STRENGTHENING GOOD GOVERNANCE IN KENYA

SOCIAL ACCOUNTABILITY ASSESSMENT REPORT FOR HEALTH FACILITIES IN KISUMU COUNTY

National Taxpayers Association

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ACRONYMS/ABBREVIATIONS

CBO	Community Based Organization
CHMT	County Health Management Team
CHVs	Community Health Volunteers
CRC	Citizen Report Card
FBO	Faith Based Organization
FGDs	Focus Group Discussions
GIZ	Deutsche Gesellschaft fur Internationale Zusammenarbeit GmbH
HC	Health Centre
HF	Health Facility
HFMC	Health Facility Management Committee
HSSF	Health Sector Services Fund
KEMRI	Kenya Medical Research Institute
KEPH	Kenya Essential Packages for Health
KHP	Kenya Health Policy
KII	Key Informant Interviews
NG-CDF	National Government-Constituency Development Fund
NGO	Non-Government Organization
NHSSP	National Health Sector Strategy Plan
NTA	National Taxpayers Association
PHO	Public Health Officer
PWD	Person living With Disability
RHS	Reproductive Health Services
YWD	Youth living With Disability

NTA Project Categorization

PROJECT CATEGORY	DESCRIPTION
Category A projects Well implemented, completed projects.	This category is for projects that were found to be well built; with good value for money
Category B projects Badly implemented, complete and incomplete projects.	This category is for projects that were poorly constructed with no commensurate value for money, and/or with budgets much larger than what is actually delivered.
Category C projects Well implemented, incomplete projects.	This category is for projects that were well implemented but on –going, i.e. money had been used to build a structure of good quality, but the construction is ongoing.
Category D projects Abandoned projects	This category is for incomplete projects which have not consistently received financial allocation for the continuation of project implementation
Category E projects Ghost projects.	This category is for projects which had been officially allocated funds but the project did not physically exist at the time of assessment and money was proven spent i.e. it is a ghost project.
Category F projects Reallocated funds.	This category is for projects that were not implemented as funds were reallocated.
Category G projects Delayed implementation.	The project is officially allocated funds but the implementation has not started and funds are in still in account.

Summary Findings from the Social Audit of Development Projects

Project Assessment Classification	Project Category	No. of Projects	Budget Allocation (Kshs)	Budget Spend (Kshs)	Outstanding Bal (Kshs)	Unaccounted (Kshs)
Well implemented, complete projects	A	3	8,497,570.00	8,497,570.00	-	-
Badly implemented, complete and ongoing projects	B	4	17,947,702.00	17,947,702.00	-	-
Well implemented, complete projects	C	-	-	-	-	-
Abandoned projects	D	4	18,143,349.96	18,143,349.96	-	-
Ghost Projects	E	-	-	-	-	-
Total		**10**	**44,588,621.96**	**44,588,621.96**	**-**	**-**

FOREWORD

This report presents findings and analysis on the overall assessment of the performance of the Kisumu Health Service provision at Level III (Health Centres) and makes recommendations on how health service delivery can be enhanced.

Significant effort has been made to re-define the service delivery strategic objectives, outlined in the Kenya Essential Package for Health (KEPH). This package elaborates the expected services the sector will deliver to Kenyans, by lifecycle cohort and service delivery level, during the period of National Health Sector Strategic Plan (NHSSP III 2013-2018).

However, the sector has to-date been operating in an environment where there are differences in activities offered at similar levels of the systems, with differences in type and quality of services. Investments, particularly in infrastructure and human resources, have not been appropriately coordinated, with the result that these inputs are not rationalized or equitably distributed across the county. The mix of inputs has not been appropriately coordinated at the different levels, such that in many areas, some inputs are available but not used as others are needed but are lacking. For example, health workers posted to facilities with inadequate equipment or commodities yet other facilities have infrastructure not put to use like maternity wards build and not in use for the last two years. This is all in an environment where increasing investments are being made in the sector, through County Government, NG-CDF funds and funding partners.

The NTA has therefore developed this Community score card report to create an enabling environment in which citizen feedback is used to solve fundamental problems in service delivery and to strengthen the performance of health facilities and help provide a rational insight in the current health sector status to guide investment and improve service delivery in the health sector in Kisumu county.

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We appreciate the County Government of Kisumu and in particular the department of Health for their support in implementation of the project.

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Our sincere gratitude goes to GIZ whose financial and technical support made this project possible. We are most greatful to Ms. Juliet Mule GIZ- Governance advisor for her valuable advice and guidance during project conceptualization and implementation.

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About NTA

- The National Taxpayers Association (NTA) is an independent, non-partisan organization that promotes good governance in Kenya through citizen empowerment, enhancing public service delivery and partnership building. NTA does this through monitoring the management of public resources and providing public services, as well as building partnerships and developing the capacity of the partners.
- Since 2006, NTA has been implementing programs focused on enhancing public accountability through monitoring the quality of public service delivery and the management of devolved funds. It has achieved this through the development of social accountability tools (notably the Citizen Report Cards), civic awareness, and citizen capacity-building, partnerships with government agencies, service providers, the private sector, civil society and community action groups.
- The NTA project developed the Citizens Report Cards (CRCs) as a social accountability tool to enable citizen engagement in relation to the management of devolved funds and government service delivery. The CRC empowers citizens to demand their rights and accountability from an evidence-based platform.
- **Our Vision:** A taxpayer responsive government delivering quality services to all
- **Our Mission:** To undertake taxpayer-transforming research & capacity building through partnerships to influence government policy & strategy
- NTA has conducted research and provided information to Kenyans through its Citizen Report Cards (CRCs), scoping studies, public forums and civic education through the media to present issues of how devolved funds are being used and their impact on development in Constituencies and Counties in a user-friendly, simple, and accessible manner.
- NTA has produced 7 CRCs in 7 Counties, Constituency Development Fund (CDF) Citizens Report Cards (CRCs) in over 134 constituencies, Local Authority Transfer Fund (LATF-now defunct) CRCs in 21 Local Authorities and 12 Health Score Cards.

About the Report

Under the building citizen demand and strengthening government service delivery programme, National Taxpayers Association (NTA) in partnership with GIZ, implemented a social accountability project that targeted 10 health centres whose goal was to **promote access to better service and prudent utilization of public resources in Kenya's Health Sector** in Kisumu County. The project adopted a community based approach that supported the community in championing accountability and monitoring of service delivery in the health facilities that they use.

This report presents findings and analysis on the overall assessment of the performance of the Kisumu health service provision at Level III (Health Centers) and makes recommendations on how health service delivery can be enhanced.

Methodology

Context & Stakeholder Analysis

The main purpose of stakeholder analysis was to be to understand and address local communities' needs, concerns and capacities. NTA, through the stakeholder analysis identified the roles of the various stakeholders in relation to the project, and in relation to those who can effect change in the project.

Base-line

In order to ensure a comparison point for end-line evaluation of the strategy, a baseline was conducted. This is information gathered before a project or initiative begins. A midline study enabled the community members to analyze the context in which they are working and establish reference points against which to measure the progress and impact. The community midline contained details of original projects and current levels of transparency, accountability, participation and effectiveness amongst others since the end of the initial phase. The momentum shall therefore be built on the results and lessons from the last phase of the engagement.

Training Community Monitors and Public Officials

Once selected, the community monitors/facilitators were trained in monitoring skills such as analyzing project documents, taking photos of the project, conducting beneficiary surveys, verifying their findings as well as advocating for the resolution of problems. The public officials in this case included sub County health management teams, the health facility managers, ward administrators and community representatives from the various health facilities.

Data Collection, Analysis and Verification

Projects to be monitored were selected (which included projects under implementation in the current financial year 2017/2018. Monitors gathered data on three key areas:

- *Access to information*- whether the communities can access key project information, such as the budget, contract and plans.
- *Community Engagement*- whether communities were involved in the project design and/or implementation.
- *Project Effectiveness*– its value for money, complies with established standards and community's satisfaction

There are numerous steps to be followed in the data collection and analysis phase, from pre-fieldwork to fieldwork and data analysis as outlined below.

Pre-Fieldwork: Accessing Project Information

This pre-fieldwork involved gathering as much appropriate information about the development projects that community members intend to monitor. NTA lead in consolidation of all these information in preparation for the training of the community monitors and the assessment process.

Fieldwork: Gathering Evidence

The aim of the field visit was to gather evidence on projects being monitored and feedback from the communities affected. This information was gathered through interviews with stakeholders, surveys and project site visits.

Data analysis

NTA involved the technical services of quantity surveyors/civil engineers where infrastructure projects were involved in order to ascertain their value for money. Projects were then classified into seven categories (Well implemented complete projects, badly implemented complete and incomplete projects, ongoing- well implemented projects, abandoned and non-existing, reallocated projects and delayed implementation). This process culminated in the development of a draft citizen report card that will constituted midline report.

Verification

The draft Citizen Report Card incorporated and integrated comments received from the county officials during the local level constructive engagement meetings as a way of validating the reports. The meetings provided an opportunity for NTA and county officials to discuss the report and make firm commitments in addressing any issues on misappropriation and abuse of public resources highlighted in the

report and to provide clear timelines on when the issues will be addressed and by whom. This process informed the finalization of the mid-line report in form of the County Citizen Report Card.

Advocacy and policy engagement strategy

One of the main strategies in the dissemination of the CRCs is through public meetings (where representatives of various actors were invited for the County launch. NTA also ran a mainstream media and social media campaign. At the facility level, NTA engaged the facility managers on monthly basis through the already existing monthly community dialogue forum. The facility managers handled any issue that could be resolved at this level. Other issues were escalated to either the sub-county health management team or the County health management team.

End-line (Follow up monitoring)

This involved assessment of the same projects with issues in the first phase that needed to be fixed after six months to determine the implementation progress of the recommendations of the initial assessment and to engage the stakeholders to resolve the pending issues and problems. This lead to the development of the end-line report.

Social Audit Findings:

- Some projects have been constructed to completion but had not been put to use denying the community the benefits of the project.
- Poor workmanship was observed during project assessment for example major cracks on walls, floors and poor fittings of tiles.
- Most of the projects are well implemented but have stalled due to shortage of funds thus not serving the intended purpose.
- Lack of community participation during selection of the projects and implementation was reported during beneficiary survey assessment. The monitors were not able to access most of the project documents.

EXECUTIVE SUMMARY

National Taxpayers Association supported by the GIZ, implemented a social accountability project that targeted 10 health centers in Kisumu County. The project adopted a community based approach to support the community to champion accountability and monitoring of service delivery in the health facilities that they use. All the stakeholders were involved; the service providers, the service users and their representatives sitting in the health facility management committee (HFMC).

The main goal for the NTA is to promote access to better services and prudent utilization of public resources.

The specific objectives are:

- Strengthen community's voice in demanding efficient and effective utilization of resources using social accountability tools.
- Strengthen follow-up action by the community structures in improving service delivery according to the service charters and social accountability findings.
- Provide critical scientific data through social audit process (Both services and project quality) to stimulate debate and action on demand for accountability.
- Ensure 40% of agreed upon recommendations from the Community Health Scorecard findings in the health sector are acted upon.

The NTA initiative was expected to produce the following results:

1. Documentation of challenges undermining effective provision, of health services in the selected facilities
2. Documentation of good practices that will enhance better service provision in the health sector in the selected facilities
3. Enhanced capacity of the community members to demand quality services, monitor infrastructure projects and advocate to fix identified issues in the health sector.

- Closely, the implementation of the programme was to support the adherence and implementation of the National Health Sector Policy 2014-2018, the Implementers Manual on Social Accountability for Health Sector

and the Norms and Standards for Health service delivery.

Following the assessment of the entitlements and responsibilities accorded different stakeholders', the following is the summary of the finding of the study based on the NHSSP III (2014-2018).

On the summary of findings, conclusions and recommendations:

1. **Improved Facility Operations**-The facilities operating on extended hours have increased over a period of time. In first assessment, there was only one facility (Airport HC) that was operating over weekend and for 24 hours. The second assessment registered an improvement with more than 4 facilities extending their working hours to attend to emergencies and maternity related services. On access to services, there was general improvement in services provided. Currently there are 90% of the facilities displaying service charter. There is need to upgrade and motivate all the health facilities to open at least over the weekend even if it six days a week.

2. **Increased demand for health services**-The number of patients per facility per week on aggregate has increased. Though the facilities are not youth friendly or disability responsive especially on reproductive health services, probably constraining the real access ratings. More campaigns through community outreaches should be held to communicate the services in the health centres, encourage early medical check-ups and informed medical decisions.

3. **Frequent Medical Stock outs**- Generally, the facilities are experiencing shortage in medical commodities. The patients are not able to fully get their drugs due to stock out. Railways HC is worst hit, and provides classical case of increased access to services but non-commensurate investment to match the demand. This is demonstrated by most of the respondents that indicated that they did not receive their prescribed medicine from the facility. Generally, the payment for medical commodities has increased, ideally doubled, while there is a marginal decline in payment towards general services. More supervision and impromptu visits should be done to the facilities to know what the patients pay for.

4. **Satisfaction with treatment and services provided is selectively considered-** The ratings for service delivery has dipped slightly, but on aggregate most of the facilities presented high level of satisfaction with services. Satisfaction with the waiting time has reduced probably due to fewer staff and more number

of patients attending facilities. More financial and human resource allocation to facilities commensurate to the human population in the area is needed.

5. **Increased visibility and utilization of channels of feedback-** Some of the common channels for seeking redress are community dialogue forums, local administrations, Sub-County Health Team or making reference to facility service charter and suggestion boxes. The level of satisfaction for the feedbacks received was universal. The patients provided mixed reactions with different participants in different facilities stating they are either happy or unsatisfied with the channels of feedback. Customer satisfaction survey to the specific general population is needed.

6. **Low Financial Allocation and Poor Human Resources for Health per facility-** The public display of financial resources is nearly non-existent in the facilities. The facilities have suffered loss and low allotment of staff to the facilities. This is attributed to facilities with no staff quarters so the staff have to live and commute from the distant areas. There has always been support of partners from KEMRI and DANIDA in regard to staff support.

7. **Improved Infrastructure and a number of initiated projects-** The facilities equipment and infrastructure has registered positive net improvement index. There are upcoming projects in various facilities.

8. **Enhanced Indicators of Social Accountability**- Level of awareness and commitment to social accountability indicators has increased. The access to information has registered increase though the demand and supply for the strategic documents for the projects are still at variance. The community participation and consultation has increased. More participants reported engagement with the facility project processes. There are more increased tools for social accountability especially on complaints and redress channels. Understanding of entitlements has equally increased. What needs to be done is that more advocacy relating political economic issues surrounding effective service delivery should be explored. Compliance with World Health Organizations and Kenya Essential Medicines Standards should be adhered to, this is a dialogue that should be taken to various county and national level stakeholders. The health facilities should position themselves for roll out of the universal health coverage programme as the Kisumu County is a pilot county under Jubilee Agenda 4 programmes.

CHAPTER ONE

SOCIAL AUDIT OF DEVELOPMENT PROJECTS

PROJECT NAME	KOLENYO HEALTH CENTRE
SUB COUNTY	SEME
WARD	CENTRAL SEME
PROJECT ACTIVITY	CONSTRUCTION OF MATERNITY WARD
ASSESMENT DATE	17TH OCT 2018
TOTAL FUNDS AWARDED	1,999,909.60
TOTAL FUNDS SPENT	1,999,909.60
VARIANCE	Nil
PROJECT CATEGORY	D
PROJECT STATUS	Incomplete and not in use
COMMENTS	The project is stalled as its last disbursement was FY 2016/17. The quality of materials used so far are good. Bush stones were used for constructing the walls, the windows and doors were fitted with good steel gauge materials. Pending works include; floor screeding, ceiling, glazing, paint works, electrical fittings, plumbing and equipping. The maternity ward consists of a labour ward with wash rooms, Family Planning room, Store, Kitchen, Toilets and an inpatient maternity ward with a 30 bed capacity. The community demands that the project should be completed so as to serve the intended purpose and to avoid long night travels for emergency deliveries to Kombewa sub-county Hospital.

PROJECT NAME	LOLWE HEALTH CENTRE
SUB COUNTY	SEME
WARD	CENTRAL SEME
PROJECT ACTIVITY	CONSTRUCTION OF 2 STAFF HOUSES
ASSESMENT DATE	16TH OCT 2018
TOTAL FUNDS AWARDED	4,997,570
TOTAL FUNDS SPENT	4,997,570
VARIANCE	Nil
PROJECT CATEGORY	A
PROJECT STATUS	Complete and in use
COMMENTS	The project was well implemented, it is complete and in use. There is visible good paint work and good finish as tiles were well fitted and a water tank with concrete support base was also constructed. The community recommended that the facility should operate at night for emergency deliveries.

PROJECT NAME	ST. MARKS LELA HEALTH CENTRE
SUB COUNTY	KISUMU WEST
WARD	CENTRAL KISUMU
PROJECT ACTIVITY	CONSTRUCTION OF MATERNITY WARD
ASSESMENT DATE	15TH OCT 2018
TOTAL FUNDS AWARDED	4,676,747.20
TOTAL FUNDS SPENT	4,676,747.20
VARIANCE	Nil
PROJECT CATEGORY	D
PROJECT STATUS	Incomplete and not in use
COMMENTS	General quality of building material used are good, the workmanship so far is good. The doors, windows, ceiling board, fascia board and tiles are properly fitted. However, the paint work is peeling an indication of insufficient coating. The project is stalled with pending works being general plumbing works, construction of a placenta pit. The community feel that the delay is denying them maternity services.

PROJECT NAME	AIRPORT HEALTH CENTRE
SUB COUNTY	KISUMU WEST
WARD	CENTRAL KISUMU
PROJECT ACTIVITY	CONSTRUCTION OF MATERNITY WARD
ASSESMENT DATE	12TH OCT 2018
TOTAL FUNDS AWARDED	7,989,693.16
TOTAL FUNDS SPENT	7,989,693.16
VARIANCE	Nil
PROJECT CATEGORY	D
PROJECT STATUS	Incomplete and not in use
COMMENTS	The quality of materials used are generally good. Bush stones were used to construct the walls, iron gal sheet were used for roofing, steel gauge windows and doors were fitted. The fascia board was however not well aligned. Pending works include construction of drainage works, ceiling board fitting, construction of septic tank and placenta pit. The community felt that it is not benefiting from the project purpose as it is incomplete and not in use. They recommended that the county government should prioritize incomplete projects and fund them to completion to serve the intended purpose.

PROJECT NAME	RAILWAYS HEALTH CENTRE
SUB COUNTY	KISUMU CENTRAL
WARD	MILIMANI MARKET
PROJECT ACTIVITY	CONSTRUCTION OF 4 DOOR PUBLIC TOILET
ASSESMENT DATE	11TH OCT 2018
TOTAL FUNDS AWARDED	1,000,000
TOTAL FUNDS SPENT	1,000,000
VARIANCE	Nil
PROJECT CATEGORY	B
PROJECT STATUS	Complete and not in use
COMMENTS	The project cost is exaggerated as the amount spent is not commensurate with the work done. The project is not serving the intended purpose since it is complete and not in use. The project has not been handed to the facility management by the contractor who has not been cleared by the County engineer. The community demands the project needs to be put to use to serve its intended purpose.

PROJECT NAME	NYALUNYA HEALTH CENTRE
SUB COUNTY	KISUMU EAST
WARD	KOLWA CENTRAL
PROJECT ACTIVITY	CONSTRUCTION OF MATERNITY WARD
ASSESMENT DATE	10TH OCT 2018
TOTAL FUNDS AWARDED	5,887,792
TOTAL FUNDS SPENT	5,887,792
VARIANCE	Nil
PROJECT CATEGORY	B
PROJECT STATUS	Incomplete and not in use
COMMENTS	The project was not well implemented as the workmanship is poor; major cracks on the walls and windows were observed during assessment. Pending works include construction of septic tank & soakage pit, placenta pit and general plumbing works. The community feels the project needs to be repaired and completed to serve its intended purpose of providing access to safe maternity delivery services.

PROJECT NAME	CHIGA HEALTH CENTRE
SUB COUNTY	KISUMU EAST
WARD	KOLWA EAST
PROJECT ACTIVITY	CONSTRUCTION OF MATERNITY WARD
ASSESMENT DATE	9TH OCT 2018
TOTAL FUNDS AWARDED	3,500,000
TOTAL FUNDS SPENT	3,500,000
VARIANCE	Nil
PROJECT CATEGORY	A
PROJECT STATUS	Complete and in use
COMMENTS	The Project was well implemented and it is complete and in use. The paint work is flawless, the doors, windows & fascia board are well fitted with good quality gal sheet iron sheets for roofing. The community appreciated its construction by NG-CDF Kisumu East constituency but indicated that it should be fully equipped by the county government for the community to benefit as health is a county function.

PROJECT NAME	ABSALOM WANGULU HEALTH CENTRE
SUB COUNTY	NYANDO
WARD	KOMBURA
PROJECT ACTIVITY	CONSTRUCTION OF 2 STAFF HOUSES
ASSESMENT DATE	6TH OCT 2018
TOTAL FUNDS AWARDED	2,600,000
TOTAL FUNDS SPENT	2,600,000
VARIANCE	Nil
PROJECT CATEGORY	B
PROJECT STATUS	Complete and in use
COMMENTS	The project was poorly implemented. The workmanship was poor as major cracks on the walls, windows and on the floor were observed during assessment. There is need for major repairs on the project walls, floor tiles and leaking roof. The amount spent is not commensurate with the work done. The community expressed dissatisfaction with the quality of workmanship indicating this would cost the facility a lot of money on repairs. It also recommended the county Government should involve the community in project implementation to avoid mistakes during construction.

PROJECT NAME	RAE HEALTH CENTRE
SUB COUNTY	NYAKACH
WARD	NORTH NYAKACH
PROJECT ACTIVITY	CONSTRUCTION OF MATERNITY WARD
ASSESMENT DATE	5TH OCT 2018
TOTAL FUNDS AWARDED	8,459,910
TOTAL FUNDS SPENT	8,459,910
VARIANCE	Nil
PROJECT CATEGORY	B
PROJECT STATUS	Complete and not in use
COMMENTS	Project was not well implemented. Poor construction work was observed during assessment of the project. Major cracks were observed on the walls, doors and windows with broken loose tiles on the floor. The amount is not commensurate with the work done. The maternity ward consist of a labour ward with wash rooms, family planning room, store, kitchen, toilets and an inpatient maternity ward with a 8 bed capacity. The project is not serving the intended purpose since it is incomplete and not in use. The community reported that the project should be equipped so that it can benefit from it and avoid long travel to Katito Sub-County Hospital.

PROJECT NAME	TAMU HEALTH CENTRE
SUB COUNTY	MUHORONI
WARD	TAMU-CHEMILIL
PROJECT ACTIVITY	CONSTRUCTION OF MATERNITY WARD
ASSESMENT DATE	4TH OCT 2018
TOTAL FUNDS AWARDED	3,477,000
TOTAL FUNDS SPENT	3,477,000
VARIANCE	Nil
PROJECT CATEGORY	D
PROJECT STATUS	Incomplete and not in use
COMMENTS	Implementation of the project has stalled due to insufficient funds. So far, the project was well implemented. It needs to be completed and equipped to serve its purpose. Pending works include ceiling fitting, floor screeding, glazing, construction of septic tank & soakage pit. The community feels it is a good project that should be completed and equipped quickly to serve its intended purpose of providing maternity services.

CHAPTER TWO

SOCIAL AUDIT OF SERVICE DELIVERY

STUDY FINDINGS

2.1 Response Rate of the Questionnaire

The following are the number of participants reached by the study in the 10 facilities.

Table 1: Number of Participants Reached per tool

	Facilities	Development/ Social Audit tool	KIIs	Health Management Questionnaire	Community FGD	Exit Interviews
1	St.Mark Lela	23	1	1	1	20
2	Absalom Wangulu	18	1	1	1	21
3	Nyalunya	20	1	1	1	17
4	Kolenyo	10	1	1	1	5
5	Tamu	18	1	1	1	19
6	Chiga	18	1	1	1	19
7	Lolwe	12	1	1	1	13
8	Rae	12	1	1	1	10
9	Airport	11	1	1	1	20
10	Railways	12	1	1	1	20
	Total	154	10	10	10	164

The response rate for social audit tool and the exit interviews was 77% and 82% respectively. The Key informants, the health management team representative, and the community focus group discussion targets were all met as planned.

Health Care and Health Centres Entitlements and Service Provision

Based on the reviewed literature, there are 48% of government-run hospitals, 35% private sector managed, FBO and NGO owned and managed health facilities are 15% and 2% respectively. The following is the distribution of health facilities in Kenya by ownership.

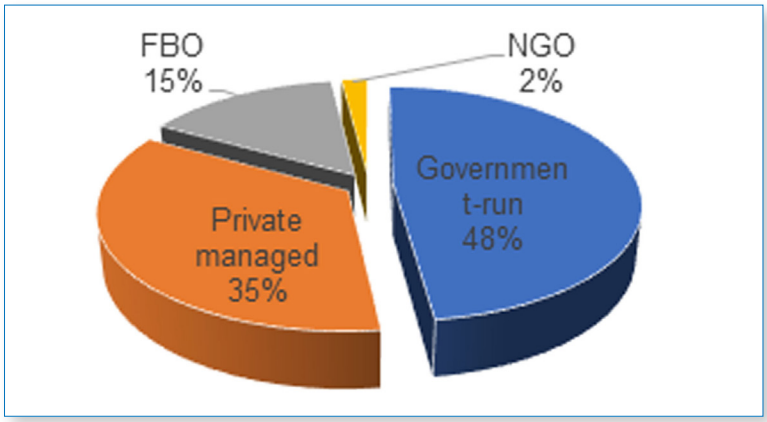


Figure 1: Distribution of health facilities by ownership

Hospitals in Kenya are structured in levels, with complicated cases being referred to a higher level. Gaps in the system are filled in by private and church run units. The NTA-GIZ accountability project has focused on health centres (level 3). Such health facilities are medium sized facilities that are meant to cover a population of 80,000. The network of health centres provides many of the ambulatory health services. Health centres generally offer preventive and curative services, mostly adapted to local needs.

2.2 Health facility operations

This section examined the general operations of the facilities, whether they operated over weekend and on 24 hours. More specifically, the laboratory operations were equally reflected.

Table 2: Summary of general and laboratory operations of the health facilities

	Facility	General Operation Weekend	Laboratory Operation weekend
1	St.Mark's Lela Health Centre	Operates from Monday-Friday 8 am to 5 pm. Currently, has extended to operate at night 24 hours	The lab operates only on Monday to Friday, 8 am to 5 pm
2	Absalom Wang'ulu Health Centre	No, as there are inadequate staff and limited hospital consumables to be extended for weekends. What is provided may not cover a quarter year. At times, the facility can extend to weekend where a delivery is involved	There is no laboratory

	Facility	General Operation Weekend	Laboratory Operation weekend
3	Nyalunya Health Centre	No, there is shortage of staff	No, shortage of staff
4	Kolenyo Health Centre	No, it is a dispensary	No laboratory
5	Tamu Health Centre	No, understaffed	No, understaffed
6	Chiga Health Centre	Partly some operations such as maternity are offered over the weekend. Operates 8am to 5 pm due to lack of adequate staff. Maternity operates 24 hrs	No, there is no laboratory technician Labs operation 8 am-5 pm from Monday to Friday
7	Lolwe Health Centre	No, there is staff shortage	No staff to cover weekend
8	Rae Health Centre	No, official operation is set for Monday to Friday 8.00 am to 5 p.m. There is no staff houses and equally rampant insecurity in the area.	No laboratory and lab technician
9	Airport Health Centre	It operates over the weekend (Saturday and Sunday	No, there is only one laboratory technician
10	Railways Health Centre	It operates from Monday to Saturday excluding Sunday 8 am-5pm	Operates from Monday to Saturday only 8am -5pm

This assessment found four facilities namely; St. Mark's Lela, Chiga, Airport and Railwaysoperating over the weekend albeit partly. The mode of extended operation beyond official work hours is mainly motivated by the maternity cases and location of the facilities. Facilities operating near urban areas were likely to work over the weekend. There is recorded improvement from one facility (St. Marks HC) working on extended hours to 4 out of the 10. This has an attribution to project intervention.

2.3 Access to Services

2.3.1 Health Service Charter

There were 90% (9 of the 10 HCs) with existing comprehensive and publicly displayed service charters. Across these facilities, the users confirmed that the health centre management had adhered to the service charters and that all the services outlined in the document were provided as per the timelines. Most of them confirmed their understanding of the importance of a service charter. It

is only in one facility Kolenyo, that the users did not express adequate on their knowledge of service charter. During assessment I, it was found that two facilities (St. Marks Lela and Absalom Wangulu) were missing the service charter. This has since changed as Absalom Wangulu is reported to have placed a service charter leaving St. Mark Lela. This is a laudable influence of the project.

2.3.2 Patients Treated at the Health Facilities

The demand for the services in the facilities was assessed. The two assessments were compared based on the one-week attendance schedule. It should however be noted that the documentation of the data per facility had certain discrepancies that would mean some of the daily attendance are under quoted. For instance, Nyalunya did not operate on holiday of 10th October, 2018, while airport data reports only patients over 5-years for the week excluding under 5.

Table 3: Number of patients attending per week

Facility	Assessment I	Assessment II	Increase in attendance
St.Mark's Lela	200	370	85%
Absalom Wang'ulu HC	248	82	-67%
Nyalunya HC	200	126	-37%
Kolenyo	396	322	-19%
Tamu HC	-	363	-
Chiga HC	-		-
Lolwe HC	452	640	42%
Rae HC	325	170	-48%
Airport HC	232	286	23%
Railways HC	297	671	126%
Average	294	337	15%

The findings show that the health facilities have on aggregate improved on the demand for the services. There are some facilities that still do not keep records such as Chiga. It may be considered improvement for Tamu in that they have progressively adopted record keeping of the facility attendances. The facilities operating beyond 5 pm and over the weekend recorded increased number of patients per week. The increased demand has not been matched with provision of medical commodities. For instance, Railways has a higher demand but high medical stock-outs.

2.3.3 Access to Health Services for Youth with Disabilities

The situation on access to health services for youth with disability or Youth friendly services has changed significantly. There are about 4 facilities that report offering youth friendly health services and Youth with disability using reproductive services. On sign language, only one facility has a trained nurse to support.

2.3.4 Service Users Proximity to Health Centre

The study examined the proximity to the health facility for the service users. At least 7 of the 10 facilities have 30% of their users accessing health facility within a radius of 1 km. St. Mark's Lela had more people accessing it with the shortest distance at 90% while Tamu had the largest distance covered by clients at 75% comparatively.

Figure 2: Proximity to health facilities

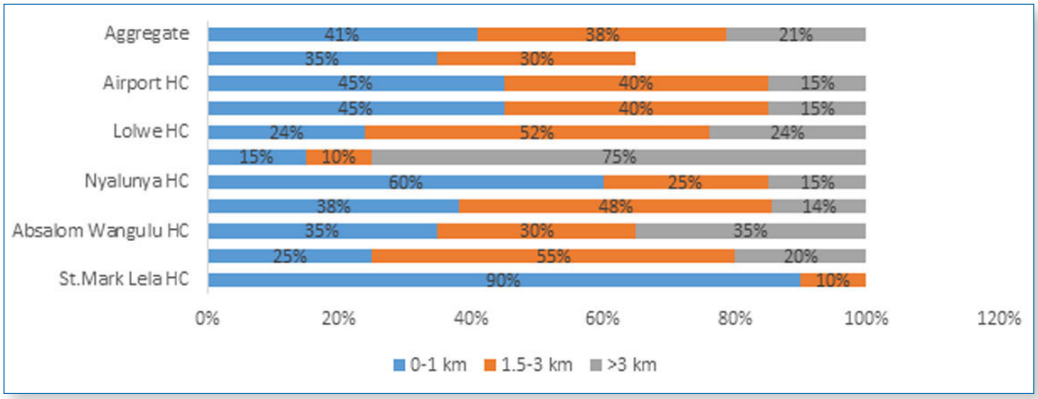


Table 4: Youth and disability friendly services

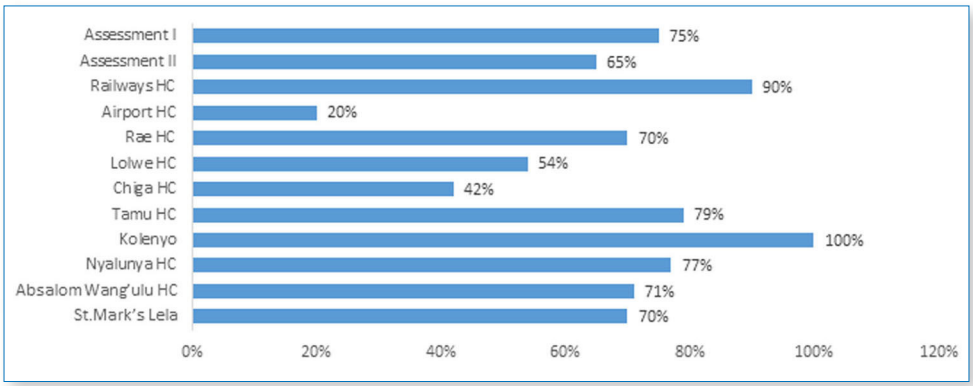
Facility	Youth Friendly Health services	Youth with disability Reproductive health services	Assistant with sign language communication
St.Mark's Lela	No, no youth centre built yet	Services providedto all youth without discrimination	No Assistant
Absalom Wang'ulu HC	No youth friendly services	Yes, RHS are available to YWD	Yes, the nursing in charge assists in sign language
Nyalunya HC	No	No	No
Kolenyo	Yes	Yes	No

Facility	Youth Friendly Health services	Youth with disability Reproductive health services	Assistant with sign language communication
Tamu HC	No	Yes	No
Chiga HC	Yes, there is youth friendly centre	Yes but not specific to YWD	No
Lolwe HC	Yes	Yes	No
Rae HC	No specific centre for youth	No specific centre for YWD RHS	No, patients accompanied by relatives familiar with sign language
Airport HC	Yes	Yes	No
Railways HC	No, no space for youth centre	Yes, RHS given to all	No

2.3.5 Availability of Drugs and Supplies

The availability of the drugs and supplies was examined. Patients were asked if they received all the drugs prescribed on the day of visit.

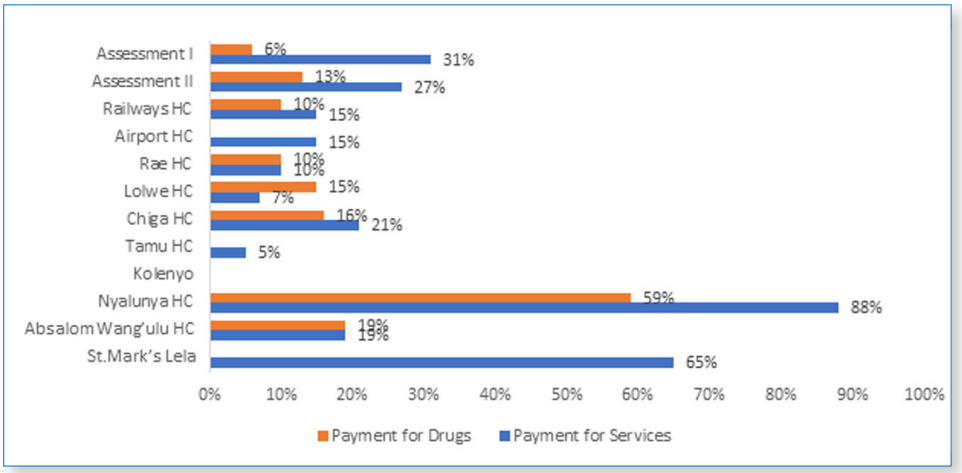
Figure 3: Received all the prescribed medication



The findings show that 70% of the facilities have up to 60% of their users reporting receiving all the required drugs. The reasons given for not receiving all the required drugs were drug stock outs or lack of exact drug prescribed for the health problem. Airport and Chiga Health Centres were performing below average on the availability of drugs prescribed.

The study further examined the type of services and commodities paid for on the material visit day.

Figure 4: Type of services and commodities paid for on the material visit day



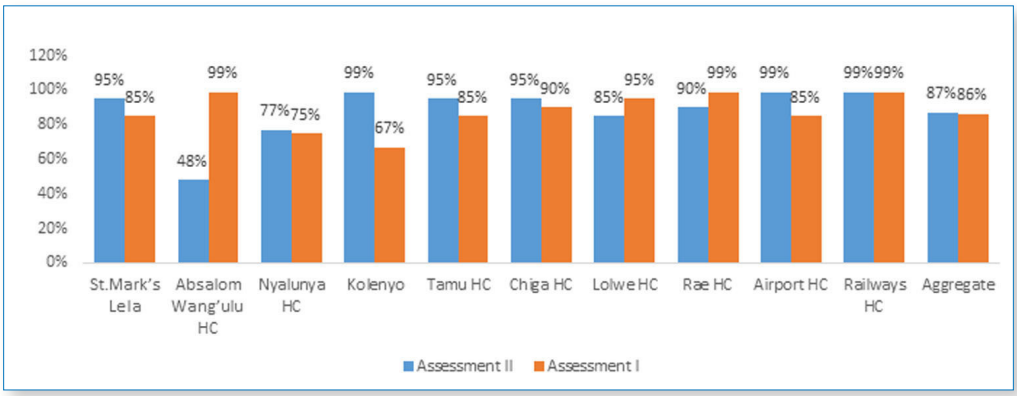
Findings show that there is a reduction in the number of persons paying for services in the health facilities from 31% in assessment I to 27% in assessment II. The proportions of service users paying for drugs and medicine has doubled from 6% in assessment I to 13% in assessment II. This could further reaffirm the insufficiency of medical supplies in the health facilities.

2.5 Perception on Health Centre Service Delivery

2.5.1 Level of Satisfaction with Health Centre Service Delivery

Overall the study showed that there were 86% of the patients/ services users who were satisfied with the treatment they received with only 14% not satisfied with services offered in assessment I while assessment II showed that, there were 87% of the patients/ services users who were satisfied with the treatment they received with only 13% not satisfied with services offered indicating a 1% increment.

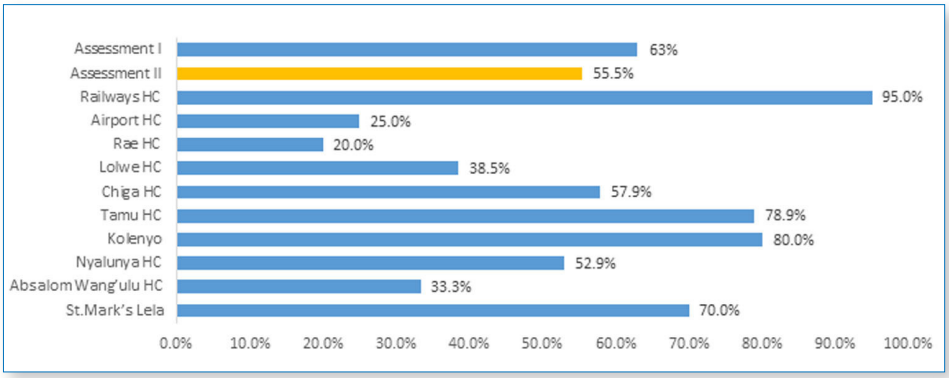
Figure 5: Satisfaction with the treatment or services offered



The level of satisfaction on the service provided was slightly increased in the period between the two assessments. Absalom Wangulu experiences a drop by about 50% of the proportion of services users reporting satisfaction on the services provided in the facility. Probably, it may be attributed to the service charter introduced that has increased awareness on the entitlements for the service users which is deviated from the services they have been receiving and or the staff shortage being experienced. Overall, the study showed that there were 87% of the patients'/services users who were satisfied with the treatment. Comparatively, this was an increment of 1%.

The study further rated the service delivery at the Health Facilities.

Figure 6: Ratings for service delivery at health facility

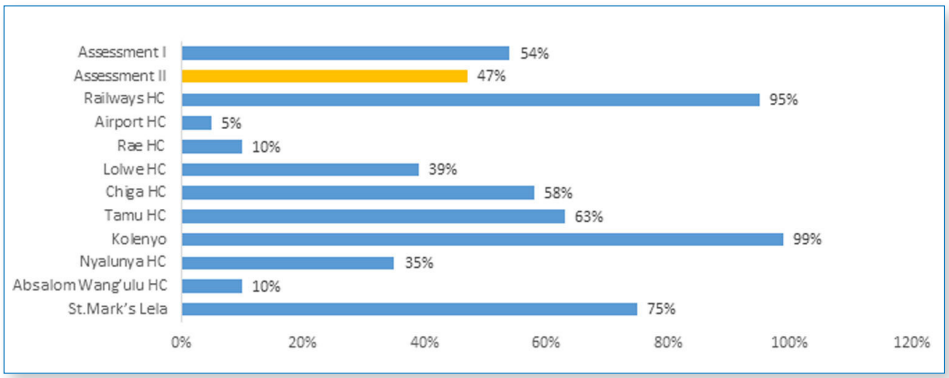


The ratings for service delivery for assessment II dipped form 55.5% on aggregate compared to assessment I at 63%. The ratings of service delivery per facility was varied. There were about 5 facilities out of the 10 reporting below average ratings

for services delivered. The challenge being unmatched entitlements to the facilities especially on the medical commodities.

The level of satisfaction with the waiting time at Health Facility was assessed for all facilities.

Figure 7: Satisfaction with waiting time at health facility



Findings show that the ratings for satisfaction with the waiting time was marginally reduced. There were 5 facilities that recorded below average ratings. The facilities reduced demand for services have low ratings for satisfaction with waiting time whereas facilities that have adjusted and are operating extended hours and over the weekend had higher ratings. Overall the rating declined from 54% to 47% this can be attributed to the increased use of service charters and improved complaints redress mechanism.

2.5.2 Channels for Health Facility User Feedback

a) **St. Mark's Lela**-The community members interacted with at St. Mark's Health Centre stated that the facility has formal and informal channels for reporting complaints. The nurse in charge, CHVs, county Facebook page, and the chief were given as some of feedback channels used. Some of the discussants acknowledged that they had made complaints to the facility management, with one stating that he had raised issues with the service charge of Ksh.20 for the registration book and Ksh.50 for treatment that patients were made to pay for in the health centre. It was confirmed that the response given to the complaint which had been sent to the facility management through a CHV was satisfactory. Community dialogue forums, local administration, and health facility personnel were mentioned as the complaint channels that exist in the community.

b) **Absalom Wang'ulu Health Centre -** The discussants admitted that there were formal and informal channels of feedback for reporting complains in the health centre if the community was not satisfied with the services. A discussant confirmed to have made a complaint to the facility of financial nature, although the response to this was stated not to have been satisfactory. The complaint was lodged through a face-to-face meeting with the staff from the health centre. The feedback mechanisms used to relay the response included community health volunteer/worker, facility service charter/accountability board, and the suggestion box.

c) **Nyalunya Health Centre**- The awareness of the community of the complaints reporting mechanisms in the health centre was found to be low. The discussants interacted with stated that they were not aware of any steps they could take to raise complaints if they were not satisfied with health services at the facility. A discussant that had made a verbal complaint about negligence in the facility expressed disappointment because she never got a response on the issue. Community dialogue forums, health facility personnel and county/sub-county health team were mentioned as the complaint/feedback channels that existed in the community.

d) **Kolenyo Health Centre**- The community at Kolenyo was aware of the existence of channels of redress at the health centre. The suggestion box at the health centre was cited as the most common channel used by the community to register their complaints to the management. A discussant cited how she had made a complaint through the assistant chief regarding two issues: time of starting operations in the health centre and lack of drugs. As at the time of the discussions, no feedback had been given yet from the management in addressing the complaint. The discussant was suspicious that she had not received feedback on the complaint because the issues had not been tabled before the HFMC. Community health volunteers were also cited as important channels of feedback within the health centre.

e) **Tamu Health Centre**- The discussant interacted with confirmed that there were channels for reporting complaints to the health centre. The channels they mentioned included health facility management committee, in-charge and dialogue days. Health facility personnel were also mentioned as complaint mechanisms that existed in the community. Generally, the

community were not happy about the feedback mechanisms in Tamu Health Centre since it was the view of most of those interacted with that the issues raised were not addressed satisfactorily.

f) **Chiga Health Centre-** It was stated that Chiga Health Centre had both formal and informal channels through which the users reported complaints regarding the services offered in the facility. Among the discussants interacted, it was established that some had made complaints to the health centre management that touched on financial management and negligence among the facility staff. The complaint/feedback mechanisms/channels that were identified to exist within the community included community dialogue forums, Local administration and health centre management committee.

g) **Lolwe Health Centre**- From the feedback, it was not clear whether Lolwe Health Centre had formal or informal channels for reporting complaints that had been made public. The discussants consulted with however exhibited an awareness the complaint mechanisms existing in the community to raise complaints as they mentioned community dialogue forums, local administration and health facility personnel as some of these channels. For instance, complaints about staff mistreatment were reported to the health centre management verbally. The response to the issue was stated to have been positive and the same had been relayed through a community health worker.

h) **Gem Rae Health Centre**- Rae Health Centre was established to have formal and informal steps for reporting complaints that had been made public in the facility. Most of the discussants expressed an awareness of the steps they needed to raise complaints if the services at the health centre did not satisfy them. They identified CHVs who were in direct contact with facility staff, CHVs representatives in the community and the suggestion box within the facility as the means through which the community members addressed their issues to the facility management. Among the ones that had ever raised issues with the health centre, time management and negligence were the focus of the complaints. These complaints were lodged through face-to-face meetings and the affected parties were satisfied with the feedback which was passed during a community outreach. The discussants interacted with further identified

community dialogue forums, community advisory group/organization, health facility personnel, and HFMC and county/sub T county personnel as the feedback mechanisms that existed in the community. The feedback mechanisms were generally found to be present in the health centre although the need to strengthen them still existed.

In general it was established that there is an increase in community awareness on the mechanisms for registering complaints in the 10 facilities. Out of the discussants interacted with, 80% explained they knew where and how to channel their complaints and grievances for redress and indicated suggestion boxes ,the ward administrator, who should be part of the health facility committee and the other, the member of County Assembly (MCA) who exercises oversight and HFMC representation of the people were mentioned as some of the channels used while CHVs were quoted as the most common channels through which the feedback to the issues raised was given to users. CHV are therefore key and pertinent to complaints and grievances mechanism. The communities however, acknowledged that they were aware that the facility should institute complaints channels. Those in the discussions who had presented their complaints before were only 20% in the assessment I. Some of the complaints presented included professional negligence by the health centre staff, poor drug supply and lateness of health centre staff. For those who complained in assessment I, the response was not satisfactory because no action was taken but in assessment II 60% of the complaints were responded to and the rest are being looked in to.

The channels of registering complaints were found to have worked for a few facilities as could be confirmed by the response of one discussant from Rae Health Centre who admitted that they had made a complaint through a phone call to the facility personnel about the rule requiring children to be accompanied by adults before they are offered treatment. It was felt that the concern raised was positively addressed since treatment services improved and delays reduced, according the discussant.

2.6 Health Facility Resources

2.6.1 Sources of Finance and Financial Accountability for Health Facilities

a) **St. Mark's Lela Health Centre**- The display of financial resources received or used in the facility was nearly non-existent. There is no public display

of HSSF funds received by the facility and the input of the community is not sought in the use of these resources. As such, it is not easy to establish whether community priorities are considered in the facility projects.

b) **Absalom Wangulu Health Centre-** The discussants affirmed that the different financial sources i.e. HSSF and community funds were displayed publicly in Absalom Wangulu Health Centre. Further, it was asserted that the financial resources were utilized with input from the community and based on their priorities and needs.

c) **Nyalunya Health Centre**- The financial sources of Nyalunya Health Centre were unknown to the community because these were not publicly displayed in the health centre. The input of the community was not sought in the utilization of the resources hence casting doubts on whether the community needs and priorities were considered.

d) **Kolenyo Health Centre**- The community members met with at Kolenyo Health Centre did not have confidence in the financial management and accountability in the facility. Most of them confirmed that financial sources, i.e. HSSF was not publicly displayed in the health centre. Additionally, they confirmed that the financial resources in the health centre were not used with input from the community and based on community priorities.

e) **Tamu Health Centre**- The financial management practices at Tamu Health Centre were highlighted by the discussants interacted with. The different financial sources in the facility e.g. HSSF funds were not publicly displayed at the health centre thereby raising concerns about accountability of the same. Further, it was found that Tamu Health Centre Committee did not seek the input of the community in the utilization of the funds in the facility.

f) **Chiga Health Centre-** Information on the different financial sources in Chiga Health Centre were found not to be readily available to the community since most of the discussants interacted with confirmed that the HSSF funds were not displayed publicly in the facility. Additionally, it was not clear if whether these financial sources were used with input from the community.

g) **Lolwe Health Centre**- The community in Lolwe was found to be unaware of most of the financial sources in the facility. Further, consultations with the community for their input in the planning and utilization of the resources was found to be low.

h) **Gem Rae Health Centre**- The different financial resources at Rae Health Centre were not displayed publicly in the facility. The discussants interacted with noted that information on HSSF funds was not readily available in the facility neither were funds used with input from the community.

2.6.2 Human Resource Capacity in the Health Facilities

a) St. Mark Lela Health Centre-The respondents indicated that the facility does not have laboratory technicians, no records officer, sign language assistant and is headed by a clinical officer with one pharmaceutical technologist , 4 nursing officers, one enrolled nurse, one public health officer that are employed by the government. Their partner DANIDA has also employed 3 staff (1 nurse, 1 records officer,1 clinical officer). KEMRI seconded a doctor to the facility. There is also a public health technician/ officer.

b) Absalom Wangulu Health Centre- The facility is doing very badly in terms of human capital. The facility does not have, a clinical officer, an enrolled nurse, a laboratory technician, a records officer, pharmaceutical technologist and a sign language assistant. The level of staffing at Absalom Wangulu was found to be very low with only one nursing officer serving the entire facility with the help of CHVs. The facility in-charge understands sign language and supports those in need

c) Nyalunya Health Centre- The facility does not have a pharmaceutical technologist, a clinical officer, an enrolled nurse, sign language assistant and a records officer. They only have one nurse, one public health officer, two subordinate staff and a laboratory technician.

a) Kolenyo Health Centre-There is no pharmaceutical technologist, clinical officer, lab technician, records officer in the facility, sign language assistant but they only have two nursing officers and a public health officer and two support staff.

b) Tamu Health Centre-The facility does not have a pharmaceutical technologist, an enrolled nurse, a sign language assistant and a health records officer. The facility has only one clinical officer, four nursing officers, one laboratory technician, one public Health officer and two support staff.

c) Chiga Health Centre-The facility reported not having a sign language assistant, a pharmaceutical technologist, a laboratory technician and

a health records officer. It however has one enrolled nurse, two nursing officers, one clinical officer and three support staff.

d) **Lolwe Health Centre-**The facility does not have a sign language assistant, a pharmaceutical technologist, an enrolled nurse, health records officer and public health officer. There are however three clinical officers, five nursing officers, two laboratory technicians and three support staff.

e) **Gem-Rae Health Centre-**This facility does not have a pharmaceutical technologist, a laboratory technician, a records officer but has three nursing officers against a possible seven, one community health worker and three subordinate staff. They said they also require a data clerk, a nutritionist and a physiotherapist. There are three subordinate staff.

f) **Airport Health Centre-**This facility has two clinical officers, one pharmaceutical technologist, nine nursing officers, one enrolled nurse, one records officer, one public health officer and eight support staff. They however require a sign language assistant and a pharmaceutical technologist.

g) **Railways Health Centre-**The facility does not have a pharmaceutical technologist, a clinical officer, an enrolled nurse, a laboratory technician, a records officer and a sign language assistant. They however have two nursing officers, one public health officer and two support staff which are not enough compared to the workload.

In general, all the facilities have inadequate staff especially those specialized in certain areas that would be of interest to the service users. The service users however, indicated that the health facility staff were courteous and respectful at 96% in assessment I and 95% in assessment II.

Table 5: state of infrastructure and entitlements per facility

	Entitlements	St.Mark Lela	Absalom Wangulu	Nyalunya	Kolenyo	Tamu	Chiga	Lolwe	Gem Rae	Airport	Railway
1	Incinerator	Absent	Absent	Present and functional	Absent	Absent	Absent	Absent	Absent	Present and functional	Burning Chamber but not functional
2	Maternity	Not functional and no equipment	Improvised	Maternity not functional	Maternity not functional	Present and not functional	Present and functional	Absent	Not functional and inadequate equipment	Present and not functional	Improvised room for maternity
3	Out-Patient	Present and functional	Present and functional	Present and functional	Present and functional	Present and functional	Present and functional	Present and functional	Present and functional	Present and functional	Yes, but no hand washing facilities and no patient toilets
4	In-Patient	Absent	Only Maternity	absent	absent	Absent	Absent	Only maternity	Absent	Absent	No inpatient
5	MNCH	Present and functional	Present and functional	Present and functional	Present and functional	Present and functional	Present and functional	Present and functional	Present and functional	Present and functional	The space not adequate
6	Minor Surgery room	Absent	Present and functional	Present and functional	Absent	Present and functional	Present and functional	Present and functional	Absent	Absent	No
7	Kitchen and store	Kitchen but no store	Absent	Present and functional	Absent	Absent	Present and functional	Present and functional	Present and functional	Absent	No Kitchen
8	Youth Friendly Services	No standalone YFS	No Youth Friendly Services	No Youth Friendly Services	No Youth Friendly Services	Youth Friendly Services	Youth Friendly Services	No Youth Friendly Services	Absent	No Youth Friendly Services	No Youth Friendly Services
9	Pharmacy	Present and functional	Drugs dispensed on table	Present and functional	Present and functional	Absent	Present and functional	Present and functional	Improvised	Present and functional	Present and functional

	Entitlements	St.Mark Lela	Absalom Wangulu	Nyalunya	Kolenyo	Tamu	Chiga	Lolwe	Gem Rae	Airport	Railway
10	Laboratory	Present and functional	Absent	Present and functional	Absent	Present and functional	Present and functional	Present and functional	Absent	Present and functional	Lab room small but used
		St.Mark Lela	Absalom Wangulu	Nyalunya	Kolenyo	Tamu	Chiga	Lolwe	Gem Rae	Airport	Railway
11	Consultation room	Present and functional	Present and functional	Present and non-functional	Present and functional	Present and functional	Absent	Present and functional	Absent	Present and functional	Present and functional
12	Staff rooms	Present and functional	Present and functional	Present and functional	Absent	Not complete and inadequate	Absent	Present and functional	Absent	Absent	No Staff houses
13	Public health office	Absent	Improvised under tree	Present and functional	Absent	Absent	Absent	Present and functional	Absent	Present	No PHO
14	Placenta pit	Present but not functional	Absent	Present and functional	Present and functional	Present and functional	Present and functional	Present and functional	Present and functional	Present	No Placenta pit
15	Water Storage	Present and functional	No gutter to direct water to the tank	Present and functional	Present and functional	Present and functional	Present and functional	Present and functional	Present and functional	Present	No water tank
16	Fence and Gate	Old gate and porous fence	Old and rusty gate	Present and functional	Fence porous	Old gate and fence	Old gate and porous fence	Present and functional	Present and functional	Present	Fence old and porous

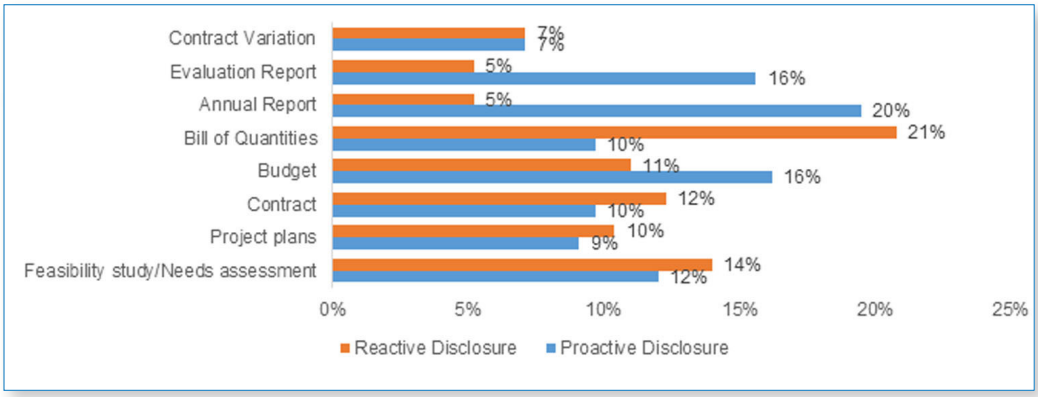
2.9 Health Facility Project Planning, Monitoring, Management and Accountability

The assessment included evaluating the participation and engagement of the public on the processes of infrastructure improvement in the health facilities. The social accountability in the project implementation in the health facilities was measured in three ways: Access to Information on project design and implementation documents, community participation and effective complaints channels and grievances redress mechanisms.

2.9.1 Access to Information on Project Implementation in Health Centre

On access to information, the community members were asked to examine the ease of access to the following documents: feasibility study/needs assessment, project plans, contract, budget, bill of quantities, annual reports, evaluation and contract variation.

Figure 8: Accessing information on project related documents



Access to information is still very low. Where proactively or reactively, sharing of information on project related costs and activities has not been accorded premium and necessary attention. It is an area that requires improvement.

2.9.2 Community Engagement and Implementation of Health Facility Projects

The Health Centres are county owned and thus participation of the community is significant. The study assessed the knowledge of the community about the project, status of beneficiary, participation in project design and implementation stages and the perception on whether the project needs were delivered.

Table 6: Knowledge and participation in implementation of health facility projects

	Knowledge of Project in HC	Direct Beneficiary in Project	Participation in Project Design	Participation at Implementation Stage	Project Delivered on Needs
St.Mark's Lela	26%	17%	9%	9%	23%
Absalom Wangulu	72%	94%	11%	33%	61%
Nyalunya	45%	70%	15%	15%	15%
Kolenyo	60%	100%	0%	0%	10%
Tamu	6%	39%	0%	0%	61%
Chiga	67%	78%	33%	6%	67%
Lolwe	83%	83%	0%	8%	83%
Gem Rae	75%	58%	17%	25%	58%
Airport	18%	82%	0%	0%	47%
Railways	100%	100%	17%	75%	75%
Total	52%	67%	11%	16%	48%

The knowledge of the community about the project was slightly above average. The study however by default targeted direct project beneficiaries, implying they had keen interest and were affected by the project. The level of participation in the project is quite low. Lastly, the perception ratings on whether the project met community needs was 48%. The future projects could bolster campaigns to foster more involvement of the community into the projects through project management committees. Direct involvement of the community could minimize waste and costs that otherwise can be covered by community contribution.

2.9.3 Awareness and Use of Complaints Redress Mechanisms within HC Projects

The study examined the level of awareness of complaints mechanism, use of complaints channel, reception of feedback and satisfaction with the complaints system.

Table 7: Awareness and satisfaction with complaints system

	Awareness of Complaints Mechanism	Used Complaints Channel	Received Response to Complaints	Satisfaction with Response to Complaint
St.Mark's Lela	17%	9%	4%	4%
Absalom Wangulu	44%	6%	11%	11%
Nyalunya	20%	10%	10%	10%
Kolenyo	10%	0%	0%	0%

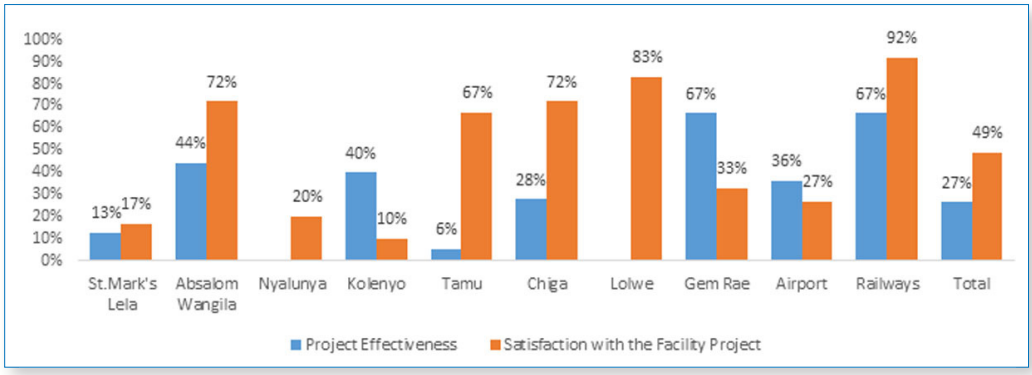
	Awareness of Complaints Mechanism	Used Complaints Channel	Received Response to Complaints	Satisfaction with Response to Complaint
Tamu	0%	0%	0%	0%
Chiga	39%	17%	17%	17%
Lolwe	0%	0%	0%	8%
Gem Rae	75%	42%	17%	25%
Airport	27%	0%	0%	0%
Railways	72%	47%	43%	92%
Total	31%	15%	14%	15%

The level of awareness on the complaints redress mechanism is quite low at 31%. Those who used the complaints system were proportionally very low at 15%. The supply side equally was not adequately responsive to offer feedback at 14%. The level of satisfaction with the complaints system was very low at 15% This was however varied by project sites as some had high levels of satisfaction of 92% at Railways health centre and as low as 0% at Airport, Tamu and Kolenyo health centres.

2.9.4 Project Effectiveness and community satisfaction with overall hc projects

The community was asked to evaluate the effectiveness of the community project in the facilities.

Figure 9: Ratings of HC project effectiveness



The rating for project effectiveness was 27% which is far less than the average. There are only two facilities (Gem Rae and Railways at 67% each) whose community reported above average ratings for project effectiveness The satisfaction for the project was average at 49%, though it varies by location. There were five facilities whose community rated above average for satisfaction with the facility project.

RECOMMENDATIONS

- County government should only implement projects whose funding is already secured and having addressed the human resources component. Full implementation and guidance from the public investment guideline should be considered. This will reduce wastage.
- Community should be well mobilized to attend and participate in the elections of HFMCs so as to give the HFMCs legitimacy, confidence and community support.
- Counties should address own source revenue with a view to enhance it and foster accountability of public funds so that it guarantees continuous supply of drugs and supplies.
- The inspection and acceptance committee at county level should include a community member and should be held personally liable for clearing projects that are poorly done for payment.
- All project documents and budgets are public documents that must be made public in line with Article 35(a) and (b) of the constitution and the Access to Information Act 2016.
- Support supervision to include comparison of performance across facilities, sub-counties and county to measure the level of adherence to set norm and standards.
- To improve on service delivery there must be an appropriate mix of input of human resources, infrastructure and commodities. This helps to avoid some inputs being available but not used in some facilities while others are needed but lacking.
- CHMT to complete, equip and put in use all projects that have stalled to avoid wastage of public funds and while considering construction of maternity wards the BQs should include drainage, septic tank and placenta pit to avoid delays in putting to use the project.
- The HFMCs should be elected democratically, inducted, trained and capacity build to improve on the management of health facilities.
- Involve citizens in implementation of projects to enhance ownership of the projects by the community in line with the constitution that encourages citizen participation.

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