Approved SNA 23/9/25

REPUBLIC OF KENYA
THE NATIONAL ASSEMBLY

THIRTEENTH PARLIAMENT – FOURTH SESSION – 2025
PUBLIC PETITIONS COMMITTEE

REPORT ON-

CONSIDERATION OF PUBLIC PETITION NO. 13 OF 2024 BY DR. LUKOYE ATWOLI REGARDING THE DECRIMINALIZATION OF ATTEMPTED SUICIDE

SEPTEMBER, 2025

Directorate of Audit, Appropriations and General Purpose Committees
Clerk's Chambers
Main Parliament Buildings
NAIROBI

Contents

CHAIRPERSON'S FOREWORD

On behalf of the Public Petitions Committee and pursuant to the provisions of Standing Order 227, it is my pleasant privilege and honour to present to this House the Report of the Committee on the Public Petition No. 13 of 2024 regarding the decriminalization of attempted suicide. The petition was presented to the House pursuant to Standing Order No. 225 (2) (b) by the Honourable Speaker of the National Assembly on behalf of Dr. Lukoye Atwoli, Professor of Psychiatry and Dean at the Medical College of East Africa, Agha Khan University.

The petitioner prayed that the Committee recommend the repeal of Section 226 of the Penal Code Cap 63 to decriminalise attempted suicide.

In consideration of the Petition, the Committee collected views from the petitioner, the Kenya Law Reform Commission, the Office of the Attorney General and the Department of Justice. The Committee observed that the High Court in Constitutional Petition No. E045 of 2022, in its Judgement dated 9th January 2025, declared Section 226 of the Penal Code unconstitutional for violating Articles 27 (non-discrimination), Article 28 (on right to inherent dignity), and Article 43 (on right to health) of the Constitution. Further, the enforcement of the provision risks undermining constitutional rights. Therefore, the Committee recommends the repeal of Section 226 of the Penal Code Cap 63 to decriminalise attempted suicide.

The Committee appreciates the Offices of the Speaker and Clerk of the National Assembly for providing guidance and necessary technical support, without which its work would not have been possible. The Chairperson expresses gratitude to the Committee Members for their devotion and commitment to duty during the consideration of the Petition.

On behalf of the Committee and pursuant to the provisions of Standing Order 199, I wish to lay the report on the consideration of Public Petition No. 13 of 2024 by Dr. Lukoye Atwoli, regarding the decriminalization of attempted suicide on the Table of the House.

Signed: _____ **Date:** 23/09/2025

HON. MUCHANGI KAREMBA, CBS, M.P.

CHAIRPERSON, PUBLIC PETITIONS COMMITTEE

PART ONE

1. PREFACE

1.1 Establishment and Mandate of the Committee

The Public Petitions Committee is established under the provisions of Standing Order 208A with the following terms of reference:

a) considering all public petitions tabled in the House;
b) making such recommendations as may be appropriate with respect to the prayers sought in the petitions;
c) recommending whether the findings arising from consideration of a petition should be debated; and
d) advising the House and reporting on all public petitions committed to it.

1.2 Committee Membership

The Public Petitions Committee was first constituted in October 2022 and reconstituted in March 2025, and comprises the following Members:

Chairperson
Hon. Muchangi Karemba, CBS, M.P.
Runyenjes Constituency
United Democratic Alliance (UDA)

Vice Chairperson
Hon. Janet Jepkemboi Sitienei, M.P
Turbo Constituency
United Democratic Alliance (UDA)

Hon. Patrick Makau King'ola, M.P.
Mavoko Constituency
Wiper Democratic Movement-Kenya (WDM-K)

Hon. Edith Vethi Nyenze, M.P.
Kitui West Constituency
Wiper Democratic Movement-Kenya (WDM-K)

Hon. Maisori Marwa Kitayama, M.P.
Kuria East Constituency
United Democratic Alliance (UDA)

Hon. Joshua Chepyegon Kandie, M.P.
Baringo Central Constituency
United Democratic Alliance (UDA)

Hon. Beatrice Kadeveresia Elachi, M.P.
Dagoreti North Constituency
Orange Democratic Movement (ODM)

Hon Suzanne Ndunge Kiamba, MP
Makueni Constituency
Wiper Democratic Movement-Kenya (WDM-K)

Hon. Ntwiga Patrick Munene, M.P.
Chuka Igambang'ombe Constituency
United Democratic Alliance (UDA)

Hon. Bernard Muriuki Nebart, M.P.
Mbeere South Constituency
Independent

Hon. Bidu Mohamed Tubi, M.P.
Isiolo South
Jubilee Party (JP)

Hon. Peter Irungu Kihungi, M.P.
Kangema Constituency
United Democratic Alliance (UDA)

Hon. John Bwire Okano, M.P.
Taveta Constituency
Wiper Democratic Movement-Kenya (WDM-K)

Hon. Peter Mbogho Shake, M.P.
Mwatate Constituency
Jubilee Party (JP)

Hon. Sloya Clement Logova, M.P.
Sabatia Constituency
United Democratic Alliance (UDA)

1.3 Committee Secretariat

The secretariat comprises:

Mr. Leonard Machira
Principal Clerk Assistant II

Ms. Anne Shibuko
First Clerk Assistant

Ms. Miriam Modo
First Clerk Assistant

Mr. Willis Obiero
Clerk Assistant III

Mr. Bernard Kipchumba
Clerk Assistant III

Ms. Patricia Gichane
Legal Counsel II

Ms. Nancy Ouma
Research Officer III

Ms. Roselyne Njuki
Principal Serjeant-at-Arms

Mr. Paul Shana
Serjeant-at-Arms

Mr. Calvin Karungo
Media Relations Officer III

Mr. Peter Mutethia
Audio Officer

PART TWO

2. BACKGROUND OF THE PETITION

2.1 Introduction

1. Public Petition No. 13 of 2024 regarding the decriminalization of attempted suicide was presented to the House on 13th August, 2024, by the Speaker of the National Assembly on behalf of Dr. Lukoye Atwoli, Professor of Psychiatry and Dean at the Medical College of East Africa, the Aga Khan University.

2. The petitioner called for the repeal of section 226 of the Penal Code, which states that *"any person who attempts to kill himself is guilty of a misdemeanour."* Further, Section 36 provides for a general punishment for misdemeanours, that *"when in this Code no punishment is specially provided for any misdemeanour, it shall be punishable with imprisonment for a term not exceeding two years or with a fine, or with both."*

3. The Petitioner submitted that criminalising suicide attempts not only fails to address underlying mental health issues but also perpetuates stigma and shame surrounding mental illness. This is despite the provisions of Section 2 of the Mental Health Act, which defines and includes in its interpretation of a person with mental illness a person with suicidal ideation or behaviour. Moreover, it inhibits accurate data collection and hinders suicide prevention efforts.

4. He observed that Kenya remains one of the few countries with such legislation criminalising attempted suicide. He averred that many countries have decriminalised attempted suicide, allowing mentally ill patients access to the services they require.

5. The Petitioner further stated that the continued application of the provisions contradicts the provisions of Article 43 of the Constitution that *"(1) every person has the right to the highest attainable standard of health, which includes the right to healthcare services, including reproductive healthcare and (2) a person shall not be denied emergency medical treatment."*

6. The Petitioner argued that Section 226 of the Penal Code, read together with Section 36, was unreasonable as it created a barrier towards access to the highest attainable standard of mental health care and emergency medical treatment.

7. Further, the Petitioner stated that the provision offends Article 28, which provides that *"every person has inherent dignity and the right to have that dignity respected and protected."*

2.2 Petitioner's Prayers

8. The Petitioner prayed that the National Assembly, through the Public Petitions Committee, repeal Section 226 of the Penal Code Cap 63 to decriminalise attempted suicide.

PART THREE

3. STAKEHOLDERS' SUBMISSIONS ON THE PETITION

3.1 The Petitioner

On Tuesday, 1st October 2024, the petitioner, Dr. Lukoye Atwoli, appeared before the Committee and presented as follows—

9. The Petitioner informed the Committee that Kenya remains one of the few countries that still has legislation criminalizing suicide attempts, a leftover from colonial times. It is instructive that the former colonial power, the United Kingdom, repealed similar legislation decades ago, affording mentally ill patients access to the services they require.

10. He urged the National Assembly to move with speed to repeal section 226 of the Penal Code, and thereby guarantee dignity to our fellow citizens who suffer from mental illness that includes suicidal ideation.

11. He observed that the Kenya National Commission on Human Rights has made an effort through various initiatives to have the matter addressed. However, no satisfactory repeal of section 226 of the Penal Code has been achieved.

12. He also clarified that the Constitutional petition No. E045 of 2022, before the High Court of Kenya, sought to have Section 226 of the Penal Code declared unconstitutional.. The petition, on the other hand, aimed to have Section 226 of the Penal Code repealed.

13. He further informed the Committee that Suicide attempts are classified in the psychiatric literature as a medical emergency requiring immediate intervention to prevent serious injury or death. There are evidence-based protocols that have been developed for the management of a patient presenting with a suicide attempt, and all these recognise this as a medical emergency.

14. The Petitioner also argued that Section 226 of the Penal Code prevented a person suffering from a medical emergency from accessing emergency treatment, by directing them into the criminal justice system instead of a health facility where they would receive life-saving care. Therefore, the Section offended Article 43 of the Constitution of Kenya 2010, and should be removed from the statute.

15. Further, Article 27(4) and (5) of the Constitution prohibit discrimination by the State or any person on grounds including health status and disability. Given that people suffering from other illnesses such as diabetes mellitus and hypertension, and people having other signs of psychological distress like depressed mood, severe anxiety and specific phobias are not subjected by law to threats of arrest and arraignment for their illnesses, treating people with suicidal ideation and behaviour as criminals constitutes discrimination on grounds of health status, and should not be allowed in the statute.

16. Additionally, Article 28 of the Constitution of Kenya provides that every person has inherent dignity and the right to have that dignity respected and protected. Categorising a person's psychological distress and signs of mental illness as a criminal offence amounts to denying their inherent dignity, and punishing them for their symptoms is the exact opposite of protecting their dignity.

17. He further argued that respecting and protecting the dignity of persons with suicidal ideation would mean they can be conveyed to a health facility where they will be assessed by a qualified mental health professional and provided with the care to take away the suicidal thoughts and behaviours. Thus allowing them to resume a dignified life as productive citizens of this republic instead of spending the rest of their days as convicted criminals on account of their illness.

18. The Petitioner also noted that Section 226 of the Penal Code was enacted before independence in the context of a very different social milieu in which the lives of the majority of citizens were at the mercy of the colonial power. The science at the time had not advanced sufficiently for society to acknowledge that suicide is the end-product of severe mental illness or extreme psychological and/or social distress that, if addressed, would significantly reduce the risk of suicide and improve the mental health of the person.

19. He noted that globally, nine people die by suicide out of 100,000 per year (2019); Kenya's rate is 6 per 100,000. He cited a study using South African data that showed that the presence of mental illness among parents increased the odds of suicidal behaviour among their adult offspring, and the greater the number of parental mental illnesses, the higher the risk of having suicidal ideation.

20. He also referred to another study conducted in Mosoriot in Nandi County (Prevalence of Psychiatric morbidity in a community sample in Western Kenya), which found that 1 in 6 people in the community had made a suicide attempt in their lifetime. The prevalence of mental illness was also high, with almost half having had at least one mental disorder in their lifetime.

21. In addition, the Petitioner noted that there were many reported cases of suicide attempts in hospitals in Kenya, and many reported suicides in the community, as evidenced by police and administrative reports.

22. Further, with worsening socio-economic circumstances and increasingly problematic social relations, suicide rates and the prevalence of mental illnesses were increasing.

23. He also informed the Committee that the World Health Organization indicates that suicides are preventable, and the measures for prevention and control that include limiting access to means, interacting with media for responsible reporting of suicide, fostering socio-emotional skills in adolescents, and early identification and management of those with suicidal behaviours. He empasized that punishment was not one of the recommendations for handling suicide in any setting.

24. In Kenya, the Mental Health Policy 2015-2030 indicated that the high burden of untreated mental illness in the country might be responsible for the daily reported cases of suicide, among other social problems we face, and in the Mental Health Action Plan 2021-2025 the

Ministry of health empasized the implementation of a suicide prevention programme as a priority action in achieving the Strategic Objective of Preventive and Promotive Mental Health.

25. The Committee was also informed that the Presidential Taskforce report of 2020 titled *"Mental Health and Wellbeing- Towards Happiness and National Prosperity"*, recommended that a National Suicide Prevention Programme be established with the role to restrict means, conduct surveillance, education, access to treatment, decriminalisation, responsible media reporting, helpline, and crisis intervention.

26. On criminalization of suicide, the Petitioner observed that the Taskforce recommended that there was a need to decriminalize suicide and amend other laws which are discriminatory and use derogatory language, and that laws relating to the criminal justice system be amended to ensure people with mental health conditions are not discriminated against by criminalization of symptoms of mental illness and get fair administration of justice.

27. He further observed that the Mental Health Action Plan sought the development and implementation of comprehensive national strategic interventions for the prevention of suicide, with special attention to vulnerable groups identified as at an increased risk of suicide. The strategies are to be implemented by the National and County governments, working in collaboration with all stakeholders.

28. In addition, he informed the Committee that one of the strategic activities in the Suicide Prevention Strategy 2021-2026 is advocating for the decriminalization of suicide by repealing Section 226 of the Penal Code.

29. The Petitioner cited a research article authored by Edith Kwobah, Steve Epstein, Ann Mwangi, Debra Litzelman and Lukoye Atwoli titled *Prevalence of psychiatric morbidity in a community sample in Western Kenya*, which found that about 25% of the worldwide population suffers from mental, neurological and substance use disorders. The article further found that up to 75% of affected persons do not have access to the treatment. In addition, data on the magnitude of the mental health problem in Kenya is scarce.

30. The Committee was informed that the research concluded by stating that a large proportion of the community has had a mental disorder in their lifetime, and most of these conditions are undiagnosed and therefore not treated. These findings indicate a need for strategies that will promote the diagnosis and treatment of community members with psychiatric disorders. To screen more people for mental illness, we recommend further research to evaluate a strategy similar to the home-based counselling and testing for HIV and the use of simple screening tools.

31. The Petitioner also cited another research article by Lukoye Atwoli, Matthew Nock, David Williams and Dan Stein, titled *Association between parental psychopathology and suicidal behaviour among adult offspring: results from the cross-sectional South African Stress and Health survey*, He noted that prior studies demonstrated a link between parental psychopathology and offspring suicidal behaviour. However, it remained unclear what aspects of suicidal behaviour among adult offspring are predicted by specific parental mental disorders, especially in Africa.

32. He stated that the results of the study were that the presence of parental psychopathology significantly increased the odds of suicidal behaviour among their adult offspring. More specifically, parental panic disorder was associated with offspring suicidal ideation, while parental panic disorder, generalized anxiety disorder and suicide were significantly associated with offspring suicide attempts. Among those with suicidal ideation, none of the tested forms of parental psychopathology was associated with having suicide plans or attempts. There was a dose-response relationship between the number of parental disorders and the odds of suicidal ideation.

33. The study concluded by stating that parental psychopathology increased the odds of suicidal behaviour among their adult offspring in the South African context, replicating results found in other regions. Specific parental disorders predicted the onset and persistence of suicidal ideation or attempts in their offspring. He recommended further research into these associations to determine the mechanisms through which parent psychopathology increases the odds of suicidal behaviour among offspring.

3.2 Kenya Law Reform Commission

The Acting Secretary, Kenya Law Reform Commission, Mr. Peter Musyimi, vide a letter dated 20th May 2025, submitted as follows—

34. The Secretary stated that the World Health Organization Policy Brief on the Health Aspects of Decriminalization of Suicide and Suicide Attempts names Kenya as one of only twenty-three countries in the world which still criminalized suicide attempts.

35. The Brief also stated that the criminalization of suicide perpetuates an environment that fosters blame and stigmatization towards people who attempt suicide and, at the same time, fail to recognize the role of social, economic and cultural factors that play a role in suicide and suicide attempts. The Brief further states that the criminalization deters people from seeking timely help and accessing interventions due to the fear of legal repercussions and stigma.

36. He noted that the Mental Health Act, Cap. 248 defined a person with mental illness as a person diagnosed by a qualified mental health practitioner to be suffering from mental illness. It included a person with suicidal ideation or behaviour.

37. He submitted that under the Act, therefore, a person who has attempted suicide would be seen more as a patient needing help than a criminal who should be punished. This was so stated in the case of Republic v SWN (Criminal Case 20 of 2019) [2022] KEHC 3312 (KLR) (7 July 2022) (Sentence) where the High Court held that: *"As the facts patently announce, here is a young woman in need of treatment, care and protection. She is certainly not a deranged criminal in need of retribution and confinement."*

38. In the above case, the Committee was informed that the accused person was found to have fatally stabbed her son, killing him immediately. She then turned the knife on herself three times in an attempt to kill herself. One of the issues before the court was its role in sentencing an accused person who was mentally ill.

39. In conclusion, the Secretary recommended that attempted suicide should be decriminalized in Kenya through the repeal of section 226 of the Penal Code.

3.3 Office of the Attorney General and Department of Justice

The Attorney General, vide a letter dated 21st May 2025, submitted as follows—

40. The Attorney General cited the following Articles of the Constitution regarding non-discrimination, protection of human dignity and the right to health in support of the petition:

    a. Article 27 (4) of the Constitution provides that the State shall not discriminate directly or indirectly against any person on any ground, including race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth.

    b. Article 28 of the Constitution provides that every person has inherent dignity and the right to have that dignity respected and protected.

    c. Article 43(1) (a) of the Constitution provides that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.

41. The Attorney General also cited a case: High Court in *Kenya National Commission on Human Rights & 2 others v Atorney General: Director of Public Prosecutions & 3 others (Interested Parties): Law Society of Kenya (Amicus Curiae) (Constitutional Petition E045 of 2022) [2025] KEHC 6 (KLR) (Constitutional and Human Rights) declared section 226 of the Penal Code unconstitutional for violating Articles 27, 28 and 43 of the Constitution.*

42. He informed the Committee that the High Court in the above-referenced case held as follows-

    Section 226 of the Penal Code offends Article 27 of the Constitution by criminalizing a mental health issue, thereby endorsing discrimination based on health, which is unconstitutional. It also indignifies and disgraces victims of suicidal ideation in the eyes of the community for actions that are beyond their mental control, which is a violation of Article 28. The existence of Section 226 exposes the survivors of suicide and potential victims with suicide ideation to possible reprisals, thereby eroding the right to have the highest attainable standard of health envisaged in Article 43 (1) of the Constitution.

43. He submitted that Article 2 (6) of the Constitution provides that any treaty or convention ratified by Kenya shall form part of the law of Kenya under the Constitution. Kenya is a signatory to the World Health Organization Global Mental Health Action Plan 2013-2030. The overall goal of the action plan is to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders. One of the recommendations in the Plan is the decriminalization of suicide, suicide attempts and other acts of self-harm.

44. He also stated that to realize global commitments such as the Global Mental Health Action Plan (2013-2030), the Ministry of Health developed the Kenya Mental Health Action Plan (2021-2025). The Plan envisions a nation where mental health is valued and promoted, and mental health conditions are treated without stigmatization and discrimination. The Plan provides a roadmap for securing reforms and building strong mental health systems with the ultimate goal of attaining the highest standard of mental health in Kenya. The Plan proposes explicitly the decriminalization of suicide and the amendment of laws which are discriminatory and use derogatory language.

45. The Attorney General concluded that, considering the declaration by the High Court as well as the national and global commitments, the Office of the Attorney General did not object to the repeal of section 226 of the Penal Code as proposed by the Petitioner.

PART FOUR

4. COMMITTEE OBSERVATIONS

Upon hearing from the Petitioner, and examining submissions from the Kenya Law Reform Commission, the Office of the Attorney General and Department of Justice, the Committee observed as follows-

46. Section 226 of the Penal Code, which criminalizes attempted suicide, is a relic of colonial legislation in commonwealth countries that no longer aligns with modern mental and public health policies.

47. The High Court in Constitutional Petition No. E045 of 2022, in its Judgement dated 9th January 2025, declared Section 226 unconstitutional for violating Articles 27 (non-discrimination), Article 28 (on right to inherent dignity), and Article 43 (on right to health) of the Constitution. Therefore, the enforcement of this provision risks undermining constitutional rights.
48. Criminalization of attempted suicide promotes stigma and barriers to mental health care by deterring vulnerable individuals from seeking help.
49. Suicidal thoughts are internationally recognized as indicators of underlying mental health conditions. Furthermore, the Mental Health Act Cap 248 includes persons with suicidal behaviour within the definition of mental illness, classifying them as individuals who need medical support and not punishment.
50. There is a need to align with global commitments on the decriminalization of suicide and prioritization of human rights-based approaches to mental health, considering that Kenya is a signatory to the WHO Global Mental Health Action Plan 2013–2030.
51. The stakeholders that made submissions to the Committee, including the petitioner, the Office of the Attorney General & the Department of Justice and the Kenya Law Reform Commission, supported the repeal of Section 226 of the Penal Code.

PART FIVE

5. COMMITTEE RECOMMENDATIONS

52. Pursuant to the provisions of Standing Order 227, the Committee responds to the Petition as follows—

On the prayer that the Committee repeal Section 226 of the Penal Code Cap 63 to decriminalize attempted suicide, the Committee notes that the High Court in Constitutional Petition No. E045 of 2022 declared Section 226 unconstitutional. The enforcement of the provision risks undermining constitutional rights. **Therefore, the Committee recommends the repeal of Section 226 of the Penal Code Cap 63 to decriminalize attempted suicide.**

Signed: _____ **Date:** 23/09/2025

HON. MUCHANGI KAREMBA, CBS, M.P.
CHAIRPERSON, PUBLIC PETITIONS COMMITTEE

THE NATIONAL ASSEMBLY
PAPERS LAID
DATE: 23 SEP 2025 DAY. Tuesday

TABLED BY:	Hon. Muchangi Karemba, MP Chairperson
CLERK-AT THE-TABLE:	A. Ushbuko

ANNEXURES

Annex 1: The Adoption List

Annex 2: Public Petition No. 8 of 2024 regarding amendment to the Penal Code to provide for the offense of sextortion

Annex 3: Minutes of the 56th Sitting of the Public Petitions Committee held on 1st October, 2024

PUBLIC PETTIONS COMMITEE

ADOPTION LIST

(i) **Consideration and adoption of the Report on** Public Petition No. 13 of 2024 by Dr. Lukoye Atwoli, regarding decriminalization of attempted suicide.

We, the undersigned, hereby affix our signatures to this Report to affirm our approval:

DATE: 16/9/2025

	HON. MEMBER	SIGNATURE
1.	Hon. Muchangi Karemba,CBS, M.P.(Chairperson)	
2.	Hon. Janet Jepkemboi Sitienei, CBS, M.P.(Vice Chairperson)	
3.	Hon. Patrick Makau King'ola, M.P.	
4.	Hon. Beatrice Kadeveresia Elachi, CBS, M.P.	
5.	Hon. Joshua Chepyegon Kandie, M.P.	
6.	Hon. Maisori Marwa Kitayama, M.P.	
7.	Hon. Edith Vethi Nyenze, M.P.	
8.	Hon. Patrick Ntwiga Munene, M.P.	
9.	Hon. Bidu Mohamed Tubi, M.P.	
10.	Hon. (Eng.) Bernard Muriuki Nebart, M.P.	
11.	Hon. Peter Mbogho Shake, M.P.	
12.	Hon. Suzanne Ndunge Kiamba, M.P.	
13.	Hon. John Bwire Okano, M.P.	
14.	Hon. Sloya Clement Logova, M.P.	
15.	Hon. Peter Irungu Kihungi, M.P.	

REPUBLIC OF KENYA
THE NATIONAL ASSEMBLY

MINUTES OF THE 33RD SITTING OF THE PUBLIC PETITIONS COMMITTEE HELD ON THURSDAY, SEPTEMBER 18, 2025, IN MASHUA CONFERENCE ROOM, SERENA BEACH RESORT AT 02.00 PM

PRESENT

1. Hon. Eric Muchangi Karemba, M.P. Chairperson
2. Hon. Janet Jepkemboi Sitienei, CBS, M.P. Vice-Chairperson
3. Hon. Beatrice Kadeveresia Elachi, CBS, M.P.
4. Hon. Joshua Chepyegon Kandie, M.P.
5. Hon. John Bwire Okano, M.P.
6. Hon. Edith Vethi Nyenze, M.P.
7. Hon. Patrick Ntwiga Munene, M.P.
8. Hon. (Eng.) Bernard Nebart Muriuki, M.P.
9. Hon. Peter Mbogho Shake, M.P.
10. Hon. Maisori Marwa Kitayama, M.P.
11. Hon. Suzanne Ndunge Kiamba, M.P.
12. Hon. Peter Irungu Kihungi, M.P.

APOLOGIES

1. Hon. Patrick Makau King'ola, M.P.
2. Hon. Bidu Mohamed Tubi, M.P.
3. Hon. Sloya Clement Logova, M.P.

SECRETARIAT

1.	Mr. Leonard Machira	Principal Clerk Assistant II
2.	Ms. Miriam Modo	Clerk Assistant I
3.	Ms. Anne Shibuko	Clerk Assistant I
4.	Mr. Bernard Toroitich	Clerk Assistant III
5.	Ms. Patricia Gichane	Legal Counsel II
6.	Ms. Nancy Akinyi	Research Officer III
7.	Ms. Roselyn Njuki	Senior Serjeant at arms
8.	Mr. Peter Mutethia	Audio Officer

MIN./PPETC/2025/172: PRELIMINARIES

The Chairperson called the meeting to order at 10:00 am.With a Prayer

MIN./PPETC/2025/173: ADOPTION OF AGENDA

The Committee then adopted the agenda as listed hereunder on the proposal of Hon. Peter Irungu Kihungi, M.P, and seconded by Hon. Suzanne Ndunge Kiamba, M.P.

AGENDA

1. Prayer
2. Adoption of the Agenda
3. Confirmation of minutes of previous sittings
4. Matters Arising
5. **Consideration of P/No. 13 of 2024 regarding Decriminalization of Attempted Suicide**
6. Any Other Business
7. Adjournment

MIN./PPETC/2025/174: CONFIRMATION OF MINUTES OF PREVIOUS SITTINGS

The Agenda was deferred.

MIN./PPETC/2025/175: CONSIDERATION OF P/NO. 13 OF 2024 REGARDING DECRIMINALIZATION OF ATTEMPTED SUICIDE

Committee Observations

The Committee observed as follows—

(i) Section 226 of the Penal Code, which criminalizes attempted suicide, is a relic of colonial legislation in commonwealth countries that no longer aligns with modern mental and public health policies.

(ii) The High Court in Constitutional Petition No. E045 of 2022, in its Judgement dated 9th January 2025, declared Section 226 unconstitutional for violating Articles 27 (non-discrimination), Article 28 (on right to inherent dignity), and Article 43 (on right to health) of the Constitution. Therefore, the enforcement of this provision risks undermining constitutional rights.

(iii) Criminalisation of attempted suicide promotes stigma and barriers to mental health care by deterring vulnerable individuals from seeking help.

(iv) Suicidal thoughts are internationally recognized as indicators of underlying mental health conditions. Furthermore, the Mental Health Act Cap 248 includes persons with suicidal behaviour within the definition of mental illness, classifying them as individuals who need medical support and not punishment.

(v) There is a need to align with global commitments on the decriminalization of suicide and prioritization of human rights-based approaches to mental health, considering that Kenya is a signatory to the WHO Global Mental Health Action Plan 2013-2030.

(vi) The stakeholders that made submissions to the Committee, including the petitioner, the Office of the Attorney General & the Department of Justice and the Kenya Law Reform Commission, supported the repeal of Section 226 of the Penal Code.

Committee Recommendations

On the prayer that the Committee repeal Section 226 of the Penal Code Cap 63 to decriminalize attempted suicide, **the Committee notes that the High Court in Constitutional Petition No. E045 of 2022 declared Section 226 unconstitutional. Therefore, the Committee recommends the repeal of Section 226 of the Penal Code Cap 63 to decriminalize attempted suicide**

Adoption of the Report

The Committee adopted the report having been proposed by Hon. Beatrice Kadeveresia Elachi, CBS, M.P. and seconded by Hon. Suzanne Ndunge Kiamba, M.P.

MIN./PPC/2025/176: ADJOURNMENT AND DATE OF NEXT MEETING

The Chairperson adjourned the meeting at 04:00 p.m. The date of the next meeting will be Friday, 19th September 2025 at 10.00 a.m.

HON. MUCHANGI KAREMBA, CBS, M.P.
CHAIRPERSON, PUBLIC PETITIONS COMMITTEE

Date: 23/09/2025

`Thirteenth Parliament Third Session

REPUBLIC OF KENYA
THE NATIONAL ASSEMBLY

MINUTES OF THE 56th SITTING OF THE PUBLIC PETITIONS COMMITTEE HELD ON TUESDAY, OCTOBER 1, 2024, IN CONFERENCE ROOM 12, NEW WING, MAIN PARLIAMENT BUILDINGS AT 11.00. A.M

PRESENT

1. Hon. Nimrod Mbithuka Mbai, M.P. — Chairperson
2. Hon. Janet Jepkemboi Sitienei, M.P. — Vice Chairperson
3. Hon. (Eng.) Bernard Muriuki Nebart, M.P.
4. Hon. Joshua Chepyegon Kandie, M.P
5. Hon. John Walter Owino, M.P.
6. Hon. Ernest Ogesi Kivai, M.P.
7. Hon. Maisori Marwa Kitayama, MP
8. Hon. Edith Vethi Nyenze, M.P.

APOLOGIES

1. Hon. Patrick Makau King'ola, M.P.
2. Hon. Bidu Mohamed Tubi, M.P.
3. Hon. Peter Mbogho Shake, M.P.
4. Hon. Sloya Clement Logova, M.P.
5. Hon. Caleb Mutiso Mule, M.P.
6. Hon. Suzanne Ndunge Kiamba, M.P.
7. Hon. John Bwire Okano, M.P.

IN ATTENDANCE

SECRETARIAT

1. Mr. Willis Obiero	Clerk Assistant III
2. Ms. Patricia Gichane	Legal Counsel II
3. Mr. Martin Sigei	Research Officer III
4. Ms. Nancy Akinyi	Research Officer III
5. Mr. Peter Mutethia	Audio Officer
6. Mr. Calvin Karungo	Media Relations Officer III
7. Mr. Paul Shana	Serjeant-at-Arms

PETITIONERS

1. Hon. (Prof.) Phylis Bartoo, MP
2. Dr. Lukoye Atwoli

MIN./PPETC/2024/348: PRELIMINARIES

The Chairperson called the meeting to order at 11:00 am. and proceedings began with prayers by Hon. Ernest Kagesi, M.P.

MIN./PPETC/2024/349: ADOPTION OF AGENDA

AGENDA

1. Prayer
2. Adoption of the Agenda
3. Confirmation of minutes of previous sittings
4. Matters Arising
5. **Meeting with Hon. (Prof.) Phylis Bartoo, MP regarding—**
   - *P/No. 11 of 2024 regarding the Waiver of the Elgeyo Border Settlement Scheme No. 45 Settlement Fund Trustees Loan; and*
   - *P/No. 12 of 2024 regarding Compensation of Residents of Crown Land (LR 883/2)(Sergoit Holding Ground) in Moiben Constituency.*
6. **Consideration of P/No. 13 of 2024 regarding Decriminalization of Attempted Suicide**
   - *Meeting with Petitioner (Dr. Lukoye Atwoli)*
7. Any Other Business
8. Adjournment

The Agenda was adopted to constitute business having been proposed by Hon. Nimrod Mbithuka Mbai, M.P. and seconded by Hon. Maisori Marwa Kitayama, MP.

MIN./PPETC/2024/350: CONFIRMATION OF MINUTES OF PREVIOUS SITTINGS

The agenda was deferred.

MIN./PPETC/2024/351: MEETING WITH HON. (PROF.) PHYLIS BARTOO, MP

The Hon. (Prof.) Phylis Bartoo, MP appeared before the Committee and submitted as follows—

P/No. 11 of 2024 regarding the Waiver of the Elgeyo Border Settlement Scheme No. 45 Settlement Fund Trustees Loan

Background to the Petition

1. Agricultural Settlement Fund Trustees was established in 1963 under the Agriculture Act (Cap 318 of the Laws of Kenya) Section 68, which was repealed by the Agriculture Fisheries and Food Authority Act, 2013.

2. The Fund is managed by the Ministry of Lands and Physical Planning. Its mandate is vested in the Settlement Fund Trustees Jointly by the Ministries of Lands, National Treasury, Interior and Agriculture.

3. The Elgeyo Border Settlement Scheme is among the schemes established under the Fund in 1963 for agricultural development and purchase of land with an initial capital of Kshs 5000, aimed at facilitating settlement and development in the region.

4. Over the years, due to various socio-economic factors and changes in land ownership, the burden of the arrears of loan repayment has become unmanageable for the Current generation of residents.

5. Many families inherited the debt without the corresponding assets or resources to repay it. Further, the original purpose of the settlement trust fund has been overshadowed by the financial strain it imposes on the community.

6. The debt incurred by the Elgeyo Border Settlement Scheme has grown exponentially over time, surpassing the initial capital investment of Kshs 5000 hence becoming a significant barrier to the economic progress and well-being of the community by hindering their ability to invest in essential infrastructure, education, health care among others.

7. The residents have over the years received demand notices regarding the arrears of loan repayment with possibilities of repossession of the land if the outstanding amounts are not paid.

Prayers

8. The Petitioners prayed that the Committee–

   (i) Engages the Settlement Fund Trustees with a view of seeking waiver of the accumulated debt of Elgeyo Border Settlement Scheme by the community; and
   (ii) Makes any other recommendation or action it deems fit in addressing the plight of the Petitioners.

P/No. 12 of 2024 regarding Compensation of Residents of Crown Land (LR 883/2) (Sergoit Holding Ground) in Moiben Constituency.

Background to the Petition

1. The Crown Land, LR No. 883/2, commonly referred to as Sergoit Holding Ground in Moiben Constituency, Uasin Gishu County totalling 1500 acres was inhabited by several clans of the Sergoit Community who used it for grazing, water catchment and cultural activities before the land was acquired by the colonial government.

2. The Sergoit Community surrendered the parcel to allow for establishment of public amenities such as schools, colleges, police stations, tree nurseries, among others against a government commitment to compensate them.

3. While some families received compensation by being given other parcels, many others were left out as the land intended for their compensation was fraudulently acquired by individuals who continue to occupy it to date.

4. In 1992, during the initial land allocation to beneficiaries as compensations, some individuals and entities were allegedly allocated parcels of land irregularly by the then provincial administration.

5. Following complaints against the compensation process by the residents, a taskforce was formed in 2016 to investigate and address the anomalies which subsequently led to three splinter groups due to internal disagreements.

6. One of the groups subdivided the land, drew à new map (Sergoit/Karuna Block S) which overlapped with the 1992 allocations thus causing boundary disputes among the residents.

7. The Sergoit Community and uncompensated landowners formed á Committee that actively pursued the matter with the support of the County Commissioner who placed a caveat on any transactions on Crown Land until the issues are resolved.

8. Out of the 1500 acres, only 900 acres is occupied by genuine beneficiaries who are also facing displacement after the 2016 subdivision map. About 450 acres was allegedly acquired and inhabited illegally by private developers while the rest of 150 acres is a water catchment area.

Prayers

9. The Petitioners prayed that the Committee–

   (i) Engages the Ministry of Lands and Physical Planning, Public Works, Housing, and Urban Development; and other relevant authorities with a view of investigating the alleged irregular land acquisitions, illegal Compensation process and other malpractices for Crown Land, LR No. 883/2 in Moiben Constituency, Uasin Gishu County; and

   (ii) Recommends the due compensation of all members of Sergoit Community who surrendered their parcels of land for public utility; and

   (iii) Makes any other recommendation or action it deems fit in addressing the plight of the Petitioners.

Committee Concerns

1. The Petitioner clarified that the land originally belonging to the community had been taken over by the government for the purpose of constructing infrastructure. In compensation, the government resettled the community on approximately

1,500 acres of land. However, the resettlement process was plagued by irregularities, with some individuals receiving inadequate land while others were left out entirely.

2. **Regarding the 2016 task force and its recommendations,** the Petitioner explained that the county government had established the task force, but it did not complete its report. Its mandate was eventually overshadowed by events as the situation became increasingly hostile, compounded by interference from various quarters.

3. **In terms of efforts to engage the National Land Commission, the Ministry of Lands, or other authorities,** the Petitioner revealed that they had not sought intervention from these institutions due to a lack of trust, stemming from previous mishandling of the issue.

4. **Regarding the number of complainants,** the Petitioner estimated the figure to be around 100 but acknowledged that this number could rise, as compensation and land disputes tend to evolve with the growth of families over generations. When asked how genuine claimants could be identified, the Petitioner noted that they had lived on their ancestral land, and although the boundaries were unclear, community members were familiar with each other.

5. **On whether the community was resettled and compensated as families,** the Petitioner confirmed that they had been, and that relevant records could be provided by the County Government of Elgeyo Marakwet.

Committee Resolution

After deliberations, the Committee resolved that the Petitioner provides additional information regarding—

a) A report by the County Commissioner on the matter;
b) List of original members of the community relocated from Elgeyo Marakwet County;
c) Information regarding the number and identity of the complainants;
d) Information regarding the compensation criteria; and
e) Any other relevant information that could facilitated the consideration of the Petition.

MIN./PPETC/2024/352: CONSIDERATION OF P/NO. 13 OF 2024 REGARDING DECRIMINALIZATION OF ATTEMPTED SUICIDE

Meeting with Petitioner (Dr. Lukoye Atwoli)

Dr. Lukoye Atwoli appeared before the Committee and presented as follows—

Background to the Petition

1. Section 226 of the Penal Code Cap 63 of the Laws of Kenya provides that "Any person who attempts to kill himself is guilty of a misdemeanour".

2. Section 36 of the Penal Code additionally provides that "When In this Code no punishment is provided for any misdemeanour, it shall be punishable with imprisonment for term not exceeding two years or with a fine, or with both."

3. The net effect of these provisions is that a person who attempts suicide and is charged and convicted of the same in a court of law is liable to imprisonment, a fine, or both.

4. The consequence of these provisions is that persons suffering from mental illness, who often develop suicidal thoughts and may attempt to kill themselves, knowing that their symptoms carry the risk of arrest and prosecution, will not present themselves for treatment and the care they need in order to improve their mental health and reduce or eliminate their risk of suicidal behaviour.

5. The Constitution of Kenya, in Article 43, provides that: (1) Every person has the right-(a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care...(2) A person shall not be denied emergency medical treatment.

6. Section 226 of the Penal Code creates an unreasonable and potentially fatal barrier to access to the highest attainable standard of mental health care, and often results in denial of emergency medical treatment for persons who may contemplate or attempt suicide, for fear of prosecution and punishment. For this reason section 226 of the Penal Code contravenes the Constitution, and also offends the right of every Kenyan to be treated with dignity as provided for under Article 28 of the Constitution.

7. Kenya remains one of the few countries that still have legislation criminalizing suicide attempts, a leftover from colonial times. It is instructive that the former colonial power, the United Kingdom, repealed similar legislation decades ago, affording mentally ill patients access to the services they require. Many other countries that

8. This petition urges the House to move with speed to repeal section 226 of the Penal Code, Cap 63 of the Laws of Kenya, and thereby guarantee dignity to our fellow citizens who suffer with mental illness that includes suicidal ideation.

9. The Kenya National Commission on Human Rights has made effort through various initiatives to have the matter addressed but so far, no satisfactory repeal of section 226 of the Penal Code has been achieved.

10. The matter has not been adjudicated upon by a competent court in which the Petitioner was a party. However, the responsibility to decriminalise attempted suicide requires a legislative process through repealing of Section 226 of the Penal Code.

11. The Constitutional petition No. E045 of 2022 before the High Court of Kenya sought to have Section 226 of the Penal Code declared unconstitutional which was

a different objective from this petition. This petition seeks to have Section 226 of the Penal Code repealed.

Prayers

The Petitioner prayed that the Committee investigates the matter and makes appropriate recommendations.

Committee Concerns

1. The Petitioner clarified that attempted suicide is not exclusively caused by mental illness. Mental health, as defined, encompasses a range of psychological distress and operates on a spectrum.

2. **Regarding the percentage of mental illnesses linked to suicide attempts**, the Petitioner noted that mental health is significantly correlated with suicide. Specifically, the risk of depression leading to suicide is around 80 percent, as individuals with depression are more likely to attempt suicide. Therefore, mental illness is the strongest predictor of suicide attempts.

3. **Concerning the urgency of decriminalizing attempted suicide,** the Petitioner explained that the proposal stems from a Presidential directive issued in 2016 in response to the mental health crisis. This directive led to the formation of a task force that recommended decriminalization. Additionally, research conducted in Mosoriot identified key factors contributing to mental illness, revealing that half of the community had experienced mental health issues, with many attempting suicide using pesticides.

4. **On the delay in repealing Kenya's law criminalizing attempted suicide,** the Petitioner indicated that no significant movement had been made towards its repeal, emphasizing that now is the time to act. Furthermore, countries such as Ghana, Botswana, and Pakistan have already repealed similar laws, which were inherited from colonial powers that themselves repealed the law in 1961.

5. **Addressing concerns about whether Kenya has enough psychologists and qualified personnel to manage mental health issues,** the Petitioner stated that no country has sufficient mental health workers. In Kenya, there are about 150 psychiatrists, and while the number is increasing, more resources need to be invested in mental health to meet growing demands.

6. **Regarding whether the Shakahola incident was an example of attempted suicide,** the Petitioner stated that he did not have full access to the report on the matter. However, he noted that the general understanding is that the victims were coerced by a religious leader into actions that led to their deaths, which would not be classified as suicide, as suicide originates from an individual's own will.

Committee Resolution

After deliberations, the Committee resolved to engage relevant stakeholders on the Petition.

MIN./PPETC/2024/353: ADJOURNMENT AND DATE OF NEXT MEETING

The Chairperson adjourned the meeting at 2:30 p.m. The next meeting will be held on Wednesday, 2nd October 2024 at 11:00 a.m.

Sign: .....

FOR (CHAIRPERSON).

Date 19-11-2024

THE NATIONAL ASSEMBLY
THIRTEENTH PARLIAMENT (THIRD SESSION)

CONVEYANCE OF PUBLIC PETITION

(No. 13 of 2024)

REGARDING DECRIMINALIZATION OF ATTEMPTED SUICIDE

1. **Honourable Members,** Article 119 of the Constitution accords any person the right to petition Parliament to consider any matter within its authority. Further, Standing Order 225(2)(b) requires the Speaker to report to the House any Petition other than those presented by a Member.

2. In this regard, **Honourable Members**, I wish to report to the House that my office has received a Petition from Dr. Lukoye Atwoli of Identification Card No. 1441XXX6, a Citizen, Professor of Psychiatry and Dean at the Medical College of East Africa, the Agha Khan University is calling for repeal of section 226 of the Penal Code on attempting suicide.

3. The Petitioner states that section 226 of the Penal Code (Cap 63 of the Laws of Kenya) states that "*any person who attempts to kill himself is guilty of a misdemeanour*". Further, section 36 provides for a general punishment for misdemeanours that, and I quote, "*when in this Code no punishment is specially provided for any misdemeanour, it shall be punishable with imprisonment for a term not exceeding two years or with a fine, or with both.*"

4. **Honorable Members,** the Petitioner holds that criminalizing suicide attempts not only fails to address underlying mental health issues but also perpetuates stigma and shame surrounding mental illness. This is despite the provisions of section 2 of the Mental Health Act (Cap 248) which defines includes in its interpretation of a person with mental illness as a person with suicidal ideation or behaviour. Moreover, it inhibits accurate data collection and hinders suicide prevention efforts.

5. The Petitioner clarifies that Kenya remains one of the few countries with such a legislation criminalizing attempted suicide. He avers that many countries decriminalized attempted suicide allowing mentally ill patients access to the services they require.

6. **Honorable Members,** the Petitioner further states that the continued application of the provisions contradicts the provisions of Article 43 of the Constitution that *"(1) every person has the right—to the highest attainable standard of health, which includes the right to health care services, including reproductive health care and; (2) a person shall not be denied emergency medical treatment."*

7. The Petitioner concludes and holds that section 226 of the Penal Code (Cap 63 of the Laws of Kenya) read together with section 36 is unreasonable; and, potentially creates a barrier towards access to the highest attainable standard of mental health care and emergency medical treatment. Further, the Petitioner states that the provision offends Article 28 which provides that *"every person has inherent dignity and the right to have that dignity respected and protected."*

8. **Honourable Members,** in light of the foregoing, the Petitioner seeks the intervention of the National Assembly in repealing section 226 of the Penal Code Cap 63 to decriminalize attempted suicide.

9. **Honourable Members,** having determined that the matters raised by the Petitioner are well within the authority of this House; and further, that the matters raised in this Petition are not pending before any court of law, constitutional or legal body, I hereby commit the Petition to the Public Petitions Committee for consideration pursuant to Standing Order 208A.

10. The Committee is required to consider the Petition and report its findings to the House and to the Petitioner in accordance with Standing Order 227(2).

I thank you.

THE RT. HON. (DR.) MOSES F. M. WETANG'ULA, EGH, MP
SPEAKER OF THE NATIONAL ASSEMBLY

Date 8/8/24

MEMO

SERIAL No.....
RECEIVED

TO: **THE DIRECTOR, LEGISLATIVE AND PROCEDURAL SERVICES, NATIONAL ASSEMBLY**

Head, PLS
Please process.
28/1/24

THRO: FOR **THE DIRECTOR LEGAL SERVICES, NATIONAL ASSEMBLY**

Forwarded: The Petition satisfies the requirements of Standing order 223 & the Petitions to Parliament (Procedure) Act 2012 and may be reported to the House.
S Lugaga
24.01.24

THRO': **THE DEPUTY DIRECTOR, NATIONAL ASSEMBLY**

THRO: **PRINCIPAL LEGAL COUNSEL II**

Forwarded, the Petition satisfies the requirements of the Petitions to Parliament (Procedure) Act, 2021
23/01/2024

FROM: **LEGAL COUNSEL II**

DATE: **23rd JANUARY, 2024**

RE: PETITION TO REPEAL SECTION 226 OF THE PENAL CODE

The above matter refers and instructions to the Legal Directorate to peruse and establish whether the Petition dated 14th December, 2023 by Dr. Lukoye Atwoli complies with the law and the National Assembly Standing Orders.

The Petitioner avers that he is a psychiatrist involved in the care of mentally ill persons. The Petitioner further avers that he is concerned that section 226 of the Penal Code provides that a

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06 FEB 2024
PROCEDURAL, RESEARCH AND JOURNALS
P. O. Box 41842, NAIROBI

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P. O. Box 41842 - 00100, NAIROBI

person who attempts suicide is guilty of a misdemeanour which is punishable with imprisonment for a term not exceeding two years or with a fine, or both, as per the provisions of section 36 of the Penal Code. That accordingly, mentally ill persons who often develop suicidal thoughts will not present themselves for the treatment and care they need in order to improve their mental health, for fear of arrest and prosecution.

The prayer as contained in the Petition is for the National Assembly to **repeal Section 226 of the Penal Code, Cap 63 of the Laws of Kenya** as it contravenes Article 43 of the Constitution that guarantees every person the right to the highest attainable standard of health. The said section further offends the right of every Kenyan to be treated with dignity as provided for under Article 28 of the Constitution, including persons who suffer from mental illness and suicidal ideation.

We have perused the Constitution, the Petition to Parliament (Procedure) Act, 2012 (hereinafter referred to as "the Act") and the National Assembly Standing Orders and advise that the Petition as presented satisfies the requirements of the Petition to Parliament (Procedure) Act, 2012 and the National Assembly Standing Orders.

In the circumstances, the Petition may therefore be tabled in the House.

MERCY G. KINYUA

MEMO

TO: THE DEPUTY CLERK, NATIONAL ASSEMBLY

THRO: THE DIRECTOR LEGAL SERVICES, NATIONAL ASSEMBLY

THRO': THE DEPUTY DIRECTOR, NATIONAL ASSEMBLY

THRO: PRINCIPAL LEGAL COUNSEL II

FROM: LEGAL COUNSEL II

DATE: 16TH OCTOBER, 2023

RE: PETITION TO REPEAL SECTION 226 OF THE PENAL CODE

The above matter refers and your instructions to the Legal Directorate to peruse and establish whether the Petition dated 11th September, 2023 by Dr. Lukoye Atwoli complies with the law and the National Assembly Standing Orders.

The Petitioner avers that he is a psychiatrist involved in the care of mentally ill persons, including those at high risk of suicidal attempts. The Petitioner further avers that he is concerned

that section 226 of the Penal Code provides that a person who attempts suicide is guilty of a misdemeanour which is punishable with imprisonment for a term not exceeding two years or with a fine, or both, as per the provisions of section 36 of the Penal Code. That accordingly, mentally ill persons who often develop suicidal thoughts will not present themselves for the treatment and care they need in order to improve their mental health, for fear of arrest and prosecution.

The prayer as contained in the Petition is for the National Assembly to **repeal Section 226 of the Penal Code, Cap 63 of the Laws of Kenya** as it contravenes Article 43 of the Constitution that guarantees every person the right to the highest attainable standard of health. The said section further offends the right of every Kenyan to be treated with dignity as provided for under Article 28 of the Constitution, including persons who suffer from mental illness and suicidal ideation.

We have perused the Constitution, the Petition to Parliament (Procedure) Act, 2012 (hereinafter referred to as "the Act") and the National Assembly Standing Orders and advise as hereunder:

a) The Petition is not in the form set out in the Schedule to the Act and the Third Schedule to the Standing Orders contrary to Section 3 of the Act and Standing Order 223 (1);
b) The Petition does not contain the identification number of the Petitioner contrary to Section 3 (i) of the Act and Standing Order 223 (1)(i); and
c) The subject matter of the Petition is not indicated on every sheet of the Petition contrary to Section 3 (e) of the Act and Standing Order 223 (1)(e);

Notwithstanding the fact that the Petition as presented does not fully satisfy the requirements of the Petition to Parliament (Procedure) Act, 2012 and the National Assembly Standing Orders, we advise that as per the provisions of Article 119 of the Constitution and Standing Order 219, the Petitioner's prayers fall under the ambit of matters which the House has authority to consider as contemplated in Articles 94 and 95 of the Constitution.

The **Mental Health Act Cap 248** was enacted to provide for the care, treatment and rehabilitation of persons with mental illness. The Act defines a "**person with mental illness**" as a person diagnosed by a qualified mental health practitioner to be suffering from mental illness, and includes a person with suicidal ideation.

Section 3 of the Act provides that a person with mental illness has a right to receive reasonable care, assistance and protection from their family and the State. Further, **Section 3A** of the Act provides that a person with mental illness has a right to the highest attainable standard of mental health services including the right to appropriate, affordable, accessible physical and mental medical health care, counselling, rehabilitation and after-care support.

Accordingly, imprisoning or punishing a person with mental illness for attempted suicide as provided under the Penal Code, amounts to denial of that person to mental health services in contravention with the Constitution and the Mental Health Act.

More importantly, **Article 27(1) and (2) of the Constitution** provides that every person is equal before the law and has the right to equal protection and equal benefit of the law and this equality includes the full and equal enjoyment of all rights and fundamental freedoms.

Article 27(4) further provides that the State shall not discriminate directly or indirectly against any person on any ground, including health status and disability.

A person with mental health illness suffers from cognitive disability and **Section 2B of the Mental Health Act** provides that such persons should be protected from discrimination. Further, **Section 3K of the Mental Health Act** provides that a person with mental illness has a right to recognition before the law and shall enjoy legal rights on an equal basis with other persons in all aspects of life.

The Mental Health Act obligates the Government to provide the necessary physical and technological infrastructure for the care, rehabilitation and provision of health services to persons with mental illness. Further, the Government is required to put in place mechanisms to ensure the rights of persons with mental illness are realised.

Accordingly, Section 226 of the Penal Code is inconsistent with Articles 27, 28 and 43 of the Constitution and should be repealed to protect the rights of persons with mental illness.

In the circumstances, the Petition may therefore be tabled in the House.

MERCY G. KINYUA

PO Box 52682,
Nairobi, 00100 Kenya
lukoye.atwoli@aku.edu

The Aga Khan University
Medical College EA
PO Box 30270, Nairobi

University Centre
3rd Parklands avenue
Cell Phone: +254 722 943397

Lukoye Atwoli, MBS, MBChB(Moi), MMed Psych(Nbi), PhD(Cape Town), IFAPA

The Clerk
National Assembly
via email: cna@parliament.go.ke

1) DLPS/DLS
Please review and advise within timelines
05/10/23

11 September 2023

Dear Sir,

Re: Petition to repeal section 226 of the penal code

1. I am a Professor of Psychiatry and the Dean at the Medical College East Africa, the Aga Khan University. I am also the Vice-Director of the Brain and Mind Institute at the Aga Khan University. I have previously served as the Vice-President of the Kenya Medical Association, and I am currently the Secretary-General of the African Association of Psychiatrists. I am also serving as the President of the African College of Neuropsychopharmacology.

2. Professionally, I Co-Chair the Board on Global Health at the US National Academies of Science, Engineering, and Medicine. I am also the current Chair of the Board of Mathari National Teaching and Referral Hospital.

3. As a psychiatrist, I am involved in the care of mentally ill persons, including those at high risk of suicidal attempts, and I write to you today to raise a concern on the legislative environment in which I operate, and to propose a legislative remedy for these shortcomings. All mental health workers in Kenya operate under the same limitations, and persons suffering from mental illness are receiving suboptimal care as a result.

4. Section 226 of the Penal Code Cap 63 of the Laws of Kenya provides that "Any person who attempts to kill himself is guilty of a misdemeanour."

5. Section 36 of the Penal Code additionally provides that "When in this Code no punishment is provided for any misdemeanour, it shall be punishable with imprisonment for a term not exceeding two years or with a fine, or with both."

6. The net effect of these provisions is that a person who attempts suicide and is charged and convicted of the same in a court of law is liable to imprisonment, a fine, or both.

7. The consequence of these provisions is that persons suffering from mental illness, who often develop suicidal thoughts and may attempt to kill themselves, knowing that their symptoms carry the risk of arrest and prosecution, will not present themselves for treatment and the care they need in order to improve their mental health and reduce or eliminate their risk of suicidal behaviour.

8. The Constitution of Kenya, in Article 43, provides that:

(1) Every person has the right-

(a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care...

(2) A person shall not be denied emergency medical treatment.

9. I hold that section 226 of the Penal Code creates an unreasonable and potentially fatal barrier to access to the highest attainable standard of mental health care, and often results in denial of emergency medical treatment for persons who may contemplate or attempt suicide, for fear of prosecution and punishment. For this reason I would argue that section 226 of the Penal Code contravenes the constitution, and also offends the right of every Kenyan to be treated with dignity as provided for under Article 28 of the Constitution.

10. Further, it is clear that Kenya remains one of the few countries that still have legislation criminalizing suicide attempts, a leftover from colonial times. It is instructive that the former colonial power, the United Kingdom, repealed similar legislation decades ago, affording mentally ill patients access to the services they require. Many other countries that had similar legislation have repealed it over the years.

11. My petition to the National Assembly is to urge the House to move with speed to **repeal section 226 of the Penal Code, Cap 63 of the Laws of Kenya,** and thereby guarantee dignity to our fellow citizens who suffer with mental illness that includes suicidal ideation.

12. To this end I request your honourable office to transmit this petition to the National Assembly Health Committee for processing and introduction of the appropriate legislation to the House in order to **repeal section 226 of the Penal Code.**

13. I remain available to provide additional information on this subject should I be asked to do so by the Committee, or by your honourable office.

Sincerely,

LUKOYE ATWOLI *MBS, MBChB (Moi), MMed Psych (Nairobi), PhD (Cape Town), IFAPA*
Professor of Psychiatry and Dean, Medical College East Africa
Vice-Director, Brain and Mind Institute
The Aga Khan University

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Cell Phone: +254 722 943397

Lukoye Atwoli, MBS, MBChB(Moi), MMed Psych(Nbi), PhD(Cape Town), IFAPA

DLPS/DLS
Please review and advise within timelines.
05/10/23

NATIONAL ASSEMBLY
RECEIVED
04 OCT 2023
CLERK'S OFFICE
P O Box 41842, NAIROBI

The Clerk
National Assembly
via email: cna@parliament.go.ke

11 September 2023

Dear Sir,

Re: Petition to repeal section 226 of the penal code

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2. Professionally, I Co-Chair the Board on Global Health at the US National Academies of Science, Engineering, and Medicine. I am also the current Chair of the Board of Mathari National Teaching and Referral Hospital.

3. As a psychiatrist, I am involved in the care of mentally ill persons, including those at high risk of suicidal attempts, and I write to you today to raise a concern on the legislative environment in which I operate, and to propose a legislative remedy for these shortcomings. All mental health workers in Kenya operate under the same limitations, and persons suffering from mental illness are receiving suboptimal care as a result.

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8. The Constitution of Kenya, in Article 43, provic

Ms Mercy Kinyua, L.C
Kindly study the Petition and advise the CNA.
9/10/23

impax
BUSINESS SOLUTIONS
Abcon House, 4th Floor, 6 Masaba Road, Lower Hill PO Box 12708-00100 Nairobi, Kenya
Tel: + 254 20 272 8348 Email: info@impaxafrica.com

NATIONAL ASSEMBLY
DIRECTORATE OF LEGAL SERVICES
RECEIVED
05 OCT 2023
P. O. Box 41842 - 00100, NAIROBI

04 OCT 2023
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P. O. Box 41842 - 00100, NAIROBI
9/10/2023

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11. My petition to the National Assembly is to urge the House to move with speed to **repeal section 226 of the Penal Code, Cap 63 of the Laws of Kenya,** and thereby guarantee dignity to our fellow citizens who suffer with mental illness that includes suicidal ideation.

12. To this end I request your honourable office to transmit this petition to the National Assembly Health Committee for processing and introduction of the appropriate legislation to the House in order to **repeal section 226 of the Penal Code.**

13. I remain available to provide additional information on this subject should I be asked to do so by the Committee, or by your honourable office.

Sincerely,

LUKOYE ATWOLI *MBS, MBChB (Moi), MMed Psych (Nairobi), PhD (Cape Town), IFAPA*
Professor of Psychiatry and Dean, Medical College East Africa
Vice-Director, Brain and Mind Institute
The Aga Khan University

THE NATIONAL ASSEMBLY
C/O THE CLERK
KENYA NATIONAL ASSEMBLY
PARLIAMENT BUILDINGS
P.O BOX 41842-00100
NAIROBI
KENYA
Email: clerk@parliament.go.ke

14 December 2023

CC:

1. The Chairperson, Health Committee;
2. The Chairperson, Justice and Legal Affairs Committee;
3. The Chairperson, Public Petitions Committee.

RE: PETITION TO THE NATIONAL ASSEMBLY UNDER ARTICLES 37 AND 119 OF THE CONSTITUTION, PETITION TO PARLIAMENT (PROCEDURE) ACT (2012) & STANDING ORDER 219 OF THE NATIONAL ASSEMBLY STANDING ORDERS CONCERNING AN URGENT APPEAL FOR REPEAL OF SECTION 226 OF THE PENAL CODE.

I, the undersigned:

Citizen of the Republic of Kenya (ID number 14418806) and Professor of Psychiatry and the Dean at the Medical College East Africa, the Aga Khan University. I am also the Deputy Director of the Brain and Mind Institute at the Aga Khan University.

I have previously served as the Vice-President of the Kenya Medical Association, and I am currently the Secretary-General of the African Association of Psychiatrists. I am also serving as the President of the African College of Neuropsychopharmacology.

Professionally, I Co-Chair the Board on Global Health at the US National Academies of Science, Engineering, and Medicine. I am also the current Chair of the Board of Mathari National Teaching and Referral Hospital. I am honoured to be a member of the US National Academy of Medicine, and an International Fellow of the American Psychiatric Association.

Wish to bring to the attention of the National Assembly the urgent need to repeal section 226 of the Penal Code, on my own behalf and on behalf of other citizens of the Republic of Kenya.

I humbly draw attention of the house on the following:

1. THAT Section 226 of the Penal Code Cap 63 of the Laws of Kenya provides that "Any person who attempts to kill himself is guilty of a misdemeanour".
2. THAT Section 36 of the Penal Code additionally provides that "When in this Code no punishment is provided for any misdemeanour, it shall be punishable with imprisonment for a term not exceeding two years or with a fine, or with both."

3. **THAT** the net effect of these provisions is that a person who attempts suicide and is charged and convicted of the same in a court of law is liable to imprisonment, a fine, or both.

4. **THAT** the consequence of these provisions is that persons suffering from mental illness, who often develop suicidal thoughts and may attempt to kill themselves, knowing that their symptoms carry the risk of arrest and prosecution, will not present themselves for treatment and the care they need in order to improve their mental health and reduce or eliminate their risk of suicidal behaviour.

5. **THAT** the Constitution of Kenya, in Article 43, provides that: (1) Every person has the right- (a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care... (2) A person shall not be denied emergency medical treatment.

6. **THAT** I hold that section 226 of the Penal Code creates an unreasonable and potentially fatal barrier to access to the highest attainable standard of mental health care, and often results in denial of emergency medical treatment for persons who may contemplate or attempt suicide, for fear of prosecution and punishment. For this reason I would argue that section 226 of the Penal Code contravenes the constitution, and also offends the right of every Kenyan to be treated with dignity as provided for under Article 28 of the Constitution.

7. **THAT** further, it is clear that Kenya remains one of the few countries that still have legislation criminalizing suicide attempts, a leftover from colonial times. It is instructive that the former colonial power, the United Kingdom, repealed similar legislation decades ago, affording mentally ill patients access to the services they require. Many other countries that had similar legislation have repealed it over the years.

8. **THAT** this petition to the National Assembly is to urge the House to move with speed to repeal section 226 of the Penal Code, Cap 63 of the Laws of Kenya, and thereby guarantee dignity to our fellow citizens who suffer with mental illness that includes suicidal ideation.

9. **THAT** I confirm that the Kenya National Commission on Human Rights has made efforts through various initiatives to have the matter addressed but so far, no satisfactory repeal of section 226 of the Penal Code has been achieved.[1]

10. **THAT** I confirm that this matter has not been adjudicated upon by a competent court in which I was a party.

11. **THAT** I submit that the responsibility to decriminalise attempted suicide requires a legislative process through repealing of Section 226 of the Penal Code.

12. **THAT** the Constitutional petition No. E045 of 2022 before the High Court of Kenya seeks to have Section 226 of the Penal Code declared unconstitutional which is a different objective from this petition. This petition to the National Assembly seeks to have Section 226 of the Penal Code repealed.

---

[1] Parliament of Kenya, 'Decriminalise suicidal tendencies, knchr tells senate shakahola committee' < http://www.parliament.go.ke/decriminalise-suicidal-tendencies-knchr-tells-senate-shakahola-committee> accessed on 14 December 2023.
And, ongoing Constitutional Petition No. E045 of 2022 before the High Court of Kenya at Nairobi.

13. **THAT** I confirm the issue of repealing Section 226 of the Penal Code is not pending before any court of law, or constitutional or legal body to the best of my knowledge, information, or belief.

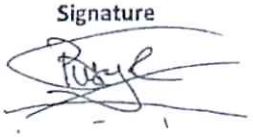
14. **THAT** I remain available to provide additional information on this subject should I be asked to do so by any Committee of Parliament, or by your honourable office.

HEREFORE, your humble petitioner pray that Parliament;

1. Dispenses with this petition immediately in view of the urgency of the matter and the gravity of the issues canvassed herein.

2. Investigates this matter and makes appropriate recommendations thereon.

And your PETITIONER will ever pray.

Name of Petitioner	**Full Address**	**National ID. No.**	**Signature**
Lukoye Atwoli MBS	PO Box 52882-00100, Nairobi lukoye.atwoli@aku.edu;	14418806	

PETITION concerning **Repeal of Section 226 of the Penal Code**

Petition to repeal section 226 of the Penal Code

5 messages

mercy kinyua <mercygkinyua@gmail.com> Tue, Oct 17, 2023 at 11:16 AM
To: lukoye.atwoli@aku.edu
Cc: Marlene Ayiro <marleneayiro@gmail.com>

Good morning Dr. Lukoye,

Reference is made to the above matter and to the telephone conversation this morning with the undersigned.

We are in receipt of your Petition to the National Assembly to repeal section 226 of the Penal Code.

We however note the following-

1. The Petition is not in the form set out in the Schedule to the Petition to Parliament (Procedure) Act, 2012 (hereinafter referred to as "the Act") and the Third Schedule to the National Assembly Standing Orders;

2. The Petition does not contain your identification number as required by Section 3 (i) of the Act and Standing Order 223 (1)(i);

3. The subject matter of the Petition is not indicated on every sheet of the Petition contrary to Section 3 (e) of the Act and Standing Order 223 (1)(e);

4. The signature contained in the Petition is a photostat copy that has been pasted or otherwise transferred to the Petition and has not been written directly on the Petition contrary to Section 3 (j) of the Act and Standing Order 223 (1)(j); and

5. The Petition does not indicate whether the issues in respect of which the petition is made are pending before any court of law or other constitutional or legal body contrary to Section 3(g) of the Act and Standing Order 223(1)(g).

Accordingly, I attach herewith a copy of the Petition to Parliament (Procedure) Act, 2012 and the National Assembly Standing Orders for your perusal and ease of reference.

Kindly amend the Petition and re-submit the same for our further action. Thank you.

Kind regards,
Mercy G. Kinyua
Legal Counsel, National Assembly

2 attachments

PetitionstoParliament_Procedure_Act_No22of2012.pdf
150K

NATIONAL AS[illegible]
1392K

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mercy kinyua <mercygkinyua@gmail.com> Tue, Nov 21, 2023 at 12:44 PM
To: lukoye.atwoli@aku.edu
Cc: Marlene Ayiro <marleneayiro@gmail.com>

Good afternoon Dr. Lukoye,

Reference is made to the above matter and to my email of 17th October 2023.

Kindly let us know if you forwarded an amended Petition for consideration by the National Assembly as advised.
Thank you.

Kind regards,
Mercy G Kinyua,
Legal Counsel
National Assembly
[Quoted text hidden]

---

lukoye.atwoli <lukoye.atwoli@aku.edu> Thu, Dec 14, 2023 at 5:30 A
To: mercy kinyua <mercygkinyua@gmail.com>
Cc: Marlene Ayiro <marleneayiro@gmail.com>, "cna@parliament.go.ke" <cna@parliament.go.ke>

Dear Ms Kinyua,

I have now addressed the issues you raised in the earlier email, and I hereby resubmit my petition.

1. It is now in the prescribed form
2. It contains my identification number
3. The subject matter is indicated on every sheet of the petition
4. I have initialed the first two pages and signed the last page of the petition
5. I have addressed the issue of matters before court.

Kindly acknowledge receipt of the same and do let me know if I need to submit anything else to have my petition considered.

Kind regards,

Lukoye Atwoli, MBS, MBChB, MMed Psych, PhD, IFAPA
Professor and Dean |Medical College East Africa
Associate Director |Brain and Mind Institute

The Aga Khan University
Medical College East Africa
Dean's Office, 5th Floor
University Centre, Nairobi
P.O. Box 30270-00100 Nairobi, Kenya.
Email: dean.mcea@aku.edu<mailto:dean.mcea@aku.edu>
T. +254 020 366 2107 | M. +254 780 322 792
www.aku.edu<http://www.aku.edu/> | Social Media Hub<https://www.aku.edu/Pages/social-media-hub.aspx>

On 21 Nov 2023, at 12:44, mercy kinyua <mercygkinyua@gmail.com> wrote:

Reference is made to the above matter and to my email of 17th October 2023.

Kindly let us know if you forwarded an amended Petition for consideration by the National Assembly as advised. Thank you.

Kind regards,
Mercy G Kinyua,
Legal Counsel
National Assembly

[Quoted text hidden]

Lukoye Atwoli Petition on s226 repeal.pdf
3485K

'ukoye.atwoli <lukoye.atwoli@aku.edu> Thu, Dec 14, 2023 at 5:31 PM
.o: mercy kinyua <mercygkinyua@gmail.com>
Cc: Marlene Ayiro <marleneayiro@gmail.com>, "cna@parliament.go.ke" <cna@parliament.go.ke>

Dear Ms Kinyua,

I have now addressed the issues you raised in the earlier email, and I hereby resubmit my petition.

1. It is now in the prescribed form
2. It contains my identification number
3. The subject matter is indicated on every sheet of the petition
4. I have initialed the first two pages and signed the last page of the petition
5. I have addressed the issue of matters before court.

Kindly acknowledge receipt of the same and do let me know if I need to submit anything else to have my petition considered.

Kind regards,

Lukoye Atwoli, MBS, MBChB, MMed Psych, PhD, IFAPA
Professor and Dean |Medical College East Africa
Associate Director |Brain and Mind Institute

The Aga Khan University
Medical College East Africa
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P.O. Box 30270-00100 Nairobi, Kenya.
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www.aku.edu<http://www.aku.edu/> | Social Media Hub<https://www.aku.edu/Pages/social-media-hub.aspx>

On 21 Nov 2023, at 12:44, mercy kinyua <mercygkinyua@gmail.com> wrote:

Good afternoon Dr. Lukoye,

Reference is made to the above matter and to my email of 17th October 2023.

Kindly let us know if you forwarded an amended Petition for consideration by the National Assembly as advised.
Thank you.

Kind regards,
Mercy G Kinyua,
Legal Counsel
National Assembly

[Quoted text hidden]
[Quoted text hidden]

Lukoye Atwoli Petition on s226 repeal.pdf
3485K

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mercy kinyua <mercygkinyua@gmail.com> Fri, Dec 15, 2023 at 3:09 PM
To: "lukoye.atwoli" <lukoye.atwoli@aku.edu>
Cc: Marlene Ayiro <marleneayiro@gmail.com>

Thank you Sir,

This is well received and noted with thanks.

Kind regards,
Mercy G. Kinyua
Legal Counsel
National Assembly
[Quoted text hidden]

26 MAY 2025

REPUBLIC OF KENYA

OFFICE OF THE ATTORNEY-GENERAL
&
DEPARTMENT OF JUSTICE

Our Ref: AG/LDD/237/1/98

21st May 2025

Mr. Samuel Njoroge
The Clerk of the National Assembly
Clerk's Chambers, Parliament Buildings
P. O. Box 41842-00100
NAIROBI

RE: REQUEST FOR WRITTEN SUBMISSIONS ON VARIOUS PUBLIC PETITIONS SUBMITTED TO THE NATIONAL ASSEMBLY—P/NO.13/2024 REGARDING DECRIMINALIZATION OF ATTEMPTED SUICIDE

We refer to your letter dated 25th April 2025 and referenced KNA/DLPS/PPETC/CORR/2025/019 through which you this Office to make submissions on the petition regrading the decriminalization of attempted suicide.

We have reviewed the Petition, the relevant legislation and caselaw and our comments are set out below.

The Petitioner proposes the repeal of section 226 of the Penal Code (Cap.63) which provides that any person who attempts to kill himself is guilty of a misdemeanour. The Petitioner avers that criminalizing suicide attempts not only fails to address underlying mental health issues but also perpetuates stigma and shame surrounding mental illness.

The High Court in *Kenya National Commission on Human Rights & 2 others v Attorney General; Director of Public Prosecutions & 3 others (Interested Parties); Law Society of Kenya (Amicus Curiae) (Constitutional Petition E045 of 2022) [2025] KEHC 6 (KLR) (Constitutional and Human Rights)* declared section 226 of the Penal Code unconstitutional for violating Articles 27, 28 and 43 of the Constitution.

Article 27(4) of the Constitution provides that the State shall not discriminate directly or indirectly against any person on any ground, including race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth.

Article 28 of the Constitution provides that every person has inherent dignity and the right to have that dignity respected and protected.

NATIONAL ASSEMBLY
RECEIVED
29 MAY 2025
PROCEDURAL RESEARCH AND JOURNALS

Article 43(1)(a) of the Constitution provides that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.

The High Court in the above referenced case held as follows—

> Section 226 of the Penal Code offends Article 27 of the Constitution by criminalising a mental health issue thereby endorsing discrimination on the basis of health which is unconstitutional. It also indignifies and disgraces victims of suicide ideation in the eyes of the community for actions that are beyond their mental control which is a violation of Article 28. The existence of Section 226 exposes the survivors of suicide and potential victims with suicide ideation to possible reprisals thereby eroding the right to have the highest attainable standard of health envisaged in Article 43 (1) of the Constitution.

Article 2 (6) of the Constitution provides that any treaty or convention ratified by Kenya shall form part of the law of Kenya under the Constitution. Kenya is a signatory to the World Health Organization Global Mental Health Action Plan 2013–2030. The overall goal of the action plan is to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders. One of the recommendations in the Plan is the decriminalization of suicide, suicide attempts and other acts of self-harm.

In order to realize global commitments such as the Global Mental Health Action Plan (2013-2030), the Ministry of Health developed the Kenya Mental Health Action Plan (2021-2025). The Plan envisions a nation where mental health is valued and promoted, mental health conditions are prevented and persons affected by mental health conditions are treated without stigmatization and discrimination. The Plan provides a roadmap for securing reforms and building strong mental health systems with ultimate goal of attaining the highest standard of mental health in Kenya. The Plan specifically proposes the decriminalization of suicide and amendment of laws which are discriminatory and use derogatory language.

In light of the declaration by the High Court as well as the national and global commitments, we do not object to the repeal of section 226 of the Penal Code as proposed by the Petitioner.

HON. SHADRACK J. MOSE, CBS.
SOLICITOR-GENERAL

KLRC
KENYA LAW REFORM COMMISSION
"A Vibrant Agency for Responsive Law Reform"
Telegrams: "LAWREFORM" NAIROBI
Telephone: Nairobi, +254-20-2241186/2241201
Fax: +254-20-2225786
www.info@klrc.go.ke

When replying please quote

Ref. No. KLRC/48/64 VOL.IV(48)

DLPS
Please deal
30/05/25

KENYA LAW REFORM COMMISSION
REINSURANCE PLAZA
3RD FLOOR
TAIFA ROAD
P.O. Box 34999-00100
NAIROBI, KENYA

.....20.....

20th May 2025

The Clerk of National Assembly
Clerk's Chambers
National Assembly
Parliament Building
P.O Box 41842 -00100
NAIROBI

Head-PPT
Please process.
Acceptance
3/6.

(3) Kadhi
Please TNA
Adv
Too 5/6

ATT: Mr. Jeremiah W. Ndombi, MBS

Dear Jeremiah,

RE: REQUEST FOR WRITTEN SUBMISSIONS ON VARIOUS PUBLIC PETITIONS SUBMITTED TO THE NATIONAL ASSEMBLY

Your letter Ref. KNA/DLPS/PPETC/CORR/2025/018 dated 25 April, 2025 refers

The Kenya Law Reform Commission has analysed the petitions and prepared the attached consolidated submissions.

We thank you for your continued support and cooperation.

Yours Sincerely

PETER M. MUSYIMI, HSC
AG. SECRETARY/CEO

KENYA LAWREFORM COMMISSION'S MEMORANDUM ON PUBLIC PETITIONS TO THE NATIONAL ASSEMBLY

MAY 2025

TABLE OF CONTENTS

A. INTRODUCTION

The Kenya Law Reform Commission (KLRC) is established under the Kenya Law Reform Commission Act, 2013 with a mandate to keep under review all the laws of Kenya to ensure that they conform to the letter and spirit of the Constitution. In this regard, KLRC advises the Government, including Parliament, on the reform and harmonisation of laws, promotion of access to justice and the development of a sound legal and regulatory framework for national development.

The Kenya Law Reform Commission (KLRC) acknowledges receipt of a letter from the National Assembly dated 25 April 2024 (ref: KNA/DLPS/ PPETC/CORR/2025/018) seeking submissions on the following issues:

(a) Proliferation of LGBTQ rights in the country;
(b) Amendment of the Penal Code to provide for the offence of sextortion;
(c) Enactment of the Kenya Robotic and Artificial Intelligence Society Bill, 2023;
(d) Decriminalisation of Attempted Suicide;
(e) Enactment of legislation of development of irrigation infrastructure;
(f) Enactment of the Bankers Professional Bill, 2023;
(g) Enactment of Legislation for Regulation of Credit Professionals;
(h) Enactment of Proposed Geophysical Professionals Bill; and
(i) Proliferation of Lesbians, Gays, Bisexuals, Transgender and Queer (LGBTQ) in the Country.

KLRC prepares this memorandum in response to the request, and in line with its mandate under section 6(c) of its Act, to provide advice technical assistance and information to the government with regard to the reform or amendment of a branch of the law. The memorandum is divided into three parts:

Part I of the memorandum addresses petitions related to enactment of amendment Acts to address the offences of sextortion and attempted suicide.

Part II of the memorandum covers the proposed enactment of laws to regulate banking, credit and geophysical professionals and the Kenya Robotic and Artificial Intelligence Society.

Part III of the memorandum responds to petitions seeking the enactment of legislation of development on irrigation infrastructure and review of the proliferation of Lesbians, Gays, Bisexuals, Transgender and Queer (LGBTQ) in the country.

PART I-CRIMINAL LAW

1. THE OFFENSE OF SEXTORTION

(a) Defining Sextortion

Sextortion is a blended word derived from the words "sex" and "extortion". The International Association of Women Judges defines sextortion as 'the abuse of power to obtain a sexual benefit or advantage.'[1]It has been said that for sexual extortion, there has to be abuse of authority in the exchange of sex for a service.[2] Sextortion has also been said to cover instances where someone makes demands with the threat of publishing another person's sexually embarrassing photos or videos. Sextortion is more about psychological than physical coercion.

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[1] International Bar Association, 'Pressure builds worldwide for legal protection against sextortion', <https://www.ibanet.org/Pressure-builds-worldwide-for-legal-protection-against-sextortion> (Accessed 12/05/2025).

[2]Center for Gender and Development, 'Confronting Sextortion' <https://ccgdcentre.org/2023/05/30/confronting-sextortion/> (Accessed 12/05/2025)

(b) Prevalence of Sextortion in Kenya

It has been reported that sextortion affects vulnerable girls and women who seek various services such as national identity cards, supplies of sanitary pads, education, trainings and job placements.[3] It has also been reported that sex for fish is very rampant along the coastlines and shores where female fishmongers give in to sexual demands of fishermen so that they can attain the first pick from the boats.[4] It has further been reported that women and girls are pressured into sex in exchange for water, especially in the slums.[5] Traders are also not spared with cases of female traders are sexually exploited by brokers and market officials, also having been reported.[6]One of the hawkers within Nairobi is reported to have informed Members of the County Assembly that she had personally experienced the vice and that "my colleagues have also been told to sleep with these officers to be allowed to hawk without interference".[7]

A report by the Kenya ICT Action Network on the challenges faced by women in Kenya on the internet lists non-consensual distribution of intimate images and sexual harassment as some of the most prominent violations of their rights across digital platforms.[8] The report further notes that professional and prominent women, including women human rights defenders, women in politics, journalists, women with disabilities and women from marginalised groups, are frequent targets of online gender-based violence. Female politicians in Kenya have been particularly vulnerable to image-based disinformation campaigns that manipulate media to sexualize them.[9] This makes them fodder for

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[3] Ibid.
[4] Ibid.
[5]Simavi, 'Sextortion: The Silent Pandemic.' <https://simavi.nl/en/news-and-stories/sextortion-the-silent-pandemic> (Accessed 12/05/2025)
[6] Daily Nation, 'Sex for Business Protection: Women Traders Recount Nairobi's Living Hell'<https://nation.africa/kenya/news/gender/-sex-for-business-protection-women-traders-recount-nairobi-s-living-hell-4488864> (Accessed 12/05/2025)
[7] Daily Nation, 'Sex-for-Hawking Space Scandal Rocks City Hall' <https://epaper.nation.africa/read/release/11079>(Accessed 14/05/2025)

[8] ICJ Kenya, 'Protect Women from Rising Online Gender Based Violence', <https://icj-kenya.org/news/protect-women-from-rising-online-gender-based-violence/> (Accessed 12/05/2025)
[9] ibid

extortion, with certain elements demanding money in order not to release intimate pictures on the internet. While this is common against women, men have also been victims of this form of sextortion. These cases set out the need for urgent legislative intervention to include the offence of sextortion in the Statute Book.

(c) Legal Framework on Sextortion in Kenya

Sextortion has been difficult to prosecute since, as stated in the petition, the existing legislation does not define it or recognize it as a form of sexual offence. The closest offence to sextortion in the Statute Book is sexual harassment created under section 23 of the Sexual Offences Act, Cap. 63A. However, the offence of sexual harassment is limited to instances of employment, education and services offered by public officials. This leaves victims of other types of predators vulnerable.

Section 37 of the Computer Misuse and Cybercrimes Act, Cap. 79 C criminalizes the publishing or distribution of intimate or obscene images of other people without consent. However, the section does not speak to the extortion and blackmail that may be employed with the threat of publishing such images. While the actual publishing is an offence, victims may not wish to have such images published in the first place, hence give in to the extortionists' demands. This is what constitutes sextortion. It is therefore necessary to specifically criminalize sextortion in all its forms.

(d) Conclusion

In view of the foregoing, it is important to amend the law to create an offence that covers all forms of sextortion. KLRC considers the Sexual Offences Act the most appropriate law to amend in order to provide for the offence of sextortion. In addition, KLRC recommends that the proposed new provision should follow section 23 of the Sexual Offences Act which covers sexual harassment and numbered section 23A.

In relation to the proposal to provide support to victims of sextortion. KLRC is of the view that it is not necessary to make any further changes to the law to facilitate support for the victims as the Victim Protection Act, Cap. 79A comprehensively addresses this issue. This statute was enacted to give effect to Article 50(9) of the Constitution and to provide for protection of victims of crime and abuse of power including protection of the dignity of victims through the provision of better information, support services, reparations and compensation from the offender.

2. DECRIMINALISATION OF ATTEMPTED SUICIDE

(a) Introduction

The World Health Organization Policy Brief on the Health Aspects of Decriminalization of Suicide and Suicide Attempts names Kenya as one of only twenty-three countries in the world which still criminalize suicide attempts.

The Brief goes ahead to state that the criminalization of suicide perpetuates an environment that fosters blame and stigmatization towards people who attempt suicide and at the same time fail to recognize the role of social, economic and cultural factors that play a role in suicide and suicide attempts. The Brief further states that the criminalization deters people from seeking timely help and accessing interventions due to the fear of legal repercussions and stigma.

(b) Analysis

The Mental Health Act, Cap. 248 defines a person with mental illness as a person diagnosed by a qualified mental health practitioner to be suffering from mental illness, and includes a person with suicidal ideation or behaviour *(emphasis ours)*.

Under the Act, therefore, a person who has attempted suicide would be seen more as a patient needing help than a criminal who should be punished. This was so stated in the

case of Republic v SWN (Criminal Case 20 of 2019) [2022] KEHC 3312 (KLR) (7 July 2022) (Sentence) where the High Court held that:

"As the facts patently announce, here is a young woman in need of treatment, care and protection. She is certainly not a deranged criminal in need of retribution and confinement".

In the above case, the accused person was found to have fatally stabbed her son killing him immediately. She then turned the knife on herself three times in an attempt to kill herself. One of the issues before the court was its role in sentencing an accused person who was mentally ill.

(c) Conclusion

In view of the foregoing, attempting suicide should be decriminalised in Kenya through the repeal of section 226 of the Penal Code and the proposed amendment is timely.

B. PART II-REGULATION OF PROFESSIONALS

1. INTRODUCTION

The KLRC was requested to analyse several legislative proposals seeking to regulate various professions. Before analysing each legislative proposal, this introductory part will address the following questions—

(a) What is a profession?

(b) What is the justification for the regulation of professionals?

(c) What are the various approaches to regulation of professionals?

(a) What is a profession?

Professionals occupy a position of great importance in the society because they deliver esoteric services to individuals, organizations and the government. The professional space has over the years accelerated as more occupations seek professional identity in addition to the traditionally established professions. In seeking to admit other occupations into the category of professions and setting mechanisms of professional regulation, one must begin by understanding definition and traits of a profession.

Prof. Horton B. (1958) set forth a criterion of a profession which can serve as a yard stick of what constitutes a profession. According to Horton, a profession must—

(a) "satisfy an indispensable social need and be based upon well established and socially accepted scientific principles;
(b) demand adequate pre-professional and cultural training;
(c) demand possession of a body of specialized and systemic knowledge;
(d) give evidence of needed skills which the public does not possess;
(e) have developed a scientific technique which is the result of tested experience;
(f) require the exercise of discretion and judgement in the manner of performance of duty;
(g) have group consciousness designed to extend scientific knowledge in technical language;
(h) have sufficient self-impelling power to retain its members throughout life and must be used as a mere stepping stone to other occupations; and
(i) recognize its obligations to society by insisting that its members live up to an established code of ethics."

Hughes E. (1968) equally argues that the essence of the idea of professionalism is that professionals profess to know better than their clients on what ails them or their affairs.

Garoupa N (2014) similarly considers a profession as an occupation with the following characteristics: specialised skills, that skill is partially or fully acquired by intellectual training, the service calls for a high degree of integrity, and it involves direct or fiduciary relations with clients.

In essence, a profession can be defined as a disciplined group of individuals, who adhere to ethical standards and who hold themselves out as, and are accepted by the public as possessing special knowledge and skills in a widely recognized body of learning derived from research, education and training at a high level, and who are prepared to apply this knowledge and exercise these skills in the interest of others.

(b) The need to regulate professionals

Regulation of professionals in any given industry is crucial for various reasons including, the need to set uniform standards for the services of that particular profession in order to ensure that consumers of the services are protected; promote accountability and continuous competencies and skills through continuous learning.

The regulation of professional groups has often been justified as being in the public interest with some scholars seeing professional associations and other similar groups as one of the four institutional bases of social order (along with the community, the market, and the state).

(c) Approaches to regulation of professionals

Recent years have witnessed an increase in interest in professional regulation with various models of regulation of professionals emerging. In this memorandum, KLRC will restrict itself to two forms of professional regulation; statutory regulation and self- regulation

(i) Statutory regulation of professionals

Under a typical statutory regulatory scheme, legislation establishes a regulatory authority that is made up of a majority of members either reelected by or appointed from the profession regulated by that authority.
In Australia, these authorities are called 'registration boards', in the United Kingdom they are known as 'Councils' and in various provinces of Canada, 'professional colleges.

These regulatory authorities have powers conferred by statute, to determine qualification and other requirements for registration and to maintain a publicly accessible register of qualified persons. Under this regime, it is an offence for an unregistered person to use those professional titles reserved for the profession.

The relevant statute sets also up a disciplinary system that, in most cases, empowers the regulatory authority to investigate complaints of professional misconduct and to impose sanctions on a practitioner, including deregistration if necessary. The effect of the regulatory scheme is to create an enforceable barrier to entry to the regulated profession and to regulate the standards of practice and conduct of registered practitioners.

(ii) Self-regulation' or peer review model

The term 'self-regulation' is used to describe the disciplining of one's own conduct by oneself. Self- regulation as an approach to professional regulation is widely used in professions, sports[10], the press, advertising and financial services. This model of regulation varies from the' command and control' model of regulation exhibited by the former model to regulation by the market. It enshrines the principle that a practitioner's peers are in the best position to judge what constitutes professional and unprofessional conduct and enables professional bodies or associations to govern their members in a manner that ensures that they are not subject to undue influence from the State or other external pressures.

[10]International Olympic Committee (IOC), Federation Internationale de Football Association (FIFA), World Athletics (formerly IAAF), the International Bar Association (IBA), World Medical Association, are examples of self-regulating bodies.

Self-regulation, may not require legislation to be effective as the professionals have the liberty to develop desirable instruments to guide their governance frameworks and code of conduct; however, where legislation is desired, it may be seen as a contract between professionals and the state to regulate a field of activity and a group of practitioners for the benefit of society.

2. REGULATION OF ROBOTICS AND ARTIFICIAL INTELLIGENCE IN KENYA

The proposed Robotics and Artificial Intelligence Society is envisioned as a professional body meant to assist in the regulation, promotion and facilitation of the activities of robotics and artificial intelligence practices in Kenya.

Many countries have leveraged the power of robotics and artificial intelligence to achieve various feats. For instance, in education, AI has the power to transform and influence training. In agriculture, robotics and AI has the ability to provide farmers with real-time observations from their farmlands which can be used to quickly identify crop or pest diseases, increase yields, thereby increasing food productivity. In security, the efficient personnel deployment and vision systems that aid in tracking criminals and the analysis of crime data helps security personnel in solving many cases. In banking and finance, AI has been used to revolutionize the use of mobile money services.

In health, great advances have been made with regards to AI and its applications in the sector. AI's deep learning medical tools assist medical professionals by studying a patient's unstructured data to give a better insight into a patient's real-time needs.

In this regard, there is need to develop a framework that will enable the development of standards and certain codes of conduct for owners and owners of robot agents.

The enactment of the Robotics and Artificial Intelligence Society Bill is intended to establish the Society as a professional body whose mandate, just like other professional bodies, will majorly be to promote standards of professional competence and practice

among members of the Society; promote research into the subject of robotics and artificial intelligence; promote international recognition of the Society; and advise the Cabinet Secretary on matters relating to standards and policies in the area of robotics and artificial intelligence in all sectors of the Kenyan economy.

This is a great step in ensuring regulation of the profession. However, there is also need to enact a comprehensive piece of legislation which would provide a legal and institutional framework for the development of the robotics and artificial intelligence in Kenya (such as a Kenya Robotics and Artificial Intelligence Act). This law would provide for among others, the development and implementation of policies on use of robotics and artificial intelligence; research and development in the robotics and artificial intelligence; education and training in the field of robotics and artificial intelligence and the regulation of concerns relating to safety, security and civil rights as well as the whole spectrum of robotics and artificial intelligence in Kenya.

With this general framework in place, the establishment of the Society would augment the efforts espoused in that framework to ensure a robust robotics and artificial intelligence profession in Kenya.

3. REGULATION OF BANKING PROFESSIONALS IN KENYA

The banking industry is the cornerstone of a country's economy. In Kenya, the industry is regulated by the Central Bank of Kenya (CBK) through the Banking Act, Cap. 488, the Central Bank of Kenya Act, Cap. 491 and the attendant Regulations.

To ensure effective service delivery, the banking industry must adapt to evolving needs of the society by addressing the key issues in the industry. Over the years, the government has demonstrated its commitment towards strengthening the banking sector.

However, Kenya, just like other developing countries, is yet to establish a regulatory body for professional bankers. This analysis aims to assess whether there is a need to

regulate professional bankers in Kenya and the key considerations in establishing a professional body.

Having carefully analysed the petition KLRC is of the considered opinion the proposed development of the Bankers Professional Bill is justified to ensure that the banking industry is properly regulated.

The proposed bill would give the Kenya Bankers Association the necessary legal impetus. The legal framework should however, clearly establish the necessary governance structure and qualifications for membership.

Although the Banking Act, Cap. 488 creates an offence against a banking officer who engages in fraudulent and reckless activities, the proposed professional body will ensure that disciplinary action is taken against the responsible officer. This will promote accountability and ensure that the public has confidence in the industry. A professional body will similarly help in setting the ethical standards of professionals in the sector.

4. REGULATION OF CREDIT PROFESSIONALS IN KENYA

Credit is a form of agreement between two parties in which the creditor or lender, gives money, goods, services, or securities in return for a promised future payment by the debtor or borrower. The lender earns a profit by getting interest on the borrowed amount from the creditor. In Kenya, there has been a rise in the number of credit professionals who offer credit at exorbitant interest rates.

Due to ineffective regulation of the credit industry, there have been numerous complaints from borrowers including;

a) Unfairly high interest rates;
b) Hidden and unreasonable methods of computing interest and oppressive penalties;
c) Use of irregular enforcement of security interest over assets of the borrowers;
d) Harassment; and

e) Breach of privacy, humiliation and stressful relationship between the borrowers and the lenders.

There are some provisions in the Consumer Protection Act which provide for unfair lending practices, rescission of agreements where there is unfair practice, default charges and penalties chargeable by providers of credit. The Act also sets out various rights of consumers including the right to prepayment so that lenders cannot prohibit prepayment of loans and the right to statements on the loans.

The Business Laws (Amendment Act) 2024 amended among others, the Central Bank of Kenya Act, Cap 491, Laws of Kenya and the Microfinance Act, Cap 493C, Laws of Kenya to extend the regulatory oversight of the Central Bank of Kenya to credit providers that were previously not subject to CBK's oversight.

Previously, non-deposit taking credit providers were not under the regulatory oversight of the CBK. The Business Laws (Amendment) Act 2024 replaced the definition of digital credit providers under the CBK Act with non-deposit taking credit providers. This means that credit providers that were previously unregulated now fall under the regulatory oversight of the CBK regardless of the medium through which they offer their credit services.

Despite the fragmented efforts to regulate some elements of the credit industry, there is still need for a robust and comprehensive legal framework to address pertinent issues especially professionalism in the industry.

Regulation of the credit profession involves controlling the access to the credit practice by means of registration and certification or licensure. The aim is to ensure that credit professionals provide services in a competent, ethical and safe manner. This will guarantee quality credit services at affordable interest rates.

The appropriate model of credit profession regulation is self-regulation. This means the regulation of the profession by itself. The credit profession may be regulated by a professional body vested with statutory powers under legislation. These self-regulatory powers and functions include registration and certification or licensure of the credit profession's members.

5. REGULATION OF GEOPHYSICS PROFESSIONALS IN KENYA

Geophysics is a specialized field of Earth science that applies principles of physics, mathematics, and engineering to study the Earth's subsurface. Geophysical professionals, commonly referred to as geophysicists, use advanced techniques to detect and measure physical properties such as seismic waves, gravitational and magnetic fields, and electrical conductivity. Their work is critical in areas such as oil and gas exploration, groundwater mapping, mineral prospecting, infrastructure development, environmental protection, and natural disaster forecasting.

Despite the significance of geophysics in Kenya's socioeconomic development, there is currently no law governing or regulating geophysicists as a distinct professional group. The Kenya Society of Geophysical Professionals has consistently advocated for the formal recognition and regulation of the profession through an appropriate legal framework.

This response sets out the case for the establishment of a Geophysical Professional Bill, which would lead to the creation of a statutory body to regulate the profession.

Geophysics qualifies as a profession by all measures. Geophysicists are experts trained to interpret the Earth's physical characteristics. Their work underpins major national interests, including natural resource development, environmental sustainability, and disaster resilience. Their skills have a direct impact on public safety, economic growth, and environmental conservation.

The regulation of geophysical professionals is not merely a matter of professional pride—it is a public interest imperative. The lack of a legal framework exposes the public and the environment to significant risks due to:

(a) Unqualified practitioners conducting critical surveys that can compromise public safety (e.g., building on unstable ground);

(b) Misrepresentation of geophysical data, which can mislead major infrastructure, mining, and water projects;

(c) Environmental harm, especially where electromagnetic and seismic surveys are poorly conducted; and

(d) Lack of accountability, leading to reputational and financial losses for both the public and private sectors.

State regulation through an Act of Parliament would:

(a) Establish minimum academic and ethical standards for practice;

(b) Create a register of licensed professionals;

(c) Promote continued professional development;

(d) Enable the enforcement of a code of ethics;

(e) Provide disciplinary procedures to sanction professional misconduct;

(f) Enhance public confidence in the profession and in geophysical outputs used for planning and development.

In many jurisdictions, geophysicists are regulated alongside geologists and surveyors, professions already governed under Kenya's Geologists Registration Act (Cap. 535) and Survey Act, respectively. Kenya now lags behind in recognizing geophysicists as distinct professionals, yet their role continues to expand across critical sectors.

Geophysical professionals perform work that directly affects public safety, natural resource management, environmental protection, and infrastructure development. To preserve the integrity of this vital profession and protect national interest, there is a compelling case for enacting a Geophysical Professionals Act. Regulation through statute

will elevate the profession, ensure quality, uphold ethics, and protect both the public and the environment from substandard or unethical practice.

The proposed Geophysical Professionals Bill should:

(a) Establish a statutory body to license and regulate the practice of geophysics in Kenya;

(b) Define the scope of professional geophysical practice;

(c) Set educational and ethical standards;

(d) Protect the public, the environment, and national economic interests; and

(e) Promote research, innovation, and international alignment.

C. PART III-GENERAL

1. LEGISLATION FOR THE DEVELOPMENT OF IRRIGATIONINFRASTRUCTURE

Kenya's agriculture sector remains the backbone of the national economy. It contributes approximately 22.4% to the Gross Domestic Product (GDP), employs over 40% of the total population and more than 70% of Kenya's rural population. The sector is particularly vulnerable to the effects of climate change, erratic rainfall and land degradation, which continue to undermine food security, economic resilience and social stability.

The Petition raises a legitimate concern over the limited development of irrigation infrastructure in Kenya, noting that—

- Only about 4% of Kenya's arable land is under irrigation;
- Two-thirds of Kenya's land mass is classified as arid or semi-arid (ASAL), yet these areas are home to communities that would benefit greatly from irrigated agriculture;
- The existing policy and legal framework do not provide mechanisms for equitable, constituency-level implementation of irrigation projects.

The Petition rightly identifies a gap in equitable infrastructure development and the need for mechanisms to support grassroots implementation and community ownership as

further elucidated in the Kenya Kwanza manifesto. However, the legal strategy proposed that is by amending the Road Maintenance Levy Fund Act to support irrigation infrastructure, raises significant issues of legal coherence, functional clarity and constitutional consistency that must be addressed through a broader policy and institutional lens.

(a) Analysis

Overview of the Petitioner's Proposals

The Petitioner proposes that—

- Parliament amends the Road Maintenance Levy Fund Act, 1993, to expand its mandate into a broader Infrastructure Development and Maintenance Fund;
- A portion of this expanded fund be dedicated to the development of irrigation infrastructure in all 290 constituencies;
- Funds be administered by the National Irrigation Authority (NIA), in collaboration with other relevant public agencies.

Constitutional and Institutional Issues Arising

This proposal, while innovative, raises four critical issues:

- Functional Integrity and Sectoral Clarity - The proposal conflates two distinct functions—roads and irrigation—which fall under separate mandates in the Fourth Schedule of the Constitution. Road maintenance is a concurrent function where at the national level, the function is administered by road authorities such as KeNHA, KeRRA, KURA and the Kenya Roads Board (KRB) while the county roads are administered by the county governments. Irrigation on the other hand irrigation is primarily a county function under agriculture, except where national interests or transboundary issues are involved.

- Earmarked Funds and Purpose-Specific Legislation - The Road Maintenance Levy Fund (RMLF) is a ring-fenced fund created under statute for a specific

and limited purpose: to finance the maintenance of public roads. Expanding its use for unrelated purposes such as irrigation risks violating the principle of purpose-specific financing, undermining sectoral planning and resource predictability.

- Institutional Coordination and Overlap - Assigning the role of implementing constituency-level irrigation projects to the NIA, a national agency, without involving county governments, introduces institutional overlap, undermines the devolved system of governance and contradicts established planning and accountability frameworks under the County Governments Act, 2012 and the Intergovernmental Relations Act, 2012.

- Governance, Accountability, and Legal Risks - Repurposing a fund established by law for a completely different sector may expose the Government to legal challenges and reduce public confidence in the consistency and predictability of fiscal legislation. It may also lead to audit queries and institutional confusion.

(b) Considerations and Proposed Approach

Policy Must Precede Legislation

One of the cardinal principles of legislative development is that policy must inform law. Article 10 of the Constitution obliges all public institutions to observe the principles of good governance, transparency and accountability. Laws enacted in the absence of a clear and coherent policy basis tend to suffer from poor implementation, stakeholder resistance and legal contradictions.

The current National Irrigation Policy (2017) provides a foundation for addressing the larger issue that the petition did not clear bring out and that is that there is a lack of

sufficient, reliable and sustainable form of financing for irrigation for agriculture. In addition, our review of the policy indicates that it may does not fully incorporate—

- The realities of devolution and the increasing role of counties in local irrigation planning;
- The Government's current development blueprint—the Bottom-Up Economic Transformation Agenda (BETA);
- Climate change adaptation and resilience as a national imperative; and
- New financing models such as blended finance, development partnerships and conditional grants.

Before any legislation is amended or introduced in order to therefore provide for the broader issue, we propose that there is a need for the policy framework to be updated, validated through public and stakeholder participation and formally adopted by Cabinet.

Risks of Expanding the Road Maintenance Levy Fund

KLRC advises against amending the Road Maintenance Levy Fund Act to introduce an unrelated function. The rationale is as follows:

- Violation of Sector-Specific Planning – The RMLF was created to address the challenge of deteriorating road infrastructure by providing a consistent and predictable source of maintenance funds. Diverting its proceeds to other sectors undermines this purpose, may delay road maintenance projects and complicates long-term sector planning.

- Erosion of Legislative Integrity - Amending a statute for an unrelated purpose undermines the logic and coherence of the legislative framework and may lead to legal uncertainty, stakeholder resistance, and institutional disputes over mandates.

- Undermining Devolution - By proposing to bypass county governments in the financing and execution of local irrigation projects, the proposal contradicts Article 6(2) and the Fourth Schedule of the Constitution, which assigns irrigation and agriculture to county governments. It risks centralising functions that ought to be implemented locally, with full public participation and contextual understanding. The other risk is the introduction of multiple implementing bodies at the county government level, if the object of the proposal is that Members of Parliament would be responsible for the projects initiated under the amended legal regime.

- Precedent for Further Misalignment - Allowing this amendment could set a problematic precedent where other earmarked funds (e.g., for health, housing, or education) are similarly targeted for unrelated sectors, thereby destabilising Kenya's carefully constructed fiscal architecture.

(c) Proposed Alternative Framework for Achieving the Petition's Objective

KLRC fully acknowledges the valid policy concern raised by the Petition—Kenya urgently needs a more inclusive, equitable and sustainable approach to irrigation infrastructure development. However, the strategy to achieve this must be institutionally sound, constitutionally aligned and fiscally sustainable. We therefore propose the following approach, rationalised on our consideration of the merits of the proposal.

Step 1: Review and Update the National Irrigation Policy (2017)

The Ministry of Water, Sanitation and Irrigation, in collaboration with the county governments, NIA and key national bodies, including KLRC and development partners, should lead a review of the national irrigation policy to—

- Clarify the roles of national and county governments;
- Outline mechanisms for intergovernmental collaboration and financing;
- Promote pro-poor, community-led, and climate-resilient irrigation models;

- Establish equitable criteria for national investment in county-based irrigation projects;
- Integrate national development goals under BETA and Vision 2030.

Step 2: Develop a Dedicated Legislative Financing Framework

Following the revised policy, Parliament may consider legislation to:

- Establish a National Irrigation Infrastructure Development Fund under the Public Finance Management Act, 2012, structured as a conditional grant to counties;
- Amend the Irrigation Act, 2019, to include provisions on collaborative planning, equitable targeting and a public participatory process for selecting irrigation projects;
- Provide for transparent criteria, performance monitoring and public reporting mechanisms to promote integrity and accountability.

A. Step 3: Institutional Collaboration through Intergovernmental Frameworks

Rather than bypassing counties or implementing the policy proposals through Members of Parliament, the revised approach should:

- Leverage Article 189 of the Constitution and the Intergovernmental Relations Act to foster coordinated service delivery;
- Use platforms such as the Intergovernmental Budget and Economic Council (IBEC) and the Summit to agree on priorities, standards and financing modalities;
- Engage community-level stakeholders to ensure that irrigation initiatives respond to local needs and conditions.

(d) Conclusions and Recommendations

In conclusion, KLRC affirms the substantive concerns raised by the Petition regarding the inadequacy of irrigation infrastructure in Kenya. However, we dutifully submit that the proposed legislative pathway—through amendment of the Road Maintenance Levy Fund Act—is legally unsound, constitutionally problematic and institutionally risky.

We therefore make the following recommendations:

- Parliament should not adopt the proposed amendment to the Road Maintenance Levy Fund Act, 1993 as a legislative mechanism for financing irrigation projects;
- Parliament to direct for a comprehensive review of the National Irrigation Policy (2017) to align it with the Constitution, BETA priorities and intergovernmental frameworks;
- The responsible Ministry, KLRC and other relevant national and county government organs to thereafter develop appropriate legislation that is anchored in the revised policy, to establish a dedicated and transparent irrigation infrastructure financing mechanism;

The process to achieve the above should be facilitative and inclusive embodied by participatory law and policy reform process that engages all relevant sector players.
As always, we remain committed to upholding the principles of democratic governance and the rule of law in Kenya by supporting every effort to improve our laws in response to the social, economic and political needs of the country.

2. REVIEW OF THE PROLIFERATION OF LGBTQ RIGHTS IN THE COUNTRY

(a) The Concept of LGBTQ

The term LGBTQ is an alphabetism for lesbian, gay, bisexual, transgender, queer or questioning. LGBTQ can be interpreted in at least two ways:

1) *Broad interpretation*: LGBTQ is often used as an umbrella term to refer to people whose sexual orientation and gender do not conform to the cultural expectations of their society.

2) *Narrow interpretation*: LGBTQ is also used to refer specifically to lesbian, gay, bisexual or transgender people. Additional terms can be included to explicitly

communicate their inclusion, such as queer, questioning, intersex, asexual and two spirit.

(b) Pronouncements by the Courts on the position of LGBTQ in Kenyan laws

The courts have had occasion to pronounce themselves on LGBTQ matters as analysed below.

EG & 7 others v Attorney General; DKM & 9 others (Interested Parties); Katiba Institute & another (Amicus Curiae) [2019] KEHC 11288 (KLR)

The petitioners initiated legal proceedings challenging *Sections 162(a), 162(c) and 165 of the* Penal Code, Cap. 63. These sections prohibit what are termed "unnatural offences" and acts of "gross indecency," which have historically been interpreted and applied to criminalize consensual same-sex sexual activity. The Petitioners contended that these provisions were unconstitutional on several grounds.

Primarily, the petitioner argued that the sections were void for vagueness, lacking clear definitions of the prohibited conduct. Furthermore, the Petitioners asserted that the provisions violated the rights to non-discrimination, human dignity and privacy as guaranteed by the Constitution.

The case was consolidated with another similar petition, Petition 234 of 2016, as both raised common issues regarding the impact of these Penal Code sections on individuals who do not conform to societal expectations of gender identity, expression or sexual orientation.

The respondents submitted that the petitioners were attempting to use the judicial process to legitimize acts that were deemed indecent and to create rights not explicitly recognized in the Constitution. It was further argued that the criminalization of

homosexuality fell within the bounds of the law and that individual liberty could be legitimately curtailed when it conflicted with the common good and public policy.

The respondent also highlighted that during the drafting of the 2010 Constitution, the issue of same-sex relationships was considered, but there was no consensus or desire to legalize them. As a result, Article 45(2) of the Constitution specifically recognizes heterosexual marriage. It was argued that permitting consensual, private same-sex relations would implicitly lead to same-sex couples cohabiting, which would contradict the spirit and intent of the Constitution as drafted.

The High Court held; -

On the issue of vagueness, the Court acknowledged that while the Penal Code sections in question did not explicitly define terms like "unnatural offences" or "against the order of nature," these phrases had been defined in legal dictionaries and prior judicial pronouncements.

Therefore, the Court concluded that the lack of explicit definitions within the statute itself did not render the provisions unconstitutionally vague. The Court also accepted the principle that fundamental rights and freedoms, while guaranteed, are not absolute and may be limited to prevent prejudice to the rights and freedoms of others.

The Court placed significant weight on the intent of the legislature and the perceived social values of Kenya. It was stated that the court had a responsibility to uphold positive African cultural values and contribute to the moral well-being of society. The Court's interpretation of *Article 45(2) of the Constitution*, which recognizes heterosexual marriage, was also crucial.

The Court reasoned that if there had been a desire by the Kenyan people to protect and recognize same-sex relationships, this would have been reflected in the drafting of the 2010 Constitution. Consequently, allowing consensual, private same-sex relations would

contradict this perceived intent. The High Court in this case dismissed the case, upholding the constitutionality of the challenged provisions of the Penal Code.

NGOs Co-ordination Board v EG & 4 others; Katiba Institute (Amicus Curiae) (Petition 16 of 2019) [2023] KESC 17 (KLR)

Facts

The case originated from the decision of the Non-Governmental Organizations Co-ordination Board (NGO Board) to reject the registration of a proposed organization aimed at addressing the violence and human rights abuses suffered by the Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (LGBTQ) persons in Kenya.

In a letter dated 25th March, 2015, the NGO Board refused to reserve any of the names proposed by Mr. Eric Gitari for this organization. The Board's Executive Director justified this refusal by citing *Sections 162, 163 and 165 of the Penal Code*, which criminalize certain sexual acts, implying that the proposed organization's focus was illegal.

Aggrieved by this decision, Mr. Gitari initiated legal action by filing High Court Petition No. 440 of 2013. He contended that the NGO Board's actions violated several articles of the Constitution, including *Article 20 (2), Article 27(4), Article 28 and Article 36*, as well as provisions of the NGO Coordination Act.

His core argument was that the refusal to register the organization, based on its focus on LGBTIQ rights and its proposed name, infringed upon the constitutional rights to freedom of association and non-discrimination.

Issues

The central issues of the case include:

1) Whether LGBTQ individuals possess the right to form associations in accordance with the law in Kenya;

2) If the answer to the first issue is affirmative, whether the NGO Board's decision to refuse the registration of the proposed NGO solely based on the choice of name and the perceived nature of the organization constituted a violation of the fundamental rights to freedom of association and non-discrimination as guaranteed by the Constitution; and

3) Whether the First Respondent, Eric Gitari, was required to exhaust internal dispute resolution mechanisms available under the NGO Coordination Act before filing his case in the High Court.

The High Court, in a decision by a three-judge bench, ruled in favour of Mr. Gitari. The court found that the limitation placed on the freedom of association for LGBTQ individuals by the NGO Board was not justifiable under *Article 24 of the Constitution.* The court held that while *Sections 162, 163, and 165 of the Penal Code* criminalize specific homosexual acts, they do not criminalize sexual orientation itself. Therefore, relying on these sections to restrict the registration of the organization was deemed unreasonable.

Regarding *Article 27* on non-discrimination, the High Court noted that the Board's objection extended beyond just the name to include the stated objects and purpose of the proposed NGO. The court held that interpreting *Article 27* in a manner that excludes individuals based on their sexual orientation would contradict fundamental constitutional principles such as human dignity, inclusiveness, equality, human rights, and non-discrimination.

The court concluded that the Board's attempt to reject the organization's formation on the grounds of furthering an "illegality" simply because it disapproved of the organization's objectives amounted to an infringement of the freedom of association.

In the end the Judges noted-

> "In conclusion, therefore, having considered the arguments on both sides, the precedents cited, the Constitution and the law, we are not satisfied that the Petitioners' attack on the constitutional validity of sections 162 and 165 of the Penal Code is sustainable. We find that the impugned sections are not unconstitutional. Accordingly, the consolidated Petitions have no merit. We hereby decline the reliefs sought and dismiss the consolidated Petitions"

Dissatisfied with the High Court's decision, the NGO Board lodged an appeal at the Court of Appeal. The appellate court, by a majority decision, dismissed the appeal and affirmed the High Court's ruling. The majority concluded that by refusing to register the NGO, Mr. Gitari was effectively "convicted" before contravening any law, and they characterized such an action as "retrogressive."

The two dissenting judges, however, held a different view. They argued that the freedom of association is subject to limitations as specified in the Constitution and that *Article 27(4)* specifically prohibits discrimination based on gender, but not sexual orientation. These dissenting judges maintained that since current laws in Kenya do not permit homosexual practices, the rejection of the proposed NGO registration was lawful.

Determination of the Supreme Court

The Court (majority decision) found that Mr. Gitari's intention was to register an organization to advocate for the rights of LGBTQ individuals, and this objective was not directly linked to the specific offenses described in *Sections 162, 163, and 165 of the Penal Code.*

As such, the Supreme Court agreed with the reasoning of both the High Court and the Court of Appeal, affirming that LGBTQ people, like all other individuals, have a fundamental right to freedom of association, which includes the right to form any kind of association.

The Supreme court when addressing the final issue, whether the Board's decision was discriminatory and contravened *Article 27*, the Supreme Court definitively ruled that the Board's refusal to register the organization focused on LGBTQ rights was indeed discriminatory.

The Court held that the word "Sex" as used in *Article 27 of the Constitution* encompasses sexual orientation. The Supreme Court upheld the High Court's position that any interpretation of the Constitution that excludes individuals based on their sexual orientation is inherently discriminatory. Based on these determinations, the Supreme Court dismissed the appeal, upholding the decisions of the lower courts and reinforcing the constitutional rights of LGBTQ individuals to freedom of association and protection from discrimination.

In a dissenting opinion, Ibrahim and Ouko SCJJ noted that –

> "...But a more pragmatic approach towards opening up the door for registration of the group would be to introduce legislative reforms, including amendment to the Penal Code and repeal of sections 162, 163 and 165 to decriminalise acts contemplated by those provisions based on the will and desire of the people of Kenya. That was the course adopted by many countries around the world. Social attitudes and concerns were constantly evolving. Lawmakers, as representatives of the people created, modified and repealed laws to achieve particular behavioural outcomes, often in an effort to respond to perceived changes in the society. The decision to repeal or amend those laws to accommodate LGBTQI community in Kenya was one that could only be made by the people from whom all sovereign power flowed or by their elected representatives and only after the involvement of the people.
>
> Though the language of article 27 of the Constitution was plain, the basic rule of constitutional interpretation was that the Constitution had to be given a holistic interpretation. Holistic interpretation had been described as interpreting the

Constitution in context. It was contextual analysis of a constitutional provision, reading it alongside and against other provisions, to maintain a rational explication of what the Constitution had to be taken to mean in the light of its history, of the issues in dispute, and of the prevailing circumstances. There was a clear distinction between 'sex' and 'sexual orientation'. Sexual orientation referred to each person's capacity for emotional, affectional and sexual attraction to, and intimate sexual relations with individuals of a different gender or the same gender or more than one gender

The word sex was used three times in the Constitution; in the article 27, in article 42(2) on the right to marry a person of the opposite sex and article 53(1)(f)(ii) on the detention in custody of a child, in conditions that took account of the child's sex. In the context of those articles, sex was used in reference to a person's sexual anatomy based on one's sex chromosomes- (male/female). The discrimination that was expressly prohibited by article 27 was on account of sex and not sexual orientation."

(c) Law Reform issues emanating from the Supreme Court's Judgement and proposed legislative reforms

As identified in the judgement in NGOs Co-ordination Board v EG & 4 others; Katiba Institute (Amicus Curiae) (Petition 16 of 2019) [2023] KESC 17 (KLR), the main contention was unbundling the definition of sex and whether to include sexual orientation in the definition of sex in Article 27(4).

The said provision states –

"27(4) The State shall not discriminate directly or indirectly against any person on any ground, including race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth."

According to the Supreme Court majority decision the use of the word "sex" under article 27(4) of the Constitution did not connote the act of sex *per se* but referred to the sexual orientation of any gender, whether heterosexual, lesbian, gay, intersex or otherwise. Further, the word "including" under the same article was not exhaustive, but only illustrative and would also comprise freedom from discrimination based on a person's sexual orientation. Therefore, an interpretation of non-discrimination which excluded people based on their sexual orientation would conflict with the principles of human dignity, inclusiveness, equality, human rights and non-discrimination.

In the opinion of the dissenting Judges, there was nothing whatsoever in article 27(4) of the Constitution or on a reading of the Constitution as a whole which suggested that the framers of the Constitution were addressing their minds in any way whatever to problems of discrimination on grounds of sexual orientation. Had that been the intention, nothing could have been easier than to state so as had been done in some of the constitutions, statutes and international instruments. The intention was to prohibit discrimination based on the consideration whether a person was male or female. They further averred that in other jurisdictions, where the right against discrimination was meant to include sexual orientation, it had been expressly stated as such in either the statutes or the national constitutions of those countries.

From the reading of the decisions in the superior courts, it is clear that they are not all agreed on the import of the provisions of the Constitution and the Penal Code on same sex relations and LGBTQ in general. As noted by the Supreme Court Judges, lawmakers, as representatives of the people have the power to create, modify and repeal laws to achieve particular behavioural outcomes, often in an effort to respond to perceived changes in the society. The decision to repeal or amend those laws to accommodate the LGBTQ community in Kenya is one that could only be made by the people from whom all sovereign power flowed or by their elected representatives and only after the involvement of the people.

One such instance is through the Family Protection Bill sponsored by Hon. Kaluma which seeks to provide for the protection of the family in furtherance of Article 45 of the Constitution, to prohibit homosexuality and same sex marriage, to prohibit unnatural sexual acts and related activities and to proscribe activities that seek to advance, advocate, promote or fund homosexuality and unnatural sexual acts.

The Bill specifically unbundles the term sex by seeking to define it as the biological state of being male or female as physically observed and assigned at birth, or as medically determined and assigned by the time the person reaches puberty. The proposed definition proposes to specifically exclude sexual orientation and gender identity. This would cure the confusion on whether "sex" as set out in the Constitution includes "sexual orientation" without explicitly stating so.

The Bill also seeks to prohibit sexual acts and other activities among persons of the same sex, same sex marriage, unnatural sexual activities and procuring of prohibited sexual activities by false pretences, detention with the intent to commit prohibited sexual activity among others. It also makes it an offence to establish premises for prohibited sexual activity, and prohibits grossly indecent acts. It prohibits sex reassignment prescriptions or procedures and the promotion or funding of prohibited activities and proposes to penalize any breach including fines, jail terms, deregistration of associations and cancellation of licences issued to businesses that promote or host prohibited activities within their premises.

Enactment of this legislation or any other legislation in this respect would create more clarity and therefore guide the courts in the interpretation of Article 27(4) as read with Article 43 of the Constitution.

D. CONCLUSION

In conclusion, KLRC is committed to ensuring that legislations are drafted and/or amended to the highest possible standards to promote their effectiveness as well as ensure their clarity and intelligibility to their intended users.

THE NATIONAL ASSEMBLY

THIRTEENTH PARLIAMENT – THIRD SESSION – 2024

PUBLIC PETITIONS COMMITTEE

LEGAL BRIEF:

PUBLIC PETITION *(NO. 13 OF 2024)*,

BRIEF ON PETITION NO. 13 OF 2024 REGARDING THE DECRIMINALISATION OF ATTEMPTED SUICIDE

October 2024

1. The petition, is brought before the House by Dr. Lukoye Atwoli, Professor of Psychiatry and Dean at the Medical College of East Africa at the Aga Khan university.
2. The petitioner draws the attention of the House to the issue of criminalization of attempted suicide under section 226 of the Penal Code.
3. The petitioner claims that the criminalization of attempted suicide fails to address underlying mental health issues and perpetuates stigma and shame surrounding mental illness.
4. He submits that section 2 of the Mental Health Act (Cap 248) defines a person with mental illness to include a person with suicidal ideation or behavior. Therefore, its criminalization limits accurate data collection and suicide prevention efforts.
5. The petitioner seeks the intervention of the House to repeal section 226 of the Penal Code.

ANALYSIS

a. The Constitution

6. Article 95(3) of the Constitution provides for the role of the National Assembly to enact legislation. Article 95 (2) of the Constitution mandates the National Assembly to deliberate and resolve the issues of concern to the people.
7. Article 43 provides for the right to the highest attainable standard of health which includes right to health care services including reproductive health. While Article 28 provides for the right to inherent dignity that is respected and protected.

b. The National Assembly Standing Orders

8. Standing order 219 provides that a public petition may seek the House to consider any matter within its authority including the enacting, amending or repealing any legislation. If the Committee considers and approves the Petition, the approved content will be reduced to a legislative proposal sponsored by the Committee for consideration by the House.
9. Standing Order 114 A (1) (b) provides for the exemption from prepublication scrutiny of a proposal sponsored by the public petitions committee.

c. Mental Health Act

12. The Act provides for the care, treatment and rehabilitation of persons with mental illness, the procedures of admission, treatment and general management of persons with mental illness in the country.
13. The Act defines a **"person with mental illness"** to means a person diagnosed by a qualified mental health practitioner to be suffering from mental illness, and includes—
    (a) a person diagnosed with alcohol or substance use disorder; and
    (b) a person with suicidal ideation or behavior;

d. Penal Code Cap. 63

18. The Penal Code provides for the offence of attempted suicide-
    Section 226. Attempting suicide
    (1) Any person who attempts to kill himself is guilty of a misdemeanor.

19. The Act also provides for the offence of aiding suicide as follows—
    Section 225. Aiding suicide
    (1) Any person who-
        (a) procures another to kill himself
        (b) counsels another to kill himself and thereby induces him to do so; or
        (c) aids another in killing himself
            is guilty of a felony and is liable to imprisonment for life.

20. Suicide is a serious mental health issue, often the result of a combination of complex factors, including untreated or poorly managed mental health conditions, life stressors, trauma, and environmental influences. Addressing suicide as a mental health issue requires a comprehensive approach involving prevention, treatment, and support.
21. The petition advocates for access to psychological support, therapy, and psychiatric care to address the root causes of suicidal thoughts instead of penalties.
22. The Committee should seek the views of the petitioner and various stakeholders to appreciate the need for the repeal of the offence of attempted suicide.

CONCLUSION

23. In light of the foregoing legal provisions, in considering the Petition, the Committee should seek to interrogate the views of —

    a) the Petitioner;
    b) the Law Society of Kenya
    c) the Ministry of Health/ Director of Mental Health;
    d) the Attorney General; and
    e) the Kenya Law Reform Commission.

GICHANE PATRICIA
LEGAL COUNSEL

Meeting with Public Petitions Committee of the National Assembly of Kenya, 01/10/24

DECRIMINALISATION OF SUICIDE ATTEMPTS BY REPEAL OF S226 OF THE PENAL CODE

1. **Section 226 of the Penal Code**- Any person who attempts to kill himself is guilty of a misdemeanour
2. **Section 36 of the Penal Code**- when in this Code no punishment is provided for any misdemeanour, it shall be punishable with imprisonment for a term not exceeding two years, or with a fine, or both.
3. **Section 2 of the Mental Health Act** defines a person with mental illness to include a person with suicidal ideation or behaviour
4. **Constitution of Kenya 2010 provides in Article 43** for the right of every person to the highest attainable standard of health, which includes the right to health care services... and that a person shall not be denied emergency medical treatment
5. Attempting to kill oneself, as described in s226 of the Penal Code, is in medical parlance labeled as a suicide attempt. Reading this with s2 of the Mental Health Act, it follows therefore that **s226 makes one of the signs of mental illness, ie a suicide attempt, a demeanour** for which a convicted person would be imprisoned for up to two years, charged a fine, or both.
6. Suicide attempts are classified in the psychiatric literature as a **medical emergency** requiring immediate intervention to prevent serious injury or death. There are evidence-based protocols that have been developed for management of a patient presenting with a suicide attempt, and all these recognise this as a medical emergency.
7. The **net effect of s226 of the Penal Code is therefore to prevent a person suffering from a medical emergency from accessing emergency treatment**, by directing them into the criminal justice system instead of a health facility where they may receive life-saving care. In so doing, **s226 of the Penal Code directly offends Article 43 of the Constitution of Kenya 2010**, and should therefore be removed from our statute books
8. Further, **Article 27(4) and (5) of CoK2010 prohibits discrimination** by the State or any person on grounds including health status and disability. Given that people suffering from other illnesses such as diabetes mellitus and hypertension, and people having other signs of psychological distress like depressed mood, severe anxiety and specific phobias are not subjected by law to threats of arrest and arraignment for their illnesses, **treating people with suicidal ideation and**

behaviour as criminals constitutes discrimination on grounds of health status, and should not be allowed in our statute books

9. Additionally, **Article 28 of the Constitution of Kenya 2010** provides that every person has inherent dignity and the right to have that dignity respected and protected. **Categorising a person's psychological distress and signs of mental illness as a criminal offence amounts to denying their inherent dignity**, and punishing them for their symptoms is the exact opposite of protecting their dignity. Respecting and protecting their dignity would mean they are conveyed to a health facility where they are assessed by a qualified mental health professional and provided with the care they need to take away the suicidal thoughts and behaviours, allowing them to resume a dignified life as productive citizens of this republic instead of spending the rest of their days as convicted criminals on account of their illness.

10. **Criticism of s226 of the Penal Code**: This section of our law was enacted before independence, and this was done in the context of a very different social milieu in which the lives of the majority of citizens were at the mercy of the colonial power. The science at the time had not advanced sufficiently for society to acknowledge that **suicide is the end-product of severe mental illness or extreme psychological and/or social distress** that if addressed would significantly reduce the risk of suicide and improve the mental health of the person

The Science today:

11. Globally, **9 people die by suicide out of 100,000 per year (2019); Kenya's rate is 6 per 100,000.**

12. A study I did with South African data (1471-244X-14-65.pdf (biomedcentral.com)) showed that **presence of mental illness among parents increased the odds of suicidal behaviour among their adult offspring**, and the greater the number of parental mental illnesses, the higher the risk of having suicidal ideation.

13. Another study we conducted in Mosoriot in Nandi County (PREVALENCE of psychiatric morbidity in a community sample in Western Kenya (nih.gov) found that **1 in 6 people in the community had had a suicide attempt in their lifetime**. The prevalence of mental illness was also high, with almost half having had at least one mental disorder in their lifetime.

14. We have not done a national survey to determine the national prevalence of mental illnesses, including suicidal ideation and behaviour, but when we do, I am convinced that we will find very high rates

15. There are many reported cases of suicide attempts in our hospitals, and many reported suicides in the community, as evidenced by police and administrative reports.

16. With worsening socio-economic circumstances and increasingly problematic social relations, suicide rates and prevalence of mental illnesses is increasing

17. WHO indicates that **suicides are preventable**, and outlines measures for prevention and control that include **limiting access to means, interacting with media for responsible reporting of suicide, fostering socio-emotional skills in adolescents, and early identification and management of those with suicidal behaviours**; punishment is NOT one of the recommendations for handling suicide in any setting

18. In Kenya, our **Mental Health Policy 2015-2030** (https://publications.universalhealth2030.org/uploads/Kenya-Mental-Health-Policy.pdf) indicates that the high burden of untreated mental illness in this country may be responsible for the daily reported cases of suicide, among other social problems we face, and in the **Mental Health Action Plan 2021-2025 the Ministry of health** (/download/kenya-mental-health-action-plan-2021-2025/ (google.com)) lays out implementation of a **suicide prevention programme** as a priority action in achieving the Strategic Objective of Preventive and Promotive Mental Health. This is partly informed by another National Government initiative, the **Presidential Taskforce report of 2020** titled "**Mental Health and Wellbeing- Towards Happiness and National Prosperity**", which recommended that a **National Suicide Prevention Programme** be established with the role to restrict means, conduct surveillance, education, access to treatment, decriminalisation, responsible media reporting, helpline, and crisis intervention.

19. Specifically on criminalisation of suicide, **the Taskforce recommended that we "Decriminalise Suicide and amend other laws which are discriminatory and use derogatory language**", and that we "**Amend laws relating to criminal justice system to ensure people with mental health conditions are not discriminated by criminalisation of symptoms of mental illness and get fair administration of justice.**"

20. The **Mental Health Action Plan** says as follows on suicide prevention: "Suicide prevention: Develop and implement comprehensive national strategic interventions for the prevention of suicide, with special attention to vulnerable groups identified

as at an increased risk of suicide. The strategies are to be implemented by National and County governments working in collaboration with all stakeholders."

21. Finally, the Kenya government promulgated a **Suicide Prevention Strategy 2021-2026** (SUICIDE-PREVENTION-STRATEGY-2021-2026.pdf (health.go.ke)), with the then CS committing that "The Ministry of Health is committed to the full implementation of this strategy", and calling for support from all relevant stakeholders

22. The Strategy indicates that "**Suicide prevention is a public health priority** and this Suicide Prevention Strategy, aims at reducing deaths by suicide". One of the strategic activities in this Plan is "**advocating for decriminalisation of suicide by repealing Section 226 of the Penal Code**".

23. The Government of Kenya therefore supports the repeal of s226 of the Penal Code, and my petition is part of my civic duty to support this government direction, as well as my responsibility as an expert in mental health who has had to deal with the gruesome results of the secrecy around suicidal ideation and behaviour, with many preventable suicide deaths in my professional history.

24. I finish by quoting the introduction of **Kenya's Suicide Prevention Strategy**, a product of rigorous consultation and public participation, with full involvement of all arms of government as well as experts and users of mental health services:

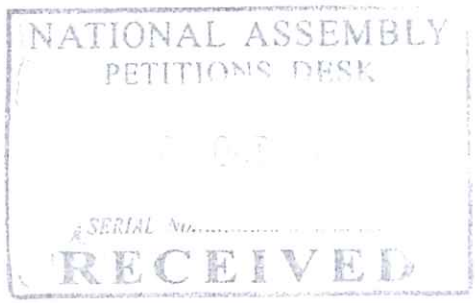
"**Suicide** is a serious global public health problem - it affects people across the lifespan, and is a leading cause of mortality especially among young people. Suicide has devastating impact on families, friends and communities as every life lost represents someone's partner, child, parent, friend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

25. And my final word: **REPEAL SECTION 226 OF THE PENAL CODE TO REDUCE STIGMA AND INCREASE ACCESS TO MENTAL HEALTH SERVICES FOR THESE PEOPLE WHO ARE IN CRITICAL NEED.**



Prof Lukoye Atwoli

01/10/2024

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BMC Psychiatry

PREVALENCE of psychiatric morbidity in a community sample in Western Kenya

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Abstract

Background: About 25% of the worldwide population suffers from mental, neurological and substance use disorders but unfortunately, up to 75% of affected persons do not have access to the treatment they need. Data on the magnitude of the mental health problem in Kenya is scarce.
The objectives of this study were to establish the prevalence and the socio-demographic factors associated with mental and substance use disorders in Kosirai division, Nandi County, Western Kenya.

Methods: This was a cross sectional descriptive study in which participants were selected by simple random sampling. The sampling frame was obtained from a data base of the population in the study area developed during door-to-door testing and counseling exercises for HIV/AIDS. Four hundred and twenty consenting adults were interviewed by psychologists using the Mini International Neuropsychiatric Interview Version 7 for Diagnostic and Statistical Manual 5th Edition and a researcher-designed social demographic questionnaire.

Results: One hundred and ninety one (45%) of the participants had a lifetime diagnosis of at least one of the mental disorders. Of these, 66 (15.7%) had anxiety disorder, 53 (12.3%) had major depressive disorder; 49 (11.7%) had alcohol and substance use disorder. 32 (7.6%) had experienced a psychotic episode and 69 (16.4%) had a life-time suicidal attempt. Only 7 (1.7%) had ever been diagnosed with a mental illness. Having a mental condition was associated with age less than 60 years and having a medical condition.

Conclusion: A large proportion of the community has had a mental disorder in their lifetime and most of these conditions are undiagnosed and therefore not treated. These findings indicate a need for strategies that will promote diagnosis and treatment of community members with psychiatric disorders. In order to screen more people for mental illness, we recommend further research to evaluate a strategy similar to the home based counseling and testing for HIV and the use of simple screening tools.

Keywords: Mental disorders, Prevalence, Mini International Neuropsychiatry Interview, Western Kenya

Background

About 25% of the population suffers from Mental, Neurological and Substance use disorders (MNS) and 14% of the global burden of disease is attributed to these disorders, but up to 75% of affected persons in many low and middle income countries do not have access to the treatment they need [1]. The objectives of the WHO mental health action plan 2013–2020 include provision of comprehensive, integrated and responsive mental health care services in community-based settings, and also emphasize the empowerment of people with mental disabilities, the need to develop a strong civil society and the importance of mental health promotion and prevention [2].

There are limited resources for mental health in many Low and Middle Income Countries (LMICs), with less than 1% of the total health budget being allocated for mental health and most of the available resources are directed towards treating severely ill patients in major psychiatric hospitals [3, 4] In many LMICs, human resources for mental health are also scarce and generally inaccessible. In Kenya for example, there are fewer than 100 psychiatrists, [5] most of who are based in Universities,

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National Referral Hospitals and a few county hospitals. Data on the burden of mental disorders at the community level are limited. Most of the existing data in Kenya today are based on research conducted in hospital settings, which may not be a true reflection of the status at the community level. One population based survey done in Nyanza revealed a 10.3% prevalence rate of common mental disorders [6].

The aim of this study was to generate evidence on the burden of mental disorders in a community sample in western Kenya. The findings of this study should provide an evidence base for the development of community based solutions to the huge treatment gap in western Kenya, and inform relevant policies that will then enable the integration of mental health services into primary care facilities.

Methods

Study design

This was a cross sectional descriptive study.

Setting

The study was conducted in Kosirai Division, Nandi County in the western part of Kenya. The study area is inhabited by approximately 36,000 people across 6,000 households, organized in 100 villages [7]. Like the rest of Nandi County, and indeed the rest of western Kenya, this community is predominantly rural with farming as the leading economic activity. This area serves as the catchment area of Mosoriot sub-county hospital, one of the sites in the AMPATH (Academic Model Providing Access to Healthcare) coverage. AMPATH is a consortium of Moi University, Moi Teaching and Referral Hospital, and North American Universities, with an existing clinical care delivery system and research infrastructure for HIV, hypertension, diabetes and cervical cancer [8]. The initial plans to integrate mental health in the AMPATH systems are underway. Kosirai division has a primary care facility staffed with a psychiatric nurse which makes it a place to start evidence based mental health work which can be scaled up to other AMPATH sites. This study forms part of the foundation on which these plans will be built.

Study population and sampling

The study targeted adults living in Kosirai Division in the period January 2014 – November 2015. Participants were selected by simple random sampling from a data base that was developed during door to door HIV/Aids counseling exercises targeting the entire population in the study area. Demographic data of persons above 14 years of age was captured regardless of the outcome of the HIV test. Published work describing the door to door strategy indicate that up to 97% of the households in the study area were accessed during this exercise [9] hence giving confidence to the authors that such data is fairly representative of the target population. From the database 8000 individuals aged 18 years and above were included in the sampling frame. A sample size of 384 participants was calculated using the Cochran formulae for sample size determination, $n = Z^2pq/e$. [10]. Given the complexity of tracing individuals in their homesteads we increased the sample size by 50%, to adjust for those who may not be traced and avoid resampling and replacements. A total of 570 participants were sampled out of who 450 were traced. 25 persons did not meet the inclusion criteria: either they were younger than 18 years or they could not the interview languages, speak Kiswahili or English and five eligible participants did not give consent to participate. A total of 420 participants were therefore interviewed for this study.

Outcome measures

Socio-demographic characteristics including age, gender, marital status and education level were collected using a researcher-designed questionnaire.

Psychiatric morbidity was defined as having at least one of the disorders included in the Mini International Neuropsychiatric Interview (MINI) Version 7 for Diagnostic and Statistical Manual 5th Edition (DSM-5). MINI is a short diagnostic structured interview, developed for Axis I psychiatric disorders and it has been shown to be reliable compared to the Structured Clinical Interview for DSM (SCID) and the Composite International Diagnostic Interview (CIDI), but with a shorter administration time [11]. It has been used in Kenya in a study by Ndetei et al. after adaptation and adoption [12]. For this study, a written permission to use and translate the MINI was granted by the author, Dr. Sheehan.

Study procedures

Data were collected from December 2015 to January 2016 by two assistants with masters' level training in psychology. The psychologists underwent a 5 day study-specific training conducted by a psychiatrist. The training involved understanding the content of the MINI, coding for various diagnoses, assessment of various symptoms, socio-demographic questionnaire and the consenting process. They carried out practical interviews with healthy adults and with stable mentally ill patients admitted in a mental health ward. The diagnosis from the MINI interviews were compared with the clinical interviews done by a psychiatrist and were rated as satisfactory.

Community health volunteers embedded in the study community mobilized the sampled community members for the study prior to the data collection process. To facilitate community entry, the research assistants were accompanied by community health volunteers into the homesteads during the interviews. The interviews were

conducted in the homesteads in the most private place and the participant was interviewed alone except in cases where corroborative history was needed.

Data and analysis

Data were collected on paper and later entered into a password protected database while the original paper forms were stored in a locked cabinet. After data entry was completed, data were cleaned and analyzed using the STATA version 13 [13]. Descriptive statistics were used for continuous data and frequency listings were used for categorical variables. Chi square tests were used to assess factors associated with prevalence of mental disorders. All analyses were carried out at 95% level of significance.

Results

A total of four hundred and twenty adults participated in the survey. The participants had a median age of 34 years and an interquartile range of 27–46 years with an almost equal male to female ratio. The study population was of a relatively low social economic background given that most of the participants earned less than 10 000 Kenya shillings (100 USD) per month. Very few participants reported ever been diagnosed or treated for mental illness (See Table 1).

Lifetime prevalence of any DSM-5 mental disorder as measured by the MINI-7 was 45.5% in this sample. Only 3.6% of those who screened positive for mental illness (7/191) had ever been diagnosed with mental illness.

As shown on Table 2 anxiety disorders, major depression and alcohol use disorders had the highest prevalence rates. Only 1.7% (7/ 420) had ever had an eating disorder. While psychotic episodes and suicidal attempts are not standalone diagnosis on DSM V, the high rates in this rural community (7.6% and 16.4% respectively) are worth highlighting.

In the correlation analysis shown on Table 3, the lifetime prevalence of any mental disorder was significantly associated with having a medical condition and age. In the logistic regression the significant variables were medical condition and age above 60 years. Adjusting for gender, marital status, education, employment and medical condition patients aged above 60 years had a lower odds (OR = 0.26, 95% CI 0.09–0.74) of having a mental disorder compared to those below 30 years. Adjusting for age, gender, marital status, education and employment in patients with a medical condition, the odds of having a mental disorder was 2.5 times that of those without a medical condition (O.R 2.53; 95% CI 1.44–4.43 as illustrated on Table 4. None of the other socio-demographic factors showed any association with lifetime mental disorder.

Table 1 Social demographic characteristics of the participants

Variable		Frequency N = 420	Percentage
Sex	Male	204	48.6
	Female	216	51.4
Marital status	Married	258	61.4
	Single	137	32.6
	Widowed/Divorced/ Separated	25	6.0
Religion	Muslim	8	1.9
	Christian	405	96.7
	Buddhist	2	0.5
	Others	4	1.0
Education level	None/Primary	194	46.2
	Secondary/Post-Secondary	226	53.8
Employment	Unemployed/Casual	127	30.2
	Formal employment	50	11.9
	Self-employment	243	57.9
Income	<10000	271	64.5
	>10 000	149	35.5
Have a medical condition	No	349	83.1
	Yes	71	16.9
Ever been diagnosed with mental illness	Yes	413	98.3
	No	7	1.7

Discussion

This study makes an important contribution, reporting for the first time the prevalence and factors associated with DSM-5 mental disorders in a rural community in an LMIC setting in sub-Saharan Africa. The prevalence

Table 2 Lifetime Prevalence of mental disorders as described in the MINI 7 for DSM V

Disorder	Actual number	(%)
Any mental disorder	191	45.5
Anxiety disorders	66	15.7
Major Depressive Disorder	53	12.6
Alcohol/substance use disorders	49	11.7
Suicide behavior disorder	28	6.7
Bipolar mood disorder	22	5.2
PTSD	19	4.5
Psychotic Disorder	4	1.0
Antisocial Personality Disorder	13	3.1
Eating disorders	7	1.7
Other significant conditions		
Suicidal attempt	64	16.4
Psychotic episodes	32	7.6

Table 3 Correlation analysis of any mental disorder and socio-demographic characteristics

	Lifetime Mental Disorder		Chi-square
Age in categories	Absent	Present	*p*-value
<30	82(53.2)	72(46.8)	0.038
30–60	122(52.4)	111(47.6)	
>60	25(75.8)	8(24.2)	
Sex			
Male	116(56.9)	88(43.1)	0.35
Female	113(52.3)	103(47.7)	
Marital status			
Married	149(57.8)	109(42.2)	0.145
Single	70 (51.1)	67 (48.9)	
Widowed/divorce/separated	10(40.0)	15(60.0)	
Education level			
None/Primary	99(51)	95(49)	0.183
Post primary	130(57.5)	96(42.5)	
Employment			
Unemployed	61(48)	66(52)	0.186
Formal	27(54)	23(46)	
Self employed	141(58)	102(42)	
Income			
<10,000	147(54.2)	124(45.8)	0.876
>10,000	82(55)	67(45)	
Medical condition			
Absent	204(58.5)	145(41.5)	<0.0001
Present	25(35.2)	46(64.8)	

rate we report of 45.5% is significantly higher than what most previous studies have found. One possible reason for the differences in the diagnostic tools used in the different studies. In this study, we used the MINI version 7 for DSM-5, which captures suicidal behavior disorder and also includes personality disorders apart from other severe mental disorders. For example, a population based household survey carried out in 2013 in a demographic surveillance site in Kisumu in western Kenya found that the overall prevalence of Common Mental Disorders was 10.3% using the Clinical Schedule Revised (CSR) [6]. This study also found that depression and anxiety were the most common disorders similar to our study where anxiety, depression and substance use disorders were the most common diagnoses. Further, a meta-analysis that included studies conducted between 1980 and 2013 around the globe reported lower lifetime prevalence of mental disorders than what we report in this study, ranging from 17.6% to 29.2% [14]. In a Nigerian survey involving 4984 people it was reported that 12.1% of the participants had a lifetime rate of at least one DSM-IV disorder with anxiety disorders being most common [15]. Finally, the South African Stress and Health Survey (SASH) found a lifetime prevalence rate for any mental disorder to be 30.3%, using the WHO World Mental Health Survey's Composite International Diagnostic Interview (CIDI) for DSM IV. Similar to our findings, the most prevalent lifetime disorders in the SASH survey were anxiety disorders [16].

In the present study, despite many participants having experienced some mental distress in their lifetime, only 3.6% (7 out of 191 who screened positive) had ever received care, indicating that a majority of people suffering mental illness in this region remained undiagnosed and untreated. Huge treatment gaps have been described in most parts of the world as demonstrated in a study involving Netherlands, Chile, United States, Canada and Germany that found that up to 60% of persons with severe mental disorders were not receiving treatment [17]. A study by Ndetei and colleagues also found that about 25% of patients in general hospital settings have mental disorders that go unrecognized and are often undertreated even when correctly diagnosed [18].

Age was associated with lower rates of having a lifetime mental disorders, with respondents aged over 60 years having rates of 24.2% compared to those younger than 60 years who had rates above 45%. It is difficult to explain the lower prevalence of mental disorders among older

Table 4 Multiple logistic regression model of the association between any mental disorder and socio-demographic characteristics

Variable	Adjusted Odds Ratio	*p*-value	[95% Conf. Interval]	
30–60 vs <30 years	1.07	0.79	0.64	1.78
>60 vs <30 years	0.26	0.01	0.09	0.74
Female vs Male	1.02	0.93	0.68	1.54
Single vs Married	1.28	0.34	0.77	2.11
(Widowed/Divorced/Separated) vs Married	2.22	0.11	0.83	5.95
Postprimary vs Primary/No education	0.69	0.10	0.45	1.08
Formal vs Unemployment	0.85	0.65	0.42	1.72
Self-employed vs Unemployed	0.72	0.21	0.43	1.20
Medical condition (Present vs Absent)	2.53	0.00	1.44	4.43

adults compared to those less than 60 years of age, but their relatively small proportion in this sample might be responsible for the difference. Persons who reported having a medical condition had a lifetime prevalence of mental disorder of 64.8% compared to 41.5% among those who did not report a medical condition. The relationship between mental illness and various medical conditions has been widely described in literature. There is evidence of increased mental disorders among patients suffering from infectious diseases like tuberculosis, HIV and also among non-communicable diseases like diabetes, hypertension and cancer [19–23]. Further, it has also been shown that persons suffering from mental disorders have a greater burden of chronic medical conditions than the general population [24]. In this study, we did not study the temporal association between the medical conditions and mental disorders, and further work, including longitudinal studies, may better describe the relationships.

Although this study did not demonstrate gender association with a lifetime mental disorder, studies have demonstrated gender differences in the prevalence of common mental disorder with women having higher rates of mood and anxiety disorders and men having higher rates of substance use disorders [25]. Similar findings were shown in a face to face household survey by WHO which aimed to establish variation in gender differences in lifetime DSM-IV mental disorders across cohorts in 15 countries in the World Health Organization World Mental Health Survey. In that study, women had more anxiety and mood disorders than men, and men had more externalizing and substance disorders than women [26]. The study in Nyanza Kenya showed significantly higher rates of having any CMD in 2013 among women [6].

None of the other socio-demographic factors were associated with a lifetime mental disorder diagnosis, or any specific disorder in this study. This is contrary to findings in other community surveys showing association with marital status [16, 27], education level [28, 29] and socio-economic status [30]. A follow up study with a larger sample size in this area would be useful to explore these possible associations as well as the reasons for lack of association with factors found to increase risk elsewhere.

Study limitations

A number of important limitations must be appreciated in understanding findings in this study. Firstly, diagnostic errors are possible especially in the section assessing for psychosis because it required interviewer observation and judgment. Secondly, a non- reporting bias is possible especially because of fear of being labeled mentally ill in a setting in which mental illness is highly stigmatized. Another limitation is that the specific medical disorders were not assessed.

Conclusion

A large proportion of the community has mental disorders and most of these conditions are undiagnosed and therefore not treated. These findings indicate a need to have strategies that will promote diagnosis and treatment of community members with psychiatric disorders. They also indicate a need for mental healthcare services at the community level in order to ensure accessibility of affordable services. In order to screen more people for mental illness, we recommend further research to evaluate a strategy similar to the home based counselling and testing for HIV and the use of simple screening tools.

Abbreviations

AMPATH: Academic model providing access to health care; CIDI: Composite international diagnostic interview; CMD: Common mental disorder; DSM: Diagnostic statistical manual; MINI: Mini international neuropsychiatric interview; MNS: Mental, neurological and substance use disorders; SCID: Structured clinical interview for DSM III disorders; WHO: World Health Organization.

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Availability of data and materials

The datasets during and/or analyzed during the current study are available from the corresponding author on reasonable request.

Authors' contributions

EK, LA, DL, SE, AM conceived and designed the protocol. EK and AM analyzed the data. EK drafted the manuscript. All authors reviewed the manuscript. All others reviewed and approved the final manuscript.

Competing interests

The authors declare that they have no competing interests.

Consent for publication

Not applicable.

Ethics approval and consent to participate

The study protocol, number 0001521, was reviewed and approved by the Institutional Research and Ethical Committee of Moi University and the Moi Teaching and Referral Hospital. Written informed consent was sought from all participants. The ability to consent was ascertained by conducting a Mini Mental State Assessment. Those who could not sign consent due to a Mini Mental State score of < 18 gave verbal assent but also had a next of kin give the written consent.

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Association between parental psychopathology and suicidal behavior among adult offspring: results from the cross-sectional South African Stress and Health survey

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Abstract

Background: Prior studies have demonstrated a link between parental psychopathology and offspring suicidal behavior. However, it remains unclear what aspects of suicidal behavior among adult offspring are predicted by specific parental mental disorders, especially in Africa. This study set out to investigate the association between parental psychopathology and suicidal behavior among their adult offspring in a South African general population sample.

Method: Parental psychopathology and suicidal behavior in offspring were assessed using structured interviews among 4,315 respondents from across South Africa. The WHO CIDI was used to collect data on suicidal behavior, while the Family History Research Diagnostic Criteria Interview was used to assess prior parental psychopathology. Bivariate and multivariate survival models tested the associations between the type and number parental mental disorders (including suicide) and lifetime suicidal behavior in the offspring. Associations between a range of parental disorders and the onset of subsequent suicidal behavior (suicidal ideation, plans, and attempts) among adult offspring were tested.

Results: The presence of parental psychopathology significantly increased the odds of suicidal behavior among their adult offspring. More specifically, parental panic disorder was associated with offspring suicidal ideation, while parental panic disorder, generalized anxiety disorder and suicide were significantly associated with offspring suicide attempts. Among those with suicidal ideation, none of the tested forms of parental psychopathology was associated with having suicide plans or attempts. There was a dose–response relationship between the number of parental disorders and odds of suicidal ideation.

Conclusions: Parental psychopathology increases the odds of suicidal behavior among their adult offspring in the South African context, replicating results found in other regions. Specific parental disorders predicted the onset and persistence of suicidal ideation or attempts in their offspring. Further research into these associations is recommended in order to determine the mechanisms through which parent psychopathology increases the odds of suicidal behavior among offspring.

Keywords: Suicide, Parental psychopathology, South Africa

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Background

Suicide contributes significantly to the global burden of disease, and is recognized as one of the leading causes of mortality and years of life lost globally [1-3]. Interest in this area has resulted in a series of epidemiological studies on suicide and related risk factors, although most of this work originates from higher income countries [1,4,5]. Recent work from the South Africa Stress and Health (SASH) study suggested that rates of suicidal behavior in less developed countries in Africa may be comparable to findings in the more developed ones [6,7]. In the SASH study, the lifetime prevalence rates of suicidal ideation, suicide plans and suicide attempts were 9.1%, 3.8% and 2.9% respectively [6].

Despite the growing body of research on suicide, relatively little is known about the predictors of suicidal ideation and attempts in the African setting. Even less is known about what factors lead those with suicidal ideation to go on to make suicide attempts. Prior studies in non-African settings have shown that suicidal behavior tends to run in families, and it has been suggested that some aspects of this are mediated at least in part by mental illness among relatives [8-13]. In particular, it has been shown that whereas suicidal ideation may be mediated by family history of mental illness, suicide attempts are more likely to be associated with family history of impulsive-aggressive behavior and mood disorders [9,10,12,14-17].

Previous work from the World Mental Health Survey Initiative has established that a wide range of parental mental disorders are associated with an increased the risk of suicidal ideation among the offspring [18]. It has been demonstrated that parental depression and generalized anxiety disorder predict onset and persistence of suicide plans, whereas parental antisocial personality disorder and anxiety disorders predict onset and persistence of suicidal attempts among those with suicidal ideation [18].

Apart from the World Mental Health Survey, previous population-based studies on parental psychopathology and the risk of suicide in the offspring have been carried out mainly in high income countries. Studies from Denmark and Sweden have shown that completed suicide and psychiatric illness in parents and other relatives are risk factors for offspring suicide, and that the effect of family suicide history is independent of the familial cluster of mental disorders [19-21]. Additionally, Stenager and Qin [22] showed a greater effect of maternal mental illness on offspring suicide, as well as the fact that the elevated risk associated with parental psychiatric history was greater in females than in males, and tended to be more prominent during the first few years after admission of a parent.

In one of the few studies from Low and Middle Income Countries, a Nigerian study [23] found that parental panic disorder and substance abuse were associated with suicidal ideation in offspring, but only parental panic disorder was associated with suicide attempts. In that study, parental panic disorder was also reported to predict the onset and persistence of suicidal ideation and attempts, and also which persons with suicidal ideation go on to make a suicide attempt. The findings from this Nigerian study suggest that the range of parental mental disorders associated with offspring suicidal behavior would be narrower in the African setting than what has been reported in higher income countries.

The current analysis of the South African Stress and Health Study (SASH) [24] data sought to explore the relationship between a range of parental psychopathology and the occurrence of suicidal ideation and attempts in the offspring in a South African general population sample. The primary hypothesis was that parental disorders such as major depression would predict suicidal ideation while anxiety and antisocial personality disorder would predict offspring suicide attempts as has been suggested by previous studies [18,25,26]. We also intended to explore the role of parental panic disorder in offspring suicidal ideation, as suggested by the study in Nigeria [23].

Secondly, the study set out to further test the hypothesis that among people with suicidal ideation, those reporting parental antisocial personality disorder and anxiety disorders would have a higher risk of developing suicide plans and attempts. A number of previous studies have demonstrated such a link, but little has been done in Africa or in other low and middle income countries [10,11,17].

The present study therefore uses a larger sample based on the population of an African country in order to determine whether previous findings can be generalized to low and middle income countries.

Method

The South African Stress and Health (SASH) study [24] was carried out as part of the World Mental Health Survey [27] to determine the prevalence rate and risk factors for mental disorders in South Africa. The survey was conducted between January 2002 and June 2004. The rationale and survey methods have been described in previous publications [24,28] and are briefly summarized here.

The SASH protocol was reviewed and approved by the Human Subjects Research Ethics Committees of the University of Michigan, Harvard Medical School and the Medical University of South Africa (MEDUNSA) [24].

The study population comprised adult South Africans residing both in households and hostels. Individuals living in institutions such as hospitals, prisons, mental health institutions and military bases were excluded from the study. A multi-stage area probability sample design was

used to select the sample. In the first stage, a stratified probability sample of primary sampling areas was selected. These areas are roughly equivalent to counties in the US or the UK, and the size was based on the 2001 South African Census of Enumeration Areas (EAs). The EAs were sampled with probabilities proportionate to their population size. In the second stage, a random sample of 5 households was selected within each EA. The third stage consisted of a random sub-selection of a single adult respondent in each selected household. The study achieved an overall response rate was 85%, resulting in a final sample consisting of 4315 respondents.

The data collection proceeded province by province with a cohort of 40–60 interviewers in each province. All SASH interviewers were trained on consenting and administration of the study instruments in centralized group sessions lasting 1 week. The interviews were conducted face to face in one of six different languages spoken by most South Africans: English, Afrikaans, Zulu, Xhosa, Northern Sotho, and Tswana. Respondent interviews lasted approximately three and a half hours, and some of them took more than one visit to complete. Written informed consent was obtained from all the participants before the interviews were conducted.

Measures

Sociodemographic variables

Sociodemographic variables included in this analysis were gender, age, marital status and education. Age consisted of four categories (in years): 18–29, 30–44, 45–59, and 60 or older. Marital status was categorized into three groups: married, previously married and never married. Education was classified depending on number of years of formal schooling into four categories: Low (0–1 year), low-average (2–7 years), high-average (8–12 years) and high (13 or more years).

Suicidal behavior

Suicidal behavior was assessed using the Suicidality Module of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI) Version 3.0, a fully structured diagnostic interview administered by trained lay interviewers [29]. This module includes an assessment of the lifetime occurrence and age-of-onset of suicidal ideation, plans, and attempts. Good inter-rater reliability, test–retest reliability, and validity have been found in earlier versions of the CIDI [30], while good validity of CIDI diagnoses compared to diagnoses based on blinded clinical reappraisal interviews have been found in WMH methodological studies [31].

As described previously [28], the translation of the English version of the CIDI into the five other languages used in the SASH study was carried out according to WHO recommendations of iterative back-translation conducted by panels of bilingual and multilingual experts. Discrepancies found in the back-translation were resolved by consensus of an expert panel.

In order to examine relations between parental psychopathology and a continuum of suicidal behaviors, we considered four dated lifetime history outcomes in a series of nested survival analyses: (i) suicidal ideation in the total sample; (ii) suicide attempt in the total sample; (iii) suicide plan among respondents with ideation; (iv) suicide attempt among respondents with ideation.

Parental psychopathology

Parental psychopathology was assessed using the Family History Research Diagnostic Criteria Interview [32] and its expansion [33]. In the current study we examined respondents' report of five different forms of possible lifetime psychopathology among their parent(s) during their childhood: major depression, panic disorder, generalized anxiety disorder, substance dependence, and antisocial personality disorder, as well as parental suicide attempt or suicide death. Although the instrument measures more than these five areas of psychopathology, they were selected due to indications from previous research that they were the main factors associated with offspring suicidal behavior. Since this data was collected as part of the larger SASH study, it was important to focus on areas that were thought to be important in order to minimize the length of the interview while collecting all the required information.

This instrument has been found to have relatively good sensitivity, although there is a risk of underreporting of familial psychopathology [32]. However it is useful in community surveys where a family study method would be very difficult to implement, including in situations where some family members are deceased.

Data analysis

In order to account for the stratified multi-stage sample design, the data were weighted to adjust for differential probability of selection within households as a function of household size and clustering of the data, and for differential non-response. A post-stratification weight was also used to make the sample distribution comparable to the population distribution in the 2001 South African Census for age, sex, and province.

The prevalence of parental psychopathology among respondents with each of the four suicidal outcomes was estimated using cross-tabulations. Predictive associations between parental psychopathology and subsequent suicidal behaviors were estimated using discrete-time survival models with person-year as the unit of analysis [34]. Survival coefficients were exponentiated to generate odds-ratios (ORs) and their standard errors for ease of interpretation.

The associations between parental psychopathology and suicidal behavior were estimated in a series of survival models that were bivariate (in which each type of parental psychopathology was considered individually) as well as multivariate (in which all parental disorders were considered simultaneously) in predicting each suicidal behavior. Further models testing whether a greater number of parental disorders are associated with an increased risk of each suicidal behavior were estimated. All models controlled for age, gender, marital status and education of the respondents.

In all analyses, standard errors of prevalence estimates and survival coefficients were estimated with the Taylor series method [35] using SUDAAN software [36] to adjust for the weighting and clustering of the SASH sample design. Multivariate significance was evaluated with Wald χ^2 tests based on design-corrected coefficient variance–covariance matrices. All significance tests were evaluated using .05 level two-sided tests.

Results

The demographic characteristics of this sample have been described previously [37] but briefly, the sample was largely female (58.6%) and Black (79.7%), although other racial groups are represented (10.4% Colored; 7.2% White; 2.7% Indian/Asian). Further, one-half was married, while most were unemployed (69.2%), had less than 12 years of education (62.7%), and lived in urban areas (59.7%).

Out of the 4315 participants, 1.5% (n = 65) reported parental major depressive disorder, while 6.4% (n = 275) reported parental panic disorder, 1.4% (n = 62) parental generalized anxiety disorder, 3.8% (n = 162) parental substance use disorder, and 3.4% (n = 148) parental antisocial personality disorder. Parental suicide was reported by 1.6% (n = 71) of the participants.

As shown in Table 1, the lifetime prevalence rates of suicidal ideation (n = 394), suicide plans (n = 171) and suicide attempts (n = 140) were 9.1% (SE 0.7), 3.8% (SE 0.4) and 2.9% (SE 0.3) respectively.

In this study, 21% of participants with suicidal ideation reported parental psychopathology, compared to 12.2% of those without suicidal ideation. Over 26% of those who attempted suicide also reported at least one parental mental disorder, compared to 12.5% of those without suicide attempts. Among those with suicidal ideation, 23.7% of those who proceeded to develop a suicide plan reported at least one parental mental disorder while those who did not have a plan reported 26.1% parental psychopathology.

Table 1 shows these prevalence rates aggregated by type and number of parental disorders. Respondents with suicidal behavior reported higher rates of all the tested types of parental psychopathology except major depression.

Preliminary bivariate survival models were estimated for the association of each parental disorder with suicidal behavior in the respondent. The models tested the effect of parental psychopathology in either parent alone and in both parents. Among all the factors tested, only suicide in a parent of the same sex as the respondent predicted respondent suicidal ideation. As a result, all subsequent analyses tested the effects of psychopathology in either parent, except in the case of parental suicide where only suicide of a parent of the same sex as the respondent was considered.

As shown in Table 2, bivariate survival models demonstrated that parental panic disorder (OR = 2.5), substance abuse (OR = 2.1) and antisocial personality disorder (OR = 2.3) were associated with suicide attempts in respondents. In those with suicidal ideation, no type of parental psychopathology was associated with offspring suicide plans or attempts.

When a multivariate model was estimated in which each form of parental psychopathology was entered simultaneously, parental generalized anxiety disorder (OR = 2.4) and suicide (OR = 2.7) remained significantly associated with suicidal ideation among respondents, whereas parental panic disorder (OR = 2.5) was associated with respondent suicide attempts. As illustrated in Table 3, among those with suicidal ideation, parental panic disorder (OR = 2.5, 95% CI 1.2-5.2) was significantly associated with having suicide plans, but no form of parental psychopathology was significantly associated with suicide attempts among ideators.

The association between the number of parental disorders and respondent suicidal behavior was estimated using a multivariate model in which only substantive predictors were used as dummy variables for the number of parental disorders. Due to the fact that very few respondents had parents with more than two disorders, only two categories were created for number of disorders, those with one disorder, and those with two or more disorders.

Compared to those with no parental disorders, respondents reporting one parental disorder had more than double the odds of suicidal ideation (OR = 2.4), and those with two or more parental disorders had nearly a three-fold increase in the odds of ideation (OR = 2.8). For suicide attempts, the magnitude of the association was similar between those with one parental disorder (OR = 1.9) compared to those without, and those with two or more parental disorders (OR = 1.9). Among those with suicidal ideation, there was no association between number of parental disorders and respondent suicide plans or attempts. This is summarized in Table 4.

In a final multivariate model including both type and number of parental disorders, parental panic disorder continued to predict respondent suicidal ideation

Table 1 Prevalence of parental psychopathology among suicidality outcomes

Parental disorder (n)		In the total sample				Among those with suicidal Ideation			
		%[1](SE) with parent disorder among:		%[1](SE) with parent disorder among:		%[1](SE) with parent disorder among:		%[1](SE) with parent disorder among:	
		Attempt	No attempt	Ideation	No ideation	Plan	No plan	Attempt	No attempt
Depression (65)		0.9 (0.7)	1.5 (0.3)	1.6 (0.7)	1.5 (0.3)	1.0 (0.6)	2.7 (1.3)	0.9 (0.7)	2.5 (1.2)
Panic (275)		14.2 (3.9)	6.1 (0.8)	9.1 (1.7)	6.0 (0.8)	14.5 (3.4)	6.5 (1.8)	14.2 (3.9)	6.6 (1.7)
GAD (62)		2.3 (1.3)	1.4 (0.3)	3.0 (0.9)	1.3 (0.3)	3.1 (1.6)	3.4 (1.8)	2.3 (1.3)	2.2 (1.1)
Substance abuse (162)		8.0 (2.2)	3.6 (0.4)	5.7 (1.1)	3.5 (0.4)	5.0 (1.7)	7.4 (2.4)	8.0 (2.2)	5.6 (1.8)
Anti-social personality disorder (148)		7.6 (2.1)	3.3 (0.4)	5.4 (1.1)	3.2 (0.4)	6.5 (1.4)	7.7 (3.0)	7.6 (2.1)	6.4 (2.4)
Suicide (Same-sex parent) (71)		3.0 (1.8)	1.6 (0.3)	4.2 (1.1)	1.4 (0.3)	2.5 (1.6)	7.3 (3.8)	3.0 (1.8)	7.1 (3.8)
Number of parental disorders	1	18.4 (3.4)	9.3 (0.7)	15.5 (2.0)	9.1 (0.7)	17.1 (3.5)	19.8 (5.2)	18.4 (3.4)	17.2 (4.9)
	2+	8.1 (2.6)	3.2 (0.4)	5.5 (1.1)	3.1 (0.4)	6.6 (1.7)	6.3 (2.2)	8.1 (2.6)	5.1 (1.6)
(N[2].%)		(140, 2.9%)	(4175, 97.1%)	(394, 9.1%)	(3921, 90.9%)	(171, 43.4%)	(223, 56.6%)	(140, 35.5%)	(254, 64.5%)

[1]Percentage (%) represents the percentage of people with the parent disorder among the cases with the outcome variable indicated in the column header. Prevalence estimates are from personyear data. For example: the first cell shows that 0.9% of those who attempted suicide had at least one parent with MDE.
[2]*N* represents the number of cases with the outcome variable, followed by the applicable percentage.

(OR = 2.5), whereas parental panic disorder (OR = 1.6), generalized anxiety disorder (OR = 2.8) and suicide (OR = 3.0) predicted respondent suicide attempts. As shown in Table 5, however, in those with suicidal ideation there was no statistically significant association between any parental disorder and suicide plan or attempt.

Parental major depressive disorder, generalized anxiety disorder and suicide were associated with younger age of onset of suicide attempts, as shown in Table 6. A similar though weaker effect was found in the association between offspring suicidal ideation and parental depression, GAD, antisocial personality disorder and suicide. Parental panic disorder was associated with later age of onset of both suicide attempts and ideation in the offspring. Among respondents with suicidal ideation, parental depression was associated with earlier age of onset of suicide plans.

Discussion

In this study, a significant proportion of respondents with suicidal ideation reported parental psychopathology. Over a fifth of respondents with suicidal ideation reported at least one parent having a mental illness, with over a quarter of those who attempted suicide reporting parental psychopathology. In a final multivariate model parental panic disorder was significantly associated with respondent suicidal ideation, whereas parental panic disorder, generalized anxiety disorder and suicide maintained a significant association with suicide attempts. Among those with suicidal ideation, none of the tested types of parental psychopathology was associated with suicidal ideation or attempts. There was a pattern consistent with a dose–response relationship between the number of parental disorders and suicidal ideation.

The findings from previous studies, largely in non-African settings, showing that the risk of suicidal ideation is related to parental history of mental illness therefore appear to hold in this study as well [8-10,14]. This is further supported by the finding of a dose–response relationship between parental disorders and suicidal ideation in this study.

Parental psychiatric morbidity is thought to increase risk of suicidal behavior in the offspring through several

Table 2 Bivariate associations between parental psychopathology and respondent lifetime suicidal behavior[1]

	In the total sample		Among those with suicidal ideation	
	Ideation	Attempts	Plans	Attempts
	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)
Depression	1.0 (0.5-2.2)	0.6 (0.1-2.4)	0.3 (0.0-1.7)	1.0 (0.1-8.1)
Panic	**1.6* (1.1-2.3)***	**2.5* (1.4-4.6)***	2.0 (0.9-4.2)	1.6 (0.7-3.9)
GAD	**2.4* (1.4-4.0)***	1.8 (0.5-6.1)	1.1 (0.2-5.8)	1.2 (0.3-4.6)
Substance abuse	**1.6* (1.0-2.4)***	**2.1* (1.1-4.1)***	0.5 (0.2-1.5)	2.1 (0.8-5.5)
Anti-social personality disorder	**1.6* (1.1-2.4)***	**2.3* (1.2-4.3)***	0.8 (0.3-1.9)	1.0 (0.3-3.3)
Suicide (same-sex parent)	**3.0* (1.7-5.5)***	1.9 (0.5-6.5)	0.4 (0.1-1.7)	0.4 (0.0-8.1)

*Significant at the .05 level, two-sided test.
[1]Each row represents a bivariate model. Models control for person-year (1–5 intervals) and demographic factors (age, sex, education level, and marital status).

Table 3 Multivariate associations between parental psychopathology and respondent lifetime suicidal behavior[1]

	In the total sample		Among those with suicidal ideation	
	Ideation	Attempts	Plans	Attempts
	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)
Depression	0.4 (0.1-1.2)	0.2 (0.0-1.1)	0.2 (0.0-2.1)	0.6 (0.0-10.5)
Panic	1.5 (1.0-2.2)	**2.5* (1.3-4.7)***	**2.5* (1.2-5.2)***	1.5 (0.6-4.1)
GAD	**2.4* (1.2-4.8)***	1.5 (0.4-6.3)	2.0 (0.4-10.5)	0.8 (0.2-4.1)
Substance abuse	1.3 (0.8-2.1)	1.6 (0.8-3.4)	0.5 (0.1-1.6)	2.1 (0.7-6.9)
Anti-Social personality disorder	1.3 (0.9-2.1)	1.8 (0.9-3.8)	1.0 (0.3-3.1)	0.7 (0.2-2.5)
Suicide (Same-sex parent)	**2.7* (1.5-4.9)***	1.5 (0.4-5.0)	0.4 (0.1-1.7)	0.4 (0.0-7.6)

*Significant at the .05 level, two-sided test.
[1]Models control for person-year (1–5 intervals) and demographic factors (age, sex, education level, and marital status).

mechanisms, including the transmission of genetic factors associated with increased levels of distress or dysfunction [38,39], the early environmental stressors that may result from high levels of parental psychopathology [40,41], or a combination of the two [42,43].

Parental panic disorder appears to fit well in this model due to the probability of genetic transmission and the environmental stressors associated with the lifestyle changes instituted by a parent with this disorder. It has for instance been demonstrated that people with panic disorder have significantly increased risk of suicidal behavior [44], and this may be among some of the environmental stressors exerted upon their offspring. Further, Oladeji and Gureje [23] argue that "parental impulsivity and aggressive behavior as is likely to occur in the context of parental panic disorder or substance abuse may predispose to family instability, abuse, and reduced parental care".

Our findings are to a certain extent similar to those in Oladeji and Gureje's work in Nigeria [23] which demonstrated an association between parental panic disorder and both suicidal ideation and attempts among offspring. However, our study further found a dose–response relationship with the risk of offspring suicidal behavior increasing with the number of parental mental disorders, a finding that was absent in the Nigerian study perhaps due to the small number of respondents with more than one disorder. Further, unlike the Nigerian study, we found no association between parental substance abuse and offspring suicidal behavior.

Our findings differ in significant ways from those based on the cross-national WMH survey sample, which found that all the tested disorders were significantly associated with respondent suicidal ideation and attempts [18]. For instance, the role of parental depression in increasing the risk of suicidal behavior in the offspring was not replicated in our study. This may be explained in part by the relatively low prevalence of parental depression in our sample compared to the WMHS sample, as well as our lower overall sample size that may have contributed to lower statistical power.

Findings from the cross-national WMHS [18] also suggested that parental depression plays a role in the emergence of suicidal ideation, and that once this emerged, suicide attempts would be mediated by factors including parental antisocial personality and anxiety disorders. The finding in the present study that none of the parental disorders predicts suicidal behavior among those with suicidal ideation suggests that other factors, including potential protective factors, may be relevant in this population. Further research is necessary to uncover these factors and their mechanisms in order to inform relevant interventions.

Among all the types of parental psychopathology examined in this study, only suicide in a parent of the same sex as the respondent predicted respondent suicidal behavior by increasing the risk of offspring suicidal ideation. Previous work has suggested that maternal mental illness and suicide has a greater impact on offspring suicide, and the elevated risk associated with parental psychiatric history

Table 4 Multivariate associations between number of parental disorders and respondent suicidal behavior[1]

	In the total sample		Among those with suicidal ideation	
	Ideation	Attempts	Plans	Attempts
Number of parental disorders	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)
1	**2.4* (1.5-3.8)***	**1.9* (1.4-2.6)***	0.9 (0.4-2.0)	1.1 (0.4-3.0)
2+	**2.8* (1.3-5.8)***	**1.9* (1.3-2.8)***	1.0 (0.4-2.5)	2.0 (0.8-4.8)

*Significant at the .05 level, two-sided test.
[1] Models control for person-years (1–5 intervals) and demographic factors (age, sex, education level, and marital status).

Table 5 Multivariate model of the associations between type and number of parental disorders and Respondent suicidal behavior[1]

	In the total sample		Among those with suicidal ideation	
	Ideation	Attempts	Plans	Attempts
	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)
Depression	0.2*(0.0-1.2)	0.4 (0.1-1.5)	0.1 (0.0-1.3)	0.6 (0.0-9.8)
Panic	**2.5 (1.4-4.7)***	**1.6 (1.1-2.4)***	2.1 (0.9-5.1)	1.4 (0.5-4.1)
GAD	1.5 (0.4-6.1)	**2.8 (1.2-6.3)***	1.1 (0.1-13.3)	0.7 (0.1-4.7)
Substance abuse	1.7 (0.5-5.0)	1.5 (0.8-2.7)	0.2 (0.0-2.2)	1.7 (0.4-6.7)
Anti-social personality disorder	1.8 (0.9-3.8)	1.5 (0.9-2.6)	0.8 (0.2-3.0)	0.6 (0.2-2.6)
Suicide (Same-sex parent)	1.5 (0.4-5.0)	**3.0 (1.6-5.7)***	0.4 (0.1-1.4)	0.3 (0.0-7.0)
Number of parental disorders				
2 or more parental disorders	1.0 (0.2-4.2)	0.6 (0.3-1.5)	3.6 (0.2-53.2)	1.6 (0.2-10.4)

*Significant at the .05 level, two-sided test.
[1]Models control for person-year (1–5 intervals) and demographic factors (age, sex, education level, and marital status).

Table 6 Interactions between life course and controls[1]

		In the total sample		Among those with suicidal ideation	
		LT attempts	Ideators	LT plans	LT attempts
Parental disorder	Respondent age[2]	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)
Depression	13-19	**0.0* (0.0-0.0)***	**0.1* (0.0-0.3)***	**0.0* (0.0-0.0)***	—
	20-29	**0.0* (0.0-0.0)***	**0.0* (0.0-0.4)***	**0.0* (0.0-0.0)***	—
	30+	0.3 (0.0-3.1)	0.4 (0.0-6.2)	5.1 (0.0-542.1)	—
Panic	13-19	3.0 (0.5-16.4)	**3.3* (1.2-8.7)***	0.1 (0.0-1.7)	0.1 (0.0-10.8)
	20-29	**6.4* (1.5-27.5)***	2.1 (0.7-6.3)	0.2 (0.0-1.5)	1.0 (0.1-14.8)
	30+	3.8 (0.8-18.4)	2.4 (0.9-6.3)	—	—
GAD	13-19	0.8 (0.1-9.9)	0.2 (0.0-1.4)	0.1 (0.0-22.2)	7.5 (0.0-1395209)
	20-29	**0.0* (0.0-0.0)***	**0.2* (0.0-0.9)***	0.0 (0.0-15.0)	0.2 (0.0-3.3)
	30+	**0.0* (0.0-0.0)***	0.6 (0.1-3.7)	—	—
Substance abuse	13-19	0.4 (0.0-10.0)	1.3 (0.3-5.1)	6.2 (0.0-12221.8)	0.9 (0.0-164695.1)
	20-29	2.6 (0.3-25.9)	0.9 (0.2-3.9)	6.8 (0.0-24235.2)	28.3 (0.0-6400573)
	30+	0.4 (0.0-12.1)	0.3 (0.1-1.8)	—	—
Antisocial personality disorder	13-19	0.9 (0.1-10.8)	**0.1* (0.0-0.8)***	—	—
	20-29	1.5 (0.1-20.1)	0.2 (0.0-1.1)	—	—
	30+	0.2 (0.0-5.4)	**0.1* (0.0-0.6)***	—	—
Suicide (Same-sex parent)	13-19	0.1 (0.0-13.2)	0.2 (0.0-1.9)	**0.0* (0.0-0.0)***	—
	20-29	0.6 (0.1-6.7)	0.3 (0.0-3.0)	**0.0* (0.0-0.0)***	—
	30+	**0.0* (0.0-0.0)***	**0.0* (0.0-0.0)***	**0.0* (0.0-0.0)***	—
Number of parental disorders					
2+	13-19	12.4 (0.2-781.5)	**17.3* (1.5-204.3)***	6.5 (0.0-961.2)	—
	20-29	2.2 (0.1-84.7)	**29.0* (2.6-319.9)***	2.4 (0.0-3009.8)	0.5 (0.0-267651.6)
	30+	13.7 (0.2-1031.3)	2.5 (0.1-104.3)	—	—

*Significant at the .05 level, two-sided test.
[1]Models control for person-years and demographic factors, as well as the significant interaction terms between person-years and demographic factors.
[2]Respondent's age at onset of suicide event.

was greater in females than in males [22,45]. A recent systematic review and meta-analysis similarly found maternal suicidal behavior to be a more potent risk factor than paternal, and children to be more vulnerable than adolescents and adults [46]. The study however reported no evidence of a stronger association in either male or female offspring.

In contrast with our findings on parental suicide increasing the risk of suicidal behavior in the same-sex offspring, Jeon and colleagues [47] reported that childhood parental death is significantly associated with lifetime suicide attempt in the opposite-sex offspring, especially when exposure occurs before age 10. This finding needs to be further investigated especially in view of the different cultural settings in these two studies.

Our study has several significant limitations that may affect the interpretation of the results. First, errors related to forgetting and recall bias may have been introduced into the results due to the retrospective self-report nature of the instruments used [48]. However, systematic reviews have demonstrated that the level of accuracy in these types of study design is often sufficient to provide useful information [49].

Second, just as in the WMH surveys, this study did not attempt to examine the full range of parental mental disorders, or even of respondent suicidal behaviors that could have been assessed. This limits the findings of this study to the variables that were examined, and it is impossible to demonstrate the effect, if any, of including the other mental disorders and behaviors.

Third, the number of parental disorders in some cases such as depression, generalized anxiety disorder and suicides were relatively low, limiting the ability of this study to provide accurate findings on the association between these disorders and respondent suicidal behavior. A possible reason for this may be the fact that adult offspring were being interviewed about parental psychopathology that may have occurred many years in the past, resulting in under-reporting.

Fourth, it is possible that this study underestimates the associations between the various parental disorders and respondent suicidal behavior because the design did not account for chronicity of the parental disorders. This would suggest that even though many of the findings in this study did not reach statistical significance, they could still be a useful indicator of the magnitude and direction of associations between parental psychopathology and suicidal behavior in their offspring.

Finally, it could be argued that the sample was not sufficiently representative of the South African general population due to the exclusion of those in institutions such as prisons, hospitals, mental hospitals and military barracks. However, due to the weighting of the data and the relatively small proportion of the general population in institutions, we believe that our results adequately reflect the situation in the general population.

Conclusions

Despite its limitations, this study provides some of the first data from Africa on the relationship between parental psychopathology and suicidal ideation. Significantly, our findings that parental psychopathology is associated with increased risk of suicidal ideation and attempts in offspring warrants further research in this area in order to confirm these findings and possibly elucidate the possible mechanisms.

Competing interests

The authors declare no competing interests.

Authors' contributions

LA was involved in the data analysis and drafted the manuscript. MKN was involved in the study design and data collection and analysis. DRW was involved in the study design and data collection and analysis. DJS was involved study design, data collection and analysis and helped in the preparation of the draft manuscript. All authors read and approved the final version of the manuscript.

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