantly contributes to the overall disease burden and loss of productivity. In Kenya, it is estimated that 25 percent of outpatients and 40 percent of inpatients exhibit symptoms of mental illness. According to the Kenya Mental Health Investment Case (2021), the national economic cost of mental illness exceeds KES 62 billion annually. In Kwale County, the situation mirrors this trend, with mental health conditions accounting for 294 cases per 100,000 people, while epilepsy accounts for 322 cases per 100,000. Additionally, substance use remains a major challenge, with over 2,300 individuals reported to be injecting drugs.

Despite the increasing demand for mental health services, provision remains limited in Kwale County. Out of 178 health facilities, only 30 offer mental health services, which are primarily found in higher-level facilities. This leaves primary and community health levels underserved.

Resources for enhancing mental health services are also scarce. The county does not have a specific budget line for mental health, making the implementation of services often reliant on donor funding. The human resource capacity is critically low, with only one psychiatrist, one clinical psychologist, two psychiatric nurses, and a small number of counselors and social workers available to serve the entire population of approximately 900,000 people. Additionally, infrastructure is inadequate, as most facilities lack dedicated mental health wards, rehabilitation centers, and private counseling spaces. The supply of psychotropic medications is inconsistent, and psychosocial support systems, such as peer networks, are still weak.

Several systemic and coordination gaps hinder effective service delivery. The county lacks functional mental health governance structures, and data collection tools remain weak, with poor integration of indicators into the Kenya Health Information System (KHIS). Stigma, discrimination, and low mental health literacy persist, discouraging help-seeking and disclosure. Additional barriers include the absence of sign language interpreters, limited support for children and adolescents with developmental or behavioral conditions, and weak inter-sectoral collaboration.

A SWOT (Strengths, Weaknesses, Opportunities, Threats/Challenges) analysis identified several strengths, including a growing pool of trained health workers, supportive leadership, active psychosocial clinics, and collaboration with partners. Opportunities are present in the ongoing national mental health reforms, the expansion of Universal Health Coverage (UHC), and partnerships with non-governmental organizations (NGOs) and faith-based organizations. However, weaknesses such as inadequate financing, poor infrastructure, a shortage of skilled personnel, and low community awareness continue to hinder progress. Additionally, threats and challenges like substance abuse, social stigma, and competing priorities remain persistent issues.

This Strategic Action Plan (SAP) envisions a county where all people enjoy optimal mental health and well-being. Its goal is to achieve the highest standard of mental health services across all levels, guided by principles of equity, human rights, inclusivity, evidence-based practice, and accountability. The SAP adopts a life-course and multi-sectoral approach, recognizing that mental health is shaped by social, economic, and environmental determinants.

Implementation of the SAP will be led by the County Department of Health, supported by a multi-sectoral coordination committee (MSCC) and a technical working group (TWG) at county and sub-county levels. Monitoring and evaluation will follow a results-based framework harmonized with national systems, using periodic reviews, stakeholder meetings, and joint learning forums to track progress.

**To realize this vision, the plan sets out four strategic objectives:**

1. To strengthen leadership and governance through functional coordination and policy development.
2. To enhance promotion and prevention through awareness, school-based and community interventions, and substance use prevention.
3. To improve access to comprehensive and quality services through integration into primary health care, strengthened referrals, and improved availability of medicines and skilled personnel.
4. To build resilient systems through improved data, research, resource mobilization, and accountability mechanisms.

Financing will be drawn from county allocations, national transfers, and partner support, with deliberate efforts to institutionalize mental health in the county's annual work plans and integrated development plan for sustainability.

Ultimately, the Kwale County MHSAP 2026–2030 offers a transformative roadmap for improving mental health outcomes, reducing stigma and discrimination, and promoting recovery and social inclusion. It underscores that mental health is central to the county's broader health and development agenda and calls for strong leadership, community engagement, and sustained investment to ensure that every individual in Kwale County lives with dignity, purpose, and hope.

**Dr. Hajara Elbusaidy**
**COUNTY DIRECTOR – HEALTH SERVICES**

CHAPTER 1

# Background

## Key Data Points on Mental Health

1 in 8 people

### Mental health is a global issue

**1 in 8 people** worldwide live with a mental health condition (WHO), costing the global economy US$ 2.5 trillion in 2010, projected to rise to US$ **6 trillion by 2030.**

Only 29%

### Massive treatment gaps persist globally

**Only 29%** of people with psychosis worldwide receive mental health services.
In low-income countries, treatment coverage drops to about 12%, compared to 70% in high-income countries.

Less than 2%

### Severe underinvestment in mental health systems

Countries spend less than 2% of health budgets on mental health on average.
**Over 70%** of mental health spending in middle-income countries still goes to psychiatric hospitals rather than community-based care.

0.6% of GDP

### Mental health burden in Kenya is high

Up to 25% of outpatients and 40% of inpatients in Kenya have mental health conditions.
Mental health disorders cost Kenya KES 62.2 billion (US$ 571.8 million) **annually—0.6% of GDP.**

30 Health facilities

## Kwale County faces critical service gaps

**Kwale County has only 31 mental health professionals serving the population, with no specific mental health budget allocation and only 30 out of 178 health facilities offering integrated mental health services.**

**Chapter 1:** →
**Background**

## 1.1 Definition and Determinants of Mental Health

The World Health Organization (WHO) defines mental health as a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well, work well, and contribute to their community[1]. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships, and shape the world we live in. Mental health is a basic human right, and it is crucial to personal, community, and socio-economic development. It is further stated that mental health is more than the absence of mental disorders. It exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes.

The determinants of mental health, as stipulated in the WHO Fact Sheet, include multiple individual, social, and structural determinants that may combine to protect or undermine our mental health and shift our position on the mental health continuum. Individual psychological and biological factors, such as emotional skills, substance use, and genetics, can make people more vulnerable to mental health problems. Exposure to unfavorable social, economic, geopolitical, and environmental circumstances – including poverty, violence, inequality, and environmental deprivation – also increases people's risk of experiencing mental health conditions. These risks can manifest themselves at all stages of life, but those that occur during developmentally sensitive periods, especially early childhood, are particularly detrimental.

## 1.2 Global Perspective for Mental Health

### 1.2.1. Prevalence of Mental and Behavioral Disorders and Consequences

Mental illness refers to suffering, disability, or morbidity due to mental, neurological, and substance use (MNS) disorders[2]. According to the WHO, in all countries, mental health conditions are highly prevalent affecting about one in eight people. Mental health conditions come with a variety of indirect costs associated with reduced economic productivity, higher rates of unemployment and other economic impacts[3]. Researchers from the World Economic Forum calculated that a broadly defined set of mental health conditions cost the world economy approximately US$ 2.5 trillion in 2010. This total cost was projected to rise to US$ 6 trillion by 2030.

### 1.2.2. State of Mental Health Systems and Services Coverage

Among the global targets stipulated in the Sustainable Development Goal (SDG) 3 to be achieved by 2030 are: 1) reducing by one-third premature mortality from non-communicable diseases through prevention, treatment and promoting mental health and well-being 2) achieving universal health coverage (UHC), including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. However, all over the world, mental health systems are marked by major gaps and imbalances in information and research, governance, resources, and services, as per the WHO Mental Health Report, 2022.

[1]https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

[2]Investing in Mental Health: Evidence for Mental Health, WHO, 2013

[3]World Mental Health Report: Transforming Mental Health For All, WHO, 2022

Based on the available information and research, the data is incomplete, and the research is insufficient. Less than five per cent of mental health research funding goes to low- and middle-income countries (LMICs) and most research is basic rather than clinical or applied. Governance gaps that exist include inadequate policies, plans, and laws; only 21% of countries report implementing policies and plans that fully comply with human rights instruments.

The limited implementation of mental health action plans, policies, and legislation is in part due to a lack of resources – both human and financial available for mental health. On average, countries dedicate less than 2% of their healthcare budgets to mental health. Within mental health budgets, community-based mental health care is consistently underfunded. Most countries spend less than 20% of their mental health budget on community mental health services. More than 70% of mental health expenditure in middle-income countries, compared with 35% in high-income countries, still goes towards psychiatric hospitals. Around half the world's population lives in countries where there is just one psychiatrist to serve 200,000 or more people, while in low-income countries, there are fewer than one mental health worker per 100,000 population. Across all income groups, there is a great shortage of specialized mental health workers for children and adolescents, with just three mental health workers of any kind per 100,000 population, and a median rate as low as 0.01 per 100,000 population in low-income countries. In these countries, the mental health workforce for children and adolescents is almost non-existent. Availability of affordable essential psychotropic medicines is limited, especially in LMICs, and far more people in these countries end up paying for these medicines out of pocket.

The gap between the prevalence of mental health conditions and the availability of treatment remains unacceptably wide globally, especially in LMICs, including those in SSA. Evidence shows that a significant number of people living with mental health conditions in LMICs do not receive any formal care at all, reflecting ongoing underinvestment and weak health system capacity. According to the WHO, only 29% of people with psychosis worldwide have access to mental health services; this coverage is much lower in low-income and SSA settings. While around 70% of individuals with psychosis in high-income countries receive treatment, this percentage drops to about 12% in low-income countries, many of which are located in SSA.

Treatment coverage for depression is also limited across regions, with especially severe gaps in LMICs. Even in high-income countries (HICs), only about one-third of people with major depressive disorder receive formal care, and coverage is significantly lower in most SSA countries, where services are rare and concentrated in urban areas.

In the context of LMICs and SSA, help-seeking for mental health conditions is further hindered by a combination of structural, socio-cultural, and economic barriers. These include poor-quality or fragmented services, a severe shortage of trained mental health professionals, low levels of mental health literacy, and widespread stigma and discrimination. In many SSA settings, formal mental health services are either non-existent or limited to a few tertiary facilities, making them geographically and financially inaccessible to most of the population. Even when services are available, out-of-pocket costs and fear of social exclusion discourage individuals from seeking care. As a result, many people in LMICs, particularly in SSA, endure prolonged mental distress without support, relying on informal, traditional, or religious coping mechanisms instead of formal mental health care.

## 1.3 The Mental Health Situation in Kenya

### 1.3.1 Prevalence and Burden of Mental and Behavioral Disorders and Consequences

In Kenya, it is estimated that up to 25% of outpatients and up to 40% of inpatients in health facilities suffer from mental conditions[4]. In addition, the probable prevalence of psychosis in Kenya is at an average of 1% of the population. The most frequent diagnoses of mental illnesses made in general hospital settings are **depression, substance abuse, stress, and anxiety disorders.** To note, there is scanty information about suicides in LMICs, but statistics from WHO estimate Kenya's crude suicide rate at 6.1 per 100,000 population, with age-standardized suicide rate of 11.0 per 100,000 population, which translates to about 4 suicide deaths per day[5]. Among the adolescents, a survey conducted in 2021 reported that over two-fifths (44.3%) of adolescents had a mental health problem in the past 12 months preceding the survey[6]. Despite there being no difference in overall prevalence of mental disorders between males (13.1%) and females (11.2%), at 5.6%, anxiety disorders had the highest prevalence of any mental disorder. Male adolescents had a higher prevalence as compared to female adolescents of Attention-Deficit/Hyperactivity Disorder (ADHD) (4.7% vs 2.3%) and conduct disorder (4.0% vs 1.5%). The survey reports that over 80% of those endorsing suicidal behavior (ideation, planning, and/or attempt) in the past 12 months had a mental health problem, while close to half had a mental disorder.

The Kenya Health Policy 2015 – 2030 highlights a link between the increasing burden of mental disorders and the rising rates of suicide, homicides, and domestic violence in Kenya. Additionally, the Kenya Mental Health Action Plan 2021-2025 indicates that persistent traumatic events—such as violence, disasters, and conflicts, along with factors like unemployment and poverty—may significantly contribute to the growing trends of post-traumatic disorders, anxiety, depression, and suicide among those affected[7].

The economic burden of mental health disorders in Kenya is reportedly high. According to the Kenya Mental Health Investment Case, in the year 2021, mental health conditions cost the Kenyan economy KES 62.2 billion, equivalent to US$ 571.8 million, and translating to 0.6% of the gross domestic product (GDP) in 2020[8]. These annual costs include KES 5.5 billion in health care expenditure and KES 56.6 billion in lost productivity due to premature mortality, absenteeism, and presenteeism. Absenteeism and presenteeism costs were highest for anxiety disorders, while bipolar disorder and alcohol use disorder were the costliest mental health conditions in terms of premature death.

### 1.3.2 Legal and Policy Frameworks for Mental Health in Kenya

In Kenya, the overarching legal framework that ensures a comprehensive rights-based approach to health services delivery is the Constitution of Kenya, 2010. Health laws and policies, including those related to mental health, should therefore be anchored on the Constitution of Kenya, 2010. The Kenya Government, through the Ministry of Health, takes leadership in the development of all health

[4]Kenya Mental Health Policy, 2015 – 2030.
[5]Kenya Suicide Prevention Strategy 2021 – 2026.
[6]Kenya National Adolescent Mental Health Survey, Kenya Findings, Survey, Brief.
[7]Kenya Mental Health Action Plan, 2021 – 2025.
[8]Kenya Mental Health Investment Case 2021, Providing Evidence for the Long-Term Health, Social and Economic. Benefits of Investment in Mental Health in Kenya.

policies, legislations, and sector strategic plans. In this regard, Kenya has developed policies and legal frameworks to create a supportive environment for the provision of mental health services.

The Mental Health (Amendment) Act, 2022, is the overall law that provides a more comprehensive framework for mental health services. It provides guidance on prevention, treatment, promotion of rights and access to care, including at the community level, and ensuring better coordination of services. Key policies that inform mental health programming includes the Kenya Mental Health Policy 2015-2030, the Mental Health Action Plan 2021-2025 and the Kenya Community Health Policy 2020-2030.

The national government, through the Ministry of Health, has developed guidelines for mental health and substance use disorders. The available national guidelines include the National Guidance on Integrating Mental Health into Key and Vulnerable Populations (KVPs) Programming in Kenya[9], the National Clinical Guidelines for Management of Common Mental Disorders, whose aim is to improve the quality of mental health care by providing a standardized approach to assessment, diagnosis, and treatment of common mental disorders[10]. The **National Protocol for Treatment of Substance Use Disorders in Kenya** provides a comprehensive continuum of services to promote recovery and enable the patient to fully integrate into society[11]. There are also National Guidelines on Workplace Mental Wellness[12] that provide recommendations for interventions to safeguard the mental well-being of employees, managers/supervisors, and organizations at the workplace. To effectively embrace digital technology in mental health, the national government has developed National Tele-Mental Health Guidelines[13]. These technologies may include telephone, mobile devices, video conferencing, email, text messaging, chat and internet-based services (e.g., social media).

### 1.3.3 State of Mental Health Systems and Services Coverage in Kenya

According to the Kenya Mental Health Policy (2015 – 2030), there is currently insufficient data and information regarding the prevalence of mental health issues in Kenya. A study conducted in 2020 revealed that the percentage of mental health research output, in relation to the country's total research output, was only 5.58%[14].

The Kenya Mental Health (Amendment) Act, 2022 provides a mental health governance and leadership function at both national and county levels[15]. At national level, the governance function is the Kenya Board of Mental Health and at the County level, the County Mental Health Council.

The Kenya Mental Health Policy 2015-2030 notes that Kenya is among the 28% of WHO member states that do not have a separate budget for mental health. Notably, Kenya spends 15 cents on mental health, while the recommended is KES 250 per capita. This has been a major impediment to the development of quality mental health services in the country. The policy states that there should be equitable resource sourcing and allocation for mental health services at all levels. The sources of funds should be from both the National and County governments, development partners, and non-state actors. Among the priority actions cited in the Mental Health Policy under financial resources is increasing the budgetary allocation to mental health services, in both national and county health sector budgets.

[9]National Guidance on Integrating Mental Health into Key and Vulnerable Populations Programming in Kenya.
[10]National Clinical Guidelines for Management of Common Mental Disorders, 2024.
[11]The National Protocol for Treatment of Substance Use Disorders in Kenya.
[12]National Guidelines on Workplace Mental Wellness.
[13]National Tele-Mental Health Guidelines January 2021.
[14]Mental Health Atlas 2020, Member State Profile (Kenya).
[15]Kenya Mental Health (Amendment) Act, 2022.

As for human resources for mental health, the Mental Health Policy acknowledges that there is an acute shortage of skilled mental health personnel. The Kenya Mental Health Investment Case, 2021, noted that nationwide, there are only 1,382 mental health professionals working under the 47 County governments and 354 employed by the National Government. The number of psychiatrists is particularly low, with only 23 working within the national government facilities and 30 across the 47 counties. However, to help address this shortage, the Kenya Mental Health Action Plan 2021 - 2025 aims to provide mental health training to 5% of healthcare providers in each county by 2025.

The Kenya Investment Case (2021) reported significant gaps in mental health care in Kenya, affecting the availability, quality, and affordability of services. Nationally, only 13% of health facilities (both private and government-run) offer at least one mental health service. The most commonly available mental health service is treatment of severe mental disorders such as depression, psychosis, or bipolar disorder (12%). The least available service is inpatient treatment for mental health conditions, with only 2% of facilities offering this service. Within the public sector, fewer than 1% of government-owned health facilities in Kenya provide mental health services. There are no mental health services in health facilities below level 4. Most mental health care is delivered in one specialized mental hospital (Mathari National Teaching and Referral Hospital (MNTRH)) and in general hospitals (levels 4, 5 and 6). The Investment Case of 2021 further states that there are only two public facilities for inpatient treatment and rehabilitation of persons with substance use disorders, and community-based mental health services are scarce and are mainly delivered by NGOs. It was also noted that the integration of mental health care into primary health care remains a major problem.

In addition, the Kenya Investment Case reported that, where mental health services are available, the facilities and equipment usually are not adequate to provide modern evidence-based treatment. The mental health services are of low quality and characterized by poor infrastructure, unsanitary conditions, coercive treatment practices, and limited delivery of psychosocial interventions. In addition, the supply of medicines for mental health care, including psychotropic drugs, is also limited. However, according to the Kenya Mental Health Policy 2015–2030, the essential drug list should include essential psychotropic drugs in adequate quantities and varieties.

According to the WHO Mental Health Atlas, 2020, there was no data on outpatient and inpatient facilities specifically for children and adolescents. This notwithstanding, the Kenya National Adolescent Mental Health Survey (K-NAMHS), found that the use of services for emotional and behavioral problems was low. In the 12 months preceding the study, fewer than one-tenth of adolescents (8.7%) had utilized any service that provides support or counselling for emotional and behavioral problems. Among these adolescents, the majority had accessed services from religious/faith leaders (34.2%) and school staff (31.9%). Only 10% had accessed services from doctors and nurses. Among primary caregivers reporting that their adolescents needed help for emotional and behavioral problems, nearly a quarter reported not being sure where to get help (24.3%) or preferred to handle the adolescent's problems themselves or with the support of family (24.1%).

Mental health promotion and prevention functioning programs were reported as being nonexistent as per the WHO Mental Health Atlas 2020 Member State Profile (Kenya). The programs included a suicide prevention program, mental health awareness / anti-stigma, early child development, school-based mental health prevention and promotion, parental/maternal mental health promotion and prevention, work-related mental health prevention and promotion, and mental health and psychosocial component of disaster preparedness, disaster risk reduction.

## 1.4 The State of Mental Health in Kwale County

In Kwale County, the data for the fiscal year 2022/2025 indicates that there were 294 new outpatient cases of mental health conditions per 100,000 population. Additionally, the number of outpatient cases for epilepsy was 322 per 100,000 population. 2,333 individuals inject drugs, and 227 use drugs. The data is not comprehensive due to the aggregated nature of the information captured in the Kenya Health Information System (KHIS). However, in 2024, a new county-specific tool was introduced to collect data on mental health services at facilities that provide these services.

On financial resources, the 2025/2026 fiscal year total budget allocation for the health sector was KES 2,882,946,944. The amount allocated for curative health services was KES 2,582,846,870, and for preventive and promotive healthcare services was KES 300,100,074[16]. This allocation translates to 29.7% of KES 9,709,768,508, which is the total county budget for fiscal year 2025/2026. However, no budget allocation is specific to mental health in the county budget for the fiscal year 2025/2026.

As per the Sector Annual Work Plan (AWP), 2024-2025, Kwale County has 824 core health workers, and the number of doctors and nurses is 82 and 571, respectively[17] Data on other cadres of human resources for health were not provided in a disaggregated format. Nonetheless, the County Sector Annual Work Plan, 2024-2025, stipulates that there were inadequate specialized health personnel for mental health. To address this challenge, the Sector AWP, 2024-2025, proposes the recruitment of specialized personnel and capacity strengthening of the existing staff.

The current total of available human resources for mental health is 31 professionals. This includes 1 consultant psychiatrist, 1 clinical psychologist, 1 clinical officer psychiatrist, and 1 medical psychologist. Additionally, there are 9 registered nurse psychiatrists (comprising 2 full-time, 3 part-time, and 4 who are not practicing), 17 counseling psychologists (with 9 full-time, 7 part-time, and 1 not practicing), and 2 counselors.

The governance and leadership structures for mental health in the county are incomplete. There exist mental health coordinators at county and sub-county levels and a mental health technical working group that provides leadership. The establishment of the governance structures, a county mental health council, is in progress.

Currently, there are 178 health facilities comprising one Country Referral Hospital, four Sub- County Hospitals, nine Health Centers, and 164 Dispensaries. In addition, there are 168 community units. Out of the 178 health facilities, 30 facilities apply an integrated approach in providing mental health services. At the community level, data collection on mental health is integrated into community data collection and reporting tools. However, community health promoters (CHPs) have not been trained in the provision of mental health services, nor are mental health services integrated in the provision of level one health services. On the provision of essential medical services, the Sector AWP, 2024-2025, identifies poor infrastructure as one of the challenges.

The County Integrated Development Plan (CIDP), 2023– 2027, identifies sector programs to be implemented that contribute to the occurrence of mental health and substance use disorders. Under the Curative and Rehabilitative Health Services Program, gender-based violence recovery centers will be established at Kinango, Samburu and Lungalunga hospitals. Improving access to gender-based violence mitigation services, a factor that may play a significant role in the rising trends of

[16]County Government of Kwale County Treasury, Medium Term 2025 County Fiscal Strategy Paper
[17]County Health Sector Annual Work Plan (AWP), 2024-2025

## Key Data Points
(WHO Mental Health Atlas 2020 – Kenya)

**Non-existent mental health promotion and prevention programmes:**

- Suicide prevention programme
- Mental health awareness / anti-stigma initiatives
- Early childhood development mental health programmes
- School-based mental health prevention & promotion
- Parental / maternal mental health promotion & prevention
- Workplace mental health prevention & promotion
- Mental health & psychosocial support in disaster preparedness & risk reduction

mental health disorders as stipulated in both the Kenya Mental Health Policy 2015-2030 and the Kenya Mental Health Plan 2021-2025, could contribute to mental wellness.

The number of health facilities offering mental health clinics to reduce the burden of ill health is the only mental health activity explicitly mentioned in the CIDP, 2015-2030, under communicable and non–communicable diseases. Mental health is not explicitly captured in the health sector's annual work plan. However, expanding the range of rehabilitative services (including mental and social support), the health sector annual work plan provides for conducting community-based rehabilitation services in all sub-counties, and construction of rehab departments in 5 hospitals which are: Msambweni CTRH, Kinango SCH, Samburu SCH, Lungalunga SCH, and Kwale SCH.

To expand access to services for some of the factors contributing to the rising trend of mental health and substance use disorders, the County Health Department needs to collaborate with the social services and talent management sectors. The CIDP stipulates that the social Services and talent management sector priorities include drug and substance abuse, sexual and gender-based violence, and community economic empowerment. (Youth, Women, and PWDs Fund).

In Kwale County, medicines for mental health conditions are available at all major hospitals and at Tiwi Rural Health Center. However, the availability of second-generation antipsychotic drugs is limited due to their high costs, with these medications primarily found at the county referral hospital and occasionally at Tiwi. While the drugs are accessible, the quantities available are not enough to meet patient demand. Additionally, the county lacks adequate mental health equipment. This action plan prioritizes both the procurement of medicines and the acquisition of equipment.

### 1.4.1 Gaps and Barriers to Access

The mental health care system in Kwale County remains **inadequately resourced**, posing significant challenges to the delivery of quality services.

1. **Financial Resources:** There is no specific budgetary allocation for mental health, limiting the county's ability to implement planned interventions.
2. **Human Resources:** The county public sector currently has only **31 skilled personnel** in mental health, of whom **10 serve on a part-time basis**, and **five are not practicing**. Additionally, there are challenges with the inappropriate deployment of available human resources for mental health at the facility level.
3. **Awareness and Literacy:** Community awareness of mental health is low, and levels of mental health literacy among health care workers (HCWs) remain inadequate.

**Service Delivery Gaps:**

**The identified gaps include:**

i. Limited promotive and preventive interventions at the community level.

ii. Lack of integration of mental health services across all levels of healthcare.

iii. Inadequate infrastructure for mental health and substance use management, including the absence of inpatient services.

iv. Insufficient treatment technologies and inadequate supply of essential mental health drugs.

v. Lack of drug treatment services tailored specifically for women.

vi. Absence of Standard Operating Procedures (SOPs) for mental health service delivery.

**Governance and Stakeholder Engagement:**

- Weak governance structures for mental health.
- Insufficient engagement of stakeholders and partners in planning, implementation, and monitoring.

**Communication Barriers:** Health facilities lack sign language interpreters, making it difficult for clients with hearing and speech impairments to access appropriate care.

These challenges contribute to poor access, low utilization, and suboptimal outcomes in mental health care across the county.

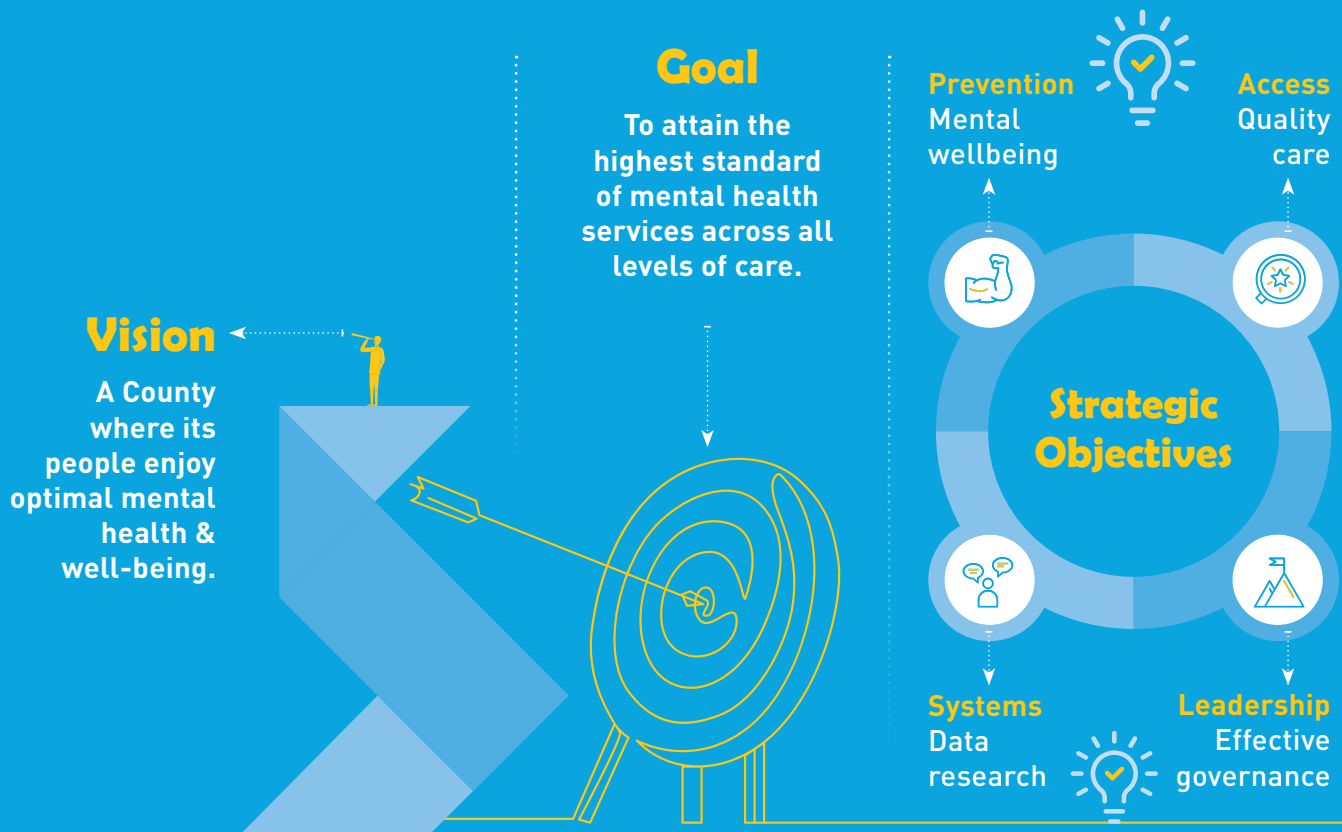
## 1.5 SWOT Analysis of Existing Mental Health Systems in Kwale

| WEAKNESSES | THREATS |
|---|---|
| No specific budget for MH at the county level the excepts in the sector AWP that has some costed MH activities | Inadequate political good-will at the county government level. |
| Lack of dissemination and domestication of existing national mental health policy, mental health action plan, legal framework, and guidelines | Inadequate prioritization of mental health at the county government level. |
| Inappropriate deployment of available skilled mental health human resources at facility level | Delayed disbursement of funds from the national government to the county government. |
| Incomplete mental health governance structure. The County Mental Health Council is yet to be gazetted. In addition, integration of mental health governance in the Community Health Committees has not been affected | Low county-level revenue collection, which leads to inadequate financial resources to meet pressing needs, including in priority sectors, e.g. health. |
| Lack of community-based promotive and preventative mental health services | County Sectoral plans have no aspect of mental health. |
| Inadequate number of psychosocial support groups for people with lived experiences and family/caretakers of people with mental health and substance use disorders | High cost of treatment. |
| Inadequate awareness at the community level of existing laws and regulations on alcohol, drug, and substance use. | Discrimination by the health insurance industry against persons with mental health conditions in accessing insurance policies. |
| Lack of skilled human resources for mental health at the community level. | Over-dependence on foreign aid to fund priority sectors i.e. health. |
| Lack of inpatient services for mental health | Un-collaborating rehabilitation facilities within the County |
| Inadequate supplies of MH drugs and equipment | Stigma and discrimination against people with mental disorders and disability at community and facility level. |
| Low levels of mental health literacy among HCWs | High level of unemployment. |
| Lack of community awareness on mental health | High poverty levels. |
| Lack of integration of MH services at all levels | Availability and accessibility to drugs and substances of abuse. |
| Lack of SOPS regarding mental health services. | Social determinants of mental health e.g. SGBV, trauma, poverty, population movements, urbanization, socioeconomic and sociocultural factors, climate change, and technological advancement. |
| Increasing cases of suicide | Increased levels of juvenile delinquency. |
| Inadequate infrastructure for MH including lack of inpatient services for mental health cases | Existence of unregulated traditional/ faith healers and traditional medicines |
| Lack of drug treatment for female in the county | High school dropout rates |
| Inadequate and incomplete data in the county as some facilities do not report on MH | Unregulated betting practices. |
| Inadequate stakeholders' engagement | |
| Communication barriers e.g. lack of sign language personnel for dumb and deaf clients in the health facilities | |
| Inadequate research on mental health in the county | |

| STRENGTHS | OPPORTUNITIES |
|---|---|
| Availability of trained MH professionals comprising: 1 consultant psychiatrist,1 clinical psychologist,1 clinical officer psychiatrist, 1 medical psychologist, 9 registered nurse psychiatrists (2 full-time, 3 part-time, and 4 not practising), 17 counselling psychologists (9 full-time, 7 half-time, 1 not practicing), and 2 counselors. | Construction of inpatient MH unit ongoing. |
| Improved referral system (directory in use in some of the health facilities) | Existence of the Kwale County Community Psychiatrist Association advocating for policy. |
| Operational psychosocial outpatient clinic | Leveraging on available community resources e.g. available sign language personnel at a nearby technical school. |
| County-funded residential drug treatment center for males for all substances and medication-assisted treatment (MAT) (opioid users, e.g. heroin) | Political goodwill at the national level. |
| Availability of some costed budget for MH activities in the AWP. | Mental health services are covered under Social Health Authority (SHA) funding. |
| Availability of SGBV center in the county-4 In place | Increased advocacy for mental health investment by stakeholders. |
| Collaboration between CHD and other county and national government departments, civil society organizations, religious organizations, the media and private sector. | Existence of media platforms. |
| Existence of county and sub-county mental health coordinators. | Technology advancement for innovation and effectiveness in service delivery, e.g., ECT, telemedicine. |
| Existence of budget-line on MH services at the county referral hospital | Existence of the national MH policies, legislation, mental health action plan, and guidelines. |
| Existence community health structures | Existence of legal frameworks like SGBV Prevention Act 2023 and Liquor Management Act 2020. |
| Existence of TWG at the county level | Existence of A Commitment Plan to End the 'Quad ripple Threat'. |
| A specific tool for collecting data at health facilities providing mental health services | Availability of willing stakeholders to support MH services. |
| Inclusion of mental health in the sectoral annual plan and the CIDP | Availability of national mental health training manuals for community and facility levels human resources. |
| | Trained human resources who are available for service deliver in both the public and private health sector. |
| | Leverage on other existing health services provision at facility and community level to integrate mental health services |
| | Availability of public-private partnership guidelines that can be applied to strengthen mental health systems. |
| | Demographic changes engender an understanding and importance of mental health. |

CHAPTER 2

# Strategic Focus



## Chapter 2:
Strategic Focus

## 2.1 County's Vision on Mental Health, Goal, and Strategic Objectives

### 2.1.1. Vision

A County where its people enjoy optimal mental health and well-being.

### 2.1.2. Goal

To attain the highest standard of mental health services across all levels of care.

### 2.1.3 Strategic objectives

**Leadership**

To strengthen effective leadership and governance for mental health.

**Access**

To ensure access to comprehensive, integrated, and high-quality, promotive, preventive, curative, palliative and rehabilitative mental health services at all levels of healthcare.

**Prevention**

To implement strategies for the promotion and prevention of mental health and substance use disorders.

**Systems**

To strengthen mental health systems, including information systems and research.

## 2.2 Cross-cutting principles and approaches

Informed by the Kenya Health Policy 2014-2030, the Kenya Mental Health Policy 2015-2030, and the WHO's Comprehensive Mental Health Action Plan 2013-2030, the cross-cutting approaches that guided the development of the costed Kwale County Mental Health Strategic Action Plan will also guide its implementation.

**The cross-cutting approaches are as follows:**

- **1. Universal health coverage:** Regardless of age, sex, socioeconomic status, race, ethnicity, religious affiliation, or any other status and following the principle of equity, persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.
- **2. Human rights:** Mental health strategies, actions, and interventions for treatment, prevention, and promotion must be compliant with the Constitution of Kenya 2010, the Kenya Health Act 2017, the Mental Health (Amendment) Act 2022, the Convention on the Rights of Persons with Disabilities, and other international and regional human rights instruments.
- **3. Evidence-based practice:** Mental health strategies and interventions for treatment, prevention, and promotion need to be based on scientific evidence and/or best practices, taking cultural considerations into account.
- **4. Life-course approach:** Mental and behavioral disorders can impact people of all ages. Therefore, policies, plans, and services for mental health must address health and social needs throughout all life stages, including infancy, childhood, adolescence, adulthood, and older age.
- **5. Multi-sectoral approach:** The use of a multi-sectoral approach is based on recognition of the importance of factoring the social determinants of mental health into efforts to achieve an overall county mental health goal. Mental health-related issues shall therefore be included in policies that relate to other sectors, such as education, labor, security, correctional services, children's services, planning, finance, the legal justice system, industrialization, agriculture, social services, environment, and other relevant sectors, as well as the private sector, as appropriate to the county's situation.
- **6. Empowerment of persons with mental disorders and psychosocial disabilities and caregivers:** Persons with mental disorders and psychosocial disabilities, and their caregivers, should be empowered and involved in mental health advocacy, promotion, and prevention, provision of psychosocial support, policy, planning, legislation, service provision, monitoring, research, and evaluation.

- **7. People-centered approach to mental health interventions:** A people-centered approach should ensure health, and mental health interventions are organized around people's legitimate needs and expectations. This calls for community involvement and participation in deciding, implementing, and monitoring interventions.

- **8. Participatory approach to the delivery of interventions:** The various actors involved in mental health service provision shall participate in the design and delivery of interventions to achieve the best possible outcomes. The private sector shall be seen as complementary to the public sector to increase the geographical coverage, scale, and scope of the health services provided.

- **9. Efficiency in the application of health technologies:** Health technologies, including e-health and specialized mental health equipment, are integral in the delivery of mental health services. Health technologies should maximize the use of existing resources and build capacity. This is in the selection of technologies that are appropriate, accessible, affordable, feasible, and culturally acceptable to the community for addressing mental health challenges, and in the application of such technologies.

- **10. Social accountability:** The constitution of Kenya obligates all institutions to be accountable to the public directly and through their representatives. Realization of the highest standards of mental health can only be achieved by bridging public perceptions and their needs through assessments, performance reporting, public awareness, transparency, and public participation in decision-making on mental health-related matters.

- **11. Community-based approach:** Empowerment of relevant community structures to provide mental health care services appropriate for the level of care, community mobilization, advocacy, and participation in community dialogues, action days, and public barazas, policy formulation, planning, legislation, monitoring, evaluation, and research.

CHAPTER 3

# Strategic Actions and Priority Investment Areas

**To achieve the set strategic objectives of the action plan, all actors in the mental health space will be expected to implement the following strategic actions and priority investment areas under each of them.**

**Chapter 3:**
Strategic Actions and Priority Investment Areas



## 3.1 Strategic Objective 1: Strengthen effective leadership and governance for Mental Health

| STRATEGIC ACTIONS | PRIORITY INVESTMENTS |
|---|---|
| 3.1.1. **Strategic Action 1.1:** Establish leadership structures for Mental Health at all levels | 1. Establish a county mental health council.<br>2. Establish a multi-sectoral coordination committee at the county level for joint planning, implementation, monitoring, and evaluation<br>3. Establish a Technical Working Group at the county level to provide technical expertise in mental health programming.<br>4. Establish an inter-departmental coordination committee at the sub-county level to ensure integration of mental health interventions.<br>5. Appoint and sensitize CHPs on mental health to champion mental health at the community level.<br>6. Integrate mental health into the Community Health Committee. |
| 3.1.2. **Strategic Action 1.2:** Promote the development and implementation of responsive policies and legislation | 1. Disseminate the national-level policies, legislation, and guidelines on mental health.<br>2. Disseminate the County Mental Health Action Plan (CMHAP) at the county and sub-county levels.<br>3. Develop and disseminate MNS Communication Strategy. |
| 3.1.3. **Strategic Action 1.3:** Mainstream Mental Health across sectors through stakeholder collaboration. | **Priority Investments under Strategic Action 1.3**<br>1. Establish a subcommittee on advocacy and partnership at the county level to ensure mainstreaming of mental health through integrated actions for multi-sectoral development and implementation of mental health plans.<br>2. Integrate mental health into all county government development plans, including County Health Plans, County Integrated Development Plans (CIDP), and Annual Development Plans (ADP).<br>3. Adopt and disseminate standard operating procedures (SOPs) to guide mental health program operationalization.<br>4. Coordinate multi-stakeholder basket funding for mental health programs and services. |

## 3.2 Strategic Objective 2: Implement strategies for the promotion and prevention of Mental Health.

| STRATEGIC ACTIONS | PRIORITY INVESTMENTS |
|---|---|
| 3.2.1. **Strategic Action 2.1**: Enhance support groups for people with lived experience and families/caregivers. | **Priority Investments under Strategic Action 2.1**<br>1. Establish psychosocial support groups for people with lived experiences of mental health.<br>2. Train psychosocial support group members for people with lived experiences to provide psychosocial support to clients with mental health and substance use disorders.<br>3. Train members of psychosocial support groups for people with lived experiences in the promotion and prevention of mental health and substance use disorders.<br>4. Establish psychosocial support groups for the families/ Caregivers of persons with lived experiences.<br>5. Train members of the psychosocial support groups for families/caregivers to provide psychosocial support to families/caregivers of clients with lived experiences of mental health.<br>6. Link members of the psychosocial support groups for people with lived experiences and families/caregivers to socioeconomic development programs.<br>In collaboration with stakeholders, support the social reintegration of persons with mental health disorders. |
| 3.2.2. **Strategic Action 2.2**: Awareness creation on mental health at all levels of care | 1. Conduct dialogues on mental health with opinion leaders at the county and sub-county levels.<br>2. Conduct community dialogue forums to create awareness on mental health at the ward level.<br>3. Conduct community outreaches on mental health at the sub-county level. |
| 3.2.3. **Strategic Action 2.3**: Awareness creation of existing laws and regulations on alcohol, drug, and substance use | **Priority Investments under Strategic Action 2.2**<br>1. Disseminate existing laws, policies, and regulations on alcohol, drugs, and substance use.<br>2. Train mental health champions to advocate for the enforcement of existing laws and regulations on alcohol, drugs, and substance use at the ward level.<br>3. Sensitize the community leaders and members to advocate for the enforcement of existing laws and regulations on alcohol, drugs, and substance use at the ward level. |

## 3.2 Strategic Objective 2: Implement strategies for the promotion and prevention of Mental Health.

| STRATEGIC ACTIONS | PRIORITY INVESTMENTS |
|---|---|
| 3.2.4. **Strategic Action 2.4**: Health education on Mental Health | **Priority Investments under Strategic Action 2.3**<br>1. Train CHPs on the promotion and prevention of mental health<br>2. Sensitize youth champions on the promotion and prevention of mental health<br>3. Train mental health champions on the promotion and prevention of mental health<br>4. Train teachers on the promotion and prevention of mental health<br>5. Train health promotion officers on the promotion and prevention of mental health<br>6. Conduct mental health education outreaches to learning institutions, prisons, police stations, and court users' committees.<br>7. Engage with local media houses to create mental health awareness to reduce stigma and discrimination.<br>8. Sensitize media persons on mental health<br>9. Sensitize bloggers on mental health<br>10. Develop, print, and distribute mental health-targeted IEC Materials for 5 different special population groups.<br>11. Collaborate with other stakeholders, e.g. MOE, prisons, police force, gender, and social services, religious organizations, and community gatekeepers to reach special populations with mental health promotion and prevention messages.<br>12. Integrate mental health messages in globally celebrated days messaging.<br>13. Conduct key mental health calendar days in conjunction with other relevant sectors.<br>14. Conduct awareness campaigns on mental health.<br>15. Integrate mental health messages in community dialogue meetings, community action days, community barazas, and facility talks. |

## 3.2 Strategic Objective 2: Implement strategies for the promotion and prevention of Mental Health.

| STRATEGIC ACTIONS | PRIORITY INVESTMENTS |
|---|---|
| 3.2.5. **Strategic Action 2.5**: Preventing Suicide | **Priority Investments under Strategic Action 2.4**<br>1. Establish community-based alcoholics and Substance Use Anonymous groups.<br>2. Sensitize gatekeepers on suicide prevention, including how to identify and refer the affected for better management.<br>3. Integrate suicide prevention messages in health talks at the facility level, community dialogues, community action days, school extracurricular activities, and public barazas.<br>4. Sensitize healthcare workers (HCWs), teachers, CHAs, police, agricultural officers, and CHPs, on suicide prevention, risk assessment tool, and referral pathways.<br>5. Commemorate world suicide day. |
| 3.2.6 **Strategic Action 3.1**: Improve Access to Curative and Rehabilitative Mental Health Services. | 1. Establish a sub-committee on service delivery at the county level.<br>2. Integrate mental health services at all levels of health care.<br>3. Train healthcare workers on sign language.<br>4. Integrate mental health referral tools into the health facilities' referral system.<br>5. Disseminate the mental health referral directory at the county and sub-county levels.<br>6. Establish an inter-unit committee at the facility level to enhance the integration of mental health services at the facility and community levels. |

## 3.3 Strategic Objective 3: Ensure access to comprehensive, integrated, and high-quality, promotive, preventive, curative, Palliative and rehabilitative Mental Health services at all levels of healthcare

| STRATEGIC ACTIONS | PRIORITY INVESTMENTS |
|---|---|
| 3.3.1. **Strategic Action 3.1:** Improve Access to Curative and Rehabilitative Mental Health Services. | 1. Establish a sub-committee on service delivery at the county level.<br>2. Integrate mental health services at all levels of health care.<br>3. Train healthcare workers on sign language.<br>4. Integrate mental health referral tools into the health facilities' referral system.<br>5. Disseminate the mental health referral directory at the county and sub-county levels.<br>6. Establish an inter-unit committee at the facility level to enhance the integration of mental health services at the facility and community levels. |
| 3.3.2. **Strategic Action 3.2:** Improve Access to Preventive and Promotive Mental Health Services | 1. Develop and distribute a facility-based mental health screening tool.<br>2. Train HCWs on the facility-based mental health screening tool.<br>3. Appoint a workplace mental health wellness committee.<br>4. Establish workplace-based mental health wellness programs.<br>5. Conduct debriefing sessions for health care workers. |
| 3.3.3. **Strategic Action 3.3:** Improve the quality of promotive, preventive, curative, palliative and rehabilitative Mental Health services. | 1. Adopt and integrate mental health supportive supervision tools into the existing supportive supervision program.<br>2. Conduct supportive supervision within which mental health is integrated.<br>3. Provide clinical supervision for psychosocial support (PSS) providers.<br>4. Provide mentorship to healthcare workers (HCWs) providing mental health services.<br>5. Integrate mental health into the existing activities of quality improvement teams (QITs) at the facility level.<br>6. Conduct monitoring and evaluation of mental health activities at the sub-county level. |

## 3.4 Strategic Objective 4: Strengthen mental health systems, including information systems and research.

| STRATEGIC ACTIONS | PRIORITY INVESTMENTS |
|---|---|
| 3.4.1. **Strategic Action 4.1:** Infrastructure improvement for Mental Health. | 1. Avail essential ICT technologies to all facilities providing mental health services.<br>2. Integrate mental health in-patient services into general wards in all major hospitals.<br>3. Advocate for the construction and completion of mental health infrastructure<br>4. Construct rehab departments in the proposed five hospitals<br>5. Construct a drug treatment center for females at the county level<br>6. Renovate rooms providing rehabilitative health services in Kwale SCH, Kinango SCH and Lungalunga SCH.<br>7. Construct new inpatient wards at Msambweni CHRH, Samburu SCH, Lungalunga SCH, Mkongani SCH, Mnyenzeni HC. |
| 3.4.2. **Strategic Action 4.2:** Mental Health Information System. | 1. Integrate mental health indicators into existing facility-based data capture and reporting tools.<br>2. Train healthcare workers on capturing and reporting mental data.<br>3. Conduct data review meetings at the county and sub-county. |
| 3.4.3. **Strategic Action 4.3:** Access to essential medicines, equipment, and technologies. | 1. Include essential drugs for mental health services in the supply chain system.<br>2. Avail essential mental health drugs at all facilities providing mental health services.<br>3. Train HCWs at the facility level on mental health drugs quantification and forecasting.<br>4. Provide essential occupational therapy equipment to the facilities providing in-patient and rehabilitation services.<br>5. Equip all major hospitals providing mental health services with essential treatment technologies.<br>6. Establish commodity auditing sections at health facilities providing mental health services. |

## 3.4 Strategic Objective 4: Strengthen mental health systems, including information systems and research.

| STRATEGIC ACTIONS | PRIORITY INVESTMENTS |
|---|---|
| **3.4.4 Strategic Action 4.4:** Increased Financing for Mental Health | 1. Establish a sub-committee on financial resources mobilization at the county level.<br>2. Advocate for budgetary allocation for mental health services as a stand-alone program.<br>3. Advocate for mental health budgeting in the sector's annual work plans at the county level.<br>4. Conduct bi-annual registration drive events for enrollment of vulnerable persons with lived experience into social protection services, e.g. SHA, Disability registration (NCPWD), etc.<br>5. Establish partnerships with stakeholders in the mental health space to pool financial resources at the county level.<br>6. Establish public-private partnerships (PPP) at the county level to address mental health. |
| **3.4.4 Strategic Action 4.5.** Mental Health Research | 1. Establish a sub-committee on Research, M&E, and Planning at the county level.<br>2. Map and segment regions by type of drugs and substances used to inform interventions.<br>3. Map stakeholders in the county, including their mental health areas of focus and geographical coverage to inform interventions.<br>4. Conduct a baseline survey to quantify the burden of mental health to inform investments.<br>5. Establish a database for research and reports done on mental health in the county.<br>6. Hold scientific conferences on mental health at the county level.<br>7. Support staff for presentation of scientific papers on mental health in-country and international scientific conferences.<br>8. Conduct experiential learning visits in-county and out of county |

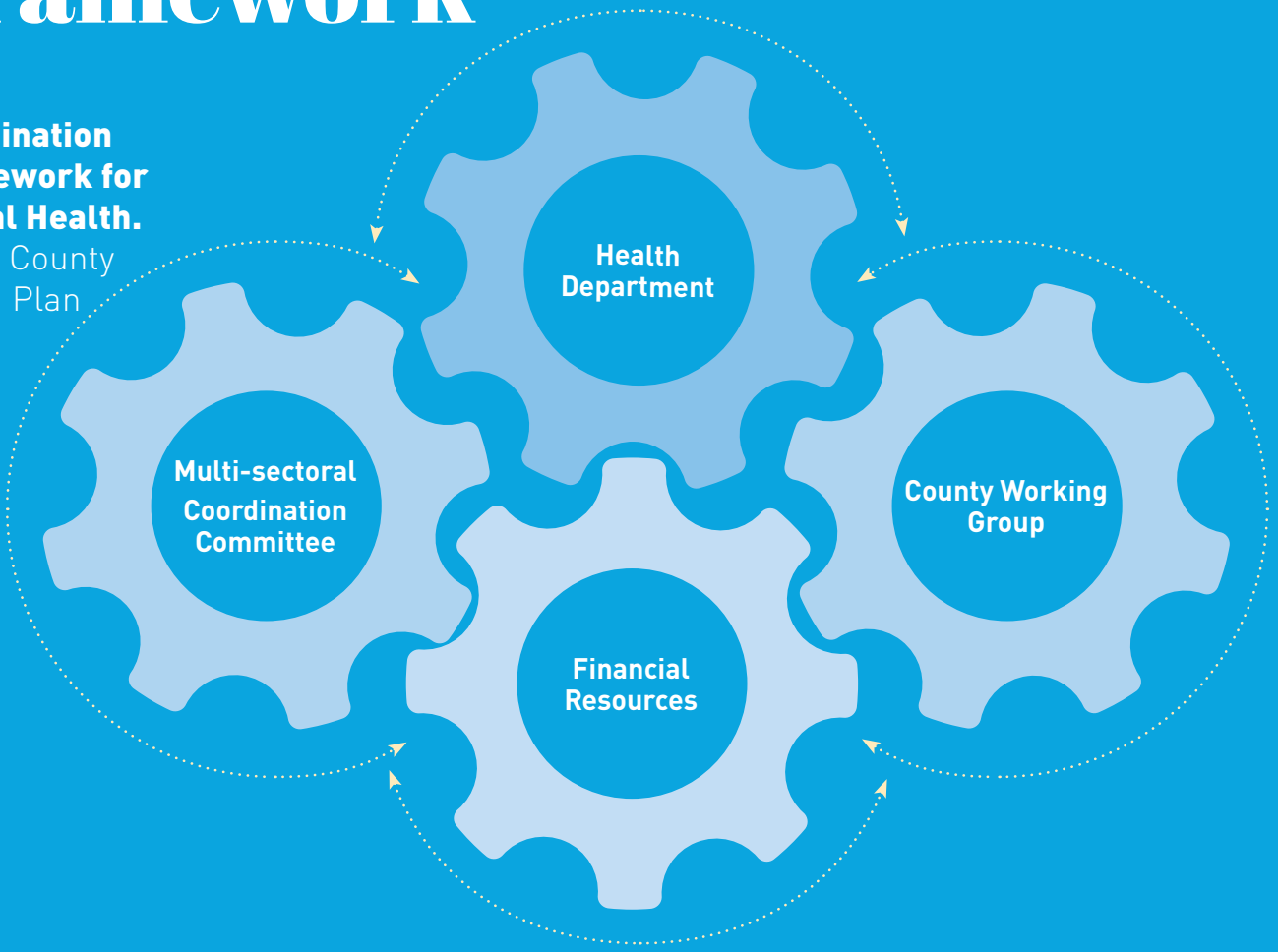
## 3.4 Strategic Objective 4: Strengthen mental health systems, including information systems and research.

| STRATEGIC ACTIONS | PRIORITY INVESTMENTS |
|---|---|
| 3.4.6. **Strategic Action 4.6.** Human Resources for Mental Health | 1. Adopt mental health national training manuals.<br>2. Conduct a training needs assessment of existing mental health service providers.<br>3. Conduct mental health TOTs training to facilitate the training of mental health service providers at facilities and community levels.<br>4. Train the existing mental health service providers as per the findings of the training needs assessment.<br>5. Conduct staffing needs assessments of human resources for mental health<br>6. Advocate at the county level for recruitment of mental-human resources as per staffing needs assessment.<br>7. Conduct CME for mental health service providers to keep them updated on new technologies and management of mental health. |

CHAPTER 4

# Implementation Framework

**Coordination Framework for Mental Health.**
Kwale County Action Plan



## Chapter 4:
Implementation Framework

## 4.1 Coordination Framework

To effectively implement this costed action plan, Kwale County will establish multi-sectoral coordination mechanisms, following the principles outlined in the Kenya Health Sector Partnership and Coordination Framework 2018 – 2030. Coordinating and harmonizing the investments and actions of all partners in the mental health space is critical to ensure that the best use is made of all available resources to address identified priorities and achieve results. An effective partnership will, among others:

1. Facilitate coordination and harmonization of investments and actions among partners through joint consultative processes, planning, budgeting, monitoring, and reviews. This approach aims to eliminate duplication of efforts and identify critical gaps that need to be addressed.
2. Promote and facilitate mutual accountability for results.

The envisioned coordination structure that will encourage participation of all players is shown in Figure 1.

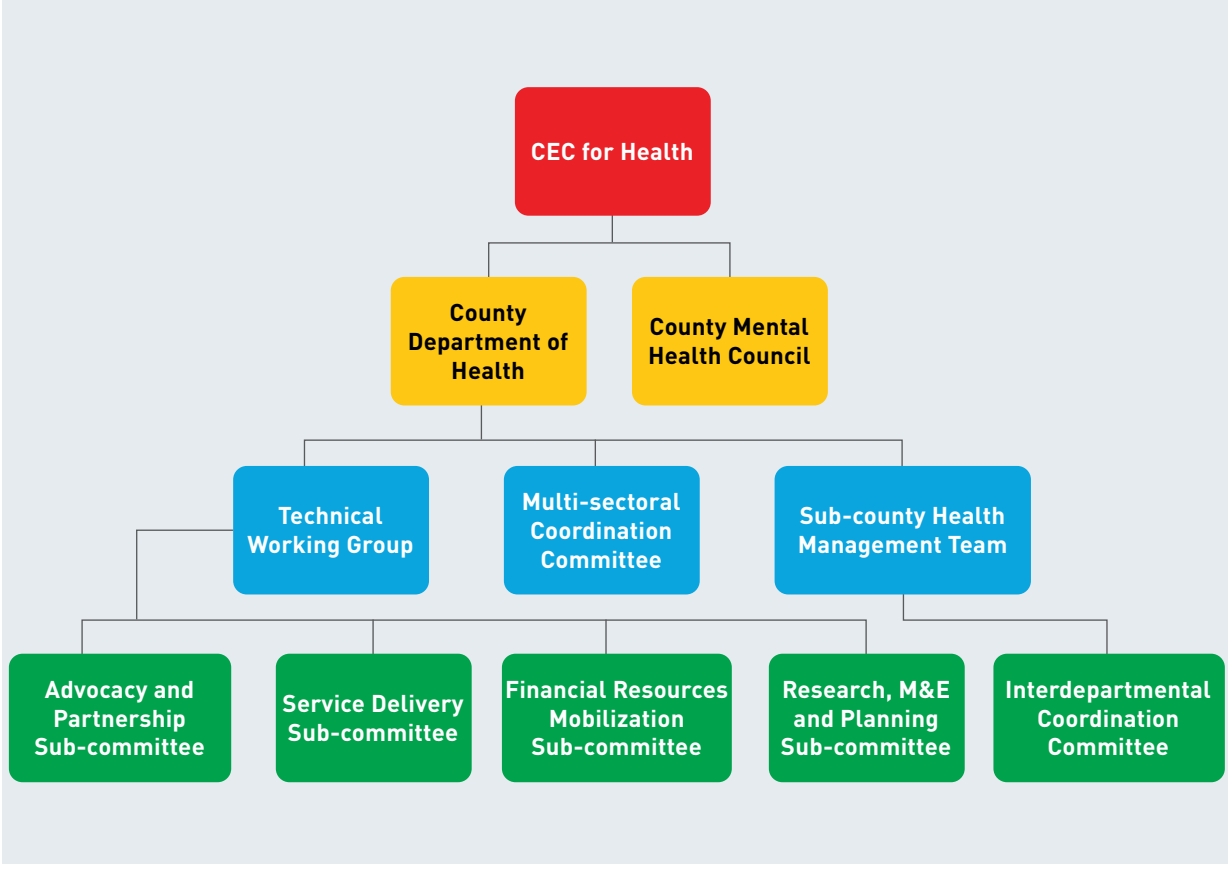
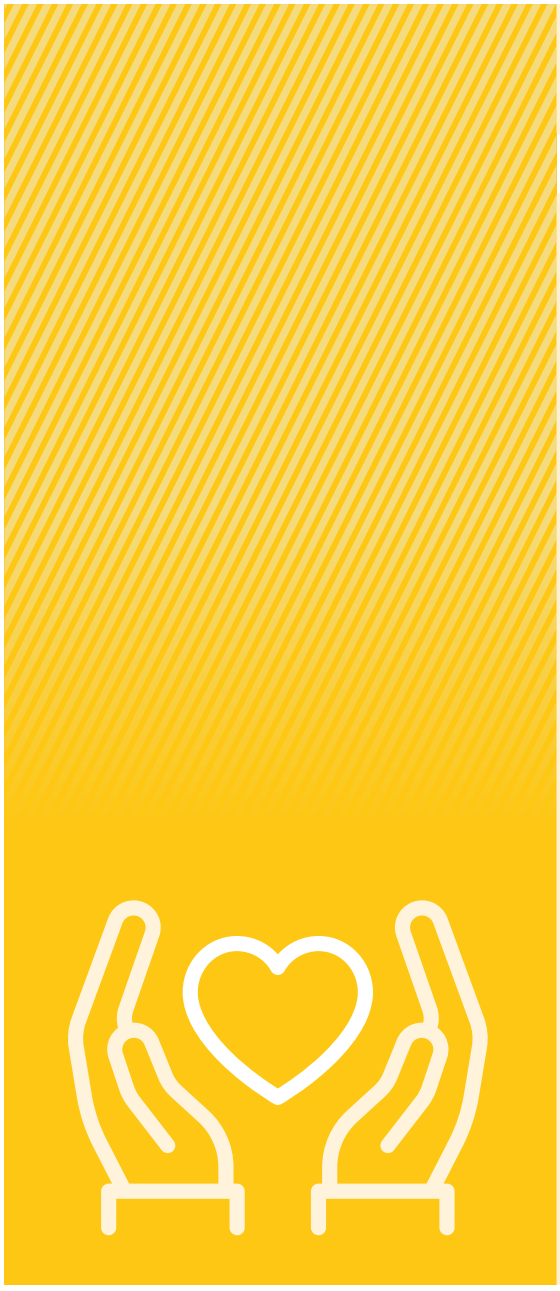



**Figure 1:** County Mental Health Coordination Structure

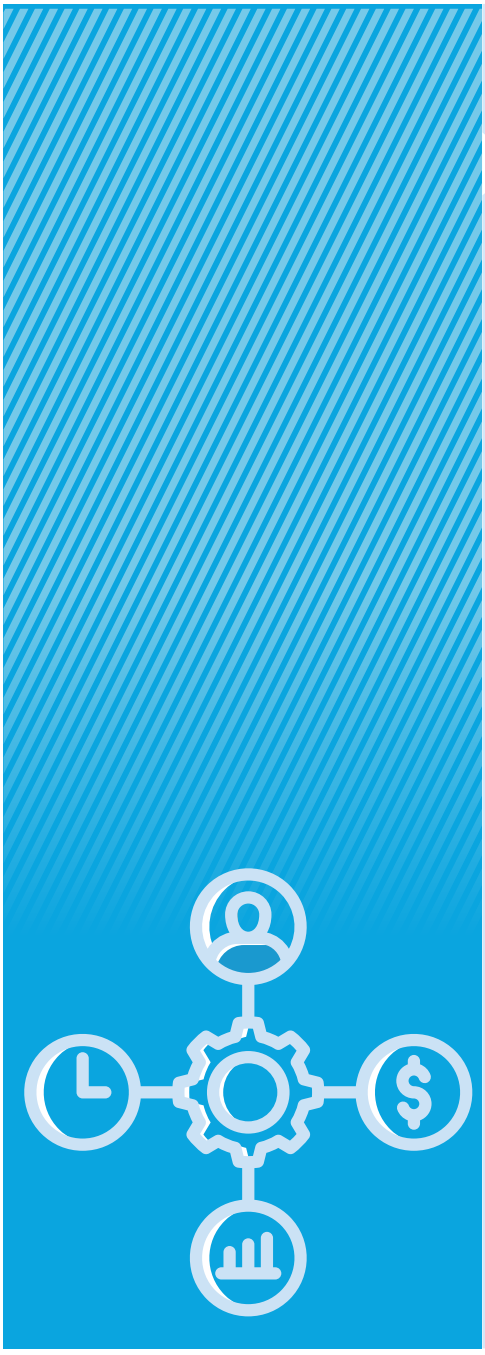
## 4.2 Roles and Responsibilities

**The Department for Health will:**



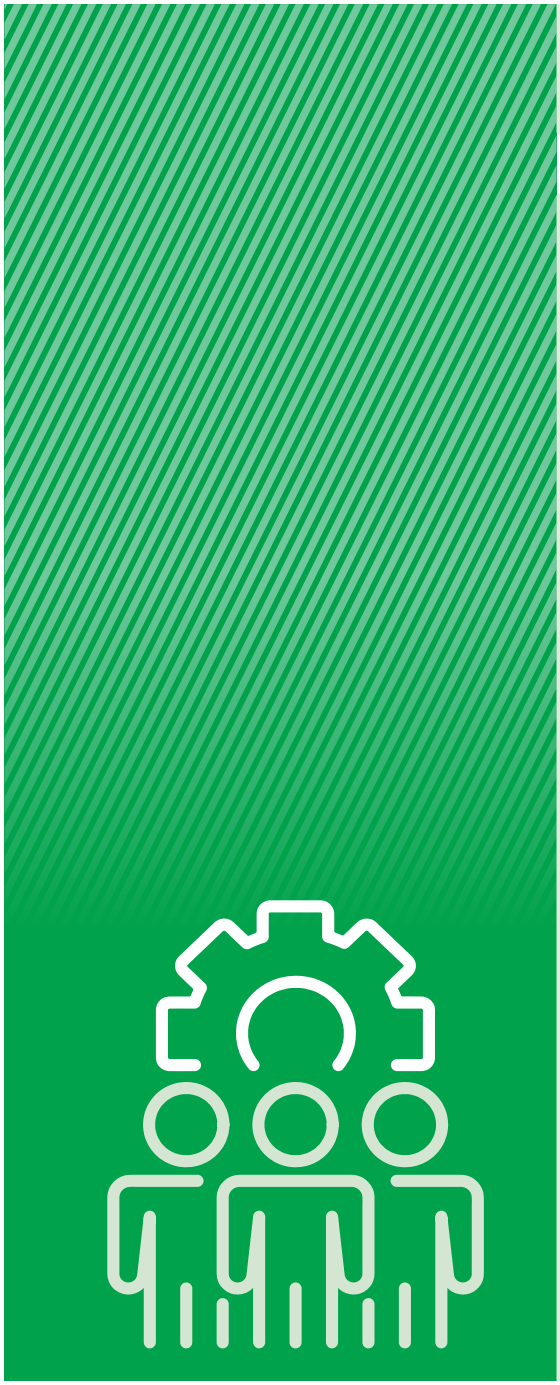
1. Provide leadership in the implementation, management, and coordination of a mental health multi-sectoral coordination committee that includes non-state actors such as the private health sector, faith-based, and civil society organizations.
2. Establish a multi-sectoral technical working group to provide technical expertise in mental health programming.
3. Ensure that national mental health policy, strategic plans, and legislation issues are integrated and mainstreamed in all county health policies, strategic plans, and legislation.
4. Ensure mental health is included in the CIDP, Strategic Plan, and AWPs.
5. Provide leadership in planning, implementation, and monitoring of the mental health annual work plans.
6. Establish and convene joint annual planning, budgeting, and monitoring processes and forums to ensure all available resources are aligned and reflected in annual plans and budgets.
7. Establish and convene joint annual review processes and forums to review the implementation of the mental health work plan.
8. Provide guidance and reporting formats to mental health partners to report on planned investments at the sub-county level.

**Multi-sectoral Coordination Committee stakeholders at the County Level will:**



1. Actively participate in the integration and mainstreaming of the national mental health policy, strategic plans, and legislation issues in all county health policies, strategic plans, and legislation.
2. Foster collaboration with mental health stakeholders across sectors to ensure a comprehensive and effective response.
3. Provide support to the county mental health process, including annual forums and conferences.
4. Share information on mental health programs, geographical coverage, and the support provided, to guide each stakeholder's prioritization of investment areas and support.
5. Provide regular reports on planned investment areas using the county-provided reporting formats for mental health.
6. Actively participate in joint annual planning and budgeting forums to ensure all available resources are aligned and reflected in annual plans and budgets.
7. Actively participate in the joint annual review processes of the implementation of the mental health work plan.
8. Align their agency's mental health review processes to the joint mental health annual review processes and forums as per the terms of the multi-sectoral coordination committee.
9. Contribute to need-based capacity building of stakeholders to actively engage and participate in mental health processes (planning, budgeting, implementation, monitoring, and evaluation) and annual review forums.

**The County Level Technical Working Group will:**



1. Provide technical input in the development, implementation, and review of county-level mental health strategies and plans.
2. Provide technical input into the processes of the county's adoption of national mental health policies, guidelines, SOPs, and service delivery models.
3. Facilitate linkages of members of the psychosocial support groups for people with lived experiences and families/caregivers to socioeconomic development programs.
4. Promote integration of mental health interventions at all levels of care as appropriate.
5. Advocate for budgetary allocation for mental health as a stand-alone program in Kwale.
6. Facilitate financial resource mobilization for mental health programs in Kwale.
7. Monitor and evaluate mental health interventions and ensure alignment with national frameworks.
8. Promote mental health research, data management, and use to inform evidence-based decision-making.
9. Facilitate the capacity building of health care workers and other stakeholders on mental health management.
10. Advocate for the recruitment, retention, and appropriate deployment of skilled mental health care workers.

## 4.3 Framework for Monitoring and Evaluation

The defined indicators in this 5-year MHSAP shall be continuously monitored and evaluated throughout the implementation process. Data will be systematically generated, captured, and used to inform decision-making, evidence-based advocacy, and programming improvements to achieve the set goal and strategic objectives of the action plan. The county government, through the health department, is responsible for the overall monitoring and evaluation of the plan. The County Health Department will coordinate with stakeholders in the mental health space in capturing data using the county-approved tools while adhering to submission deadlines to ensure data availability. The County Health Department will submit mental health data to the national level as per the requirements of the prevailing health information management system.

Every quarter, mental health data will be analyzed and compiled into reports for presentation at County Health Management Team (CHMT) meetings to support informed decision-making. Additionally, an annual status report will be prepared to evaluate progress made in implementing the annual work plan, highlighting any gaps and challenges encountered. This report will be presented at the annual work plan implementation review forums, where stakeholders can suggest recommendations for management action.

## 4.4 Mobilization of Financial Resources

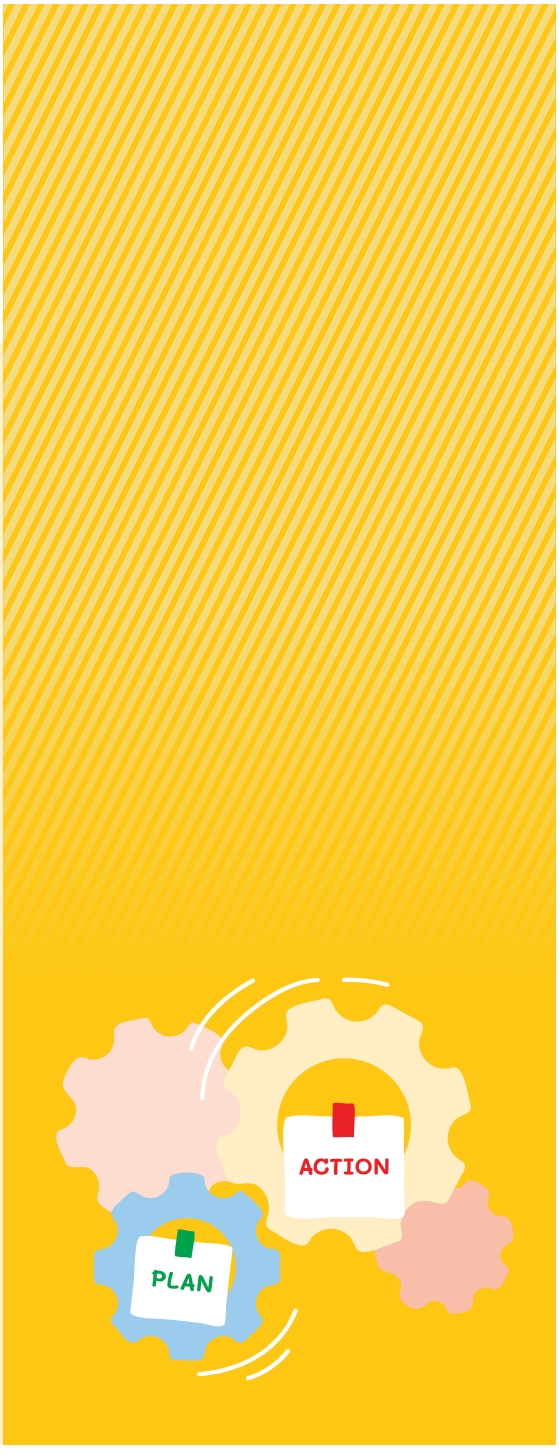
### 4.4.1 Approaches for financial resource mobilisation

Effective implementation of the strategic action plan, leading to the achievement of the set objectives, depends on adequate and sustained mental health funding. Various approaches to secure mental health funding will be utilized, including the exchequer, user fees, partners' funds, health insurance, and public-private partnerships.

## 4.4.2. Priority interventions for sustainable funding in the implementation of this 5-year action plan

**In this 5-year MHSAP, priority interventions geared toward ensuring sustainable funding for mental health have been identified as follows:**

1. Include mental health services in all health plans-CIDP, ADP and AWP.
2. Coordinate utilization of multi-stakeholder funding for mental health conditions programs and services to avoid funding duplication.
3. Develop mental health costed annual work plans.
4. Liaise with SHA to accredit all mental health, substance and drug use rehabilitation centers.
5. Conduct bi-annual registration drives events to enroll vulnerable persons with lived experience into SHA and other social protection programs.
6. Train the members in the support groups of those with lived mental health experiences and the caregivers to advocate for an increased mental health budget.
7. Establish partnerships with stakeholders in the mental health space to pool financial resources.
8. Establish public-private sector partnerships.



CHAPTER 5

# Costed Monitoring and Evaluation Matrix

**This section outlines the various strategic actions against their output indicators and the estimated cost over the five-year period of implementation.**

**Chapter 5:**
Costed Monitoring and Evaluation Matrix

| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Strategic Objective 1: To strengthen effective leadership and governance for mental health** | | | | | | | | | | |
| **Strategic Action 1.1:** Establish leadership structures for mental health at all levels | | | | | | | | | | |
| **1.1.1** Establish a County Mental Health Council | Mental Health Council established at the county level | Number of MH councils established | 1 | Gazettement of the Council | 130,000 | 130,000 | - | - | - | - |
| | | Number of MH councils' meetings held to induct members on roles and responsibilities | 1 | 1-day induction meeting for 15 pax. | 111,500 | 111,500 | - | - | - | - |
| | | Number of MH councils' meetings held | 20 | 20 meetings (held quarterly for 15 pax per meeting for 1 day, for 5 years) | 2,230,000 | 446,000 | 446,000 | 446,000 | 446,000 | 446,000 |
| **1.1.2** Establish a multi-sectoral coordination committee at the county level | Multi-sectoral coordination committee established at the county level | Number of multi-sectoral coordination committees established | 1 | No budget | - | - | - | - | - | - |
| | | Number of multi-sectoral coordination committee meetings held | 20 | 20 meetings (held quarterly for 20 pax per meeting for 1 day, for 5 years) | 1,620,000 | 324,000 | 324,000 | 324,000 | 324,000 | 324,000 |
| **1.1.3** Establish a technical working group (TWG) at the county level | A TWG established at the county level | Number of technical working groups established | 1 | No budget | - | - | - | - | - | - |
| | | Number of TWG meetings held | 20 | 20 Meetings (held quarterly for 30 pax per meeting, for 5 years) | 2,420,000 | 484,000 | 484,000 | 484,000 | 484,000 | 484,000 |
| **1.1.4** Establish interdepartmental coordination committees (ICCs) at the sub-county level to ensure integration of MH interventions | ICCs established at the sub-county level | Number of ICCs established at sub-county level | 6 | No budget | - | - | - | - | - | - |

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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **1.1.4** Establish interdepartmental coordination committees (ICCs) at the sub-county level to ensure integration of MH interventions | | Number of meetings held by the ICCs per sub-county (6) | 120 | 120 meetings (held quarterly per sub-county for 15 pax per meeting, for 5 years) | 1,800,000 | 360,000 | 360,000 | 360,000 | 360,000 | 360,000 |
| **1.1.5** Appoint and sensitize CHPs on MH to champion MH at the community level | CHPs appointed and sensitized on MH to champion mental health at the community level | Number of CHPs appointed and sensitized on MH to champion mental health at the community level (1 CHP per CU) | 168 | 6 workshops (1 workshop per sub-county for 28 pax and 1 facilitator) | 456,000 | 456,000 | - | - | - | - |
| **1.1.6** Integrate mental health into the Community Health Committee | Mental health integrated into Community Health Committees | Number of Community Health Committees within which mental health is integrated | 168 | No budget | - | - | - | - | - | - |
| | | Number of Community Health Committee chairs sensitized on mental health | 168 | 6 workshops (1 workshop per sub-county for Community unit chairs and 1 facilitator) | 456,000 | 456,000 | - | - | - | - |
| **Strategic Action 1.2:** Promote development and implementation of responsive policies and legislation | | | | | | | | | | |
| **1.2.1** Disseminate the national-level policies, legislation, and guidelines on mental health and drug use disorders | National-level policies legislation, and guidelines on mental health and drug use disorders | Number of workshops held to disseminate national-level policies and legislation on mental health and drug use disorders | 6 | 6 workshops (1 workshop per sub-county for 40 pax and 2 facilitators) for 2 days | 2,094,000 | 2,094,000 | - | - | - | - |
| | | Number of workshops held to disseminate national-level guidelines on mental health and drug use disorders | 6 | 6 workshops (1 workshop per sub-county for 40 pax and 2 facilitators) for 3days | 3,138,000 | 3,138,000 | - | - | - | - |



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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **1.2.2** Disseminate the County Mental Health Action Plan (CMHAP) at the county and the sub-county levels | CMHAP disseminated at the county and sub-county levels | Number of dissemination workshops held to disseminate CMHAP | 7 | 7 workshops (1 at county level and, 1 per sub-county for 40 pax per workshop for 1 day). | 1,207,000 | 1,207,000 | - | - | - | - |
| **1.2.3** Develop and disseminate MNS Communication Strategy | MNS Communication Strategy developed | Number of MNS communication strategies developed and disseminated | 1 | Consultants' fees at KES 50000 per day for 11 days | 550,000 | 550,000 | - | - | - | - |
| | MNS Communication Strategy disseminated at the county and sub-county levels | Number of dissemination meetings held to disseminate the MNS Communication Strategy | 7 | 7 workshops (1 at county level and 1 per sub-county for 40 pax per workshop for 1 day, and 1 consultant at county level for 1 day) | 1,211,500 | 1,211,500 | - | - | - | - |
| **Strategic Action 1.3.** Mainstreaming Mental Health across Sectors (Stakeholder collaboration) | | | | | | | | | | |
| **1.3.1** Establish a subcommittee on advocacy and partnership at the county level to ensure mainstreaming of MH through integrated actions for multi-sectoral development and implementation of MH plans. | Subcommittee on advocacy and partnership established at the county level | Number of advocacy and partnership subcommittees established at county level | 1 | No budget | - | - | - | - | - | - |
| | | Number of meetings held by the advocacy and partnership subcommittee at the county level | 20 | 20 meetings (held quarterly for 7 pax per meeting, for 5 years) | 580,000 | 116,000 | 116,000 | 116,000 | 116,000 | 116,000 |
| **1.3.2** Integrate mental health into all county government development plans, including County Health Annual Work Plan, County Integrated Development Plan (CIDP), Annual Development | Mental health integrated into all county government development plans | Number of county government development plans in which MH is integrated (CIDP, ADPs and AWPs) | 11 | No budget | - | - | - | - | - | - |
| | Mental health integrated into all county government development plans | Number of county government development plans in which MH is integrated (CIDP, ADPs and AWPs) | 5 | 5-day meeting to develop health sector AWPs, for 30 pax per day, for 5 days | 3,305,000 | 601,000 | 601,000 | 601,000 | 601,000 | 601,000 |

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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **1.3.3** Adopt and disseminate standard operating procedures (SOPs) to guide mental health program operationalization | SOPs to guide MH program operationalization adopted and disseminated | Number of workshops held to adopt SOPs to guide mental health program operationalization | 1 | 3-day meeting for 7 pax to adopt SOPs. | 85,000 | 85,000 | - | - | - | - |
| | | Number of workshops held to disseminate SOPs to guide MH program operationalization | 7 | 7 workshops (1 at the county level and 1 per sub-county for 40 pax, per workshop for 1 day). | 1,207,000 | 1,207,000 | - | - | - | - |
| **1.3.4** Coordinate multi-stakeholder basket funding for MH programs & services | Multi-sectoral stakeholders' basket funding for MH coordinated | Number of coordination meetings for multi-sectoral stakeholders' MH basket funding held at the county | 20 | 20 meetings (held quarterly for 7 pax, per meeting, for 5 years) | 580,000 | 116,000 | 116,000 | 116,000 | 116,000 | 116,000 |
| **Strategic Objective 2: Implement strategies for the promotion and prevention of Mental Health** | | | | | | | | | | |
| **Strategic Action 2.1.** Enhance support groups for people with lived experience and families/caregivers | | | | | | | | | | |
| **2.1.1** Establish psychosocial support (PSS) groups for people with lived experiences of MH | PSS groups established for people with lived experiences | Number of PSS groups for people with lived experiences established (10 per year over 2 yrs) | 20 | 20 (1 meeting to establish a PSS group per Ward for 15 pax and 2 facilitators, for 1 day). | 550,000 | 275,000 | 275,000 | - | - | - |
| **2.1.2** Train members of PSS groups for people with lived experiences to provide psychosocial support to clients with mental health and substance use disorders | PSS group members trained to provide psychosocial support to clients with mental health and substance use disorders | Number of PSS group members for people with lived experiences trained to provide psychosocial support to clients with mental health and substance use disorders (30 per year) | 60 | 2 training workshops (30 pax, and 2 facilitators per workshop for 2 days). | 548,000 | | 274,000 | 274,000 | - | - |
| **2.1.3** Train members of PSS groups for people with lived experiences in the promotion and prevention of mental health and substance use | PSS group' members trained in the promotion and prevention of MH and substance use | Number of PSS group members for people with lived experiences trained in the promotion and prevention of MH and substance use (30 people per year) | 60 | 2 training workshops (30 pax, and 2 facilitators per workshop for 3 days). | 810,000 | 405,000 | 405,000 | - | - | - |



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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **2.1.4** Establish psychosocial PSS groups for the families/Caregivers of persons with lived experiences | PSS groups for the families/Caregivers of persons with lived experiences established | Number of PSS groups for the families/Caregivers of persons with lived experiences established (10 in a year) | 20 | 20 (1 meeting, to establish a PSS group per Ward for 15 pax and 2 facilitators for 1 day). | 550,000 | 275,000 | 275,000 | - | - | - |
| **2.1.5** Train members of the PSS groups for families/ caregivers to provide psychosocial support to families/ caregivers of clients with lived experiences of MH | Members of PSS groups for families/Caregivers trained to provide PSS to families/ caregivers of clients with lived experiences | Number of members of the PSS groups for families/Caregivers of people with lived experiences trained to provide PSS to families/caregivers of people with lived experiences | 60 | 2 training workshops (30 pax, and 2 facilitators per workshop for 2 days). | 548,000 | 274,000 | 274,000 | - | - | - |
| **2.1.6** Link members of the PSS groups for people with lived experiences and families/caregivers to socioeconomic development programs | PSS group members by type of PSS group linked to trade skills training and talent development programs | Number of PSS group members by type of PSS group linked to trade skills training programs | 300 | 300 (150 members with lived experiences and 150 members of families/caregivers | 216,000 | - | - | 72,000 | 72,000 | 72,000 |
| | PSS group members by type of psychosocial group linked to programs providing tools of trade | | 300 | 300 (150 members with lived experiences and 150 members of families/caregivers). | 216,000 | - | - | 72,000 | 72,000 | 72,000 |
| | PSS group members by type of PSS group linked to enterprise development training programs | | 300 | 300 (150 members with lived experiences and 150 members of families/caregivers). | 216,000 | - | - | 72,000 | 72,000 | 72,000 |

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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **2.1.7** Establish community-based alcoholics; and substance use anonymous groups | Community-based alcoholic; and substance use anonymous groups established | Number of Community-based alcoholic; and substance use anonymous groups established | 30 | 30 (1 per sub-county per year for 5 years). | 510,000 | 102,000 | 102,000 | 102,000 | 102,000 | 102,000 |
| **2.1.8** In collaboration with stakeholders, support the social reintegration of persons with MH | Persons with MH supported for social reintegration | Number of people with MH supported for social reintegration | 500 | 500 pax.<br><br>120 reintegration outreaches (quarterly per sub-county, for 5 years). (50 in year 1, 100, year 2, 150, year 3, 150, year 4 & 50, year 5) | 1,320,000 | 132,000 | 264,000 | 396,000 | 396,000 | 132,000 |
| **Strategic Action 2.2:** Awareness creation on Mental Health at all levels of care | | | | | | | | | | |
| **2.2.1** Conduct dialogues on MH with opinion leaders at county and sub-county levels | Dialogues on MH conducted with opinion leaders at county and sub-county levels | Number of dialogues on MH conducted with opinion leaders at county and sub-county levels | 70 | 70 dialogues (1 at the county and 1 per sub-county biannually for 30 pax per dialogue, for 5 years). | 8,470,000 | 1,694,000 | 1,694,000 | 1,694,000 | 1,694,000 | 1,694,000 |
| **2.2.2** Conduct community dialogue forums to create awareness on MH at the ward level | Community dialogue forums to create awareness on MH conducted at ward level | Number of community dialogue forums to create awareness on MH conducted at ward level | 400 | 400 dialogue Forums (held quarterly, 1 per ward with 2 facilitators, for 5 years). | 1,800,000 | 360,000 | 360,000 | 360,000 | 360,000 | 360,000 |
| **2.2.3** Conduct community outreaches on MH at the sub-county level | Community outreaches on MH conducted at sub-county level | Number of community outreaches on MH conducted at sub-county level | 150 | 150 outreaches (5 outreaches per sub-county per year for 5 years). | 375,000 | 75,000 | 75,000 | 75,000 | 75,000 | 75,000 |



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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Strategic Action 2.3:** Awareness creation of existing laws and regulations on alcohol, drug, and substance use. | | | | | | | | | | |
| **2.3.1** Disseminate existing laws and regulations on alcohol, drugs, and substance use | Existing laws and regulations on alcohol, drugs, and substance use disseminated | Number of workshops held to disseminate existing laws and regulations on alcohol, drugs, and substance use | 14 | 14 workshops (7 workshops, 5 days per workshop per year for 40 pax and 2 facilitators per workshop, 1 at the county level and 1 per sub-county, years 2 and 3) | 12,194,000 | - | 6,097,000 | 6,097,000 | - | - |
| **2.3.2** Train MH champions to advocate for the enforcement of existing laws and regulations on alcohol, drugs, and substance use at ward level | MH champions trained to advocate at ward level for the enforcement of existing laws and regulations on alcohol, drugs, and substance use | Number of MH champions trained to advocate at ward level for the enforcement of existing laws and regulations on alcohol, drugs, and substance use | 20 | 1 training workshop for 3 days for 20 pax and 2 facilitators (1 pax per ward) | 285,000 | 285,000 | - | - | - | - |
| **2.3.3** Sensitize the community leaders and members to advocate for the enforcement of existing laws and regulations on alcohol, drugs, and substance use at the ward level. | Community leaders and members sensitized to advocate for the enforcement of existing laws and regulations on alcohol, drugs, and substance use at ward level | Number of community leaders and members sensitized to advocate for the enforcement of existing laws and regulations on alcohol, drugs, and substance use at ward level | 500 | 100 pax (5pax per ward per year and 1 facilitator per sub-county per year for 5 years) | 1,385,000 | 277,000 | 277,000 | 277,000 | 277,000 | 277,000 |
| **Strategic Action 2.4:** Health education on Mental Health | | | | | | | | | | |
| **2.4.1** Train CHPs on the promotion and prevention of MH | CHPs trained on the promotion and prevention of MH | Number of CHPs trained on the promotion and prevention of MH | 1780 | 60 training workshops (2 workshops per sub-county for 30 pax and 2 facilitators, per year, 4 days each for 5 years). | 32,190,000 | 6,438,000 | 6,438,000 | 6,438,000 | 6,438,000 | 6,438,000 |

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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **2.4.2** Sensitize youth champions on the promotion and prevention of MH | Youth champions sensitized on the promotion and prevention of MH | Number of youth champions sensitized on promotion, and prevention of MH | 100 | Sensitization workshops for 100 youth champions (5 per ward and 2 facilitators for 2 days per per year). | 1,041,000 | 208,200 | 208,200 | 208,200 | 208,200 | 208,200 |
| **2.4.3** Train MH champions on the promotion and prevention of MH | MH champions trained on the promotion and prevention of MH | Number of MH champions trained on the promotion and prevention of MH | 20 | Training workshop for 20 champions (1 per ward and 2 facilitators for 3 days in year 2). | 283,000 | - | 283,000 | - | - | - |
| **2.4.4** Train teachers on the promotion and prevention of MH | Teachers trained on the promotion and prevention of MH | Number of teachers trained on the promotion and prevention of MH | 1000 | Training workshop for 1000 teachers (33 pax and 2 facilitators per sub-county for 3 days per year for 5 years). | 13,170,000 | 2,634,000 | 2,634,000 | 2,634,000 | 2,634,000 | 2,634,000 |
| **2.4.5** Train health promotion officers on the promotion and prevention of MH | Health promotion officer trained on MH | Number of health promotion officers trained on promotion and prevention MH | 7 | 1 training workshop (7 pax and 2 facilitators for 3 days) in year 2) | 18,100 | - | 18,100 | - | - | - |
| **2.4.6** Conduct MH health education outreaches to learning institutions, prisons, police stations, and court users committees | MH health education outreaches conducted | Number of health education outreaches on MH conducted in learning institutions | 1200 | 240 outreaches (2 outreaches per institution for 1 day, per year, for 5 years). | 5,910,000 | 1,182,000 | 1,182,000 | 1,182,000 | 1,182,000 | 1,182,000 |
| | | Number of health education outreaches on MH conducted in prisons | 20 | 20 outreaches (2 outreaches per prison. Each outreach to include prisoners & wardens, for 1 day, per year for 5 years). | 120,000 | 24,000 | 24,000 | 24,000 | 24,000 | 24,000 |
| | | Number of health education outreaches on MH conducted in police stations | 160 | 160 Outreaches (2 outreaches per police station (16 stations for 1 day per year for 5 years). | 807,500 | 161,500 | 161,500 | 161,500 | 161,500 | 161,500 |



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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **2.4.6** Conduct MH health education outreaches to learning institutions, prisons, police stations, and court users committees | MH health education outreaches conducted | Number of health education outreaches on MH conducted for court users' committees | 20 | 20 outreaches (2 outreaches per committee (2 committees) for 1 day, per year for 5 years) | 120,000 | 24,000 | 24,000 | 24,000 | 24,000 | 24,000 |
| **2.4.7** Engage with local media houses to create MH awareness to reduce stigma and discrimination | Local media houses engaged | Number of local media houses engaged | 3 | No budget | - | - | - | - | - | - |
| | Local language radio talk shows on MH conducted | Number of local language radio talk shows on | 120 | 120 (2 shows per station per quarter per year for 5 years | 480,000 | 96,000 | 96,000 | 96,000 | 96,000 | 96,000 |
| **2.4.8** Sensitize media persons on MH | Media persons sensitized on MH | Number of media persons sensitized on MH | 100 | Sensitization workshops for 100 (20 pax, and 2 facilitators per year at the county level for 5 years). | 690,000 | 138,000 | 138,000 | 138,000 | 138,000 | 138,000 |
| **2.4.9** Sensitize bloggers on MH | Bloggers sensitized on MH | Number of bloggers sensitized on MH | 150 | Sensitization workshop for 150 (30 pax and 2 facilitators per year at the county level). | 990,000 | 198,000 | 198,000 | 198,000 | 198,000 | 198,000 |
| **2.4.10** Develop, print, and distribute MH targeted IEC Materials for 5 different special population groups | Targeted IEC materials developed, printed and distributed for 5 different special populations groups | Number of workshops held to develop targeted IEC materials for 5 special population groups | 1 | 1 workshop (for 30 pax and 1 facilitator for 3 days at the county level, in year 1). | 566,500 | 566,500 | - | - | - | - |
| | IEC materials for 5 special population groups printed | Number of IEC materials printed for 5 special population groups | 5000 | 5000(200 copies per special population group per year for 5 years | 250,000 | 50,000 | 50,000 | 50,000 | 50,000 | 50,000 |
| | Distribution of targeted IEC materials for special population groups conducted. | Number of outreaches conducted to distribute IEC materials by type of special population group | 50 | 50 (5 outreaches twice a year, 5 days each for 5 years). | 649,000 | 129,800 | 129,800 | 129,800 | 129,800 | 129,800 |

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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **2.4.11** Collaborate with other stakeholders e.g. MOE, prisons, police force, gender, and social services, religious organizations, and community gatekeepers to reach special populations with MH promotion and prevention messages | Special populations members reached with MH promotion and prevention messages conducted in collaboration with stakeholders | Number of special populations members reached with MH promotion and prevention messages in collaboration with other stakeholders | 3600 | 3600 (30 pax per sub-county (6) per quarter for 1 day per year for 5 years) | 564,000 | 112,800 | 112,800 | 112,800 | 112,800 | 112,800 |
| **2.4.12** Integrate MH messages in globally celebrated days messaging | MH messages developed for integration into globally celebrated days messaging | Number of MH messages in form of banners developed for integration into globally celebrated days messaging | 5 | 1-day meeting per year for 5 years to integrate MH messages into globally celebrated days. | 127,500 | 25,500 | 25,500 | 25,500 | 25,500 | 25,500 |
| | | Number of messages in form of a banners printed and distributed | 5 | 5 banners designed and printed | 50,000 | 10,000 | 10,000 | 10,000 | 10,000 | 10,000 |
| **2.4.13** Conduct key MH calendar days in conjunction with other relevant sectors | Key MH calendar days celebrated in conjunction with relevant sectors | Number of key MH calendar days conducted with other relevant sectors | 5 | All inclusive | 14,540,000 | 2,908,000 | 2,908,000 | 2,908,000 | 2,908,000 | 2,908,000 |
| **2.4.14** Conduct awareness campaigns on MH | MH awareness campaigns conducted | Number of MH awareness campaigns conducted | 5 | All inclusive | 7,400,000 | 1,480,000 | 1,480,000 | 1,480,000 | 1,480,000 | 1,480,000 |



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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **2.4.15** Integrate MH messages in community dialogue meetings, community action days, community barazas, and facility talks | MH messages developed for integration into community dialogue meetings, community action days, community barazas, and facility talks | Number of MH messages in form banners for integration in community dialogue meetings, community action days, community barazas, and facility talks developed | 2 | 1-day meeting to develop 2 banners for 10 pax | 25,500 | 25,500 | - | - | - | - |
| | | Number of banners printed | 2 | 2 banners | 20,000 | 20,000 | | | | |
| | Community dialogue meetings held within which MH messages are integrated | Number of Community dialogue meetings held within which MH messages are integrated | 800 | 800 outreaches (2 outreaches per ward, for a day, per quarter, per year, for 5 years). | 2,144,000 | 428,800 | 428,800 | 428,800 | 428,800 | 428,800 |
| | Community action days held within which MNS messages are integrated | Number of community action days held within which MNS messages are integrated | 400 | 400 outreaches (1 outreach per ward, for 1 day, per quarter, per year, for 5 years) (80 in a year) | 1,144,000 | 228,800 | 228,800 | 228,800 | 228,800 | 228,800 |
| | Community barazas held within which MH messages are integrated | Number of community barazas held within which MH messages are integrated | 400 | 400 outreaches (1 outreach per ward, for a day, per quarter, per year, for 5 years) (80 in a year) | 1,144,000 | 228,800 | 228,800 | 228,800 | 228,800 | 228,800 |
| | Facility talks held within which MNS messages are integrated | Number of facility talks held within which MNS messages are integrated | 7120 | 178 facilities (2 per facility, per quarter, per year for 5 years | No Budget | | | | | |

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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Strategic Action 2.5:** Preventing Suicide | | | | | | | | | | |
| **2.5.1** Sensitize gatekeepers on suicide prevention, including how to identify and refer the affected for better management. | Gatekeepers sensitized on suicide prevention, including how to identify and refer the affected for better management | Number of gatekeepers sensitized on suicide prevention, including how to identify and refer the affected for better management | 150 | 5 sensitization workshops (for 30 pax and 2 facilitators, per workshop, 3 days each, per year for 5 years at the county level). | 2,975,000 | 595,000 | 595,000 | 595,000 | 595,000 | 595,000 |
| **2.5.2** Integrate suicide prevention messages in health talks at facility level, community dialogues, community action days, school extra-curriculum activities, and public barazas | Meetings held to develop suicide prevention messages for integration into community dialogues, community action days, school extra-curriculum activities, and public barazas. and facility talks | Number of meetings held to develop suicide prevention messages for integration | 5 | 5 meetings (1 meeting per year for 10 pax to develop messages in form of banners, for 5 years) | 627,500 | 125,500 | 125,500 | 125,500 | 125,500 | 125,500 |
| | | Number of suicide prevention messages banners printed and distributed | 5 | 5 banners (1 banner per year for 5 years designed and printed). | 50,000 | 10,000 | 10,000 | 10,000 | 10,000 | 10,000 |
| | Suicide prevention messages integrated in health talks at facility level. | Number of health talks at facility level with integrated messages on suicide prevention | 1800 | Monthly health talks (held in 30 facilities offering MH services for 5 years) | No Budget | - | - | - | - | - |
| | Suicide prevention messages integrated in community dialogues | Number of health talks in community dialogue meetings with integrated messages on suicide prevention | 120 | 1 health talk (held quarterly per sub-county (6), for 5 years) | No Budget | - | - | - | - | - |
| | Suicide prevention messages intergrated in community action days | Number of health talks during community action days with integrated messages on suicide prevention | 120 | 1 health talk (held quarterly per sub-county (6), for 5 years) | No Budget | - | - | - | - | - |



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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **2.5.2** Integrate suicide prevention messages in health talks at facility level, community dialogues, community action days, school extra-curriculum activities, and public barazas | Suicide prevention messages integrated in school extra-curriculum activities | Number of health talks in school extra-curriculum activities with integrated messages on suicide prevention | 5500 | 550 Schools (2 per school, per year for 5 years) | No Budget | - | - | - | - | - |
| | Suicide prevention messages integrated in public barazas | Number of health talks during public barazas with integrated messages on suicide | 400 | Health talks (1 per baraza per ward (20), per quarter for 5 years | No Budget | - | - | - | - | - |
| **2.5.3** Sensitize healthcare workers (HCWs), teachers, CHAs, police, agricultural officers, and CHPs, on suicide prevention, risk assessment tool, and referral pathways | Teachers, HCWs, CHAs, police, agricultural officers, and CHPs sensitized on suicide prevention, risk assessment tool, and referral pathways | Number of teachers, HCWs, CHAs, police, agricultural officers, and CHPs sensitized on suicide prevention, risk assessment tool, and referral pathways | 900 | 30 sensitization workshops (1 workshop for 30 pax and 2 facilitators per sub-county, 2 days each per year for 5 years). | 8,010,000 | 1,602,000 | 1,602,000 | 1,602,000 | 1,602,000 | 1,602,000 |
| **2.5.4** Commemorate world suicide day | World suicide day commemorated | Number of world suicide days commemorated | 5 | 5 (1 per year county-wide) | 14,540,000 | 2,908,000 | 2,908,000 | 2,908,000 | 2,908,000 | 2,908,000 |
| **Strategic Objective 3: Ensure access to comprehensive, integrated and high-quality, promotive, preventive, curative, Palliative and rehabilitative Mental Health services at all levels of healthcare** | | | | | | | | | | |
| **Strategic Action 3.1.** Improve Access to Curative and Rehabilitative Mental Health Services | | | | | | | | | | |
| **3.1.1** Establish a service delivery subcommittee at the county level | Service delivery sub-committee established | Number of service delivery sub-committees established | 1 | No budget | - | - | - | - | - | - |
| | | Number of meetings held by the service delivery subcommittee | 20 | 20 Meetings (1 per quarter for 7 pax, for 5 years). | 580,000 | 116,000 | 116,000 | 116,000 | 116,000 | 116,000 |
| **3.1.2** Integrate MH services at all levels of health care | MH services integrated in all health facilities | Number of health facilities integrating MH services. | 178 | 178 health facilities (30 in year 1, 30 in year 2 and 90 in year 3 and 28 in year 4) | - | - | - | - | - | - |

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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **3.1.3** Train healthcare workers on sign language | Healthcare workers trained on sign language | Number of healthcare workers trained on sign language | 75 | 1 training for 15 pax per year for 5 years | 2,625,000 | 525,000 | 525,000 | 525,000 | 525,000 | 525,000 |
| **3.1.4** Integrate MH referral tools into the health facilities referral system | MH referral tools integrated into the health facilities referral system | Number of MH referral tools integrated into the health facilities referral system | 1 | 3 days meeting for 10 pax to design the integrated tool | 76,000 | 76,000 | - | - | - | - |
| | | Number of integrated health-based MH referral tools printed and distributed | 1000 | 200 pieces (200 pieces per year for 5 years) | 1,000,000 | 200,000 | 200,000 | 200,000 | 200,000 | 200,000 |
| **3.1.5** Disseminate the MH referral directory at the county and sub-county level | MH referral directory disseminated at the county and sub-county levels | Number of virtual dissemination meetings conducted | 1 | 1 virtue meeting for 50 pax. | 25,000 | 25,000 | - | - | - | - |
| | | Number of health referral directories printed and distributed | 178 | 178 pieces (1 per health facility) | 17,800 | 17,800 | - | - | - | - |
| **3.1.6** Establish an inter-unit committee at the facility level to enhance the integration of MH services at the facility and community levels | An inter-unit committee established at the facility level to enhance the integration of MH services at the facility and community levels | Number of facilities with established inter-unit committees to enhance the integration of MH services at | 178 | 1-day inception meeting for 1780 pax | 890,000 | 500,000 | 195,000 | 195,000 | - | - |
| | | Number of meetings held by the inter-unit committees | 3092 | 3092 (1 meeting per facility per quarter distributed as follows: 400 in year 1, 556 in year 2 and 712 in year 3,4 and 5) | - | - | - | - | - | - |



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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Strategic Action 3.2.** Improve Access to Preventive Mental Health Services | | | | | | | | | | |
| **3.2.1** Develop and distribute a facility-based MH screening tool | A facility-based MH screening tool developed | Number of facility-based MH screening tools developed | 1 | 2 days meeting for 20 pax to develop MH screening tool | 101,000 | 101,000 | - | - | - | - |
| | Facility-based MH screening tool printed & distributed | Number of facility-based screening tools printed and distributed | 17800 | 100 tools per facility (178) @ KES 50 per copy | 4,450,000 | 890,000 | 890,000 | 890,000 | 890,000 | 890,000 |
| **3.2.2** Train HCWs on facility-based MH screening tool | HCWs trained on facility-based MH screening | Number of HCWs trained on facility- based MH screening | 900 | 30 training workshops (1 per sub-county for 30 pax and 2 facilitators per training for 2 days, per year for 5 years). | 8,070,000 | 1,614,000 | 1,614,000 | 1,614,000 | 1,614,000 | 1,614,000 |
| **3.2.3** Appoint workplace mental health wellness committee | Workplace mental health wellness committee appointed | Number of workplace mental health wellness committees appointed | 15 | 15 committee inception meetings (10 pax per committee). | 75,000 | 75,000 | - | - | - | - |
| **3.2.4** Establish workplace-based MH wellness programs | Workplace-based wellness programs established | Number of workplace-based wellness programs established | 15 | No budget | - | - | - | - | - | - |
| **3.2.5** Conduct debriefing sessions for health care workers (HCWs) | Debriefing sessions for HCWs conducted | Number of debriefing sessions for HCWs conducted | 20 | 20 debriefing sessions (1 session per quarter for 20 HCWs per debriefing session, for 1 day per year for 5 years). | 810,000 | 162,000 | 162,000 | 162,000 | 162,000 | 162,000 |
| **Strategic Action 3.3.** Improve the quality of promotive, preventive, curative and rehabilitative Mental Health services | | | | | | | | | | |
| **3.3.1** Adopt and integrate MH supportive supervision tools into the existing supportive supervision program | Supportive supervision tools within which MH is integrated and adopted | Number of MH supportive supervision tools adopted & integrated into the existing supportive supervision program | 1 | 2 days meeting to develop an integrated tool. | 50,500 | 50,500 | - | - | - | - |

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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **3.3.2** Conduct supportive supervision within which MH is integrated | Support supervision within which MH is integrated conducted | Number of support supervision within which MH is integrated conducted | 1200 | 1200 supportive supervision sessions (10 facilities per sub-county, for 5 days, per quarter per year for five years). | 5,760,000 | 1,152,000 | 1,152,000 | 1,152,000 | 1,152,000 | 1,152,000 |
| **3.3.3** Provide clinical supervision for psychosocial support (PSS) providers | Clinical supervision provided to PSS providers | Number of clinical supervisions for PSS providers provided | 60 | 60 clinical supervision sessions (1 session for 35 pax and 2 facilitators per month per year for 5 years). | 4,770,000 | 954,000 | 954,000 | 954,000 | 954,000 | 954,000 |
| **3.3.4** Provide mentorship to healthcare workers (HCWs) providing MH services | Mentorship provided to HCWs providing MH service | Number of HCWs providing MH services mentored | 1080 | 1080 HCWS (I session of mentorship for 3 HCWs, and a mentor for 1 day, per month per sub-county, per year, for 5 years) | 1,620,000 | 324,000 | 324,000 | 324,000 | 324,000 | 324,000 |
| **3.3.5** Integrate MH into the existing activities of quality improvement teams (QITs) at the facility level | MH integrated into the activities of existing QITs at the facility level | Number of existing QITs integrating MH in their activities | 100 | 100 (20 QITs with 10 pax each and 1 sub-county QI focal person per year for 5 years) | 750,000 | 150,000 | 150,000 | 150,000 | 150,000 | 150,000 |
| **3.3.6** Conduct monitoring and evaluation of MH activities at the sub-county level | M&E for MH activities scheduled and conducted in each sub-county | Number of scheduled M&E for MH conducted, and reports done in each sub-county | 1200 | 1200 M&E (10 facilities per sub-county, per quarter for 5 days, per year for five years). | 5,760,000 | 1,152,000 | 1,152,000 | 1,152,000 | 1,152,000 | 1,152,000 |



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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Strategic Objective 4: Strengthen Mental Health systems, including information systems and research** | | | | | | | | | | |
| **Strategic Action 4.1.** Infrastructure Improvement for Mental Health | | | | | | | | | | |
| **4.1.1** Avail essential ICT technologies to all facilities providing MH services | All facilities providing MH services are equipped with ICT essential technologies | Number of facilities providing MH services equipped with essential ICT (phones, internet, computer etc.) (Hospitals, H/C) | 15 | 22 computers with i7 processors (2 computers per hospital, 1 computer per H/C). 22 computers in years 2 and 4, Local area network (LAN) installation in 12 facilities, WIFI connection for 12 facilities @ K, and WIFI payment for 12 facilities | 8,006,000 | - | 4,003,000 | - | 4,003,000 | - |
| **4.1.2** Integrate MH in-patient services into general wards in all major hospitals | MH in-patient services integrated into general wards in all major hospitals | Number of major hospitals integrating MH in-patient services | 6 | One (1) meeting (for 10 pax, for 1 day to design an integration tool. | 25,500 | 25,500 | - | - | - | - |
| **4.1.3** Advocate for the construction and completion of MH infrastructure | Construction of MH infrastructure completed | Number of MH infrastructure constructed and completed | 20 | No budget | - | - | | - | - | - |
| | | Number of advocacy sessions for the completion of the MH infrastructure undertaken | 10 | 10 Advocacy sessions for the construction completion of MH infrastructure at the county level (2 per year for 7 pax). | 180,000 | 36,000 | 36,000 | 36,000 | 36,000 | 36,000 |
| **4.1.4** Construct rehab departments in the proposed five hospitals | Rehab departments in the proposed five hospitals constructed | Number of rehab departments constructed in the proposed five hospitals | 5 | All-inclusive (Building materials, equipment, and furniture) | 25,000,000 | 10,000,000 | 10,000,000 | 5,000,000 | - | - |
| **4.1.5** Construct a drug treatment center for females at the county level | A drug treatment center for females established | Number of drug treatment centers for females established | 1 | All-inclusive (Building materials, equipment, and furniture) | 10,000,000 | 10,000,000 | - | - | - | - |

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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **4.1.6** Construct rehabilitative units in Msambweni CRH, Kwale SCH, Kinango SCH and Lungalunga SCH | Rehabilitative units constructed in Msambweni CRH, Kwale SCH, Kinango SCH, and Lungalunga SCH renovated | Number of rehabilitative units constructed in Msambweni CRH, Kwale SCH, Kinango SCH, and Lungalunga SCH | 4 | All- inclusive (Building materials, equipment, and furniture) | 40,000,000 | 10,000,000 | 20,000,000 | 10,000,000 | - | - |
| **4.1.7** Construct new inpatient wards at Msambweni CRH, Samburu SCH, Lungalunga SCH, Mkongani SCH, Mnyenzeni HC | New inpatient wards constructed at Msambweni CRH, Samburu SCH, Lungalunga SCH, Mkongani SCH, Mnyenzeni HC | Number of proposed health facilities with new inpatient wards | 5 | All-inclusive (Building materials, equipment, and furniture) | 50,000,000 | 20,000,000 | 20,000,000 | 10,000,000 | - | - |
| **Strategic Action 4.2.** Mental Health Information system | | | | | | | | | | |
| **4.2.1** Integrate MH indicators into existing facility-based data capture and reporting tools | MH indicators integrated into existing facility-based data capture and reporting tools | Number of facility-based data capture and reporting tools with integrated MH indicators | 2 | 2 (1 for data capture and 1 for reporting). 2-day meeting for 10 pax to develop the integrated data capture and reporting tools) | 51,000 | 51,000 | - | - | - | - |
| | | Number of data capture and reporting tools printed and distributed | 1780 | 1780 (1 tool for data capture and 1 for reporting per facility per year) for 5 years | 1,780,000 | 356,000 | 356,000 | 356,000 | 356,000 | 356,000 |
| | | Number of facilities using MOH MH data capture and reporting tools | 178 | No Budget | - | - | - | - | - | - |
| **4.2.2** Train healthcare workers on capturing and reporting MH data | Healthcare workers trained on MH data capturing and reporting. | Number of healthcare workers trained on capturing and reporting MH data | 1800 | 60 training workshops (for 30 pax, and 2 facilitators per sub-county for 2 days, biannually per year for 5 years). | 15,990,000 | 3,198,000 | 3,198,000 | 3,198,000 | 3,198,000 | 3,198,000 |



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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **4.2.3** Conduct data review meetings at the county and sub-county | Data review meetings conducted at the county and sub-county levels | Number of data review meetings conducted at the county level | 10 | 10 (2 per year at county level for 40 pax each). | 2,402,500 | 480,500 | 480,500 | 480,500 | 480,500 | 480,500 |
| | | Number of data review meetings conducted. At sub-county level | 120 | 120 (1 per sub-county, per quarter, per year, for 5 years for 30 pax). | 14,460,000 | 2,892,000 | 2,892,000 | 2,892,000 | 2,892,000 | 2,892,000 |
| **Strategic Action 4.3.** Access to essential medicines, equipment and technologies | | | | | | | | | | |
| **4.3.1** Include essential drugs for MH services in the supply chain system | MH essential drugs included in the supply chain system | Number of supply chain system that have included MH essential drugs | 1 | One day meeting for 30 pax to include MH drugs into supply chain system. | 45,000 | 45,000 | - | - | - | - |
| **4.3.2** Avail essential MH drugs at all facilities providing mental health services | Essential drugs for MH drugs availed at all facilities providing mental health services | Number of health facilities providing MH services with essential MH drugs | 50 | Procurement of Essential drugs for mental health services. | 250,000,000 | 50,000,000 | 50,000,000 | 50,000,000 | 50,000,000 | 50,000,000 |
| **4.3.3** Train HCWs at the facility level on MH drugs quantification and forecasting | HCWs at the facility level trained on MH drugs quantification and forecasting | Number of HCWs trained on MH drugs quantification and forecasting | 100 | 4 training workshops (25 pax and 5 facilitators per workshop for 5 days biannually, in years 1 and 2). | 3,902,000 | 1,951,000 | 1,951,000 | - | - | - |
| **4.3.4** Avail essential occupational therapy equipment to the facilities providing in-patient and rehabilitation services | Occupational therapy equipment provided | Number of facilities supplied with Occupation therapy equipment | 50 | 50 dart Boards, 50 table tennis sets and table, 50 footballs, 50 sewing machines, 1000, meters of fabric, 50 TV sets and 50 radios (40%,30%,20%,10%) | 6,450,000 | 2,580,000 | 1,935,000 | 1,290,000 | 645,000 | - |

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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **4.3.5** Equip all major hospitals providing MH services with essential treatment technologies | Major hospitals providing MH services equipped with essential treatment technologies | Number of major hospitals providing MH services equipped with treatment technologies (ECT Machine, EEG Machine) | 5 | ECT and EEG (Equip 3 facilities in year 1 and 2 in year 2) | 24,000,000 | 14,400,000 | 9,600,000 | - | - | - |
| **4.3.6** Establish commodity auditing sections at health facilities providing MH services | Commodity auditing sections at health facilities providing MH services established | Number of health facilities providing MH services with commodity auditing sections | 50 | Auditing meeting by 10 pax, for 5 days, per quarter, per year, for 5 years, | 4,000,000 | 800,000 | 800,000 | 800,000 | 800,000 | 800,000 |
| **Strategic Action 4.4.** Increased financing for Mental Health | | | | | | | | | | |
| **4.4.1** Establish a sub-committee on financial resources mobilization at the county level | Sub-committee on financial resources mobilization established | Number of sub-committees on financial resources mobilization established operational | 1 | No Budget | - | - | - | - | - | - |
| | | Number of meetings held by the subcommittee on financial resources mobilization | | 20 Meetings (1 meeting for 7 pax per quarter per year for 5 years). | 580,000 | 116,000 | 116,000 | 116,000 | 116,000 | 116,000 |
| **4.4.2** Advocate for budgetary allocation for MH services as a stand-alone program | Advocacy sessions conducted for budgetary allocations for MH as a stand-alone program | Number of advocacy sessions conducted for budgetary allocation for mental health services as a stand-alone program | 5 | 5 advocacy sessions (1 session for 7 pax per year for 5 years). | 90,000 | 18,000 | 18,000 | 18,000 | 18,000 | 18,000 |
| **4.4.3** Advocate for MH budgeting in the sector annual work plans at the county level | Advocacy sessions conducted for MH budgeting in the sector annual work plans | Number of advocacy sessions conducted for MH budgeting in sector annual work plans | 5 | 5 advocacy sessions (1 session for 7 pax per year for 5 years). | 90,000 | 18,000 | 18,000 | 18,000 | 18,000 | 18,000 |



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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **4.4.4** Conduct bi-annual registration drive events for enrollment of vulnerable persons with lived experience into social protection services e.g. SHA, Disability registration, (NCPWD), etc | Bi-annual registration drive events conducted | Number of bi-annual registration drive events conducted | 60 | 60 (2 per sub-county for 10 pax each, for 1 day, per year for 5 years). | 1,530,000 | 306,000 | 306,000 | 306,000 | 306,000 | 306,000 |
| **4.4.5** Establish partnerships with stakeholders in the MH space to pool financial resources at the county level | Partnerships with stakeholders in the MH space established to pool financial resources | Number of established partnerships with stakeholders in the MH space to pool financial resources | 1 | No budget | | - | - | - | - | - |
| | | Number of meetings held by the established partnerships with stakeholders in the MH space to pool financial resources | 10 | 10 meetings (2 meetings at the county, for 20 pax, for 1 day, per year, for 5 years). | 1,205,000 | 241,000 | 241,000 | 241,000 | 241,000 | 241,000 |
| **4.4.6** Establish public-private partnerships (PPP) at the county level to address MH | Public-private partnership established at the county level to address MH | Number of public-private partnerships established at the county level to address MH | 1 | No budget | - | - | - | - | - | - |
| | | Number of public-private partnership projects on MH being implemented in the county | 5 | No budget | | - | - | - | - | - |

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|---|---|---|---|---|---|---|---|---|---|---|
| **Strategic Action 4.5.** Mental Health Research | | | | | | | | | | |
| **4.5.1** Establish a Research, M&E, and Planning Sub-committee at county level | Research, M&E and Planning Sub-committee established | Number of sub-committees on Research, M&E and Planning established. | 1 | No budget | - | - | - | - | - | - |
| | | Number of meetings held by the Research, M&E, and planning subcommittee | 20 | 20 Meetings (1 meeting for 7 pax per quarter per year for 5 years). | 580,000 | 116,000 | 116,000 | 116,000 | 116,000 | 116,000 |
| **4.5.2** Map and segment regions by type of drugs and substances used to inform interventions | Mapping and segmenting of regions by type of drugs and substances used conducted to inform interventions | Number of mappings and segmentation of regions by type of drugs and substances used, conducted to inform interventions | 1 | No budget | - | - | - | - | - | - |
| | Findings of mapping and segmentation of regions by type of drugs and substances used to inform interventions disseminated | Number of workshops held to disseminate findings of mappings and segmentation of regions by type of drugs and substances used to inform interventions | 7 | 7 workshops (1 at the county and 1 per sub-county for 30 pax per workshop) | 862,000 | 862,000 | - | - | - | - |
| **4.5.3** Map stakeholders in the county, including their MH areas of focus and geographical coverage to inform interventions | Meetings to map stakeholders, including MH areas of focus and geographical coverage, conducted | Number of meetings to map stakeholders, including mental MH areas of focus and geographical coverage, conducted | 3 | 3 meetings (held at the county level every other year for 30 pax per meeting for 2 days), | 1,083,000 | 361,000 | - | 361,000 | - | 361,000 |



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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **4.5.4** Conduct a baseline survey to quantify the burden of MH to inform investments | Baseline survey to quantify MH burden to inform interventions conducted | Number of baseline surveys conducted to determine the burden of MH to inform interventions | 1 | Consultant's fee including research assistants if required for 25 days. | 1,251,000 | 1,250,000 | - | - | - | - |
| | Findings of the baseline survey to quantify MH burden to inform interventions disseminated | Number of workshops to disseminate findings of the baseline survey on MH burden to inform interventions | 7 | 7 workshops (1 at the county and 1 per sub-county for 30 pax per workshop) | 907,000 | 907,000 | - | | - | - |
| **4.5.5** Establish a database for research and reports done on MH in the county | Database for research and reports done on MH established in the county | Number of databases for research and reports done on mental health established at the county level | 1 | No budget | - | - | - | - | - | - |
| **4.5.6** Hold scientific conferences on MH at county level | Scientific conference on MH held at county level | Number of scientific conferences on MH held.at county level | 2 | 2 scientific conferences, each 2 days (3rd and 5th year) to cater for county team only of 20 pax. Conference package for 20 pax. | 484,000 | - | - | 242,000 | - | 242,000 |
| **4.5.7** Support staff to present scientific papers on MH at in-country and international scientific conferences | Staff supported to present scientific papers on MH in local and international conferences | Number of staff supported to present scientific papers on MH locally and internationally. | 10 | 10 (2 pax per year. Support includes: Scientific conference registration, transport, and accommodation for in-country and international etc), per year for 5 years | 2,000,000 | 400,000 | 400,000 | 400,000 | 400,000 | 400,000 |
| **4.5.8** Conduct experiential learning visits in-county and out of county | Experiential learning visits conducted in-county and out of the county | Number of experiential learning visits conducted in the county | 15 | 15 visits (3 in-county visits for 1 day, per year for 5 years). | 227,500 | 45,500 | 45,500 | 45,500 | 45,500 | 45,500 |
| | | Number of experiential learning visits conducted out of county | 10 | Out of count (2 visits, 1 day each for 15 pax per year for 5 years) | 1,155,015 | 231,003 | 231,003 | 231,003 | 231,003 | 231,003 |

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| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Strategic Action 4.6. Human Resource for Mental Health** | | | | | | | | | | |
| **4.6.1** Adopt MH national training manuals (CHP and Clinical MH guidelines) | MH national training manuals adopted | Number of MH national manuals adopted | 2 | No budget | - | - | - | - | - | - |
| **4.6.2** Conduct training needs assessment of existing MH service providers | Training needs assessment on existing MH service providers conducted | Number of training needs assessments on existing MH service providers conducted | 3 | No budget | - | - | - | - | - | - |
| | | Number of virtual meetings held to share the report | 3 | 3 virtual meetings to share the report (in years 1, 3, and 5 for 53 pax each). Internet bundles | 82,500 | 27,500 | - | 27,500 | - | 27,500 |
| | | Number of training needs assessment reports printed | 21 | Printing of 21 reports (1 for the county and 1 per sub-county per training needs assessment conducted) every other year. | 63,000 | 21,000 | - | 21,000 | - | 21,000 |
| **4.6.3** Conduct MH TOTs training to facilitate training of MH service providers at facilities and community | MH TOTs trained | Number of MH TOTs trained | 150 | 5 training workshops (1 training workshop for 30 pax and 3 facilitators, for 5 days, per year for 5 years). | 5,180,000 | 1,036,000 | 1,036,000 | 1,036,000 | 1,036,000 | 1,036,000 |
| **4.6.4** Train the existing MH service providers as per the findings of the training needs assessment | Existing MH service providers trained as per the findings of the training needs assessment | Number of existing MH service providers trained as per the findings of the training needs assessment | 300 | 10 training workshops (2 training workshops for 30 pax each and 2 facilitators per training, for 3 days, per year for 5 years). | 5,950,000 | 1,190,000 | 1,190,000 | 1,190,000 | 1,190,000 | 1,190,000 |



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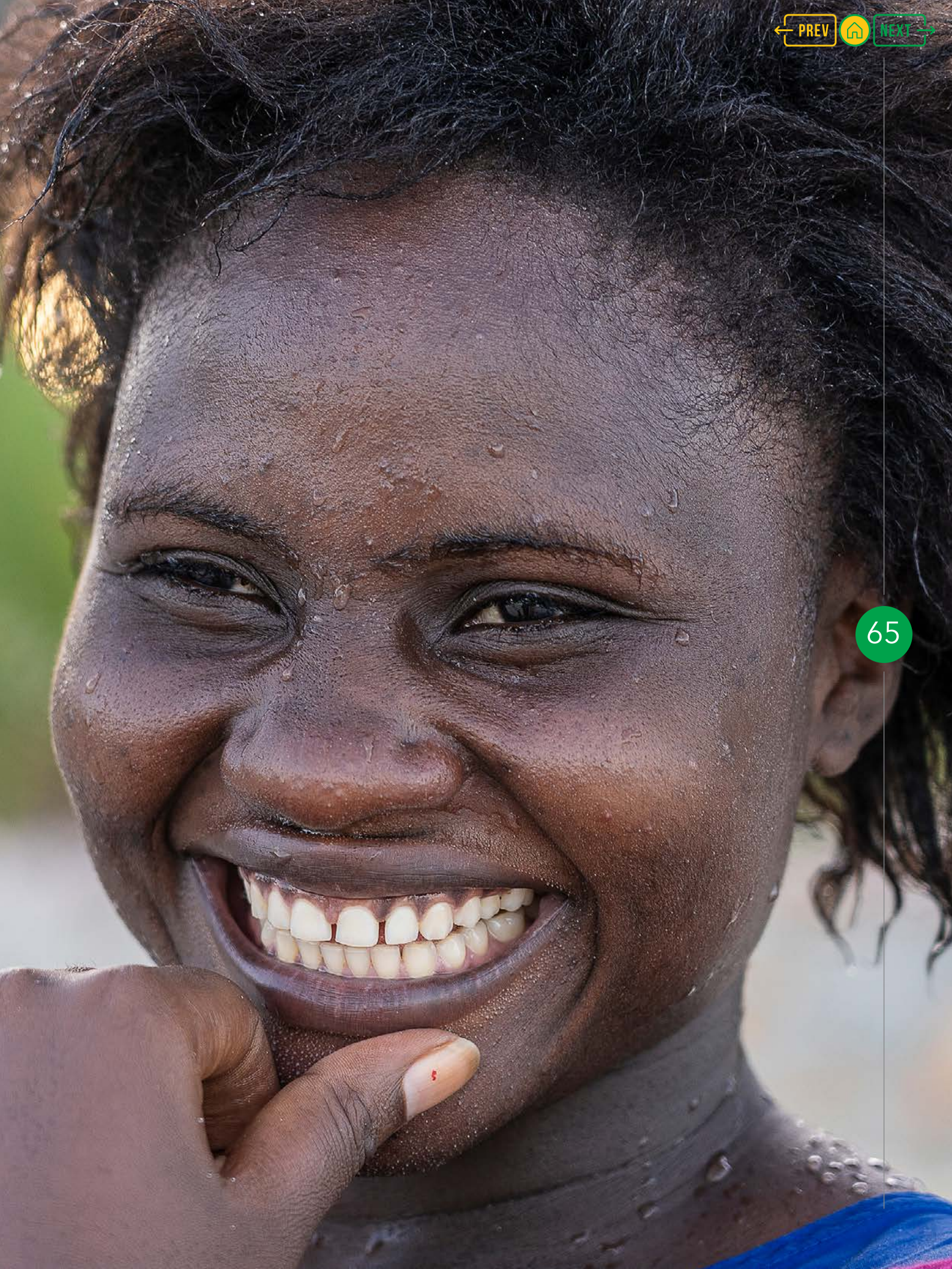
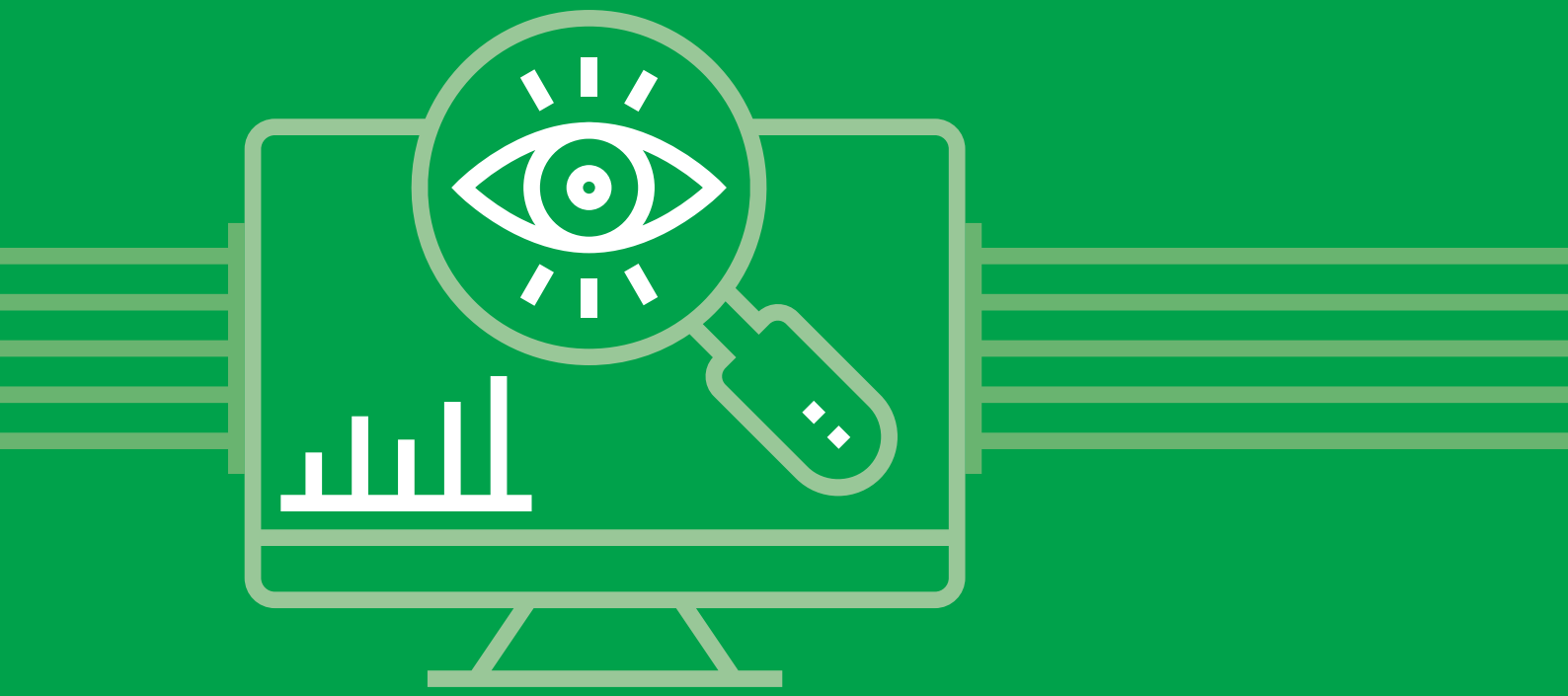
| Activities | Output | Output Indicator | Target | Cost Item Description | Total Cost | YR1 | YR2 | YR3 | YR4 | YR5 |
|---|---|---|---|---|---|---|---|---|---|---|
| **4.6.5 Conduct** staffing needs assessments of human resources for MH | Staffing needs assessment of human resources for MH | Number of staffing needs assessments for HR for MH done | 3 | No budget | - | | | | | |
| | | Number of virtual meetings held to share the report | 3 | 3 virtual meetings to share the report (in years 1, 3, and 5 for 53 pax each). | 82,500 | 27,500 | - | 27,500 | - | 27,500 |
| | | Number of staffing needs assessment reports printed | 21 | 21 reports (1 for the county and 1 per sub-county per staffing needs assessment conducted). | 63,000 | 21,000 | - | 21,000 | - | 21,000 |
| **4.6.6** Advocate for recruitment of MH-human resources as per Count staffing needs assessment | MH human resource recruitment advocacy sessions undertaken | Number of MH human resources recruitment advocacy sessions undertaken | 5 | 5 advocacy sessions (1 session for 7 pax per year for 5 years). | 90,000 | 18,000 | 18,000 | 18,000 | 18,000 | 18,000 |
| **4.6.7** Conduct CME for MH service providers to keep them updated on new technologies for the management of MH | CME conducted for MH service providers | Number of CME conducted for the MH service providers | 2848 | 2848 CME (4 CME per facility (178 facilities) for 5 pax each, and 1 facilitator, per facility, for 1 day each, from year 2, per year for 4 years). | 11,404,000 | - | 2,851,000 | 2,851,000 | 2,851,000 | 2,851,000 |

PREV
NEXT



CHAPTER 6

# Monitoring and Evaluation Framework



## Chapter 6:
Monitoring and Evaluation Framework

| Component Area | Indicator | Target | Yr 1 | Yr 2 | Yr 3 | Yr 4 | Yr 5 |
|---|---|---|---|---|---|---|---|
| To strengthen effective leadership and governance for mental health | Number of MH councils established at the county level | 1 | 1 | | | | |
| | Number of MH councils' meetings held to induct members on their roles and responsibilities | 1 | 1 | | | | |
| | Number of MH councils meetings held | 20 | 4 | 4 | 4 | 4 | 4 |
| | Number of multi-sectoral coordination committees established at the county level | 1 | 1 | | | | |
| | Number of multi-sectoral stakeholders' meetings held | 20 | 4 | 4 | 4 | 4 | 4 |
| | Number of Technical Working Groups established at county level | 1 | 1 | | | | |
| | Number of quarterly Technical Working Group meetings held at the county level | 20 | 4 | 4 | 4 | 4 | 4 |
| | Number of interdepartmental coordination committees established at sub-county level | 6 | 6 | | | | |
| | Number of meetings held by the interdepartmental coordination committee at the sub-counties level | 120 | 24 | 24 | 24 | 24 | 24 |
| | Number of community health units with mental health CHPs appointed and sensitized on their roles | 168 | 168 | | | | |
| | Number of Community Health Committees within which mental health is integrated | 168 | 168 | | | | |
| | Number of Community Health Committee chairs sensitized on mental health | 168 | 168 | | | | |
| | Number of sub-county dissemination meetings held to disseminate national-level policies and legislation on mental health | 6 | 6 | | | | |
| | Number of sub-county dissemination meetings held to disseminate national-level guidelines on mental health | 6 | 6 | | | | |
| | Number of dissemination meetings held to disseminate CMHAP | 7 | 7 | | | | |
| | Number of MH Communication Strategies developed and disseminated | 1 | 1 | | | | |
| | Number of dissemination meetings held to disseminate the MH Communication Strategy | 7 | 7 | | | | |
| | Number of sub-committees on advocacy and partnership established at the county level | 1 | 1 | | | | |

| Component Area | Indicator | Target | Yr 1 | Yr 2 | Yr 3 | Yr 4 | Yr 5 |
|---|---|---|---|---|---|---|---|
| To strengthen effective leadership and governance for mental health | Number of quarterly meetings held by the advocacy and partnership subcommittee at the county level | 20 | 4 | 4 | 4 | 4 | 4 |
| | Number of county government development plans in which mental health is integrated | 11 | 2 | 3 | 2 | 2 | 2 |
| | Number of workshops held to adopt SOPs to guide mental health program | 1 | 1 | | | | |
| | Number of workshops held to disseminate SOPs to guide mental health program operationalization | 7 | 7 | | | | |
| | Number of coordination meetings for multi-sectoral stakeholders' basket funding held at the county and sub-county level | 20 | 4 | 4 | 4 | 4 | 4 |
| To implement strategies for the promotion mental health, prevention of mental and substance use disorders | Number of Support groups for people with lived experiences established | 20 | 10 | 10 | | | |
| | Number of Support group members for people with lived experiences trained to provide psychosocial support to clients with mental health and substance use disorders | 60 | 30 | 30 | | | |
| | Number of support group members for people with lived experiences trained in the promotion and prevention of MH and substance use disorders | 60 | 30 | 30 | | | |
| | Number of psychosocial support groups for the families/Caregivers of persons with lived experiences established | 20 | 10 | 10 | | | |
| | Number of members of the psychosocial support groups for families/Caregivers of people with lived experiences trained to provide psychosocial support to families/caregivers of people with lived experiences | 60 | 30 | 30 | | | |
| | Number of support group members for people with lived experiences linked to trade skills training and talent development programs | 150 | | 50 | 50 | 50 | |
| | Number of support group members for the families/Caregivers of persons with lived experiences linked to trade skills training programs | 150 | | 50 | 50 | 50 | |
| | Number of support group members for people with lived experiences linked to programs providing tools of trade | 150 | | 50 | 50 | 50 | |

| Component Area | Indicator | Target | Yr 1 | Yr 2 | Yr 3 | Yr 4 | Yr 5 |
|---|---|---|---|---|---|---|---|
| To implement strategies for the promotion mental health, prevention of mental and substance use disorders | Number of support group members for the families/Caregivers of persons with lived experiences linked to programs providing tools of trade | 150 | | 50 | 50 | 50 | |
| | Number of support group members for people with lived experiences linked to enterprise development training programs | 150 | | | 50 | 50 | 50 |
| | Number of support group members for the families/Caregivers of persons with lived experiences linked to enterprise development training programs | 150 | | | 50 | 50 | 50 |
| | Number of Community-based alcoholic; and substance use anonymous groups established | 30 | 6 | 6 | 6 | 6 | 6 |
| | Number of people with MH supported for social reintegration | 500 | 50 | 100 | 150 | 150 | 50 |
| | Number of dialogues on MH conducted with opinion leaders at the county and sub-county levels | 70 | 14 | 14 | 14 | 14 | 14 |
| | Number of community dialogue forums to create awareness on MH conducted at the ward level | 400 | 80 | 80 | 80 | 80 | 80 |
| | Number of community outreaches on MH conducted at the sub-county level | 150 | 30 | 30 | 30 | 30 | 30 |
| | Number of workshops held to disseminate existing laws and regulations on alcohol, drugs, and substance use | 14 | | 7 | 7 | | |
| | Number of MH champions trained at ward level to advocate for the enforcement of existing laws and regulations on alcohol, drugs, and substance use | 20 | 20 | | | | |
| | Number of community leaders and members sensitized to advocate for the enforcement of existing laws and regulations on alcohol, drugs, and substance use at ward level | 500 | 100 | 100 | 100 | 100 | 100 |
| | Number of CHPs trained on the promotion and prevention of MH | 1780 | 356 | 356 | 356 | 356 | 356 |
| | Number of youth champions sensitized on promotion, and prevention of MH | 100 | 20 | 20 | 20 | 20 | 20 |
| | Number of MH health champions trained on the promotion and prevention of MH | 20 | | 20 | | | |
| | Number of teachers trained on the promotion and prevention of MH | 1000 | 200 | 200 | 200 | 200 | 200 |
| | Number of health promotion officers trained on promotion and prevention of MH | 7 | 7 | | | | |

| Component Area | Indicator | Target | Yr 1 | Yr 2 | Yr 3 | Yr 4 | Yr 5 |
|---|---|---|---|---|---|---|---|
| To implement strategies for the promotion mental health, prevention of mental and substance use disorders | Number of health education outreaches on MH conducted in learning institutions | 1200 | 240 | 240 | 240 | 240 | 240 |
| | Number of health education outreaches on MH conducted in prisons | 20 | 4 | 4 | 4 | 4 | 4 |
| | Number of health education outreaches conducted in police stations | 160 | 32 | 32 | 32 | 32 | 32 |
| | Number of Health education outreaches conducted for court users' committees | 20 | 4 | 4 | 4 | 4 | 4 |
| | Number of local media houses engaged | 3 | 3 | | | | |
| | Number of local language radio shows on MH conducted | 120 | 24 | 24 | 24 | 24 | 24 |
| | Number of media persons sensitized on MH | 100 | 20 | 20 | 20 | 20 | 20 |
| | Number of bloggers sensitized on MH | 150 | 30 | 30 | 30 | 30 | 30 |
| | Number of workshops held to develop IEC materials by type for 5 special population groups | 1 | 1 | | | | |
| | Number of IEC materials printed for special population groups | 5000 | 1000 | 1000 | 1000 | 1000 | 1000 |
| | Number of outreaches conducted to distribute IEC materials by type of special population group | 50 | 10 | 10 | 10 | 10 | 10 |
| | Number of special populations members reached with MH health promotion and prevention messages in collaboration with other stakeholders | 3600 | 720 | 720 | 720 | 720 | 720 |
| | Number of messages in form of a banner printed and distributed | 5 | 1 | 1 | 1 | 1 | 1 |
| | Number of key MH calendar days conducted with other relevant sectors | 5 | 1 | 1 | 1 | 1 | 1 |
| | Number of MH awareness campaigns conducted | 5 | 1 | 1 | 1 | 1 | 1 |
| | Number of MH messages in form of a banner for integration in community dialogue meetings, community action days, community barazas, and facility talks developed | 2 | 2 | | | | |
| | Number of banners printed | 2 | 2 | | | | |
| | Number of Community dialogue meetings held within which MH messages are integrated | 800 | 160 | 160 | 160 | 160 | 160 |
| | Number of community action days held within which MH messages are integrated | 400 | 80 | 80 | 80 | 80 | 80 |
| | Number of community barazas held within which MH messages are integrated | 400 | 80 | 80 | 80 | 80 | 80 |

| Component Area | Indicator | Target | Yr 1 | Yr 2 | Yr 3 | Yr 4 | Yr 5 |
|---|---|---|---|---|---|---|---|
| To implement strategies for the promotion mental health, prevention of mental and substance use disorders | Number of facility talks held within which MH messages are integrated | 7120 | 1424 | 1424 | 1424 | 1424 | 1424 |
| | Number of gatekeepers sensitized on suicide prevention including how to identify and refer the affected for better management | 150 | 30 | 30 | 30 | 30 | 30 |
| | Number of meetings held to develop suicide prevention messages for integration | 5 | 1 | 1 | 1 | 1 | 1 |
| | Number of suicide prevention message banners printed and distributed | 5 | 1 | 1 | 1 | 1 | 1 |
| | Number of health talks at facility level with integrated messages on suicide prevention | 1800 | 360 | 360 | 360 | 360 | 360 |
| | Number of health talks in community dialogue meetings with integrated messages on suicide prevention | 120 | 24 | 24 | 24 | 24 | 24 |
| | Number of health talks during community action days with integrated messages on suicide prevention | 120 | 24 | 24 | 24 | 24 | 24 |
| | Number of health talks in school extra-curriculum activities with integrated messages on suicide prevention | 5500 | 1100 | 1100 | 1100 | 1100 | 1100 |
| | Number of health talks during public barazas with integrated messages on suicide | 400 | 80 | 80 | 80 | 80 | 80 |
| | Number of teachers, HCWs, CHAs, police, agricultural officers, and CHPs sensitized on suicide prevention, risk assessment tool, and referral pathways | 900 | 180 | 180 | 180 | 180 | 180 |
| | Number of world suicide days commemorated | 5 | 1 | 1 | 1 | 1 | 1 |
| Ensure access to comprehensive, integrated, and high-quality, promotive, preventive, curative, and rehabilitative mental health services at all levels of health care | Number of sub-committees on service delivery established | 1 | 1 | | | | |
| | Number of meetings held by the sub-committee on service delivery | 20 | 4 | 4 | 4 | 4 | 4 |
| | Number of healthcare facilities integrating MH care services. | 178 | 30 | 30 | 90 | 28 | |
| | Number of healthcare workers trained on sign language | 75 | 15 | 15 | 15 | 15 | 15 |
| | Number of MH referral tools integrated into the health facilities referral system | 1 | | | | | |
| | Number of integrated health-based MH referral tools printed and distributed | 1000 | 200 | 200 | 200 | 200 | 200 |
| | Number of MH health referral directory virtual dissemination meetings conducted | 1 | 1 | | | | |

| Component Area | Indicator | Target | Yr 1 | Yr 2 | Yr 3 | Yr 4 | Yr 5 |
|---|---|---|---|---|---|---|---|
| Ensure access to comprehensive, integrated, and high-quality, promotive, preventive, curative, and rehabilitative mental health services at all levels of health care | Number of health referral directories printed and distributed | 178 | 178 | | | | |
| | Number of facilities with established inter-unit committees to enhance the integration of MH services | 178 | 100 | 39 | 39 | | |
| | Number of meetings held by the inter-unit committees at facility level | 3092 | 400 | 556 | 712 | 712 | 712 |
| | Number of facility-based screening tools developed | 1 | 1 | | | | |
| | Number of facility-based screening tools printed and distributed | | | | | | |
| | Number of HCWs trained on facility-based MH screening tool | 900 | 180 | 180 | 180 | 180 | 180 |
| | Number of workplace mental health wellness committees appointed | 15 | 15 | | | | |
| | Number of workplace-based wellness programs established | 15 | 15 | | | | |
| | Number of debriefing sessions for HCWs conducted | 20 | 4 | 4 | 4 | 4 | 4 |
| | Number of MH supportive supervision tools adopted & integrated into the existing supportive supervision program | 1 | 1 | | | | |
| | Number of support supervision within which MH is integrated conducted | 1200 | 240 | 240 | 240 | 240 | 240 |
| | Number of clinical supervisions for PSS providers provided | 60 | 12 | 12 | 12 | 12 | 12 |
| | Number of HCWs providing MH services mentored | 1080 | 216 | 216 | 216 | 216 | 216 |
| | Number of existing QITs integrating MH in their activities | 100 | 20 | 20 | 20 | 20 | 20 |
| | Number of scheduled M&E for MH conducted and reports done in each sub-county | 1200 | 240 | 240 | 240 | 240 | 240 |
| To strengthen mental health systems including information and research | Number of facilities providing MH services equipped with ICT (phones, internet, computer etc.) as appropriate for the level of care | 15 | | 8 | | 7 | |
| | Number of major hospitals integrating MH in-patient services | 6 | 3 | 3 | | | |
| | Number of MH infrastructure constructions completed | 20 | 4 | 6 | 5 | 3 | 2 |
| | Number of advocacy sessions for MH infrastructure construction completion undertaken | 10 | 2 | 2 | 2 | 2 | 2 |
| | Number of rehab departments constructed in the proposed five hospitals | 5 | 2 | 2 | 1 | | |

| Component Area | Indicator | Target | Yr 1 | Yr 2 | Yr 3 | Yr 4 | Yr 5 |
|---|---|---|---|---|---|---|---|
| To strengthen mental health systems including information and research | Number of drug treatment centers for females established | 1 | 1 | | | | |
| | Number of rehabilitative units rehabilitative constructed in Kwale County | 4 | 1 | 2 | 1 | | |
| | Number of proposed health facilities with new inpatient wards | 5 | 2 | 2 | 1 | | |
| | Number of facility-based data capture and reporting tools with integrated MH indicators | 2 | 2 | | | | |
| | Number of data capture and reporting tools printed and distributed | 1780 | 356 | 356 | 356 | 356 | 356 |
| | Number of facilities using MOH MH data capture and reporting tools | 178 | 178 | | | | |
| | Number of healthcare workers trained on capturing and reporting MH data | 1800 | 360 | 360 | 360 | 360 | 360 |
| | Number of data review meetings conducted at the county level | 10 | 2 | 2 | 2 | 2 | 2 |
| | Number of data review meetings conducted. At sub-county level | 120 | 24 | 24 | 24 | 24 | 24 |
| | Number of supply chain system that have included MH essential drugs | 1 | 1 | | | | |
| | Number of health facilities providing MH services with essential mental health drugs | 50 | 50 | | | | |
| | Number of HCWs trained on MH drugs quantification and forecasting | 100 | 50 | 50 | | | |
| | Number of facilities supplied with Occupation therapy equipment | 5 | 3 | 2 | | | |
| | Number of major hospitals providing MH services equipped with essential treatment technologies (ECT Machine, EEG Machine | 3 | 2 | | | 1 | |
| | Number of health facilities providing MH services with commodity auditing sections | 50 | 10 | 10 | 10 | 10 | 10 |
| | Establish a sub-committee on financial resources mobilization at the county level | 1 | 1 | | | | |
| | Number of meetings held by the subcommittee on financial resources mobilization | 20 | 4 | 4 | 4 | 4 | 4 |
| | Number of advocacy sessions conducted for budgetary allocation for MH services as a stand-alone program | 5 | 1 | 1 | 1 | 1 | 1 |
| | Number of advocacy sessions conducted for MH budgeting in sector annual work plans | 5 | 1 | 1 | 1 | 1 | 1 |

| Component Area | Indicator | Target | Yr 1 | Yr 2 | Yr 3 | Yr 4 | Yr 5 |
|---|---|---|---|---|---|---|---|
| To strengthen mental health systems including information and research | Number of bi-annual registration drive events conducted | 60 | 12 | 12 | 12 | 12 | 12 |
| | Number of established partnerships with stakeholders in the MH space to pool financial resources | 1 | 1 | | | | |
| | Number of meetings held by the established partnerships with stakeholders in the MH space to pool financial resources | 10 | 2 | 2 | 2 | 2 | 2 |
| | Number of public-private partnerships established at the county level to address MH | 1 | | | | | |
| | Number of public-private partnership projects on MH being implemented in the county | 5 | 1 | 1 | 1 | 1 | 1 |
| | Number of sub-committees on Research, M&E, and Planning established | 1 | 1 | | | | |
| | Number of meetings held by the subcommittee on Research, M&E, and planning at the county level | 20 | 4 | 4 | 4 | 4 | 4 |
| | Number of mappings and segmentation of areas by type of drugs and substances used conducted to inform interventions | 1 | 1 | | | | |
| | Number of workshops held to disseminate findings of mappings and segmentation of regions by type of drugs and substances used to inform interventions | 7 | 7 | | | | |
| | Number of meetings to map stakeholders, including MH areas of focus and geographical coverage, conducted | 3 | 1 | | 1 | | 1 |
| | Number of baseline surveys conducted to determine the burden of MH | 1 | 1 | | | | |
| | Number of workshops to disseminate findings of the baseline survey to quantify MH burden to inform interventions held | 7 | 7 | | | | |
| | Number of databases for research and reports done on mental health established at the county level | 1 | 1 | | | | |
| | Number of scientific conferences on MH held at county level | 2 | | | 1 | | 1 |
| | Number of staffs supported to present scientific papers on MH in-country and international scientific conferences. | 10 | 2 | 2 | 2 | 2 | 2 |
| | Number of experiential learning visits conducted in the county | 15 | 3 | 3 | 3 | 3 | 3 |

| Component Area | Indicator | Target | Yr 1 | Yr 2 | Yr 3 | Yr 4 | Yr 5 |
|---|---|---|---|---|---|---|---|
| To strengthen mental health systems including information and research | Number of experiential learning visits conducted out of county | 10 | 2 | 2 | 2 | 2 | 2 |
| | Number of training needs assessments on existing MH service providers conducted | 3 | 1 | | 1 | | 1 |
| | Number of virtual meetings held to share the training needs assessment report | 3 | 1 | | 1 | | 1 |
| | Number of training needs assessment reports printed | 21 | 7 | | 7 | | 7 |
| | Number of MH TOTs trained | 150 | 30 | 30 | 30 | 30 | 30 |
| | Number of existing MH service providers trained as per the findings of the training needs assessment | 300 | 60 | 60 | 60 | 60 | 60 |
| | Number of staffing needs assessments of human resources for MH conducted | 3 | 1 | | 1 | | 1 |
| | Number of virtual meetings held to share the report | 3 | 1 | | 1 | | 1 |
| | Number of training needs assessment reports printed | 21 | 7 | | 7 | | 7 |
| | Number of MH TOTs trained | 150 | 30 | 30 | 30 | 30 | 30 |
| | Number of existing MH service providers trained as per the findings of the training needs assessment | 300 | 60 | 60 | 60 | 60 | 60 |
| | Number of staffing needs assessments for human resources for MH | 3 | 1 | | 1 | | 1 |
| | Number of virtual meetings held to share the staffing needs assessment report | 3 | 1 | | 1 | | 1 |
| | Number of MH staffing needs reports printed | 21 | 7 | | 7 | | 7 |
| | Number of MH human resources recruitment advocacy sessions undertaken | 5 | 1 | 1 | 1 | 1 | 1 |
| | Number of CME conducted for the MH service providers | 2848 | | 712 | 712 | 712 | 712 |

# List of Contributors

| | Name | Organization |
|---|---|---|
| 1. | Dr. Hajara Elbusaidy | County Government of Kwale, Director – Health Services |
| 2. | Dr. Noreen Zecha | Kwale County NCD Coordinator |
| 3. | Edward Munene Miano | Executive Director – HERAF |
| 4. | Dr. Margret Makumi | Independent Consultant – HERAF |
| 5. | Anthony Wanjala | Court Administrator – Kwale Law Courts |
| 6. | Winnie Juma | Kwale Community of Practice (KCOP) |
| 7. | Falsy Abdalla | Kenya Red Cross |
| 8. | Prischilla Maina | CO – Mental Health and Psychiatry |
| 9. | Anne Okello | Counselling Psychologist – County Government of Kwale |
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| 13. | Phillip Gichimba | Clinical Psychologist – County Government of Kwale |
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| 15. | Sirte Ali Marvji Dhanji | SC AYP |
| 16. | Clara Mulwa | Caregiver / County Emergency Response |
| 17. | Prisca Mwongeri | G for Girls |
| 18. | Salim Juma | Communication Officer – Community of Practice |
| 19. | Consesa Matunda | SCMHFP – County Government of Kwale |
| 20. | Hellen Arunga | Ministry of Education |
| 21. | Trizer Ireri | MH – Focal Person |
| 22. | Mwanatumu Kassim | County HRIO |
| 23. | Munira Abdalla | Haki Yetu Organization / Court Users Committee |
| 24. | Bernice Kiragu | Health Rights Advocacy Forum |
| 25. | Christine Mwangi | Health Rights Advocacy Forum |
| 26. | Lucy Mwati | Health Rights Advocacy Forum |
| 27. | Hajra Ruwange | County Department of Social Services & Talent Development |
| 28. | Mwanajuma Ali Dziwa | Ministry of Education |
| 29. | Dr. Arthur Nderitu | County Pharmacist - County Government of Kwale |
| 30. | Juma Mwakitenje | KCOP |
| 31. | Elizabeth Mwashegu | Adolescent and Youth Program |
| 32. | Dr. Frederick Murunga Wekesah | African Population and Health Research Center (APHRC) |

# Beneath the Surface

# MENTAL HEALTH STRATEGIC ACTION PLAN

## 2026 - 2030

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