SCIENTIFIC COMMUNICATION

REPORTING ON MENTAL HEALTH ILLNESS (MHI) IN KENYA: HOW WELL ARE WE DOING?

INTRODUCTION

Mental health illnesses (MHI) contribute to approximately 13% of the total global disease burden, while in low- and middle-income countries this burden is even higher, estimated at 25% and 34%, respectively (1). A paucity of attention has been given to mental health in developing countries where 76-85% of those affected remain untreated. In Kenya, the prevalence of MHI is projected to be between 10-37% in the general population (3).

MHI refers to a wide range of disorders that affect mood, thinking and behavior, including depression, anxiety, schizophrenia, post-traumatic stress and addiction. The prevalence of MHI appears higher among those who live in poverty, at risk of displacement or conflict, or have chronic diseases such as HIV (4). This problem is exacerbated by the lack of quality mental health services and providers, absence or non-implementation of national policies, minimal integration of mental health care in primary care and insufficient funding (1). In Kenya, the Ministry of Health (MoH) recently launched an innovative mental health policy to provide a framework for reforms in mental health service delivery (5).

Implementation of successful MHI interventions requires a robust recording and reporting system to monitor and evaluate progress and impact. In addition, serviceable health information systems at community, county and national levels are fundamental for evidence-based decision-making and improved service delivery for MHI. Since 2011, Kenya has utilised a national digital healthcare information platform (DHIS2) to monitor healthcare service delivery and outcomes. This report describes the current state of the routine data collection and reporting for mental illnesses in Kenya.

MATERIALS AND METHODS

This is a retrospective review of the mental illness data reported by public health facilities from the 47 counties in Kenya between 2011 and 2015. The country has approximately 6,000 health facilities for an estimated population of 46 million. Primary health care services are provided by the MoH, largely free-of-cost, but most specialty services, including mental health, require out-of-pocket expenses. For the entire country, there are approximately 50 psychiatrists and 400 nurses with additional psychiatric training to provide care to individuals with MHI (7). Data for this review were extracted from the Kenya DHIS2. Analysis was conducted in Excel (Microsoft Corp., Redmond, Washington).

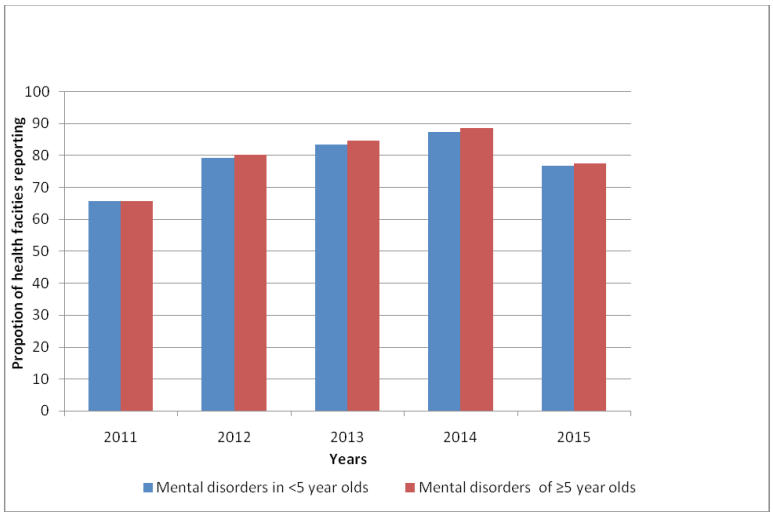
*Ethics Approval:*Ethics approval was obtained from the Moi University & Moi Teaching and Referral Hospital Institutional Review Ethics Committee (Eldoret, Kenya) and Médecins Sans Frontières Ethics Review Board (Geneva, Switzerland). Permission was also granted by the Kenya MoH.

RESULTS

In 2011, approximately 65% of healthcare facilities reported caring for patients diagnosed with an MHI (Figure 1). In comparison, this number improved to almost 90% for those both < 5 and ≥ 5 years old, in 2014. However, there was a decrease to 75% of health care facilities reporting in 2012. In general, the proportion of facilities was similar in reporting for each year, regardless of the age group. Annually, each county reported 90,000 mental health consultations with minimal variation over the five years.

Figure 1

Mental health illnesses reporting rate from Kenya Ministry of Health facilities for patients less than 5 years and above 5 years of age between 2011 and 2015.



DISCUSSION

Our review findings highlight the need for multiple improvements in the MHI data collection tool for evidence-based decision-making and provision of quality health care. First, the data are arbitrarily disaggregated as age less than five and age above five years. The burdens of mental illnesses vary greatly by age with older adults experiencing greater burden compared to children (3). Collapsing those greater than five years into one group, significantly limits the ability to strategically plan and operationalize for those in greatest need.

Second, gender data is missing. Women, especially those living in developing countries, suffer disproportionate risk factors and co-morbidities resulting into increased susceptibility to MHI (1). Pregnancy, gender-based violence, conflicts and other social pressures are documented risk factors for MHI (1).

Third, specific mental illnesses are not collected. Each requires precise management including diagnostic criteria, medications, duration of therapy, multi-disciplinary approaches and social support (4). Such lack of disaggregation likely contributes to the lack of clear definitions of what constitutes a mental illness and leads to suboptimal patient care. Clear guidelines including adoption of internationally accepted classification is desperately needed.

The findings from the data quality assessment (DQA) conducted in 2010 revealed that MHI at the community level had the poorest reporting rates at 34%, compared to 90% of assessed indicators at facility level (1). This was attributed to lack of training, support supervision for staff handling data and unclear indicator definitions for mental illness. The recently launched Kenya mental health policy is a critical milestone, however, further steps including guidelines, training and improved resource allocation are imperative.

CONCLUSION

There is currently a gap in the amount of specific data captured and reported for mental health in Kenya. Given the large proportions who are suffering from these chronic diseases, it is time to realize the constitutional goal of highest attainable standards of health to all, 'including mental health'. A comprehensive reporting tool for mental illness is critical to aid in policy making.

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