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CLERK AT THE TABLE:	<u>INZOFU MWALE</u>

DEPARTMENTAL COMMITTEE ON HEALTH REPORT ON THE STATUS OF
NATIONAL REFERRAL HOSPITALS

DIRECTORATE OF COMMITTEE SERVICES
THE NATIONAL ASSEMBLY
PARLIAMENT BUILDINGS
NAIROBI.

MAY, 2019

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ABBREVIATIONS

AMPATH	Academic Model Providing Access to Healthcare
KMTC	Kenya Medical Training College
KNH	Kenyatta National Hospital
MAT	Medically Assisted Therapy
MES	Managed Equipment Service
MoU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
MTRH	Moi Teaching and Referral Hospital, Eldoret
MUCHS	Moi University College of Health Sciences
NHIF	National Hospital Insurance Fund.
PWIDs	People Who Inject Drugs
PWUDs	People Who Use Drugs
S4A	Shoe 4 Africa
TB	Tuberculosis
UHC	Universal Health Coverage
USAID	United States Agency for International Development

CHAIRPERSON'S FOREWORD

The Constitution of Kenya 2010 in the Fourth Schedule devolved provision of health services, save for national referral health facilities and National health policy. The country's health policy is currently driven by the Kenya Health Policy 2014-2030 which intends to see the attainment of the highest standard of health. It is under this ambit that the government has embarked on a roll out of Universal Health Coverage (UHC), with a 100% target by 2022.

The country currently has five referral health facilities, namely-

- i) Kenyatta National Hospital;
- ii) Moi Teaching and Referral Hospital;
- iii) National Spinal Injury Hospital;
- iv) Mathari National Teaching & Referral Hospital; and
- v) Kenyatta University Teaching and Referral Hospital.

Kenyatta University Teaching and Referral Hospital is the latest addition to the list, and the Committee was instrumental in the start of its operations through a report tabled in Parliament, that compelled the National Treasury to allocate resources for its dry run and eventual roll out of services. The President has since signed an Executive Order for its establishment as a legal entity and its operationalization is underway.

The Committee visited and met with the boards and managements of the hospitals in this pursuit.

The Committee wishes to thank the Office of the Speaker of the National Assembly and the Office of the Clerk of the National Assembly for the necessary support extended to it in the execution of its mandate. I wish to also thank the Members of the Committee for their expert, insightful and thoughtful participation and their dedication. I also thank the secretariat for its technical service, dedication, and facilitation to the Committee to

produce this report. The Committee further extends its appreciation to the respective facilities for the support and cooperation extended to the Committee during the visits.

On behalf of the Members of the Committee, and pursuant to Standing Order no. 199(6), it is my distinguished honour and privilege to present this report of the Departmental Committee on Health on the Status of National Referral Hospitals for debate and adoption by the House.

Thank You

SIGNED


HON. SABINA CHEGE, MP (CHAIRPERSON)

DATE.....
8/5/19

EXECUTIVE SUMMARY

In efforts to streamline operations of health facilities that are under the management of national government, the Committee embarked on an inquiry on the operations of these hospitals and a fact finding mission to visit and meet with management and staff of Mathari National Teaching Hospital, the National Spinal Injury Referral Hospital, Moi Eldoret Teaching and Referral hospital and Kenyatta National Hospital.

In Mathari Hospital, the Committee found a hospital under perpetual neglect by the Ministry, with its facilities run down and dilapidated. The hospital is run as a department of the Ministry, starving it of the autonomy it requires to be well managed. The hospital has an acute shortage of staff, compounded by an overstretched maximum security wing whose management is left to the hospital with no requisite resources. The facility's challenges include neglected patients, many of whom lack NHIF membership cards. Even for those who use the insurer, the NHIF takes inordinately long to compensate the hospital. The hospital's land has also been encroached.

The National Spinal Injury Hospital on the other hand is built on a small piece of land and with no room for expansion. The hospital also lacks autonomy and faces the same challenges of inadequate staff, lack of equipment and low funding.

Moi Teaching and Referral Hospital in Eldoret hand suffers the burden of serving patients from 21 counties in the rift valley and western regions of the country. The hospital has had relative success in staff management, donor partnerships and has a vision for expansion. The hospital also faces inadequate funding and has had to shoulder waivers for indigents.

Kenyatta National Hospital lacks a substantive chairperson of the board, as well as a CEO. The hospital is unduly overstretched and has previously faced several crises, caused by grossly inadequate funding, industrial action, outdated equipment, staff inadequacy

and suffers the burden from an almost collapsing county healthcare system. The hospital has seen KURA and NLC acquire its land without commensurate compensation.

The Committee recommends full autonomy for Mathari and Spinal Injury hospitals, with improved funding and equipment. Mathari hospital must review the status of the maximum security wing together with the State Department of Correctional Services. The hospital should also acquire its title deed.

Moi Teaching and Referral hospital should be equipped to cater for the numerous patients, and funded to bridge budgetary shortfalls. Development partners who have faced administrative challenges must be facilitated by the Ministry of Foreign Affairs.

The Ministry should ensure that Kenyatta National Hospital gets substantive leadership and its budgetary allocation enhanced. The NLC and KURA should immediately compensate the hospital for the land acquired for road construction.

National Hospital Insurance Fund (NHIF) and Kenya Medical Supplies Authority (KEMSA), as enablers of Universal Health Coverage (UHC) should immediately boost their capacity, among other recommendations detailed in this report.

1.0 PREFACE

1.1 Establishment and Mandate of the Committee

Mr. Speaker Sir,

The Departmental Committee on Health is established pursuant to the provisions of Standing Order No. 216(5) of the National Assembly and in line with Article 124 of the Constitution which provides for the establishment of the Committees by Parliament. The mandate and functions of the Committee is to;

- a) Investigate, inquire into, and report on all matters relating to the mandate, management, activities, administration, operations and estimates of the assigned Ministries and departments;*
- b) Study the programme and policy objectives of the Ministries and departments and the effectiveness of the implementation;*
- c) Study and review all legislation referred to it;*
- d) Study, assess and analyze the relative success of the Ministries and departments as measured by the results obtained as compared with its stated objectives;*
- e) Investigate and inquire into all matters relating to the assigned Ministries and departments as they may deem necessary, and as may be referred to them by the House;*
- f) Vet and report on all appointments where the constitution or any law requires the National Assembly to approve, except those under Standing Order 204; and*
- g) Make reports and recommendations to the House as often as possible, including recommendation of proposed legislation.*

The Departmental Committee is mandated to cover the functions of the Ministry of Health alongside Semi-autonomous Government Agencies (SAGAs) including but not limited to; Kenyatta National Hospital; Moi Teaching and Referral Hospital; Kenya

Medical Training College; Kenya Medical Supplies Authority and National Hospital Insurance Fund.

1.2 Oversight

The Committee is mandated to cover the functions of the Ministry of Health in accordance with the Fourth Schedule of the Constitution. This includes semi-autonomous agencies and regulatory bodies that fall under the Ministry.

1.3 Committee Membership

The Committee comprises the following Honourable Members;

	NAME	POLITICAL PARTY	CONSTITUENCY/ COUNTY
1	Hon. Sabina Chege, MP – Chairperson	Jubilee	Murang'a
2	Hon. Swarup Ranjan Mishra, MP – Vice Chairperson	Jubilee	Kesses
3	Hon. (Dr.) Eseli Simiyu, MP	Ford Kenya	Tongaren
4	Hon. (Dr.) James Nyikal, MP	ODM	Seme
5	Hon. Alfred Agoi Masadia, MP	ANC	Sabatia
6	Hon. (Dr.) James Kipkosgei Murgor, MP	Jubilee	Keiyo North
7	Hon. Muriuki Njagagua, MP	Jubilee	Mbeere North
8	Hon. (Dr.) Mohamed Dahir Duale, MP	KANU	Daadab
9	Hon. Stephen Mule, MP	Wiper Democratic Movement	Matungulu
10	Hon. Esther M. Passaris, MP	ODM	Nairobi
11	Hon. Gladwell Jesire Cheruiyot	KANU	Baringo
12	Hon. Kipsengeret Koros, MP	Independent	Sigowet-soin

13	Hon. Martin Peters Owino, MP	ODM	Ndhiwa
14	Hon. Mercy Wanjiku Gakuya, MP	Jubilee	Kasarani
15	Hon. Prof. Mohamud Sheikh Mohamed, MP	Jubilee	Wajir South
16	Hon. Patrick Munene Ntwiga, MP	Jubilee	Chuka Igamba Ng'ombe
17	Hon. Tongoyo Gabriel Koshal, MP	CCM	Narok West
18	Hon. Zachary Kwenya Thuku, MP	Jubilee	Kinangop

1.4 Secretariat

The Committee is facilitated by the following members of the Secretariat;

1. Mr. Victor Weke - Clerk Assistant I
2. Mr. Muyodi Meldaki Emmanuel - Clerk Assistant III
3. Mr. Ahmed Hassan Odhwa - Principal Research Officer
4. Ms. Lynette Otieno - Legal Counsel I
5. Mr. Erick Kanyi - Fiscal Analyst

2.0 MATHARI NATIONAL TEACHING AND REFERRAL HOSPITAL

2.1 Background

1. Mathari National Teaching and Referral Hospital is a specialized national referral facility for mental health patients that was established in 1904 as a Small Pox isolation Centre and which later became a lunatic Asylum. In 1924, it became Mathari Mental Hospital and later in 1964 it became Mathari Hospital. In 1978, a maximum security unit was opened for law offenders with mental illness.
 2. The Hospital is the only public institution in the country offering specialized psychiatric Services, forensic services, drug rehabilitation services and training in psychiatry for doctors and other health workers from both public and private institutions from the region. It also offers a comprehensive care Clinic for HIV patients.
 3. The hospital has a bed capacity of 700 but with 650 beds currently (332 beds in the civil unit and 318 in the maximum security unit. It has average bed occupancy of 119% in the civil unit and 115 % in the maximum security unit.
 4. The hospital offers the following services: -
 - i) Receive referrals of mentally ill persons from other facilities for specialized care
 - ii) Receive mentally ill law offenders from courts, prisons and police department for assessment and forensic mental health care
 - iii) Provide treatment and rehabilitation for persons with addiction and behavioral disorders
 - iv) Provide training and research facilities in mental health
 - v) Participate as a national referral hospital in national health policy planning.
-

2.2 Visit to the facility

5. The Committee visited the facility on Thursday 15th November 2018 and met with the management led by Dr. Jumba, the Medical Superintendent. He led the Committee

on a guided tour of the facility's various departments i.e. Medically Assisted Therapy (MAT) clinic, Acute psychiatric ward for male patients and the maximum security unit. During the tour, discussions with the personnel were held on the experiences and challenges they faced on daily basis and possible solutions to their problems.

6. The management informed the Committee that the Hospital offers primarily specialized mental health services at inpatient and outpatient level comprising of general psychiatry services, child and adolescent psychiatry, substance use disorder (addiction) management and forensic psychiatry. The hospital also offers non-psychiatric services such as general medical outpatient (child and adult), antenatal services, mother –child Health and Family planning services, physiotherapy, occupational therapy, orthopedic, diabetic clinic, disability assessment and dental services.
7. In the recent years the hospital had witnessed some positive development on its infrastructure as it acquired 200 KVA transformers, 1 staff van, 3 water tanks and constructed General Out-patient Clinics waiting bay (GOPC). The hospital's human resource was also boosted by hiring of 10 nurses though on contract terms, 2 HRIO and 1 psychologist. There was also improved supply of 2nd generation antipsychotic FIF/ recurrent.
8. The management stated that the facility faced a myriad of challenges including lack of representation at Mid Term Expenditure Framework (MTEF) or any budgetary high level meeting. This was due to the fact that the hospital operated as a department of the Ministry rather than a semi-autonomous legal entity. To compound this challenge, the steering committee's term had expired with the ministry having not constituted another one.
9. Moreover, a lack of a vote on the utilization of recurrent budgetary allocation results in restriction in accessibility of funds and sometimes inability of funds utilization. Due to the processes and authorization requirements at the headquarters, this hampered processes of procurement plan approval, tendering processes and ultimately exchequer issues.

10. The hospital's recurrent allocation was reduced in the 2018/19 from 114m to 92m with drug allocation dropped from 17m to 2.6m for the entire year. Over the years the budgetary allocation had remained constant despite an increment in the number of patient and cost of living. During the FY 2017/2018 the development funds were reduced from 75m to 18m. However, none of these funds were paid by the end of June 2018. To compound the situation, the NHIF owed the hospital Ksh. 105 Million.
11. As a result of these budgetary constraints, the current hospital infrastructure is dilapidated, run-down and does not meet the norms and standards of a referral and teaching facility. The hospital's facilities have not expanded to accommodate the rising needs of the patients. The roofs are leaking, the walls are cracked and crumbling, the sewage system is destroyed resulting in constant blockages and the water pipes are old with several leakages on the system. There was erratic water supply and huge water losses due to leakages hence huge water bills.
12. On staffing, there were severe shortages of staff in all cadres. The total number of staff is 386 against a recommended 1077 sufficient to run the facility under ideal international acceptable standards. A percentage of 36%. The hospital operates with only 164 nurses against a required 500 nurse, 11 psychiatrist against a required 20, 5 clinical officers against a required 10. Currently, the budgetary allocation for salaries/compensation to employees for the hospital is 615M. However, the hospital does not utilize the allocated amount fully as a result of non-exchequer releases.
13. The hospital's forensic unit, maximum security unit established in 1978, has been neglected since then. It has a physical capacity of 194 beds. However at any one particular time the actual occupancy is almost 140%. The unit has an outpatient that runs 3 times a week attending to 155 offenders per month.
14. There is no clear policy direction in which ministry the maximum security unit belongs to is still going on. This had resulted in lack of ownership of the clients, ineffective service delivery, and lack of funding, prolonged hospital stay, ineffective referral and management of the medical ill clients.

15. There is no clear funding for the mentally ill patients in the facility; their medical care, social amenities; food and nutrition are all taken care of from the general budget of the hospital.
16. To address these challenges, the management proposed a raft of recommendations including Mathari hospital having a charter to operate as a SAGA. This would mean that budgetary provisions are appropriated directly to the hospital whose management is able to secure all the required resources and run the hospital independently.
17. There was also need to increase income through the several institutions using MNTRH as a teaching center. The MOU with KMTTC needs to be reviewed as their students are a larger consumer of resources and products at the hospital. Also, an inculcated health system for the mentally ill offenders with steady funding needs to be set up and the NHIF should also explore new system where mentally ill patients are covered.
18. Currently the hospital is in a protracted struggle to secure a title deed and there had been an increased encroachment of the facility's land and this sabotages its future expansion plans.

Medically Assisted Therapy (MAT) clinic

19. The Committee also toured MAT clinic where active drug users underwent Medically Assisted Therapy (MAT) which involved administering of methadone and counseling. The Committee was informed that the programme was launched in 2015. The clinic administered Methadone on a daily basis to heroin addicts most of whom were unemployed youths who hail from the informal settlements around. Majority of them engage on petty crimes to sustain their addiction.
20. Since its launch the programme has enrolled 950 addicts and currently it has 750 active clients. The programme's retention rate stands at 82% thanks to the effective tracing mechanisms they employ to trace defaulters. The programme has so far reached over 3,000 people and it plans to target 9,000 People who inject drugs (PWIDs) in Nairobi.

21. The Committee was further informed that there was high prevalence of HIV, Hepatitis B & C and TB among the PWIDs who visit the clinic. The same group suffers from higher rates of food insecurity and malnutrition. Several interventions had been incorporated into the harm reduction program to help the affected addicts, these includes: Needle and syringe programmes (NSP), HIV testing and counseling (HTC), Provision of antiretroviral therapy (ART), provision of condoms and many other interventions intended to provide care for PWIDs.
22. However, some of the interventions offered at the clinic i.e medically assisted therapy and providing clean needles to PWID are not anchored in law and thus are implemented at the discretion of the law enforcement apparatus. There have been incidences where the police burned and confiscated NSP and even arrested the personnel attending to the PWIDs.
23. The Committee later interacted with people who use drugs (PWUDs) who shared their pain, their journey to recovery from drug addiction, experiences at the hand of the law enforcement officers; stigma they face from the public and frustration that comes with failure to get social support from their community.

3.0 THE NATIONAL SPINAL INJURY REFERRAL HOSPITAL

3.1 Background

24. The National Spinal Injury Referral Hospital was founded in 1944 as a facility to care for World War II soldiers who had spinal cord injury and at that time it was known as Amani Chesire Home. Currently the facility is a specialist hospital within the national government with a mandate of providing care to persons with spinal disorders;
25. The original structure was a house that was then donated to the government by Amani Chesire, it is the only hospital in the region offering spinal rehabilitation services to persons with spinal cord injuries and it has a capacity of only 35 beds.
26. The hospital offers the following services;

- i) Curative Spinal Services such as spine, plastic and general surgeries; nursing care, medical care, diagnostic laboratory and radiology.
- ii) Rehabilitative Services including; physiotherapy, occupational therapy, psychosocial therapy and orthopedics.
- iii) Promotive and Preventive Spine care; including chronic pain management; health education on spine care to general public and former patients.

3.2 Visit to the facility

27. The Committee visited the facility on Thursday 22nd November 2018. Dr. Soren Otieno, the Medical Superintendent led the Committee on a guided tour of the facility's various sections i.e. Operating theatre, Laboratory, wards, kitchen, Laundry, intensive Care Unit (ICU) and Radiology department. During the tour, discussions with the personnel were held on the experiences and challenges they faced on daily basis and possible solutions to their problems. Thereafter, the Committee held a post-tour de-briefing with the management.
28. The Committee was informed that the facility's goal of care focusses on maximizing the residual neurological function and preventing further neurological injury. They enable patients to maximize their neurological recovery and general health in a short time period, be educated about all aspects of their injury and care, and be functionally able to return home as independent and productive as possible prepared to resume their lives.
29. The hospital boasts of skilled and dedicated and experienced medical personnel who include: surgeons, medical officers, pharmacists, nurses, physiotherapists, occupational therapist and social workers amongst others.
30. The hospital had benefited from the MOH Managed Equipment Services (MES) where it acquired; MRI scan, digital x-ray, fluoroscopy C- Arm machine and theatre equipment. They had enabled the hospital to increase patient attended to from 300 in 2013 to 800 in 2017 and the hospital's quarterly budget had increased consequently from 3 Million in 2013 to 19 million in 2018.

31. However, in the execution of its mandate the facility still faced a number of challenges including limited capacity of only 35 beds. This was at variance with the lengthy admission period which can take up to 2 months attributable to increased population, increased road traffic accidents and construction injuries.
32. Further, the hospital faced an acute shortage of human resources including anesthesiologists, neurosurgeons, plastic surgeons, medical officers, pharmacists, pharmaceutical technologists, physiotherapists, nurses, occupational therapists and support staff. The hospital lacked adequate medical equipment including orthopedic hospital beds, ICU/HDU, laboratory machines, incineration services and spine operation sets amongst others.
33. Inadequate development and recurrent funds to undertake major renovation of the wards and outpatient departments posed a serious challenge; the recurrent fund allocation was affected by a chronic pending bill that impacted the budget for implementation of needed services. IFMIS frequent downtime further aggravated implementation of the budget with resultant compromised efficiency of services.
34. A lack of emergency room services contributed to late admissions with patient having complications of spinal diseases. This was further compounded by poor pre-historical care systems and referral systems leading to delayed admission and interventions with resultant undesirable outcomes. Those who manage to make it to the hospital and later discharged face poor follow up with high morbidity and mortality. A cross sectional study (unpublished) showed a 40% mortality at 2 years post-discharge.
35. The facility had however benefited from donations i.e Safeway Right donated an ICU bed, ventilator and infusion pump worth Kshs. 11,000,000 and also built a gazebo worth Kshs. 700,000. These were however insufficient because as the only facility that deals with spinal injury in the region the hospital needed;
 - i. An upgrade to be a regional spine center of excellence and a training center on spinal disorders;
 - ii. There was need to develop linkages with regional and Sub-National hospitals for enhanced referral and tele-medicine services for prompt admission, management and post-resettlement care of patients;

- iii. Leverage on existing enhanced corporate (local and international) interest for CSR and Public Private Partnership;
- iv. Expansion preferably within Mathari National Teaching and Referral Hospital which has a huge undeveloped land.

4.0 MOI TEACHING AND REFERRAL HOSPITAL

4.1 Background

36. The Hospital was established under Legal Notice No.78 of 12th June 1998 under the State Corporation Act Cap 460 and is mandated to:

- i) To provide specialized health services on a referral basis from within and outside Kenya.
- ii) To provide facilities for medical education to Moi University directly or through other corporation health institutions.
- iii) To provide training facilities for health and other allied health institutions
- iv) To participate in National Health Planning.

37. The facility covers over 21 counties in western Kenya region and patients across the border. This represented over 25 million people in the catchment area, with Uasin Gishu County alone being 1.2 million people.

4.2 Visit by the Committee to the facility

38. The Committee conducted an inspection visit to the Moi Teaching and Referral Hospital on Monday, 11th February 2019 where it held a meeting with the hospital administration, other stakeholders and also inspected the facility. The Committee was taken through the Hospital's strategy (MTRH 2017-2022 strategy), general operations and services offered, MTRH role in support of the Big 4 Agenda, financial operations, clinical workload for the last 10 years, ongoing projects and challenges as follows:-

39. The board and management submitted that MTRH's role in supporting the Government in achieving its health objectives both at the national and international level was strategic. To ensure realization of its mandate, the growth of the Hospital is shaped by its development strategies which dictate the direction of infrastructural growth and service delivery. The Hospital was currently in the 2nd year of implementation of MTRH 2017-2022 Strategy. The yearly Performance Contracts target is drawn from the Strategy to ensure full implementation and realization of the Strategy at the end of its cycle.
40. The Hospital's Key strategic focus areas are; Customer Centric, Excellent Clinical Outcomes, Operational Excellence; Strategic Partnerships and Sustainability.
41. Due to non-existence of a fully functional County Referral Hospital, MTRH provides services from primary level to tertiary level. The services range from preventive, curative, rehabilitative, diagnostic and specialized services across all medical disciplines. MTRH also provides services in its two Private Wings to augment the income flow to support Operations and Maintenance.
42. Apart from providing training facilities for teaching institutions, particularly Moi University College of Health Sciences as per the Legal Notice, the Hospital also runs a fully accredited MTRH College of Health Sciences. The 7th Graduation was held on 7th December 2018.
43. The hospital ran a tripartite collaborative programme with a consortium of North American Institutions and Moi University College of Health Sciences (AMPATH). The programme targets HIV/AIDS and chronic diseases in the North Rift and Western Kenya region.
44. Offer services were offered through Centres of Excellence (COE) to ensure efficiency of service delivery-e.g AMPATH, Shoe4Africa Children's Hospital (S4A), Riley Mother and Baby Hospital (RMBH), Chandaria Cancer and Chronic Diseases Centre (CCCCDC), Cardiac Care Unit (CCU), Renal Unit, Neuro-Surgical Centre, Mental Health and Rehabilitation etc. Most of these COEs have been made possible through support from partners.

Clinical burden

45. On its clinical workload, the Hospital has a bed capacity of 900 with an average daily patient work load of 1,500 outpatients and 1,200 inpatients. The Average Length of Stay (ALOS) is currently almost 8 days. The bed occupancy is always above 110% because of high patient number occasioned by dual function of the Hospital-as referral and as primary healthcare.
46. Most referral-ins comes from 8 counties of Uasin Gishu, Kakamega, Baringo, Trans-Nzoia, Homabay, Bungoma, Nandi and Kericho in that order.
47. Most recent clinical successes- carried out 7 successful Open Heart Surgeries and 24 Hour Trauma Theatre (minimized waiting time for trauma surgeries). The table below summarizes the hospital's workload in the last ten years;

Year	OPD attendances	Admissions	Lab tests	Radiology examinations	Theatre	Referrals In
2008	182,001	28,982	311,269	33,800	7,197	1,954
2009	239,812	32,005	504,164	35,395	6,713	2,272
2010	240,,936	34,435	478,579	39,365	7,747	2,921
2011	234,316	30,281	341,112	40,435	7,196	2,264
2012	205,666	32,433	438,237	34,219	8,020	1,633
2013	222,559	37,408	516,867	48,733	8,279	1,384
2014	258,387	41,847	527,162	45,596	9,056	2,108
2015	386,487	45,336	534,008	66,904	10,801	2,432
2016	327,145	44,068	647,502	58,434	11,135	2,368
2017	292,910	37,761	550,929	58,406	8,523	2,480
2018	373,745	45,348	809,575	79,407	12,312	5,310
TOTAL	2,963,964	409,904	5,659,404	540,694	96,979	22,900

Finances

48. On the hospital's finances, the Hospital's budget is geared towards provision of referral and specialized health care services. The sources of funds include Government Grants and Internally Generated Funds/ Appropriations in Aid. Recurrent grants supports Personnel Emolument (PE) only. Although efforts have been made to bridge the funding gap experienced in the prior years, there have been delay in capturing recurrent supplementary grants with a consequence of under-allocation in the subsequent years.
49. The grants for 2018/19FY has a deficit of Kshs. 1,286,096,427 resulting from allocation of 5,122,344,144 against budget requirements of Kshs 6,408,440,571. The deficit is required to fully implement the new basic structure and continue the implementation of phase two of health service allowance and nursing service allowance as per approved CBAs.
50. Also, total recurrent grants of Kshs. 444 million consisting of Kshs. 350 million for June 2016 salary disbursement and Ksh. 94 million for June 2018 salary disbursement are outstanding, hence pending bills on payroll commitments. This grant from The National Treasury & Planning through Ministry of Health is meant for staff salary payments (plus loan deductions), making MTRH one month late in staff personal loans payments.
51. The Hospital received only Kshs. 30 million for Development in the FY 2018/19. This is less than 5% of the requirements for capital expenditure for the Hospital.
52. As at 31st January 2019, Corporate Debtors stood at Kshs. 313,839,862 while individual debtors stood at Kshs. 514,580,335.92. To reduce the risks of uncollectable individual debts, Management stopped the use of Identity Cards as collaterals fully implemented from 2016/17FY.
53. However, uncollectible debts secured on Identity cards and commitment letters from the inception of the Hospital in the year 2000 amounting to Kshs. 500 million had been recommended for write-off. The Hospital waives bills of indigent clients who can't pay their bills based on their socio-economic status. Since the year 2000 to June

2018, the Hospital had waived Ksh. 1,000,992,740 from this category of clients. For 2018/19FY, the first half of the year waivers stood at Kshs. 77,536,795.36

54. These waivers and bad debts affect the Hospital's cash flow since the money from sales is expected to be used to pay suppliers. The Government is therefore requested to reimburse the Hospital all waived bills and written-off debts amounting to kshs. 1,505,282,435.

55. The outstanding amounts to Hospital suppliers as at 31st January 2019 was Kshs. 431,763,018. The amount is outstanding due to poor cash inflow arising from waived bills of indigent clients.

Inventory of Health Workforce and Student Registrars

56. Current staffing stands at 3759. No staff on contract except those in Top Management positions as a matter of good Corporate Governance (M1-M3). There are a total of 142 Postgraduate Medical Registrars across disciplines who apart from accessing training facilities and practical exposure in MTRH, also support in the provision of healthcare.

Partnerships

57. The Hospital Management submitted that it continued to recognize the mutual impact of collaborating with various partners locally and internally to enhance delivery of healthcare and collaboration in research and training.

58. The hospital had a MoU with Moi University College of Health Sciences (MUCHS) for mutual clinical service and teaching provision. Other training arrangements include collaboration with University of East Africa Baraton, Ortum Mission Hospital, Nursing School and Kaplong Mission Hospital.

59. The hospital had a longstanding collaboration with Indiana University through the Consortium of North American Institutions had resulted in construction of AMPATH Centre, many satellite health centres, Riley Mother and Baby Hospital, Cardiac Care Unit, Main Theatres.

60. Others include the Shoe 4 Africa (S4A) Foundation aiding in the construction of S4A Children's Hospital, as well as the Eli Lilly Company that donates mental health and diabetes drugs worth Kshs. 2 billion annually provided free to patients. An MoU

between Ministry of Health (MOH), and National Treasury and Partners see the drugs shipped VAT exempt. Others foreign collaborations include Doctor2Doctor of Netherlands, Linkoping University and Ottengland County in Sweden for Maternity and Newborn Care, Chandaria Foundation, Smile Train, Operation Eye Sight International among others.

61. The hospital also had an MOU with Uasin Gishu, Elgeyo Marakwet and Nandi Counties that supported procurement of 4 complete ICU units at Kshs. 35 million. In support of county hospitals, the hospital supported upward and downward referrals, capacity development, a renal haemodialysis project support, primary healthcare and general support towards UHC.
62. The hospital also collaborated with Kenyatta National Hospital (KNH) for Open Heart Surgeries with 17 surgeries done so far. MTRH also provides support to Tenwek Mission Hospital on Renal Services, Plateau Mission Hospital, Ya Mumbi Catholic Hospital and Kapseret Mission Hospital.

The Committee also interacted with other stakeholders and was informed as follows;

- a) Prof. Grace Ettyang, Ag. Principal Moi University College of Health Sciences (MUCHS) and Dr. Faraj Some Ag. Dean Moi University School of Medicine (MUSOM)

63. They informed the meeting that the creation Moi University School of Medicine elevated the then Uasin Gishu District Hospital to Moi Teaching and Referral Hospital in 1998. And that the cordial relationship between the Colleges and Hospital was as a result of a vibrant Memorandum of Understanding (MoU).

64. The colleges faced challenges including difficulty in delivery of academic and administrative services due to a freeze recruitment of public servants. Also, discrimination in payment of practice allowance had resulted in demotivation as student registrars earned more than medical doctors lecturers, who felt that they equally qualify for the allowances paid to doctors working in public hospitals.

b) Dr. Adrian Gardner – Field Director, Indiana University (AMPATH Consortium)

65. He informed the Committee that AMPATH Consortium brings together several partners of MTRH from North American institutions led by Indiana University (IU). The biggest funder was the US government through USIAD. Through the partnership, various infrastructures had been put up in addition to student exchange programmes and provisions of clinical care.
66. He requested the Committee to look into challenges experienced by the partners including double taxation subjected to the expatriates, who are not remunerated in Kenya but are required to pay taxes while being taxed in their home countries, and delay in processing expatriates visa and work permits which sometimes take up one year to process.

c) Prof. Sylvester K. Kimaiyo – Chief of Party AMPATH

67. He notified the Committee that AMPATH-Plus had research and care arms under the management of MTRH, Moi University College of Health Sciences and Indiana University. The AMPATH-Plus ran a chronic disease programme through population health in the entire western Kenya region.
68. The programme funds were well managed in accordance to US Federal Government requirements and MTRH receives funding of the programme directly and manages it through a dedicated Grants Office, the Research and Sponsored programme Office.
69. He highlighted the challenge of Kenya – US Government agreement which has not been signed on account that The National Treasury & Planning wants the funding to go through National Treasury while the US Government wants the funds to be disbursed directly to MTRH.
70. As a result the US Government is deducting a dollar for every two (2) dollars paid as taxes. He called upon the Committee to look into the matter with the ministry of Foreign Affairs and International Trade.

d) Ms. Everlyne Rotich – CEC Health, County Government of Uasin Gishu

71. She noted the close working relationship between the County Government and MTRH in the provision of Health Care including procurement of four complete ICU units.
72. She highlighted challenges of staffing, particularly of specialized doctors who are reluctant to work in lower level facilities and the fact that the county did not receive conditional grants since the county does not have a level 5 facility.
73. She also raised issue of KEMSA's capacity to supply all the health commodities for the county hospitals.
74. She stressed on the need for disbursement of resources for devolved health functions and also called for a national Health Summit involving all stakeholders in health to discuss issues concerning health care in the country.

e) Mr. David King'etich - Principal, KMTC, Eldoret Campus

75. The Principal informed the Committee that the college ran three courses in the campus and partners closely with MTRH in training of health personnel.
76. He noted that the issue of skewed distribution of Human Resource for Health was a reality that needed to be looked at seriously. He also supported the idea of having a health summit.

Hospital Successes and Challenges

77. The Hospital's management listed its successes on projects, clinical services and general operations including conclusion of procurement process for the Proposed Design, Construction, Equipping and Financing of 2,000 bed Multi-Specialty Moi Teaching and Referral Hospital in Kiplombe, Eldoret. The National Treasury & Planning has given its approval; the Attorney-General has provided clearance for the signing of PCC and GCC as required by Public Procurement and Asset Disposal Act, 2015.

78. Further, construction of new modern Laundry and Kitchen was ongoing and Kshs 200 million was required. The hospital had equipped specialized areas (increase of ICU beds from 6 to currently 17 ICU and 3 HDU beds. Equipping of additional 12 ongoing, Neurosurgical Centre, Diagnostics-128 CT, 64 CT Scan, Neuro-surgical Suite etc.)
79. The hospital had constructed a CT Scan hosting building and installed a 128 Slice CT Scan.
80. Other positive steps included introduction of 24 hour theatre operations to reduce waiting time for trauma theatre operations, commencement of Open Heart Surgeries with 7 successful surgeries done in September 2018 and 10 in November 2018, consistent provision of Renal Transplants with 45 transplants done so far since 2006, installation of modern Microwave Clinical Waste Management Plant to effectively manage clinical waste and medical outreaches to reduce undeserving referrals of maternal and paediatric cases to MTRH from County Hospitals.
81. The hospital had approved of new Human Resource Instruments on Human Resource Policy and Procedures, Organization Structure, Grading & Staff Establishment and Career Guidelines for Clinical and Corporate jobs) by State Corporations and Advisory Committee. The hospital had also introduced online payments through direct banking and MPESA to ensure prudent financial management.
82. The hospital's consistency in customer focus has seen MTRH being rated the best public Hospital in the Country as per the recent E-Survey Consumer Report.
83. Ongoing projects include construction of Biosafety Laboratory Level II (BSL II) and Isolation Centre, purchase and installation of 1.5T Magnetic Resonance Imaging (MRI), installation of Neuro-Surgical Synergy Unit from Medtronic (US) through Surgipharm on Placement Contract (the only one in Africa), purchase of Neuro-Microscope and Fluoroscopy machine to aid clinical diagnostics and management, equipping of Chandaria Cancer & Chronic Disease Management Centre Radiotherapy Unit- Awaiting delivery of radiotherapy machines (Brachytherapy, Linear Accelerator and Treatment Planning System) procured by IAEA and establishment of Cardiac Catheterization Laboratory (Cath Lab).

84. The hospital faced numerous challenges including overcrowding in the wards (both patients and students), budget deficits that has affected payment and implementation of Personnel allowances, limited capital development funding- funding has been around 4% of the capital requirements and waivers of bills for poor patients due to poverty. In 2017/18 FY, the hospital waived Kshs 209 million. From 2001/2002 FY to 2017/18 FY, MTRH Board waived Kshs 1.5 billion without any reimbursements from The National Treasury & Planning after approval by Board.

85. The Hospital's management made the following requests to the Committee;

- i. Support enactment of MTRH Act of Parliament to replace the Legal Notice No. 78 of 12th June 1998.
- ii. Additional allocation of Kshs. 1,624,480,000 required to fully cover Personnel Emoluments as per the implemented CBA's and Basic salary structure as approved by Salary and Remuneration Commission (CBA).
- iii. Allocation of arrears of Kshs. 444,597,999 (being Kshs. 350,639,441 for June 2016 salaries grants disbursed by the National Treasury and Planning to MOH that had not been received by MTRH and Kshs. 93,958,558 balance of Grants for salaries for June 2018 not disbursed by the National Treasury & planning).
- iv. Support for the construction of the new 2,000 bed Multi-Specialty MTRH at Kiplombe, Eldoret.
- v. Increase capital budget allocation to MTRH to at least Kshs. 500 million per annum to cater for various needs of Multi-Specialty healthcare. For. 2019/2020, these amounts will cater for 1.5 Tesla MRI machine Kshs. 200 million, equipping of laundry/kitchen boilers and other equipment Kshs. 250 million and catheterization laboratory for heart diseases kshs. 50 million.

5.0 KENYATTA NATIONAL HOSPITAL

5.1 Background

86. Kenyatta National Hospital (KNH) was established under Legal Notice No.109 of 6th April 1987 and is mandated to:

- i) Receive patients on referral from other hospitals or institutions within or outside

- Kenya for specialized health care;
- ii) Provide facilities for medical education for the University of Nairobi Medical School, and for research either directly or through other co-operating health institutions;
 - iii) Provide facilities for education and training in nursing and other health and allied professions;
 - iv) Participate as a national referral hospital in national health planning.

87. The hospital is the biggest health facility in the country with a bed capacity of 1,800. There are 50 wards, 24 clinics and 28 operating theatres. On average the hospital provides service to 2,093 inpatients daily and 73,618 admissions annually, and 2,500 outpatients daily and 600,000 annually.

88. The general bed occupancy in the Hospital is 114% as at end of February 2019.

5.2 Visit to the facility

89. The Committee visited the facility on Wednesday 20th March 2019 and held discussions with non-management staff, management and board of the hospital.

90. During the meeting with non-managerial staff, discussions were held as to general working conditions, challenges, staff welfare, and potential areas of improvement. A number of issues were raised especially on understaffing. They also notably reported that meetings with heads of departments usually amounted to nothing. Other issues included the following;

- i) At the oncology department, the staff observed that the number of sessions covered by NHIF on cancer treatment was inadequate. They called for up to 35 sessions for radiotherapy and 12 sessions for chemotherapy. They noted that NHIF paid more money to private hospitals and abroad than to local public hospitals, for the same procedures. The department saw an average of 300 patients daily, with an average waiting time of 60 days. This long wait was sometimes compounded by

breakdown of machines and equipment. They finally called for completion of the cancer center of excellence;

- ii) Staff at the pharmacy department reported inadequate numbers, especially on the highly specialized pharmacists;
- iii) The surgical team reported various challenges especially on equipment procured through the East African Kidney Institute project. The equipment for intrusive surgical procedures was not fit for use and the laser machine had a factory error. In fact, the end users were not consulted before procurement. The hospital had only 12 surgical theatres, and they hoped the Merali project would be completed and equipped, even though the designs were not the best. Beds in the wards were not proper as they could not prop up patients with certain injuries. The hospital lacked resuscitation equipment and they were not provided with ICT support to make their work easy and error free.
- iv) The resident engineers and architects reported that the buildings at the hospital were old and in need of repair. Maintenance of equipment was a challenge as they were obsolete. They also decried a huge disparity in pay between themselves and other professions in the hospital;
- v) Staff at the Accident & Emergency centre decried the inability of NHIF to cover emergency services. This posed financial challenges to patients. They also requested for doctors/ medical officers trained specifically in trauma and emergency. The lack of referral guidelines meant the hospital was overcrowded as there were chronic staff shortages. The lack of a health information management system compounded problems at the hospital.

The lack of a social worker office at casualty also posed a challenge as patients could not be vetted on their ability to pay on entry;

- vi) The nursing cadre was the most understaffed with average nurse to patient ratio being 1:20. In certain wards this could go as high as 1:50. The staffing shortage was at 811. They also asked for training and mentorship in specialized areas like ENT and oncology, while those who undertook specialized training were stuck in the same job group. The shortfall was made worse by overburdening nurses with non-nursing functions including feeding and cleaning patients, billing, etc.

Nurses also faced insecurity from unruly patients and their relatives. They also reported being coerced by management to join unions not of their choice and a lack of a director of nursing position as was the case for other cadres;

Nurses also highlighted the issue of them being in different contractual arrangements yet they did the same work;

- vii) Student registrars decried the lack of support at the hospital. 70% of them were self-sponsored and therefore lacked housing and stipends, despite doing the bulk of the work at the hospital. They barely had time to study. The Principal Secretary at the Ministry had also sat on terms of engagement agreement for self-sponsored registrars to date;
- viii) Staff at procurement and supplies decried the stringent provisions of the Procurement and Disposal Act which proscribed upfront payment for goods. This made sourcing of essential and often emergency supplies like radio-pharmaceuticals difficult;
- ix) Radiology department noted that lack of automation and ICT support seriously impeded their work as they could not archive records efficiently. The department also lacked space and they called for decentralization of the service to various departments. Approvals from NHIF took inordinately long (48 hours) subjecting patients to suffering. The entire hospital had only one CT-scan machine which had broken down for a while;
- x) Medical personnel at the department of medicine reported that they probably had the heaviest workload and congestion due to their handling of numerous ailments. The wards with a capacity of 36 held 70-100 patients. They reported that the department had a 30% death rate of patients due to avoidable issues like lack of equipment and medical supplies. The hospital had not had an MRI scan machine since 2017;
- xi) An official of the KUDHEIHA union reported that they were championing health, safety, infrastructure and remuneration of its members. Agreements had been reached with management on non-monetary terms to a large extent and they were waiting for consensus on monetary issues;

- xii) Human resource department reported that all the challenges witnessed at the hospital boiled down to inadequate resource allocation. They reported salary arrears at almost Kshs. 3 Billion. This also hampered training;
- xiii) ICT representatives submitted that the hospital's tender for an integrated ICT solution was cancelled at the behest of the Ministry's MES project. They however noted that this project did not capture all of the hospital's needs in terms of back office Enterprise Resource Planning. They therefore advertised for this component for finance, human resource and procurement at Kshs. 300 Million. They needed to also procure the other half to cater for the clinical component at a similar cost;
- xiv) Other departments including corporate services, cardiology and orthopedics report understaffing, slow and non-servicing of equipment. It was also noted that handling of dead bodies was not proper as the mortuary was overstretched and bodies were temporarily stored in fire exits;

91. The Committee then met with management and board of the hospital who made the following submissions;

- i) The hospital had endeavored to implement recommendations of the Committee's report on the alleged sexual assault, breakdown of equipment, surgical mix-up and general operations of the hospital. In particular, the following had been done;
 - The KNH Board of Management was reconstituted in accordance with section 7(3) of the State Corporations Act, Cap 246. However, the term of the chairperson of the board had come to an end and they were awaiting appointment of the same. The top level management had also been appraised, as well as recruitment of a substantive CEO which had however been stayed due to a court case;
 - For patient support services, the Hospital had established a quality health care department to focus on patient affairs, patient safety, process improvement to enhance communication and information systems, quality assurance, public health and infection prevention control;

- To boost security, the hospital had engaged 122 private security guards to compliment the 153 in-house guards. The hospital had also improved lighting and installed 113 CCTV surveillance cameras. All matters security were now driven by the Security and Safety Strategy 2017-2022;
 - To manage crowds, the hospital had initiated restrictions of 2 visitors per patient at a time in selected areas, with the intention of enforcing it throughout the hospital. The hospital was also enforcing adherence to visiting hours. An automated patient and visitor management system will be rolled out alongside the implementation of ERP through a business process re-engineering model;
 - On acquisition of equipment, the hospital had shared with the ministry its plant and equipment replacement plan 2017-2022, at a cost of Kshs. 5.2 billion;
 - The two patients in the botched surgery case had been reviewed and had fully recovered. The one who was erroneously operated on was duly compensated;
 - The hospital was in the process of reviewing its relationship with the University of Nairobi on the matter of student registrars. The hospital was also pro-actively engaging with development partners for strategic linkages;
 - The hospital was also implementing varied recommendations of the Kenya Medical Practitioners and Dentists Board including review of standard operating procedures, internal continuous training and development of nurses and other staff despite budgetary constraints, among others.
- ii) Financially, the hospital had a cash flow deficit of Kshs. 1.591 billion with a further Kshs. 2.997 billion personnel emolument gap. The procurement plan had been implemented to a tune of Kshs. 1.754 billion against a target of Kshs. 2.052 billion, representing a 85% status. The hospital requested for Ksh. 3.603 billion in the upcoming supplementary budget to address its cash obligations, and a further Kshs. 4.9 billion for the 2019/20 financial year;

- iii) On the inventory of health personnel, the hospital undertook a human resource gap analysis to determine the optimal staffing level in clinical areas. The analysis focused on doctors and nurses since they are key pillars of clinical services. The findings of the gap analysis indicated a shortage of staff owing to increase in number of patients, emerging disease patterns and expanded services. The Hospital needed Kshs 2.625 billion per year (included in the Kshs. 4.9 billion additional requirement for FY 2019/20 above) for additional staffing requirement for effective service delivery. The total staffing shortfall stood at 1456 staff;
- iv) On ongoing projects include the Cancer Treatment Centre (CTC), Renal Upgrade, Day Care surgical Centre, the microwave waste processor and the Burns Management and Paediatrics emergency Centre. All these were at various stages of completion;
- v) The hospital had achieved several success stories including Hip-spica and child reflection box innovations, introduction of kangaroo mother care, re-attachment of a severed hand and separation of conjoined twins;
- vi) The hospital had been dispossessed of its land of approximately 7 acres costing Kshs. 4.2 billion by the Kenya Urban Roads Authority through the National Land Commission for building of an access road. They had not received requisite compensation as NLC claimed there were no demolished structures on the land;
- vii) Procurement of essential radiopharmaceuticals had been hampered by the Public Procurement and Asset Disposal Act which forbid advance payment. This had seriously affected cancer patients;
- viii) Under the ICT strategy 2017-2022, the hospital had procured the ERP system that automated administrative support services. The hospital now required Kshs. 300 million to fully complete the ICT infrastructure by acquiring a health management information system;
- ix) The Hospital engaged a consultant to develop a site master plan that would guide the development of infrastructure and renovation of the existing facilities to meet the changing needs of the Hospital;

- x) The NHIF owed the hospital Kshs. 1.2 billion for services rendered and rebate claims. This had affected its cash flow;
- xi) On the matter of nurses' union, the hospital had since allowed nurses to join a union of their choice, including the Kenya National Union of Nurses who had raised various complaints. Negotiations were currently underway on matters of concern to the union;
- xii) On the East African Kidney Institute (EAKI) project, construction of the extension of the existing renal unit was at 75%. Most of the equipment delivered in the first batch had been installed while some were rejected by the user department. Renal preceptorship training for five lots had been done while construction of the main building was yet to commence;
- xiii) The hospital had ministry driven projects of CT-scan, MES equipment and a Radiology Data Center that were in progress. However the hospital did not have adequate information from the ministry regarding these projects.

6.0 RESPONSE BY THE MINISTRY ON HEALTH ON THE COMMITTEE'S PRELIMINARY FINDINGS

92. On Thursday 6th December, 2018 Dr. Rashid Aman, the Chief Administrative Secretary, appeared before the Committee to respond to various issues observed by the Committee in its interaction with the various hospitals. He submitted as follows:

6.1 Mathari National Teaching & Referral Hospital

93. The hospital lacked a management committee because after expiry of the previous one in March 2017, identification of suitable persons had taken long but would be finalized by end of December, 2018. The hospital was managed as a unit of the Ministry because it lacked legal autonomy. The Ministry was considering gazetting a legal notice on the same, for ease of management.

94. However, the hospital was involved in the budget making process as the Ministry has adopted a bottoms-up approach and is participatory. The Ministry operated within ceilings set by Treasury and was a victim of austerity measures across the board, resulting in pending bills of Kshs. 40 Million at the hospital. The Ministry was however pursuing additional funding from Treasury through the Supplementary Estimates II.
95. Due to the aforementioned financial constraints and the perennial low funding since independence, the hospital was in a dilapidated state. Even as increased financial allocation was being pursued, the Ministry has sought development partners to improve conditions at the hospital, and has renovated three wards and updated the laundry.
96. The hospital housed mentally challenged criminals as it was a legal requirement. Those referred there are a responsibility of the Ministry and adds to the need for increased budgetary allocation. The Ministry was in talks with the departments of Correctional Services and that of Social welfare for matters of contribution and re-integration, as well as establishing mental health units across the country;
97. The Ministry had since engaged with the University of Nairobi on a MoU between them and public hospitals for training of students. The same would be cascaded down to KMTC.
98. Many of the patients were not registered with NHIF as they lacked identification documents majorly due to their mental states and abandonment by relatives. The Ministry was engaging with the department of Correctional Services with a view to obtain identification cards of those available, for NHIF registration.
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99. The NHIF offered patients to the facility a capitation rebate of Kshs. 300 per family per quarter. This was inadequate and the Ministry was engaging with NHIF to review the figure. Further, the Ministry was pursuing NHIF to pay the Kshs. 105 Million it owed the hospital.
100. The hospital did not have a title deed but pursuing its title deed with the Ministry of Lands and would be obtained soon.

The Committee also sought responses from the Ministry of Interior and Coordination of National Government, State Department for Correctional Services on the operations of maximum security unit at Mathari National Teaching and Referral Hospital.

101. They submitted that the maximum security unit at the hospital unit was established by the Ministry of Health in 1978 to cater for mentally disordered offenders. The patients in Maximum Security Unit are committed by a court of law in the Criminal Justice System (Criminal Procedure Code Cap 75, Section 166), Mental Health ACT part VII section 16) and Prisons act Cap 90 section 38. These statutes outline their removal to the Hospital and subsequent discharge from the mental Health facility or back to prison.
102. The facility is manned by 24 prison officers under the command of a Chief Inspector of prisons. The State Department had no existing MoU with the hospital and they did not provide any budgetary support for their clients, the prisoners.
103. On patients that had overstayed at the facility, the Kenya Prison Service presented 15 of such cases and 13 are being considered for release by the Power of Mercy. This year, there were 29 psychiatric patients committed under presidential pleasure at Kamiti Maximum Prison waiting to be transferred to Mathari National Teaching & Referral Hospital Maximum Security Unit for consideration and assessments by the Probation department and the Power of Mercy for their possible release.
104. Rehabilitation and reintegration of inmates back into society was part of the core mandate of State Department. This was an ongoing process and included formal education programs, vocational training programs, guidance and counseling, substance abuse programs (including methadone for heroin addicts), creative and performing arts and farming.
105. The Kenya Prisons Service had no specialized mental health wings for holding and treatment of patients. What they had was a psychiatrist and a clinic which was outpatient.
106. The State Department recommended recruitment of more mental health Personnel (Psychiatrists, Psychologists, Psychiatric Nurses, Clinical Officers, Social and Welfare

officers) and the establishment of at least 10 Psychiatric units in Major prisons in the country (Kamiti maximum prison, Langata Womens Prison, Shimo la tewa prison, Manyani Maximum Prison, Kingongo prison in Nyeri, Naivasha Maximum Prison, Kisumu Main Prison, Kakamega Prison, Eldoret Main prison and Kisii main prison.

107. They also called for increased budgetary allocations for Kenya Prisons Service for Medical drugs and expenses for inmates and the registration of inmates with NHIF under the Universal Health Coverage program. This will cater for their treatment costs wherever they seek medical attention.

6.2The National Spinal Injury Referral Hospital

108. The hospital faced the same financial challenges as Mathari, and also depended on the Ministry for financial budgetary support, as its unit. The Ministry would also set up its management board by end of December, 2018.

109. It was indeed true that the hospital was overstretched as it sat on 1.4 acre piece of land with no room for expansion. The Ministry was however in plans to move the facility to the Mathari Hospital grounds, with a new 320 bed neuro-spinal hospital, at a cost of Kshs. 1 Billion for infrastructure and Kshs. 2 Billion for equipment.

110. The hospital had a shortage of staff as well as stagnation due to delays in promotion. The matter had been taken up with the Ministry of Public Service, Youth and Gender Affairs and the process of filling gaps in the staff establishment was ongoing.

111. The hospital lacked adequate equipment due to underfunding and budgetary cuts. It had been allocated Kshs. 35.5 Million development funds in financial year 2017/18 in attempts to arrest the situation before relocation becomes a reality.

112. The NHIF had since settled Kshs. 4 Million out of the Kshs. 6 Million it owed the hospital. The balance was being pursued.

6.3 Kenyatta National Hospital

113. The Principal Secretary submitted that the hospital was currently ongoing transition. Recruitment of a substantive CEO was pending a determination of a court case. The appointment of a new Chairperson was also in progress.
114. The Ministry noted the financial constraints facing the hospitals and said that this was due to financial ceilings imposed upon the Ministry. The ministry would strive to facilitate the hospital and push Treasury for further allocations.
115. On the matter of detained patients at the hospital, the Ministry regretted that this happened and reported that internal administrative mechanisms were being undertaken to address the matter.
116. The Ministry would further provide information on the East Africa Kidney Institute project in due course.

7.0 COMMITTEE OBSERVATIONS

117. After inspection visits and meetings with the management of the referral Hospitals and the Ministry of Health the Committee observed that:

7.1 Mathari National Teaching & Referral Hospital

118. The only major mental health Hospital in Kenya, the Mathare National Teaching and Referral Hospital does not meet international standards based on the entire status of the facility, services offered, staff ratio and many other lacking set standards for a functional health institution.

119. The Hospital has an acute shortage of staff in all cadres; the available staff does not meet international ratios. For example at the Maximum security unit, 1 female nurse is in charge of 147 patients.

120. The Hospitals buildings are old, dilapidated with cracks on the wall, leaking roofs and lack essential facilities such as toilets, bathrooms sink and ventilations. The Hospital has a poor drainage and sewerage system.

121. The Hospital caters for a huge number of capital offenders due to delay by the legal system in collecting these patients even after their letters of capability to stand trials have been issued. This has overstretched the facility's meagre resources.

122. A majority of the patients at the facility are those who have been abandoned by their families due to the stigma associated with mental illness.

123. One major cause of Mathare National Teaching and Referral Hospital's financial challenges is as a result of it serving patients referred by the judiciary and police service for mental assessment for suitability to take plea and such patients do not pay the facility neither do the referring agencies make any compensation to the hospital for the expenses incurred.

124. The Maximum Security Unit of the hospital where the patients referred from the police custody and judiciary is overcrowded and is faced with security challenges. In addition, patients in this unit have overstayed in the facility as their discharge require court orders.

125. There was inadequate communication between the Ministry of Health and the other government agencies that require the services of Mathare Hospital resulting in the facility offering its services for free to patients referred from the police custody, judiciary and prisons department.
126. As a training institution, Mathare offers its training facilities to other hospital workers without commensurate compensation or facilitation.
127. Although teaching and research is one of the core functions of the Hospital; the high demand for training has overstretched the hospital's available training facilities.
128. Though classified as a National teaching and referral Hospital the facility has no autonomy as it's still managed as a unit in the Ministry of Health.
129. Many of the patients are not registered with NHIF due to lack of identification cards. Further, the NHIF took inordinately long to refund the facility. As at end of April, the insurer owed the hospital Kshs. 100 million.
130. The public health system in Kenya has failed to adequately care for mental health patients.

7.2 The National Spinal Injury Referral Hospital

131. The hospital's capacity is overstretched since it caters for patients being referred from hospitals in East and Central Africa.
132. The hospital has a limited bed capacity of 35 and at any given time the beds are always full hence lengthening the admission period for the waiting patients.
133. The hospital is in an appalling situation with dilapidated buildings with no significant expansion since independence.
134. The facility is built on a small parcel of land with no room for expansion, wards are small hence limited physiotherapy space for patients who require enough space to exercise
135. The hospital has an acute shortage of staff in all cadres coupled with stagnation of staff due for promotion. This has affected the staff morale.
136. Though classified as a National referral Hospital the facility has no autonomy as it's still managed as a unit in the Ministry of Health.

137. Inadequate medical equipment including orthopedic hospital beds, ICU/HDU, laboratory machines, incineration services and spine operation sets amongst others.
138. The hospitals laboratory runs only basic test as it depends on one small hemogram machine of donated by well-wishers. For the laboratory to run efficiently the facility requires well equipped and advanced apparatus, including an appropriate hemogram machine.
139. Most of hospital's equipment donated by the well-wishers are inoperative and lacked service contracts hence making it hard and expensive for the hospital to repair them.
140. The facility's kitchen space is limited, it lacks cold room to store vegetables, and the nutritionists are also overworked as they double up as caterers.
141. Due to delay of NHIF reimbursements the agency owed the hospital between Kshs. 5-6 Million.
142. The hospital benefited from the Ministry Managed Equipment System (MES) where it acquired essential equipment such as MRI scan, digital x-ray, fluoroscopy C-Arm machine and theatre equipment.

7.3 Moi Teaching and Referral Hospital

143. The Hospital had realized savings and increased efficiency as a result of its decision to embrace 'placement contract model' for its equipment.
144. The Hospitals has enhanced service delivery and collaboration in research and training by utilizing its partnership with both local and international institutions.
145. Compared to other referral hospitals MTRH has experienced successes on projects that have been finalized and ongoing, clinical services and general operations.
146. The facility covers over 21 counties in western Kenya region and patients neighboring counties which translate to over 25 million people in the catchment area. Most referral-ins come from 8 counties of Uasin Gishu, Kakamega, Baringo, Trans-Nzoia, Homabay, Bungoma, Nandi and Kericho in that order.
147. Like other referral Hospitals in the country, MTRH also faces the issue of overcrowding. Despite having a bed capacity of 900 the facility experiences a daily patient work load of 1,500 outpatients and 1,200 inpatients and a bed occupancy of

110% because of high patient number occasioned by dual function of the Hospital-as referral and as primary healthcare centre.

148. The Hospital's cash flow has been greatly affected by waivers and bad debts, as at 31st January 2019, Corporate Debtors stood at Kshs. 313,839,862 while individual debtors stood at Kshs. 514,580,335.92.
149. Delivery of academic and administrative services at the hospital's colleges had been hampered by a number of reasons including a freeze on recruitment of personnel and demotivation as a result of disparity in payment of practice allowances between student registrars and lecturers.
150. The relationship between international partners and the Hospital risks being jeopardized as a result of issues concerning double taxation subjected to the expatriates, delay in processing expatriates visa and work permits which sometimes take up to one year to process and delay in signing the agreement between Kenya – US Government in regards to funds meant for AMPATH Plus programme for chronic disease.

7.4 Kenyatta National Hospital

151. The current leadership vacuum at the hospital does not portend well with operational decision making. The recruitment of the CEO has been challenged in court while the term of the Chairperson expired in March 2019 with the Executive having not appointed a replacement.
152. The hospital was severely constrained due to perennial underfunding. This has seen a lack of plant and equipment maintenance and replacement. The hospital currently needs Kshs. 3.6 Billion, plus an additional Kshs. 4.9 Billion for the upcoming financial year.
153. The lack of critical equipment has seen services severely hampered. The CT-scan project by the Ministry is yet to see that earmarked for the hospital delivered while procurement of a MRI scan has taken inordinately long.
154. The hospital faces a staffing shortfall of near crisis proportions. A current shortfall of 1,456 staff has seen services greatly compromised.

155. The hospital is overcrowded due to a broken referral system. The hospital also closed its outpatient clinic that had been previously used to decongest the main hospital. This is compounded by the poor delivery of services at lower level hospitals, especially the nearby Mbagathi hospital that closes its doors at 5pm.
156. The patient waiver system for indigents was impaired by the lack of adequate social workers at the points of entry. This led to accumulation of bills, and even patients being detained.
157. The National Land Commission and the Kenya Urban Roads Authority had annexed land of approximately 7 acres at the hospital without the requisite compensation of approximately Kshs. 4.2 billion.
158. The hospital had several incomplete projects due to inadequate exchequer release for GoK counterpart funding.
159. The lack of a complete ICT system had affected efficiency and effectiveness at the hospital. The stalled HCIT system under MES had left the hospital with no ICT solutions for its needs.

8.0 COMMITTEE RECOMMENDATIONS

The Committee makes the following recommendations for the respective facilities;

1.1 Mathari National Teaching & Referral Hospital

160. The Ministry of Health should initiate and fast track the process of giving Mathare National Teaching and Referral Hospital autonomy by anchoring its gazzeted status as a National Teaching and Referral Hospital in law, within three months of adoption of this report;
161. The Ministry of Health and Treasury should in the next financial year increase the financial allocation to the Hospital to cater for priority needs of medication, staffing and rehabilitation of existing facilities;
162. The NHIF and the hospital to reconcile the hospital's claims and settle those due within three months of adoption of this report;
163. The Ministry in consultation with the hospital to within three months of adoption of this report review the hospital's relationship with KMTC and other training institutions by signing an MoU to provide logistical and financial support to the hospital for the deployment and training of students;
164. The Ministry of Health and the State Department of Social Welfare, to ensure that 'half way' homes are set up for the patients who have been abandoned due to stigma associated with mental illness, where such patients could go through occupational therapy. This should be done within a year of adoption of this report;
165. The Ministry of Interior and Co-ordination of National Government should within one year of the adoption of this report budget for and set-up specialized mental wings in the major prisons to serve mental cases.
166. In the alternative, the wing at Mathari Hospital that caters for remandees and prisoners be gazzeted as part of Kenya Prisons Service, to enable the State Department for Correctional Services take over its operations;
167. The Ministry of Lands should within six months of the adoption of this report issue the hospital with a title deed for its land. This should be done after a survey of the hospital's land that has suffered encroachment over the years;

168. The Ministry of Health should within six months of the adoption of this report review the Mental Health Act with a view to seal policy gaps and update it to international standards. This review should result in increase in mental health facilities in the country.

1.2 The National Spinal Injury Referral Hospital

169. The Ministry of Health should within three months of adoption of this report initiate and fast track the process of giving the hospital autonomy by anchoring its gazzeted status as a National Teaching and Referral Hospital in law.

170. The Ministry of Health and Treasury should increase in the next financial year the financial allocation to the hospital to cater for priority needs of medication, equipment, staffing and rehabilitation of existing facilities.

171. The Ministry of Health should within six months of adoption of this report work out modalities to immediately move the facility to the proposed Mathari National Teaching & Referral Hospital grounds and actualize the plans of upgrading it into a regional spine center of excellence.

1.3 Moi Teaching and Referral Hospital

172. The Ministry of Health should, in the next financial year, increase capital budget allocation to MTRH to at least Kshs. 500 million per annum to cater for various needs of Multi-Specialty healthcare. For FY 2019/2020, these amounts will cater for 1.5 Tesla MRI machine (Kshs. 200 million); Equipping of Laundry/Kitchen Boilers and other equipment (Kshs 250 million) and Catheterization Laboratory for Heart Diseases (Kshs. 50 million).

173. In addition more funds should be allocated in the next financial year to cater for the Hospital's current deficit of Kshs. 1,624,480,000 required to fully cover Personnel Emoluments as per the signed CBA, and expedite allocation of arrears of Kshs. 444,597,999 (being Kshs. 350,639, 441 for June 2016 salaries and grants disbursed by The National Treasury & Planning to Ministry of Health and not received by MTRH

and Kshs. 93,958,558 balance of Grants for salaries for June 2018 not disbursed by The National Treasury.

174. The Ministry of Health, Treasury, Ministry of Foreign Affairs and the Department of Immigration to harmonize issues of double taxation and delay in issuance of work permits for expatriate partners working with MTRH, within three months of adoption of this report.
175. The Ministry of Health and the National Treasury to fastrack the in signing the agreement between Kenya – US Government on funds meant for AMPATH Plus programme, and finalized within six months.

1.4 Kenyatta National Hospital

176. The KNH Board should within three months of adoption of this report, restructure top level management and substantively competitively recruit persons with administrative, managerial and leadership expertise.
177. The Ministry of Health and the hospital to immediately prioritize purchase of essential equipment at the hospital, including additional CT-Scans, MRI machines, ICU beds, and other critical equipment estimated at an annual cost of Kshs. 500 Million. This includes immediate equipping of the day care centre at an estimated cost of Kshs. 176 Million and the infectious diseases unit at an estimated cost of Kshs. 45 Million.
178. The Ministry of Health and the National Treasury should hire essential staff and medical personnel to acceptable ratios. At an estimated annual cost of Kshs. 2.625 Billion. Treasury to allocate resources to cater for personnel emoluments arising from a return to work formula of 2016/17 is adhered to and deficit of personnel emoluments of Kshs. 2.9 Billion funded to boost worker morale.
179. The hospital to immediately set up a social-work office at the casualty area to help in immediate vetting of potential indigents. This will be fed into a credit management system for patients unable to immediately pay for services.

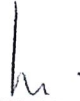
180. Treasury should, in the next financial year, honour its counterpart commitments for completion of capital projects at the hospital, including the Burns and Pediatrics Emergency centre (BADEA), and the Merali project.
181. KNH in consultation with the Ministry should in the next one year re-establish an outpatient clinic to enable it sift through walk-in or self-referred patients, to free the main hospital of non- or self-referred cases.
182. The hospital should, develop an ICT policy and roll out a comprehensive ICT support system to reduce cases of human error, lapses and leakages of finances in the next financial year.
183. KNH within six months of adoption of this report implement its new human resources management recognizes rights of all workers and cadres at the hospital.
184. The Ministry of Health includes the KNH in the cancer centre project, and make it a centre of excellence to alleviate the heavy burden the hospital currently faces.

1.5 Other cross-cutting recommendations

185. The Ministry of Health in conjunction with the Kenyatta National Hospital and Moi Teaching and Referral Hospital should within six months establish paid training positions in these hospitals. These will be filled up by student registrars who will train and provide services in these facilities. This will free county governments of the burden of paying doctors who are on study leave, enabling them recruit replacements;
186. The National Land Commission and Kenya Urban Roads Authority should within three months of adoption of this report compensate the hospital in full for its land that was annexed for construction of road.
187. The Ministry of Health in liaison with the boards of the national referral hospitals must review criteria for appointment of persons to management positions in the hospitals and come up with a mechanism that ensures merit based recruitment.
188. As part of its mandate on health policy and standards, the Ministry of Health must within six months of adoption of this report design a referral policy, for management

of patients between county and national hospitals. This will help decongest referral hospitals.

189. To address concerns by public health facilities on procurement and pricing of medicine, Kenya Medical Supplies Authority (KEMSA) should within three months boost its capacity, and reconsider its procurement model to provide for competitive pricing, procuring directly from manufacturers and leveraging on economies of scale.
190. The Ministry and the National Hospital Insurance Fund (NHIF), to as part of the current reform process should establish uniform procedures for coverage regardless of whether the services are offered in public or private hospitals or location of access of service.
191. The NHIF observes a uniform turnaround time for approvals for procedures, and eventual re-imbursement to public and private health facilities.
192. NHIF must review its limits on medical conditions to make sure limits/ sessions paid for cover the full breadth of treatment and recovery.
193. The NHIF to adopt technology and roll out a smart card system that uses chip and biometric technology, to curb fraud.

SIGNED 

HON. SABINA CHEGE, MP (CHAIRPERSON)

DATE..... 8/5/19