

The Insanity of Kenya's 'Guilty but Insane' Verdict

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Abstract

A person may be insane while committing an unlawful act, leading them to raise the defence of insanity in court. This defence argues that the person's illness prevented them from having the criminal intent needed to satisfy the mens rea requirement for criminal responsibility. The successful establishment of this defence in Kenya leads to the court issuing a special verdict of 'guilty but insane' (GBI). This verdict sees that the defendant is incarcerated in a place of safe custody where they can be treated for the illness that contributed to their commission of the offence. While isolation and treatment of the defendant form the primary aims of the verdict, this paper demonstrates that they are barely achieved in Kenya. This is because the conditions crucial to the verdict's implementation—medication and therapy, a place of custody and the presence of psychiatrists—are wanting in the country. After examining the institutional barriers to the realisation of the verdict's objectives, the paper studies various responses to these challenges by Kenya and Ghana. It finds solutions that promote the realisation of the verdict's aims such as the provision of educational opportunities in forensic psychiatry.

Keywords: *Criminal responsibility, forensic psychiatry, guilty but insane verdict in Kenya, insanity, Kenyan Penal Code*

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I. Introduction

Every person is presumed to be sane by the law while committing an act.¹ If a defendant is, however, insane while committing an act, they may raise the defence of insanity.² In law, insanity is a disease of the mind that hampers a person's ability to appreciate the nature or wrongfulness of their actions.³ The law views a 'disease of the mind' as 'any disease that causes the mind to malfunction'.⁴ In cases of insanity, the court will apply a set of rules to the defendant's case to ascertain their mental state during the commission of the offence and determine their criminal responsibility.⁵ The rules of insanity applied in Kenyan courts are the M'Naghten rules which stipulate that:

'...to establish a defence on the ground of insanity, it must be clearly proved that, at the time of committing the act, the party accused was labo[u]ring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; if he knows it, that he did not know he was doing what was wrong'.⁶

The three limbs of the M'Naghten rules—the disease of the mind, the nature and quality of the act and the knowledge of the wrongfulness of the act—are mirrored in the definition of insanity in the Penal Code.⁷ These limbs are imperative in determining criminal culpability which is 'the degree to which an individual is accountable for an illegal act that he or she committed'.⁸ For a person to be found liable for the commission of a crime, the wrongful act itself (the '*actus reus*') and the intent to commit the wrongful act in question (the '*mens rea*') must be present.⁹ However, the disease of the mind negates the *mens rea* aspect as it prevents the defendant from appreciating the unlawful nature of their actions.¹⁰

¹ Section 11, *Penal Code* (Act No. 12 of 2012).

² Section 12, *Penal Code* (Act No. 12 of 2012). The defendant has the burden of proving insanity according to section 107, *Evidence Act* (Act No. 19 of 2014).

³ Section 12, *Penal Code* (Act No. 12 of 2012).

⁴ Andoh B, 'The M'Naghten rules – the story so far' 61(2) *Medico-Legal Journal*, 1993, 95.

⁵ Andoh B, 'The M'Naghten rules – the story so far', 93.

⁶ *R v McNaughten M'Naghten* (1843), The United Kingdom House of Lords. Nduge M, 'Cognition and volition impairment in criminal conduct: A look into the application of the M'Naghten test in Kenya' 4(1) *Strathmore Law Review*, 2019, 89.

⁷ Section 12, *Penal Code* (Act No. 12 of 2012).

⁸ Grossi L and Green D, 'An international perspective on criminal responsibility and mental illness' 1(2) *Practice Innovations*, 2017, 1.

⁹ Edwards J, 'Theories of criminal law' Stanford Encyclopedia of Philosophy, 06 August 2018 – <https://plato.stanford.edu/entries/criminal-law/> - on 21 December 2020.

¹⁰ This is inferred from the stipulation of the M'Naghten rules in *R v McNaughten M'Naghten* (1843), The United Kingdom House of Lords.

If the defendant is successful in satisfying the prongs of the M'Naghten rules, and thus establishes the defence of insanity, the court is required to issue a special verdict of 'guilty but insane' (GBI).¹¹ Thereafter, the court notifies the President of the defendant's case. While awaiting the response of the President, the defendant is taken into custody in a place the court deems appropriate.¹² The President may then respond by ordering that the defendant be transferred to a mental health facility, prison or any other place where the defendant is detained for the duration of their sentence.¹³

Mathari Hospital is the mental health facility that forms the case-study of this paper. This is because it is the only hospital with an in-patient forensic psychiatric unit, which is a unit unique to mentally ill offenders.¹⁴ The alternative to Mathari Hospital is any Kenyan prison where medical officers are responsible for the health of all persons, including GBI prisoners.¹⁵ Therefore, any person declared GBI in any other county, aside from Nairobi, is directed to a prison within the county in question.¹⁶ The Mental Health Act orders for the establishment of specialised sections within Kenyan prisons to, *inter alia*, host 'convicted criminal prisoners who are persons suffering from mental disorder'.¹⁷

The GBI verdict is therefore a special verdict that is cognisant of the defendant's unique situation. It aims to cater to their need for psychiatric treatment in a favourable setting such as a hospital.¹⁸ In addition, the verdict responds to the needs of public order and security as it 'keep[s] dangerous individuals off the streets' by placing persons found GBI in safe custody.¹⁹ For this to be realised, there are three common conditions.²⁰ The first condition is medication and

¹¹ Section 166(1), *Criminal Procedure Code* (Act No. 12 of 2012).

¹² Section 166(2), *Criminal Procedure Code* (Act No. 12 of 2012).

¹³ Section 166(3), *Criminal Procedure Code* (Act No. 12 of 2012).

¹⁴ Kenya National Commission on Human Rights, *How to implement article 12 of convention on the rights of persons with disabilities regarding legal capacity in Kenya: A briefing paper*, 2013, 64. Mathai M and Ndetai D, 'Overcrowded prisons and low psychiatric provision: The situation of mentally ill prisoners in Kenya' in Konrad N, Völm B and Weisstub D (eds), *Ethical Issues in Prison Psychiatry*, Springer, Heidelberg, 2013, 254

¹⁵ Section 29(1), *The Prisons Act* (Act No. 10 of 1998). Section 166 (3), *Criminal Procedure Code* (Act No. 12 of 2012).

¹⁶ For example, in Mombasa, the appellant in *Leonard Mwangemi Munyasia v Republic* (2015) eKLR was directed to Shimo La Tewa prison after receiving the GBI verdict. Similarly, in Busia, the accused in *Republic v POO* (2019) was sentenced to Busia GK prison following the issuance of the GBI verdict.

¹⁷ Section 9(3), *Mental Health Act* (Act No. 11 of 1993).

¹⁸ Fentiman L, 'Guilty but mentally ill': The real verdict is guilty' 26(3) *Boston College Law Review*, 1985, 615.

¹⁹ Fentiman L, 'Guilty but mentally ill', 615.

²⁰ These conditions are derived from the M'Naghten rules and section 166 of the Criminal Procedure Code. McGraw B, 'The guilty but mentally ill plea and verdict: Current state of the knowledge' 30(1) *Villanova Law Review*, 1985, 166 and 187.

therapy which are crucial for the rehabilitation of the defendant so that they may re-enter society as 'behaving and productive citizens'.²¹ The second condition is a place of custody. The environment of this place should be favourable to the recovery of the GBI person and not trigger relapses. The third condition is the presence of medical professionals, particularly forensic psychiatrists and nurses who specialise in the treatment, assessment and care of GBI persons.²² These conditions speak to the GBI verdict's two substantive objectives:²³

- i) The isolation of GBI offenders as a matter of public security; and
- ii) The rehabilitation or psychiatric treatment of these incarcerated offenders.

This paper posits that these conditions are largely absent in Kenya due to systemic problems that further act as barriers to the successful execution of the verdict's aims. These problems range from the concerning conditions of Mathari Hospital and Kenyan prisons to the limited number of psychiatrists in the country.²⁴ This collectively leads to undesirable situations that oppose the aims of the GBI verdict, such as the escape of persons found GBI from the place of custody.²⁵ These impediments arise from institutional failure and are largely caused by shortcomings in the judiciary, the Kenya Prisons Service, the education system and the government as a whole.

These institutional constraints markedly impede the effectuation of the rehabilitative aim. This is because the implementation of the special verdict is comparable to the implementation of the usual 'guilty' verdict. The core difference between the two verdicts 'rests only on the need for treatment'. While the GBI verdict calls for the confinement *and* treatment of a mentally ill offender, the 'guilty' verdict focuses *solely* on the confinement of a 'criminally responsible'

²¹ World Health Organization, *World Report on Disability*, 2011, 97. Maidman B, 'The legal insanity defense: Transforming the legal theory into a medical standard' 96(5) *Boston University Law Review*, 2016, 1841.

²² Asuga-Bunyassi L, 'Prevalence of substance abuse among forensic psychiatry inpatients at Mathari hospital' Published, University of Nairobi, Nairobi, 2008, 8-9.

²³ The term 'isolative' in this paper refers to the confinement of convicted offenders (in this case, GBI offenders) in a place of custody where their rights are lawfully limited. The term 'rehabilitative', in this paper, is used to refer to the provision of healthcare services to GBI offenders for the betterment of their mental well-being.

²⁴ Kajilwa G, 'Mathari hospital: No hope in sight for suffering patients' *The Standard*, 1 April 2019 -<https://www.standardmedia.co.ke/health/article/2001318952/mathari-hospital-no-hope-in-sight-for-suffering-patients> - on 20 January 2020.

²⁵ Ministry of Health, *Mental health and well-being: Towards happiness and national prosperity: A report by the Taskforce on mental health in Kenya*, 2020, 54 and 97.

offender.²⁶ In practice, however, Kenyan GBI offenders are placed in custody but seldom receive psychiatric treatment.

Currently, there is limited literature accessible on forensic mental health services due to the larger dearth of scholarship on mental health services as a whole in Kenya.²⁷ Consequently, the statistics of 'offenders with mental illnesses' are difficult to trace and pinpoint in prison reports available.²⁸ The data of GBI persons in Mathari Hospital is also impacted: the most-recent statistics state that there were forty-four patients between 2016 and 2017.²⁹ As a result, this paper's arguments are largely based on inferences from the data available.

This paper aims to fill the lacuna of scholarship by shedding light on circumstances facing GBI persons while simultaneously calling for more research on this. The chapter breakdown of this paper is as follows. Section I is this introduction. Section II and III evaluate primary and secondary sources to analyse the implementation of the verdict from colonialism to today and to understand the institutional problems that obstruct the effective implementation of the verdict's aims. Section IV is a comparative study between Kenya and Ghana where the paper draws lessons on how Kenya can control the problems discussed in the previous section. Section V makes recommendations based on the outcome of the paper's findings and Section VI concludes.

II. The History of the Implementation of the GBI verdict in Kenya

i. The history of the GBI verdict

The GBI verdict is a special verdict that orders the 'conventional criminal sanction and psychiatric treatment for a mentally ill defendant'.³⁰ It plays multiple

²⁶ Fentiman L, 'Guilty but mentally ill', 631.

²⁷ Kenya National Commission on Human Rights, *Silenced minds: The systemic neglect of the mental health system in Kenya, A human rights audit of the mental health system in Kenya*, 2011, 4 and 42-43. Bitta M, Kariuki S, Chengo E and Newton C, 'An overview of mental health care system in Kilifi, Kenya; results from an initial assessment using the World Health Organization's assessment instrument for mental health systems' 11(1) *International Journal of Mental Health Systems*, 2017, 1.

²⁸ Sereria H, 'Assessment and treatment of special needs offenders', United Nations Asia and Far East Institute for the Prevention of Crime and the Treatment of Offenders, 10 February 2013, 216 and 220 - https://www.unafei.or.jp/publications/pdf/RS_No94/No94_PA_Sereria.pdf - on 06 February 2021.

²⁹ Chege N, "Guests of the state' causing trouble at Mathari hospital' Kenyans, 18 April 2016 - <https://www.kenyans.co.ke/news/guests-state-causing-trouble-mathari-hospital> - on 04 February 2021.

³⁰ Frey R, 'Guilty but mentally ill verdict and due process' 92(3) *Yale Law Journal*, 1983, 475. It is known as the 'guilty but mentally ill' verdict in some countries.

roles in various countries; however, the common functions are the 'confinement of the mentally-ill offender and court-ordered psychiatric treatment' of that offender.³¹

The origin of this verdict is rooted in the famous case of *Queen v M'Naghten* where M'Naghten attempted to shoot the Prime Minister of England but unintentionally shot the Minister's secretary instead.³² Psychiatrists who examined M'Naghten revealed that he was laboured from paranoia during the commission of this offence and acted under an insane delusion when he attempted to shoot the Prime Minister.³³ Ultimately, the court found M'Naghten not guilty by reason of insanity and thereupon acquitted him.³⁴ This verdict was not received well by the general public and the Queen because M'Naghten had committed a 'horrendous act of violence' and faced no legal repercussions.³⁵

Thus, the GBI verdict was created to see that these persons are hospitalised for treatment, because GBI persons are essentially ill, while simultaneously addressing the public's need for security.³⁶ With this history in mind, the paper will now delve into the implementation of the GBI verdict in Kenya.

ii. Colonial period: 1895 to 1963

a. Legal framework

The GBI verdict was introduced into Kenya during colonialism following the application of English laws such as the Act for the Safe Custody of Insane Persons Charged with Offences (1800), otherwise known as the Criminal Lunatics Act, and the Trial of Lunatics Act (1883).³⁷

³¹ Frey R, 'Guilty but mentally ill verdict and due process', 477.

³² *R v McNaughten M'Naghten* (1843), The United Kingdom House of Lords.

³³ *R v McNaughten M'Naghten* (1843), The United Kingdom House of Lords.

³⁴ *R v McNaughten M'Naghten* (1843), The United Kingdom House of Lords.

³⁵ Maidman B, 'The legal insanity defense', 1835.

³⁶ Lubulellah E, 'Mandatory' death penalty in Kenya: An examination of its legality in light of the Constitution of Kenya 2010 and the "right to freedom from inhuman or degrading treatment or punishment" Published, University of Nairobi, Nairobi, 2017, 94. Wanyama J, 'A call to strengthen the law on insanity in Kenya' 2(1) *Strathmore Law Review*, 2017, 14.

³⁷ Ambani J and Ahaya O, 'The wretched African traditionalists in Kenya; The challenges and prospects of customary law in the new constitutional era' 1(1) *Strathmore Law Journal*, 2015, 47. Ndeti D, Muthike J and Nandoya E, 'Kenya's mental health law' 14(4) *Bjpsych International*, 2017, 96. See also, *Trial of Lunatics Act 1883* (Chapter 38 46 and 47 Vict) and *Criminal Lunatics Act 1800* (39 & 40 Geo 3 c 94).

The 1800 Act called for the incarceration of mentally ill offenders and the transfer of these prisoners to asylums if they were 'unable to tolerate prison'.³⁸ The 1883 Act complemented these provisions as it ordered that GBI persons would receive a special verdict where they would be detained in safe custody as criminal lunatics 'pending the pleasure of the Crown'.³⁹

b. Places of custody

The places of custody alluded to in the Acts were prisons or asylums.⁴⁰ There were no erected prisons before the advent of the British and, therefore, the British government constructed prisons from 1895, with the largest prisons located in Nairobi, Mombasa and Kisumu.⁴¹ The functions of colonial prisons were strictly to punish, not rehabilitate, contrary to the rehabilitation aspect of the GBI verdict.⁴² This punitive argument unfortunately justified the endemic of corporal punishment, the poor hygienic conditions and the low 'quality of prison staff' in prisons.⁴³

Overcrowding was also a predominant characteristic of Kenyan prisons due to the overpopulation of prisoners, some of whom were convicted for minor offences. This congestion subsequently led to increased violence as well as 'unhealthy environment[s] and prisoners'.⁴⁴ Due to the limited space and 'absence of segregation', GBI prisoners (or 'lunatics') and other prisoners were often locked up together.⁴⁵ These combined conditions deteriorated the physical, psychological and mental state of prisoners.⁴⁶ Given the concerns raised surrounding the 'harmful environment' of English prisons for 'mentally ill prisoners' in general and the fact that colonial prisons in Kenya were managed by

³⁸ Macdonald H, 'The Straffen case and the M'Naghten rules' 7(1) *Southwestern Law Journal*, 1953, 113. Forshaw D, 'The origins and early development of forensic mental health' in Soothill K, Rogers P and Dolan M (eds) *Handbook of forensic mental health*, Willan Publishing, Cullompton, 2008, 72-73.

³⁹ Section 2(1), *Trial of Lunatics Act 1883* (Chapter 38 46 and 47 Vict). Macdonald H, 'The Straffen case and the M'Naghten rules', 113.

⁴⁰ Forshaw, 'The origins and early development of forensic mental health', 72-73.

⁴¹ Branch D, 'Imprisonment and colonialism in Kenya c.1930-1952: Escaping the Carceral Archipelago' 38(2) *The International Journal of African Historical Studies*, 2005, 243-246.

⁴² Branch D, 'Imprisonment and colonialism in Kenya c.1930-1952', 244-245. Stephens O, 'A comparative study of prison systems in African countries', Published, University of South Africa, Pretoria, 2018, 100.

⁴³ Branch D, 'Imprisonment and colonialism in Kenya c.1930-1952', 245-246.

⁴⁴ Stephens O, 'A comparative study of prison systems in African countries', 100-101.

⁴⁵ Branch D, 'Imprisonment and colonialism in Kenya c.1930-1952', 253.

⁴⁶ Bourgeat E, 'Penalty, violence and colonial rule in Kenya', Published, University of Oxford: St Antony's College, Oxford, 2014, 267-268.

the British, this paper premises that GBI persons may have also been adversely affected.⁴⁷

Kenyan 'criminal lunatics' were moved back and forth between colonial prisons and mental hospital wards.⁴⁸ However, the environment in asylums was not any better. The Nairobi Lunatic Asylum, later known as Mathari Mental Hospital, was the only public psychiatric hospital in Kenya that hosted GBI persons such as Elijah Masinde.⁴⁹ Despite being titled as a hospital, Mathari mimicked the 'restrictive and isolated atmosphere of a prison'.⁵⁰ Furthermore, treatment was custodial rather than curative, which barely satisfied the rehabilitative aim of the GBI verdict.⁵¹

Mathari was divided into a European section and an African section.⁵² The European section received better 'wards, food and other amenities' than the African section.⁵³ The African section of the hospital became overcrowded by 1925 due to the growth of the general Kenyan populace, and the situation heightened to the point where patients would be placed in 'the gaol until beds became available'.⁵⁴ As separation was done by race, Mathari held Kenyan 'criminal lunatics' together with other Kenyan patients.⁵⁵ The division between sane and insane patients is essential and its absence raises concerns such as the possibility of insane patients 'corrupting' other patients in the hospital.⁵⁶

Overcrowding led to suicide attempts and the spread of diseases, since many patients were forced to sleep on the floor.⁵⁷ The surroundings were so unbearable

⁴⁷ Cox C and Marland H, 'Broken minds and beaten bodies: Cultures of harm and the management of mental illness in mid-to-late nineteenth-century English and Irish persons' 31(4) *Social History of Medicine*, 2018, 688.

⁴⁸ Mahone S and Vaughan M, *Psychiatry and empire*, Palgrave Macmillan, Hampshire, 2007, 58.

⁴⁹ Wolf J, 'Dini ya Msambwa: Militant protest or millenarian promise?' 17(2) *Canadian Journal of African Studies*, 1983, 265. Othieno-Nyaura E, 'Characteristics of psychiatric in-patients who engage in assaultive behaviour in Mathari Hospital, Nairobi', Published, University of Nairobi, Nairobi, 1991, 8-9.

⁵⁰ Othieno-Nyaura E, 'Characteristics of psychiatric in-patients who engage in assaultive behaviour in Mathari Hospital, Nairobi', 8-9.

⁵¹ Othieno-Nyaura E, 'Characteristics of psychiatric in-patients who engage in assaultive behaviour in Mathari Hospital, Nairobi', 8-9.

⁵² McCulloch J, 'Colonial psychiatry and "the African mind"', Cambridge University Press, Cambridge, 1995, 20-22. Mathari also housed Asian patients.

⁵³ Njenga F, 'Focus on psychiatry in East Africa' 181(4) *The British Journal of Psychiatry*, 2002, 354.

⁵⁴ McCulloch J, 'Colonial psychiatry and "the African mind"', 21.

⁵⁵ McCulloch J, 'Colonial psychiatry and "the African mind"', 21.

⁵⁶ Forshaw, 'The origins and early development of forensic mental health', 78.

⁵⁷ McCulloch J, 'Colonial psychiatry and "the African mind"', 25-27.

that 'the threat of escape was a constant problem'.⁵⁸ Escape of 'criminal lunatics' was a public security problem that was frequently encountered in England, with James Hadfield's case being a key example of such an instance, and hence this paper presupposes that the constant threat was equally a public security problem in Kenya.⁵⁹ This threat also imperilled the isolative aspect of the GBI verdict as there is a probability that fugitive GBI prisoners intermingled with other Kenyan citizens, even though they were envisioned to be confined for a given duration.

Clearly, there were challenges in sustaining the isolative aim of the special verdict. However, beyond these encumbrances, this paper believes that this aim was roughly met because there were some collective attempts at ensuring GBI persons were detained. The same may not be said about implementing the rehabilitative aim, as this paper will shortly establish.

c. Treatment and psychiatrists

Mathari's psychiatrists were merely a handful of Europeans because of the shared disinterest in working at colonial asylums.⁶⁰ The sparsity of psychiatrists constrained the number of Africans that received Western medicine, such as insulin shock therapy, as there were not enough physicians 'to monitor the patient's progress'.⁶¹ This case was further aggravated by the fact that Mathari often lacked funds to provide basic treatment and resources to its patients, let alone specialised treatment.⁶²

The colonial government greatly contributed to the vexations of the hospital and institutional failures that fettered the execution of the substantive aims of the special verdict, especially the rehabilitative aim. Despite the passing of the English Mental Health Act (1959), which sought to manoeuvre matters concerning mentally ill persons, the government failed to provide 'institutional support and resources' to Mathari that would have aided in the purchase of medication for patients.⁶³ This is unfortunate because governmental assistance would have promoted the implementation of the GBI verdict's rehabilitative objectives.

⁵⁸ McCulloch J, 'Colonial psychiatry and "the African mind"', 21.

⁵⁹ Gordon H and Khosla V, 'The interface between general and forensic psychiatry: A historical perspective' 20(5) *Advances in Psychiatric Treatment*, 2014, 351 and 354-355.

⁶⁰ Njenga F, 'Focus on psychiatry in East Africa', 354. McCulloch J, 'Colonial psychiatry and the African mind', 3.

⁶¹ McCulloch J, 'Colonial psychiatry and "the African mind"', 25. This type of medicine was typically availed to Europeans and Asians within the hospital.

⁶² McCulloch J, 'Colonial psychiatry and "the African mind"', 25-26.

⁶³ Mahone S and Vaughan M, *Psychiatry and empire*, 41.

Furthermore, the government placed reins on the use of traditional medicine (TM) in hospitals, to favour the use of Western medicine, even though TM and its practitioners would have led to an increment of treatment and clinicians available.⁶⁴ Studies had shown that some African TM at the time, such as Rau-wolfia, were 'as effective if not more effective' than medicine therapies 'practised in the West'.⁶⁵ Thus, GBI persons may have benefitted from such medicine in their road to rehabilitation if the government had considered traditional options.

From these points, this paper remarks that there was less institutional support in actualising the rehabilitative aim than there was in enforcing the isolative aim of the GBI verdict. The paper concludes that during colonialism, the GBI verdict operated for the most part as another 'guilty' verdict. This is because GBI offenders were ordinarily held in custody under punitive conditions but received little to no specialised treatment. At this juncture, the paper turns to examine the execution of the verdict's aims following Kenya's independence to determine if colonial conditions continued to exist or if they improved.

iii. Pre-devolution: 1963 to 2010

a. Legal framework

Kenya attained its independence in 1963 and there was a shift from colonial rule to African rule.⁶⁶ Despite this shift in political power, the new Kenyan government inherited outdated colonial legislation, including the English Mental Health Act (1959), which was unconstructive in mending the situations facing GBI persons.⁶⁷ Fortunately, this Act was amended in 1989. The amended Act provided for the establishment of mental hospitals and special centres within prisons for the 'reception' and treatment of GBI prisoners in the spirit of the verdict's aims.⁶⁸

The Prison Act (1963) also underwent some revisions until 1998, though it continued to lack specific provisions on GBI prisoners and their treatment.⁶⁹ The Act instead discussed the basic health and management measures taken

⁶⁴ Harrington J, 'Governing traditional medicine in Kenya: Problematization and the role of the Constitution' 77(2), *African Studies*, 2018, 2.

⁶⁵ Mwayo A, Ndeti D, Mutiso V and Khasakhala L, 'Traditional healers and provision of mental health services in cosmopolitan informal settlements in Nairobi, Kenya' 16(2) *African Journal of Psychiatry*, 2013, 135.

⁶⁶ Carnegie Endowment for International Peace, *Kenya: Adapting to political ebbs and flows*, 2017, 25.

⁶⁷ Ndeti D *et al*, 'Kenya's mental health law', 96.

⁶⁸ Section 9(1-3), *Mental Health Act* (Act No. 10 of 1989).

⁶⁹ See generally, *The Prisons Act* (Act No. 10 of 1998).

for all prisoners.⁷⁰ It also promoted the establishment of prison infirmaries, the presence of medical officers and the examinations of prisoners, the cleanliness of prisons and the creation of separate cells for male prisoners, female prisoners and minors.⁷¹ This paper evaluates the progress made as these promotions clearly speak to the dual aims of the GBI verdict.

b. Place of custody

Despite the laws in place, the prison environment continued to deviate. Congestion intensified due to the rise of prisoners in colonial prisons that were designed to hold fewer prisoners.⁷² The courts were guilty of the overcrowding in prisons because many inmates were actually remand prisoners awaiting trial. The courts frequently delayed and adjourned the cases of these prisoners, forcing them to stay in limited prison space longer than was necessary.⁷³ Due to this overpopulation, there was the spread of disease and poor ventilation as well as shortages of food, bedding, psychiatrists and medicine.⁷⁴ GBI prisoners often competed with other prisoners for these declining resources, even though the GBI verdict requires that they receive resources specific to their rehabilitation.⁷⁵

Prisons surveyed some options to decongest their facilities, including introducing policies that allowed prisoners to serve their sentences by carrying out community service in their communities.⁷⁶ However, this initiative was reported to be ineffective as the community service programmes were 'too slow and weak to effectively address overcrowding'.⁷⁷ Prisons also transferred GBI prisoners to Mathari Hospital as per their mandate.⁷⁸ However, unbeknownst to them, similar problems were awaiting these prisoners in Mathari.

⁷⁰ Part III and IV, *The Prison Act* (Act No. 10 of 1998).

⁷¹ Section 22-33, *The Prisons Act* (Act No. 10 of 1998).

⁷² Penal Reform International, *Towards methods of improving prison policy in Kenya*, 2001, 30.

⁷³ Mathai M and Ndetai D, 'Overcrowded prisons and low psychiatric provision', 253.

⁷⁴ Penal Reform International, *Towards methods of improving prison policy in Kenya*, 30. Mathai M and Ndetai D, 'Overcrowded prisons and low psychiatric provision', 250-253. There are some extreme cases whereby there were suffocations and deaths as a result of this overcrowding.

⁷⁵ Mathai M and Ndetai D, 'Overcrowded prisons and low psychiatric provision', 253.

⁷⁶ IRIN News, 'Prisons still overcrowded despite new decongestion policy' *The New Humanitarian*, 04 February 2003 -<https://www.thenewhumanitarian.org/report/41413/kenya-prisons-still-overcrowded-despite-new-decongestion-policy>- on 02 January 2021.

⁷⁷ United States Department of State, 'U.S. Department of State country report on human rights practices 2005 – Kenya', RefWorld, 8 March 2006 -<https://www.refworld.org/docid/441821862f.html>- on 24 January 2021.

⁷⁸ Office of the Auditor-General, *Performance audit report on the provision of mental healthcare services in Kenya*, 2017, 17. Nyayieka I, 'Underfunding, staff poaching put Mathari Hospital on sick bed' *Business Daily*, 11 November 2018 -<https://www.businessdailyafrica.com/bd/data-hub/underfunding-staff-poaching-put-mathari-hospital-on-sick-bed-2227018>- on 25 January 2021.

Mathari remained the only public referral psychiatric hospital in Kenya. The hospital effectuated structural changes where two sections were created: the Civil Section and the Maximum Security Unit (MSU). The Civil Section is comprised of wards dedicated to males, females and, among others, children.⁷⁹ The MSU was opened in 1978 as an in-patient forensic psychiatric unit for 'law offenders with mental illness[es]' and their treatment.⁸⁰ This section was established due to the breakout of fourteen mentally ill criminals from Mathari which put public security at peril, something the GBI verdict strives to uphold through its isolative aim.

Hence, in response to the concerns of the public, the government built the MSU.⁸¹ The MSU started with two hundred beds for GBI patients but this bed capacity later became inadequate for the growing population.⁸² Referrals from the Kenya Prisons Service (KPS) and courts, albeit legal, furthered the financial strain of Mathari which was fraught with complications such as dilapidations within parts of the hospital.⁸³

The degeneration problem would have been fixed through better allocation of funds as this paper argues that the poor infrastructure may have favoured patients who wanted to abscond.⁸⁴ However, the government allotted less than one percent of the total health budget to mental health, which was too little for Mathari to use to redress such problems.⁸⁵ Once again, this paper notes the lack of adequate institutional assistance in carrying out the GBI's isolative aim. Unfortunately, a similar conclusion can be drawn after assessing the execution of the rehabilitative aim.

⁷⁹ Othieno-Nyaura E, 'Characteristics of psychiatric in-patients who engage in assaultive behaviour in Mathari Hospital, Nairobi', 9.

⁸⁰ The National Assembly, *Departmental Committee on health report on the status of national referral hospitals*, 12.

⁸¹ Asuga-Bunyassi L, 'Prevalence of substance abuse among forensic psychiatry inpatients at Mathari hospital', 25.

⁸² Korste R, 'Eight encounters with mental health care Kenya' In2MentalHealth – 14 February 2013 -<https://in2mentalhealth.com/2013/02/14/eight-encounters-with-mental-health-care-kenya/> - on 30 December 2020. Office of the Auditor-General, *Performance audit report on the provision of mental healthcare services in Kenya*, 2017, 21.

⁸³ Ministry of Health, *A report on the performance status, 2003 and 2004, Health management information system*, 2004, 151.

⁸⁴ Seppänen A, Törmänen I, Shaw C and Kennedy H, 'Modern forensic psychiatric hospital design: Clinical, legal and structural aspects' 12(1) *International Journal of Mental Health Systems*, 2018, 3.

⁸⁵ Kigamwa P and Njenga F, 'Mental health policy and programmes in Kenya', 12-14. Ministry of Health, *A report on the performance status, 2003 and 2004, Health management information system*, 151.

c. Treatment and psychiatrists

Aside from financial afflictions, the mental hospital also experienced strain in human resources. As previously mentioned, all the psychiatrists in Kenya before independence were European. After independence, there was a slow but steady growth of Kenyan psychiatrists who were taught at the University of Nairobi (established in 1970) and trained at Mathari Hospital.⁸⁶ The training certainly did lessen the gap in psychiatrists; however, its impact barely curbed the problem of staff shortage in the hospital.⁸⁷ Thus, although the criminal mentally-ill patients (including GBI persons) constituted two-thirds of the hospital's total in-patients, these patients hardly received medical support from the hospital.⁸⁸ This acts contrary to the rehabilitative aspect of the GBI verdict as the verdict entitles GBI patients to medical support for their betterment.

The successive governments, fortunately, ventured into numerous activities to ameliorate these hindrances. They promulgated a new constitution that denounced cruel and inhuman treatment, a common phenomenon in mental hospitals and prisons during colonialism.⁸⁹ Moreover, the government adopted 'mental health' as the ninth element in public healthcare in 1982 and created a division of mental healthcare in 1987.⁹⁰

These developments had minimal benefits due to the poor mental health budget. This low issuance to mental health was because of the government's attention on 'more life-threatening' diseases in Kenya such as 'measles, malaria and tuberculosis'.⁹¹ Consequently, this inattention heavily impacted the provision of treatment. The neglect was furthered by the absence of the right to health in the 1963 Constitution. This is because the government had no onus to provide a satisfactory standard of health to Kenyans, including GBI persons who

⁸⁶ Kigamwa P and Njenga F, 'Mental health policy and programmes in Kenya' 2(8) *Board of International Affairs of the Royal College of Psychiatrists*, 2005, 12-13. From the 1980s, these psychiatrists would study at the University of Nairobi, graduate and undergo a training programme in psychiatry at Mathari Hospital. By 2005, around forty-seven psychiatrists were serving a population of thirty million Kenyans.

⁸⁷ Ndeti D, Pizzo M, Maru H, Ongecha F, Khasakhala L, Mutiso V and Kokonya D, 'Burnout in staff working at the Mathari psychiatric hospital' 11(3) *African Journal of Psychiatry*, 2008, 199-201.

⁸⁸ Mathai M and Ndeti D, 'Overcrowded prisons and low psychiatric provision: The situation of mentally ill prisoners in Kenya', 253. Kamunge G, 'Stigmatization of Mathare mental hospital nursing staff caring for the mentally ill' Published, University of Nairobi, Nairobi, 2011, 14. Ministry of Health, *A report on the performance status, 2003 and 2004, Health management information system*, 151.

⁸⁹ Ibrahim M, 'Mental health in Kenya: Not yet uhuru' 1(2) *Disability and the Global South*, 2014, 393-394. Section 18, *Constitution of Kenya* (1963).

⁹⁰ Ministry of Health, *A report on the performance status, 2003 and 2004, Health management information system*, 1987, 126.

⁹¹ Kigamwa P and Njenga F, 'Mental health policy and programmes in Kenya', 12.

require special care.⁹² Therefore, the absence of state obligation paired with the low budget discussed made it difficult for Mathari's doctors to obtain quality treatment for the illnesses of mental health patients, such as electroconvulsive treatment, despite Mathari's core services and functions.⁹³ These realities were a severe blow to the rehabilitative aspect of the GBI verdict.

Political leaders such as Jomo Kenyatta also recycled the practice inherited from colonialism of shunning TM and its connoisseurs, despite their reportedly 'effective and culturally sensitive interventions' delivered in the 'treatment of mental health problems' that would assist GBI persons if considered.⁹⁴ This is because some studies have proven that some forms of TM are just 'as effective' as conventional medicine in treating some mental illnesses such as dementia.⁹⁵

Such benefits led the Alma-Ata Declaration (1970) to coax countries like Kenya to reconsider this harsh stance and embrace the role of healers and TM in the healthcare system.⁹⁶ The Declaration was proclaimed after the outcome of World War Two where health was a growing concern.⁹⁷ In this regard, the Declaration appealed to countries to incorporate TM to raise their standards of health.⁹⁸ However, there persisted great reluctance to do this in Kenya due to the continued 'distrust between allopathic and traditional practitioners' that was fuelled by the superstitious conceptions of TM.⁹⁹

This paper concedes that there was evidently greater effort to meet the rehabilitative objective of the verdict during the pre-devolution era than there was

⁹² Roux-Kemp A, 'The enforceability of health rights in Kenya: An African constitutional evaluation' 27(1), *African Journal of International and Comparative Law*, 2019, 128. See generally, *Constitution of Kenya* (1963). World Health Organization, 'Human rights and health' World Health Organization, 29 December 2017 – <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health> on 04 January 2021.

⁹³ Kamunge G, 'Stigmatization of Mathare mental hospital nursing staff caring for the mentally ill', 12.

⁹⁴ Harrington J, 'Governing traditional medicine in Kenya', 3. Abdullahi A, 'Trends and challenges of traditional medicine in Africa', 116. Musyimi C *et al*, 'Mental health treatment in Kenya: task-sharing challenges and opportunities among informal health providers', 2.

⁹⁵ Akhondzadeh S and Maleki J, 'Herbal medicines in the treatment of psychiatric and neurological disorders' 1(1) *Iran J Psychiatry*, 2006, 3.

⁹⁶ World Health Organization, *Report of the international conference on primary health care, Alma-Ata, USSR, 6-12 September 1978*, 1978, 4-5. Harrington J, 'Governing traditional medicine in Kenya', 3.

⁹⁷ Dionisio P, 'The reasons behind the flop of Alma-Ata principles', *Policies for Equitable Access to Health*, 16 June 2015 – <http://www.peah.it/2015/06/the-reasons-behind-the-flop-of-alma-ata-principles/> on 24 January 2021.

⁹⁸ Rifkin S, 'Alma Ata after 40 years: Primary health care and Health for All – from consensus to complexity' 3(3) *BMJ Global Health*, 2018, 1-2.

⁹⁹ Harrington J, 'Governing traditional medicine in Kenya', 3. Abdullahi A, 'Trends and challenges of traditional medicine in Africa' 8(5) *African Journal of Traditional, Complementary and Alternative Medicines*, 2011, 117.

during colonialism. However, there remained a disconnect in the complementary fulfilment of the GBI verdict's isolative and rehabilitative aims. Various Kenyans were found GBI and were thereafter referred to MSU or a prison for incarceration. In these facilities, treatment that was critical to their recovery or mental wellbeing was insufficiently administered. This situation was further complicated by the fact that health was not recognised as a right during this period. In effect, the verdict's implementation continued to almost mirror the implementation of a 'guilty' verdict. To assess the implementation of the GBI verdict in the present day, this paper now looks at the progress made since 2010.

III. The Current Implementation of the GBI Verdict in Kenya: Devolution and Beyond

i. Legal framework

2010 was a landmark year in Kenya because of the pronouncement of a new constitution that introduced elements of devolution and a comprehensive rights framework, which presently have a great impact on mental healthcare.¹⁰⁰ Devolution made the national government responsible for the management of national referral services, which includes Mathari Hospital.¹⁰¹ The human rights framework also guaranteed GBI prisoners and patients, among other Kenyans, the right to the highest standard of health.¹⁰²

The 2010 Constitution also acknowledges the role of international law, as Kenya is a party to several international treaties.¹⁰³ This recognition is important because it places accountability on the Kenyan government to fulfil international obligations, including those to do with mentally ill persons, healthcare and prisons. For example, the Banjul Charter, which was ratified by Kenya in 1992, calls for states to take measures to protect the physical and mental health of people and provide medical attention to all, a call that extends to GBI persons given their verdict's rehabilitation aim.¹⁰⁴

¹⁰⁰ Chapter Four and Eleven, *Constitution of Kenya* (2010).

¹⁰¹ Fourth Schedule, *Constitution of Kenya* (2010). Tsofa B, Goodman C, Gilson L and Molyneux S, 'Devolution and its effects on health workforce and commodities management – early implementation experiences in Kilifi Country, Kenya' 16(169) *International Journal for Equity in Health* (2017), 1-2. Ministry of Health, *Mental health and wellbeing: Towards happiness and national prosperity*, 2020, 2 and 58.

¹⁰² Article 43, *Constitution of Kenya* (2010). Article 51, *Constitution of Kenya* (2010).

¹⁰³ Article 2(5), *Constitution of Kenya* (2010).

¹⁰⁴ Article 16, *African (Banjul) Charter on Human and Peoples' Rights*, 21 October 1986, CAB/LEG/67/3 rev. 6, 21 I.L.M. 58 (1982). Kenya Law, 'African (Banjul) Charter on Human and Peoples' Rights' Kenya Law, 1 February 2001 -<http://kenyalaw.org/treaties/treaties/11/African-Banjul-Charter-on-Human-and-Peoples-Rights-on-22-January-2021>.

Alterations were also made to laws such as the Criminal Procedure Code in 2012, which continues to be relied upon in GBI cases.¹⁰⁵ Similarly, the Mental Health Act was modified in 2012 to confront matters concerning the 'conditions in mental health facilities'.¹⁰⁶ The Mental Health Act (2012) established the Kenya Board of Mental Health to ensure that the conditions in the mental health facilities would align with international standards such as the International Covenant on Economic, Social and Cultural Rights.¹⁰⁷ There are also discussions on making future revisions to the 2012 Act such as laying out provisions that recognise GBI persons and support the verdict's aims.¹⁰⁸

ii. Place of custody

Despite the legal progress, prisons continue to be characterised by the same issues of 'overcrowding', 'limited access to adequate health care', 'lack [of] appropriate medical personnel', 'poor sanitation' and 'infectious diseases' which affect all prisoners.¹⁰⁹ The last issue is especially alarming in light of the communicable coronavirus (COVID-19).¹¹⁰ These conditions compounded have previously resulted in the death of some inmates and demonstrate the inadequacy of prison conditions for the prisoners and recuperation of GBI inmates.¹¹¹

Kenyan courts have implemented policies, such as the introduction of technology, that were centred on promoting the expediency of trials to resolve the matter of congestion.¹¹² However, it was stated that while these policies have

¹⁰⁵ Section 166, *Criminal Procedure Code* (Act No. 12 of 2012). However, none of the alterations touched on the GBI verdict.

¹⁰⁶ Ndeti D *et al*, 'Kenya's mental health law', 96.

¹⁰⁷ Section 5(b)(d) and (f), *Mental Health Act* (Act No. 11 of 1993). Article 12, *International Covenant on Economic, Social and Cultural Rights*, 03 January 1976, 993 UNTS 3.

¹⁰⁸ Part VI, *Mental Health Bill* (2014).

¹⁰⁹ Onyango O, 'The challenges facing rehabilitation of prisoners in Kenya and the mitigation strategies' 2(2) *International Journal of Research in Social Sciences*, 2013, 39. Kenya National Commission on Human Rights, *State of healthcare for prisoners in Kenya*, 2019, 3 and 39. Stephens O, 'A comparative study of prison systems in African countries', 237.

¹¹⁰ World Health Organization, *Contact tracing in the context of COVID-19*, 2020, 1.

¹¹¹ Kenya Human Rights Commission, 'Statement by the Kenya Human Rights Commission on prisons, conditions of detention and policing in Kenya at the 60th Ordinary session of the African Commission on Human and People's Rights in Niamey, Niger', 15 May 2017 -https://www.khrc.or.ke/2015-03-04-10-37-01/press-releases/600-statement-by-the-kenya-human-rights-commission-on-prisons-conditions-of-detention-and-policing-in-kenya-at-the-60th-ordinary-session-of-the-african-commission-on-human-and-people-s-rights-in-niamey-niger.html#_ftn2- on 01 January 2021.

¹¹² Gainer M, 'Transforming the courts: Judicial sector reforms in Kenya, 2011-2015', *Innovations for Successful Societies*, 2015, 4-7 - https://successfulesocieties.princeton.edu/sites/successfulesocieties/files/MG_OGP_Kenya.pdf on 24 January 2021.

had some success, several initiatives have been arduous to implement due to 'internal resistance'.¹¹³

KPS has also made concerted efforts to improve these conditions by hiring additional medical practitioners and professionals, as well as creating sentence remissions for offenders serving life sentences.¹¹⁴ Furthermore, the Service has categorised GBI persons as 'Special Psychiatric Offenders' although it is uncertain where these persons reside due to the unavailability of data.¹¹⁵ However, the Service has not addressed other matters such as providing 'specialised training to deal with offenders with special needs' and psychiatric units for mentally ill convicts.¹¹⁶

Similarly, little has been done to reform the state of Mathari, which is still the only hospital with an in-patient forensic psychiatric unit. A Departmental Committee on Health and Taskforce visited the hospital in 2018 and 2020 respectively to inspect the facility. While the Committee noted 'some positive development on [Mathari's] infrastructure', they had also observed that the hospital had leaking roofs, cracked walls and destroyed sewage systems which made habitation intolerable for its patients.¹¹⁷ The situation has worsened to the point where Mathari's patients have attempted to escape the hospital by 'jumping over the facility's walls'.¹¹⁸ This phenomenon limits the isolative aim of the GBI verdict since patients may have not completed their rehabilitation and may consequently pose harm to Kenyans.¹¹⁹

Likewise, the Taskforce stated that Mathari lacks the 'basic infrastructure to deliver modern evidence-informed psychiatric care' and 'lacks in providing an

¹¹³ Gainer M, 'Transforming the courts: Judicial sector reforms in Kenya, 2011-2015', 4.

¹¹⁴ Stephens O, 'A comparative study of prison systems in African countries', 238.

¹¹⁵ Matata L, 'Kenyans living with mental illness get lost in the criminal justice system' Petty Offences, 18 November 2016 -<https://pettyoffences.org/kenyans-living-with-mental-illness-get-lost-in-the-criminal-justice-system/> - on 21 January 2021. Kenya National Commission on Human Rights, *State of healthcare for prisoners in Kenya*, 2019, 37.

¹¹⁶ Stephens O, 'A comparative study of prison systems in African countries', 237. PDO Kenya, 'Prisons psychosocial support program' PDO Kenya, 19 February 2017 - <https://www.pdokenya.org/prison-support1.html> - on 05 February 2021.

¹¹⁷ The National Assembly, *Departmental Committee on health report on the status of national referral hospitals*, 12-14.

¹¹⁸ Business Today, 'Patients escape from Mathari Mental Hospital' Business Today, 05 December 2016 - <https://businesstoday.co.ke/100-escape-from-mathari-mental-hospital/> - on 04 February 2021. Menil V, Knapp M, McDaid and Njenga F, 'Service use, charge, and access to mental healthcare in a private Kenyan inpatient setting: The effects of insurance' 9(3) *PLOS One*, 2014, 6.

¹¹⁹ Munguti R, 'Three nurses in court for abetting escape of 81 Mathari hospital patients' Nairobi News, 22 June 2017 - <https://nairobi.news.nation.co.ke/news/nurses-charged-releasing-mathari-patients> - on 04 February 2021.

environment for treating the illness as well as the rehabilitation of behaviour of those admitted'.¹²⁰ These observations continue to point at the poor fulfilment of the isolative aim of the GBI verdict, which subsequently affects the achievement of the rehabilitative aim.

The Committee and Taskforce also noted the neglect and congestion of the MSU. This unit has been neglected due to the conflict between the Ministry of Health and the Ministry of Interior over where the MSU lies since the MSU is part of a mental hospital but holds criminals.¹²¹ Consequently, in the absence of a 'clear policy direction', there is mismanagement of mentally ill patients and 'ineffective service delivery'.¹²²

Overcrowding prevails because there has been no release of patients within this unit since 2016 due to 'inefficient and protracted processes'.¹²³ The MSU was recorded to hold more patients than its physical capacity, often having occupancy of one hundred and forty percent. This percentage does not make it easy for the understaffed personnel as one nurse deals with over one hundred and forty-seven 'convicts with mental illnesses' and these nurses often do not know how to 'care for the mentally ill offenders'.¹²⁴ Consequently, this contributes to ineffective service delivery as GBI patients barely receive the medical attention that is required to meet the verdict's aims.¹²⁵

The bottleneck situation has built up to the point where the hospital was forced to stop admitting mentally ill convicts, as reported in September 2020, since the hospital is catering for more referrals than it can hold.¹²⁶ This decision affects all mentally ill offenders as Mathari is the only national hospital that has a forensic department for these persons.¹²⁷ GBI persons are now expected to

¹²⁰ Ministry of Health, *Mental health and wellbeing: Towards happiness and national prosperity*, 2019, 4, 7 and 52.

¹²¹ Ministry of Health, *Mental health and wellbeing: Towards happiness and national prosperity*, 2019, 96.

¹²² The National Assembly, *Departmental Committee on health report on the status of national referral hospitals*, 14.

¹²³ Ministry of Health, *Mental health and wellbeing: Towards happiness and national prosperity*, 2019, 96.

¹²⁴ The National Assembly, *Departmental Committee on health report on the status of national referral hospitals*, 14. The National Assembly Hansard Report, 27 June 2019, 50. Mageto I, 'Evidence-based Master of Science in forensic nursing curriculum: A model for Kenya' Published, University of Nairobi, Nairobi, 2015, 54.

¹²⁵ The National Assembly, *Hansard Report*, 27 June 2019, 50.

¹²⁶ Gitonga A, 'Congestion forces Mathari to turn away sick convicts' The Standard, 10 September 2020 -<https://www.standardmedia.co.ke/health/health-science/article/2001385911/congestion-forces-mathari-to-turn-away-sick-convicts>- on 30 December 2020. The National Assembly Hansard Report, 27 June 2019, 21.

¹²⁷ Gitonga A, 'Congestion forces Mathari to turn away sick convicts' The Standard, 10 September 2020 -<https://www.standardmedia.co.ke/health/health-science/article/2001385911/congestion-forces-mathari-to-turn-away-sick-convicts>- on 30 December 2020.

be transferred to prison following the issue of the special verdict, where their environments are arguably worse than those in Mathari.¹²⁸

By and large, this paper observes that the isolative objective continues to face serious enforcement limitations. The situation has barely improved since the implementation challenges that were prominent during the previous two periods highlighted are present within this period as well. Regrettably, a similar case can be made for the rehabilitative objective.

iii. Treatment and psychiatrists

Kenya does not have a separate mental health budget as mental healthcare funds are apportioned from the country's health budget.¹²⁹ This is a problem because Mathari 'does not receive any funding for mentally ill offenders which translates to very constrained services offered' to these offenders.¹³⁰ This fact was further aggravated by the drastic drop in Mathari's budget from one hundred and fourteen million Kenyan shillings to ninety-two million Kenyan shillings between 2018 and 2019.¹³¹ Fortunately, in 2020, Mathari's budget was increased to around one billion Kenyan shillings.¹³² However, the budget has progressively been proven to marginally cover the costs of services to GBI patients, much less other expenses, and this paper predicts that the same may apply even with the increment.¹³³ It is disappointing that Mathari shoulders these annually-increasing costs alone; the hospital receives no assistance from KPS even though Mathari receives referrals from prisons and KPS has a higher budget.¹³⁴

This state of affairs is also compromised by the low rate of psychiatrists per one hundred thousand population in Kenya.¹³⁵ The shortage of personnel subsists because of brain drain and the fact that a good portion of psychiatrists

¹²⁸ Gitonga A, 'Congestion forces Mathari to turn away sick convicts' The Standard, 10 September 2020 -<https://www.standardmedia.co.ke/health/health-science/article/2001385911/congestion-forces-mathari-to-turn-away-sick-convicts>- on 30 December 2020.

¹²⁹ Ministry of Health, *Kenya Mental Health Policy 2015-2030: Towards attaining the highest standard of mental health*, 2015, 10.

¹³⁰ Ministry of Health, *Mental health and wellbeing: Towards happiness and national prosperity*, 2019, 56. The National Assembly, *Departmental Committee on health report on the status of national referral hospitals*, 15.

¹³¹ The National Assembly, *Departmental Committee on health report on the status of national referral hospitals*, 14.

¹³² The National Treasury and Planning, *Budget Statement FY 2021/21*, 2020, 53.

¹³³ Office of the Auditor-General, *Performance audit report on the provision of mental healthcare services in Kenya*, 2017, 17-20.

¹³⁴ Office of the Auditor-General, *Performance audit report on the provision of mental healthcare services in Kenya*, 2017, 18-19. The National Treasury and Planning, *Budget Statement FY 2021/21*, 2020, 59.

¹³⁵ See World Health Organization, *Mental Health ATLAS 2017 Member state profile: Kenya*, 2017, 1.

practise in private hospitals rather than public hospitals.¹³⁶ The former reason exists due, *inter alia*, to 'general dissatisfaction with an under resourced service delivery environment' and 'dissatisfaction with pay'.¹³⁷ This paper argues that the latter reason exists for the same reasons, since private hospitals generally offer better working environments and remuneration than public hospitals.¹³⁸ The effect is that there are not enough psychiatrists to track the rehabilitation progress of GBI patients.

Some educational institutions constructed during pre-devolution began to offer psychiatry to counter this emigration rate and encouraged the pursuit of mental health as a career.¹³⁹ While this helped increase the presence of general psychiatrists in the country to approximately one hundred in 2016, no institution currently offers forensic psychiatry or forensic nursing science, which are areas of psychiatry relevant to the treatment of mentally ill offenders.¹⁴⁰ The Kenya Medical Training College (Mathari Branch) (KMTC-M) promises to offer forensic psychiatry as a two-week short course, however, at an unknown date.¹⁴¹

Existing partnerships between Mathari and other entities, such as Safaricom, have aided the hospital in battling these encumbrances.¹⁴² However, Mathari continues to lack rudimentary resources and medical equipment, such as a Magnetic Resonance Imaging (MRI) scanner.¹⁴³ Furthermore, with drug

¹³⁶ Meyer AC and Ndeti D, 'Providing sustainable mental health care in Kenya: A demonstration project' National Center for Biotechnology Information, 13, 13 January 2015 –<https://www.ncbi.nlm.nih.gov/books/NBK350312/> on 23 December 2020. Brownie S and Oywer E, 'Health professionals in Kenya: strategies to expand reach and reduce brain drain of psychiatric nurses and psychiatrists' 13(3) *BJPsych International*, 2016, 55-56.

¹³⁷ Brownie S and Oywer E, 'Health professionals in Kenya: strategies to expand reach and reduce brain drain of psychiatric nurses and psychiatrists', 56.

¹³⁸ Pires B, Oliveira L, Siqueira C, Feldman L, Oliveira R and Gasparino R, 'Nurse work environment: Comparison between private and public hospitals' 16(4) *Einstein (São Paulo)*, 2018, 1.

¹³⁹ University of Nairobi (Department of Psychiatry), 'About us' 19 November 2019 – <https://psychiatry.uonbi.ac.ke/index.php/basic-page/about-us-0-> on 23 December 2020.

¹⁴⁰ Mageto I, 'Evidence-based Master of Science in forensic nursing curriculum: A model for Kenya', Published, University of Nairobi, Nairobi, 2015, 54-57. Meyer AC and Ndeti D, 'Providing sustainable mental health care in Kenya: A demonstration project' National Center for Biotechnology Information, 13, 13 January 2015 –<https://www.ncbi.nlm.nih.gov/books/NBK350312/> on 23 December 2020.

¹⁴¹ Kenya Medical Training College, 'KMTC Mathari campus' 22 July 2019 –<https://kmtc.ac.ke/mathare-> on 23 December 2020.

¹⁴² Safaricom Newsroom, '20 years of investing in communities in Kenya' Safaricom Newsroom, 12 November 2020 – <https://newsroom.safaricom.co.ke/20-years-of-investing-in-communities-in-kenya/> on 05 February 2021.

¹⁴³ Igadwah L, 'Congestion and staff shortage ail Mathari Hospital' Business Daily, 08 January 2019 –<https://www.businessdailyafrica.com/bd/news/congestion-and-staff-shortage-ail-mathari-hospital-2233964-> on 22 January 2021.

allocation funds reduced, GBI persons receive meagre and unsatisfactory treatment for their mental health contrary to various laws and the rehabilitation aim of the GBI verdict.¹⁴⁴ The physical health of patients in Mathari is also at risk due to the infectious COVID-19, given the already mentioned congestion and poor sanitation and hygiene practices in Mathari.¹⁴⁵

The Health Act attempted to reconcile the challenge of treatment and psychiatrists by creating provisions that added TM and traditional healers to the healthcare system in 2017.¹⁴⁶ This is huge progress as the principles underscored in the Alma-Ata Declaration are finally captured.¹⁴⁷ TM is reportedly more accessible and affordable, attributes that would work favourably to Mathari given its reduced drug funds. In addition, healers reportedly deliver effective 'psychosocial support to patients' which would aid GBI persons with psychosocial disorders, and they are easier to meet than conventional doctors.¹⁴⁸ However, the effects of these reconciliations are limited because of the poor coordination between traditional healers and other health workers stressed by the dismissal of healers' contributions.¹⁴⁹ Furthermore, there are concerns over adverse effects that some TM may have on patients and its irrational use.¹⁵⁰ This contributes to the reluctance and suspicion of the usage of TM.

This study appreciates the greater efforts by the education system, KPS, the courts and other institutions in realising the objectives of the GBI verdict. However, their actions are not enough to resolve the institutional failures that have been present since colonialism and the pre-devolution period. Presently, both aims are poorly met and the isolative aim is fulfilled significantly better than the rehabilitative aim. The paper now diverts its focus to Ghana to infer lessons as to how the GBI verdict can be better implemented in Kenya.

¹⁴⁴ The National Assembly, *Departmental Committee on health report on the status of national referral hospitals*, 14.

¹⁴⁵ Ochillo M and Elsie O, 'Mental health implications of COVID-19 in Kenya', 36-37.

¹⁴⁶ See generally, Part X, *Health Act* (Act No. 21 of 2017).

¹⁴⁷ World Health Organization, *Report of the international conference on primary health care, Alma-Ata, USSR. 6-12 September 1978*, 1978, 4-5.

¹⁴⁸ Chebii W, Muthee J and Kiemo K, 'The governance of traditional medicine and herbal remedies in the selected local markets of Western Kenya' 16(39) *Journal of Ethnobiology and Ethnomedicine*, 2020, 2-6. Green B and Colucci E, 'Traditional healers' and biomedical practitioners' perceptions of collaborative mental healthcare in low-and middle-income countries: A systematic review' 57(1), *Transcultural Psychiatry*, 2020, 100.

¹⁴⁹ Mesha Science, 'Study: Traditional healers key to end mental health stigma' Mesha Science, 29 November 2019 - <https://meshascience.org/study-traditional-healers-key-to-end-mental-health-stigma/> - on 08 February 2021.

¹⁵⁰ Gakuya D, Okumu M, Kiama S, Mbaria J, Gathumbi P, Mathiu P and Nguta J, 'Traditional medicine in Kenya: Past and current status, challenges, and the way forward' 8 *Scientific African*, 2020, 3-4.

IV. The Implementation of the GBI verdict in Ghana – A Comparative Study

i. *Justification for selecting Ghana*

In the last two sections, this paper identified the main challenges that limit the realisation of the GBI verdict's aims. However, these problems are not unique to Kenya and it is in this light that Ghana is examined. Ghana is an African country that has retained the GBI verdict after its independence in 1957.¹⁵¹ As will be seen through the limited literature available, Ghana was chosen because it is experiencing similar problems as Kenya in implementing the dual aims of the GBI verdict.¹⁵² Despite these obstacles, Ghana has adopted measures that bring the country closer to achieving these aims and making the verdict tenable.

ii. *The GBI verdict in Ghana: Challenges and responses*

a. *Places of custody*

The dual aims of the GBI verdict are captured in Ghana's Criminal Code (1960) and Criminal Procedure Code (1960). If a person is found GBI, the court may refer the convicted person to Ghana's psychiatric hospitals for incarceration and treatment.¹⁵³ Currently, there are only three psychiatric hospitals in Ghana to which GBI persons are referred: Accra Psychiatric Hospital, Ankaful Psychiatric Hospital and Pantang Hospital.¹⁵⁴ There is overcrowding in the psychiatric hospitals which results in poor ventilation and the spread of communicable diseases.¹⁵⁵ Ghana's civil society tackles this problem by organising refurbishments of the three psychiatric hospitals to improve their state of affairs for the benefit of mentally ill patients as Safaricom did for Mathari.¹⁵⁶ These renovations, *inter*

¹⁵¹ University of Oxford (Faculty of History), 'Was the Gold Coast 'decolonised' or did Ghana win its independence' 27 July 2017, 1 -<https://www.history.ox.ac.uk/::ognode-637356::/files/download-resource-printable-pdf-1-> on 02 January 2021. Section 27, *Criminal Code 1960* (Act 29). Section 137, *Criminal Procedure Code, 1960* (Act 30).

¹⁵² Akerele O, 'The decentralization of the Ghanaian mental health system through the medical and non-profit sector: A case to improve access to care and disrupt the "othering" of the mentally ill?' 13(13) *Intersect*, 2020, 7.

¹⁵³ Section 27, *Criminal Code 1960* (Act 29). Section 137, *Criminal Procedure Code, 1960* (Act 30).

¹⁵⁴ Section 27, *Criminal Code 1960* (Act 29). National Academies of Sciences, Engineering and Medicine, *Providing sustainable mental and neurological health care in Ghana and Kenya: Workshop summary*, National Academies Press, Washington, 2017, 39. Section 137, *Criminal Procedure Code, 1960* (Act 30).

¹⁵⁵ Fournier O, 'The status of mental health care in Ghana, West Africa and signs of progress in the Greater Accra region' 24(3) *Berkeley Undergraduate Journal*, 2011, 18-19.

¹⁵⁶ Ayettey L, 'Ghana Navy renovates Accra Psychiatric Hospital' Daily Guide Network, 22 August 2019 -[https://dailyguidenetwork.com/ghana-navy-renovates-accra-psychiatric-hospital/-](https://dailyguidenetwork.com/ghana-navy-renovates-accra-psychiatric-hospital/) on 29

alia, are concentrated on the inadequacies of the psychiatric hospitals and the cited escapes that were recorded in Pantang.¹⁵⁷ Ghana has also taken a step further by continuously discharging patients to community psychiatric nurses, unlike the MSU which stopped this in 2016.¹⁵⁸ This repatriation aids in liberating space for the rehabilitation of patients such as those found GBI and promotes the isolative objective of the special verdict.

Some Ghanaian prisons, such as Sunyani Central Prison, have separate cells for 'criminal lunatics' such as GBI persons.¹⁵⁹ While this is a difference between Ghanaian and Kenyan prisons, one similarity is overcrowding.¹⁶⁰ As previously discussed, Kenya undertook community service and technology to ameliorate the overcrowding situation. Ghanaian Prisons took a different approach to this situation. For example, Sunyani Central Prison established settlement camp prisons. These settlement camp prisons receive prisoners from Sunyani and aid in decongestion.¹⁶¹ While these camps are present in Kenya, there are only for leper prisoners.¹⁶² The Ghanaian camps are advantageous to the isolative objective of the GBI verdict as they create more places where GBI persons can be held in custody. While Kenya detains GBI persons in either Mathari or prisons, Ghana holds these persons in either one of the three psychiatric hospitals, a prison or a settlement camp.

December 2020. BeekoN, '94 batch of Wesley Girls renovates Ankaful Psychiatric Foster Ward', 26 May 2020 –<https://newsghana.com.gh/94-batch-of-wesley-girls-renovates-ankaful-psychiatric-foster-ward/> on 29 December 2020. Citi Newsroom, 'Refurbishment of Pantang Psychiatric Hospital launched', 31 July 2019 –<https://citinewsroom.com/2019/07/refurbishment-of-pantang-psychiatric-hospital-launched/> on 29 December 2020.

¹⁵⁷ Roberts M, Mogan C and Asare J, 'An overview of Ghana's mental health system: Results from an assessment using the World Health Organization's assessment instrument for mental health systems (WHO-AIMS)' 8(16) *International Journal of Mental Health Systems*, 2014, 11. Bone T and Roberts M, 'An investigation into the routes to inpatient care at the Pantang Hospital in Ghana via the criminal justice system' 53(2) *Ghana Med J*, 2019, 104.

¹⁵⁸ Buertey A, Attiogbe A and Aziato I, 'Stigma by association: Experiences of community psychiatric nurses in the Accra Metropolis, Ghana' *International Journal of Africa Nursing Sciences*, 2020, 2 - <https://www.sciencedirect.com/science/article/pii/S2214139120301372?via%3Dihub> – on 07 February 2021.

¹⁵⁹ Addai-Boateng C, 'Assessment of emotional and administrative support services in the reformation and rehabilitation of prison inmates: A case study of the Sunyani Central Prisons' Published, Kwame Nkrumah University, Kabwe, 2015, 51 and 79.

¹⁶⁰ United States Department of State, 2019 country reports on human rights practices: Ghana, 2019, 2. Aaniazine A, 'Using rehabilitation programmes to reduce the number of recidivists in Tamale Central Prisons in the Northern Region of Ghana' Published, University of Development Studies, Tamale, 2017, 30.

¹⁶¹ Addai-Boateng C, 'Assessment of emotional and administrative support services in the reformation and rehabilitation of prison inmates', 50.

¹⁶² Section 41, *The Prison Act* (Act No. 10 of 1998).

The paper will now examine how the rehabilitative objective is addressed by Ghana and how they have responded to implementation challenges surrounding this objective.

b. Psychiatrists and medicine

A great challenge facing Ghana's psychiatric hospitals is the number of psychiatrists. Ghana has around forty psychiatrists, including forensic psychiatrists, to serve the Ghanaian population of thirty million people.¹⁶³ While Kenya has more psychiatrists, both countries struggle to meet the acceptable standard of one psychiatrist to ten or eleven thousand citizens.¹⁶⁴

As highlighted, Kenya has attempted to handle this by streamlining traditional healers into the healthcare system and establishing universities that teach psychiatry. However, despite these efforts, there remain concerns regarding the legitimacy of healers as they are registered under the Ministry of Culture and the absence of operational forensic psychiatric courses.¹⁶⁵

Ghana similarly handles this problem by incorporating traditional healers and TM into the mental healthcare system due to their accessibility and large numbers.¹⁶⁶ To assure the public concern of the legitimacy of traditional healers, however, the Ghanaian Traditional Medicine Practice Council issues licenses to official traditional healers who are registered under the Ministry of Health.¹⁶⁷ This improves the image of healers, in addition to aiding the public in distinguishing actual healers from quacks.¹⁶⁸

Furthermore, Ghana set up a post-graduate college where students are trained in forensic psychiatry which has contributed to the growth of the

¹⁶³ Mantey-Small A, 'A reflection on Ghana's mental health system' 18(11) *Current Psychiatry*, 2019, 3. Lambert J, Nantogmah F, Dokurugu A, Alhassan H, Azuure S, Yaro P and Körner J, 'The treatment of mental illness in faith-based and traditional healing centres in Ghana: Perspectives of service users and healers' 14(7) *Global Mental Health*, 2020, 2.

¹⁶⁴ World Health Organization, *Mental health ATLAS 2017 member state profile: Ghana*, 2017, 1. Burvill P, 'Looking beyond the 1:10,000 ratio of psychiatrists to population' 26(2) *Australian and New Zealand Journal of Psychiatry*, 1992, 265.

¹⁶⁵ Gakuya D *et al*, 'Traditional medicine in Kenya', 3.

¹⁶⁶ See Preamble, *Traditional Medicine Practice Act, 2000* (Act 575). Section 31, *Traditional Medicine Practice Act, 2000* (Act 575). Kpobi L, Swartz L and Omenyo C, 'Traditional herbalists' methods of treating mental disorders in Ghana' 56(1) *Transcultural Psychiatry*, 2019, 251. Kpobi L and Swartz L, 'Indigenous and faith healing for mental health in Ghana: An examination of the literature on reported beliefs, practices and use of alternative mental health care in Ghana' 11(1) *African Journal of Primary Health Care and Family Medicine*, 2019, 1.

¹⁶⁷ Section 17-24, *Traditional Medicine Practice Act, 2000* (Act 575). Section 2(2), *Traditional Medicine Practice Act, 2000* (Act 575).

¹⁶⁸ Gakuya D *et al*, 'Traditional medicine in Kenya', 3. Ministry of Health, *Policy Guidelines on Traditional Medicine Development*, 2005, 3.

population of available psychiatrists.¹⁶⁹ This area of sub-specialisation is currently taught over two years as compared to the two-week-long short course offered by KMTC-M which promises to offer forensic psychiatry as a two-week-long short course as previously mentioned.¹⁷⁰ Moreover, contrary to Kenya, Ghana made it compulsory for all 'graduates from medical schools' to take on a '6-month psychiatry duty' to narrow the psychiatric gap.¹⁷¹ This means that more students in Ghana learn psychiatry in greater detail and may have more than ample knowledge on how to treat GBI persons.

The availability of treatment is another hurdle because of the inadequate funding from the Ghanaian government and the lack of political will to increase it.¹⁷² Like Kenya, Ghana has circumvented this problem by taking advantage of its partnerships for the provision of additional funds and services so that GBI persons can enjoy an adequate standard of mental health care.¹⁷³ This reconciliation is further complemented by Ankaful Psychiatric Hospital's collaboration with faith-based healers to improve the 'care of patients' in the hospital.¹⁷⁴ This improves the standard of health accessible to patients. Unfortunately, this is not the case in Kenya due to the aforementioned limited collaboration between conventional and non-conventional doctors.

These are only some of the actions that Ghana has taken to lower certain barriers to the realisations of the GBI verdict's aims. Ghana indeed has some institutional constraints that affect the implementation of the GBI verdict. However, these constraints do not compound to the point where the

¹⁶⁹ Asare J, 'Comment: A historical survey of psychiatric practice in Ghana (1962)' 46(3) *Ghana Medical Journal*, 2012, 115. Ghana College of Physicians and Surgeons, *Ghana College of Physicians Surgeons, Faculty of psychiatry, curriculum for membership and fellowship*, 2011, 9 and 38.

¹⁷⁰ Ghana College of Physicians and Surgeons, 'Duration of fellowship programmes', Ghana College of Physicians and Surgeons, 15 February 2018 -https://gcps.edu.gh/jaymens_up/2018/02/Sub-specialization-of-Faculties-and-duration-FELLOWS.pdf - on 23 January 2021.

¹⁷¹ Xinhua, 'Ghana seeks to address nationwide psychiatrist shortfall', Xinhuanet, 15 February 2020 - http://www.xinhuanet.com/english/2020-02/15/c_138786224.htm - on 04 March 2021.

¹⁷² The government expenditure on mental health in Ghana is one point one zero percent of the total health budget according to the World Health Organization, *Mental health ATLAS 2017 member state profile: Ghana*, 1. Donkor A, 'Psychiatric institutions in Ghana: Towards an understanding of Erving Goffman's typology' Published, University of Ghana, Accra, 1989, 40. National Academies of Sciences, Engineering and Medicine, *Providing sustainable mental and neurological health care in Ghana and Kenya: Workshop summary*, 37. See also, Mantey-Small A, 'A reflection on Ghana's mental health system', 3-5.

¹⁷³ The Kintampo Project, *The mental health system in Ghana*, 2013, 17-18. Section 57(1) and (2), *Mental Health Act, 2012* (Act 846). Mantey-Small A, 'A reflection on Ghana's mental health system', 5.

¹⁷⁴ Ministry of Health Ghana, 'Holistic Assessment of the health sector programme of work 2013, Ghana' 30 July 2014, 56 - <https://www.moh.gov.gh/wp-content/uploads/2016/02/Holistic-Assessment-Report-June-2014140811072318.pdf> - on 07 February 2021.

implementation of the special verdict is similar to that of the 'guilty' verdict. This is because, while both Kenya and Ghana have endeavoured to implement the isolative aim of the verdict, Ghana goes a step further than Kenya in actualising the rehabilitative aim. The rehabilitative objective is remarkably important because GBI persons usually have a stronger need for health services than other offenders. Furthermore, the rehabilitative object is what distinguishes a 'guilty' verdict from a GBI verdict. As Ghana's problems are similar to those in Kenya, Ghana demonstrates that Kenya can also take actions to achieve similar effects.

V. Recommendations

Considering the lessons inferred from the previous sections, this paper proposes recommendations to implement the GBI verdict more effectively. These proposals strive to move the verdict from operating as merely punitive and isolative, as it has been in practice, to more isolative and rehabilitative as per the original substantive aims of the special verdict.

The first set of recommendations propose bettering the place of custody. While some existing initiatives and policies seek to increase the expeditiousness of trials and foster decongestion, there is a lack of cohesion in following through with these projects. Therefore, the paper urges collaboration between members of the Judiciary to effectuate these policies as they are responsible for issuing the GBI verdict and the congestion within Mathari Hospital due to their referrals. Similarly, KPS should extend settlement camp prisons to more prisoners, like Ghana, to aid in decongesting these penal institutions.

KPS should also create special cells for GBI persons to allow them to recuperate while undisturbed as some Ghanaian prisons have. Furthermore, it is recommended that the government increases its budget for mental health so that Mathari may have sufficient funds to undergo renovations and expansion or so that new in-patient forensic psychiatric units can be constructed.

There should also be an amendment to the Prison Service Act and the Mental Health Act. These alterations should be tailored to recognising GBI persons, clarifying the roles of KPS and the Ministry of Health in managing these persons and improving service delivery. The Mental Health Bill (2014), which has not been enacted into law, takes a step in this direction but the Bill only appreciates mentally ill persons who are not yet convicted and fails to specify the body responsible for GBI persons.¹⁷⁵ KPS can participate in improving services

¹⁷⁵ Part VI, *The Mental Health Bill* (2014).

to GBI persons by sensitising the wardens on how to handle the effect of prison conditions on GBI persons' rehabilitation progress.

The second set of recommendations concern treatment. The government is advised to create a separate budget allocation to mental health so as to demystify the funding that goes to the treatment of GBI persons. The drug allocation should also be increased for Mathari to purchase equipment and medicine needed to rehabilitate GBI persons. In addition, as in Ghana, the Ministry of Health should welcome and register healers under their mandate. This will aid in dispelling the stigma surrounding the healers and encourage future collaborations between orthodox doctors and healers in the management of patients. This collaboration could also promote the regulation of TM as it would encourage extensive study on how to administer it and the forms of TM that present little to no side effects.

The last set of recommendations speak to psychiatrists. To moderate the psychiatric shortage in the country and brain drain, the government is urged to make more opportunities for Kenyans to learn and be trained in forensic psychiatry. For example, the government could aid KMTC-M in piloting its forensic psychiatric course. Alternatively, the government may make it mandatory for all medical students to study general psychiatry, as in Ghana, to increase the availability of personnel for GBI persons. Mathari can also refer patients to community nurses and healers, where applicable, like Ghana, to improve access to healthcare and liberate space.

VI. Conclusion

This paper discussed the objectives of the GBI special verdict. It has demonstrated that these objectives are poorly implemented in Kenya due to the insufficient conditions created by institutional failure. Combined, these conditions devalue the special verdict as its implementation is almost akin to the implementation of the regular 'guilty' verdict.

Kenya's solutions to these problems range from amending existing laws to initiating programmes that offer various courses in psychiatry. However, these measures have not been enough to counter the barriers that seem to become more challenging by the year. After highlighting the initiatives undertaken by Ghana to resolve some of these problems, this paper believes that Kenya can achieve the dual aims of the GBI verdict through active cooperation and commitment by relevant institutions in Kenya.