

Schnellrecherche der SFH-Länderanalyse vom 17. Juli 2017 zu Kenia: Behandlung von Diabetes, psychiatrische Versorgung

Fragen an die SFH-Länderanalyse:

- Kann Diabetes in Kenia behandelt werden?
- Wie ist die psychiatrische Versorgung in Kenia?
- Werden psychisch Kranke diskriminiert?
- Können posttraumatische Belastungsstörungen (PTBS), Depressionen und Schizophrenie in Kenia behandelt werden?

Die Informationen beruhen auf einer zeitlich begrenzten Recherche (Schnellrecherche) in öffentlich zugänglichen Dokumenten, die uns derzeit zur Verfügung stehen.

1 Gesundheitssystem

Mangel an Ressourcen. Laut einem Artikel von *Dustin Grunert* aus dem Jahr 2016 mangelt es dem kenianischen Gesundheitssystem an Ressourcen. Es fehle an Infrastruktur, an Medikamenten und an ausgebildetem Personal.

Es gibt keine allgemeine Krankenversicherung, Gesundheitsdienstleistungen sind für viele unerschwinglich. Laut *Dustin Grunert* (2016) gibt es in Kenia keine allgemeine Krankenversicherung. Die nationale Gesundheitsversicherung, in die Arbeitgeber und ihre Angestellten einzahlen müssen, komme nur für die Zimmerkosten auf. Die Kosten für Arztbesuche, Behandlungen und Medikamente müssten von den Patientinnen und Patienten getragen werden. Jedoch gelten 40 Prozent der Kenianerinnen und Kenianer als arm. So erklärte *Nancy Ngugi*, Direktorin der Diabetesklinik im *Kenyatta National Hospital*, im November 2014 gegenüber der Weltgesundheitsorganisation (WHO), dass für viele Kenianerinnen und Kenianer die hohen Kosten ein entscheidendes Hindernis beim Zugang für Gesundheitsdienstleistungen seien. Personen mit niedrigem Einkommen könnten sich Medikamente, Arztbesuche und Tests nicht leisten.

2 Behandlung von Diabetes

Zunahme der Anzahl Personen, die an nicht übertragbaren Krankheiten einschliesslich Diabetes leiden. Laut *Dr. William Maina*, Leiter des dem kenianischen Gesundheitsministerium untergeordneten *Directorate of Preventive and Promotive Health Services*, stellt die Zunahme von Personen, die an nicht übertragbaren Krankheiten wie Diabetes, Herzerkrankungen, Schlaganfällen und Krebserkrankungen leiden, eine grosse Belastung für das kenianische Gesundheitssystem dar (WHO, November 2014). Die Informationen von *Dustin Grunert* (2016) bestätigen dies.

Diabetes-Diagnosen werden zu spät erstellt, und es mangelt an Wissen bei der Bevölkerung. Laut Informationen der Weltgesundheitsorganisation (WHO) vom No-

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vember 2014 erhalten die meisten an Diabetes erkrankten Personen ihre Diagnose zu spät. Zu diesem Zeitpunkt sei es nicht mehr möglich, Komplikationen der Krankheit vorzubeugen. Eine Diagnose erfolgt gemäss *Nancy Ngugi* oft durch medizinische Outreach-Programme oder erst, nachdem bei den Patientinnen und Patienten bereits für Diabetes typische Symptome wie Durst, Veränderung der Sehkraft, Müdigkeit und dauerhafter Hunger eingetreten sind. Die kenianische Bevölkerung wisse wenig über Diabetes.

Insbesondere in öffentlichen Gesundheitseinrichtungen mangelt es an Fachpersonal für die Behandlung von Diabetes, die Qualität der Behandlungen ist nicht angemessen, und viele erkrankte Personen müssen eine weite Anreise und lange Wartezeiten in Kauf nehmen. Gemäss *Nancy Ngugi* fehlt in Kenia medizinisches Fachpersonal für Diabetes. Die meisten Patientinnen und Patienten würden von Personen behandelt, die nur ein geringes Wissen über Diabetes hätten. Dies sei auch im *Bungoma County Hospital* der Fall (*Namukhula*, 2015). Laut *Dustin Grunert* (2016) müssen an Diabetes erkrankte Patientinnen und Patienten im *Kenya-tta Hospital* eine weite Anreise und lange Wartezeiten in Kauf nehmen. Die Wartezeiten sind gemäss einem in *Missing Medicines* (14. März 2016) zitierten Patienten besonders in öffentlichen Gesundheitsinstitutionen ein Problem. Dort sei eine Behandlung zwar günstiger als im Privatsektor. Es gebe aber nur wenige genügend ausgebildete Fachpersonen, und die Qualität der Dienstleistungen sei nicht angemessen.

In öffentlichen Spitälern mangelt es an Medikamenten, Tests und medizinischem Material zur Diabetes-Behandlung. Hohe Preise auf dem privaten Markt machen benötigte Medikamente und Verbrauchsmaterial für viele unerschwinglich. In staatlichen Spitälern sind Medikamente und medizinisches Verbrauchsmaterial zum Teil nicht verfügbar. Auf dem privaten Markt sind diese für die meisten Kenianerinnen und Kenianer unbezahlbar. Ein 32-jähriger kenianischer Diabetiker, zitiert in *Missing Medicines* (14. März 2016), musste laut eigener Aussage monatlich um die 120 US-Dollar ausgeben, um Diabetes angemessen behandeln zu können. So wie er könnten viele Kenianerinnen und Kenianer diesen Betrag nicht bezahlen. So kosteten 60 Injektionsspritzen auf dem freien Markt 120 US-Dollar. Der Test HbA1c, ein gängiger Diabetestest, werde in öffentlichen Spitälern nicht angeboten. Auf dem privaten Markt koste er 350 USD. Aus einer kenianischen Masterarbeit zum *Bungoma County Hospital* aus dem Jahr 2015 geht hervor, dass dort mangels angemessener Infrastruktur essentielle Tests zur Diabetesbehandlung wie Tests auf Uringlukose, Urinketone, Gesamtcholesterin und Insulin nicht durchgeführt wurden (*Namukhula*, 2015).

Das *Bungoma County Hospital* verfügte gemäss *Namukhula* (2015) nur über ein einziges Blutzuckermessgerät. Gemäss *Missing Medicines* (14. März 2016) sind Blutzuckermessgeräte und Teststreifen in öffentlichen Spitälern nicht verfügbar. Auf dem freien Markt koste ein Blutzuckermessgerät 300 USD. Abhängig vom benutzten Blutzuckermessgerät werden verschiedene Teststreifen benötigt, die zwischen 20 und 350 USD kosten und nicht immer verfügbar sind. Eine Insulinpumpe koste 7000 USD und das dazugehörige Verbrauchsmaterial bis zu 2400 USD pro Monat. Laut dem Bericht von *Dustin Grunert* aus dem Jahr 2016 kostet eine Monatspackung Tabletten zur Behandlung von Diabetes 35 Euro. Patientinnen und Patienten seien somit ge-

zwungen, Tabletten einzeln in der Apotheke zu kaufen, sich gegenseitig mit Tabletten auszuhelfen oder Medikamente abzusetzen. Laut *Missing Medicines* (14. März 2016) versäumen sie aus Geldmangel Arztbesuche und spritzen sich Insulin seltener als nötig.

Grunert, Dustin, *Deutsches Ärzteblatt*, 2016:

«(...) Dennoch sind immer noch 40 Prozent der Kenianer von Armut betroffen. Und die mangelnden Ressourcen sind vor allem im Gesundheitssystem zu erkennen.

Es fehlt an Ausrüstung, Medikamenten und geschultem Personal. (...)

Nicht-übertragbare Krankheiten (NCDs), wie kardiovaskuläre Leiden, **Diabetes mellitus**, nephrologische und onkologische Erkrankungen **stellen eine zunehmende Gefahr für die Volksgesundheit dar**. Jedes Jahr sterben weltweit 38 Millionen Menschen an NCDs, fast dreiviertel davon in Ländern mit niedrigem und mittlerem Einkommen. In Kenia wird bereits jeder vierte Todesfall durch eine NCD verursacht.

Mehrere Stunden Wartezeit

Im Kenyatta Hospital sieht man heute schon die ersten Auswirkungen der steigenden Krankheitszahlen durch NCD. **Der Wartebereich der diabetologischen Klinik ist bis zum Bersten gefüllt. Über Stunden warten Patienten, um behandelt zu werden.** Manche haben tagelange Reisen hinter sich, um sich dort ärztlichen Rat zu holen. (...)

Krankenversicherung fehlt

Neben der mangelnden Infrastruktur ist insbesondere die mitunter jahrzehntelange Finanzierung der Behandlung von chronischen Erkrankungen problematisch. In Kenia gibt es, wie in vielen anderen afrikanischen Ländern auch, keine allgemeine Krankenversicherung. Angestellte und deren Arbeitgeber müssen zwar in die nationale Gesundheitsversicherung einzahlen, die aber nur Zimmerkosten übernimmt. Die Kosten für Arzt, Behandlung und Medikamente müssen die Patienten aus eigener Tasche finanzieren.

Wenige Autostunden nordöstlich von Nairobi liegt in der Nähe von Mwea Town inmitten gewaltiger Reisfelder ein kleines Dorf. Hier lebt die 52-jährige Mary Wangari in einfachen Verhältnissen. Eine Lehmhütte mit Wellblechdach und ein kleiner Tisch, auf dem eine alte Nähmaschine steht, ist zu Hause und Arbeitsplatz. Vor zehn Jahren wurde bei Mary Wangari Diabetes diagnostiziert. Seither kämpft sie damit, ausreichend Geld zu verdienen, damit es sowohl zum Lebenunterhalt, als auch für die Medikamente reicht. **Üblicherweise kauft sie ihre Tabletten einzeln in der Apotheke. Eine Monatspackung wäre für sie und viele andere Patienten in ihrer Lage unerschwinglich. Mit 35 Euro im Monat verschlingen die Medikamentenkosten fast die Hälfte dessen, was Wangari mit ihrer Arbeit an der Nähmaschine verdienen kann. Auch ihre Nachbarin Lucia Kameni leidet an Diabetes. Gelegentlich leihen sich beide Tabletten voneinander oder von anderen Nachbarn. Fast jeder hat Schwierigkeiten, regelmäßig das Geld für die Behandlung aufzu-**

treiben. Fehlt es, wird die Behandlung kurzzeitig abgesetzt.» Quelle: Grunert, Dustin, Gesundheitsversorgung in Kenia: Jede Tablette zählt, in: Deutsches Ärzteblatt, 2016:

www.aerzteblatt.de/archiv/175244/Gesundheitsversorgung-in-Kenia-Jede-Tablette-zaehlt.

WHO, November 2014:

«(...) most people living with diabetes in Kenya are diagnosed too late, when preventing complications of the disease is no longer possible.

*“Across Kenya, **community awareness around diabetes is low**,” notes Dr Nancy Ngugi, Head of the Diabetes Clinic at Kenyatta National Hospital. **People are often diagnosed through medical outreach camps or when patients arrive at the hospital with complications of diabetes like thirst, vision change, fatigue and constant hunger**, she adds.*

*For many Kenyans, **the cost of health care is a key obstacle to treatment**. “Health care is not free in Kenya,” says Dr Ngugi. “In lower-income communities, we find that life is hard. People do not have money to buy drugs, to see the doctor, to get their tests done.”*

*(...) Dr. William Maina leads the Directorate of Preventive and Promotive Health Services in Kenya’s Ministry of Health. He notes the growing strain that diabetes and other non-communicable diseases (NCDs)—such as heart disease, stroke and cancers—are placing on the national health care system. **“We are seeing the burden of NCDs escalate in this country.** If you walk into any hospital, you will find more than half the occupancy of hospital beds is due to NCDs. Almost half of deaths reported by hospitals are due to NCDs,” he says. (...)*

*“We need to educate medical personnel about the management of diabetes because **we do not have many specialists in this country**,” notes Dr Ngugi. **“Most of our patients are being handled by people who really don’t know a lot about diabetes.”**» Quelle: WHO World Health Organization, Kenya faces rising burden of diabetes, November 2014: www.who.int/features/2014/kenya-rising-diabetes/en/.*

Namukhula, Frida, 2015:

«5.2.2 Medical facilities and infrastructure on management and control of diabetes mellitus in health projects.

*The study established that **Bungoma County hospital was not adequately equipped with facilities and infrastructure to manage and control diabetes mellitus**. For instance the study found out that **the clinic tested patients only for fasting random glucose, while urine glucose ketone, total cholesterol and insulin test, although essential for all diabetics was not performed** as per the guidelines due to inadequate equipment.*

From the findings **the hospital had only one glucometer that served both the general hospital and the diabetes clinic**. The study established that the facility had **inadequate personnel**. The hospital lacked consulting physician specialists like diabetologists and neurologists instead the clinic was headed by clinical officers with the medical doctors stepping in after routine duties in the general hospitals. Health education was done mostly by a nutritionist the only one in the entire hospital without use of teaching aids. The subordinate staffs (the cleaners) were in charge of taking the patients' blood pressure weight and recording in the clinic registry an indication of **understaffing**.

The study further established that **the hospital did not have adequate counseling, education and observation rooms** as indicated by respondents. The consulting health workers squeezed in one room sharing three desks. Basically there was no privacy between patients this hindered confidentiality. The clinic had only one observation bed in the main consultation room which was not much used. Therefore inadequate medical facilities worsens diabetes cases hence its prevalence.

5.2.3 Networking and partnership linkages on management and control of diabetes mellitus in health projects.

The study found that Bungoma County Hospital was not affiliated to any diabetes management organization. In fact **most of the health workers did not know any organization that rendered diabetes management services**. In addition the hospital did not have any joint partnerships with any learning institutions to enable exchange of ideas and expertise from other health practitioners. However the respondents agreed that partnership and networking was essential in management and control of diabetes mellitus in Kenya.

5.3 Conclusion

Findings from this study show that **professionalism of health workers, medical facilities and infrastructure (resources) networking and partnership linkages on the management and control of diabetes mellitus is inadequate** at the hospital and most other facilities in Kenya in general. The hospital as a known fact was **ill equipped with inadequate health personnel** especially physician specialists to care for diabetics. **The hospital lacks equipment and other physical facilities and general infrastructure** for example **drugs for treating diabetes and related conditions were intermittent and costly, inadequate health personnel and insufficient observation and consultancy rooms** hence the rising prevalence cases. Despite the existing inadequacies, training more professionals associated with diabetes management as well as provision of medical infrastructure especially screening and diagnostic equipment and subsidized drugs which can be accessed through partnership linkages, will help manage diabetes better and reduce prevalence. Most of the factors that lead to the development of diabetes mellitus can be avoided or controlled.» Quelle: Namukhula, Frida: Factors Influencing Management and Control of diabetes mellitus in Health Projects: A case of Bungoma County Hospital in Bungoma County, Kenya, 2015, S. 53ff (Masterarbeit): erepository.uonbi.ac.ke/bitstream/handle/11295/92959/Namukhula_Factors%20influencing%20manage-

[ment%20and%20control%20of%20diabetes%20mellitus%20in%20health%20projects.pdf?sequence=1.](#)

Missing Medicines, 14. März 2016:

«Proper management of diabetes in Kenya would cost about 120 USD per month. Not many can afford that here, myself included. I have missed clinics due to lack of money. Many mornings I skip my injection, evenings as well, so as to balance the remaining insulin I have until I get enough money to buy the next cartridge.

Initially I used an insulin pen, and one cartridge cost me about 7 USD, with each pen tip costing 0.30 USD each. Note that several pen tips per day are needed and each pen one should really only be used once. Getting the tips was a challenge so I had to change to the less expensive vial and syringes. One vial of mixtard insulin costs about 6 USD in the private sector. At government hospitals it is subsidized to 2 USD. This is a significant difference, but there is a catch. At a government hospital they are dealing with masses but the service is inadequate. Doctors are few and waiting times to see a doctor could be up to four months.

When I need another vial of insulin it is sometimes not even available at government hospitals, and therefore I am forced to buy it in the private sector. HbA1c (a standard diabetes test) is not offered at the Government hospitals (at least not the one I have attend) and it costs 350 USD in the private sector. Test strips cost between 20 USD and 350 USD depending on the glucometer one is using. The catch here is the availability of those specific strips, so one has to factor in that before buying a glucometer. I have not seen those things at the government hospitals when I attended clinics.

Insulin pumps are making a slow entry in the Kenyan market, but they cost 7000 USD and this doesn't include the cost of monthly consumables which cost up to 2400 USD. (...)

Mbolonzi's typical monthly expenses:

<i>Item</i>	<i>Government Price (USD)</i>	<i>Private Sector Price (USD)</i>
<i>Consultation</i>	<i>40</i>	<i>350</i>
<i>2 vials of insulin</i>	<i>40</i>	<i>120</i>
<i>60 syringes</i>	<i>Free</i>	<i>120</i>

HbA1c test	Not available	350
Glucometer (one-off)	Not available	300
100 test strips	Not available	500
Total cost	80	1,740

I opt for a government hospital when possible to spend less but I miss out on some essential management tools and practices.» Quelle: Missing Medicines, Mbolonzi's story: Access to insulin in Kenya, 14. März 2016: <http://missingmedicines.co.uk/mbolonzis-story/>.

3 Psychiatrische Versorgung in Kenia

Die psychiatrische Versorgung in Kenia ist unterfinanziert und weist einen Mangel an Personal auf. *Victoria de Menil*, damals Doktorandin am *Department of Social Policy* der *London School of Economics*, vertrat die Meinung, dass die Psychiatrie innerhalb des nationalen Gesundheitssystems in Kenia marginalisiert werde (*Africa Research Institute*, 27. Juni 2013). Weniger als 0,5 Prozent des kenianischen Gesundheitsbudgets werden der psychiatrischen Versorgung zugeteilt. Es mangle sowohl finanziell als auch personell an Ressourcen im allgemeinen Gesundheitssystem. Insbesondere sei der Bereich der psychiatrischen Versorgung unterfinanziert und personell unterbesetzt. *Dr. Frank Njenga*, damals Präsident der *African Association of Psychiatrists*, bezeichnete in einem Interview mit CNN am 25. Februar 2011 die Situation der psychiatrischen Versorgung in Kenia als «katastrophal». *Victoria de Menil* publizierte im Februar 2015 zusammen mit Martin Knapp einen Artikel in der Zeitschrift *BJPsych International* des *Royal College of Psychiatrists*. Darin wird die Lücke im kenianischen Gesundheitssystem analysiert. Gemäss ihren Berechnungen hat Kenia eine Rate von lediglich 0.62 psychiatrischen Pflegepersonen pro 100'000 Einwohnerinnen und Einwohner. Somit bräuchte Kenia eine zwanzigfache Anzahl an psychiatrischen Pflegepersonen, um die Bedürfnisse der Menschen mit psychischen Krankheiten decken zu können. Auch *Rachel Jenkins*, emeritierte Professorin im Bereich psychischer Gesundheit am *King's College London*, schrieb in einem am 26. Mai 2015 publizierten Artikel, dass die psychiatrische Versorgung in Kenia mangelhaft sei. Die Ärztinnen und Ärzte seien überlastet. Im Vereinigten Königreich trägt eine psychiatrische Pflegeperson Verantwortung für 5'000 bis 10'000 Personen, in Kenia für circa 250'000 Menschen. In der Provinz Nyanza gebe es beispielsweise nur einen Psychiater für 2 Millionen Einwohner, welcher vor einigen Jahren sogar für 5 Millionen Einwohner zuständig war. Als weiteres Beispiel für den Ressourcenmangel kann die Situation im Bezirk Kilifi aufgeführt werden: Gemäss *Bitta, Kariuki, Chengo* und *Newton*, welche 2014 eine Studie zur psychiatrischen Versorgung im *Kilifi County* durchgeführt und 2017 publiziert haben, gibt es in Kilifi keinen Psychia-

ter oder Psychologen, es stehen lediglich zwei psychiatrische Pflegepersonen für eine Bevölkerung von 1,2 Millionen zur Verfügung. Ein Budget für die psychiatrische Versorgung gebe es in *Kilifi County* nicht.

Psychisch Kranken ist es kaum möglich, die Art ihrer Behandlung zu wählen. In einem Bericht von *Users and Survivors of Psychiatry Kenya (USP Kenya)*, welcher dem *UN Committee on Rights of Persons with Disabilities* im August 2015 ausgehändigt wurde, wird darauf hingewiesen, dass das *Mathari Hospital* das einzige öffentliche auf psychiatrische Behandlungen spezialisierte Spital sei. Gemäss dem *USP Kenya*-Bericht müssen viele psychisch erkrankte Menschen wegen fehlender Alternativen eine erzwungene Behandlung akzeptieren. Eine Überarbeitung vom aktuell noch gültigen *Mental Health Act* von 1989 ist vorgesehen. Nach dem gleichen Bericht soll im neuen Gesetz berücksichtigt werden, dass Menschen mit psychischen Erkrankungen die Handlungsfähigkeit und die Versicherung für kostenlose Unterstützung zugesprochen wird. Zudem sollen Ausbeutung, Missbrauch, Folter, erniedrigende Behandlung und chemische Zwangsmassnahmen verboten werden. Nichtsdestotrotz blieben Bemühungen, den derzeitigen Rechtsrahmen aufzuheben und somit zu verhindern, dass psychisch erkrankte Menschen ihrer Handlungsfähigkeit und ihren Freiheiten beraubt werden, bisher erfolglos.

Erzwungene Einweisungen. Am 4. März 2014 publizierten *USP Kenya*, die *Kenya Association of the Intellectually Handycapped (KAIH)* und der *Mental Disability Advocacy Center (MDAC)* gemeinsam einen Bericht über die Situation der psychiatrischen Versorgung in Kenia. Dabei stützten sie sich auf Forschungen, die zwischen 2011 und 2014 durchgeführt worden sind. Laut dem Bericht haben die meisten interviewten Personen ausgesagt, dass sie unfreiwillig eingewiesen worden seien. Es sei legal, Menschen ohne ihre Zustimmung einzuweisen, wenn von den Ehepartnern, von Familienmitgliedern oder von anderen Personen inklusive der Polizei vermutet wird, dass sie eine «psychische Störung» haben. Auch in der Fallstudie zum Bezirk Kilifi zeigen *Bitta, Kariuki, Chengo und Newton (2017)* auf, dass die Mehrheit der Einweisungen unfreiwillig sei. Besonders gewalttätige Patientinnen und Patienten werden angekettet in ambulante Behandlungszentren gebracht; es sei unklar, wie lange sie bereits vorher angekettet worden waren. Viele Patienten werden über lange Zeiten zu Hause festgebunden und isoliert.

Sehr schlechte Bedingungen im *Mathari Hospital* in Kenia. Am 4. September 2014 hat die *Kenya National Commission on Human Rights (KNCHR)* einen Bericht über den Zustand der psychiatrischen Versorgung in Kenia publiziert. Es wird kritisiert, dass die Erkennungsrate von psychischen Störungen sehr tief sei. Ausserdem ist gemäss dem Bericht die Infrastruktur im *Mathari Hospital* mangelhaft, und die psychiatrische Abteilung wird als unhygienisch beschrieben. Zusätzlich zum Wassermangel seien die sanitären Bedingungen miserabel. Unter Verweis auf einen CNN-Dokumentarfilm von 2011 weist die *KNCHR* auf die unzureichende Behandlung von Menschen mit psychischen Erkrankungen im *Mathari Hospital* hin. Der Dokumentarfilm zeigt, wie Patientinnen und Patienten in unmenschlichen und unwürdigen Bedingungen gehalten werden und mit möglichen Menschenrechtsverletzungen wie Zwangsmedikation, überfüllte Krankenstationen und Vergewaltigungen unter den Patientinnen und Patienten konfrontiert sind. Am 12. Mai 2013 haben vierzig Patientinnen und Patienten vom *Mathari Hospital* das Sicherheitspersonal überwältigt und

sind anschliessend geflohen (Al Jazeera, 17. Mai 2013). Gemäss Al Jazeera hatten die Patientinnen und Patienten gesagt, dass sie wegen der schlechten Behandlung geflohen seien. Im gleichen Artikel erklärte die britische *Health Charity Managerin Joyce Kingori*, dass Patientinnen und Patienten im *Mathari Hospital* «unglücklich und seditiert» seien.

Africa Research Institute, 27. Juni 2013:

«Where does mental health care sit in the order of priorities in Kenya's public health system?»

Mental health is marginalised within Kenya's health care system. Less than 0.5% of the total health budget is set aside for mental health care. Although this is the mean for low-income countries, it is simply too little to provide appropriate and sustained care. By comparison, the UK's National Health Service allocates 12% of a much larger budget to mental health care. About 80% of Kenya's mental health budget is spent on psychiatric hospitals. The funding for community care is negligible and the practice of early intervention or prevention is almost non-existent.

The problems facing mental health care reflect those facing Kenya's health system as a whole. There is a general shortage of resources, including not having enough of health care professionals. To reach the standards set out by the Kenya Ministry of Health, approximately 70,000 more nurses are needed. The general nursing shortage has a knock-on effect on mental health. ***Around half of the too-few nurses with specialist mental health training are not employed as psychiatric nurses, because they are needed for other nursing work.***

Throughout 2012 there were numerous large-scale public health worker strikes – at one point involving over 40,000 workers. Many health care professionals do not have access to basic provisions, such as plastic gloves or clean syringes, and their salaries are inadequate. The competing demands for health funds are immense. (...)

How might new legislation such as the Mental Health Bill 2013, shape mental health care service provision?

*The Mental Health Bill 2013 is due to come before the Kenyan Parliament this year. The new legislation will **replace the Mental Health Act 1989 which mainly relates to hospitals and the circumstances in which someone can be hospitalised.** The Bill includes provisions for prevention and addresses recovery as a notion – both important steps which reflect a change of approach. It also makes reference to human rights and establishes a Mental Health Board which could be an important structure in overseeing the provision of mental health care. Boards like this have been written into past legislation and not implemented. The key to the success of this bill will be appropriate budgeting and strong leadership, including representation from people accessing the services.»* Quelle: Africa Research Institute, Reforming Kenya's ailing mental health system. In conversation with Victoria de Menil, 27. Juni 2013: www.africaresearchinstitute.org/blog/mental-health-in-kenya/.

CNN, 25. Februar 2011:

«Dr. Frank Njenga, president of the African Association of Psychiatrists and a leading expert in the field, believes the scale is "catastrophic." "We as a people have perfected the system of hiding our friends, relatives and other loved ones who have intellectual disability away from sight," Njenga said. "Out of sight, out of mind, no funding, neglected completely." He says that the greatest neglect comes from the Kenyan government. The Kenyan government spends less than 1% of its health budget on mental health, though its own figures show that one-quarter of all patients going to hospitals or clinics complain of mental health issues. And the Health and Medical Services ministries have been plagued by a series of corruption scandals in recent years. More than \$3 billion in public money was stolen in 2009, according to the Kenyan Ministry of Finance. This could have funded the entire ministry responsible for mental health -- for 10 years. The minister of medical services, Anyang Nyong'o, says mental health is a high priority, but it needs more funding from his central government. "It is definitely starved of resources, and that is not because we want to intentionally starve mental health; that is because the resource base as we have for running health services is very narrow," he said. "The policy is very clear," Njenga said. "Mental health services are a priority in this country. The practice is also clear. They are not."» Quelle: CNN: Kenya's mentally ill locked up and forgotten, 25. Februar 2011: [edi-tion.cnn.com/2011/WORLD/africa/02/25/kenya.forgotten.health/](http://edition.cnn.com/2011/WORLD/africa/02/25/kenya.forgotten.health/).

Pattison de Menil, Victoria und Knapp, Martin, 2015:

«Kenya's Ministry of Health estimates there are 500 practising psychiatric nurses nationally (Kiima & Jenkins, 2010); however, because of the shortfall of general nurses – estimated at 66 782 (Rakuom, 2010) – not all psychiatric nurses work in mental health. Psychiatric nurses in Kenya have prescribing rights and therefore can, and do, perform the functions of a psychiatrist and of a general doctor – as they do elsewhere in Africa (Chetty & Hoque, 2013). (...)

The study demonstrates one way in which the mental health treatment gap in Kenya is adversely affected by the overall health treatment gap, as rare skilled labour is being drawn away from the practice of psychiatry to other areas of health. We found that half of those with psychiatric nursing qualifications in Kenya are employed for functions other than delivery of mental healthcare – a finding consistent with previous estimates (Kiima & Jenkins, 2010). A contributing factor is that a quarter of those with psychiatric nursing qualifications also hold other specialty nursing qualifications, especially in community health and midwifery. It should also be noted that not all nurses who have worked in a mental health setting have psychiatric nursing qualifications, as was the case of 17% of our sample.

If the sample of nurses participating in this modest survey is representative, the results would imply that only 238 of the estimated 500 practising psychiatric nurses in Kenya work specifically with mental health patients, which amounts to a ratio of 0.62 psychiatric nurses per 100 000. Though low, this nonetheless amounts to higher than the average for low-income countries, which are estimated to

have an overall mean of 0.42 (World Health Organization, 2011). Moreover, in response to the demand for mental health services, roughly half of the people on the case-loads of psychiatric nurses in general practice are patients with mental health needs. The training of a nurse is often known by colleagues, as a result of which a psychiatric nurse will commonly be referred psychiatric cases, even when employed for other functions.

Kakuma et al (2011) argue in The Lancet that the necessary ratio of specialist human resources to achieve desirable coverage for mental disorders in low-income countries is 22.3 health workers per 100 000 population: 6% psychiatrists, 54% nurses in mental health settings and 41% psychosocial care providers. This works out to a ratio of 12 mental health nurses per 100 000. **To achieve that ratio, Kenya would need 4650 nurses working in mental health settings – 20 times the estimated number of psychiatric nurses practising full-time mental healthcare.** Policy efforts to address this wide gap in human resources focus on two strategies: taskshifting counselling to lay health workers (Kakuma et al, 2011); and integrating mental health into primary care by training clinical officers (Jenkins et al, 2010b, 2013). A stepped-care strategy also applied in settings with higher densities of specialised providers. (...)

In conclusion, it appears that **psychiatric nurses are migrating internally to nursing positions in other areas of healthcare, aggravating the existing 'brain drain' for mental health.**» Quelle: Pattison de Menil, Victoria; Knapp, Martin: Participation of psychiatric nurses in public and private mental healthcare in Kenya, in: Royal College of Psychiatrists BJPsych International; Vol. 12, Issue 1, Februar 2015, S. 19f: www.rcpsych.ac.uk/pdf/PUB_InterV12n1.pdf.

King's College London, 26. Mai 2015:

«According to Professor Jenkins, Kenya is ill-equipped to deal with these issues due to the scarcity of primary and specialist mental health care in the country. She said: 'A doctor in the UK – who has five to six years of medical training - looks after a population of around 1,700, whereas a Kenya primary care health worker –who only has three years of training - looks after a population of around 10,000. 'Similarly in Kenya there is roughly one psychiatric nurse for 250,000 people, whereas in the UK there is one psychiatric nurse per 5-10,000 people.' Looking specifically at the Nyanza Province, there was previously one psychiatrist for a population of around five million, although this has recently increased to one in two million.'» Quelle: King's College London, Study reports rise in psychotic symptoms in Kenya, 26. Mai 2015: www.kcl.ac.uk/ioppn/news/records/2015/May/Study-reports-rise-in-psychotic-symptoms-in-Kenya.aspx.

Bitta, Mary A.; Kariuki, Symon M.; Chengo, Eddie; and Newton, Charles R. J. C., 2017:

«We conducted an initial assessment of state of mental health systems in Kilifi County and documented resources, policy and legislation and spectrum of mental, neurological and substance use disorders.

Methods

This was a pilot study that used the brief version of the World Health Organization's Assessment Instrument for Mental Health Systems Version 2.2 to collect data. Data collection was based on the year 2014.

Results

Kilifi county has two public psychiatric outpatient units that are part of general hospitals. There is no standalone mental hospital in Kilifi. There are no inpatients or community based facilities for people with mental health problems. Although the psychiatric facilities in Kilifi have an essential drugs list, supply of drugs is erratic with frequent shortages. There is no psychiatrist or psychologist in Kilifi with only two psychiatric nurses for a population of approximately 1.2 million people. Schizophrenia was the commonest reason for visiting outpatient facilities (47.1%) while suicidal ideation was the least common (0.4%). Kenya's mental health policy, which is being used by Kilifi County, is outdated and does not cater for the current mental health needs of Kilifi. There is no specific legislation to protect the rights of people with mental health problems. No budget exists specifically for mental health care. There have been no efforts to integrate mental health care into primary care in Kilifi, and there is no empirical research work to evaluate its feasibility.

Conclusion

There is an urgent need to increase resources allocated for mental health in particular infrastructure and human resource. Policy and legislations need to be established to protect the rights of people with mental illnesses, and mental health should be integrated with primary care to increase access to services. (...)

Human rights and equity

*The status of voluntary/involuntary admission to general hospitals, which serve as admission facilities for mental health patients, is in general not taken into account. However, **it is estimated that the majority of admissions are involuntary.** The proportion of patients who were restrained or secluded at least once within the last year in all facilities is unknown. **Most violent patients visiting psychiatric outpatient units are chained by caregivers, but it is difficult to precisely know for how long this happens before hospitalisation.** However, reports from our community fieldworkers suggest that the **patients are isolated and tethered at home for sustained periods.***

*There are **no beds allocated for psychiatry** within the County, not even in Kilifi County Hospital, the only referral hospital in the region. This greatly limits access to care as admission is dependent upon availability of beds in the general hospital. There is equity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) within the County.» Quelle: Mary A. Bitta; Kariuki, Symon M.; Chengo, Eddie; and Newton, Charles R. J. C., An overview of mental health care system in Kilifi, Kenya: results from an initial assessment using the World Health Organization's Assessment Instrument for Mental Health Systems. In: Interna-*

tional Journal of Mental Health Systems, 2017:

www.ncbi.nlm.nih.gov/pmc/articles/PMC5392905/.

USP Kenya - Users and Survivors of Psychiatry Kenya, August 2015:

*«The Committee should however note that **while there are positive promotional initiatives, initiatives to repeal and amend laws that allow deprivation of legal capacity and deprivation of liberty are yet to be realised. The Mental Health Bill 2014 which is the law meant to repeal the current mental health act 1989 remains a draft to date. The Bill has enabling provisions in relation to implementation of article 12. It recognizes people with psychosocial disability as having legal capacity, the need for provision of support for free, prohibits exploitation, abuse, torture and degrading treatment and prohibits chemical constraint.** (...)*

*Community based services and alternatives to mental health services are yet to be introduced in Kenya despite several studies by KNCHR 'Silenced Minds: The systemic neglect of the mental health system in Kenya' (2011) and the Independent Legal Medical Unit (IMLU) 'The State of Mental Health in Kenya; Victimization and Torture Among Persons with Mental Disabilities' (2013) calling for introduction of such services by the government. According to the research by KNCHR in 2013 on article 12, **lack of choices or alternatives has forced many persons with psychosocial disability to accept forced treatment as the only available alternative. Kenya lacks enough mental health facilities and alternative to medical facilities. The only specialised referral hospital is the Mathari hospital which is ill equipped.**»*

Quelle: USP Kenya - Users and Survivors of Psychiatry Kenya: Report to the Committee on Rights of Persons with Disabilities on the Review of Kenya's Initial Report on Implementation of the Provisions of the UN Convention on Rights of Persons with Disabilities: Responses to Kenya's list of issues, August 2015, S. 5ff.

USP Kenya - Users and Survivors of Psychiatry Kenya, USPK - Users and Survivors of Psychiatry Kenya, KAIH - Kenya Association of the Intellectually Handicapped; MDAC - Mental Disability Advocacy Center, 4. März 2015:

«12. The research took place between 2011 and early 2014 and was comprised of a legislative and policy analysis; and qualitative research including interviews with persons with intellectual disabilities, persons with psycho-social disabilities, and their family members and carers.

13. The key findings include the following:

a) While the 2010 Kenyan Constitution recognises persons with disabilities as persons before the law, this recognition is limited in practice, especially for persons with psycho-social disabilities and persons with intellectual disabilities.

*b) A significant number of **persons with mental disabilities experienced restriction of their decision-making rights through informal social processes within the family and their local communities.** The social restriction of autonomy and decision-making rights is **more pronounced among women and younger persons with mental disabilities.** (...)*

Article 12 in relation to Article 25: Denial of health care choices (...)

28. The majority of people we spoke to in our investigation reported being involuntarily admitted to hospitals. The Mental Health Act allows people suspected of having a “mental disorder” to be involuntarily admitted. Police officers can detain someone on the basis that they believe that person has a “mental disorder” and any person’s spouse, relative (in their absence) or any other person can make an application for involuntary admission to a psychiatric hospital.» Quelle: USPK - Users and Survivors of Psychiatry Kenya; KAIH - Kenya Association of the Intellectually Handicapped; MDAC - Mental Disability Advocacy Center: DPO/NGO Information to the 3rd Pre-sessional Working Group of the United Nations Committee on the Rights of Persons with Disabilities. For consideration when compiling the List of Issues on the First Report of the Republic of Kenya under the Convention on the Rights of Persons with Disabilities on 20 April 2015, 4. März 2015: www.ecoi.net/file_upload/1930_1429869476_int-crpd-ico-ken-19783-e.doc.

KNCHR - Kenya National Commission on Human Rights, 4. September 2014:

«27. In 2011, CNN aired a documentary titled ‘Locked Up and Forgotten’ on the decaying health infrastructure in Kenya particularly in Mathari Psychiatric Hospital the leading public mental health institution. The documentary reported that persons with mental disorders were being held in inhumane and degrading conditions. Alleged human rights abuses highlighted included: forced medication, crowded wards; and rape and sodomy by the other patients. (...)

29. There is a very low detection rate for mental disorders including alcohol and substance abuse disorders. In a study only 4.1% of patients had been diagnosed with a mental health condition while the researchers’ diagnoses showed a prevalence rate of 42.3% for depressive symptom. At the Mathari Hospital the average bed occupancy is 85% for the Maximum Security unit and 105% for the civil units. Moi Teaching and Referral Hospital had the highest rate of over 200%. Poor physical infrastructure was one of the challenges undermining effectiveness of mental health facility. Sanitation conditions are also poor.

30. A report by Kenya National Commission on Human Rights observed that accommodation at the psychiatric ward was unclean and unhygienic with rooms smelling and covered in urine. Water shortage also plays a major role in sanitation and insecurity. This is in contravention with Principle 14 of the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care which lays down the appropriate resources for mental health centers to include appropriate professional care and that every mental institution should be inspected by the competent authorities with sufficient frequency to ensure that the conditions, treatment and care of patients comply with these principles.

31. The government has failed to take deliberate, concrete and targeted steps to realize the right to mental health. The mental health sector is underfunded by the government leading to poor quality of services in the mental health facilities. Sufficient steps should be taken by the government to progressively realize the right to people with mental disorder.» Quelle: KNCHR - Kenya National Commission

on Human Rights: Information presented by the Kenya National Commission on Human Rights, 4. September 2014:

www.ecoi.net/file_upload/1930_1411470747_g1415637.pdf.

Al Jazeera, 17. Mai 2013:

«Kenya Clinic Riot spotlights mental health

*Nairobi, Kenya - **Workers in Kenya's health sector describe it as a "wake-up call" for a country that they say is failing to treat its citizens who suffer from mental illness. Patients rioted over conditions in the nation's biggest secure mental unit, Mathari Hospital, on May 12. They overpowered guards, broke free and fled through the slums of north Nairobi. On Friday, police were still seeking 16 of the 40 escapees. (...) Those breaking out of Nairobi's mental clinic said they had received poor treatment, police told Al Jazeera. A senior clinician appeared on local television and bemoaned cash shortages at the "old, dilapidated buildings" he manages. "The place is overcrowded and the patients inside are unhappy and sedated," said Joyce Kingori, a manager for Britain's mental health charity BasicNeeds, who visits the clinic regularly. "Not even our prisons look like that." (...)***

The breakout is not Mathari's first scandal. In 2011, a television crew filmed an inmate locked inside a cell with a corpse. It prompted a probe by the Kenya National Commission on Human Rights that declared services "woefully under-resourced". Quelle: Al Jazeera: Kenya clinic riot spotlights mental health, 17. Mai 2013: www.aljazeera.com/indepth/features/2013/05/201351711252816185.html.

4 Diskriminierung und Stigmatisierung von psychisch kranken Personen

Soziale Stigmatisierung und Menschenrechtsverletzungen. In seinem Bericht über Menschenrechtsverletzungen von psychisch kranken Menschen in Kenia vom 2013, gibt *USP Kenya* als Haupteckentnis an, dass Menschen mit einer psychischen Krankheit verschiedenen Menschenrechtsverletzungen ausgesetzt sind. Am häufigsten wird dabei über Stigmatisierung und Diskriminierung, verbale und körperliche Übergriffe, Ausbeutung und Vergewaltigungen berichtet. Zudem betont die *KNCHR* in einem am 30. Juli 2015 veröffentlichten Bericht, dass Menschen mit einer Behinderung oft auf «grausamer, unmenschlicher und erniedrigender» Art behandelt werden. Im Bericht werden Beispiele erwähnt, bei denen Menschen gefesselt und zwangsbehandelt werden. Gemäss der *KNCHR* entsprechen diese Arten von Behandlung Folter. Im Bericht von *USP Kenya/KAIH/MDAC* vom 4. März 2015 wird darauf hingewiesen, dass die kenianische Gesetzgebung selbst eine diskriminierende Haltung gegenüber Menschen mit einer geistigen Behinderung zeige, da sie abschätzige Bezeichnungen wie «geisteskrank» beinhalte. Gemäss dem Menschenrechtsbericht von 2016 des *U.S. Department of State* werden Menschen mit psychischen und physischen Behinderungen in Kenia stark diskriminiert. Das Bewusstsein der kenianischen Gesellschaft im Hinblick auf Menschen mit einer Behinderung ist gering. Diese werden stark stigmatisiert. Der gleiche Bericht weist auf Aussagen von NGOs hin, welche berichten, dass Menschen mit einer Behinderung nur einge-

schränkten Zugang zu Bildung und Arbeit haben. Dies hänge einerseits mit einem schlechten Zugang aus baulichen Gründen, andererseits mit dem Widerstand vonseiten des Lehrpersonals und der Eltern zusammen. Gemäss einer Umfrage der kenianischen NGO *Twaweza ni Sisi* (zitiert im Menschenrechtsbericht des *U.S. Department of State*, 2016) glaubt 73 Prozent der kenianischen Bevölkerung nicht, dass Kinder mit einer Behinderung in ihrer Gemeinde Zugang zur Sekundarschule haben sollen. Die *KNCHR* schätzt, dass 67 Prozent der behinderten Personen einen Primarschulabschluss haben, 19 Prozent einen Sekundarabschluss und 2 Prozent einen Universitätsabschluss. Sieben Prozent werde der Zugang zur Bildung von den Behörden gänzlich verwehrt. *Bitta, Kariuki, Chengo und Newton* deuten in ihrer Studie 2017 darauf hin, dass Menschen mit einer psychischen Behinderung oft zu Hause isoliert und vor der Öffentlichkeit versteckt leben würden. Das *U.S. Department of State* (2016) berichtet von Tötungen von Menschen mit einer Behinderung sowie von Folter und Missbrauch.

Kein Schutz vor Diskriminierung. Obwohl die kenianische Gesetzgebung die Diskriminierung von Menschen mit jeglicher Art von Behinderung verbietet, setzt die kenianische Regierung gemäss der *KNCHR* diese Gesetze nicht um (*U.S. Department of State, Bureau of Democracy, Human Rights and Labor*, 2016). Gemäss dem *KNCHR*-Bericht vom 4. September 2014 ist die kenianische Regierung nicht in der Lage, bewusste, konkrete und gezielte Massnahmen zu treffen, um das Recht auf psychische Gesundheit zu gewährleisten.

Traditionelle Vorstellungen und Aberglaube auf dem Land. In ländlichen Gebieten Kenias sind traditionelle Vorstellungen und Aberglaube in Bezug auf psychische Krankheiten geläufig. Nach *Mary Wahome*, Direktorin des Programms *Reason for Hope* (ins Leben gerufen von der *Kenya Schizophrenia Foundation*), werden psychische Krankheiten in Ngong, *Kajiado County*, mit Geistern, Exorzismus, Dämonen usw. in Beziehung gebracht, die dementsprechend behandelt werden müssen (*Samrack*, 2016).

Diskriminierung von Frauen mit geistiger Behinderung. Gemäss dem 2013 veröffentlichten Bericht von *USP Kenya* werden Frauen innerhalb des kenianischen psychiatrischen Gesundheitssystems unverhältnismässig oft mit Menschenrechtsverletzungen konfrontiert. Ähnlich argumentiert die *KNCHR* in ihrem Bericht vom 30. Juli 2015, dass Frauen mit einer Behinderung in Kenia einer doppelten Diskriminierung ausgesetzt seien. Sie hätten ein grösseres Risiko, Opfer von sexueller Nötigung, geschlechtsspezifischer Gewalt, Ausbeutung und Misshandlung zu werden. Im gleichen Bericht wird darauf hingewiesen, dass Frauen mit Behinderungen das Recht verwehrt wurde, Entscheide bezüglich ihrer eigenen reproduktiven Gesundheit zu treffen. Frauen wurden ohne ihr Einverständnis sterilisiert. Diese Angaben werden von *USP Kenya*, *KAIH* und *MDAC* (4. März 2015) bestätigt. Gemäss ihrem Bericht hat die kenianische Regierung bislang nichts unternommen, um diese Praktiken zu verbieten.

USP Kenya- Users and Survivors of Psychiatry Kenya, 2013:

«1. Persons with psychosocial disabilities in Kenya experience human rights violations on a range of issues. The most commonly reported are stigma and discrimination, verbal and physical abuse, exploitation and rape.

2. Most persons with psychosocial disabilities do not report the human rights violations that they encounter to the justice sector.

- This is mainly because of lack of awareness on their human rights at both the individual and family level.

- Lack of support from family members when such incidents occur especially in instances where some of the violations are committed by close family members.

- Prejudice and discrimination from local dispute resolution mechanism.

3. Women are at greater risk of experiencing human rights violations as highlighted by the numerous cases of rape in the study.

4. There is a link between poverty and human rights violations. Most of the people interviewed had no jobs and were fully dependent on their families for support.»

Quelle: Users and Survivors of Psychiatry in Kenya (USP Kenya): Reviewed Human Rights Violation Users Mental Health Kenya Report 2013: <http://de.scribd.com/doc/199590360/USPKENYA-Reviewed-Human-Rights-Violation-Users-Mental-Health-Kenya-Report-2013>.

KNCHR - Kenya National Commission on Human Rights, 30. Juli 2015:

«Women with disabilities (Art.6)

7. Women with disabilities often suffer double discrimination and are at a higher risk of sexual abuse, gender based violence, exploitation and ill-treatment. The KNCHR Report on reproductive health rights indicated that women across all disability types were denied the rights to make their own reproductive health decisions. Several women with disabilities reported during the inquiry that medical procedures such as sterilization and hysterectomy were conducted on them without their consent and even at times knowledge. This situation still obtains as indicated by a study conducted by Users and Survivors of Psychiatry Kenya (USP Kenya) in 2013 and the KNCHR monitoring visits conducted in various parts of the country. (...)

Liberty and Security of the Person (Article 14)

24. The law in Kenya still has provisions that allow for the deprivation of liberty on the grounds of actual or perceived mental and psychosocial disability in the guise of protecting the members of the public from potential danger that may be posed by the person with disability. The involuntary detention of persons with disabilities based on presumptions of risk or dangerousness tied to disability labels is contrary to the right to liberty. (...)

Freedom from Torture or Cruel, Inhuman or Degrading Treatment or Punishment (Art. 15)

29. **Persons with disabilities are often treated in cruel, inhuman or degrading manner.** This happens in many situations but **mostly when they require medication or treatment for various health issues.** Their consent is not sought on most occasions and in some instances they are tied up with ropes or handcuffed and treated by force. **Such treatment amounts to torture, is cruel, inhuman and degrading.** (...)

Living independently and being included in the community (Art. 19)

38. There are **no support systems to enable persons with disabilities live independently within the community.** The practice in Kenya is for family members of a person with disabilities to be their default guardian and to make decisions about their welfare. The other common practice in Kenya is the **institutionalization of persons with mental disabilities where the family is not able to assist the person and they are in a position to afford the services from such institutions.** In most instances under such arrangements, the person with disability is not able to live independently and to participate in the community. (...)

Health (Art. 25)

In its report on reproductive health rights in Kenya in 2011, KNCHR found that **persons with disabilities had great challenges accessing information on health, accessing health facilities, meeting the cost of health services, encountered negative attitude from medical personnel, and endured abusive and coercive treatment at most health facilities.** During the subsequent monitoring of implementation of the CRPD in 2013, KNCHR encountered similar cases from persons with disabilities as had been found during the inquiry thereby **implying that not much had changed during the intervening.**» Quelle: KNCHR - Kenya National Commission on Human Rights: A Report to the Committee on the Rights of Persons with Disabilities. A Response to the List of Issues on Kenya's Initial Report on the Implementation of the Convention on the Rights of Persons with Disabilities, 30. Juli 2015, S. 7ff: www.ecoi.net/file_upload/1930_1440682692_int-crpd-nhs-ken-21336-e.doc.

U.S. Department of State, Bureau of Democracy, Human Rights and Labor, 2016:

«Persons with Disabilities

The law prohibits discrimination against persons with physical or mental disabilities in employment, education, access to health care, or the provision of other state services. **The government did not effectively enforce these provisions. A number of laws limit the rights of persons with disabilities.** The Marriage Act limits the rights of persons with mental disabilities to get married; the penal code criminalizes "rape of an imbecile"; the Law of Succession limits the rights of persons with disabilities to inheritance; and the Mental Health Act allows guardians to make all decisions for persons "of unsound mind." The constitution provides legal safeguards for the representation of persons with disabilities in legislative and appointive bodies. (...)

There was **limited societal awareness** of persons with disabilities and significant stigma attached to disability. Learning and other disabilities not readily apparent were not widely recognized. **NGOs reported that persons with disabilities had limited opportunities to obtain education and job training at all levels due to lack of accessibility of facilities and resistance on the part of school officials and parents to devoting resources to students with disabilities.** A survey published by NGO Twaweza ni Sisi on July 20 stated 73 percent of citizens did not believe children with disabilities in their communities should be enrolled in secondary school. The KNCHR estimated that 67 percent of persons with disabilities had a primary education, 19 percent attained secondary education, and 2 percent reached university level, while 7 percent of persons with disabilities reported that authorities denied them all access to education because of their disability.

According to a 2014 survey by the NGO Handicap International on the rights of persons with disabilities in the country, 85 percent of persons with disabilities experienced verbal abuse related to their disability and 17 percent experienced gender-based violence. Of those who reported abuse, 47 percent neither reported the incident to police or other authorities nor sought medical help or counseling. They cited fear of reprisal or of being misunderstood as their reasons. Of those who reported abuse to some authority, the majority reported the incident to community elders rather than police.

Authorities received reports of **killings of persons with disabilities as well as torture and abuse**, and the government took action in some cases. For example, the Nation newspaper reported on March 3 that a woman was arrested and would be prosecuted in Nairobi after 11 disabled children were found in poor living conditions, locked up, and malnourished in her home.

Persons with disabilities faced **significant barriers to accessing health care**. They had difficulty obtaining HIV testing and contraceptive services due to the perception they should not engage in sexual activity. According to Handicap International, 36 percent of persons with disabilities reported facing difficulties in accessing health services; cost, distance to a health facility, and physical barriers were the main reasons cited. (...)

The Ministry for Devolution and Planning is the lead ministry for implementation of the law to protect persons with disabilities. The quasi-independent but government-funded parastatal National Council for Persons with Disabilities assisted the ministry. Neither entity received sufficient resources to address effectively problems related to persons with disabilities. The Association for the Physically Disabled of Kenya carried out advocacy campaigns on behalf of persons with disabilities, distributed wheelchairs, and worked with public institutions to promote the rights of persons with disabilities. The KNCHR noted that awareness of the rights of persons with disabilities increased as a result in some counties, but it faulted the government for not ensuring equal protection of the rights of persons with disabilities throughout the country.

Nominated and elected parliamentarians with disabilities formed the Kenya Disability Parliamentary Caucus in 2013 and issued a strategy statement focusing on improving economic empowerment and physical access for persons with disabilities as well as integrating disability rights into county government policies.» Quelle: U.S. Department of State. Bureau of Democracy, Human Rights and Labor. Country Reports on Human Right Practices for 2016: Kenya, 2016: <https://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper>.

USPK - Users and Survivors of Psychiatry Kenya; KAIH - Kenya Association of the Intellectually Handicapped; MDAC - Mental Disability Advocacy Center, 4. März 2015:

*«e) **Legislation itself reflects discriminatory attitudes towards persons with disabilities, with derogatory terms such as ‘unsound mind’ and ‘mental infirmity’ frequently used. (...)***

Article 12 in relation to Article 17, 15 and 23: Forced and coerced sterilisation

*18. Testimony of persons with disabilities we spoke to during our investigation in Kenya show that **women with mental disabilities experience intersectional discrimination on the basis of their disability and their gender.** One woman who lived with other women in a missionary centre said told researchers: “I don’t think I would get children. I will tell you something, you see here [lifts up the blouse and reveals a scar on her stomach] here I was made an operation. This is contraceptive, all of us had been done like this, we cannot get children. Nobody asked me. They should have asked me, because I love children [...]. I feel bad, but what can I do now?” (emphasis added) **This testimony alleges that women with mental disabilities, in particular women with intellectual disabilities, are sterilised without their free and informed consent. (...)***

*To the best of our knowledge no specific research has been carried out on the use of forced or coerced sterilisation against women and girls in Kenya. However, **these sources of information suggests that it is a common occurrence in the country, and that the State has not taken concrete action to prohibit such practices.**»*

Quelle: USPK - Users and Survivors of Psychiatry Kenya; KAIH - Kenya Association of the Intellectually Handicapped; MDAC - Mental Disability Advocacy Center: DPO/NGO Information to the 3rd Pre-sessional Working Group of the United Nations Committee on the Rights of Persons with Disabilities. For consideration when compiling the List of Issues on the First Report of the Republic of Kenya under the Convention on the Rights of Persons with Disabilities on 20 April 2015, 4. März 2015: www.ecoi.net/file_upload/1930_1429869476_int-crpd-ico-ken-19783-e.doc

Samrack, 20. März 2016:

*«**Millions of Africans suffer from mental illness, but local suspicion -and, some say, ignorance- can leave them undiagnosed and forced to suffer mistreatment and abuse. (...)***

“[People in some communities] still believe that mental health is not a sickness but something that can be dealt with by the community spirits, exorcism or demons and other things,” says Reason for Home Program Director Mary Wathome. “So for us, our main work is to let them know that it is an illness which, if treated well and given intervention, can be managed.”» Quelle: Samrack. Diaspora News & Updates: Mental Health Care Still a Challenge in Rural Kenya, 20. März 2016: <http://www.samrack.com/mental-health-care-still-a-challenge-in-rural-kenya/>.

5 Behandlung von posttraumatischen Belastungsstörungen (PTBS), Depression und Schizophrenie

Keine spezialisierten öffentlichen Institutionen für die Behandlung von PTBS. Einer Anfragebeantwortung des *BAMF (Bundesamt für Migration und Flüchtlinge)* vom 30. September 2013 ist zu entnehmen, dass es keine spezialisierten Institutionen zur Behandlung von PTBS gebe. Gemäss dem gleichen Bericht ist das einzige Spital, welches psychiatrische Dienste anbietet, das *Mathari Hospital* in Nairobi. Zum Zeitpunkt der Publikation der Anfragebeantwortung seien die Kosten für eine Einzelberatung 500.00 KES (circa 4.63 CHF bei einem Wechselkurs 1: 0.0093 am 13. Juli 2017). Die Kosten für die stationäre Behandlung im *Mathari Hospital* seien auf 700.00 KES (circa 6.51 CHF) pro Tag festgelegt. Die Behandlung in privaten Einrichtungen sei wesentlich teurer. Laut der Anfragebeantwortung liegen im *Chiruma Lane Medical Center* die Kosten für Sprechstunden zwischen 2500 und 3000 KES (circa 22.95 und 27.55 CHF) und für die stationäre Behandlung zwischen 6000 und 9000 KES täglich (circa 55.05 und 82.60 CHF). Zum Vergleich: die Weltbank (World Bank, 2016) schätzt das durchschnittliche jährliche Einkommen in Kenia auf 1380 U.S. Dollar im Jahre 2016 (circa 148'387 KES beim Wechselkurs 1: 0.0093 am 13. Juli 2017).

Schizophrenie ist der häufigste Grund für Besuche von ambulanten Einrichtungen in Kilifi County. Gemäss der Forschung von *Bitta, Kariuki, Chengo und Newton* leiden 47.1 Prozent der Patientinnen und Patienten, die eine ambulante psychiatrische Einrichtung in *Kilifi County* aufsuchen, an Schizophrenie. Diese Krankheit ist somit der häufigste Grund für Besuche von ambulanten Einrichtungen.

Zugang und Kosten von Medikamenten. Gemäss den Angaben, welche ein in Nairobi ansässiger Psychiater am 11. September 2015 per E-Mail bereitgestellt hat, sind Antidepressiva und neuroleptische Medikamente inklusive Mianserin und Lorazepam in Kenia verfügbar. Dazu hat eine in Nairobi praktizierende Apothekerin am 16. September 2015 per E-Mail gegenteilig ausgesagt, dass weder Mianserin noch Lorazepam auf dem kenianischen Markt verfügbar seien. Als Alternativen, welche in Kenia verfügbar sind, hat sie auf Anafranil (Clomipramin Hydrochlorid) 25 mg beziehungsweise Diazepam 10 mg hingewiesen. Laut ihren Angaben kostet eine Packung Anafranil (30 Tabletten) 1465.00 KES (circa 13.64 CHF beim Wechselkurs 1: 0.009 am 13. Juli 2017). Eine Packung Valium (Diazepam) mit 25 Tabletten kostet 605.00 KES (circa 5.63 CHF). Als Generika ist Diazepam verfügbar. Eine Packung von 25 Tabletten kostet 25.00 KES (circa 0.23 CHF). Der Kauf von jedem Artikel ist an eine zusätzliche Gebühr von 100.000 KES (circa 0.93 CHF) gebunden.

BAMF - Bundesamt für Migration und Flüchtlinge, 30. September 2013:

«Anfrage:

1.) Bestehen im Zielland Kenia medizinische Behandlungsmöglichkeiten/Krankenhäuser oder Fachärzte für die **Behandlung psychischer Erkrankungen, insbesondere für PTBS oder/und Depressionen?** (...)

Antwort:

1.) Den Auskunft gebenden Stellen zufolge gibt es vor Ort **keine diesbezüglich spezialisierten Einrichtungen**. Das **einzige staatliche Krankenhaus für psychiatrische Fälle, die den Zugang zur Wirklichkeit verloren haben, ist das „Mathari Hospital“ und befindet sich in Nairobi**. Fälle werden nur mit entsprechender Überweisung angenommen; **die Kosten pro Konsultation liegen bei 500 Kes. Ein stationärer Aufenthalt mit Krankbett kostet 700 Kes.pro Tag; die Medikamentenkosten sind abhängig vom verschriebenen Präparat.**

Eine psychiatrische Einrichtung im privaten Sektor wäre das „Chiromo Lane Medical Center“. Pro Konsultation fallen Kosten in Höhe von 2.500-3.000 Kes. an. Ein stationärer Aufenthalt kostet zwischen 6.000 und 9.000 Kes. pro Tag; die Medikamentenkosten richten sich nach dem jeweils verschriebenen Präparat..» Quelle: BAMF - Bundesamt für Migration und Flüchtlinge: Medizinische Versorgung in Nairobi, 30. September 2013: www.bamf.de/SharedDocs/MILo-DB/DE/Rueckkehrfoerderung/Laenderinformationen/Rueckkehrfragen/MedVer/2013/20130930_nairobi-kenia-medvers_dl.pdf?__blob=publicationFile.

World Bank: GNI per capita, Atlas method (Current US\$), Kenya, 2016: http://data.worldbank.org/indicator/NY.GNP.PCAP.CD?locations=KE&year_high_desc=false.