MINISTRY OF HEALTH

Suicide Prevention Strategy 2021-2026

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National Strategy for implementation by all stakeholders to prevent suicide and promote mental wellbeing.

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ABBREVIATIONS AND ACRONYMS

AWP	Annual Work Plan
CBO	Community Based Organization
CECM	County Executive Committee Members
CHV	Community Health Volunteer
CHMT	County Hospital Management team
COG	Council of Governors
CSR	Corporate Social Responsibility
CSO	Civil Service Organizations
FBO	Faith Based Organizations
GHO	Global Health Observatory
HCWs	Health Care Workers
HDSS	Health and Demographic Surveillance System
HIC	High Income Countries
HIS	Health Information System
HPTs	Health Products and Technologies
HRMH	Human Resource for Mental Health
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education and Communication
KEMRI	Kenya Medical Research Institute
KEPSA	Kenya Private Sector Alliance
KHIS	Kenya Health Information System
KRC	Kenya Red Cross
LMIC	Low and Middle Income Countries
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MH	Mental Health
MH GAP	Mental Health Gap Action Plan
MIN ICT	Ministry of Information Communication and Technology
MOE	Ministry of Education
MOH	Ministry of Health
NACADA	National Authority for the Campaign Against Alcohol and Drug Abuse
NCCJR	National Committee on Criminal Justice Reforms
NGOs	Non Governmental Organizations
NHIF	National Health Insurance Fund
PFA	Psychological First Aid
SDGS	Sustainable Development Goals
SOPs	Standard Operating Procedures
SPS	Suicide Prevention Strategy
SWOT	Strengths Weaknesses Opportunities and Threats
TOTs	Trainer of Trainers
TWG	Technical Working Group
UN	United Nations
WHO	World Health Organization

FOREWORD

Suicide is a complex, yet preventable public health problem resulting from the interaction of psychological, social, biological and environmental factors. It is among the leading causes of death among young people in many countries, Kenya included, yet the policy and research investment in its prevention has been relatively small.

The prevention of suicide is complex and, while feasible, no easy task; it requires a coordinated multisectoral response of the health, education, labor and agriculture sectors among others. It also needs the engagement of various partners such as county governments, the private sector, faith- based organizations, civil society and non-governmental organizations.

Comprehensive public health action to prevent suicide addresses the population at large as well as vulnerable groups. It involves a whole series of activities, ranging from the environmental control of risk factors and means for suicide, to early identification and effective treatment of people with mental health disorders as well as responsible reporting of suicide by the media.

This Suicide Prevention Strategy 2021-2026, aims to reduce suicide mortality through the amendments of relevant legislative framework and policies for effective suicide prevention and development, and implementation of a data system on suicide risk surveillance. It also sets direction on improving access to mental health services including establishment of suicide prevention helplines and integration of care at community and primary health level. Additionally, it will guide public education on suicide prevention and combat stigma.

The Ministry of Health is committed to the full implementation of this strategy and I therefore call upon all relevant stakeholders to support this process. I am confident that this strategy will inform the coordination, partnerships and monitoring necessary to guide implementation of successful suicide prevention mechanisms in order to achieve the set vision of a healthy nation where there are fewer deaths from suicide.

Sen Mutahi Kagwe, EGH
Cabinet Secretary, Ministry of Health

ACKNOWLEDGEMENT

The Kenya Suicide Prevention Strategy 2021-2026 was developed through a consultative process by key stakeholders whose inputs contributed significantly in a variety of ways.

Foremost, I acknowledge the Cabinet Secretary for Health whose leadership and guidance ensured that all the necessary resources and technical inputs were provided for effective planning and development of the Strategy.

I am grateful to the Division of Mental Health, headed by the Director for Mental Health under the leadership of the Director General for Health and with support from Heads of Directorates in the Ministry of Health. Special thanks go to the Multisectoral Technical Working Group for their guidance in the development of this first ever Suicide Prevention Strategy.

We appreciate the Council of Governors, various Ministries, State Departments and Agencies, Non-Governmental Organizations, Users Organizations, Mental Health Professional Associations and all other persons whose effort, contributions and support made it possible to have the Suicide Prevention Strategy.

We thank the World Health Organization (WHO) for technical and financial support toward the development of the strategy.

We take this opportunity to call upon all the stakeholders and partners for future engagements with the goal of implementing the strategy by the year 2026. Your investment and collaboration in this regard will be of paramount importance in realizing this goal.

Susan N. Mochache, CBS
Principal Secretary, Ministry of Health

EXECUTIVE SUMMARY

Suicidal behavior refers to a spectrum of self-destructive behavior ranging from temporary wishes of one's death to completed suicide. Many different Psychiatric disorders of different severities can contribute to suicide. Suicide is the fourth leading cause of mortality among 15-29 year olds (WHO 2019). Globally, 700,000 persons are estimated to die by suicide every year with most of the deaths occurring in low and middle income countries.

Suicides can be prevented when effective strategies are employed to mitigate risk factors and enhance protective factors. Suicide prevention is a public health priority and this Suicide Prevention Strategy, aims at reducing deaths by suicide. This is in line with the sustainable goal number three that aims to "ensure healthy lives and promote well-being for all at all ages."

The World Health Organisation (WHO 2019) estimates Kenya's age standardized suicide rate to be 11.0 in 100,000. However there is scarcity of data on suicide in Kenya. Mental illnesses are often associated with suicidal behaviour. Suicidal thoughts associated with depression lifetime prevalence is 7.9% while for other mental illnesses it is 5-8%.

The goal of this suicide prevention strategy is to attain a 10% reduction in suicide mortality by the year 2026. The strategic objectives that will be pursued to achieve this goal are;

1 To establish and operationalize suicide prevention program at national and county level. This will be achieved through appointment of a national focal person for suicide prevention program and establishment of intersectoral committee on suicide prevention at National and County level.

2 To strengthen supportive policy, legal and financing environment for effective implementation of suicide prevention program. The activities to achieve this objective will include advocating for decriminalization of suicide by repealing Section 226 of the Penal Code; collaborating with Ministry of Agriculture and other relevant stakeholders to develop a Pesticide Control Policy; and mobilizing financing for suicide prevention at national and county level.

3 To improve access to comprehensive, integrated, and quality services for suicide interventions at all levels of care. Some of the key activities will include development of multisectoral guidelines and protocols for comprehensive management of suicide; mainstreaming and integration of screening, assessment and treatment interventions for suicide risk factors at all levels of health care system; setting up a national suicide prevention helpline; Integration of care and referral pathways for persons with suicidal behavior at community and all health care service levels; and strengthening existing community health activities to include mental health and suicide prevention during household visits and dialogue days

4 To increase awareness on suicide and suicide prevention, and address stigma; this will involve development of a training package on suicide prevention and training the various targeted groups; conducting annual and targeted suicide prevention campaigns

5 To strengthen systems for surveillance and research on suicide. This will entail establishment of a national suicide and suicide attempts surveillance and registry system; integration of the collection and reporting of data on suicide and suicidal attempts by all health facilities through KHIS and IDSR; generation of regular reports on suicide and suicide attempt; and conducting a national Survey on suicide and suicide attempts

The roles and responsibilities of implementing this strategy lie with both state and non-state actors working synergistically. The state actors include the national and county governments. The non- state actors include the private sector, private health facilities, faith based organizations, professional organizations, development partners, law makers, media, academic/research institutions, communities and individuals.

The Ministry of Health will maintain an implementation tracking plan for the suicide prevention strategy. There will be an annual Strategy review review meeting that will involve key stakeholders to discuss performance, implementation challenges and best practices, and recommend any modifications needed to inform decisions on how to accelerate achievement of set targets. The implementation period is between 2021 and 2026 with a midterm and end term evaluation.

Dr. Patrick Amoth, EBS
Ag. Director General for Health

CHAPTER 1: BACKGROUND

1.1.Introduction

Suicide is a serious global public health problem - it affects people across the lifespan, and is a leading cause of mortality especially among young people. Suicide has devastating impact on families, friends and communities as every life lost represents someone's partner, child, parent, friend or colleague.

Suicide has multifaceted causes as is often a result of a convergence of genetic, biophysiological, psychological, socioeconomic, cultural and other risk factors. There is well established link between suicide/suicidal behavior and mental health though many suicides happen impulsively in moments of crisis with a breakdown in the ability to deal with life stresses, such as financial problems, relationship break-up or chronic pain and illness. Certain groups have more vulnerability to suicidal behavior. Around 20% of global suicides are through pesticide self-poisoning with the other most common methods being hanging and use of firearms.
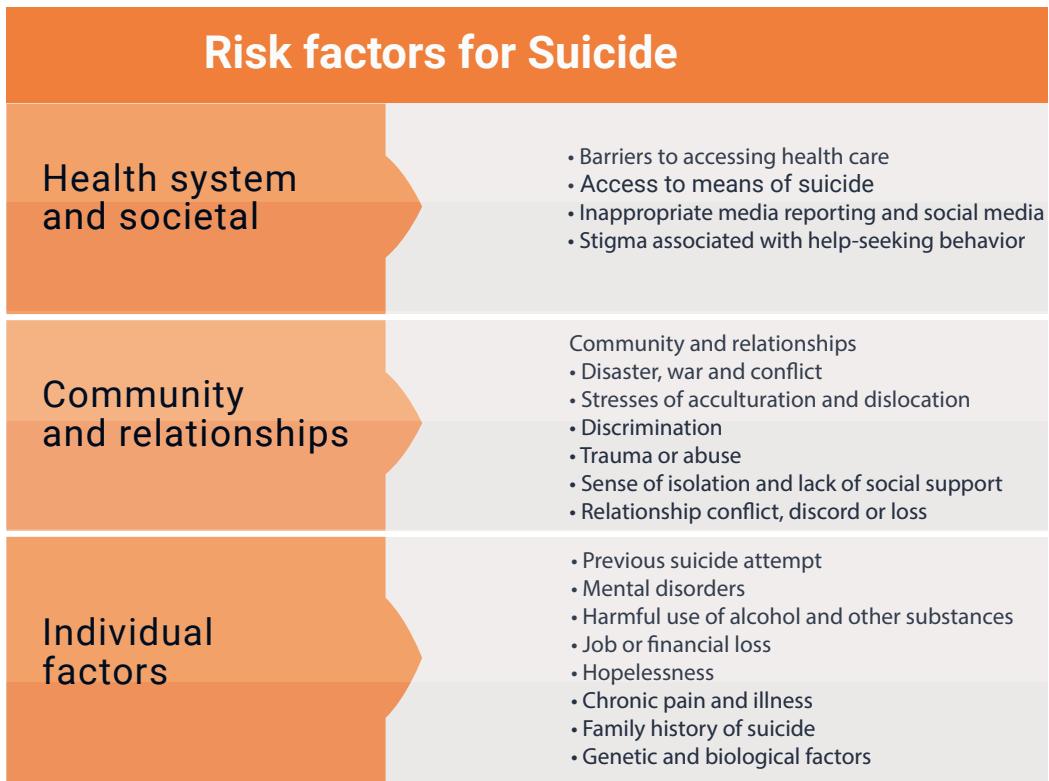
Suicides are preventable though the heterogeneity in causation presents challenges for suicide prevention experts. This can be overcome by adopting a multilevel and cohesive approach through comprehensive multisectoral, integrated and synergistic suicide prevention strategies, with considerations of best practices and evidence-based interventions as well as the cultural and social context. Effective preventive strategies should mitigate risk factors and enhance protective factors to improve resilience.

Suicide prevention is a public health priority and this Suicide Prevention Strategy, aims at reducing deaths by suicide and suicidal behavior by reducing factors that increase suicide risk and increasing factors that promote resilience. It highlights integrative strategies to help prevent suicide that encompass work at the individual, systems and community level based on the best available evidence

1.2.Risk factors for suicide

There are multiple contributing factors and causal pathways to suicide and understanding them is important to help devise a range of interventions for its prevention. These factors interact in a complex way to contribute to suicidal behaviors directly but can also contribute indirectly by influencing individual susceptibility to mental disorders.

Suicide Risk factors

Risk factors for Suicide

Health system and societal	• Barriers to accessing health care • Access to means of suicide • Inappropriate media reporting and social media • Stigma associated with help-seeking behavior
Community and relationships	Community and relationships • Disaster, war and conflict • Stresses of acculturation and dislocation • Discrimination • Trauma or abuse • Sense of isolation and lack of social support • Relationship conflict, discord or loss
Individual factors	• Previous suicide attempt • Mental disorders • Harmful use of alcohol and other substances • Job or financial loss • Hopelessness • Chronic pain and illness • Family history of suicide • Genetic and biological factors

1.3. Protective factors

Protective factors guard people against the risk of suicide. It's important to have interventions geared towards strengthening factors that have been shown to increase resilience and connectedness and that protect against suicidal behavior. Some protective factors counter specific risk factors while others protect individuals against a number of different suicide risk factors. The following are some protective factors;

- Strong personal relationships and social connectedness
- Cultural, religious or spiritual beliefs that discourage suicide
- Life skills and Lifestyle practice of strong coping mechanisms and wellbeing
- Self-esteem and a sense of purpose in life
- Effective mental health care.

1.4. Suicide prevention Interventions

Effective suicide prevention is comprehensive and requires a combination of efforts that work together to address different aspects of the problem, addressing vulnerabilities and leveraging on the protective factors. The evidence-based interventions prevention strategies can be classified into three levels as follows;

Universal interventions: these are designed to reach whole populations, with the aim of reducing risk factors and enhancing protective factors across the entire population. Typically, such approaches include (but are not restricted to) reducing access to means of suicide, improving media reporting of suicide and providing community education about suicide prevention.

Selective interventions: these target vulnerable subgroups whose members are not yet manifesting suicidal behaviors, but exhibit proximal or distal risk factors that predispose them to do so in the future. These may include gatekeeper training or programs that involve screening those thought to be at elevated risk.

Indicated interventions: these are designed for specific vulnerable people who are identified through screening programs or by clinical presentation as already beginning to exhibit suicidal thoughts or behaviors, and may include psychological or pharmacological treatment of underlying mental disorders.

1.5. Rationale for the Suicide Prevention Strategy

The Ministry of Health, through the Division of Mental Health, has national mandate to address mental health related issues including suicidal behavior, by coordinating various state and non-state agencies in providing evidence informed interventions that contribute to reduction in deaths by suicide. The policy and research attention that suicide prevention has received in Kenya has been relatively small in comparison with the magnitude of the problem.

Kenya, being a UN member state, has adopted the Global commitments and Sustainable Development Goals, and is on the path to attainment of Universal Health Coverage. Suicide prevention is an integral part of **Global Mental Health Action Plan** 2013-2030, with the goal of reducing the rate of suicide in countries by 10% by 2020 . **The Sustainable Development Goals (SDGs)** has reduction of suicide mortality as an indicator under **Goal 3.**

3 GOOD HEALTH AND WELL-BEING	**Ensure healthy lives and promote well-being for all at all ages** • Target 3.4: by 2030, reduce by one-third premature mortality from non- communicable diseases through prevention and treatment and promote mental health and well-Being. • Indicator 3.4.2: Reduce Suicide mortality rate

The Taskforce on Mental Health 2020, in their report, found that Kenya has a high burden of mental illness measured by numbers of years lost due to ill health, disability and premature mortality with huge gaps in access to care . There were high reported cases of depression, suicide and substance use in various epidemiological studies as well as by the media reporting. The huge treatment gap, stigma and discrimination worsen the burden of mental illness. There are many barriers and challenges which affects reporting of suicide and preventive measures; these include cultural beliefs, the Penal Code which criminalizes suicide and suicidal attempts.

Some of the taskforce recommendations to address the burden of mental illness and suicide in Kenya include:

- Declare mental ill health as a National Public Health Emergency.
- Amend the law (Penal code) to decriminalize suicide
- Establish a National suicide prevention program with the role to restrict means, conduct surveillance, education, improve access to treatment, decriminalization, ensure responsible media reporting, helpline and crisis intervention.
- Establish community-based services with focus on primary mental health care.

The development of this suicide prevention strategy has been informed by the need to address the existing gap in providing multisectoral coordination in reduction of suicide related deaths as guided by the Global Action Plan, National policies and recommendations by the Taskforce in order to promote attainment of universal health coverage.

1.6. Strategy Development Process

This strategy has been developed through a consultative process that involved key stakeholders through a National Technical Working Group, convened under Ministry of Health's' Division of Mental Health. It was informed by extensive literature review on suicide, examination of international treaties which Kenya is a signatory and national laws and policies.

CHAPTER 2: SITUATIONAL ANALYSIS
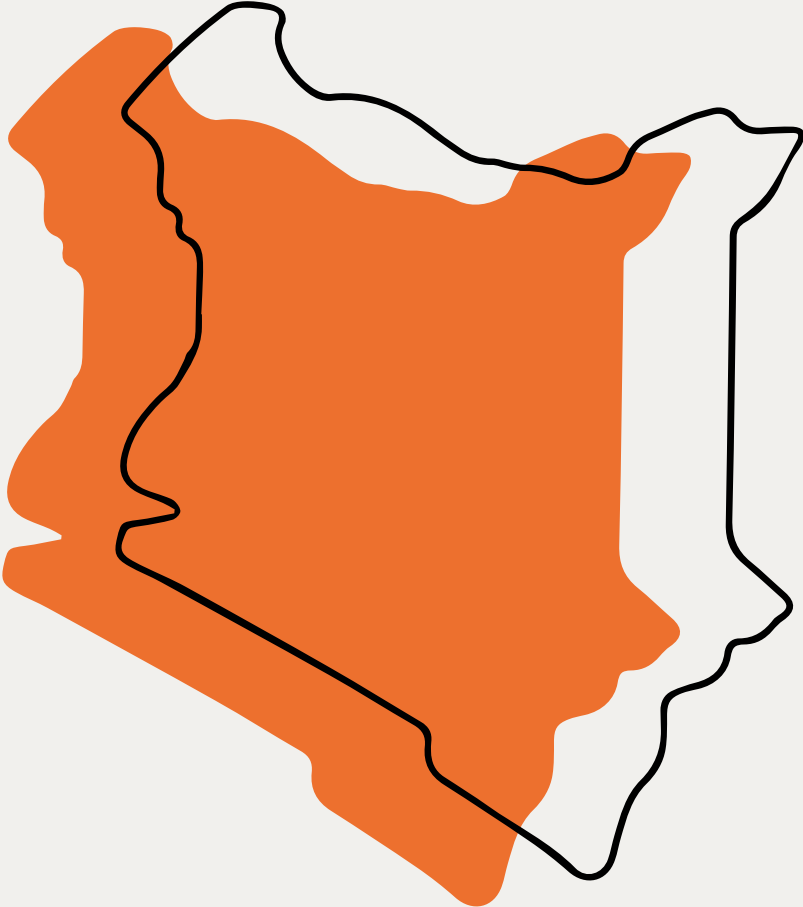
2.1. Global Suicide Burden

According to WHO, globally, there are over 700,000 suicide deaths annually which translates to one suicide every 40 seconds . For every suicide, 20 people make a suicide attempt and many more have serious thoughts of suicide. Most suicides occur in low and middle-income countries where there are huge gaps in health systems and resources with limitation in early identification, treatment and support of people in need.

Suicide is the fourth leading cause of death among 15–29-year-olds . In low- and middle-income countries the male-to-female suicide ratio is 1.5 men to woman. Suicide rates are highest in persons aged 70 years or over for both men and women in almost all regions of the world. For each suicide, approximately 135 people suffer intense grief or are otherwise affected, translating to108 million people per year who are profoundly impacted by suicidal behavior.

The ingestion of pesticide, hanging and firearms are among the most common methods of suicide globally, but many other methods are used with the choice of method often varying according to population group .

2.2. The Kenyan situation;

There is scanty information about suicides in Low- and Middle-Income Countries, including Kenya. A key contributor to this is the fragmented nature of reporting systems for suicide mortality. In Kenya, data on intentional self-harm is difficult to distinguish from cases of accident or homicide. Even when recorded only partial data is available, for example, information on the method of suicide is often missed. This warrants the urgent need for establishing systematic reporting practices for suicide. Statistics from WHO estimates Kenya crude suicide rate at 6.1 per 100,000 population with age standardized suicide rate 11.0 per 100,000 population which translates to about 4 suicide deaths per day .

Mental illnesses are often associated with suicidal behavior and the prevalence of common mental illnesses in Kenya which include depression and anxiety disorders is about 10.3%. Additionally, 42% of those attending general medical facilities in Kenya have symptoms of severe depression. Suicidal thoughts associated with depression lifetime prevalence is estimated at 7.9%, and for other mental illness is estimated at 5-8%

2.3. SWOT analysis

The Strength, Weaknesses, Opportunities and Threats identified in suicide prevention are as follows:

S

Strengths:

- National Mental Health Policy
- Mental Health Action Plan
- Increasing awareness on mental health
- Taskforce on mental health findings and recommendations
- Universal Health Coverage as a key National agenda
- Division of Mental health at the National Level MoH structure

W

Weaknesses:

- Lack of National surveillance and reporting system on suicide
- No comprehensive and countrywide coordinated suicide prevention program
- Weak mental healthcare systems
- Poor access to prevention interventions, treatment and aftercare services
- Criminalization of suicide and suicidal behaviors in the law
- Discriminative health care financing by insurance providers in treatment of mental illness and suicide behaviour
- Lack of mental health coordination units in most county health leadership and management teams
- Weak mainstreaming of MH in other sectors
- Weak Multisectoral collaboration and coordination of mental health with other sectors e.g., education, social services, criminal justice system, treasury, public service
- Inadequate financing towards MH systems
- Lack of integration of MH into primary healthcare service delivery

O

Opportunities:

- Political good will
- Use of technological innovation to reach wider population
- Established Community Organizations to support the population.
- Public private partnerships

T

Threats:

- Stigma associated with suicidal behaviour and mental illness
- Sensationalized media reporting
- Social media associated trauma: Cyberbullying
- Technology as an enabler to access to suicidal behaviour
- Addictive use of technology e.g., gaming, gambling
- Maladaptive behaviour as a result of technology use leading to social isolation
- Easy access to pesticides, prescription drugs and other lethal means of suicides
- Poverty, unemployment and societal conflicts
- Easy access and rising trends of alcohol and drug use

CHAPTER 3: STRATEGIC DIRECTION

VISION

A Kenya where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and well-being.

MISSION

Promote, coordinate and support appropriate intersectoral action plans and programs for the prevention of suicidal behaviors at National, County, and community levels.

GOAL

To achieve a **10%** reduction in suicide mortality by **2026**

3.1. Guiding principles and approaches:

1. Coordinated multisectoral approach:
Harmonized coordination of intersectoral partnerships and collaboration of multiple public and private sectors (such as health, education, social services, criminal justice system, agriculture, employment, NGOs, Corporates)

2. Universal Health Coverage approach:
All people, regardless of race, gender, socioeconomic or any other status should access quality comprehensive health services without experiencing financial hardship.

3. Human rights approach:
Health is a human right as enshrined in the constitution of Kenya and international human rights instruments.

4. Evidence Based interventions;
Interventions should be based on scientific evidence and/or best practices, taking into consideration the cultural context.

5. Empowerment and inclusion:
Vulnerable population, people with lived experience and bereaved families should be empowered and involved in advocacy, awareness creation, policy planning and implementation.

6. Primary healthcare approaches; Life course, Social accountability, People centered and Participatory.
Provide interventions based on scientifically sound and socially acceptable methods and technology, universally accessible to all age cohorts, coordinated around people`s needs, respects their preferences, with community participation and responsiveness.

7. Equity principle:
All individuals in a community irrespective of their gender, age, race, geographical location, culture, socioeconomic or any form of diversity should have equal opportunities. Focus should be on inclusiveness, non-discrimination, social accountability, and gender equality.

8. Innovation and Technological approach:
Application of innovative technology to increase efficiency and effectiveness of interventions for better outcomes.

3.2. Key Strategic Objectives:

1. To establish and operationalize suicide prevention program at national and county level.
2. To strengthen supportive policy, legal and financing environment for effective implementation of suicide prevention program.
3. To improve access to comprehensive, integrated, and quality services for suicide interventions at all levels of care.
4. To increase awareness on suicide and suicide prevention, and address stigma.
5. To strengthen systems for surveillance and research on suicide.

3.3. Key Activities to achieve the Strategic Objectives

To achieve the key objectives, multicomponent interventions will be implemented along several domains as below;

3.3.1. Objective 1: To establish and operationalize suicide prevention program at national and county level

The Taskforce on Mental Health in Kenya, in their 2020 report, recommended that mental ill health be declared a National Public Health Emergency . They further recommended the establishment of a national suicide prevention program to restrict means enhance surveillance, education, and access to treatment. This strategic objective will ensure implementation of coordination mechanisms for effective suicide prevention across the country in a multisectoral approach.

Key Implementation Domains	Key Activities
• Leadership and governance • Oversight and coordination	i. Appointment of focal person for suicide prevention program ii. Establish intersectoral committee on suicide prevention at National and County level

3.3.2. Objective 2: To strengthen supportive policy, legal and financing environment for effective implementation of suicide prevention program.

The Kenya Mental Health Policy 2015-2030 provides for a framework on interventions for securing mental health systems reforms in Kenya . However, its implementation has not been prioritized at national, county and community levels. The Mental Health Act enacted in 1989 which consolidates the laws relating to the care of persons with mental disorders is now outdated Some of the legislations in Kenya have clauses which negatively impact on people with mental health conditions, psychosocial, intellectual and cognitive disabilities, including criminalization of suicide attempt under section 226 of the penal code.

The Kenyan Government's total expenditure on mental health is around 0.01% of the total government health expenditure and this underfunding has made menta health care inaccessible.

There is need to review and amend relevant laws to align them with the constitutional dispensation, the provisions of the health act and international laws (CRPD) and to address emerging issues. Additionally, improved mental health financing is necessary to ensure a successful and impactful suicide prevention program.

Key Implementation Domains	Key Activities
• Legal • Policy • Financing	i. Advocate for decriminalization of suicide by Repealing Section 226 of the Penal Code ii. Collaborate with Ministry of Agriculture and other relevant stakeholders to develop a Pesticide Control Policy iii. Mobilize financing for suicide prevention at national and county level

3.3.3. Objective 3: To improve access to comprehensive, integrated, and quality services for suicide interventions at all levels of care.

Access to suicide prevention and treatment services means the availability and timely use of evidence-based quality care to achieve the best health and social outcomes. Access to comprehensive, quality care is important for promoting and maintaining mental wellness, health and managing any associated comorbid disease, preventing premature death and reducing unnecessary disability.

Although suicidal behavior has continued to be highly prevalent in the Kenyan population, many of those who are affected do not have adequate access to preventive, treatment and aftercare services.

This objective aims at reducing the barriers to accessing services and ensuring provision of quality and evidence-based suicide interventions at various levels in a continuum of care that include crisis intervention, treatment, follow up and postvention.

Key Implementation Domains	Key Activities
Access to promotive, preventive care, rehabilitative and aftercare services	i Develop and disseminate multisectoral guidelines and protocols for comprehensive management of suicide ii. Mainstream and integrate screening, assessment and treatment interventions for suicide risk factors at all levels of health care system. iii. Set up and operationalize a national suicide prevention helpline. xi. Integrate care and referral pathways for persons with suicidal behavior at community and all health care service levels xii. Strengthen existing community health activities to include mental health and suicide prevention during household visits and dialogue days

3.3.4. Objective 4: To increase awareness on suicide and suicide prevention, and address stigma.

Part of the reason why suicide issues have not been addressed in Kenya is because of lack of awareness as to why people actually opt to end their own lives. Adequate information on suicide play a significant role in preventing suicide and mitigating stigma against affected individuals, families and communities. This strategic objective aims to equip stakeholders with knowledge and skills on responsible case reporting and how to identify persons at risk of suicide, offer brief interventions and refer them for appropriate treatment.

Key Implementation Domains	Key Activities
• Advocacy, public awareness communication • Media reporting • Education and training	i Develop a training package on suicide and suicide prevention for targeted group ii. Train the targeted groups (HCWs, media practitioners, Police, teachers, clergy, administrative leaders) on suicide and suicide prevention iii. Conduct an annual Countrywide awareness campaign on suicide prevention during the month of September iv. Conduct targeted media campaigns on suicide and suicide prevention

3.3.5. Objective 5: To strengthen systems for surveillance and research on suicide.

Timely, accurate and quality data on suicide is critical for decision making and financing. This strategic objective will increase availability of data on suicide in the Kenya Health Information System and the integrated disease surveillance and response platform.

Key Implementation Domains	Key Activities
• Surveillance • Research	i. Establish national suicide and suicide attempts surveillance and registry system ii. Integrate collection and reporting of data on suicide and suicidal attempts by all health facilities through KHIS and IDSR iii. Generate regular reports on suicide and suicide attempts iv. Conduct a national Survey on suicide and suicide attempts

# CHAPTER 4: IMPLEMENTATION FRAMEWORK
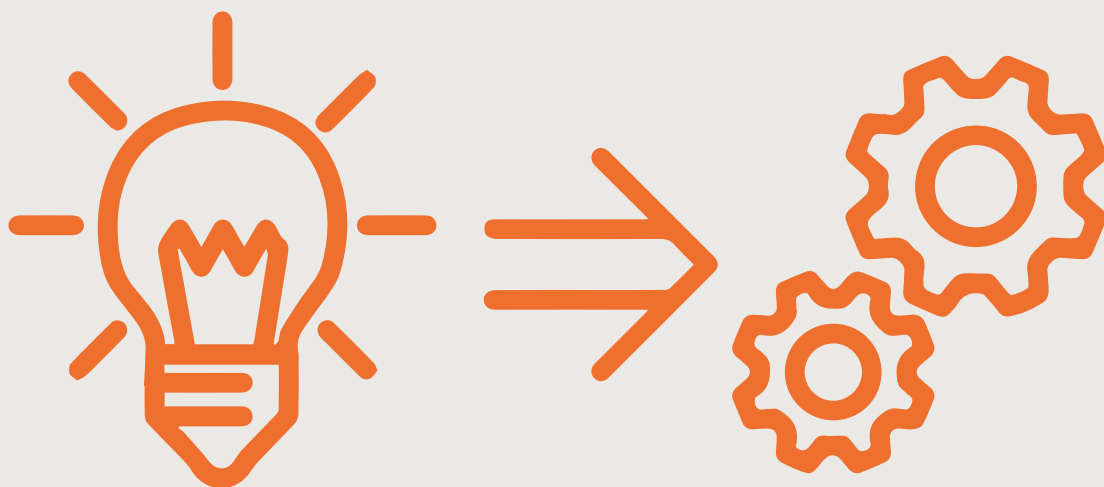
4.1. Coordination & Governance
4.1.1. Overview
Leadership and Governance will play a critical role in successful implementation of this Suicide prevention strategy by providing a framework for engagement with various institutions, private sector, county governments and line ministries working in Suicide programming within the country. This will be even more critical because of the devolution of health service delivery and the need to have functional governance mechanisms at both levels. The oversight and coordination will be led by Ministry of Health through the proposed Suicide Prevention Program and Commission on Mental Health and Happiness. The strategy will be implemented in accordance to existing relevant policies and legislative framework. The established National programme will provide the necessary tools, guidelines, technical support, monitoring and evaluation. The counties will establish County Mental health Councils and Mental health coordination units that will cascade programme elements to the community level through County Focal Persons. The financing of the suicide prevention programme annual work plan will be through the MTEF framework. Other sources of financing will be donors, civil society organizations, philanthropy, corporate CSR and the private sector.

The strategy will be implemented in five years with monitoring of specific targets and indicators using a tool. The multi-sectoral actors will be responsible for various activities and interventions upon which they will report to the national level. The roles and responsibilities of the various actors may be crosscutting and may overlap. The baseline survey and mid-term review will be conducted to inform the progress of interventions and strengthen systems.

Draft National Suicide Prevention Institutional and Accountability Framework
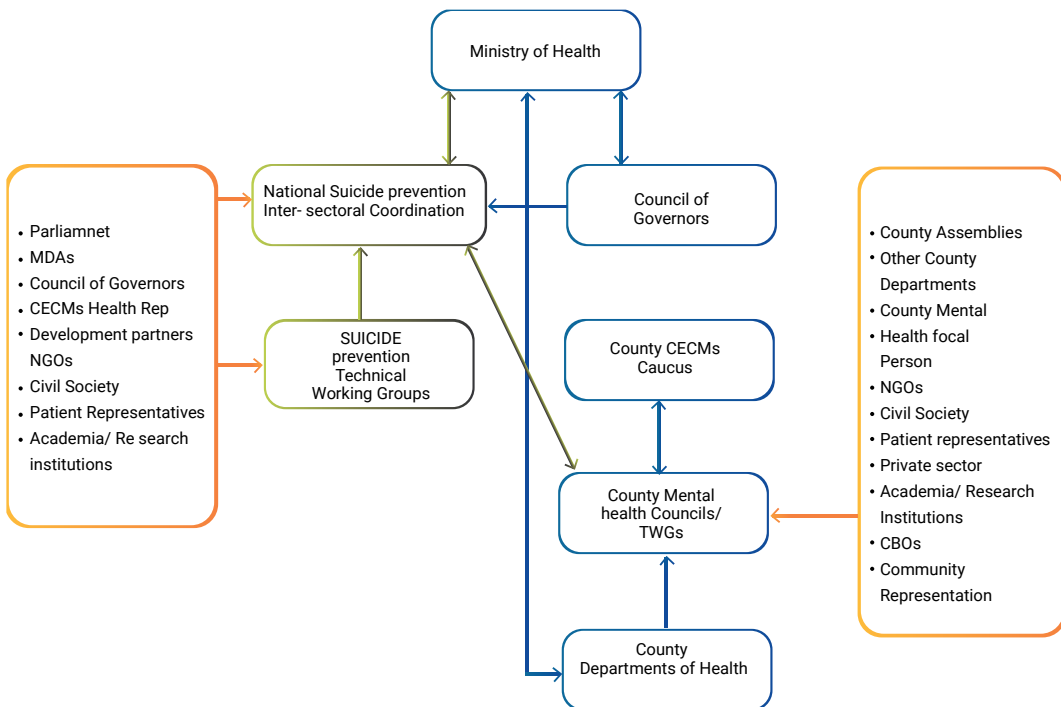
4.1.2. Roles and Responsibilities

For the structures outlined in the figure above to efficiently function, this strategy envisioned to strengthen linkages and harmonization of approaches between the various stakeholders. This requires a clear understanding of the roles and responsibilities of each of the actors towards realization of the broad objectives of this strategy.

Stakeholder	Roles and Responsibilities
Ministry of Health	- Provide overall leadership and stewardship in suicide management and prevention advocacy and social mobilization. - Development and review of policies and guidelines for suicide prevention. - Provide a framework for stakeholder engagement and revitalize multisector stakeholder coordination mechanisms. - Strengthen international collaboration in support of national plans for the prevention and control of Suicide. - Provide overall technical oversight for suicide Prevention activities in Kenya. - Allocate and mobilize adequate resources for suicide prevention activities. - Forge appropriate regional and local multi-sectoral partnerships. - Provide sector frameworks to guide investments in suicide prevention. - Provide a resource mapping repository. - Coordination of suicide prevention data management and dissemination as well as research and technology platforms. - Capacity development for human resources for mental health (HRMH). - Support country efforts to prevent and control Suicide. - Facilitate systematic and timely information exchange among stakeholders. - Strengthen advocacy to raise the priority accorded to the prevention of suicide.
County Governments	- Implement national policies and guidelines on suicide prevention at the county level. - Suicide prevention service provision at all levels. - Prioritizing suicide prevention in the health financing policy. - Provision of well-equipped health facilities. - Hiring, training, retention, and remuneration of HRMH in line with Kenya staffing norms. - Advocacy and policy geared towards suicide management and prevention. - Ensuring availability of essential health products and technologies (HPTs). - Resource allocation & mobilization and create conducive environment for implementing partners towards suicide prevention. - Streamlining referral services. - Establish multi-sectoral forums geared towards suicide management and prevention.

Ministries, State Departments and Agencies (MDAs)	• Workplace mental health and suicide prevention programmes • School mental health program • School social emotional skills training
	• Partnership and collaboration in the implementation of suicide prevention strategies • MDAs formulate and implement relevant policies on suicide prevention • Capacity building and strengthening of systems aimed at addressing mental health determinants and suicide risk reduction
Private Sector	• Provide financial support for Suicide prevention and control interventions. • Ensure manufacturing of quality, affordable, accessible health care goods, and services (e.g. medicines, pharmaceutical products, and rehabilitation). • Undertake corporate social responsibility (CSR) activities targeting community awareness for Suicide prevention. • Insurance companies should develop medical cover packages which do not discriminate the management of suicidal behaviour. • Conduct responsible advertising and follow suicide risks control laws and policies. • Support technology innovation and use in the health sector. • Support implementation of suicide prevention and control initiatives at their workplaces. • Comply with policies, strategies, and guidelines on suicide prevention. • Develop workplace policies that do not discriminate against people who have attemptesuicide. • Participate in resource mobilization. • Provide a healthy and friendly environment to support suicide prevention. • Create incentives for employers to reduce psychological and job-related stress, enhance stress management, and introduce easy-to-implement programmes to promote well-being in the workplace.
Private Health Facilities	• Offer quality healthcare for persons who have attempted suicide seeking care in private hospitals. • Undertake CSR activities targeting community awareness for Suicide prevention. • Comply with policies, strategies, and guidelines on Suicide prevention and Control. • Build capacity for suicide prevention and control. • Participate in data sharing on suicide related information.
Faith Based Organizations	• Suicide care provision in line with the suicide prevention strategy. • Linkage to patients/people that have prior Suicide attempts. • Mobilize resources for suicide prevention activities. • Contribute consensus building and connect local communities with the health care system. • Provision of care and support to the vulnerable groups. • Strengthen human resource for health. • Promote healthy lifestyles to address risk factors to suicide.
Development Partners	• Provide technical support and capacity building. • Support resource mobilizing and financing of suicide prevention interventions. • Participate in multisectoral coordination committees.

Regulatory and professional bodies	• Review and development of curricula to incorporate suicide prevention strategies. • Implementation of the HRH for mental health specifically addressing staffing gaps, task sharing, career progression and recognition. • Expanding the availability of specialists, guideline development and dissemination, capacity building, research and conducting advocacy at both national and county level for
Law makers (National and county governments)	• Pass bills for prevention and control of Suicide • Lobby for increased allocation of resources for suicide prevention strategies. • Provide an oversight for suicide implementation in the country. • Implement suicide prevention and management laws
Academic, Research and Health Training Institutions	• Support education and training on suicide prevention. • Review education curricula in consultation with regulatory bodies to respond to the evidence based suicide prevention interventions.
People with lived Experience	• Participate in strategic planning and multisectoral implementation of suicide prevention strategy. • Participate actively in promotion of mental health and evidence based suicide prevention interventions. • Advocate for increased resources toward implementation of suicide prevention programmes at community levels. • Provide peer support and care programmes. • Advocate for inclusive policies, access human right based community mental health services and decriminalization of suicide attempt and suicide.
Media	• Engage in advocacy and community mobilization in implementation of this strategy. • Participate in development and dissemination of health messages on suicide and risk factors • Educate the public on suicide and the risk factor across all levels. • Sensitize and mobilize their members for effective implementation of this strategy. • Advocate and ensure accurate and evidence-based reporting on suicide prevention strategies. • Conduct responsible advertising and adhere to and promote suicide risk control policies and Regulations.
Individuals and Communities	• Adopt appropriate health care seeking behaviors. • Participate actively in health promotion and suicide prevention activities. • Increase demand by lobbying and seeking for insurance policies for financial and social protection. • Participate in social mobilization activities to raise awareness for suicide prevention. • Participate in the budget making process and implementation of policies and plans. • Adopt annual screening on mental wellbeing and suicide risks.

4.2. Monitoring and Evaluation Framework

The monitoring and evaluation framework identifies results expected in the course of implementation of the Suicide Prevention Strategy, together with indicators that will measure the progress of achievement of these results. These high impact indicators, if achieved will contribute significantly to the ultimate goal of reducing suicide mortality rate in the country. Counties, health facilities and all other stakeholders will be expected to align with the reporting tools and processes provided for in this Strategy to ensure collection of standardized data.

The Ministry of Health will maintain an implementation tracking plan. There will be an annual Suicide Prevention Strategy review meeting that will involve key stakeholders to discuss performance, implementation challenges and best practices, and recommend any modifications needed to inform decisions on how to accelerate achievement of set targets. Further, there will be a mid-term and end-term evaluation to complement the knowledge base of routine monitoring data to assess the utility, relevance and effectiveness of the Strategy.

The table below details the data sources for the indicators, frequency of reporting, targets, and timelines for each of the targets.

Monitoring & Evaluation Framework

Strategic Objective 1: To establish and operationalize suicide prevention program at national and county level.								
Key activities	Indicator	Source of data	Periodicity	Target				
				2021	2022	2023	2024	2025/26
1. Establish a focal point for suicide prevention at national and county level	Focal person for suicide prevention appointed at national level	Appointment letter	Once	1				
	Proportion of counties with a focal person for mental health/ suicide prevention	Appointment letter/County Mental Health Coordinators Database/CHMT Lists	Annually	70%	100%			
2. Establish Multisectoral Suicide Prevention Committees at both National and County Level	Suicide Prevention Committee established at National level	Appointment letters/TORs/Meeting Minutes	Once	1				
	Proportion of counties with multisectoral suicide prevention committee	Appointment letters/TORs/Meeting Minutes	Annually	20%	100%			

				1	1	1	1	1
3. Provide technical assistance to counties to implement suicide prevention strategy	Counties technical assistance reports	Suicide prevention activities integrated in county AWPs;	Annually	1	1	1	1	1
	Proportion of counties implementing suicide prevention activities	Quarterly implementation reports AWP	Quarterly	4	4	4	4	4

Strategic Objective 2: To strengthen supportive policy, legal and financing environment for effective implementation of suicide prevention program.								
4. Advocate for decriminalization of suicide by repealing section 226 of the penal code	Pesticides Control Policy on Suicide means Prevention	Penal code, Kenya Law Website	Once			1		
5. Collaborate with Ministry of Agriculture and other relevant stakeholders to develop and operationalize a pesticide control policy as a means of suicide prevention	Pesticides Control Policy on Suicide means Prevention	Pesticide control policy	Once			1		
6. Mobilize financial resources for suicide prevention at national and county level	Proportion of required resources allocated towards suicide prevention	Expenditure reports/mental health budget	Annually	50%	75%	100%	100%	100%
	Proportion of counties with a dedicated mental health budget	County Health Budgets	Annually		50%	75%	100%	100%

Strategic Objective 3: To improve access to comprehensive, integrated, and quality services for suicide interventions at all levels of care.

Key activities	Indicator	Source of data	Periodicity	2021	2022	2023	2024	2025/26
7. Develop and disseminate multisectoral guidelines and protocols for comprehensive management of suicide.	Developed guidelines for community and primary care workers on suicide management	MoH Guidelines Portal	Once	0	100%			
	Proportion of counties implementing protocols on suicide assessment, treatment and referral and follow-up of persons with suicide risk and postvention	Dissemination and implementation reports	Quarterly	0	50%	100%		

Key activities	Indicator	Source of data	Periodicity	2021	2022	2023	2024	2025/26
8. Mainstream and integrate screening, assessment and treatment interventions for suicide risk factors at all levels of health care system.	Proportion of counties that are effectively utilizing screening & assessment tools	Report on assessment tools that are validated	Once	0	50%	100%		
	Proportion of persons attending health facilities screened for suicide risk	IDSR & KHIS	Annually	0	20%	40%	80%	100%
	Proportion of persons at risk receiving interventions	IDSR & KHIS	Annually	0	20%	40%	80%	100%
9. Set up and operationalize a national suicide prevention helpline	Operational suicide prevention helpline in place	Implementation reports	Once	0		100%		
	Proportion of callers with suicide risk linked to care through the helpline.	Helpline Reports				100%	100%	100%

10. Integrate care and referral pathways for persons with suicidal behavior at community and all health care service levels	Proportion of community and health care services that have care and referral pathways activities.	IDSR & KHIS	Quarterly	0	20%	40%	80%	100%
	Proportion of health facilities with access to a mental health service provider.	Mapping report	Annually	0	10%	25%	50%	75%
	Proportion of counties with established care coordination forums	Care Coordination report	Quarterly	0%	50%	100%		
11. Strengthen existing community health activities to include mental health and suicide prevention during household visits and dialogue days	Proportion of persons at risk of suicide referred to a health facility by CHVs.	KHIS	Quarterly	0	0	20%	40%	80%

Strategic Objective 4: Increase awareness of suicide and suicide prevention and address stigma

Key interventions	Indicator	Source of data	Periodicity	Target				
				2021	2022	2023	2024	2025/26
12. Develop a suicide prevention and management training package for targeted groups	Training packages available				1			
13. Train HCWs,	Number of TOTs trained	Training reports	Annually	100	100	100	100	100

Key interventions	Indicator	Source of data	Periodicity	2021	2022	2023	2024	2025/26
Media practitioners, police, teachers, clergy leaders, media, administrative leaders on suicide and suicide prevention	Number of individuals trained on the packages			2000	2000	2000	2000	2000
14. Conduct an annual countrywide awareness campaign on suicide prevention during the month of September.	Annual campaigns conducted	Campaign reports	Annually	1	1	1	1	1
15. Conduct targeted media campaign	Media campaigns conducted	Campaign reports		1	2	2	2	2

Strategic Objective 4: Increase awareness of suicide and suicide prevention and address stigma								
Key interventions	Indicator	Source of data	Periodicity	Target				
				2021	2022	2023	2024	2025/26
16. Establish national suicide and suicide attempt Surveillance and registry system	Suicide surveillance system and registry established	Police, Mortuary, Hospital records			1			
17. Integrate collection and reporting of data on suicidal attempts by all health facilities through KHIS and IDSR.	Proportion of health care facilities reporting on suicidal attempts and suicidal deaths (%)	DHIS				50%	75%	100%
	Number of reports generated annually	DHIS			4	4	4	4

GLOSSARY

Crisis intervention in suicide behavior refers to methods used to offer immediate, short-term help to individuals as direct effort to stop or prevent persons attempting or contemplating suicide from killing themselves.

Decriminalization is the reclassification in law relating to certain acts or aspects of such to the effect that they are no longer considered a crime, including the removal of criminal penalties in relation to them

Mental Health is a state of wellbeing in which individual realizes her or his own potential/abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to contribute to her or his community.

Mental health worker is a person who is trained and offers services for the purpose of improving an individual's mental health and/or researches in the field of mental health.

Postvention refers to programs and interventions for survivors following a death by suicide. It is the provision of crisis intervention, support and assistance for those affected by a completed suicide.

Self-harm; non-fatal self-injurious acts without suicidal intent. However, suicide intent can be difficult to assess as it may be surrounded by ambivalence or even concealment.

Suicidal behavior refers to a range of behaviors that include thinking about suicide (or ideation), planning for suicide, attempting suicide and suicide itself.

Suicide attempt is used to mean any non-fatal suicidal behavior such as self-poisoning, injury or self-harm which may or may not have a fatal intent or outcome.

Suicide is the act of killing oneself.

Survivors refer to individuals affected by suicide death of a close person and include family members, friends, classmates, neighbors, colleagues etc.

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