HERAF
Transforming Health System

Social Audit Report of Kangonde, Ekalakala, Kisiiki and Kithyoko Health Facility Projects in Machakos County

A Cry for Completion and Operationalization of this Community Hospitals

MACHAKOS COUNTY - JUNE 2024

HERAF
Transforming Health System

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LIST OF ABBREVIATIONS

ADP	Annual Development Plan
BQ	Bill of Quantities
CIDP	County Integrated Development Plan
FGD	Focus Group Discussion
HFMC	Health Facility Management
KII	Key Informant Interviews
KMPDC	Kenya Medical Practitioners' Dentists Council
MOH	Ministry of Health
PET	Pre and Early Term Delivery Kits
PPH	Postpartum Hemorrhage
SCMOH	Sub-County Medical Officer of Health

1.1 Background

The devolved health functions per Schedule IV of the Constitution of Kenya, 2010[1] place responsibility for county referral services, primary healthcare and community health services with counties. County referral hospitals are all level 4 and 5 hospitals and provide comprehensive and specialized health services. Primary care facilities are all level 2 and 3 facilities providing preventive and basic outpatient curative services. Community health services are promotive and provided at household level. In Machakos, 39% of health facilities are MOH -owned while the private for profit owns 54% of all health facilities in the county as shown by table 1 below.

Table 1: Number of health facilities in Machakos County by ownership

Sub county	Public	FBO	NGO	Private	Total
Athi river	10	8	4	118	**140**
Kangundo	16	0	0	16	**32**
Kathiani	17	3	1	8	**29**
Kalama	15	1	0	3	**19**
Machakos	21	4	1	34	**60**
Masinga	38	2	0	12	**52**
Matungulu	21	1	1	33	**56**
Mwala	29	6	1	20	**56**
Yatta	33	4	1	33	**71**
Total	**200**	**29**	**9**	**277**	**515**
Ownership %	*39%*	*6%*	*2%*	*54%*	*100%*

Source: Kenya Health Master Facility List, 2024[2]

Machakos county in its medium plans 2013-2017[3] and 2018-2022[4] endeavored to upgrade one health centre per ward to a community hospital (Health Centre 3B). This was aimed at improving access to healthcare facilities especially among the rural populations, reducing the need for long travels and making medical services more accessible.

[1] GOK, 2010. The Constitution of Kenya.
[2] Ministry of Health, 2024. Kenya health Master Facility List.
[3] Machakos County Integrated Development Plan 2013-2017.
[4] Machakos County Integrated Development Plan, 2018-2022

1.2 Introduction to community hospitals

Community hospitals are health service delivery structures providing comprehensive health services, these align to Level 3B facilities. According to KMDPC[5] a level 3B -community hospital should have the following minimum features. These are:

- Inpatient bed capacity of at least 24 beds (mandatory) 6 for the male, 6 for the female, 6 for the pediatric and 6 for the maternity ward.
- Outpatient services.
- Caesarean section services.
- Blood transfusion services.
- Radiologic and imaging services.
- Functional maternity theatre.
- Patient referral services
- Holding room for dead bodies
- PPH and PET kits
- Medical waste management system.

1.3 Social audit

Social audits are participatory processes in which civil society organisations, community members and government officers evaluate the use of public resources and identify how best to improve outcomes of public programs and policies. Additionally, they evaluate the quality of community participation in decision making, implementation and how well the projects serve the needs of target residents.

The social audit targeted four community hospital projects in Masinga and Yatta sub-counties of Machakos County: Kithyoko, Kangonde, Ekalakala, and Kisiiki. These facilities fell within the jurisdiction of the project sites that benefited from the SPARKe project that empowered community members to follow up and assess utilization of public funds. Hence, these community projects provided a fertile ground for the community members to put into practice the knowledge acquired over the period. The Kenya Master Health Facility List identifies the facilities of Kithyoko, Kangonde, Ekalakala and Kisiiki as MOH basic health centers with 24 hours operation. They were all public facilities that benefitted from public resources.

1.4 The main purpose

To enhance accountability and transparency in the upgrade of community hospital projects in Masinga and Yatta sub counties of Machakos County.

Specific objectives

1. To track public expenditure on the upgrade of community hospital projects.
2. To establish the physical status of community hospital projects.
3. To give community members a platform to voice their views on the investments and status of the community hospital projects.

[5] KMPDC Mandatory Requirements by Facility Level. Kenya medical Practitioners and Dentist Council.

1.5 Key stakeholders and target audience

The stakeholders in each of the targeted health facilities included members of the County Executive, the County Assembly, Facility In charges, Health Care Workers, community members/patients and Facility Management Committee members. The others were the ward administrators, the women, the youth and civil society organizations working in the community. Also, national government officers at county levels including the Chiefs and assistant chief.

1.6 Methodology

Desktop review and analysis of secondary data, Focus Group Discussions (FGD), Key Informant Interviews (KII), checklists, and photography were the major methods used to collect data. The data collected was validated in stakeholders' forums that also acted as platforms for disseminating the findings and for seeking clarifications and feedback from government officers.

2.0 FINDINGS

2.1 Project Selection

Community hospitals were conceptualized in 2013 by the Machakos County government with the intention of upgrading 40 primary healthcare facilities to community hospitals. That is, upgrade one health centre per ward to a community hospital (level 3B) as documented in CIDP I and CIDP II. The audit revealed that these were relatively small public infrastructural projects dubbed community hospital projects. They were identified and executed by the County Executive. They were short term and theoretically they were expected to have followed a clear timeline as illustrated in Figure 1 Below.

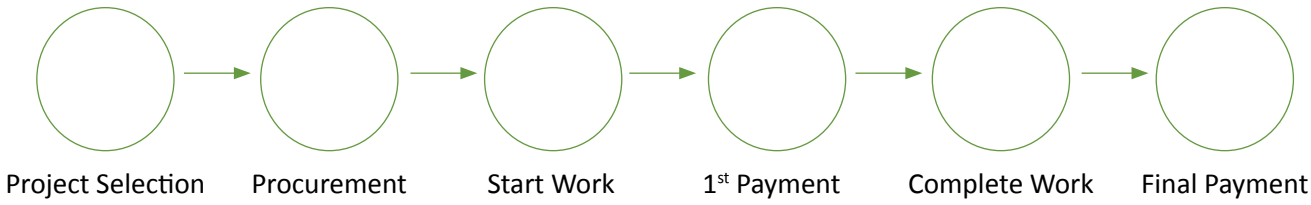

Figure 1: Timeline of public infrastructure project[6]

2.2 Procurement

The social audit could not ascertain how the procurement processes, which identified private contractors to undertake the works, were conducted. Community members revealed that these were plans were conceived and planned for execution at the executive level of the County government.

[6] William, M. 2016. The Political Economy of Unfinished Development Projects: Corruption, Clientelism, or Collective Choice?

The tender documents entailed provision of the main works, electrical and mechanical works in each of the community projects, therefore, each of the contractors was required to deliver structures ready for equipping. According to Table 2 below, it emerged that the availability of standard tender documents, required as per the Public Procurement and Asset Disposal Act, 2015 (Part VI- 70(6)7, varied from one facility to another.

Table 2: Tender documents availability per facility

Tender Document	Availability			
	Kithyoko	Kisiiki	Ekalakala	Kangonde
1. Availability of Project File	√	√	√	√
2. Contract Agreement Form	√	X	√	√
3. Tender Form	X	X	X	X
4. Bill of Quantities	X	X	√	√
5. Schedule of Requirements	X	X	X	X
6. Technical specifications	X	X	X	X
7. General conditions of Contract	X	X	X	X
8. Special conditions of Contract	X	X	X	X
9. Notification of Award	√	X	X	√
10. Project inspection status	√	X	√	√
11. Completion and handing over status	X	X	√	X

The analysis of tender document availability for the community hospitals reveals notable differences across the projects. Kithyoko Hospital presents a different scenario, with some key documents like the project file and contract agreement form readily accessible. However, critical documents such as the tender form, Bill of Quantities, and technical specifications were missing. This incomplete documentation raised concerns about the project's readiness and its potential impact on timely execution.

In stark contrast, Kisiiki Hospital suffered from a severe lack of essential tender documents. None of the key documents, including the project file, contract agreement form, and Bill of Quantities, are available. This absence suggests significant hurdles in project initiation and raises doubts about the project's progress and completion status.

Ekalakala and Kangonde hospitals faired relatively better in terms of document availability. Both projects possess essential documents like the project file and contract agreement form, along with additional items such as the bill of quantities and notification of award. Despite these positives, critical documents like the tender form and contractual conditions were still missing, leaving room for potential barriers in project management.

[7] Laws of Kenya. Public Procurement and Asset Disposal Act 33 of 2015 (REVISED EDITION 2022)

2.3 Project Execution

2.3.1 The Contraction periods

The contractual periods for the four community hospital projects varied from one to another and depended on the magnitude of the contracted works.

Table 3: Community Hospitals Contractual Periods

Community Hospital	Contractual period (Weeks)	Period taken (Weeks)
1. Ekalakala	16	28
2. Kangonde	18	68
3. Kithyoko	12	108
4. Kisiiki	NB	NB

NB – indicates that the data was not available

The audit sought to explore if all the projects were completed within the contracted period. The findings revealed a range of outcomes, with some projects completed, some significantly delayed, and others not completed at all. Specifically, the survey found that the Ekalakala and Kangonde hospitals were eventually completed but much later than planned. Ekalakala, which had a contractual period of 16 weeks, took 28 weeks to complete, resulting in a 12-week delay. Similarly, Kangonde, with an 18-week contractual period, took 68 weeks, experiencing a 50-week delay. In Kisiiki hospital, there was no data available to indicate the contractual period or the magnitude of the contracted works, suggesting possible issues with project initiation or record-keeping.

2.3.2 Community Involvement

Community hospitals are community-based, hence the participation of the community is significant. The audit assessed the community's knowledge about the project and their participation status in the identification, design, and implementation stages.However, it emerged from the focus group discussions and key interviews that the identification and the procurement stages of the projects were alien to them. That is, community members had no knowledge of how the projects and the contractors were identified. On average only one to two persons in each focused group discussion of fifteen respondents each had some prior knowledge about the projects. Some community members were informed about the project in public baraza but this information was not widely shared. No further information was shared until they noticed commencement of the works.

2.3.3 Physical Status of Each Community Hospital

One purpose of the social audit was to assess the physical and completion status of each of the contracted works. This was assessed through observations and physical verification. According to physical verification reports and key informants' interviews, all the works were conducted in 2013/2014 and 2014/2015 financial years. Since then there were no other works including

equipping of the facilities. This is against the fact that community hospitals have mandatory basic requirements that they should meet. This necessitated community members to remark that all the 4 community hospitals had stalled. The social audit team observed and noted that each of these structures were temporally converted for other urgent services as they wait for completion and operationalization.

Below is a summary of the observations and pictorial evidence noted by the teams in each of the 4 facilities.

2.3.3.1 Facility 1: Ekalakala Community Hospital

STATUS OF EACH PROJECT UNIT	REMARKS / COMMENTS
Status of Kitchen room **Overall status - Stalled.** **However, the following features are complete:** • Installed sink • Electrical installation • Floor is tiled • Wall are painted • Ceiling installed and painted • Drainage system connected **What features are incomplete?** • Cooking space/slap for the cooker. • Electricity connection • Kitchen rack for drying of kitchen ware	The kitchen is currently used as an MCH consultation room.  Pic 1: Repurposed Kitchen room to an MCH Consultation Room **Other necessary installations:** • Construction of a kitchen store for storage of kitchen supplies • Cleaning and decontamination space

STATUS OF EACH PROJECT UNIT	REMARKS / COMMENTS
The Laundry **Overall status – Stalled** **Complete features include**: • 2 concrete sinks • Plumbing works. • Electrical installation. • Floor tiled. • Walls painted. • Ceiling installed and painted • Connected to the sewer system. **What is needed to complete the laundry unit?** • Water connection and storage tanks. • Shelfs and lockable cabinets • Office Table and staff chairs	Laundry room currently used as a consultation room. Pic 1: Laundry Room sinks  Pic 2: Laundry room temporally used as Consultation/ examination room 
The Mini-Theatre **Overall status – stalled** **What has been done so far:** • Theatre room with adjoining toilet and store. • Floor is tiled • Walls painted. • Ceiling installed and painted. • Electrical installation. • Sluice room.	 Pic 3: Theatre Room is temporarily used as an MCH consultation room **The mini-theatre to be complete it should have:** • Room for receiving patients and post-anesthesia recovery. • Gender-specific changing rooms. • Room for scrubbing for operations. • Equipment sterilizing area.

STATUS OF EACH PROJECT UNIT	REMARKS / COMMENTS
Construction of a new Incinerator **Overall status – No construction took** place yet it was part of the works contracted.	Continued use of the burning chamber  Pic 4: Facility Burning Chamber
The Store and Washroom **What has been done so far:** • Construction of one roomed store. • Staff washroom / toilet **What is needed to complete the store and washroom?** • Erection of shelves and lockable cupboards • Plumbing works and toilet seat installation.	 Pic 5: Store room is currently used as the Nutrition Room • The store room currently used as the nutrition room. • Staff toilet currently used to store nutrition materials.
The walk ways **What has been done so far:** • Walkway with sun-roof connecting the new and old buildings • Concrete floor **Missing** • Ramp for accessibility by all • Widen the walkways to accommodate wheelchairs and pedestrians. • Ensure the walkways are smooth but slip proof.	 Pic 6: Walkway connecting the Community Hospital project to the Maternity Ward at Ekalakala Health Centre

2.3.3.2 Kisiiki Community Hospital

STATUS OF EACH PROJECT UNIT	REMARKS / COMMENTS
Kitchen room Overall status – Stalled but in use. Complete features: • Tabletop in place. • Sink with a tap. • Lockable cabinets. • Tiled floor. • Painted walls. • Electrical fittings. • Ceiling installed. Missing • Chimney. • Drainage connection to sewer. • Electricity connection. • Kitchen store.	 Pic 1: Theatre Kitchen that is currently being used for preparation of staff refreshments  Pic 2: Elevated cabinets installed in the theatre kitchen  Pic 3: Cooking area fitted with electrical cooker fittings.

STATUS OF EACH PROJECT UNIT	REMARKS / COMMENTS
Mini-Theatre **Overall Status – Stalled** What has been done so far: • Mini-theatre room. • Floor is tiled • Wall are painted. • Ceiling installed. • Electrical installation. • Sluice room constructed.	 Pic 4: Mini-Theatre designated building **Missing:** • Room for receiving patients and for post-anesthesia recovery. • Gender-specific changing rooms with adequate linen. • Room for scrubbing for operations. • Equipment sterilizing area.
General Wards **Overall Status – Stalled** **What has been done:** • Two separate wards with nursing station room in between. • One washroom in each wardroom • Floor is tiled • Walls are painted. • Ceiling installed and painted • Electrical fittings. **Missing:** • Connection to drainage system. • Sex segregated ablution block. • Washing basins/sink. • Door /opening connecting wards to nursing station room.	 Pic 5: General Wards block consisting of the Male and Female Wards and Nursing station  Pic 6: Rear side of the General Wards with the waste water drainage directed outside and not connected to any drainage system.

STATUS OF EACH PROJECT UNIT	REMARKS / COMMENTS
Non-Pharmaceuticals Store **Overall Status – Stalled** **What has been done:** • One room as store constructed • Floor is tiled. • Wall are painted. • Ceiling installed. • Electrical fittings.	 Pic 7: Non-pharmaceutical store currently used to store drugs and other medical commodities **Other necessary installations:** • Be leak proof - currently the roof is leaking • Be well aerated with temperature control – away from direct sunlight • Burglary proof – steel doors and windows with rails.
Sluice Room **Overall Status – Stalled** What has been done: • Sluice room constructed. • Floor is tiled. • Walls are painted. • Ceiling installed. • Electrical fittings.	**Other necessary installations:** • Construction of a soiled and storage area • Hand wash basin • Chemical storage area • Proper ventilation and lighting.

2.3.3.3 Kithyoko Community Hospital

STATUS OF EACH PROJECT UNIT	REMARKS / COMMENTS
Staff Quarters **Overall status – Stalled** **Complete features include:** • 1 block of 2 self-contained bedroom. **Missing** • Running water with storage tanks. • Electrical fittings. • Fencing to separate the staff quarters from the other facilities. • Fixing windows and ceiling. • Plastering of walls. • Floor tiling. • Repair of the roofing materials-infested with termites • Connection to sewer system /septic tank • Paving walkways	Building designated as the staff quarters  Pic 1: Building designated as the staff quarters **Also, missing:** • Electricity connection. • Elevated cabinets in the kitchen area for storage
Hospital Kitchen Unit **Overall status – stalled** **Complete features are:** • 1 block of 4 rooms constructed as a kitchen and laundry unit. • Walls and roofing. • Doors and windows fixed. • Electrical fittings. **Missing:** • Construction of a kitchen store for storage of kitchen supplies • Water connection • Electricity connection • Shelves and lockable cabinets	The kitchen is currently used as a store for assorted items.  Pic 2: Room designated as the Kitchen with installed kitchen sink and tabletop

STATUS OF EACH PROJECT UNIT	REMARKS / COMMENTS
Laundry Unit **Overall status – Stalled** **What has been done so far:** • The room ready. • Walls and roofing done • Doors and windows fixed. • Electrical fittings. **Missing** • Water connection and storage tanks. • Shelves and lockable cabinets. • Office table and staff chairs.	 Pic 3: Building designated as the Kitchen & Laundry Unit
Wards **Overall status – Stalled** **What has been done:** • Construction of a building designated as wards with 2 ward rooms, office and washrooms. • Roofing is done • Septic tank partially dug, not complete for construction. **Missing:** • Plastering of walls and floors • Tilling • Electrical fittings and installation • Plumbing works • Water connection • Ceiling fixing and painting • Painting of walls • Construction of septic tank. • Drainage system connected to the septic tank • Door between the wards and the attendants' room. • Sex disaggregated washrooms.	 Pic 4: Building designated as Wards  Pic 5: Partially done pit designated for the Septic Tank **Other necessary installations:** • Reinforcemnt of the building blocks – they are wearing out. • Construction of an emergency room • Hand washing sink coonected to piped water. • Sex-disaggregated changing rooms.

2.3.3.4 Kangonde Community Hospital

STATUS OF EACH PROJECT UNIT	REMARKS / COMMENTS
Staff Houses **Status – Stalled and in use** **What has been done:** • Two bedroomed houses. • In-house drainage system linked to the facility septic tank. • In-house bathroom and flushable toilet • Electrical fittings. **Missing** • Electricity connection. • Water connection.	 Pic 1: Staff Houses **Also, missing:** • Fencing off the staff quarters
Theatre **Overall status – stalled** **What has been done so far:** • Theatre room with adjoining toilet and store. • Floor is tiled • Walls painted. • Ceiling installed and painted. • Electrical installation. • Sluice room. **Missing:** • Room for receiving patients and for post-anesthesia recovery. • Gender-specific changing rooms. • Room for scrubbing for operations. • Equipment sterilizing area.	 Pic 2: Front side of the Community Hospital Project inclusive of the theatre

STATUS OF EACH PROJECT UNIT	REMARKS / COMMENTS
Incinerator **Overall status – Not initiated** **What needs to be done:** • Construction and installation of a modern incinerator and adoption of non-burn technology at the facility.	 Pic 3: Constructed Waste burning chamber
Drainage System **Overall Status – Complete** **What has been done so far:** • Soak pit • Septic tank • Placenta Pit	 Pic 4: Septic Tank  Pic 5: Placenta Pit  Pic 6: Soak Pit

STATUS OF EACH PROJECT UNIT	REMARKS / COMMENTS
Fencing **Overall Status – Partial fencing/Stalled** **What has been done so far:** • Fencing partially done – front side only using barbed wire • Metallic gated erected. • Security office at the gate. **What features are incomplete?** • Complete fencing of the facility.	 Pic 7: Kangonde Community Hospital Gate  Pic 8: Kangonde Community Hospital perimeter fence which was partially done

2.4 The Project Payments

In a nutshell, the contractor should begin the works on the project and after completing the first stage request for partial payments from the County government, which should inspect the work completed and if satisfactory, make the payment. The same process should apply in the second stage of the project. That is, the contractor should complete the project and request for full payment. Once the County government inspects the work and is satisfied, makes the full payment. However, scrutiny of the contacts offered, these projects had only one stage for infrastructural developments. That is, each contactor was to undertake the works to full completion, and request for the full payment, which was to be made upon satisfaction of the works by the government. Table 2 below provide the cost of contact and amount paid and balances in each of targeted community hospitals.

Table 4: Community Hospitals Contracted Works and Costs

Community Hospital	Specific works	Cost as per contract (Kshs)	Amount paid (Kshs)	Balance (Kshs)
1. Ekalakala	Theatre Kitchen unit Laundry unit Incinerator Walkways	6,343,250	5,549,075	634,325
2. Kangonde	Staff houses Theatre Incinerator Drainage System Fencing	8,514,350	8,514,350	0
3. Kithyoko	Ward Laundry unit Kitchen unit Staff Houses	9,208,206	1,749,600	7,458,606
4. Kisiiki	General Wards Staff Quarters Incinerator Kitchen Laundry	NB	NB	NB
Total		**24,065,806**	**15,813,025**	**8,092,931**

NB – indicates that the data was not available

2.5 Sources of Finances

The county government has various sources of funds. These include local revenue, equitable share, conditional grants, loans and donor funding. It was the desire of the survey to track the source of community projects funds, flow and ultimate expenditure. However, access to budget documents was a challenge. Hence, other than the figures in the awarded contracts, tracing the budgeted amounts and trickle down to facility levels remained a challenge due to inadequate budget documents accessibility. It also emerged facility and sub county government officers either lacked the information or were not allowed to diverge the same. Authority to access such information could only be granted at higher levels, and despite several requests both formally and informally this was not forthcoming up to the time of writing this report. As a result, community members may not tell whether the support to upgrade the facilities was derived from local revenue, equitable share, conditional grant, donor funding or it was a loan.

2.6 Completion, Handover, and Launch

Once the full payments are made the project should be handed over to the government in order to put it into use. The social audit revealed that completion certificate was only issued to Ekalakala health centre and was issued with the completion certificate as indicated in Table 4 Below.

Table 5: Community Hospital Completion and Handover

Facility	Site visit dates	Inspection report	% of works completed	Completion certificate
Ekalakala	6.9.2014	01.03.2017	100%	07.11.2014
Kangonde	27.05.2014 05.06.2016	27.05.2014 17.07.2015	100%	None
Kisiiki	None	17.06.2015	22%	None
Kithyoko	05.06.2016	None	-	None

Though on July 5, 2019, the Chief Officer of the Health Department sent a letter to the SCMOH, requesting preparations for the commissioning of Ekalakala Community Hospital by the Governor there were no records to confirm this happened. Similarly, in Kangonde, though the works was reported 100% compete there was no record no certificate of completion available, and there was no information regarding project commissioning.

The social audit could not authentically reveal why Kisiiki and Kithyoko projects remained incomplete for over 10 years since their start. It was however clear that in some of the facilities, they could not be equipped for operationalization as the contractors had not completed the physical structures as specified in the contract. However, it was not clear whether they signed into a contract they could not technically and financially fulfill, or they run out of cash or the government failed to disburse payments to them in tranches for works satisfactorily done.

It also emerged that, though Ekalakal and Kangonde hospital construction works were complete, almost 10 years since the physical structures were recorded as complete there were no signs of equipping and operationalizing them for the public use.

2.7 Beneficiary Satisfaction Level

The respondents were unsatisfied with each of the four projects as they were incomplete. Hence, not in use, denying community members access to improved and quality health care services, and employment opportunities. None of the projects had contributed to enhanced quality of health care in the community as intended. They were conceived to improve the delivery of health services at the health facilities and alleviate the suffering, reduce the cost of treatment and the number of patients seeking for health care services at county referral hospitals but this had not been achieved. Their incompleteness denied community members these services yet, public resources derived from tax payers sweat were pumped into each of these projects.

Further, these community hospitals were intended to improve availability, affordability and physical accessibility of services, drugs and commodities within the locality of the community in order to reduce socio-economic and long-distance travel barriers. Unfortunately, community members lamented that specialized services that were anticipated despite the investment in infrastructures were not accessible locally and they had to travel long distances to seek for them thereby draining their pockets. This was in contrast to the intended objectives of the community hospitals. Community members called on the County government to focus on completing the pending works if any, equipping, staffing and operationalizing the facilities.

3.0 CONCLUSION AND RECOMMENDATIONS

3.1 Conclusion

The audit revealed inefficiencies in delivery of public projects as exhibited by non-completion of the proposed community hospital projects. Though people's taxes were invested, 10 years down the line they could not the benefits intended. Thereby, losing the value for their sweat.

The physical verification of the facilities reveals that many projects remain stalled or incomplete, with crucial features like kitchens, laundry units, and theatres not fully operational. Consequently, these structures are temporarily repurposed for other urgent services, failing to fulfill the intended purpose of community hospitals. This raises concern in the willingness of incoming governments to complete projects initiated by past regimes, hampered by many factors including pending bills, quality of works in the stalled projects and competing priorities. Suggestions by community members are listed as key remarks in each of the project item.

Access to information was one of the main challenges that faced this exercise. Essential documents such as certificates of completion, project inspection reports, and commissioning details were either missing or incomplete for several projects, indicating inadequate record-keeping and oversight. Access to this information was attributed to various reasons such as bureaucracy in government offices and reluctance to share the information as this was considered sensitive as it bounded on money. Low cadre officer's despite been privy to the needed information required express authorization from their seniors. These affected the duration and completeness of the report.

The audit brought to the fore the high appetite for the governments to invest in infrastructure development especially construction or upgrade of health facilities without commensurate investments in the requisite equipment, commodities, products and technologies and, human resources for health (the software). This may be due to the visibility of new structures which are more likely to give the political class more mileage as compared to renovating and upgrading the existing ones. It should however, be noted that the anticipated political mileage would easily be achieved if such projects are completed and fully operationalized.

Though MOH provides norms and standards for health facility construction, equipping and staffing, their adherence remains a challenge. The standards of some of the buildings was found wanting. These included the size of the rooms, status of floors, walls, ceiling and paintings; and internal fittings for water, electricity, communication and other hospital requirements. There were issues regarding the status, lack off and positioning of the doors in wards, quality of building materials used. Failure to adhere to health facility construction norms and standards may compromise safety, open up to litigation leading to project delays, reputation and damage. These anomalies may complicate equipping and operationalization of these facilities.

3.2 Recommendations

The County government should prioritize the completion of stalled and incomplete facilities by addressing specific issues identified during physical verification. The local Members of County Assembly with support from community members should ensure there is allocation of necessary and adequate resources to ensure all essential features of a community hospital are fully operational in the next financial year (2025/26).

The county government should comply to access to information requirements in the Access to Information Act, 2016, Public Finance Management Act, 2015 and Public Procurement and Asset Disposal Act, 2015. Gaps in this report were as result of lack of access to crucial information at facility level which was further complicated by bureaucracy in accessing such information at County level. We call for establishment of a centralized system for managing and updating project records to enhance transparency and accountability.

The County government inspection unit should conduct periodic audits and inspections to evaluate progress and quality of work. They can engage independent bodies or third-party auditors and community members to provide unbiased assessments and recommendations. The County Assembly Budget Implementation committee should complement this ensuring projects are implemented within specifications, budgets and are timely.

The County Government to implement a comprehensive community engagement strategy that actively involves local communities, beginning with the needs assessment and continuing through all stages of project planning, execution, and monitoring. This strategy should include regular public meetings, accessible information dissemination, and effective feedback mechanisms for all county projects including flagship projects. This can be realized through funding and capacity training of the county public participation, civic engagement and customer service unit.

Community organized groups including civil society organisations should raise citizens voices at each stage of the project's implementation through social accountability tools in order to forestall real or imagined hindrances that may hamper effective management of public projects. However, for these to happen, county government in partnerships with civil society organisations should empower community members and leaders with knowledge and tools to effectively participate in and monitor public projects. They should also be provided with resources and political goodwill from all the stakeholders.

Health Rights Advocacy Forum (HERAF)
Ring Road Kilimani, Nairobi – Head Office
Imani House, Masinga Town, Machakos County - Field Office
P.O. Box 100667, 00101 Nairobi, Kenya.
Tel: +254735333007
Email: Heraf@heraf.or.ke | Webisite: www.heraf.or.ke
Facebook: Heraf Kenya | X: HERAF_Kenya
Instagram: heraf_kenya | LinkedIn : HERAF Kenya

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