OFFICE OF THE AUDITOR-GENERAL

Enhancing Accountability

PERFORMANCE AUDIT REPORT ON

PROVISION OF MENTAL HEALTHCARE SERVICES IN KENYA

DECEMBER 2017

Vision

Effective accountability in the management of public resources and service delivery.

Mission

Audit and report to stakeholders on the fairness, effectiveness and lawfulness in the management of public resources for the benefit of the Kenyan People.

Core Values

Independence

Integrity

Professionalism

Innovation

Team Spirit

Motto

Enhancing Accountability

Foreword by the Auditor-General

I am pleased to publish and publicize this performance audit report which assessed the provision of mental healthcare services in Kenya. My Office carried out the audit under the mandate conferred to me by the Public Audit Act, 2015 Section 36. The Act mandates the Office of the Auditor – General to examine the Economy, Efficiency and Effectiveness with which public money has been expended pursuant to Article 229 of the Constitution.

Performance, financial and continuous audits form the three pillar audit assurance framework that I have established to give focus to the varied and wide scope of the audit work done by my Office. The framework is intended to provide a high level of assurance to stakeholders that public resources are not only correctly disbursed, recorded and accounted for, but that there is positive impacts on the lives of all Kenyans through effective use of public resources.

This audit report on mental health management is important in ensuring that Kenyans are in complete state of well-being. A healthy population will be able to realize their potential, cope with the normal stresses of life, work productively and make active contribution to the community. Our performance audits examine not just compliance with policies, obligations, laws, regulations and standards, but also whether the resources are managed in a sustainable manner.

The report shall be tabled in Parliament in accordance with Article 229 (7) of the Constitution. I have, as required in Section 39 (1) of the Public Audit Act, submitted the original copy of the report to Parliament. In addition, I have remitted copies of the report to the Cabinet Secretaries for the Ministry of Health and Ministry of Finance and to the Principal Secretaries for health and for the National Treasury.

FCPA Edward R.O. Ouko, CBS
AUDITOR – GENERAL

27 December 2017

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LIST OF ABBREVIATIONS

FIF	-	Facility Improvement Fund
GoK	-	Government of Kenya
KNH	-	Kenyatta National Hospital
KHSSP	-	Kenya Health Sector Strategic Plan
MNT&RH	-	Mathari National Teaching and Referral Hospital
MoH	-	Ministry of Health
MSU	-	Maximum Security Unit
MTRH	-	Moi Teaching and Referral Hospital
NHIF	-	National Hospital Insurance Fund
OAG	-	Office of the Auditor-General

GLOSSARY OF TERMS

The Main Classes of Mental illnesses are[1]:

Neurodevelopmental disorders: Covers a wide range of problems that usually begin in infancy or childhood, often before the child begins grade school. Examples include autism spectrum disorder, attention deficit/hyperactivity disorder and learning disorders.

Schizophrenia spectrum and other psychotic disorders: Psychotic disorders cause detachment from reality such as delusions, hallucinations, and disorganized thinking and speech. The most notable example is schizophrenia, although other classes of disorders can be associated with detachment from reality at times.

Bipolar and related disorders: Includes disorders with alternating episodes of mania periods of excessive activity, energy and excitement and depression.

Depressive disorders: Include disorders that affect how you feel emotionally, such as the level of sadness and happiness, and they can disrupt your ability to function. Examples include major depressive disorder and premenstrual dysphoric disorder.

Anxiety disorders: Anxiety is an emotion characterized by the anticipation of future danger or misfortune, along with excessive worrying. It can include behavior aimed at avoiding situations that cause anxiety. This class includes generalized anxiety disorder, panic disorder and phobias.

Obsessive compulsive and related disorders: These disorders involve preoccupations or obsessions and repetitive thoughts and actions. Examples include obsessive compulsive disorder, hoarding disorder and hair pulling disorder

Feeding and eating disorders: Include disturbances related to eating, such as anorexia, nervosa and binge eating disorder.

Dissociative disorders: These are disorders in which your sense of self is disrupted, such as with dissociative identity disorder and dissociative amnesia.

Substance related and addictive disorders: Include problems associated with the excessive use of alcohol, caffeine, tobacco and drugs as well as gambling disorder.

Personality disorders: A personality disorder involves a lasting pattern of emotional instability and unhealthy behavior that causes problems in your life and relationships. Examples include borderline, antisocial and narcissistic personality disorders.

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[1] http://www.mayoclinic.org/diseasesconditions/mentalillness/basics/testsdiagnosis/

EXECUTIVE SUMMARY

Background of the audit

1. The World Health Organization's (WHO) Constitution of 1948 define health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Kenya Mental Health Policy 2015 - 2030 defines mental health as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. Mental healthcare service delivery in Kenya is managed by both the National and County governments.

2. The Kenya National Commission on Human Rights report on Mental Health System in Kenya, November, 2011 estimated that up to 25% of out-patients and up to 40% of in-patients in health facilities in Kenya suffer from some form of mental health condition. WHO estimates that 60% of people attending primary care clinics have diagnosable mental disorder (WHO: 2008).

3. The Kenya Mental Health Policy 2015-2030 indicates that mental disorders are important risk factors for other diseases, as well as unintentional and intentional injury. Mental disorders also increase the risk of getting ill from other diseases such as HIV, cardiovascular disease, diabetes, and vice-versa. The policy also indicates that mental disorders have an impact on individuals, families, communities and nations and often lead individuals and families into poverty.

4. In addition, provision of healthcare services was devolved to the county governments in 2010 and effected in 2013 and it would be important to establish how the counties are providing mental healthcare services and why Mathari Hospital continues to receive a high number of first time patients for assessment of mental illnesses as opposed to referrals from county hospitals.

5. It is for these reasons that the Auditor-General considered it important to conduct a performance audit on provision of mental healthcare services in Kenya.

Objectives and Scope of the Audit

6. The audit examined whether the Ministry of Health and County Governments have put in place measures that are effective for

provision of mental healthcare services. Specifically, it established whether standards and guidelines have been put in place to guide provision of mental healthcare services in the country and assessed the extent to which the set standards and guidelines are being used to effectively deliver mental healthcare services at the national referral hospital; and at the county psychiatric units. Further, the audit examined the operations of Mathari Hospital, and all the 19 Mental Health (Psychiatric) Units for a period of 5 financial years covering 2011/2012 to 2015/2016.

Methods Used in Gathering Audit Evidence

7. We conducted the audit in accordance with the International Standards of Supreme Audit Institutions (ISSAI) issued by the International Organization of Supreme Audit Institutions (INTOSAI) as well as relevant SAI standards and guidelines applicable to performance auditing. We gathered audit evidence through document review, interview and physical verification

Assessment Criteria

8. The audit assessed the provision of mental healthcare services against criteria drawn from the statutory mandate and strategic goals. We also referred to recommended practices on management of mental healthcare from the UN Resolution on Protection of Persons with Mental illness which Kenya has committed to abide to.

Summary of Our Findings

9. The Ministry of Health has put some effort in managing provision of mental healthcare services in the country by passing the Kenya Mental Health Policy 2015-2030 in May 2016 and has also embarked on updating the mental health legislation by drafting the Mental Health Bill 2016. However, delivery of mental health services is still facing the following challenges;

Lack of full implementation and updates on the Mental Health Act,1989.

10. The Ministry of Health is responsible for provision of appropriate legislation, health policy and standards management. However, information gathered during the audit indicate that management of mental healthcare services is still inadequate due to lack of full implementation of the provisions of the Mental Health Act 1989 and lack of updates on the Act to incorporate the provisions of the Constitution of Kenya 2010.

11. The Mental Health Act provides procedures for admission, treatment and care of persons with mental illnesses among other provisions. There still lacks County Mental Health Councils whose functions include; to coordinate mental healthcare activities in the counties; to inspect mental hospitals to ensure that they meet the prescribed standards; to initiate and organize community or family based programmes for the care of persons suffering from mental disorder. The rights to be accorded to the mental health patients have also not been incorporated in the legislation.

The Health Sector Referral System Is Not Well Functioning in the Provision of Mental Healthcare Services

12. As at December 2014, there were 3,956 government-owned health facilities which provide general health services in the Country. Besides Mathari national referral hospital, mental healthcare services are only available at 29 of the 284 hospitals in Level 4 and above of the referral chain. This represents just 10% of the total facilities in Level 4 and above and 0.7% of the 3,956 government-owned health facilities. This indicates that patients seeking services at all health facilities in levels 1 to 3, and in 255 facilities that are in level 4 and above of the referral chain have no access to mental healthcare services. Additionally, all mentally ill law offenders who require in-patient services can only be admitted in Mathari Hospital regardless of severity of their condition.

Inadequate Management of Mental Healthcare Services at the National Referral Hospital

13. National referral hospitals provide specialized healthcare services and should operate with a defined level of autonomy. However, Mathari hospital which is the only hospital in the country offering specialised psychiatric services and training operates under a department in the Ministry of health. The hospital has a big workload in line with its mandate but has not been effective in provision on mental healthcare services.

14. Available information indicates that for the three financial years, 2013/14, 2014/15 and 2015/16 the hospital was provided only about 30% of the funds allocated under the recurrent expenditure and nothing under the development expenditure. Additionally, the hospital does not receive any cost sharing funding for the patients under the Maximum Security Unit, yet these patients represent about 35% of all the inpatients in the hospital. The hospital also does not receive any funding for the students they train from the public universities and colleges.

15. As a result, delivery of services at the hospital is affected by lack of critical equipment such as Computerized Tomography (CT) Scan and Magnetic

Resonance Imaging (MRI) machines which are needed for proper diagnosis. The wards were also insufficient and the hospital has an average bed occupancy rate of 115%. Further, the hospital experiences stock out on critical drugs and does not have adequate skilled and qualified personnel to handle the patients. The effect is that patients receive poor services, sometimes the diagnosis is delayed and the condition could become worse. The patients and their families then continue suffering since these patients are totally dependent.

Inadequate Management of mental Healthcare Services at the Psychiatric Units

16. The country has a total of 47 counties yet the psychiatric units are only available in 25 counties indicating that 22 of the counties do not have mental health care facilities. The patients in the 22 counties that do not have mental health care facilities have to bear the cost of seeking services in the nearest county that has a psychiatric unit and the cost may be high for the patients and relatives.

17. Mental healthcare service delivery at the counties that have psychiatric units have also not been adequately managed. 15 out of 19 psychiatric units visited lacked all the basic equipment while 4 units had at least one machine with only 2 units having functional Electroconvulsive Therapy (ECT) machines. 4 psychiatric units only provided outpatient services while in the 15 units that had psychiatric wards, the average number of beds was 23 against an average number of 28 patients leading to sharing of hospital beds. Additionally, 11 units lacked critical drugs while most units were short of the different professionals that offer mental healthcare services for example the ratio of psychiatric nurses to patients in 7 of 12 units that provided data on inpatients indicated that the ratio is below WHO recommended ratio of 1 psychiatric nurse to 6 patients.

Lack of rehabilitation facilities and outreach programmes

18. The World Health Organization optimal mix of services show that the majority of mental health care can be self-managed or managed by community mental health services and where additional expertise and support is needed a more formalized network of services is required which include primary care services, followed by specialist community mental health services and psychiatric services based in general hospitals and lastly by specialist and long stay mental health services.

19. Community mental health services such as rehabilitation services and half way homes would help in discharging patients from psychiatric hospitals thus easing the scarce and expensive hospital beds. The audit revealed that

in many rural areas there is a chronic gap between the need for and availability of mental healthcare services.

20. Of the 16 hospitals with in-patient services, heads of 14 hospitals stated that they lack rehabilitation centres to be used by the recuperating patients and patients recovering from drug abuse while only Mathari Hospital and MTRH had alcohol and drug abuse rehabilitation centres. Lack of rehabilitation and outreach programs can be attributed to the fact that, in managing of mental healthcare services in Kenya, the national and county governments seem to be focusing more on hospital admissions and specialists' services as opposed to self and community care services.

Conclusions

21. The Ministry of Health has not effectively delivered on its mandate of provision of Health Policy and Standards Management and the referral system in place is not effective for provision of mental healthcare services.

22. Mathari Hospital lacks sufficient resources to acquire and maintain the equipment, physical facilities, drugs and qualified personnel needed to deliver services efficiently. At the counties, mental healthcare service is characterised by lack of mental health budget, inadequate facilities, insufficient medical drugs and shortage of qualified personnel needed for efficient mental healthcare service delivery.

23. There has also not been adequate awareness campaigns to enlighten the public on mental illnesses thus patients with mental illnesses are stigmatized and criminalised. The country lacks government regulated rehabilitation centres and homes for patients recovering from mental illnesses and which are meant to help them gain skills and behavioural changes with the aim of regaining their functionality, productivity as well as preventing disability.

Recommendation

24. The Ministry should ensure the Mental Health Bill 2014 is finalised for enactment so as to incorporate the County Governments, the rights to be accorded to the patients with mental illnesses, as well as incorporating the County Mental Health councils. In addition, the Ministry should effectively communicate the already developed standards and guidelines to enhance efficient mental healthcare service delivery.

25. The Ministry together with the County Governments should endeavour to integrate mental healthcare services at all levels of healthcare facilities so that all citizens can easily access these services. Consequently, the Ministry

should strengthen mental healthcare linkages to ensure that only referred patients are admitted at Mathari Hospital.

26. For effective delivery of specialised mental health care services at the Mathari referral hospital;
    i. The Ministry should consider making Mathari Hospital a semi-autonomous Government Agency as expected of a national referral hospital. This will enhance its capacity to mobilise resources and to deliver services in line with the hospitals mandate.

    ii. The hospital management through the Ministry of Health should liaise with the Ministry of Interior, Coordination of National Government - Department of Correctional Services on how to cater for the patients in the Maximum Security Units wards to avoid overstretching the available resources at the hospital.

    iii. The management of the hospital through the Ministry's legal department should enact a policy on initiating binding Memoranda of Association with the various public and private institutions that train their students at the hospital. This will ensure that the resources for training and the training facilities are appropriately provided without overstretching the resources for other services.

    iv. The financing for and consumption of forensic services should be debated on and agreed by the Criminal Justice System. The various government ministries should cooperate on the delivery of forensic services in the country and there is need for an agreement on who does what with regards to these services.

    v. In integrating general health services at Mathari hospital, the Ministry should consider investing in this services so as not to negatively affect delivery of mental health care services. The Ministry also needs to re-consider the level of general services that should be provided at the referral hospital to ensure the hospital retains its status and only offers services at its level as opposed to walk in services.

27. To support and improve mental healthcare service delivery throughout the country, the Ministry and all the County Governments should prioritize provision of mental healthcare services, to ensure that there are adequate relevant qualified personnel and provision of critical medical equipment and drugs.

28. To destigmatize, decriminalize and reach all the patients with mental illnesses, the Ministry in conjunction with County Governments should;

    i. Ensure that substance use related and addictive disorders are managed in hospitals thus the healthcare facilities should make available bed capacity for patients with these disorders.

    ii. Carry out public awareness campaigns and outreach programmes to sensitize and inform the public about mental illnesses.

    iii. Establish some aftercare rehabilitation and social support services to be provided in the Community e.g. halfway homes to be regulated by MoH & Social Services. This would help the recovering patients gain skills and behavioural changes with the aim of regaining their functionality, productivity as well as preventing disability.

29. The complete set of measures that the Auditor-General has recommended to Ministry of Health and County Governments on provision of mental healthcare services in Kenya are outlined in Chapter 6 of this report.

1.0 BACKGROUND TO THE AUDIT

Introduction

1.1 The World Health Organization's (WHO) Constitution of 1948 define health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Kenya Mental Health Policy 2015 - 2030 defines mental health as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

1.2 Mental illnesses refer to disorders generally categorized by impairment of mood, thought and or behaviour. The Diagnostic & Statistical Manual of Mental Disorders (DSM-5), lists the types of mental illnesses as Neurodevelopment disorders, Schizophrenia Spectrum & other Psychotic disorders, Bipolar & related disorders, Depressive disorders, Anxiety disorders, Obsessive-Compulsive & related disorders, Feeding & Eating disorders, Dissociative disorders, Substance related & addictive disorders, and Personality disorders.

1.3 Hospitals use medication paired with psychotherapy as the most effective way to promote recovery from mental illness. Psychotherapy involves counselling of patients through talking about the patient's problems with a trained counsellor or psychotherapist. It further helps a patient understand what may have caused the mental problem, how to manage and deal with it and overcome issues that are causing emotional pain or discomfort.

1.4 Mental healthcare service delivery in Kenya is managed by both the National and County governments. At National level, the Ministry of Health deliver services through Mathari National Teaching and Referral Hospital[2] which is a national Referral hospital for Mental health and a Unit within Moi Teaching and Referral Hospital (MTRH) which is a general referral hospital.

1.5 At the counties, the services are offered through 18 psychiatric units that operate within some level 4 or 5 hospitals. The 18 units and their respective counties are in **Appendix 1** of this report.

[2] Hereby referred to as Mathari Hospital in this report.

Motivation for the Audit

1.6 The following factors motivated the Office to carry out the audit: -

i) The Kenya National Commission on Human Rights report on Mental Health System in Kenya, November, 2011, estimated that up to 25% of out-patients and up to 40% of in-patients in health facilities in Kenya suffer from some form of mental health condition. Additionally, the report indicated that the available mental health services are not of sufficient quality, there are overcrowded and under staffed wards, infrastructure is not conducive for recovery and that patients are housed in isolated, poorly ventilated and dilapidated wards.

ii) WHO estimates that 60% of people attending primary care clinics have diagnosable mental disorder (WHO: 2008). The Kenya Mental Health Policy 2015-2030 indicates that mental disorders are important risk factors for other diseases, as well as unintentional and intentional injury. Mental disorders also increase the risk of getting ill from other diseases such as HIV, cardiovascular disease, diabetes, and vice-versa. The policy also indicates that mental disorders have an impact on individuals, families, communities and nations and frequently lead individuals and families into poverty.

iii) Provision of healthcare services was devolved to the county governments in 2010 and effected in 2013. This means that, for the first time, the services at the 18 County hospitals are not being managed by the Ministry of Health and therefore, it would be important to establish how the counties are providing mental healthcare services and why Mathari Hospital continues to receive a high number of first time patients for assessment of mental illnesses as opposed to referrals from county hospitals.

2.0 DESIGN OF THE AUDIT

Audit Objectives

2.1 The objective of the audit was to examine whether the Ministry of Health and County Governments have put in place measures that are effective for provision of mental healthcare services, and specifically;

i) To establish whether standards and guidelines have been put in place to guide provision of mental healthcare services in the country.

ii) To assess the extent to which the set standards and guidelines are being used to effectively deliver mental healthcare services at the national referral hospital; and at the county psychiatric units

Scope of the Audit

2.2 The audit team examined the operations of Mathari Hospital, and all the 19 Psychiatric Units for a period of 5 financial years covering 2011/2012 to 2015/2016.The period was considered because it is the period that provision of healthcare services has been devolved. The team also examined the extent to which standards and guidelines for provision of mental healthcare services have been developed and communicated, carried out inspection of the adequacy and state of the available infrastructure, reviewed the treatment process, assessed availability of psychotic drugs and evaluated the adequacy of skilled personnel.

Methods Used in Gathering Audit Evidence

2.3 We conducted the audit in accordance with the International Standards of Supreme Audit Institutions (ISSAI) issued by the International Organization of Supreme Audit Institutions (INTOSAI) as well as relevant SAI standards and guidelines applicable to performance auditing. The INTOSAI general auditing standards states that the audit and the SAI must be independent, possess required competence and exercise due care to provide a guide on execution and reporting of audit findings

2.4 To obtain information on the responsibilities and operations of the ministry of Health, the counties and how the hospitals deliver mental healthcare services, we interviewed the senior management at the Ministry of Health, County officers of health, hospitals Medical superintendents and other mental health facility personnel as listed in **Appendix 2.**

2.5 To obtain information on the goals, objectives and roles of the Ministry in the management of mental healthcare service delivery in the Country, we reviewed the Ministerial Strategic and Investment Plan 2014-2018, Kenya

Health Policy 2014-2030, Mental Health Act 1989, Mental Health Policy 2015-2030, Mental Health Bill 2014 and other documents that are listed in **Appendix 3**. Further, to obtain information on the operations of the mental health facilities, we visited Mathari National Referral Hospital and 19 Psychiatry Units across the country and reviewed, patients Drugs and Personnel records**.** We also visited psychiatric wards to examine the living conditions which include the level of occupancy, hygiene & sanitation, beddings and state of the infrastructure.

2.6 The data collected was analysed by quantitative analysis which involved trend analysis and descriptive statistics. We also used qualitative analysis by way of analysing data collected from interviews and examination of relevant documents. In addition, the evidence collected was presented using tables and graphs as appropriate.

Assessment Criteria

2.7 The audit assessed the provision of mental healthcare services against criteria drawn from the statutory mandate and strategic goals. We also referred to recommended practices on management of mental healthcare from the UN Resolution on Protection of Persons with Mental illness which Kenya has committed to abide to. Details on the audit criteria are provided in the findings chapter and is also listed in **Appendix 4**.

3.0 DESCRIPTION OF THE AUDIT AREA.

3.1 The Constitution of Kenya 2010 brought about a major change in governance framework including devolving the health function from the National Government to 1 National and 47 County Governments.

3.2 The responsibilities of the national Government in provision of healthcare include an oversight role in the provision of efficient and high quality healthcare system; and provision of regulations and setting of standards & policies for use in management and delivery of healthcare services in the Country. These roles are carried through the Ministry of Health (MoH).

3.3 With respect to mental healthcare services, the national Government is responsible for the administration and operations of Mathare National Referral Hospital which is the only specialised hospital for mental healthcare services in the country. The county Governments are responsible for the administration and operations of the psychiatric units within the County hospitals.

Statutory Mandate for Ministry of Health

3.4 According to the Fourth Schedule of the Constitution of Kenya 2010 and Executive Order Number 2 of 2013, some of the core mandates of the Ministry of Health are:

i. Health policy and standard management
ii. Capacity building and technical assistance to counties
iii. Medical services policy
iv. Preventive, promotive and curative health services
v. National health referral services
vi. Health education management
vii. Health inspection and other public health services

Policy Objectives of Mental Health

3.5 The policy objectives of mental health as outlined in the Kenya Mental Health Policy 2015-2030 include:

i. To strengthen effective leadership and governance for mental health.
ii. To ensure access to comprehensive, integrated and high quality, promotive, preventive, curative and rehabilitative mental health care services at all levels
iii. To implement strategies for promotion of mental health, prevention of mental disorders and substance use disorders.
iv. To strengthen mental health systems.

Organization of the Health Services Referral System

3.6 The Kenya Health Sector Referral Strategy 2014-2018 indicates that the health system in Kenya is organized around six levels of care based on the scope and complexity of services offered.

- **Level I** comprises community units (CUs) that are a collection of households staffed by volunteer community health workers. Activities at the community unit level focus mainly on promotive health through health education, treatment of minor ailments, and identification of cases for referral to health facilities.

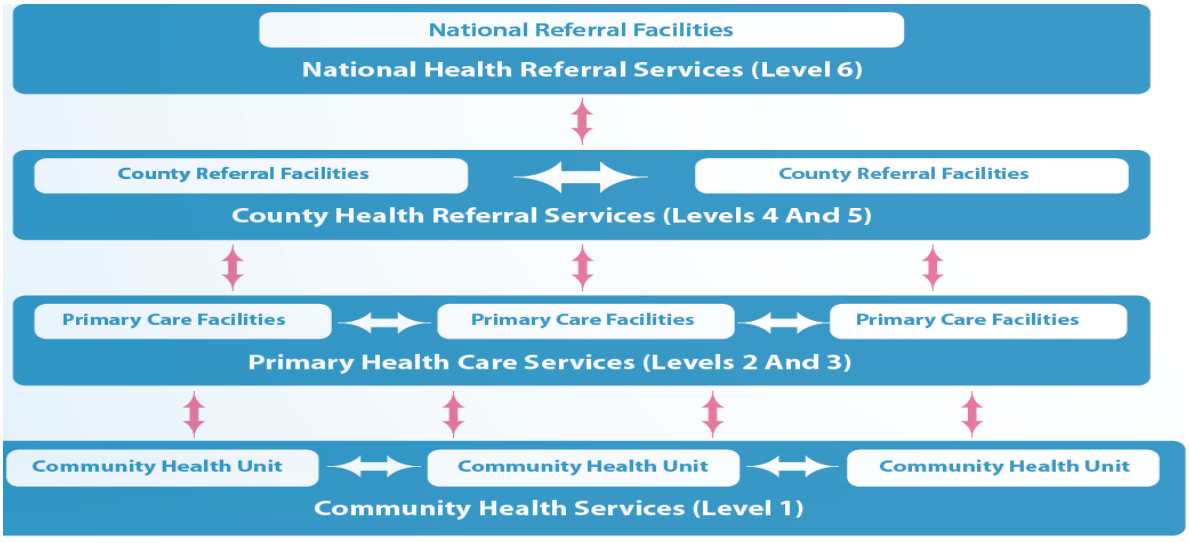
- **Levels 2 (dispensaries) and 3 (health centres)** offer primary health care services and form the interface between the community and the higher level facilities. These facilities offer basic outpatient care, minor surgical services, basic laboratory services, maternity care, and limited inpatient facilities. They also coordinate the community units under their jurisdiction.

- **Levels 4 and 5** are the secondary referral facilities that form the county referral facilities and offer a broad spectrum of curative services, and some are also health training centres.

- **Level 6** constitutes the tertiary referral facilities that offer specialised care and specialised training to health workers. The national government manages these facilities, but they are semi-autonomous organisations in operations.

3.7 The movement of patients for all kinds of ailments is expected to follow this chain from one level to the other as shown in **Figure 1.**

Figure 1: Overall Referral Chain



Source: Kenya Health Sector Referral Strategy 2014-2018

Statutory Mandate for Mathari National Teaching and Referral Hospital (MNT&RH)

3.8 The Hospital operates under the Mental Health Act CAP 248 that mandates the Hospital to:

i. Receive psychiatric patients on referral from other hospitals within or outside Kenya for specialized care.
ii. Receive mentally ill law offenders from prisons and police departments who need assessment and forensic health care.
iii. Provide training and research facilities in mental health.

Vision and Mission of Mathari National Teaching and Referral Hospital (MNT& RH)

3.9 The Vision of MNT&RH is to be recognized nationally and internationally as one of the finest institutions offering psychiatric services and as a centre of excellence in referral, training and Research in mental health. The Mission of MNT&RH is to provide specialised mental healthcare services, offer training and conduct research in mental health.

Functions of Mathari National Teaching and Referral Hospital (MNT& RH)

3.10 According to the Investment Plan 2011 – 2016, the core functions of Mathari hospital are to offer:

i. Specialized psychiatric services
ii. Forensic services
iii. Drug addicts rehabilitation services
iv. Training in psychiatry for doctors and other paramedics from both public and private institutions.
v. Offer other general medical services for outpatients.

Strategic Objectives of Mathari National Teaching and Referral Hospital (MNT& RH)

3.11 The strategic objectives of MNT&RH as outlined in the Investment Plan 2011 - 2016 include:

i. Improve access to affordable mental health care services
ii. To improve quality of mental healthcare services
iii. Improve efficiency and effectiveness of service delivery.

Mental Healthcare Service Delivery Process Description

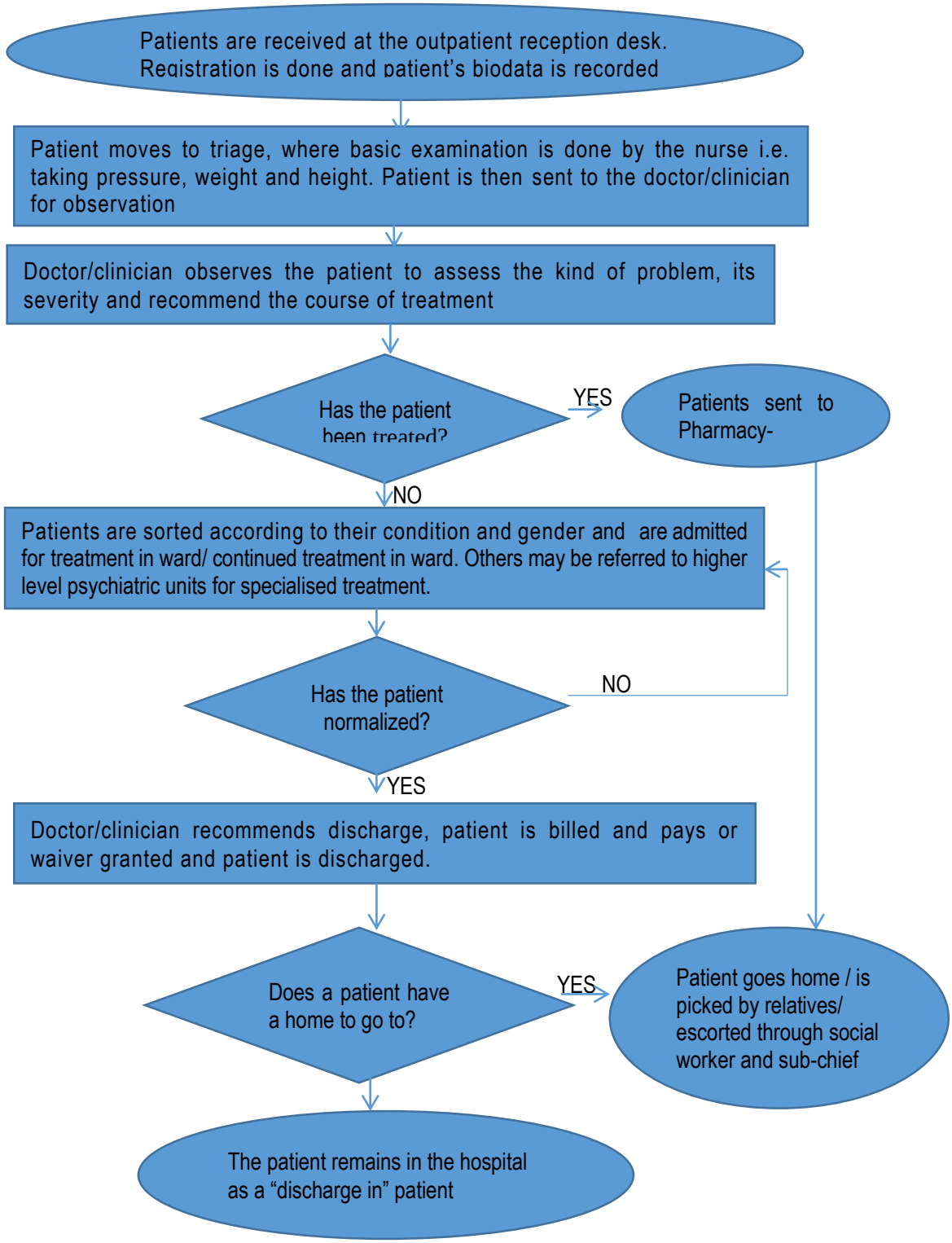
3.12 The process of offering healthcare services at the hospitals starts with receiving of both voluntary and involuntary[3] mental health patients by the records officer. After registration, the patients proceed for consultation and depending on the condition, the patient will either be treated and sent to the

[3] a voluntary patient is a person who presents himself or herself voluntarily to a mental health facility while an involuntary patient is one who is likely to benefit by treatment in a mental hospital but is for the time being incapable of expressing himself as willing or unwilling to receive treatment- Mental health Act Part V and VI

pharmacy for medication, sent for further examination for diagnostic purposes or may be booked for inpatient or referred to a higher level health facility either for more specialized treatment or for inpatient services. The inpatients continue receiving treatment coupled with daily assessment till the medical staff in charge is satisfied that the patient has recovered/is stable and can be discharged.

3.13 As a practice, a voluntary patient is reviewed within Seventy-two hours and is not retained for more than 42 days. An involuntary patient on the other hand is admitted for a period not exceeding six months and does not continuously stay for a period exceeding three years. Some mental patients may lack someone to pick them or may be unwanted at home if the mental disorder had led them into performing unacceptable acts to the society, thus they stay in the hospital as “discharge in” patients. The elaborate process is depicted in **Figure 2.**

Figure 2: Process description.



Sources of Funding for Psychiatric Units

3.14 The national referral hospitals receive funds directly from the Ministry of Health while the psychiatric units are funded by their County Governments through their respective county hospitals. In addition, all the hospitals in the referral chain generate internal revenue from the patients through the cost sharing programme also called Facility Improvement Fund (F.I.F). The total funds received for mental health in Mathari national referral Hospital and 4[4] psychiatric units for the period between 2011/2012 to 2015/2016 is as summarized in **Table 1.**

Table 1: Funding for Mental Health in Kenya Shillings

F/Y	National Referral	Other Psychiatric Units			
	Mathari	MTRH	Kisii	Gilgil	Kerugoya
2015/2016	219,186,944	89,777,806.50	3,875,900	17,075,138.40	484,550
2014/2015	225,652,274	89,873,683.50	2,505,595	12,642,208.80	133,104
2013/2014	280,262,347	89,900,065.40	1,785,500	10,933,808.80	471,635
2012/2013	56,351,808	89,682,648	1,800,585	11,135,594.40	276,035
2011/2012	53,248,972	89,082,780.40		9,452,086.40	428,959

Source: OA-G analysis of data from questionnaires for Mathari Hospital and 4 psychiatric units

[4] N/B the other 15 County hospitals were not able to quantify the amount allocated to Mental Health since the County Government does not give specific allocation for mental health but health in general.

4.0 Findings of the audit

4.1 The Government has put some effort in managing provision of mental healthcare services in the country by passing the Kenya Mental Health Policy 2015-2030 in May 2016. The ministry has also embarked on reviewing and revising the mental health legislation by drafting the Mental Health Bill 2016. The ministry is working towards achieving the objectives of the Kenya Mental Health Policy 2015-2030 by;

i. Developing of the mental Health Plan (2017-2021) which is in its drafting stage,
ii. Integration of mental health into the Health Information System (HIS),
iii. Developing a mental health reporting tool,
iv. Developing a monitoring and evaluation framework for mental health services, and
v. Developing guidelines and standards on Promotion, Prevention, Care, Treatment and Rehabilitation of persons with mental, neurological and substance-use disorders.

4.2 However, despite the above mentioned steps towards improvement in mental healthcare services, evidence gathered during the audit indicate that mental healthcare services in Kenya are not being effectively delivered. According to World Health Organization, a healthcare system, is the organization of people, institutions, and resources that deliver healthcare services to meet the health needs of target populations.

4.3 This therefore means that the required resources i.e. personnel, treatment, infrastructure, diagnostic equipment and rehabilitative services are adequately provided to offer quality healthcare services. Principle 14(1) of UN Resolution on Protection of Persons with Mental Illness, states that a mental health facility shall have access to the same level of resources as any other health establishment. Article 20(5)(b) of the Constitution of Kenya 2010 states that, in allocating resources, the State shall give priority to ensuring the widest possible enjoyment of the right or fundamental freedom having regard to prevailing circumstances, including the vulnerability of particular groups or individuals.

4.4 Data and information gathered during the audit revealed that the Government does not seem to have given priority in ensuring the widest possible enjoyment of the right or fundamental freedom of persons with mental illnesses. **Case Study 1** highlights some of the challenges the mental health patients go through while seeking treatment.

Case Study 1: Highlights of some of the challenges faced by mental health patients in seeking treatment in the hospitals.

Case Title: My road to recovery has been long and expensive
Name: Samuel Boiyo
Media: Daily Nation
Date: 7 September 2016
Summary highlight: Samuel says "When you are the patient, you don't quite appreciate the absurdity of your behaviour because honestly, I don't remember behaving oddly at any time".
Details: The details below are highlights of the case touching on different areas in the treatment process.

1. Mistreatment of mentally ill patients
Samuel indicates that he was diagnosed with mental illness in 2006 and that on the two times he fell critically ill, he was taken to jail instead of being taken to hospital. In jail he was badly beaten by police officers for "being uncooperative and a nuisance" and the cellmates also beat him "for being an irritant". When the court process began, he was remanded at the Industrial Area prison in an isolation block for people displaying psychiatric behavior and here he was injected with CPZ and remained in a zombielike state for three days. He was in prison for five months, receiving the CPZ injections to manage his condition. Thereafter he was admitted to Mathari Hospital for 3 months where he was treated with Haloperidol — a drug that gave him seizures so he had to take Carbamazepine (Telogretol) to control the convulsions — Quetiapine and CPZ. But he says these drugs made his limbs stiff.

2. Misdiagnosis leading to wrong treatment
In June 2010, four years after he was diagnosed with a mental illness, it turned out his condition had been misdiagnosed. He had been receiving treatment for schizophrenia when in fact, he had bipolar disorder. With this condition he was told by the doctor that to stabilise his condition to enable him to live a normal life, he would have to be on medication for life.

3. First vs Second Generation drugs
Another doctor advised him about the second generation drugs which, though expensive, are more effective. Samuel says that since he started taking them, his condition has stabilised and unlike when he was on the first generation drugs, he has not had a relapse. He indicates that the side effects of the first generation drugs are degrading and asks … "***is it possible for the government to make life better for us? Is there something the government can do for those of us who are too poor to afford the better, second generation medication?***

Professional insights on the drugs: In this article, Dr Ngugi Gatere, a consultant psychiatrist, says most first generation antipsychotics, especially when used in high doses — as often happens — have extrapyramidal effects. These include dystonia (continuous spasms and muscle contractions), akathisia (motor restlessness), Parkinsonism (rigidity), bradykinesia (slowness of movement), and tardive dyskinesia (tremors, drooling and irregular jerky movements). He adds that while they would like to recommend that patients take the second generation drugs which have fewer side effect, they are too expensive for most patients. He says out of 80 patients, only about 10 can afford the second generation drugs. These newer drugs are better because they are condition specific, and hence have fewer side effects. Meanwhile the old drugs work on many areas of the brain, hence their many side effects. He adds that the government should subsidize the treatment of chronic mental illnesses just like it has done for other chronic illnesses."

Dr. Ogato, the Medical Superintendent at Mathari Hospital adds that by not treating the mentally ill with the appropriate drugs, the country is losing a good majority of the estimated 5 million mental health patients to unproductivity.

Source: Media article summary by OAG Kenya

4.5 In addition to **Case 1**, documentary review and interviews with the officers in the Ministry of health and management teams in Mathari and the 19 psychiatric units in the Country revealed that mental healthcare services have not been effectively delivered due to; lack of full implementation and updates on the mental Health Act of 1989; lack of a well-functioning referral system in provision of mental healthcare services; management challenges at both the Mathari hospital and the psychiatric units across the counties; and lack of rehabilitation facilities and outreach programmes to aid in recovery.

1) Lack of full implementation and updates on the Mental Health Act, 1989.

4.6 Article 43(1) (a) of the Constitution of Kenya 2010 provides the overarching legal framework to ensure a comprehensive rights-based approach to healthcare service delivery. In addition, the Executive Order No. 2/2013 and Ministerial Strategic and Investment Plan July 2014 to June 2018, mandates the Ministry of Health to provide Health Policy and standards management. However, information gathered during the audit indicate that management of mental healthcare services is still inadequate due to;

a. Lack of full implementation of the provisions of the Mental Health Act 1989

4.7 The Mental Health Act is a law which provides for procedures on admission, treatment and care of persons with mental illnesses among other provisions. Based on this law, the Ministry of Health has provided forms to be administered by hospitals as requirements during admission, treatment and care of the patients.

4.8 However, the provisions of Mental Health Act have not been fully implemented e.g. the District Mental Health Councils were never created yet they had key functions including; to coordinate mental healthcare activities in the district; to inspect mental hospitals to ensure that they meet the prescribed standards; to initiate and organize community or family based programmes for the care of persons suffering from mental disorder. Under devolution, these councils would have become the County Mental Health Councils serving the same functions in the Counties.

4.9 In the absence of these councils those managing the psychiatric units across the counties only report to the medical superintendents in charge of the hospitals thus the issues affecting delivery of mental healthcare services may not receive the attention they deserve. Any other intervention may have to come from the directorate of mental health services at the Ministry and these may not address the specific needs of these units.

b. The Mental Health Act 1989 is yet to be updated in line with the Constitution of Kenya 2010

4.10 Interviews with the Mental Health Directorate officials at the MoH revealed that the Mental Health Bill 2016 which is crucial in governing provision of mental healthcare services, and is expected to replace the Mental Health Act 1989 is yet to be enacted. Further, a review of the Kenya Health Sector Strategic and Investment Plan (KHSSP 2014- 2018) revealed that the plan is silent on mental health, yet it is meant to guides both National and County Governments plus partners on the operational priorities to focus in addressing the health agenda in Kenya.

4.11 All the interviewed psychiatrists and other mental healthcare personnel indicated that they use the procedures outlined in the Mental Health Act, 1989 which narrowly focuses on inpatient admission and does not put into consideration the rights to be accorded to mental patients. The rights are; right to the highest attainable standard of health, right to protection against physical, economic, social and other forms of exploitation, abuse and degrading treatment, right against discrimination on the ground that he or she is suffering from mental illness, right against coercion and the right to have recognition as persons before the law and enjoyment of legal capacity on an equal basis with others in all aspects of life. The hospitals also use the Mental Health Policy 2015 Mental Health Policy which is not anchored to the Act or any sessional paper.

4.12 The Mental Health Act, 1989 misses out on the prerequisite resources needed to deliver effective mental health services that ensures the highest attainable quality in provision of mental health services and lacks a standard care process to be followed for mental healthcare service provision by the County Governments. Though the Ministry has developed other standards and guidelines to be used for Mental Healthcare service provision which include Mental Health in Primary Care Diagnostic and Treatment Guidelines, 2006 and Substance Use Disorder Treatment Protocol, these have not been effectively communicated to the psychiatric units across the counties.

4.13 The Ministry attributes the delayed enactment of the Mental Health Bill 2016 to the fact that the Health Bill 2015 on which all the other laws relating to provision of health services are anchored, is yet to be enacted by Parliament. The use of the Act in its current form has led to continued provision of services which are not centred on the rights of mental patients. Mathari hospital still draws its mandate from this 1989 Act thereby receiving mentally ill offenders from all prisons and police departments across the

country regardless of the presence of the other 18 psychiatric units in the counties.

2) The health sector referral system is not well-functioning in the provision of mental healthcare services

4.14 According to the Kenya Health Sector Referral Implementation Guidelines, most of the population of Kenya is rural and poor thus a well-functioning referral system should strengthen lower-level facilities and create opportunities for balanced distribution of funds, services, human resources and provide coordination and standardization of referral services and continuity across the different levels of care. Additionally, the findings of a human rights audit on the Mental Health System in Kenya by Kenya National Commission on Human Rights indicate that approximately 20-25% of outpatients seeking primary healthcare present symptoms of mental illness at any one time, and that this psychiatric disorders remain undiagnosed thus unmanaged.

4.15 Mental healthcare services are not available in all levels of the referral system. By December 2014, there were 3,956 government-owned health facilities which provide general health services across the Country. However, besides Mathari National Referral Hospital, mental healthcare services are only available in 29 of the 284 hospitals in Level 4 and above of the referral chain representing just 10% of the total facilities in Level 4 and above and 0.7% of the 3,956 government-owned health facilities.

4.16 Though all the healthcare facilities are expected to provide mental healthcare services (both integrated and specialized), the analysis indicates that patients seeking services at all health facilities in levels 1 to 3, and in 255 facilities that are in level 4 and above of the referral chain have no access to mental healthcare services. Additionally, the director of mental health indicated that the country needs about 22,000 psychiatric beds to fully cater for mental patients in the whole country but currently has only 2,500 psychiatric beds.

4.17 Further, interviews with the hospitals' management in the 19 hospitals we visited, revealed that although the hospitals have adopted the Health Sector Referral Strategy developed by MoH, they are faced with challenges that strain the forward and counter referrals. These include; patients organising for their own transport due to unavailability of ambulances, lack of coordination between the referring facility and the receiving facility and lack

of continuity of care as the patients' data from referring facility is not captured.

4.18 In addition, though Mathari hospital is mandated to receive psychiatric patients on referral from other hospitals for specialized care, this has not been the case. A review of patients' records revealed that majority of the psychiatric patients seeking services at the hospital are non-referral. For instance, in financial years 2014/2015 and 2015/2016, only 0.43% and 1.14% of patients attended to were referral cases respectively as shown in **Table 2.** Referral vs. Non-referral patients

Table 2: Referral vs. Non-referral patients

Financial year	Referral patients	Non-referral(walk in) patients	Total	% of referral
2014/2015	209	47,951	48,160	0.43
2015/2016	466	40,551	41,017	1.14

Source: OAG analysis of Mathari Hospital's Patients records

4.19 This is attributed to the fact that the existing psychiatric units in the counties lack adequate personnel e.g. psychiatrists and other resources and the public lacks information on the existence of these psychiatric units. Additionally, information from all the 19 psychiatry units revealed that all mentally ill offenders who require inpatient services can only be admitted in Mathari Hospital, regardless of severity of their condition.

4.20 In addition, for the referral system to work as planned, the Ministry must ensure that all the required number of staff are available in all levels of healthcare, both in the various fields of specialization and in numbers. Principle 14(1)(a) of UN Resolution on Protection of Persons with Mental Illness states that a mental health facility shall have access to the same level of resources as any other health establishment, and in particular qualified medical and other appropriate professional staff in sufficient numbers.

4.21 These professional staff include consultant psychiatrist who assesses both mental and physical aspects of psychological problems; clinical psychologists who apply psychology for the purpose of understanding, preventing and revealing psychologically based distress; psychiatric nurse who plan and provides support, medical and nursing care to mental patients; medical social workers who assess and provide case management and rights advocacy to individuals with mental health problems and

psychotherapists who use psychological methods based on personal interactions to help a person change and overcome problems in desired ways.

4.22 Ministry of Health statistics as at 2015 indicated that in all the different professionals required in provision of mental healthcare services, the numbers available were way below the required numbers. For example, there were only 92 psychiatrists instead of the 1,533 required and 327 psychiatrist nurses instead of 7,666 required in the Country as indicated in **Table 3.**

Table 3: Mental Health Personnel

Designation	In post		Total	Required Number	Shortage
	Public Hospital	Other Hospitals			
Psychiatrists	36	56	92	1,533	1,441
Psychiatrist Nurses	187	240	427	7,666	7,239
Psychologists	31	10	41	3,066	3,025
Occupational therapists	25	-	Survey ongoing	920	
Medical Social Workers	23	27	50	920	870

Source: OAG Analysis of Ministry Personnel for Mental Health

4.23 The Ministry has not worked out the ideal ratio for professionals per patient thus relies on the WHO recommended ratios. However, these ratios may not be practicable for the Kenyan economy thus the ideal ratio for the different professionals in Kenya per population as provided by the ministry of health is as shown in **Table 4.** With an estimated population of 46 million in 2017, the current staffing for the different professionals thus drastically falls short of the ideal ratio. For example, while it's expected that a psychiatrist should serve 30,000 citizens, currently a psychiatrist is serving about half a million citizens. This in turn means that the referral system in place cannot work for provision on mental healthcare services since most of this staff are unavailable in almost all institutions in level 1 to 4 of the referral chain, while others are thinly distributed between level 5 and 6 facilities.

Table 4: Ministry of Health Ideal Ratio for professionals

Cadre	Ideal Ratio	Current Ratio
Psychiatrists	1:30,000	1: 500,000
Psychiatric Nurses	1:6,000	1:107,728
Psychologists	1:15,000	1:4,600,000
Medical Social Workers	1:50,000	1:920,000
Occupational Therapists	1:50,000	-

Source: OAG Analysis of MNT&RH Staff Establishment

4.24 The use of referral system that is not well functioning in provision of mental healthcare services is attributed to the fact that the Government has not taken sufficient steps to make provision of mental healthcare services available at most health facilities despite the increasing number of mental health patients. The effect is that patients with mental disorders face difficulties in accessing mental healthcare services. Their families in turn must bear the burden of living with their untreated sick persons who remain unproductive, dependent and sometimes a risk to themselves, the family and the society depending on the nature and extent of illness.

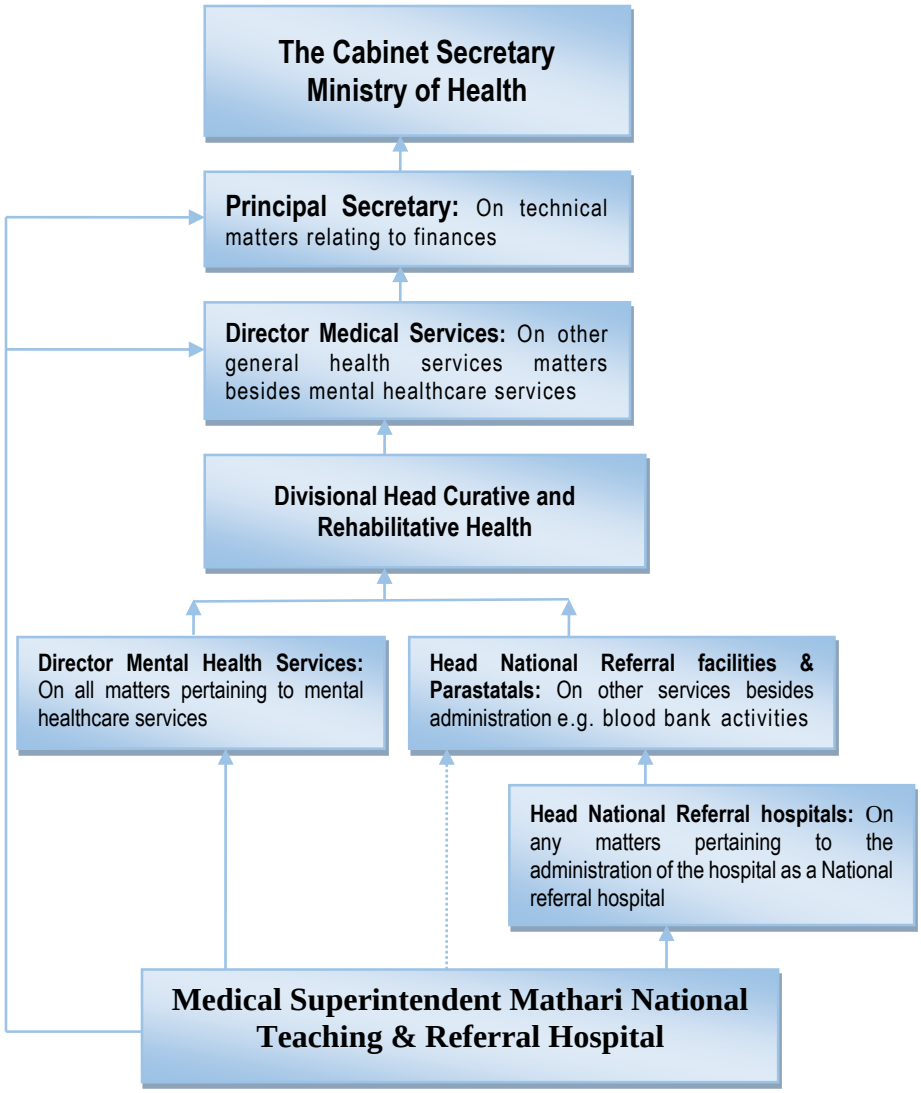
3) Management challenges in provision of mental healthcare services at Mathari Hospital

4.25 Mathari Hospital is the only specialised national referral hospital for mental healthcare services in the country. At level 6 of the referral chain, the hospital is expected to provide the highest level of specialised care for patients with mental illnesses. According to the Kenya Health Sector Referral Strategy, national referral hospitals provide specialized healthcare services and should operate with a defined level of autonomy.

4.26 As a national referral hospital in the country, Mathari hospital should have a charter and operate as a Semi-Autonomous Government Agency managed by a board of directors and headed by a chief executive officer. This would mean that budgetary provisions are appropriated directly to the hospital whose management is then able to secure all the required resources and run the hospital independently.

4.27 However, the hospital operates under the Curative and Rehabilitative Health department under the Ministry of Health. The hospital thus is headed by a Medical Superintendent who reports to about five different offices according to need as shown in **Figure 3**.

Figure 3: Reporting Structure for Mathari Hospital



Source: OAG depiction of information on reporting structure obtained from Mathari hospital

4.28 The hospital therefore lacks a defined level of autonomy thereby lacking the benefits that the other semi-autonomous referral hospitals have, as indicated in **Case 2.**

Case 2: Experience of Kenyatta Hospital as a Semi-Autonomous Government Agency

Case Title: Hospital Autonomy in Kenya; the Experience of Kenyatta National Hospital (KNH)
Authors: David Collins (Management Sciences for Health), Grace Njeru (Ministry of Health Kenya), Julius Meme (Kenyatta National Hospital)
Date: June 1996

Summary highlight: Summary of the findings of a study carried out by Meme et al, 1996 that highlight the notable improvements at KNH as a result of making it autonomous.

Management improvements: Senior administrative management was strengthened with the transfer of qualified personnel from other government departments with a more clearly defined departmental structure, and more delegation of authority to department heads. KNH specialists were no longer subject to transfer by the Ministry of Health and their salaries were levelled with those of their public university colleagues.

The supplies situation: This also improved, mainly due to increased financial resources, speedier payment of bills, freedom to procure directly, and some internal decentralization of supplies management.

***Government funding*:** The funding to KNH changed to a block grant, which increased budgetary flexibility, and this, with greater control, resulted in more effective internal use of funds. Financial management improvements have been reflected in more timely, detailed, and accurate financial statements.

The role of KNH in the national health care system: KNH benefitted through reductions in outpatient attendances thereby freeing some hospital resources and increasing KNH's ability to serve as a national referral hospital.

Donor Assistance: Increased autonomy at KNH improved its ability to negotiate, plan, implement, and be accountable for donor assistance projects and to report on performance.

Source: Meme et al, 1996.

4.29 In addition to lack of autonomy, which could also be a contributing factor, the following management weaknesses were noted at the hospital:

a) Insufficient Financial Resources

4.30 To deliver services effectively, every organization needs to plan and budget for sufficient financial resources to deal with the workload. Evidence gathered indicate that Mathari Hospital in spite of being a national referral hospital, a training centre and the only hospital in the country with a Maximum Security Unit (MSU), is not allocated financial resources that are commensurate to its status.

4.31 An analysis of the number of psychiatric inpatients indicated that as at the time of the audit, Mathari Hospital was offering services to an average of 906 psychiatric inpatients per day translating to 330,690 patient per year.

320 of these patients were in the Maximum Security Unit while 586 were in the Civil wards. Further, the hospital receives approximately 400-500 students per quarter across the different courses.

4.32 To maintain an inpatient at the hospital, the actuarial estimate given by National Hospital Insurance Fund (NHIF) is Kshs. 3,500 per day per patient. The hospital would therefore need Kshs**.** 3,171,000 per day translating to about Kshs. 1,157,415,000 per year for maintaining inpatients alone. Additionally, the hospital is mandated to receive mentally ill law offenders from prisons and police department across the country for assessment and forensic mental health services[5], for both outpatient and inpatient care. These patients are in the Maximum Security Unit and are in three categories; remandees, special category and those convicted of crimes. Most of these patients have a long stay though they are expected to leave the hospital immediately they have been certified to be of sound mind, this is usually not the case.

4.33 The Hospital also offers teaching and training facilities to psychiatry students from Government's medical training centres, public universities as well as private hospitals and universities. The hospital receives about 500 students per quarter resulting to about Kshs. 2000 students per year. The management estimates that it costs the hospital about Kshs. 2000 per month, per student which translates to 48 Million per annum. The workload therefore means the hospital would require Kshs.1,157,415,000 and Kshs.48 million for inpatients and students upkeep respectively per year resulting to Kshs 1,205,415,000.The figure will even be higher when outpatients[6]' needs are included.

4.34 Documentary review of financial records indicate that the hospital received approximately KShs. 280 million, 220 million and 215 million in financial years 2013/14, 2014/15 and 2015/16 respectively for recurrent expenditure. The funding appears to be reducing each subsequent year. In comparison with the daily costs related to patients and students, the funds provided were only 23%, 18% and 18% of the estimated service cost in the three years respectively representing a shortfall of up to 82% in 2015/16 financial year as shown in **Table 5**. This also means that in 2015/16 financial year, with an amount of Kshs 215 Million, to cater for the 330,690 inpatient days,

[5] Forensic mental health services are specialized services for people who have a mental health problem, have been arrested, remanded or have been to court and found guilty of a crime

[6] The financial analysis did not include the outpatients since their data as well as comparative actuarial estimates were not available at the time of the audit.

the hospital allocated less[7] than Kshs.650 to each patient per day which is only 19% of the NHIF actuarial cost of Kshs. 3500 per patient per day.

Table 5: Annual service cost as compared to funds received

Cost of 330,690 inpatient-days/year @3,500/day			1,157,415,000	
Cost of 2000 Students /year @2,000/student			48,000,000	
Total service cost per year			**1,205,415,000**	
		Total received compared to service cost	**Shortfall of amount received compared to service cost**	
Total amount received for recurrent (GOK & FIF)		**% received**	**Shortfall (Kshs)**	**% Shortfall**
2015/2016	215,186,944	18%	990,228,056	82%
2014/2015	219,652,274	18%	985,762,726	82%
2013/2014	280,262,347	23%	925,152,653	77%

Source: OAG Analysis of Mathari Financial records.

4.35 Though there was no explanation provided by the Ministry as to why the hospital receives minimal funding, the fact that the referral hospital has not been given autonomy is a possible major cause. Information gathered during the audit indicates that there are other several factors that lead to insufficiency of the funds as explained below;

Minimal or lack of remittances for students under training

4.36 Though the hospital is mandated to provide training and research facilities in mental health, the hospital does not get any funding for training from the ministry. At the Ministry, the budget for training is allocated to the Department of Research and Development under program based budgeting. No evidence was provided to show that any of these funding was disbursed to Mathari hospital. Further, the hospital lacks a Memorandum of Understanding with all the public institutions that take their students to the hospital and as such these students do not pay for the services rendered. The private institutions, despite having an MOU with the hospital, remit only Kshs 1,500 per student per month which is less than the estimated cost of Kshs 2,000. This means there is lack of effective enforcement of the MOU with regards to training and attachment fees chargeable.

[7] The calculations are based on the in patients only. This means the situation is worse since there are outpatients, students and other daily expenses to be met at the hospital.

Lack of cost sharing funds for the patients at the MSU

4.37 As at the time of audit the MSU ward held an average of 320 patients per day representing about 35% of the total number of inpatients in the entire Hospital and translating to 116,800 inpatient-days per year. Considering the NHIF actuarial estimates of Kshs. 3,500 per day per patient, the hospital spends approximately Kshs. 1,120,000 per day on MSU patients and translating to Kshs. 408.8 Million per year. The hospital however doesn't receive any cost sharing funds for these patients from the Inspector General of police, the Prisons Department or the Ministry in-charge of the Social Services. Interviews with the hospital management and the officials at the Ministry of Health indicated that though there has been deliberations on this issue, no policy has yet been approved on who should take care of the MSU patients in Mathari. The hospital therefore has to bear the cost.

Low disbursements for recurrent and lack of disbursements for development expenditure.

4.38 A review of the Government's printed estimates for the three financial years 2013/14 to 2015/16 indicate that the hospital was allocated a total of Kshs 1.15 billion and Kshs 96.5 Million under the recurrent and development votes respectively. However financial records at both the Ministry and the hospital indicate that the hospital actually received a total of Kshs 447.5 million for recurrent vote and nothing for the development vote as shown in **Table 6**.

Table 6 : Mathari Hospital Funds

	Recurrent Expenditure				Development expenditure		
Financial Year	**Approved Estimates in Kshs**	**Actual Allocation in Kshs**	**Variance in Kshs**	**% Variance**	**Approved Estimates in Kshs**	**Actual Allocation in Kshs**	**Variance in Kshs**
2015/2016	453,665,436	127,436,960	**326,228,476**	72%	31,500,000	-	**31,500,000**
2014/2015	187,960,246	134,971,200	**52,989,046**	28%	45,000,000	-	**45,000,000**
2013/2014	510,927,227	185,126,072	**325,801,155**	64%	20,000,000	-	**20,000,000**
Total	**1,152,552,909**	**447,534,232**	**705,018,677**		**96,500,000**		**96,500,000**

Source: OAG Analysis of GoK funds for Mathari Hospital

4.39 The variance is as high as 72% for recurrent and 100% for development respectively in 2015/16 financial year and no explanation was provided for the variance. The hospital management estimates that it would require about Kshs 20 Million to refurbish a ward and Kshs. 50 Million to construct a new 40-bed ward. Had the development funds been disbursed, the hospital would've constructed a 40-bed ward and refurbished two wards

while better services would have been provided to the patients had all the recurrent funds been released to the hospital.

4.40 Further, the recurrent allocation from the MoH for operations for the 3 years since Mathari Hospital was elevated to a national teaching and referral hospital has been reducing despite an increase in the workload and cost of living. e.g. In 2014/15 compared to 2013/14, the amount of recurrent funding reduced with about Kshs 50 million, despite the number of patients increasing by 2,213 as indicated in **Table 7**.

Table 7: Government of Kenya (GoK) Recurrent Funding Vs Workload

Financial Year	GoK Recurrent Funding (Kshs)	Decrease in Funding (Kshs)	Workload (Patients)	Increase in workload
2015/2016	**127,436,960**	-7,534,240	**14,092**	-294
2014/2015	**134,971,200**	-50,154,873	**14,386**	2,213
2013/2014	**185,126,073**		**12,173**	

Source: OAG Analysis of Mathari Hospital Funding and Patients' Records

4.41 This in turn means that all the funds generated by the hospital are used to maintain the patients as opposed to facility improvement. Facilities Improvement Fund (F.I.F) Operation Manual December 2002 on good management of F.I.F shows that the fund should be used for visible improvements in the health facilities. However, interviews with the hospital management revealed that the F.I.F was mostly used for operations and the little allocation for development was not used for maintenance of wards but for purchasing of Motor vehicle, land survey and processing the title deed. **Table 8** shows the total F.I.F Funds collected by Mathari Hospital in the period under review.

Table 8: Mathari Hospital Internally Generated Funds

Financial Year	Recurrent Allocation	Development Allocation	Total Collected
2015/2016	91,749,984	-	**91,749,984**
2014/2015	84,681,074	6,000,000	**90,681,074**
2013/2014	91,136,275	4,000,000	**95,136,275**
2012/2013	56,351,808	-	**56,351,808**
2011/2012	48,901,858	-	**48,901,858**
Total	**372,820,999**	**10,000,000**	**382,820,999**

Source: OAG Analysis of internally generated funds at Mathari Hospital

4.42 As a result of insufficiency in the financial resources, the hospital is faced with the challenges of inadequate resources for service delivery while the patients have to contend with poor services as indicated below;

Inadequate diagnostic and treatment equipment for service delivery

4.43 Principle 14(1)(b) of The UN Resolution on Protection of Persons with Mental Illness states that a mental health facility shall have access to the same level of resources as any other health establishment and in particular, diagnostic and therapeutic equipment for the patient. A mental health referral hospital needs ECT (Electroconvulsive Therapy)[8], EEG (Electroencephalogram)[9], CT scan[10] and Magnetic Resonance Imaging machine (MRI)[11]. These equipment assist in diagnosis and treatment of mental illnesses and related ailments. The ECT is a crucial equipment during assessment and treatment of patients with mental illnesses. The equipment helps to provide important insights into the causes and nature of a disease and to show structural abnormalities in the brains of patients. The equipment helps to rule out other illnesses such as epilepsy and tumours that could cause symptoms similar to mental disorders.

4.44 Though Mathari hospital has both the ECT and EEG machines it lacks other critical equipment such as CT scan and MRI machine which are needed for proper diagnosis and effective mental healthcare service delivery. Interview with the Deputy Medical Superintendent revealed that the patients who need the CT scan and the MRI, and can afford to pay, are sent to Kenyatta National Referral Hospital (KNH) for the procedure. According to the KNH Service Charter, the minimum cost of a CT scan and MRI examination is Kshs 8,500 and Kshs 17,000 respectively.

4.45 The patients who cannot afford to pay have to wait indefinitely for availability of funds from relatives or the hospital, as they take drugs to manage their condition. Lack of CT scan and MRI also means that patients only receive basic treatment of undiagnosed condition thereby prolonging treatment and denying the patient a right to proper treatment.

Deplorable and insufficient number of wards

4.46 Principle 13(2) of the UN Resolution on Protection of Persons with Mental Illness states that; the environment and living conditions in mental healthcare facility shall be as close as possible to those of the normal life of persons of similar age. Additionally, Mental Health Act, 1989, Part IV Section 9 (6), indicates that every mental hospital shall have facilities for

[8] A psychiatric treatment in which seizures are electrically induced in patients to provide relief from a psychiatric illness.

[9] A machine used to create a picture of the electrical activity of the brain. It's used to diagnosis mental disorders.

[10] A machine that uses x-rays to make detailed pictures of parts of the inside body

[11] A type of scan that uses strong magnetic field and radio waves to produce detailed images of the inside of the body

inpatient and outpatient treatment of persons suffering from mental disorders.

4.47 A review of patient records at Mathari Hospital indicated that although the actual number of beds increased from 574 in 2011/2012 to 768 beds in 2015/16 representing an increase of 34%, there has also been an increase in the average number of patients in the wards from 596 in 2011/12 to 906 in 2015/16 representing an increase of 52%. Further analysis of patient records for the five financial years indicated that on average, there were 106 patients showing an overcapacity rate of 15.5% as shown in **Table 9.**

Table 9: Overcapacity at Mathari hospital

Financial Year	No. of Beds	Average daily No. of in-patients	Average daily No. of in-patients over no. of beds	Bed Occupancy Rate (%)
2015/2016	768	906	138	118
2014/2015	759	979	220	129
2013/2014	667	727	60	109
2012/2013	640	736	90	115
2011/2012	574	596	22	104
Average	**682**	**788**	**106**	**115**

Source: OA-G Analysis of patients records at Mathari Hospital.

4.48 In addition to congestion, most of the wards are in deplorable conditions and do not provide conducive living conditions for the patients. Physical observations at Maximum Security Unit (MSU) in Mathari Hospital show that the ward is in a deplorable condition which has reduced the bed capacity from 347 to 320. The unit lacked toilets and instead the patients used buckets to relieve themselves while one of the wards had a hole on the roof, which would obviously cause leaks during the rainy seasons as indicated in **Figure 4**. The patients must in turn suffer under these conditions and this could worsen their current conditions and/or breed more ailments.

Figure 4: Status of some of the facilities at Mathari Hospital

Physical evidence of deplorable state of wards as at 26th October 2016
Institution: Mathari National Teaching and Referral Hospital
Source of funding: GOK/ Cost Sharing
Ward Status: Toilet in deplorable state, Buckets used as toilets, Hole in the roof,
Performance issue: Improper use of money meant for Facility Improvement. The hospital collects an average of 76,564,200 per year for Facility improvement and collected 91,749,984 in 2015/2016 part of which was meant to improve facilities as a result of cost sharing between patients and the hospital. Best practice on F.I.F management states that the hospital ought to use money to make money and make visible improvement on the hospital. Allocating money for renovation of hospitals would go a long way in improving services at the hospital. Patients are using toilets without water in the MSU, there were no toilets inside the wards to be used at night and as such patients use buckets as toilets. Further, the ward had a hole in the roof causing leakages during the rainy seasons thus making the situation worse for the patients. The wards in the MSU are in dire need of renovation.

A toilet in deplorable state in a ward; Buckets used as toilets in the MSU; A hole in the roof in the MSU

Source: Photos taken by the audit team during physical verification on 26th October 2016

Insufficient Medical Drugs.

4.49 Principle 14(1)(d) states that a mental health facility shall have access to the same level of resources as any other health establishment, and in particular, adequate, regular and comprehensive treatment, including supplies of medication. Drugs used in treatment of mental illnesses are categorised into 1st and 2nd generation drugs. Interview with the head of mental health unit at the Ministry of Health and a research paper by Schizophrenia Research Institute revealed that 2nd generation drugs are the

best for mental health treatment since they have a shorter curative period compared to 1st generation drugs.

4.50 As at the time of the audit, Mathari Hospital was using both 1st and 2nd generation drugs for treatment of mental illnesses. Interview with the Hospital officials revealed that of the drugs available, 80% were 1st generation while only 20% were 2nd generation. A review of drug records at the hospital showed that the hospital experiences stock outs for as long as a month and this was attributed to low funding, delayed funding and the long procurement process at the Ministry. The effect of insufficient supply of drugs is that patients stay longer in hospital awaiting availability of these drugs which means delayed treatment and more psychological effects on the patients, higher operational costs to the hospital and related undesirable effects on the patient's family.

Shortage of Qualified Personnel.

4.51 Mathari Hospital does not have adequate skilled and qualified personnel to handle the number of patients that seek services in the facility. Of the 17 psychiatrists and 179 psychiatric nurses in public hospitals, 7 psychiatrists and 104 psychiatric nurses are deployed at Mathari Hospital. The total number of staff involved in mental healthcare at Mathari Hospital as per the staff establishment is outlined in **Table 10**.

Table 10: Key Mathari Hospital Mental Health Staff

Designation	In post	Required	Shortage
Consultant Psychiatrists	7	18	11
Psychiatric Nurses	104	295	191
Psychologists	0	2	2
Occupational Therapist	13	33	20
Medical Social Workers	5	27	22

Source: OA-G Analysis of MNT&RH Staff Establishment

4.52 The World Health Organisation recommends a ratio of 1 psychiatric nurse to every 6 mentally ill patients. A review of patient and staff records at the national referral hospital indicate that the ratio of a psychiatric nurses to patients is below WHO recommended ratio as indicated in **Table 11**. The situation is worse in the Maximum Security Unit that has 1 nurse attending to 152 patients who have been booked in as law offenders.

Table 11: **Nurse to patient ratio at some of the wards in Mathari**

Ward Names	5F	6F	9M	Maximum Security Unit
Number of psychiatrist patients per Psychiatric Nurse	54	68	70	152

Source: OA-G Analysis of Mathari personnel

4.53 Mathari Hospital management and staff attribute the inadequate personnel to its inability to retain them as compared to the private institutions that provide better pay and working conditions. This is compounded by the fact that there are few psychiatrists in the country and their demand is on the increase yet the hospital provides no incentives to retain these critical staff. In addition, the hospital deals with patients who are law offenders with criminal tendencies and who pose a big risk to fellow patients and the staff taking care of them.

4.54 Lack of adequate skilled personnel negatively affects mental healthcare service delivery at the hospital and increases the risk of violence and threat to life especially in the Maximum Security Unit since the few staff available are not able to handle the large number of patients.

b) Provision of General Health services

4.55 Though the mandate of Mathari hospital according to Mental Health Act CAP 248 only caters for mental healthcare services, the core functions of the hospital according to Investment plan 2011-2016 includes offering other general medical services for outpatients. Subsequently the hospital also offers general services including maternal child healthcare, diabetic clinic, dental services, laboratory services and orthopaedic services.

4.56 The explanation provided for the situation is that the ministry of health is working towards achieving the optimal mix of services according to the WHO recommendation and that the integration concept is a perfect and a must application for cost effective and quality services for specialized referral and training institutions. The worldwide recommendations are that services should be integrated to reduce stigmatization of the patients therefore integrating services at Mathari hospital improves the perception of the people towards the hospital. In addition, the HIV and Diabetes patients for instance, that have mental illnesses needs to be taken care of wholly at the hospital thus the need to introduce the general services at Mathari Hospital.

4.57 In consideration of the above explanation, it would have been expected that there be special funding for the inception of these services at Mathari hospital. However, no evidence has been provided to indicate that such funding was received at the hospital and instead some of the psychiatric wards were converted to offices and treatment room in order to create room for the integration of the general services. The initial bed capacity in the hospital was 1,200 but the conversion has reduced the bed capacity to 768 which is a lost capacity of 432 beds or 36%. In addition to the reduced bed capacity, all other available resources including personnel had to be shared between mental healthcare services and the general services.

4.58 It is therefore not clear why the already limited resources for the only mental health referral hospital in the country are being strained to cater for other services that are available elsewhere. In addition, there is no evidence that the Ministry has been holding information and sensitization campaigns to reduce the stigma attached to the hospital and to the mentally ill.

4.59 In addition, if mental healthcare services have not been adequately catered for at the only specialized referral hospital for psychiatric cases, then introducing other services will only make the situation worse especially since there was no capital injected for provision of these general services. Further, Mathari is a referral hospital and these general services are not being offered on a referral basis but on a walk in basis thereby contradicting the hospitals service level. The result is that the mental health patients have to share the fewer wards, lower medical drugs provision regardless of the fact that the available resources were not adequate for the mental healthcare workload.

4) Inadequate management of mental healthcare services at the psychiatric units

4.60 In line with the Constitution of Kenya, 2010, health functions were devolved to the 47 County Governments. As at the time of the audit in October 2016, mental healthcare services at the counties were only being provided in 30 hospitals which are in only 25 of the 47 counties in the country. Just like at the national level, audit evidence gathered indicates that mental healthcare service delivery at the counties have also not been sufficiently managed and is characterized by:

Lack of Mental Health Budget Provision

4.61 According to the constitution of Kenya, 2010, the sources of revenue for the counties include; revenue generated within the county, revenue received

from national government and revenue sourced externally. Section 109(2) of Public Finance Management (PFM) Act 2012 provides that, except for the exceptions provided by the Act, all the money raised or received by the County be paid into the County Revenue Fund. The monies in these fund should be spent in accordance with the budgeting process stipulated in Section 125(1) of the PFM Act 2012.

4.62 Interviews with County government officials and hospitals management revealed that Counties do a programme-based budget and the approved budget line items for health include, Personnel emoluments, operation and maintenance, medical drugs, non-pharmaceuticals, x-ray and lab supplies and training expenses among others. However, it was difficult to quantify funds allocated to mental health as there is no budget line and no direct funding for mental health thus the counties do not budget for Mental Health.

4.63 Interviews with hospital management indicated that the psychiatric units do not make their budgets thus the budgeting and purchase of medical drugs is done for the hospital as a whole and are not classified as antipsychotics or general drugs. Therefore, except for the 4 hospitals indicated in **Table 12**, the other 15 hospitals were not able to quantify the expenditure on mental healthcare services.

Table 11: **Mental Health Expenditure**

Financial year	Psychiatric Units			
	Moi T&RH	**Kisii**	**Gilgil**	**Kerugoya**
2013/14	89,900,065	1,785,500	10,933,809	471,635
2014/15	89,873,684	2,505,595	12,642,209	133,104
2015/16	89,777,807	3,875,900	17,075,138	484,550
Total	**269,551,555**	**8,166,995**	**40,651,156**	**1,089,289**

Source: OAG Analysis of Mental health expenditure in Millions

4.64 Though the data available by the 4 units show a steady increase in mental health expenditure, except Gilgil which started as a mental healthcare facility, the maximum amount spent on mental healthcare for the period under review was just 3% of their overall hospital allocation while the remaining 97% of the allocation was spent on other general services as shown in **Table 12** below.

Table 12: Overall hospital allocation vs mental health allocation

Hospital	Total Allocation	Mental Health Allocation	%
Moi	16,762,474,374.00	448,316,984	3
Kisii	848,764,614.00	9,967,580	1
Gilgil	76,548,546.00	61,238,837	80
Kerugoya	218,132,457.00	1,794,283	1
Total	**17,905,919,991.00**	**521,317,683.60**	

OAG Analysis of funding from four units

4.65 Though the counties attributes the low funding on mental healthcare to lack of a budget line for Mental Health from Controller of Budget (COB) which would guide in budgeting for mental healthcare services, this doesn't seem to be the case. Rather, lack of budgets and funding for mental healthcare services is an indicator of low priority given to mental healthcare services at the county level. As a result, delivery of these services at the psychiatric units is negatively affected by;

Inadequate Diagnostic and Treatment Equipment for Service Delivery

4.66 The basic equipment needed in the counties for effective Diagnosis and treatment of mental disorders are: ECT (Electroconvulsive Therapy), EEG (Electroencephalogram), CT scanners and Magnetic Resonance Imaging machine (MRI). 15 of the 19 units visited lacked all this equipment while the remaining 4 units had at least one of the machine as shown in **Table 13.**

Table 13: Analysis of equipment available at the Units

Unit	Machine	No.	Functional
Moi	ECT	1	Yes
	EEG	1	Yes
Nakuru	ECT	2	Yes. One machine is non-functional.
Kakamega	ECT	1	No
Kisumu	ECT	1	No

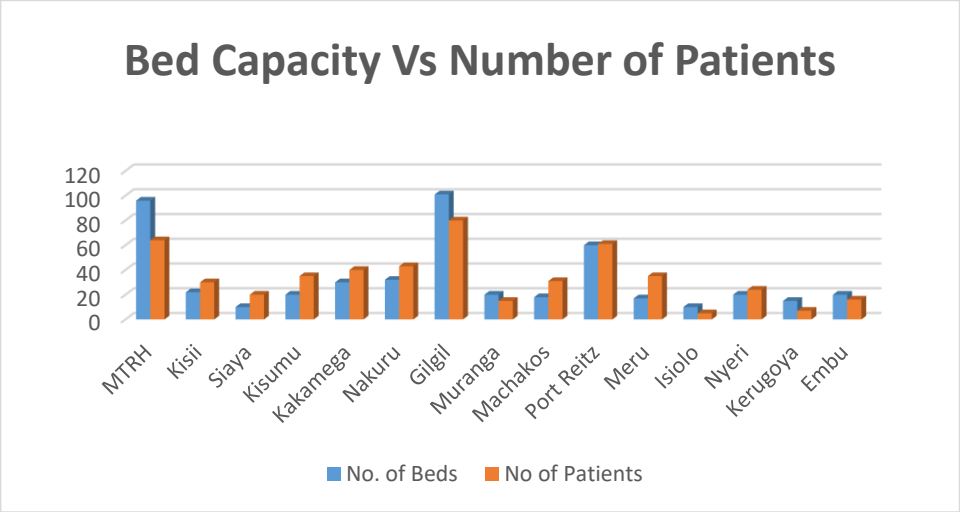
Source: OAG Analysis of equipment in four units

4.67 Non availability of functional equipment at the units means that patients have to incur the cost of related tests in other hospitals and most of the patients are usually referred to Mathari Hospital for the test, regardless of the distance and the costs related. The patients who cannot afford to pay for the transport costs to Mathari have to stay at the hospital and as a result, it takes longer to get the right diagnosis and treatment leading to more psychological problems to the patients, increased number of patients in the wards as well as increased burden to the family.

Insufficient Number of Wards in the Units

4.68 According to Mental Health Act, 1989, Part IV Section 9 (6), every mental hospital shall have facilities for inpatient and outpatient treatment of persons suffering from mental disorder. Of the 19 units visited, 15 indicated that they had psychiatric wards while the remaining 4 i.e. Kericho, Jaramogi Oginga Odinga, Garissa and Thika did not have psychiatric wards. These 4 hospitals thus treat patients on outpatient care while those patients who require inpatient facilities are referred to the closest of the 15 units that have psychiatric wards. Of the 15 units with psychiatric wards, the average number of beds was 23 against an average number of 28 patients. As at the time of the audit, 9 of the 15 hospitals had more inpatients in the psychiatric wards than the available number of beds thus the patients were sharing beds as shown in **Figure 5** below.

Figure 5: **Bed Capacity Vs Number of Patients**



Source: OAG Analysis of bed capacity vs number of patients

4.69 In addition, most of the wards were in poor condition with several beds without mattresses, broken doors and windows and cracked walls as shown in **Figure 6** below. Though the general wards in most hospitals have been renovated, the mental health units have not been rehabilitated indicating lack of prioritisation of mental healthcare services by the hospitals' management and County Governments. As a result, the buildings do not provide the right living environment for the patients.

Figure 6: Status of some of the facilities at the Units

Case 3(a): Poor State of Wards at the Psychiatric Units
Photos: Deplorable state of wards
Institution: Several Psychiatric Units
Source of funding: GOK/ Cost Sharing
Ward Status: Beds without mattresses, Toilet without running water, broken doors, renovated general ward and non-renovated psychiatric unit
Performance issue: Poor living conditions for patients. Most of the wards were in poor condition with several beds without mattresses, broken doors and windows and cracked walls as shown in the photos below. In Siaya, the hospital was recently renovated but the psychiatric ward has not been renovated and or expanded since its inception in 1952

Beds without mattresses that patients use at Gilgil and a toilet without running water at Nyeri psychiatric ward

Recently renovated facility at Siaya hospital and a psychiatric unit in a dilapidated state within the same hospital
Source: OAG Kenya photos taken 26/10/2016

Insufficient Medical Drugs.

4.70 As at the time of audit, a review of drug records maintained at the units indicated that 11 of the 19 units use 1st generation drugs only indicating that the 2nd generation drugs are expensive and not readily available while the remaining 8 units use both 1st and 2nd generation drugs. Further analysis indicate that 11 units complained of insufficiency in antipsychotic drugs while the remaining 8 units stated that the drugs were adequate for their patients. The effect of insufficient supply of drugs is that the patients have to procure the drugs privately while those who cannot afford to buy them have no option but to stay longer in hospitals awaiting their availability. This causes a financial burden to both the hospital and the family, while the patient is denied timely treatment.

Shortage of personnel

4.71 The professionals required for treatment and management of mental illnesses are Consultant psychiatrist, clinical psychologists, psychiatric nurse, medical social workers, and psychotherapists. 9 of the 19 units had psychiatrists while 10 did not have thus rely on visiting consultants, medical officers and psychiatric nurses to attend to the patients. All 19 units had psychiatric nurses, only 4 of the units had psychologists, 11 units had Medical social workers while only 6 units had occupational therapists. **Table 14** below shows the average number of patients in units with wards, against the mental health personnel in these units.

Table 14: Patients vs mental personnel in the Units

Unit	Patients	Nurses	Psychiatrist	Psychologists	Medical Social Workers	Occupational Therapists
MTRH	64	7	1	28	5	5
Kisii	30	4	1	0	0	0
Siaya	20	1	0	0	2	2
Kisumu	35	3	0	0	2	0
Kakamega	40	9	0	0	0	1
Nakuru	43	6	1	1	0	1
Gilgil	80	15	1	0	1	1
Muranga	15	4	1	0	2	0
Machakos	31	11	0	1	0	0
Port Reitz	61	4	0	0	1	2
Meru	35	2	1	0	1	0
Isiolo	5	3	0	0	0	0
Nyeri	24	2	1	1	0	0
Kerugoya	7	2	0	1	1	0
Embu	16	2	1	0	1	0

Source: OAG Analysis of mental health professionals vs Number of Inpatients

4.72 While information on the standard ratio for each of these professionals is not readily available, World Health Organization (WHO) recommends a ratio of 1 psychiatric nurse to every 6 mentally ill patients. Though the audit revealed that most of the units had more psychiatric nurses compared to the patients as shown in **Table 15**, the lack of patients can be attributed to the fact that most patients prefer to go to Mathari hospital, mostly due to lack of information about the existence of these facilities, or poor services offered at these facilities.

Table 15: **Nurse to Patients ratio at the units**

Unit	Psychiatric nurses	patients	Ratio of nurses to patients
MTRH	7	64	1:9
kisii	4	30	1:8
siaya	1	20	1:20
kisumu	3	35	1:12
kakamega	9	40	1:5
Nakuru	6	43	1:8
Gilgil	15	80	1:5
Muranga	4	15	1:4
Machakos	3	31	1:10
Port reitz	16	61	1:4
Meru	18	35	1:2
Isiolo	2	5	1:3
Nyeri	12	24	1:2
Kerugoya	4	7	1:2
Embu	8	16	1:2

Source: OAG Analysis of Number of Patients per Nurse

5) Lack of rehabilitation facilities, outreach programmes and integration of mental health services in general hospitals.

4.73 According to World Health Organization, majority of mental health issues can be managed by the patient themselves, family, informal community as well as trained health care providers and professional. WHO has developed the optimal mix of services that provide guidance to countries on how to organize mental healthcare services as indicated in **Figure 7.**

4.74 The figure illustrates that the majority of mental health care can be self-managed or managed by community mental health services. Where additional expertise and support is needed a more formalized network of services is required which include Primary Health Care (PHC) services, followed by specialist community mental health services and psychiatric services in general hospitals and lastly by specialist and long stay mental health services. The figure also shows that mental hospitals and specialist services present the highest cost, yet are the least frequently needed service as opposed to self-care or informal community care, which has a high frequency of need and can be provided at a relatively low cost.[12]

[12] http://www.who.int/mental_health/policy/services/2_Optimal Mix of Services_Infosheet.pdf

Figure 7: WHO pyramid Framework for optimal mix of services for mental health

4.75 Though the Ministry of Health indicated that they have come up with strategies that would ensure the achievement of the WHO recommendations, the strategies as listed below have not been adequately carried out:

i. Integration of mental health services in general Hospitals,
ii. Community mental health outreach - provision of community mental health services through training of community health and health extension workers in primary care level in mental health at basic and specialized level,
iii. Scaling up mental health services in general hospitals for both integrated and specialized services.
iv. Provision of primary care guidelines - support supervision and psychotherapeutic products, equipment and technologies at primary care.
v. Creating partnerships and collaboration with NGO's, Faith-based institutions, other Government ministry/departments/agencies, traditional healers, caregivers, users and support groups and mental

health promotion campaigns through information and educational materials and media-communication.

4.76 The audit revealed that in many rural areas there is a chronic gap between the need for and availability of mental healthcare services. As a result, the patients suffering from mental illnesses are always stigmatized and treated as criminals. The country has a total of 47 counties yet the facilities that offer mental healthcare services are only available in 25 counties indicated in **Appendix 5** of this report, and the patients in the remaining 22 counties have to travel for long distances to seek mental healthcare services. In addition, the heads of the available units indicated that there are no outreach programs that would sensitize the community on mental health matters, reduce stigmatization of persons with mental illnesses, and assist healthcare personnel to reach out to the patients who are far from the facilities.

4.77 WHO also recommends building of community mental health services such as rehabilitation services and half way homes which would help in discharging patients from psychiatric hospitals thus easing the scarce and expensive hospital beds. Further, according World Psychiatric Association (WPA) Journal of October 2006, patients suffering from severe and persistent mental illness require psychiatry rehabilitation, whose goal is to help mentally ill patients develop emotional, social and intellectual skills needed to live, learn and work in the community with the least amount of professional support.

4.78 Rehabilitation services are also provided as a step down for those patients moving from secure mental health facilities but have long term and complex mental health needs. Further, evidence from the Practical Mental Health Commissioning shows that around two thirds of people supported by rehabilitation services progress to successful community living within five years and around 10% achieve independent living within the period.

4.79 Of the 16 hospitals with in-patient services, heads of 14 hospitals stated that they lack rehabilitation centres to be used by the recuperating patients and patients recovering from drug abuse while only Mathari Hospital and MTRH had alcohol and drug abuse rehabilitation centres. Lack of rehabilitation and outreach programs can be attributed to the fact that, in managing of mental healthcare services in Kenya, the national and county governments seem to be focusing more on hospital admissions and specialists' services as opposed to self and community care services.

5.0 Conclusions

5.1 The audit concludes that the measures put in place by the Ministry of Health (MoH) and County Governments have not been effective in the provision of mental healthcare services, both at national and county level. The main reasons are the provisions of the mental Health Act of 1989 have never been fully implemented, the Act has also not been updated in line with Constitution of Kenya 2010, and there are management challenges in the hospitals delivering mental healthcare services both at the National and County Level. Specifically;

5.2 The Ministry of Health has not effectively delivered on its mandate of provision of Health Policy and Standards management. As such the psychiatric units are still using the guidelines provided in the Mental Health Act 1989 which does not incorporate the rights of the mental health patients and the county mental health councils that would support in management of these units and the related issues. Further, the already developed standards and guidelines to be used for mental healthcare service provision have not been communicated effectively to all the hospitals for use.

5.3 The referral system put in place by the Ministry of Health is not effective for mental healthcare services since the services are only available in very few health facilities. Even in these few facilities patients face various challenges in accessing specialized services including lack of coordination between the referring and the receiving facility and continuity of care.

5.4 Provision of Mental healthcare services has not been adequately managed by the MoH at the National referral hospital. The hospital is provided minimal resources in compared with the workload leading to shortage of critical equipment, wards and other physical facilities, medical drugs and qualified personnel needed to deliver services efficiently. In addition, those who consume the training and forensic services have not been contributing the resources needed to cater for the services rendered causing more strain.

5.5 Provision of mental healthcare services have not been adequately managed by the counties since the available psychiatric units are also faced with inadequate facilities, insufficient medical drugs and shortage of qualified personnel needed for efficient mental healthcare service delivery.

5.6 The National and County Governments have not developed outreach programs, half way homes and rehabilitation centres thus many patients are still unreached and locked in by families, patients with mental illnesses are still stigmatized while most recovering patients face rejection by family and community and still remain in hospitals instead of being integrated back into the community.

6.0 Recommendations

6.1 In view of the findings and conclusions of the audit, the recommendations for implementation by the Ministry of Health and County Governments intended to facilitate efficient provision of mental healthcare are:

6.2 The Ministry should ensure the Mental Health Bill 2014 finalised for enactment so as to incorporate the constitutional provisions that include the County Governments, the rights to be accorded to the patients, as well as incorporating the County Mental Health councils. In addition, the Ministry should effectively communicate the already developed standards and guidelines to all the hospitals for use in enhancing efficient mental healthcare service delivery.

6.3 The Ministry together with the County Governments should endeavour to integrate mental healthcare services at all levels of healthcare facilities so that all citizenry can easily access these services. Consequently, the Ministry should strengthen mental healthcare linkages to ensure that only referred patients are admitted at Mathari Hospital.

6.4 For effective delivery of specialised mental health care services at the Mathari referral hospital;

i. The Ministry should consider making Mathari Hospital a semi-autonomous Government Agency as expected of a national referral hospital. This will enhance its capacity to mobilise resources and to deliver services in line with the hospitals mandate for provision psychiatric health services and training.

ii. The hospital management through the Ministry of Health should liaise with the Ministry of Interior, Coordination of National Government - Department of Correctional Services on how to cater for the patients in the Maximum Security Unit wards to avoid overstretching the available resources at the hospital.

iii. The management of the hospital through the Ministry's legal department should enact a policy on initiating binding Memoranda of Association with the various public and private institutions that train their students at the hospital. This will ensure that the resources for training and the training facilities are appropriately provided without overstretching the resources for other services.

iv. The financing for and consumption of forensic services should be debated on and agreed by the Criminal Justice System. The various government ministries should cooperate on the delivery of forensic services in the country

and there is need for an agreement on who does what with regards to these services.

v. In integrating general health services at Mathari hospital, the Ministry should consider investing in this services so as not to negatively affect delivery of mental health care services. The Ministry also needs to re-consider the level of general services that should be provided at the referral hospital to ensure the hospital retains its status and only offers services at its level as opposed to walk in services.

6.5 To support and improve mental healthcare service delivery throughout the country, the Ministry and all the County Governments should prioritize provision of mental healthcare services, to ensure that there are adequate relevant qualified personnel and provision of critical medical equipment and drugs.

6.6 To destigmatize, decriminalize and reach all the patients with mental illnesses, the Ministry in conjunction with County Governments should;

i. Ensure that substance use related and addictive disorders are managed in hospitals thus the healthcare facilities should make available bed capacity for patients with these disorders.

ii. Carry out public awareness campaigns and outreach programmes to sensitize and inform the public about mental illnesses.

iii. Establish some aftercare rehabilitation and social support services to be provided in the Community e.g. halfway homes to be regulated by MoH & Social Services. This would help the recovering patients gain skills and behavioural changes with the aim of regaining their functionality, productivity as well as preventing disability.

APPENDICES

Appendix 1: List of the original 19 Psychiatric Units visited

	Hospital	County
1.	Gilgil	Nakuru
2.	Nakuru Level 5	
3.	Machakos Level 5	Machakos
4.	Embu Level 5	Embu
5.	Nyeri Level 5	Nyeri
6.	Kakamega Level 5	Kakamega
7.	Jaramogi Oginga Odinga Referral	Kisumu
8.	Kisumu County Hospital	
9.	Kisii Referral	Kisii
10.	Muranga	Muranga
11.	Kirinyaga	Kirinyaga
12.	Siaya Hospital	Siaya
13.	Thika Level 5	Kiambu
14.	Meru Hospital	Meru
15.	Isiolo Hospital	Isiolo
16.	Moi Teaching & Referral Hospital	Uasin Gishu
17.	Kericho Hospital	Kericho
18.	Garissa Hospital	Garissa
19.	Port Reitz	Mombasa

Appendix 2: List of Officers Interviewed

Position of the interviewee	Purpose of the interview
Director of Mental Health	To understand general outlook of mental health in Kenya
Head of National Referral Hospitals	Responsibility of the Ministry for Mathari Hospital as a referral.
Head of Standards Department	Statistics on mental healthcare in Kenya
Curative & Rehabilitative Department Official	To obtain Guidelines/process in treatment of various mental illnesses, Mental Health Care Standards and to understand the Status of Mental Health Bill.
Chief Officers of Health- County	To understand general outlook of mental health in the various counties
Medical Superintendents	To understand the various functions and operations of MNT&RH and the 19 other hospitals
Supply Chain Management Officers	To understand how the procurement process of drugs is carried out.
Accountants	To understand how Ministry, Counties, Hospitals are funded and also revenue collection.
Nursing Officer i/c	To understand service delivery process for both inpatient and outpatient.
Psychiatrists	To understand the various psychiatric conditions treated at MNTRH and the Mental health Units
Psychiatric Nurses	To understand the various psychiatric conditions treated at MNTRH and the Mental health Units
Pharmacists	To know the various drugs used to treat mental health at the hospitals.
Health Records Officers	To know the mental health patients data
Human Resource Officers	To know the number of staff involved in mental healthcare at the Ministry and Counties

Appendix 3: Documents Reviewed

Document	Information needed from the document
Mental Health Act 1989	Requirements of a mental health facility
Mental Health Policy 2015-2030	To obtain information on management and coordination of mental health in Kenya
Kenya health Sector Strategic and Investment plan 2014-2018	To understand the goals, strategy, action plans guiding health in the country
Ministerial Strategic and Investment plan 2014-2018	To obtain information on operations of the Ministry.
Kenya Health Policy 2014-2030	To obtain information on management and coordination of health in Kenya
DSM IV/V	To understand the various mental health disorder clusters
AIEs	Sources and level of funding
Constitution of Kenya 2010	To assess whether the ministry and the hospital are delivering service as required by the constitution.
UN Resolution on protection of Persons with mental illnesses	To understand how mental healthcare services should be managed
Kenya Health Sector Referral Strategy	To understand how the referral system works
Kenya Human Resources Strategy	To understand the Human Resources requirement in Kenya

Appendix 4: Audit Criteria

Audit Sub-Objective	Audit Criteria	Source of Criteria
To establish whether standards and guidelines have been put in place to guide provision of mental healthcare services in the country.	The Ministry is mandated with provision of Health Policy and Standards Management while the Ministerial Strategic Plan 2014-2017, indicates that the primary role of the Ministry of Health is to provide the policy framework that will facilitate the attainment of highest possible standard of health, and in a manner responsive to the needs of the population. Part IV states that the Minister may, in consultation with the Board, make rules for the control and proper management of mental hospitals and may by such rules prescribe the standards to be maintained for mental hospitals. Further, Part IV Section 9 (6) states that every mental hospital shall have facilities for inpatient and outpatient treatment of persons suffering from mental disorder.	The Executive Order No. 2/2013 The Mental Health Act, 1989
To assess the extent to which the set standards and guidelines are being used to effectively deliver mental healthcare services at the national referral hospital; and at the county psychiatric units	Article 20(5)(b) of the states that, in allocating resources, the state shall give priority to ensuring the widest possible enjoyment of the right or fundamental freedom having regard to prevailing circumstances, including the vulnerability of particular groups or individuals. Principle 13(2) of states that; the environment and living conditions in mental healthcare facility shall be as close as possible to those of the normal life of persons of similar age. Additionally, Principle 14(1) states that a mental health facility shall have access to the same level of resources as any other health establishment and in particular; 14(1)(a) qualified medical and other appropriate professional staff in sufficient numbers, 14(1)(b) diagnostic and therapeutic equipment for the patient and 14(1)(d) adequate, regular and comprehensive treatment, including supplies of medication.	The Constitution of Kenya 2010 The UN Resolution on Protection of Persons with Mental Illness

	Most of the population of Kenya is rural and poor. An effective referral system is expected to ensure health services to all people in Kenya. The system should provide coordination and standardization of referral services and continuity of care across the different levels of care.	The Kenya Health Sector Referral Implementation Guidelines
	A referral hospital should have a utility vehicle, communication gadgets, fully equipped theatre with anaesthetic machine, vacuum machine, physiological monitors, theatre tables, specialised sets and diagnostic kits.	The Kenya Health Sector Referral Strategy 2014-2018, Logistics for Expertise Movement
	Section 109(2a) states that the County Treasury for each County Government shall ensure that all money raised or received by or on behalf of the County Government is paid into the County Revenue Fund.	Public Finance Management Act 2012
	Good management of F.I.F shows that F.I.F should be used in visible improvements in the hospitals	Facility Improvement Fund Operation Manual December 2002

Appendix 5: List of counties with hospitals that offer mental healthcare services

	County	Hospital
1.	Nakuru	**1.** Gilgil hospital, **2.** Nakuru Level 5
2.	Machakos	**3.** Machakos Level 5
3.	Embu	**4.** Embu Level 5
4.	Nyeri	**5.** Nyeri Level 5
5.	Kakamega	**6.** Kakamega Level 5
6.	Kisumu	**7.** Jaramogi Oginga Odinga Referral **8.** Kisumu County Hospital
7.	Kisii	**9.** Kisii Referral
8.	Muranga	**10.** Muranga
9.	Kirinyaga	**11.** Kirinyaga
10.	Siaya	**12.** Siaya Hospital
11.	Kiambu	**13.** Thika Level 5 hospital
12.	Meru	**14.** Meru Hospital
13.	Isiolo	**15.** Isiolo Hospital
14.	Uasin Gishu	**16.** Moi Teaching & Referral Hospital
15.	Kericho	**17.** Kericho Hospital
16.	Garissa	**18.** Garissa Hospital
17.	Mombasa	**19.** Port Reitz **20.** Coast general hospital
18.	Kitui	**21.** Kitui level 4 hospital
19.	Nairobi	**22.** Mama Lucy hospital **23.** Mbagathi level 4 hospital
20.	Narok	**24.** Narok level 4 hospital
21.	Trans-Nzoia County	**25.** Kitale level 4 hospital
22.	Makueni	**26.** Makueni level 4 hospital
23.	Kilifi	**27.** Malindi level 4 hospital
24.	Tharaka Nithi	**28.** Chuka level 4 hospital
25.	Bungoma	**29.** Webuye level 4 hospital

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