



ETHICS AND ANTI-CORRUPTION COMMISSION



UNODC

United Nations Office on Drugs and Crime

CORRUPTION AND UNETHICAL CONDUCT **IN THE KENYAN HEALTH CARE PROJECTS**

A Study of Procurement and
Financial Management Practices





ETHICS AND ANTI-CORRUPTION COMMISSION



UNODC

United Nations Office on Drugs and Crime

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LIST OF ABBREVIATIONS

BQ	:	Bill of Quantities
CECM	:	County Executive Committee Member
CEO	:	Chief Executive Officer
CO	:	Chief Officer
COVID-19	:	Corona Virus Disease 2019
CRA	:	Commission for Revenue Allocation
CSPRO	:	Census Survey Processing System
EACC	:	Ethics and Anti-Corruption Commission
FBO	:	Faith Based Organization
IBM	:	International Business Machines
IFMIS	:	Integrated Financial Management Information System
IMSS	:	Information Management Systems
KNBS	:	Kenya National Bureau of Statistics
MCA	:	Member of County Assembly
MDAs	:	Ministries Departments and Agencies
MoH	:	Ministry of Health
MP	:	Member of Parliament
NECS	:	National Ethics and Corruption Survey
NGO	:	Non-Governmental Organizations
PFM	:	Public Finance Management
PPADA	:	Public Procurement and Asset Disposal Act
SCM	:	Supply Chain Management
SPSS	:	Statistical Product and Services Solution
UHC	:	Universal Health Coverage
UNODC	:	United Nations Office on Drugs and Crime



FOREWORD

This study is a culmination of a joint research between EACC and UNODC, Eastern Africa. The joint research was borne out of the need to undertake an in-depth inquiry into the extent of corruption and unethical conduct in health care projects.

The report presents findings on magnitude and processes most prone to corruption and unethical conduct; extent of adherence to public procurement and financial management laws; effectiveness of information management systems; anti-corruption measures in procurement and financial management; and challenges in the implementation of health care projects. The study was conducted in both national and county health facilities drawn from 25 sampled counties across the country.

The study assessed the implementation status of randomly selected health care projects that revealed certain projects took inordinately long periods to complete. There were instances where completed projects were not in operation. In some cases, the tender sum of the winning bidder, the budgeted amount and the engineer's estimates were the same, indicating possibility of collusion.

Key recommendations drawn from the study included debarment of contractors who mismanage projects and engage in corruption and unethical conduct; debarment from practice and where applicable practicing licenses withdrawn of government officers who collude with contractors in committing procurement and financial malpractices; entities ensure transparency and accountability in project planning, prioritization and execution; and robust public participation before and during project implementation.

The report provides insightful findings, which stakeholders can use to develop an elaborate action plan for strengthening and monitoring the delivery of health care projects. I call upon all stakeholders in the health sector to review the findings of the study and to put in place mechanisms for implementing the recommendations to improve health care delivery in the country.

I take this opportunity to express gratitude to United Nations Office on Drugs and Crime (UNODC), for collaborating with the Commission in the promotion of ethics, integrity good governance and anti-corruption initiatives.

TWALIB MBARAK, CBS
SECRETARY/ CHIEF EXECUTIVE OFFICER
ETHICS AND ANTI-CORRUPTION COMMISSION



STATEMENT FROM UNODC

Corruption in the healthcare sector kills. Around the world, corruption in the health sector undermines the integrity and credibility of the healthcare system, jeopardizes service delivery, and ultimately erodes public trust. Worse still, unethical conduct in healthcare has far-reaching and devastating consequences particularly for vulnerable populations who rely on these systems for their well-being and survival. When resources are misallocated or siphoned off through corrupt schemes it can result in a lack of essential medicines, inadequate medical facilities and supplies as well as underfunded programs leading to fatalities that could have otherwise been avoided. Furthermore, corruption undermines accessibility of health care services, affordability of those services if accessed and the quality of the services available. This is detrimental to any public healthcare system, especially where resources are scarce.

This report is a culmination of a close collaborative study between the Ethics and Anti-Corruption Commission (EACC) and UNODC in Eastern Africa and gives an in-depth summary of the analysis of the project procurement and financial management processes of health care projects within the health sector. The National Ethics and Anti-Corruption survey 2021 ranked the Ministry of Health first among institutions most prone to corruption by 18.8% of the respondents surveyed. Similarly, County health services ranked first (18.7%) as county governments' departments most prone to corruption.

The Commission's assessment of the procurement and financial management systems in healthcare projects, illustrates significant challenges in the overall healthcare project chain, including professional malpractice, non-adherence to laws and regulations, ineffective oversight and monitoring as well as poor planning that substantially hampers implementation. The statistics are even more worrisome as some 86% of healthcare personnel acknowledge the scale of corruption and unethical conduct within the sector, with records showing project overpayments running well into tens of millions, among other regrettable data.

On behalf of UNODC, it is my hope that the findings of this report will serve as a call to action to all stakeholders to develop a comprehensive action plan to address the bottlenecks in countering corruption in the healthcare sector. It is imperative that strategies are put in place to strengthen anti-corruption measures and to ensure that Kenyan citizens have access to quality, equitable healthcare. It is also my belief that the recommendations will be used to strengthen health care delivery systems not only in Kenya, but in other countries within the region that are facing similar challenges.

NEIL J. WALSH
REGIONAL REPRESENTATIVE
UNITED NATIONS OFFICE ON DRUGS AND CRIME, ROEA



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Even though there was some improvement in ranking, the health sector remained the most prone to corruption and unethical conduct."





EXECUTIVE SUMMARY

Surveys conducted by the Ethics and Anti-Corruption Commission (EACC) depicts Ministry of Health (MoH) as one of the institutions with high ranking in matters of corruption and unethical conduct. In addition, the extent of corruption and unethical conduct in procurement and financial management in relation to health care projects are not well documented. It is against this background that the Commission pursued this study so as to undertake an in-depth inquiry into the extent of corruption and unethical conduct in the health care projects especially in procurement and financial management. The study relied on cross sectional research design as its framework for data collection and analysis. It was conducted in national and county health facilities drawn from 25 sampled counties across the country. Data was collected through face-to-face in-depth interviews with the target respondents. The data collected was cleaned, coded and analyzed using International Business Machines (IMB) Statistical Product and Services Solution (SPSS) software.

The following are key highlights of the study findings:

a) Magnitude of Corruption and Unethical Conduct

- ✚ Eighty-six percent (86.3%) of health staff and 80.6 percent of members of the public acknowledged the prevalence of corruption and unethical conduct in the health sector. In addition, 88.0 percent and 93.7 percent of health staff and members of the public respectively admitted that corruption and unethical conduct were widespread in the health sector;
- ✚ Sixty percent (59.7%) of health staff and 70.0 percent of members of the public indicated there was high prevalence of corruption and unethical conduct in health care provision at the county level; and
- ✚ Sixty-five (64.7%) and 43.5 percent of the members of the public and contractors respectively admitted that corruption and unethical were widespread in health care projects.

b) Processes Prone to Corruption and Unethical Conduct

- ✚ Half of the health staff (50.9%) and 43.5 percent of contractors mentioned tendering as the phase of procurement where corruption and unethical conduct were most likely to occur;
- ✚ Forty-four percent (43.5%) of the health staff identified tender award as the stage most plagued by corruption and unethical conduct. On the contrary, most contractors (34.1%) identified tender evaluation as the stage with the highest prevalence of corruption and unethical conduct;
- ✚ Thirty-two percent (32.4%) and 33.1 percent of the health staff identified budgeting and project costing as the financial management phase and procedure respectively where corruption and unethical conduct is most likely to occur.

c) Extent of Adherence to Public Procurement and Financial Management Laws

i) Selection Criterion and Public Participation in Health Care Projects

- + Need-based (25.8) was the most critical factor that guided selection of health care projects to be implemented in the health sector. However, political influence (6.5%) was also mentioned as a factor that determine project selection; and
- + Sixty six percent (66.2%) of the health staff indicated there was active involvement of members of the public as key stakeholders in planning and execution of health care projects while 78.7 percent of members of the public refuted their active involvement by their respective counties and/ or national health facilities.

ii) Development of Specifications and Pricing of Health Care Projects

- + Forty-five percent (44.6%) of the health staff indicated that specifications and pricing of health care projects were anchored on engineer's estimates. However, nine percent (8.5%) of contractors revealed that there were instances where prevailing market prices and additional money for facilitation were used as a guideline in determining the value of the contract ; and
- + Seven percent (6.6%) of health staff indicated that contractors who bid for health care projects were involved in development of specifications and pricing estimates. Similarly, seven percent (6.5%) of contractors indicated that they were involved in the development of specifications.

iii) Budgeting and Project Implementation Period

- + Majority of health staff (89.2%) indicated that health care projects had been budgeted for. However, 10.8 percent of

health staff noted that some projects were not sufficiently funded;

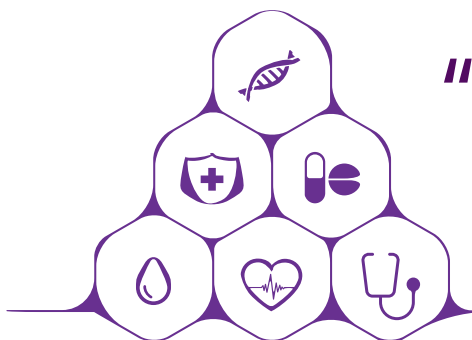
- + Meru, Tharaka-Nithi and Embu counties had more health care projects that had been completed at costs above planned budget; and
- + Awareness of health care projects completed beyond the contract period were high in Tharaka-Nithi, Embu and Homa-Bay counties and low in Makueni, Kitui and Turkana. Factors that contributed to late completion of projects were delayed disbursements of funds (53.4%), Covid-19 pandemic (14.2%), change of contract terms (10.3%), change of leadership (8.3%) and corruption (6.9%).

iv) Accessibility and Publication of Procurement Opportunities for Projects

- + Sixty-nine percent (69.2%) of health staff indicated that procurement opportunities were accessible to prospective bidders compared to 30.9 percent who indicated that they were not; and
- + Makueni, Kakamega and Nakuru counties had the highest levels of accessibility to procurement opportunities as indicated by respondents while Wajir, Garissa and Kajiado had the lowest levels.

v) Procurement Methods Applied in Health Care Projects

- + Open tendering (78.9%), followed by request for quotations (12.2%) and restricted tendering (4.6%) were procurement methods frequently applied in health care projects as identified by health staff; and
- + The three main reasons presented by health staff for the choice of the respective procurement method were fairness and transparency (34.7%), competitiveness (22.5%) and procurement law (19.8%).



// The study relied on cross sectional research design as its framework for data collection and analysis. It was conducted in national and county health facilities drawn from 25 sampled counties across the country."

vi) Termination of Health Care Projects before Completion

- ✚ Sixteen percent (16.4%) of health staff were aware of health care projects that had been terminated before completion. In addition, eight percent (8.1%) of contractors indicated that projects that were undertaken by their firms were terminated before completion; and
- ✚ Key reasons for projects termination were lack of capacity by contractors (16.5%), contractors abandoning the project (16.5%) and insufficient funds (16.0%). On the other hand, contractors pointed out falsification of regulatory certificates, lack of financial capacity and budgetary constraints in the MoH as reasons for project termination.

vii) Delay, Overpayment and Payment of Incomplete Projects

- ✚ Majority of health staff (64.6%) acknowledged that there were instances of delayed payments to contractors. Equally, 80.7 percent of contractors indicated that payments were delayed. In addition, 95.3 percent of the health staff observed that there was one or more instances where payments were delayed; and

- ✚ Five percent (4.7%) and 4.8 percent of health staff stated they were aware of overpayment and instances of payments for incomplete projects respectively.

d) Effectiveness of Information Management System

- ✚ Sixty-two percent (61.6%) of the health staff observed that Information Management Systems (IMs) were used in procurement and financial management while 38.4 percent stated that they were not in use; and
- ✚ Sixty-eight percent (68.3%) of the health staff stated that IMs were effective while 12.9 percent stated they were not. The main reason given for the ineffectiveness of the systems was ease of manipulation of information (58.9%).

e) Anti-Corruption Measures in Procurement and Financial Management

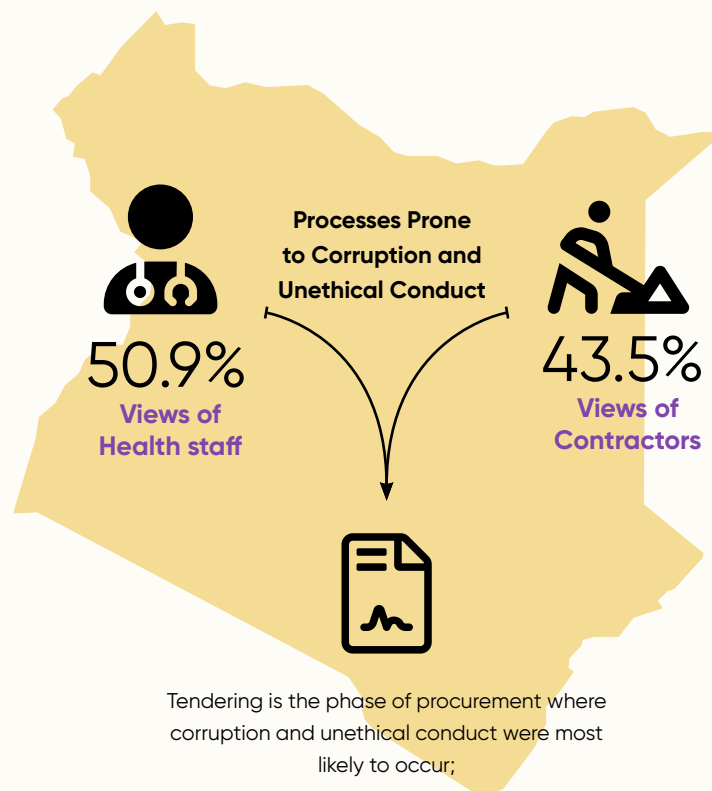
- ✚ Thirty-four percent (33.6%) of health staff acknowledged existence of anti-corruption measures to ensure the integrity of contractors, 49.9 percent were not aware while 16.5 percent indicated there were none;
- ✚ Forty-two percent (42.2%) of health staff stated that anti-corruption measures to monitor implementation of health care

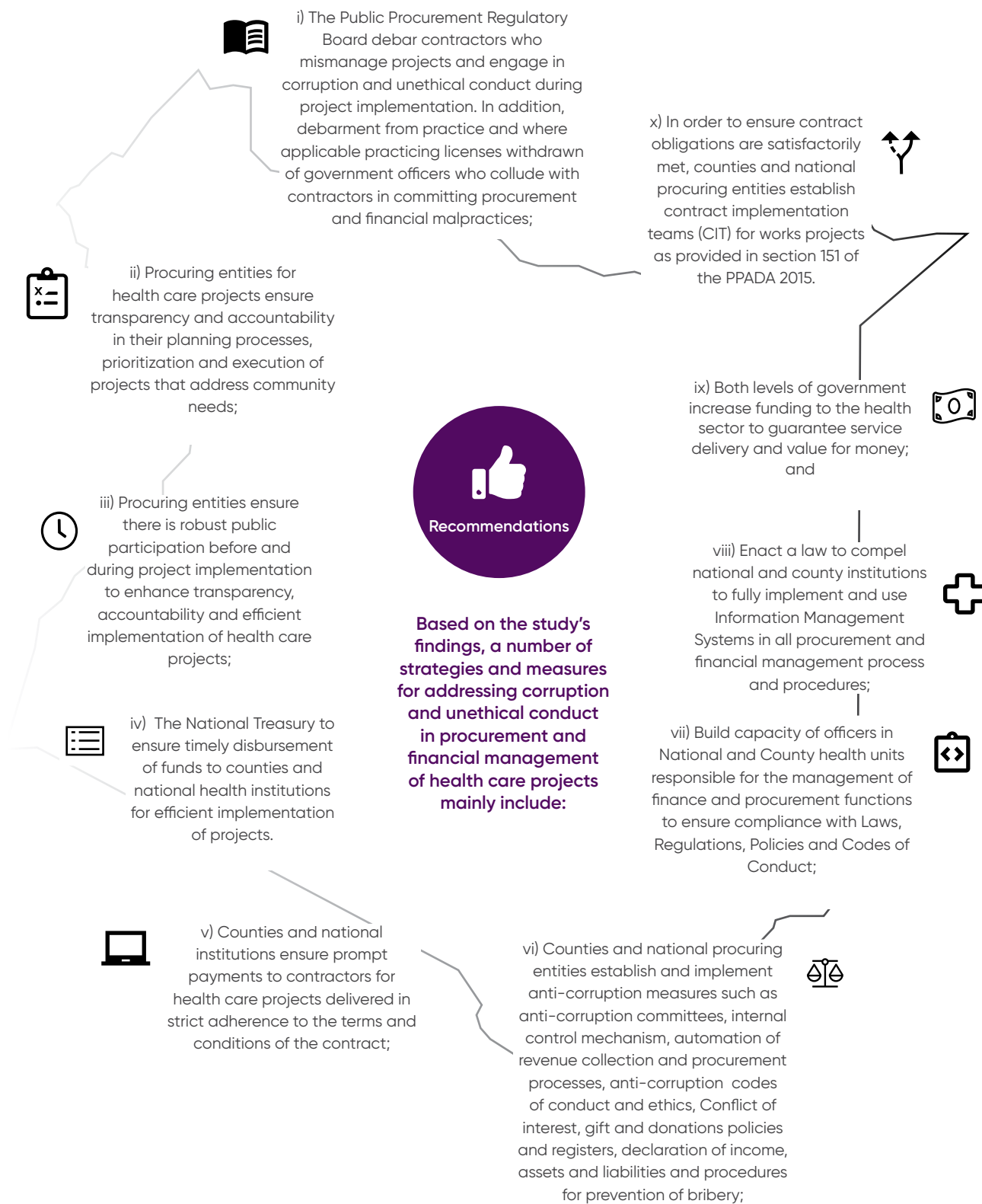
projects were in place, 14.3% indicated there were none while 43.5% pointed out that they were not aware of their existence; and

- ✚ Forty-one percent (41.2%) of health staff indicated that anti-corruption measures were effective while 4.5 percent disagreed. Forty-three percent (42.9%) of them were indifferent.

f) Challenges in the Implementation of Health Care Projects

- ✚ Financial constraints (27.8%), delay in approval of finances (14.7%), corruption (8.8%), understaffing (8.7%) and political interference (6.0%) were some of the key challenges highlighted by the respondents in the implementation of health care projects.





1

Background



1. CHAPTER ONE: BACKGROUND

INTRODUCTION

This chapter describes the structure of the health care system in Kenya, procurement and financial management in health care, rationale and objectives of the study.

1.1. STRUCTURE OF HEALTH CARE SYSTEM IN KENYA

The Government major policy objective is to improve peoples' health through enabled utilization of modern health care services. The Constitution of Kenya (2010) provides an overarching legal framework for delivery of health care services, premised on a comprehensive rights-based approach. As provided in the Constitution, provision of health care services is a devolved function, which is undertaken by County Governments. Therefore, the National Government, under the Ministry of Health (MoH), only focuses on policy formulation in health management and management of national referral health facilities.

Health care services are provided by the public sector (with major players including the MoH and affiliated departments, County Governments, agencies and facilities) and the private sector (which includes private For-Profit Organizations, Non-Governmental Organizations (NGOs), and Faith Based Organizations (FBOs)). Kenya's health care provision system is organized in a six-tier hierarchical manner as follows: Level 1: Community; Level 2: Dispensaries; Level 3: Health Centres; Level 4: Primary referral facilities; Level 5: Secondary referral facilities and Level 6: Tertiary referral facilities (MoH, 2014).

According to the Economic Survey 2021, the total number of health facilities was 14,600. Level 2 facilities accounted for 77.9 percent, Level 3 health facilities accounted for 16.1 percent while levels 4, 5 and 6, accounted for 6 per cent of the total facilities. Level 1 comprises of individual community health workers established by the Government in its desire to attain Universal Health Care (UHC). County Governments are responsible for levels one to five, see appendix 1, while national government is in charge of level 6 which are parastatals.

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The Constitution of Kenya (2010) provides an overarching legal framework for delivery of health care services, premised on a comprehensive rights-based approach.”

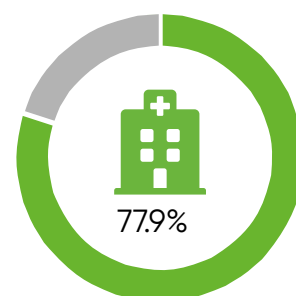
1.2. PROCUREMENT AND FINANCIAL MANAGEMENT IN HEALTH CARE

Health care related public procurement enables the government to deliver services to the citizenry by ensuring timely access to quality health care services at fair prices. As provided in the Public Procurement and Asset Disposal Act (PPADA), 2015, there are a number of procurement methods that can be used in sourcing for goods and services by all government agencies. They include open tendering, two stage tendering, request for proposal, design competition, restricted tendering, direct tendering, request for quotation, low value procurement, force account, electronic reverse auction, framework agreement and specifically permitted procurement. The most preferred method is open tender; the rest are alternative procurement methods implemented only when a given set of circumstances prevail.

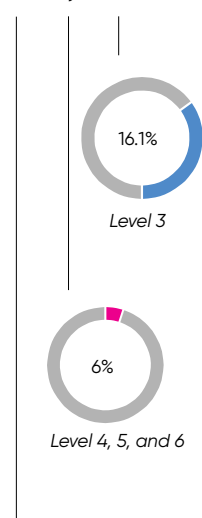
Chapter 12 of the Constitution of Kenya and the Public Finance Management (PFM) Act 2012 prescribe procedures for public sector institutions in the areas of budget, treasury, accounting, and control. The health care system in Kenya relies on several sources of funding including public (government), private firms, households and donors (including faith-based organizations and NGOs) as well as health insurance schemes.

The total expenditure in the health sector between FY 2017/2018 and FY 2021/2022 was KES 955 billion, which was approximately six percent of the cumulative national budget. The total budget expenditure by counties on health care was KES 508 billion, out of which KES 420 billion was recurrent while KES 88 billion was development representing 82% and 18% respectively (Economic Survey 2022).

At the onset of the COVID-19 outbreak, the National Government expenditure on health care services increased both at recurrent and development expenditure in 2019/20 Financial Year (FY). Recurrent expenditure on health care services increased to KES 60.8 billion, out of which KES 26.9 billion went to hospital services. Development expenditure on health care services increased substantially to KES 42.3 billion, with public health services expenditure accounting for 76.5%. Similarly, County Governments' expenditure on health care services showed recurrent expenditure on health care services increased by 17.4% to KES 89.1 billion. In the same period, development expenditure increased by nine percent (9.4%) to KES 17.6 billion (Economic Survey, 2020).



Percentage of health facilities that are level 2 in Kenya



Level 1: Individual community health workers established by the Government.

1.3. PROBLEM STATEMENT

The Global Corruption Report (2011) cites Kenya's health care system as having issues with conflict of interest, lacking accountability mechanisms, transparency and professionalism resulting to abuse and misappropriation of the funds meant to alleviate disease. Previous studies by EACC depict a health sector bedeviled by rampant corruption. National Ethics and Corruption Survey (NECS) conducted by EACC in 2016, ranked the Ministry of Health (MoH) as the second most corrupt Government Ministry (33%). Similarly, county health services were ranked first as most prone to corruption (37.4%). Both NECS 2017 (27.8%) and NECS 2018 (17.9%) ranked county health services

as second most prone to corruption. In addition, County health departments were ranked second (15.2%) in NECS 2017 and first (12.1%) in NECS 2018, as most prone to corruption.

The findings of these studies generated concern and provoked the need to undertake a more critical and in-depth study so as to understand the extent of corruption and unethical conduct in the health sector. Despite legal and institutional reforms carried out in public procurement and financial management in Kenya, corruption and unethical conduct continue to thrive in these areas. It is however important to note that the extent of corruption and unethical conduct in procurement and financial management in relation to health care projects are not well documented. It is against this background that EACC and UNODC collaborated to undertake an in-depth study targeting the health sector, in particular to assess the nature, magnitude and causes of corruption and unethical conduct in public procurement and financial management in health care projects in Kenya.

1.4. OBJECTIVES OF THE STUDY

The study sought to assess the extent of corruption and unethical conduct in the health sector focusing on procurement and financial management in health care projects. The specific objectives of the study were to:

- a) Identify the nature, magnitude, causes and processes that are vulnerable to corruption and unethical conduct in procurement and financial management;
- b) Evaluate the extent of adherence to public procurement and financial management laws and attendant regulations;
- c) Identify and evaluate effectiveness of measures being implemented by different procuring entities to combat corruption and unethical conduct;
- d) Identify challenges in the implementation of health care projects; and
- e) Propose measures and strategies for addressing corruption and unethical conduct in procurement and financial management.

1.5. ORGANIZATION OF THE REPORT

This report is presented in four chapters. Chapter 1 provides the background, Chapter 2 describes the methodology, Chapter 3 present research findings while conclusion and recommendations are captured in Chapter 4. The distribution of health facilities in counties and sample details are appended.



...corruption and unethical conduct in procurement and financial management in relation to health care projects are not well documented."


2

Methodology



2. CHAPTER TWO: METHODOLOGY

INTRODUCTION



This Chapter outlines specific procedures and techniques used to identify, select, process, and analyze data for the study. It details the research philosophy, design, sampling procedure and size, data collection and analysis techniques, quality control mechanisms and ethical consideration for the research process.

2.1. RESEARCH PHILOSOPHY

A pragmatic approach was employed to undertake the research. This was done through quantitative and qualitative approach to gather, analyze and make inference on the extent of corruption and unethical conduct in health care projects. The key objective of quantitative approach was to establish the nature and magnitude of corruption and unethical conduct in procurement and financial management in implementation of health care projects. The qualitative approach carried out an in-depth analysis on challenges and recommendations.

2.2. RESEARCH DESIGN

This was a cross sectional study of public health projects at both the national and county levels. The design entailed collection of data on more than one case and at a single point in time in order to collect a body of quantifiable data in connection with two or more variables, which were then examined to detect patterns of association.

2.3. STUDY TARGET AND SAMPLING

2.3.1. Study Target

The study target was public health care projects, employees from public health facilities across the 25 sample counties, the general public and contractors involved in project implementation.

2.3.2. Sample Design

The study sample was drawn in two stages. In the first stage, target counties were selected from Commission of Revenue Allocations' (CRA)



This was a cross sectional study of public health projects at both the national and county levels. "

3rd revenue sharing basis to counties for Financial Year 2019/2020. Twenty-five (25) counties with the largest revenue allocation were sampled in the study, relying on purposive sampling technique. Subsequently, data was collected in the 25 counties as presented in Table 1. The CRA sampling frame was deemed adequate since it used a number of parameters including health services to arrive at one formula for revenue sharing among counties. Health services parameters used in the formula were health care facility gaps and the demand for health services.

Map of Sampled Counties



Table 1: Counties Sampled

- + Nairobi City
- + Tharaka-Nithi
- + Turkana
- + Bungoma
- + Kilifi
- + Embu
- + Uasin Gishu
- + Siaya
- + Garissa
- + Kitui
- + Nakuru
- + Kisumu
- + Wajir
- + Machakos
- + Narok
- + Homa-Bay
- + Marsabit
- + Makueni
- + Kajiado
- + Migori
- + Meru
- + Kiambu
- + Kakamega
- + Kisii
- + Mombasa

In the second stage, health care facilities as well as health staff, members of the public and contractors were selected as target respondents. Consequently, 1,280 health staff, 500 members of the public, 150 contractors and 56 key informants drawn from County Health and Finance Departments were sampled. The detailed sample used in the study is provided under Appendix II.

2.4. RESEARCH QUALITY CONTROL

The research process was monitored continually to ensure quality standards were adhered to. Data collection clerks were trained before initiating the data collection exercise. Quantitative questionnaires were checked for logic and completeness, fieldwork spot-check was undertaken by the team leader and double-checked by a supervisor. Data was captured using tablets with Census and Survey Processing (CSPPro) System, which minimized human errors and ensured speed and accuracy in data collection and capture. The use of tablets also eliminated the need for data entry, thereby reducing costs, increasing speed and eliminated data entry errors.

2.5. DATA COLLECTION

In the study, both quantitative and qualitative data collection strategies were utilized. Data was collected through face-to-face in-depth interviews with the target respondents. Data collection was aided by six (6) sets of tools, comprising three (3) Questionnaires (each for health care staff, members of the public, contractors and three (3) data collection guides each for key informants, site visits and secondary data collection.

The data collection instruments were administered by well-trained Research Assistants. Secondary data from National Ethics and Corruption Surveys was also utilized to establish status of corruption indicators in the health sector. Consequently, 1,190 health sector employees, 495 members of the public, 61 project contractors, and 47 procurement and financial experts were interviewed.

2.6. DATA ANALYSIS

Data was captured using tablets with Census and Survey Processing (CSPPro) System. Once the fieldwork was complete, the open-ended questions were coded. The data was then cleaned and analyzed using IMB SPSS software. Frequency tables were generated to aid in the analysis and presentation of data. Key variables were cross tabulated to assess patterns of association. In regard to qualitative data obtained from key informant interviews, content analysis was used to establish relationships among the dependent and independent variables. Content analysis helped to establish recurring patterns trends and relationships from the qualitative data. It entailed examining qualitative and/or multiple responses from individuals to establish cross cutting themes and attributes that did not depend on absolute numbers.

2.7. ETHICAL CONSIDERATION

Consent was sought from the Council of Governors which oversights execution of public health function at the county level because health is a devolved function. In addition, heads of national health facilities and target respondents gave consent for the exercise. Letters of introduction were also issued to the technical team involved in the data collection. The respondents were anonymized to remove key identifiers.



1,190
Health sector
employees



495
Members of
the Public



61
Project
Contractors



47
Procurement
& financial
experts



The research process was monitored continually to ensure quality standards were adhered to."

3

Findings



3. CHAPTER THREE: FINDINGS OF THE STUDY

INTRODUCTION

This chapter presents the findings of the study based on five themes: nature, magnitude, causes and processes prone to corruption and unethical conduct; adherence to public procurement and financial management laws; assessment of select health care projects; anti-corruption measures in procurement and financial management; and challenges in implementation of health care projects.

3.1. NATURE, MAGNITUDE, CAUSES AND PROCESSES PRONE TO CORRUPTION AND UNETHICAL CONDUCT

Corruption and unethical conduct are manifested in different forms at various phases of health project procurement processes and financial management. The study examined the various forms of corruption and unethical conduct that are present at different phases of health project procurement and financial management at the county and national level.

3.1.1. Nature of Corruption and Unethical Conduct

The study examined malpractices at the three phases of procurement namely pre-tender, tender and post-tender. The pre-tender phase is further divided into initiation and planning stages respectively.

The health staff interviewed identified favoritism (20.8%), conflict of interest (19.5%) and bribery (16.3%) as main forms of corruption and unethical encountered at the initiation stage while manipulating of costs (21.1%), distorting procurement plans (14.9%) and favoritism (14.0%) were the main forms of corruption and unethical conduct encountered at the planning stage of health projects, presented in Table 2.

Table 2: Nature of Corruption and Unethical Conduct at Project Pre-Tendering Phase

Pre-Tendering Phase			
Project Stage (Initiation Stage)		Project Stage (Planning Stage)	
Nature of corruption and unethical conduct	%	Nature of corruption and unethical conduct	%
Favouritism	20.8	Manipulating of costs	21.1
Conflict of interest	19.5	Distorting procurement plans	14.9
Bribery	16.3	Favouritism	14.0
Poor planning	7.6	Collusion	11.7
Cost inflation	6.8	Bribery	9.4
Abuse of office	4.7	Conflict of interest	7.5
Collusion	4.7	Lack of public participation	5.5
Lack of public participation	4.7	Political interference	4.5
Political influence	4.7	Tribalism/nepotism	3.9

Pre-Tendering Phase			
Project Stage (Initiation Stage)		Project Stage (Planning Stage)	
Nature of corruption and unethical conduct	%	Nature of corruption and unethical conduct	%
Tribalism/nepotism	4.2	Others	7.5
Others	5.8		

Table 3 presents the most prevalent forms of corruption and unethical conduct across the tendering stages of invitation, opening, evaluation and award.

Table 3: Nature of Corruption and Unethical Conduct at Project Tendering Phase

Tendering Phase							
Invitation To Tender	%	Tender Opening	%	Tender Evaluation	%	Award of Tender	%
Favouritism	41.7%	Favouritism	44.4%	Favouritism	42.0%	Favouritism	40.7%
Bribery	16.8%	Conflict of interest	10.9%	Bribery	16.2%	Bribery	31.9%
Conflict of interest	13.5%	Manipulation of tender application	10.1%	Conflict of interest	10.9%	Tribalism/Nepotism	7.9%
Canvassing	8.8%	Bribery	7.7%	Collusion	10.1%	Conflict of interest	6.2%
Lack of public advertisements	7.8%	Abuse of office	6.9%	Abuse of office	6.3%	Collusion	4.0%
Tribalism/Nepotism	4.6%	Lack of public advertising	6.9%	Tribalism/Nepotism	4.0%	Abuse of office	3.3%
Political influence	2.1%	Canvassing	4.4%	Bid rigging	3.6%	Lobbying/Canvassing	1.9%
Others	4.6%	Collusion	3.2%	Canvassing	3.0%	Others	4.0%
		Nepotism	2.4%	Others	3.8%		
		Others	3.2%				

Making payment for substandard works and bribery were the most prevalent forms of corruption and unethical conduct at the post-tendering phase of health projects as presented in the Table 4.

Table 4: Nature of Corruption and Unethical Conduct at the Post Tendering Phase

Post-Tendering Phase			
Implementation	%	Closure	%
Making payment for substandard works	64.1%	Making payment for substandard works	32.2%
Bribery	11.5%	Bribery	30.6%
Bill of quantities alteration	6.9%	Delayed payments	16.9%
Unnecessary project delays	5.7%	Collusion	6.3%
Lack of public participation	3.7%	Conflict of interest	3.1%
Collusion	2.2%	Cost exaggeration	2.4%
Misappropriation of funds	1.7%	Alteration/distortion of information	2.0%

Post-Tendering Phase			
Implementation	%	Closure	%
Others	4.2%	Lack of public participation	2.0%
		Favouritism	2.0%
		Fund embezzlement	2.0%
		Others	0.8%

Budgeting, commitment, verification and payment were identified as the four phases in financial management of health care projects. Costs inflation, undue influence and collusion were most prevalent forms of corruption and unethical conduct at the budgeting phase as presented in the Table 5.

Table 5: Nature of Corruption and Unethical Conduct at the Budgeting Phase

Budgeting Phase			
Identification of Project	%	Cost Estimation of Projects	%
Costs inflation	22.0%	Costs inflation	83.7%
Undue influence	15.2%	Collusion	5.5%
Conflict of interest	14.8%	Fraud	2.5%
Poor planning	13.8%	Bribery	2.2%
Favouritism	13.6%	Under valuation	2.2%
Bribery	8.0%	Others	4.0%
Collusion	9.7%		
Others	2.9%		

Costs inflation, misappropriation of funds and bribery were the most prevalent forms of corruption and unethical conduct at commitment phase of financial management of health care projects as presented in Table 6.

Table 6: Nature of Corruption and Unethical Conduct at the Commitment Phase

Commitment Phase					
Placing of Orders within the Budgetary Ceilings	%	Approval of Expenditure Commitment	%	Reserving of Funds for the Payment of the Items Ordered	%
Costs inflation	29.0%	Misappropriation of funds	28.0%	Bribery	32.5%
Substandard goods and services	27.8%	Approval of non-budgeted works/goods/services	19.1%	Favouritism	13.8%
Collusion	10.5%	Undue influence	11.7%	Price inflation	11.7%
Bribery	9.3%	Conflict of interest	11.0%	Conflict of interest	10.0%
Favouritism	6.9%	Delays in approval and disbursement of funds	11.0%	Misappropriation of funds	7.5%
Conflict of interest	4.4%	Favouritism	5.3%	Undue influence	6.3%
Neglecting procedures	3.6%	Collusion	5.3%	Collusion	6.3%

Commitment Phase					
Placing of Orders within the Budgetary Ceilings	%	Approval of Expenditure Commitment	%	Reserving of Funds for the Payment of the Items Ordered	%
Misappropriation of funds	2.4%	Disregarding the law	3.5%	Embezzlement of funds	6.3%
Forgery	2.4%	Abuse of office	2.5%	Delays	4.6%
Others	3.6%	Others	2.5%	Others	1.3%

Acceptance of substandard items and non-delivery of items, price inflation and non-adherence to laws and regulations were the most prevalent forms of corruption and unethical conduct at verification phase. See Table 7.

Table 7: Nature of Corruption and Unethical Conduct at the Verification Phase

Verification Phase					
Ascertain that Delivery of Work Conforms to the Terms of the Contract	%	Determining Prices Reflect Fair Market Costs	%	Adherence to Laws and Regulations	%
Acceptance of substandard items and non-delivery of items	52.3%	Price inflation	55.8%	Non-adherence to laws and regulations	41.5%
Bribery	20.1%	Failure to do market surveys	16.2%	Bribery	15.3%
Conflict of interest	7.7%	Collusion	11.6%	Collusion	9.7%
Collusion	6.6%	Bribery	5.3%	Negligence	9.7%
Undue influence	3.3%	Conflict of interest	3.9%	Self interest	8.5%
Alteration of orders	5.0%	Substandard items	3.2%	Conflict of interest	5.6%
Improper verification	2.4%	Favouritism	2.5%	Favouritism	4.4%
Others	2.6%	Others	1.4%	Misappropriation of funds	4.0%
				Others	1.2%

Bribery, non-adherence to laws and regulations and delay in payments were the most rampant forms of corruption and unethical conduct identified at the payment phase of financial management of health care projects as shown in Table 8.

Table 8: Nature of Corruption and Unethical Conduct at the Payment Phase

Payment Phase			
Adherence to Laws and Regulations	%	Ensuring that There Are No Multiple Payments	%
Bribery	39.4%	Bribery	35.2%
Non-adherence to laws and regulations	20.9%	Delay in payment	13.5%
Favouritism	9.2%	Excess payment	13.5%
Delay in payment	7.7%	Collusion	9.5%
Collusion	7.0%	Fraud	8.6%
Inflated prices	4.9%	Favouritism	6.3%
Compromised checks	3.4%	Failure to follow guidelines	6.3%
Negligence	3.4%	Abuse of office	3.2%

Payment Phase			
Adherence to Laws and Regulations	%	Ensuring that There Are No Multiple Payments	%
Others	4.1%	Omissions	2.3%
		Others	1.7%

Moreover, 34.5 percent of the members of the public acknowledged awareness of malpractices in health care projects. Bribery (18.3%), embezzlement of funds (17.7%) and favoritism (13.4%) were the main malpractice identified as illustrated in Figure 1.

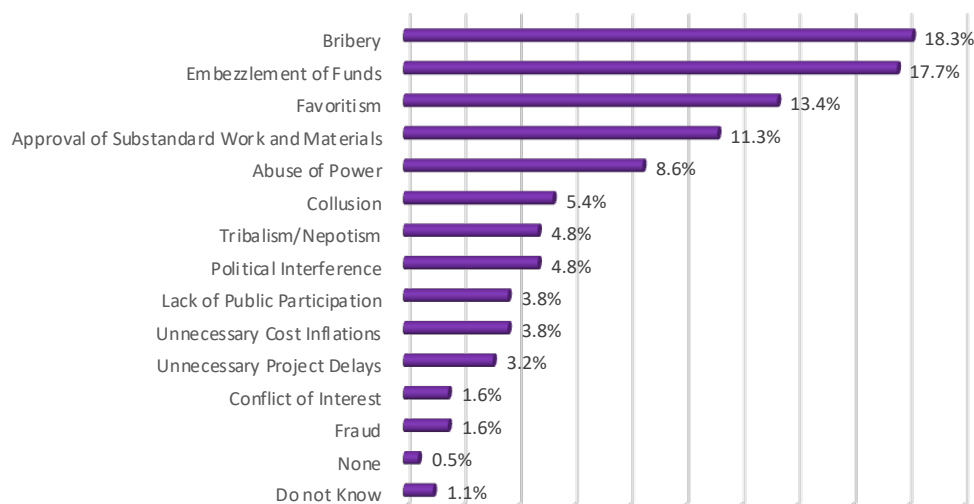


Figure 1: Malpractices in Health Care Projects (Members of the Public)

Contractors (45.2%) also indicated that it is common for them to pay some irregular payments or gifts to get things done. In addition, 30.6 percent knew in advance, what was to be offered as an irregular payment or gifts.

Key Informants also acknowledged manifestation of corruption and unethical conduct in the Kenyan health sector as illustrated by quotes from Wajir and Migori Counties:

“

Influence of tender awards to favor the desired contractors by top officials in the procuring entity. It normally happens during evaluation and certification of works for payments” Wajir County.

“

Use of proxies to take up tenders, misuse of funds meant to improve health sector, conflict of interest by people in the system are common” Migori County.

”

Key Informants also acknowledged manifestation of corruption and unethical conduct in the Kenyan health sector.”

Contractors were asked to indicate whether they had witnessed a violation of ethical standards, policy or law by public officers when seeking public services.

Twenty nine percent (29%) of contractors indicated that there was violation of government ethical standards, policy or the law by public officers. Table 9 presents the most prevalent violations.

Table 9: Forms of Ethical Standards, Laws and Policy Violations by Public Officers

Forms of Ethical, Laws and Policy Violations Witnessed in Public officers	%
Bribery demands	27.6%
Unnecessary delay in services and payments to contractors	20.7%
Lack of courtesy	10.3%
Absenteeism	6.9%
Favouritism	6.9%
Bid rigging	6.9%
Non-adherence to laws and regulations	6.9%
Abdication of duty by public officers	6.9%
Abuse of office	3.4%
Unstandardized license inspection requirements	3.4%

Bribery was frequent in every phase of procurement and financial management of health care projects. In this regard, further analysis was done to establish awareness of health staff on the extent of bribery payments in health care projects. Four percent (4.3%) of health staff interviewed admitted awareness of bribery payments for health care projects contrary to 95.7% who noted that there were no cases of bribery in health care projects. In explaining the reasons behind their responses, health staff who admitted awareness noted that bribery was expected (45.7%), was demanded (26.1%), voluntary (26.1%) and was to avoid service delay (2.2%) as shown in Figure 2.

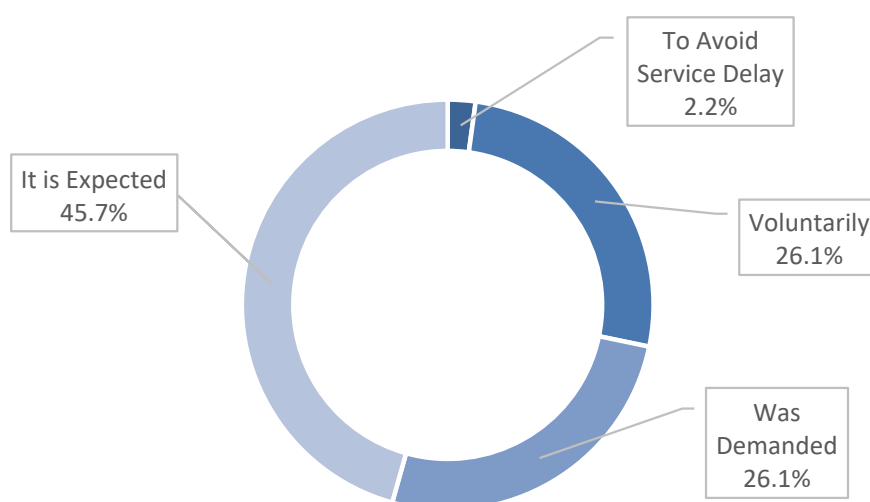


Figure 2: Reasons for Bribery Payments in Health Care Project

Project initiation stage (32.7%) recorded the highest instances of bribery as indicated by health staff. This was followed by tender award (26.5%) and implementation (22.4%), presented in Figure 3.

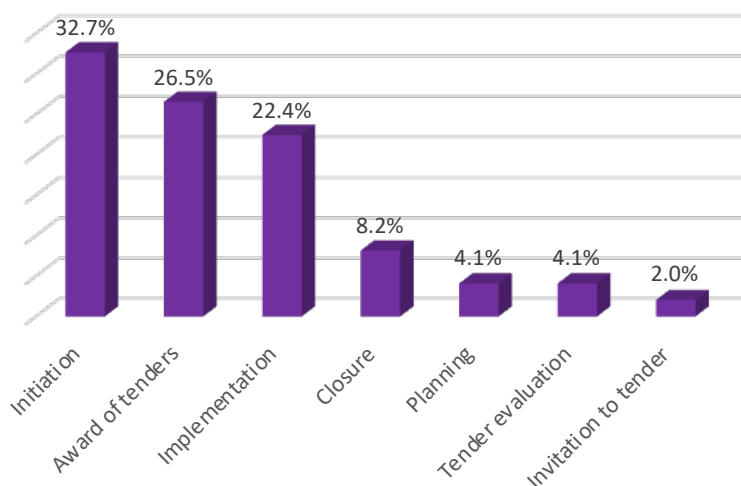
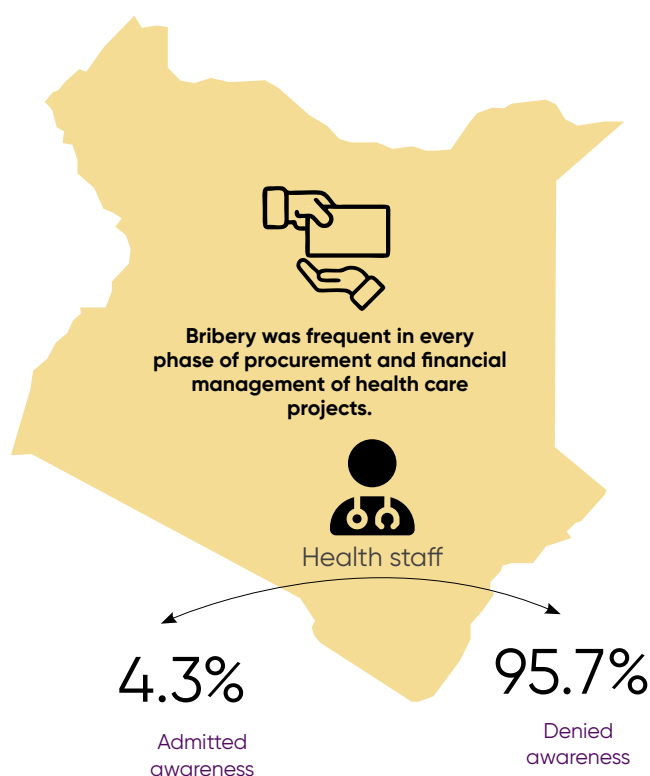


Figure 3: Project Implementation Stages Attracting Bribery



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Contractors (45.2%) also indicated that it is common for them to pay some irregular payments or gifts to get things done."

Majority of health staff mentioned county government employees (59.2%) as those who were receiving bribe. This was followed by county health employees (22.5%) and national government employees (13.7%) shown in Figure 4. It is worth noting that others who were receiving bribe as mentioned by the health staff included managers, directors, head of departments, procurement and finance officers, chief officers (COs), county executive committee members (CECMs), governors, members of county assemblies (MCAs), administrators, engineers and public health officers.

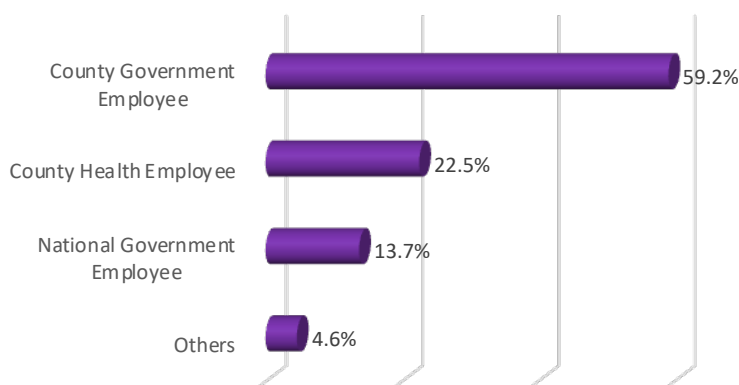


Figure 4: Bribe Recipients in Health Care Projects

Bribery payments were mainly in the form of cash as indicated by 68.8 percent of the health staff, wireless transfer of money (1.6%) and favours (1.6%) while 28.1 percent did not know the form of bribe payment. The average bribe paid for health care projects was approximately KES 395,909. The highest amount of bribe paid was KES 3,000,000 and the lowest amount of bribe paid was KES 5,000. Others paid 10 percent of the project value.

3.1.2. Magnitude of Corruption and Unethical Conduct

Eighty-six (86.3%) percent of health staff at the national and county governments acknowledged the prevalence of corruption and unethical conduct in the health sector. Similarly, most members of the public interviewed (80.6%), admitted corruption and unethical conduct was prevalent. In addition, prevalence of corruption and unethical conduct in health care provision at the county level was acknowledged by 59.7 percent of health staff and 70.0 percent of members of the public. Further, the study revealed that corruption and unethical conduct was widespread in the health sector. The findings are as shown in Figure 5.

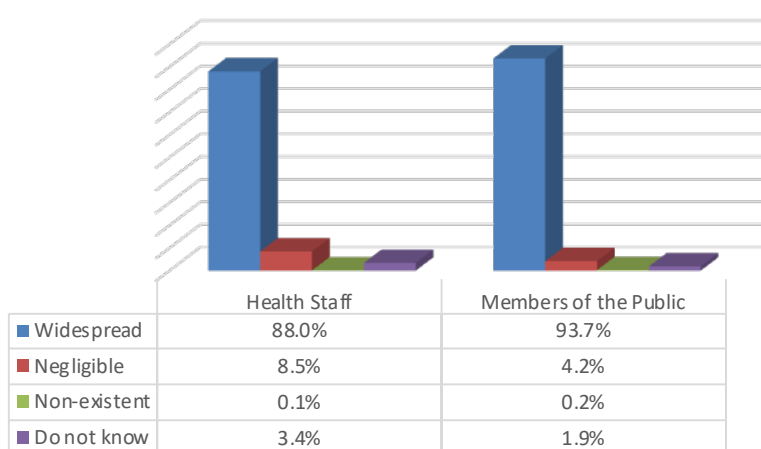


Figure 5: Extent of Corruption and Unethical Conduct in the Kenyan Health Sector

The finding on the extent of corruption and unethical conduct in procurement and financial management in health care projects are summarized in Figure 6. Sixty-five percent (65.0%) of members of the public and 43.5 percent of contractors admitted that corruption and unethical conduct were widespread in health care projects.

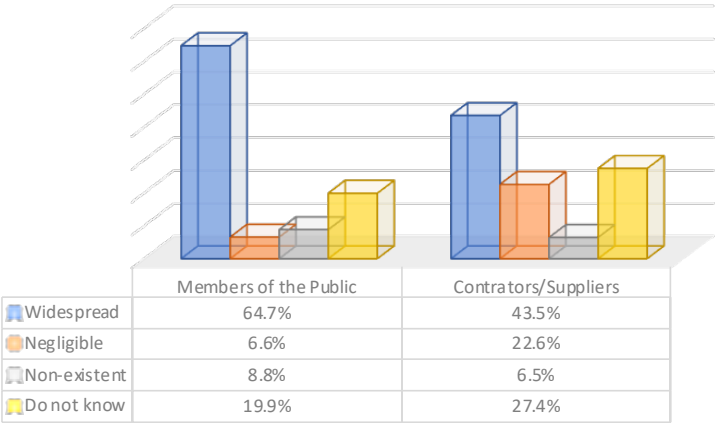


Figure 6: Extent of Corruption and Unethical Conduct in Health Care Projects

In addition, 36.4 percent of members of the public indicated that corruption and unethical conduct are high in procurement and financial management of health care projects as shown in Figure 7.

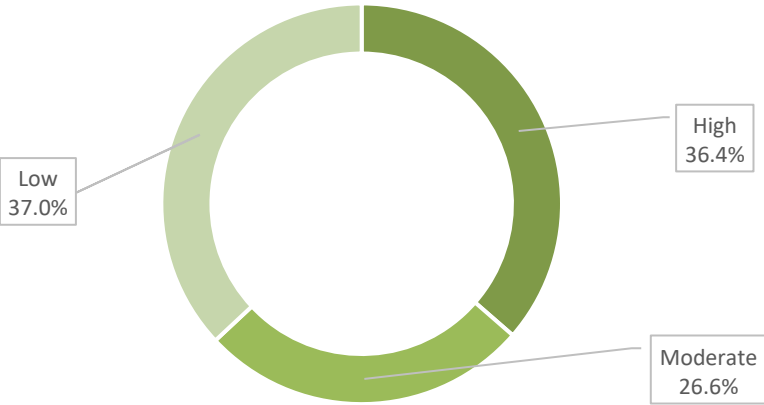


Figure 7: Prevalence of Corruption and Unethical Conduct in Health Care Projects

Contractors were asked to indicate on average, the percentage of monies they gave as unofficial payment per annum to public officers. Twenty-three percent (23.3%) of contractors indicated that they gave 1-10%, eight percent gave 11-20% while three percent gave 21-50% of their revenue as unofficial payment as indicated in Figure 8.

“
County government employees were mentioned by most of health staff (18.1%) as those who were receiving bribe.”

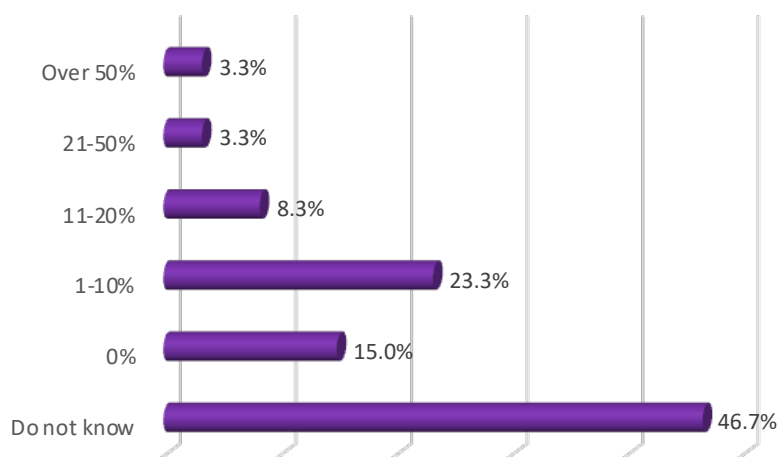


Figure 8: Unofficial Payments by Contractors as a percentage of revenue

3.1.3. Causes of Corruption and Unethical Conduct

According to contractors, the main reasons why public officers engage in corruption and unethical conduct are greed (29.5%), low and delay in salary payment (18.2%), and selfishness (9.1%). Other reasons are as presented in Figure 9.

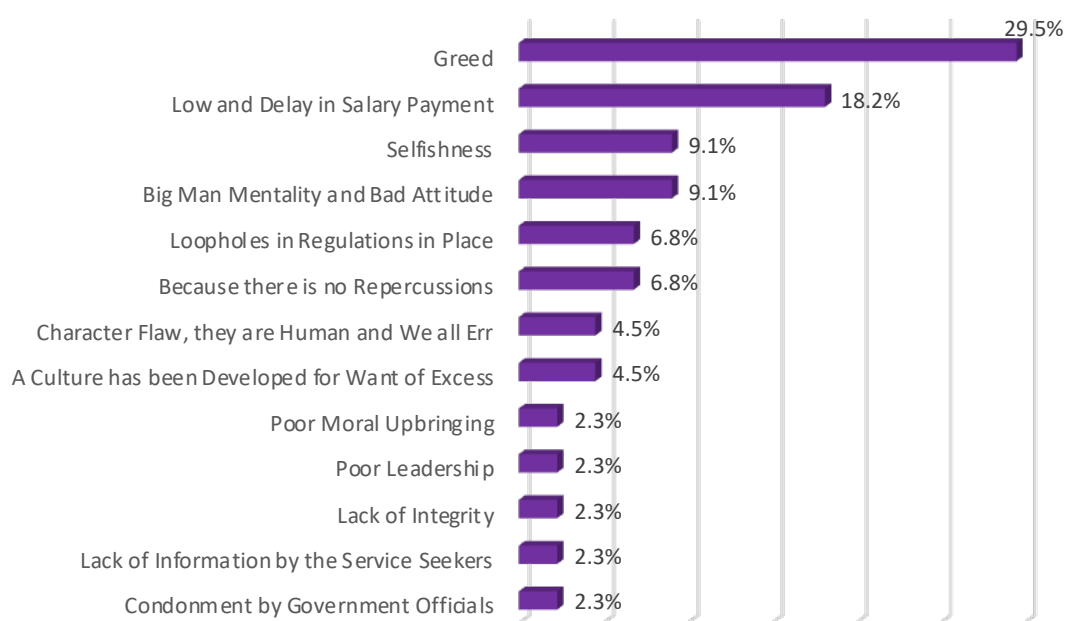


Figure 9: Reasons for Public Officers Engaging in Corruption and Unethical Conduct

Further, contractors identified greed (26.4%), high cost of living (11.0%) and delay in payments (11.0%) as the main causes of corruption and unethical conduct in the Kenyan health sector as shown Figure 10.

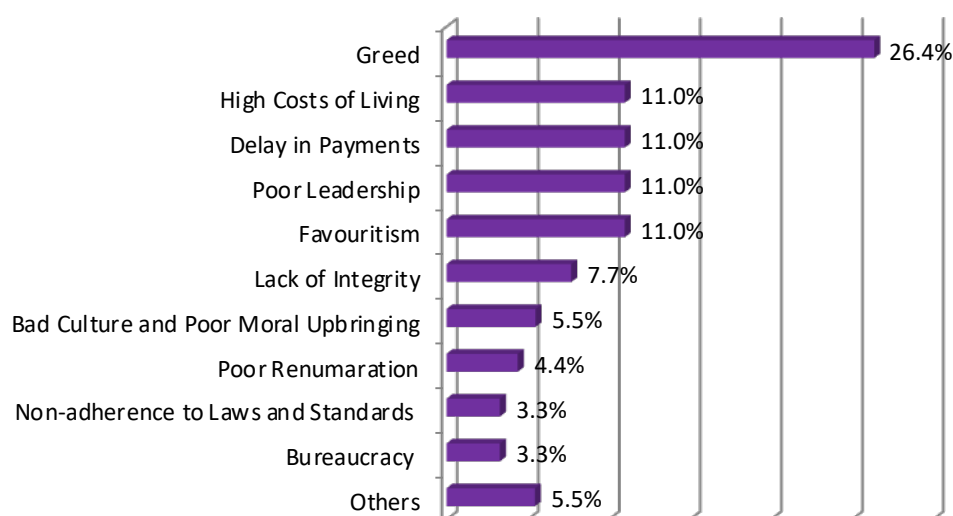


Figure 10: Causes of Corruption and Unethical Conduct in the Kenyan Health Sector

3.1.4. Processes Prone to Corruption and Unethical Conduct

The respondents were asked to identify procurement phases prone to corruption and unethical conduct in health care projects. Half of the health staff (50.9%) and 43.5 percent of contractors identified tendering phase as most prone to corruption and unethical conduct. This was followed by the pre-tendering phase and post-tendering phase as shown in Figure 11.

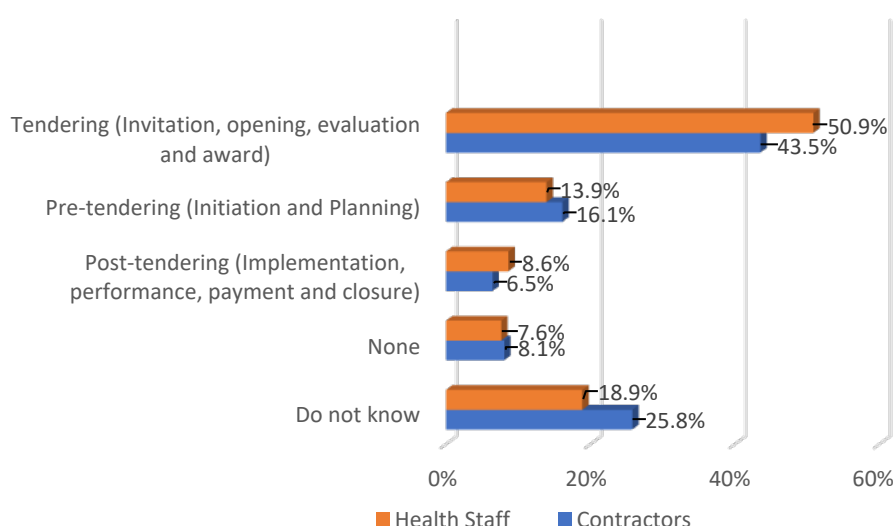


Figure 11: Project Procurement Phases Prone to Corruption and Unethical Conduct

In addition, the tender award stage was identified by 43.5 percent of health staff as the stage most plagued by corruption and unethical conduct. On the contrary, most contractors (34.1%) identified tender evaluation stage as most riddled with corruption and unethical conduct as depicted in Figure 12.

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... the tender award stage was identified by 43.5 percent of health staff as the stage most plagued by corruption and unethical conduct."

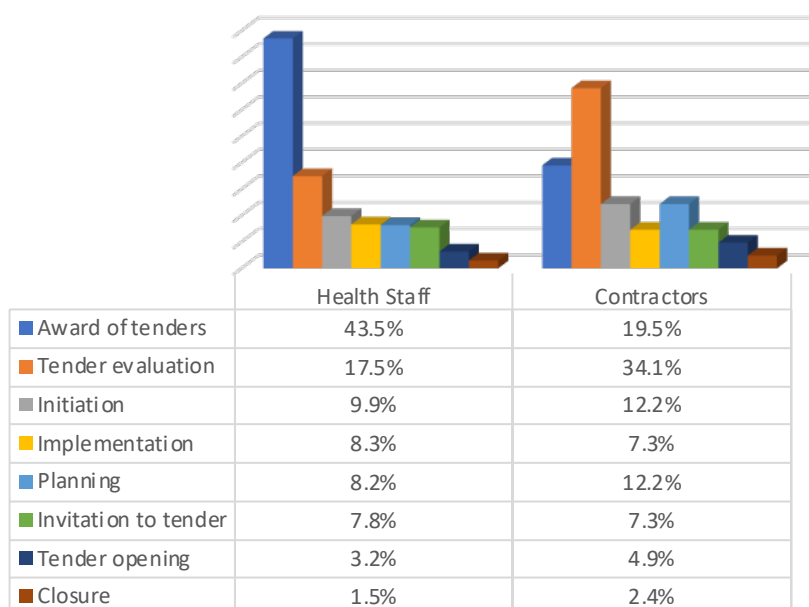


Figure 12: Project Procurement Stages Most Riddled with Corruption and Unethical Conduct

The respondents were asked to identify financial management phases in health care projects where corruption and unethical conduct were most likely to occur. Budgeting was identified by 32.4 percent of the health staff, payment (24.5%) and verification (17.8%). The finding is shown in Figure 13.

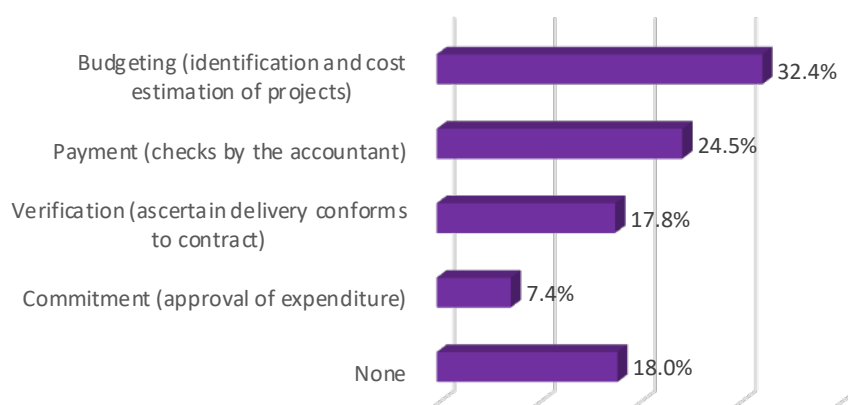


Figure 13: Financial Management Phases Prone to Corruption and Unethical Conduct

In addition, 33.1 percent of health staff identified project costing as the financial management procedure where corruption and unethical conduct was most rampant. Verification and adherence to laws and regulations were among other procedures most prone to corruption and unethical conduct as indicated in Figure 14.

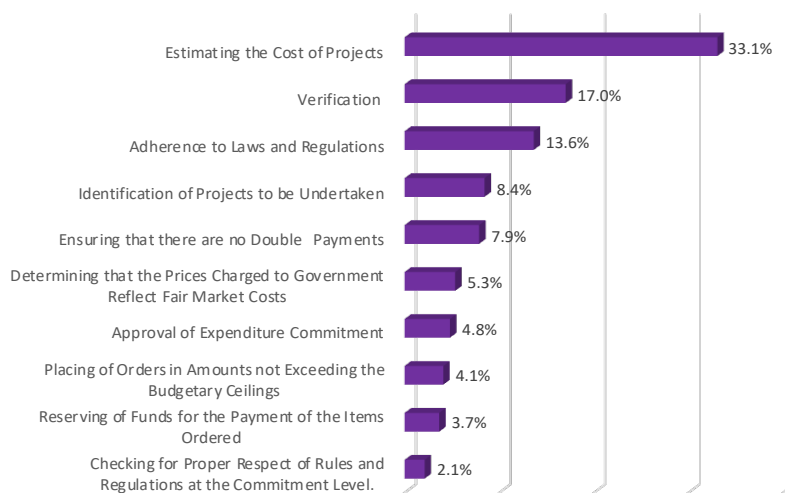


Figure 14: Financial Management Procedures where Corruption and Unethical Conduct is Most Rampant

3.2. ADHERENCE TO PUBLIC PROCUREMENT AND FINANCIAL MANAGEMENT LAWS

The study examined the extent of adherence to public procurement and financial management laws in regards to the set criterion for selecting health care projects, the extent of public involvement and awareness of health care projects. It also looked into specifications and budgeting as provided for in procurement and financial management laws and regulations amongst others.

3.2.1. Selection Criterion and Public Participation in Health Care Projects

The study sought to establish critical factors that guide selection of health care projects as well as the level of public participation. Need based (25.8%), distance (24.3%) and social behaviour (22.9%) were the three key factors as indicated in Figure 15.

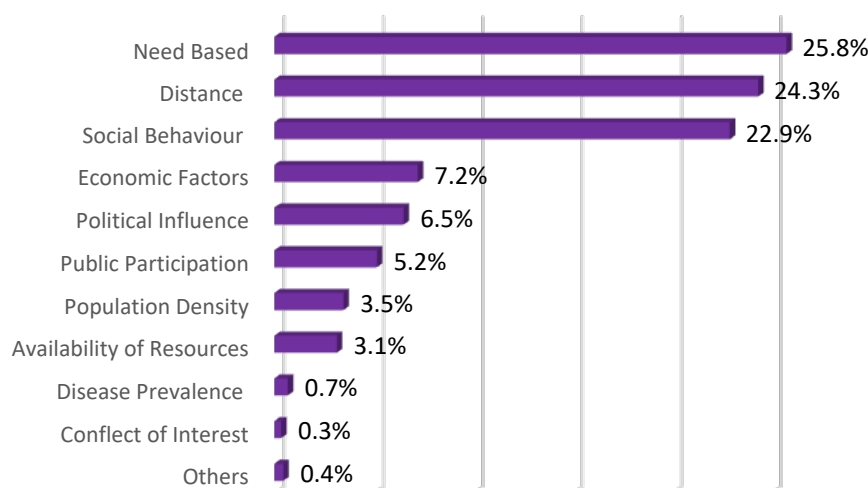
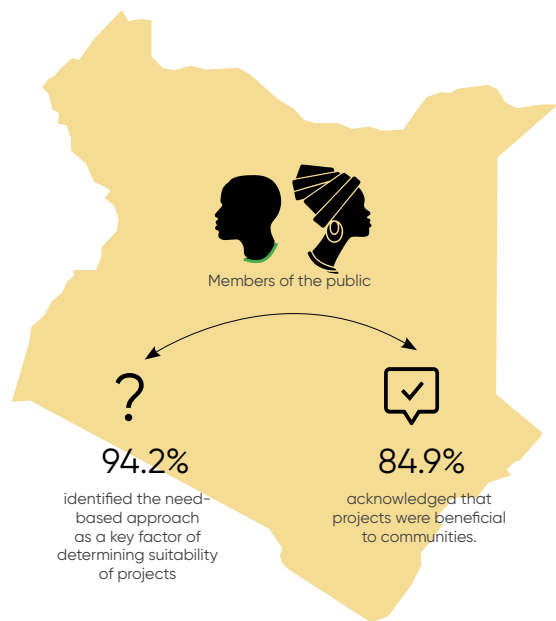


Figure 15: Factors Determining Selection of a Health Care Project

Members of the public (94.2%) also identified the need-based approach as a key factor of determining suitability of projects. In addition, 84.9 percent of the same respondents acknowledged that projects were beneficial to communities.



In addition, the study examined whether members of the public, as key stakeholders, were involved in planning and execution of health care projects. Majority of the health staff (66.2%) indicated that members of the public were actively involved in planning and execution. However, members of the public (78.7%) indicated that they were not involved (Figure 16). Nonetheless, most members of the public (54.8%) were aware of health care projects being implemented in their areas.

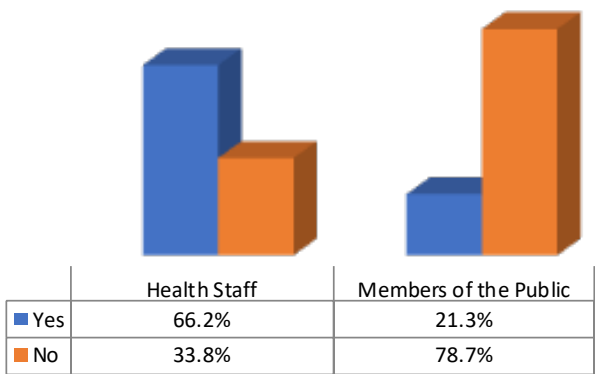


Figure 16: Involvement of Members of the Public in Health Care Project Implementation

Makueni, Kisumu and Migori counties had the highest levels of public involvement in the implementation of health care projects. On the other hand, Garissa, Wajir and Nairobi counties had the lowest levels of public involvement. The finding is shown in Figure 17.

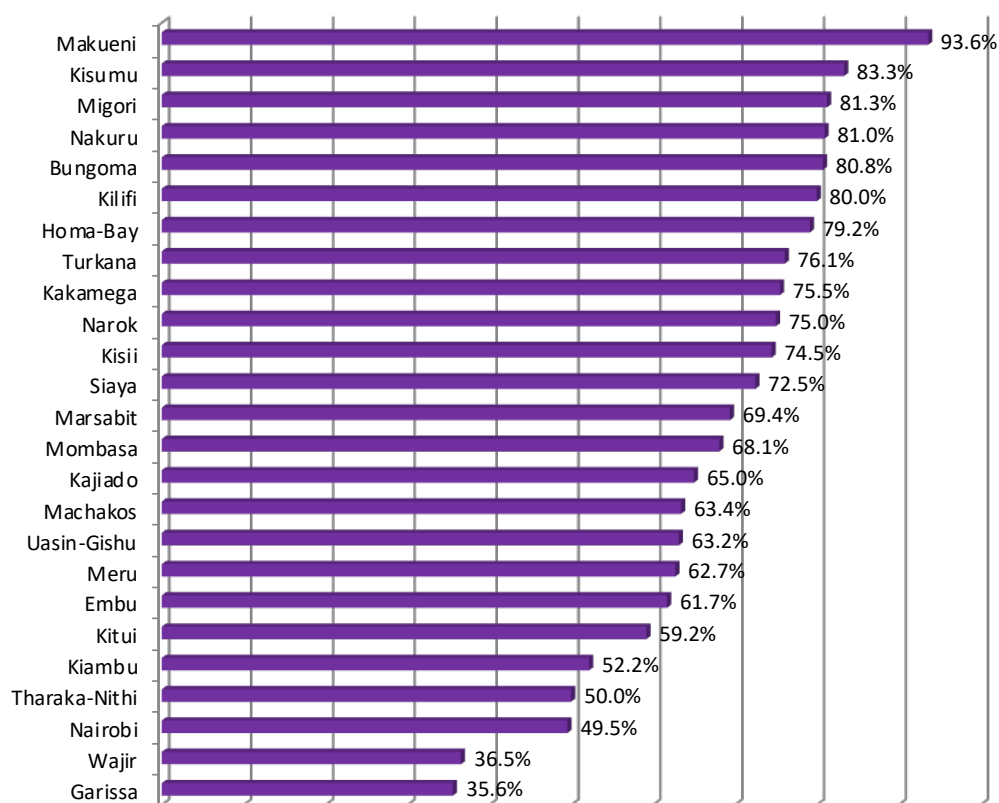


Figure 17: Level of Public Participation in the Implementation of Health Care Projects in Counties

Invitation to public fora (45.0%), submitting proposals in public barazas (16.2%) and appointment to project committees (13.3%) were the key ways in which members of public were involved in health care projects as illustrated in Table 10.

Table 10: Nature of Public Involvement in Health Care Projects

Nature of Public Involvement in Health Care Projects	%
Invitation to public fora	45.0%
Submitting proposals in public barazas	16.2%
Appointment to project committees	13.3%
Community representation in hospital boards	12.6%
Selection of community representatives to participate in projects	5.6%
Stakeholder engagement meetings	1.3%
Others	6.0%

3.2.2. Development of Specifications and Pricing of Health Care Projects

Forty five percent (44.6%) of the health staff interviewed indicated that specifications and pricing of health care projects were anchored on engineer's estimates and user department specifications (7.7%) as shown in Table 11.

Table 11: Guidelines for Development of Specifications and Pricing of Health Care Projects

Methods of Specifications Development and Pricing of Health Care Projects	%
Engineer's estimates	44.6%
User department specifications	7.7%
Consulting a few contractors on specifications and prevailing market prices	6.2%
Consulting technical experts	4.8%
A combination of engineer's estimates, consulting a few contractors on specifications, and prevailing market prices	5.7%
Market surveys	3.5%
Consulting only one contractor on specifications and prevailing market prices	2.7%
Referring to own previous specification and cost of similar projects	2.4%
None	12.0%
Others	10.4%

However, 8.5 percent of contractors revealed that there were instances where prevailing market prices and additional money for facilitation was used as a guideline in determining the value of the contract.

Health staff (6.6%) indicated that contractors who bid for health care projects were involved in development of specifications and pricing estimates. Similarly, 6.5 percent of contractors indicated that they were involved in the development of specifications. In support of this view, 75.0 percent of contractors revealed that they had participated in tendering for the same projects where they had been involved in developing specifications. The study established that the contractors who participated in the development of specifications were eventually awarded the contract. Embu, Wajir and Homa-Bay counties had the highest proportions of contractors who participated in the development of specifications and bidding for the same project as presented in Figure 18.

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the contractors who participated in the development of specifications were eventually awarded the contract."

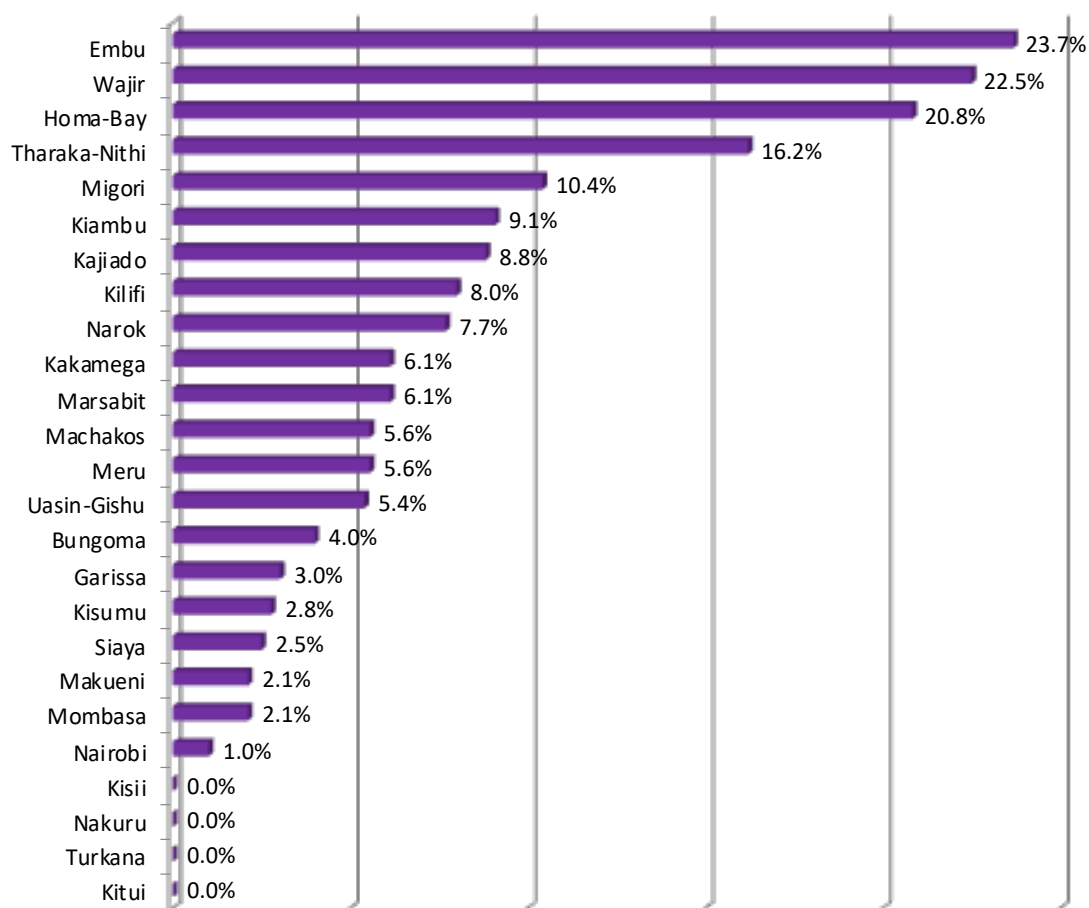


Figure 18: Contractors Participation in Development of Specifications and Bidding for the same Health Care Project(s)

3.2.3. Budgeting and Project Implementation Period

The study set out to establish whether health care projects were budgeted for, completed within budget and contract period. Majority of health staff (89.2%) indicated that health care projects had been budgeted for. However, 10.8 percent of health staff noted that some of the projects were not sufficiently funded. The most under funded health care projects were those funded by county governments as indicated by 86.2 percent of health staff, followed by national government (9.8%) and by donors (4.0%) as shown in Figure 19.

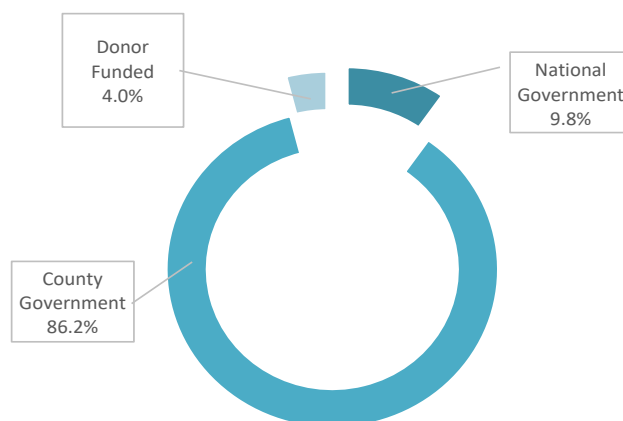


Figure 19: Underfunded Health Care Projects

The study established 94.3 percent of health care projects were completed within budget while 79.1 percent were completed within the contract period as shown in Figure 20.

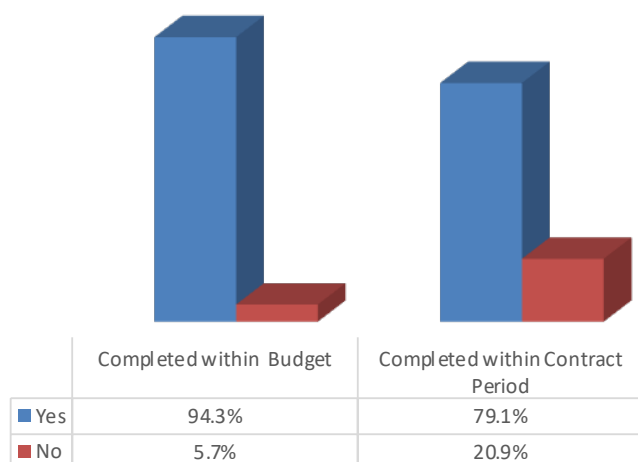


Figure 20: Health Care Projects Completed within Budget and Contract Period

Respondents indicated that Meru, Tharaka-Nithi and Embu counties had more health care projects that had been completed at costs above planned budget as shown in Figure 21.

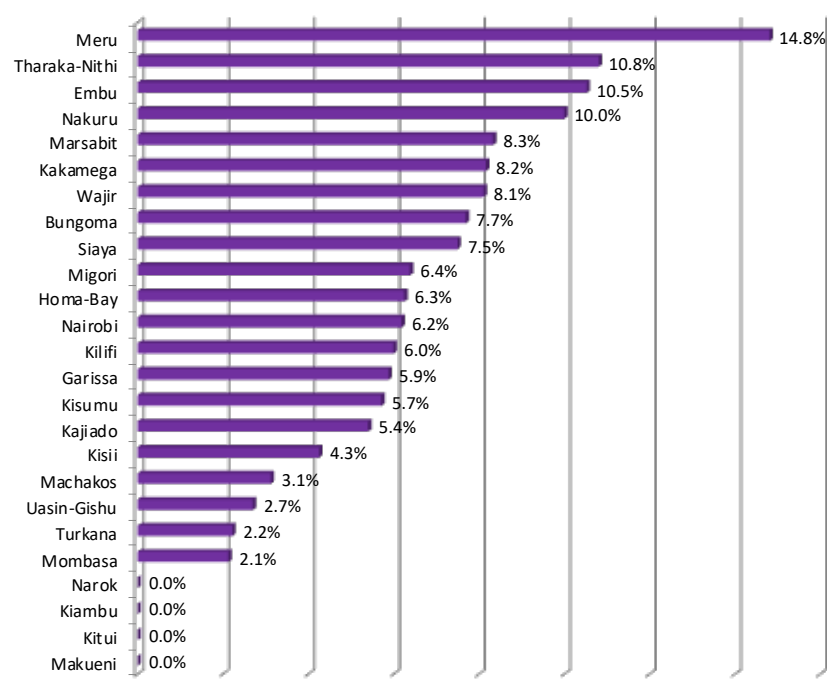


Figure 21: Awareness of Health Care Projects Completed Above Planned Budget

Health staff interviewed provided various reasons for the over expenditure recorded. The reasons ranged from additions in the bill of quantities (24.3%), insufficient budget allocation (10.5%), embezzlement of funds (8.6%), inflation of cost (8.6%) and bribery (6.9%) among other factors as detailed in Table 12.

Table 12: Reasons for Over Expenditure in Health Care Projects

Reasons for Over Expenditure	%
Additions in the bill of quantities	24.3%
Insufficient budget allocation	10.5%
Embezzlement of funds	8.6%
Inflation of cost	8.6%
Bribery	6.9%
New terms and conditions of contract	5.1%
Substandard work	5.1%
Conflict of interest	3.5%
Un-procedural variations	3.5%
Misappropriation of funds	3.5%
None	10.5%
Others	10.0%

The study established that projects completed beyond the contract period were high in Tharaka-Nithi, Homa-Bay, and Embu, and were low in Makueni, Kitui and Turkana counties as illustrated in Figure 22.

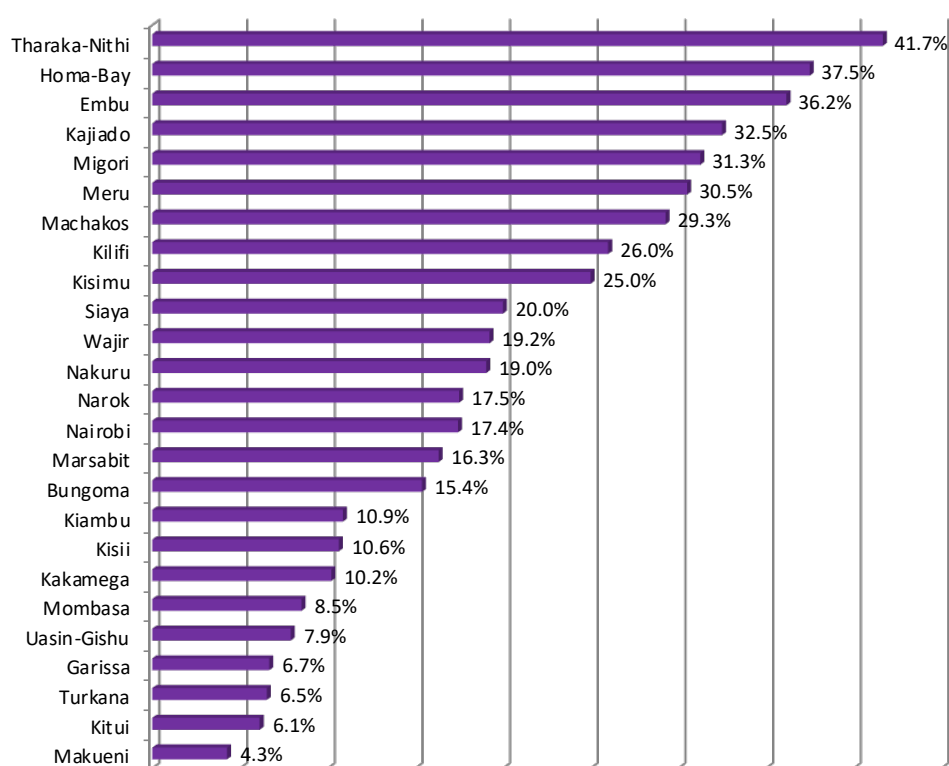


Figure 22: Awareness of Health Care Projects Completed beyond the Contract Period

The study identified factors that contributed to late completion of projects as delayed disbursements of funds (53.4%), Covid-19 Pandemic (14.2%), change of contract terms (10.3%), change of leadership (8.3%) and corruption (6.9%) as presented in Figure 23.

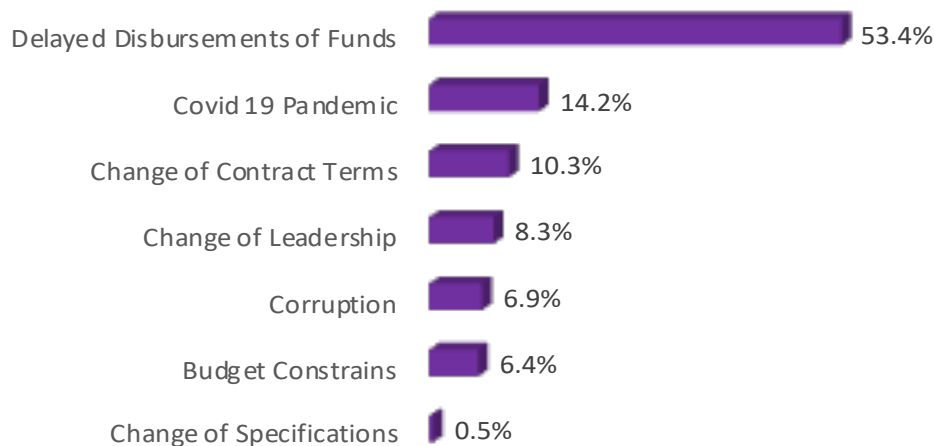


Figure 23: Reasons for Late Completion of Health Care Projects

3.2.4. Accessibility and Publication of Procurement Opportunities in Projects

The study examined whether public procurement opportunities of health care projects were accessible and whether they were publicized to ensure competition. Sixty nine (69.2%) percent of health staff indicated that procurement opportunities were accessible to prospective bidders compared to 30.9 percent who indicated that they were not accessible. Makueni, Kakamega and Nakuru counties had the highest levels of accessibility to procurement opportunities while Wajir, Garissa and Kajiado counties had lowest levels of accessibility as presented in Table 13.

Table 13: Accessibility to Health Care Projects Procurement Opportunities

County	Very Accessible	Accessible	Not Accessible
Makueni	51.1%	44.7%	4.3%
Kakamega	40.8%	53.1%	6.1%
Nakuru	50.0%	42.9%	7.1%
Uasin-Gishu	71.1%	21.1%	7.9%
Kisii	19.1%	63.8%	17.0%
Kisumu	25.0%	52.8%	22.2%
Kitui	10.2%	67.3%	22.4%
Mombasa	29.8%	46.8%	23.4%
Homa-Bay	16.7%	58.3%	25.0%
Machakos	22.0%	51.2%	26.8%
Bungoma	23.1%	50.0%	26.9%
Meru	6.8%	66.1%	27.1%
Nairobi	12.8%	59.6%	27.5%
Siaya	25.0%	42.5%	32.5%
Turkana	30.4%	37.0%	32.6%
Migori	14.6%	50.0%	35.4%
Kilifi	14.0%	50.0%	36.0%
Kiambu	23.9%	39.1%	37.0%
Narok	7.5%	50.0%	42.5%

County	Very Accessible	Accessible	Not Accessible
Embu	12.8%	42.6%	44.7%
Marsabit	2.0%	51.0%	46.9%
Tharaka-Nithi	6.3%	43.8%	50.0%
Kajiado	10.0%	35.0%	55.0%
Garissa	4.4%	40.0%	55.6%
Wajir	3.8%	40.4%	55.8%

The study identified newspaper adverts, health care agency/county website, and notice board at the health care agency/county offices among others, as ways through which procurement opportunities were publicized to notify prospective bidders. In addition, it was established that 6.1 percent of procurement opportunities were not publicized as presented in Table 14.

Table 14: Mode of Publicising Procurement Opportunities in Health Care Projects

Mode of Publication for Health Care Projects Opportunities	%
Newspaper adverts	21.1%
Newspaper adverts/health care agency/county website	13.4%
Newspaper adverts/notice board at the health care agency/county offices/ health care agency/county website	11.2%
Newspaper adverts/notice board at the health care agency/county offices	8.4%
Notice board at the health care agency/county offices	4.6%
Health care agency/county website	3.7%
Newspaper adverts/health care agency/county website/public procurement information portal (PPIP)	2.7%
Newspaper adverts/notice board at the health care agency/county offices/ health care agency/county website/PPIP	2.4%
Notice board at the health care agency/county offices/health care agency/ county website	2.0%
Newspaper Adverts/Public procurement Information Portal (PPIP)	1.8%
Newspaper adverts/health care agency/county website/PPIP	1.4%
Newspaper adverts/notice board at the health care agency/county offices	0.7%
Health care agency/county website/public procurement information portal (PPIP)	0.7%
Newspaper adverts/notice board at the health care agency/county offices/ health care agency/county website/PPIP	0.6%
Newspaper adverts/notice board at the health care agency/county offices/ PPIP	0.6%
Newspaper adverts/notice board at the health care agency/county offices/ health care agency/county website/PPIP	0.5%
Newspaper adverts/health care agency/county website/PPIP	0.3%
Opportunities not publicized	6.1%
Others	7.1%
Do not know	10.8%

Similarly, most contractors learnt of procurement opportunities through newspapers and county/ health agency websites. However, most members of the public learnt of these opportunities through friends (23.6%).

3.2.5. Procurement Methods Applied in Health Care Projects

The study established that open tendering (78.9%), followed by request for quotations (12.2%) and restricted tendering (4.6%) were procurement methods frequently applied as detailed in Figure 24.

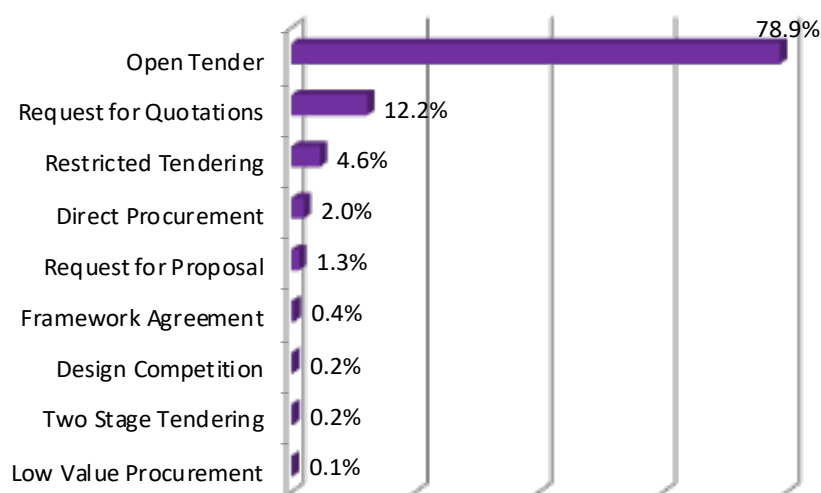


Figure 24: Frequently Applied Procurement Method in Health Care Projects

Open tendering was identified by 91.9 percent of contractors as the common procurement method used in sourcing for contractors. Fairness and transparency (34.7%), competitiveness (22.5%) and adherence to procurement law (19.8%) were the three main reasons identified by health staff for the choice of the respective procurement method as illustrated Figure 25.

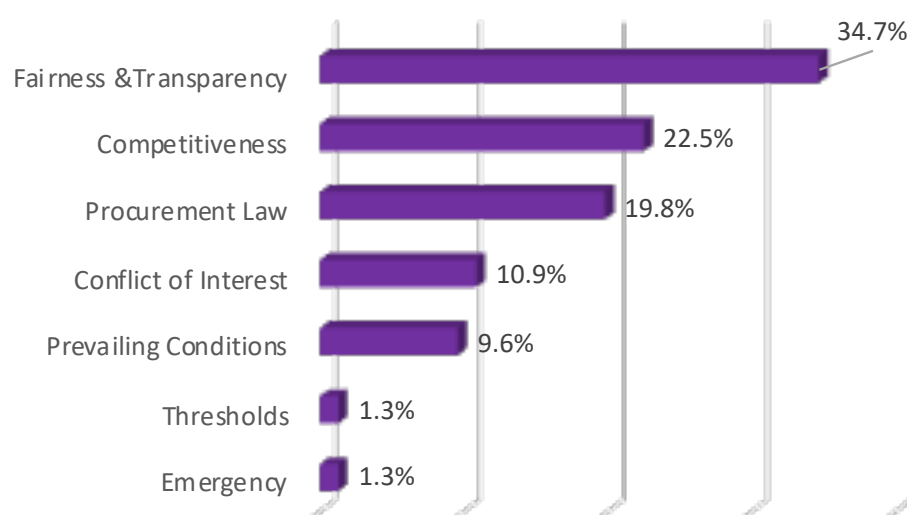
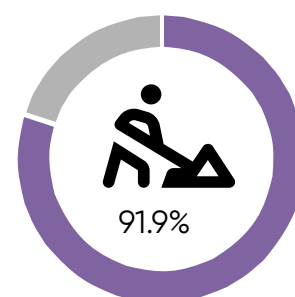
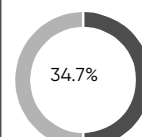


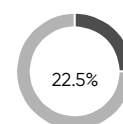
Figure 25: Reasons for Preference of Procurement Methods



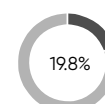
Reasons for using open tendering was to source contractors



Fairness and transparency



Competitiveness



Adherence to procurement law

3.2.6. Fraudulent Variations of Contracts in Health Care Projects

Majority of the health staff (96.1%) indicated that they were not aware of any fraudulent variations in contracts. However, 3.9 percent of the health staff who acknowledged awareness of fraudulent variations identified as payment in excess of BQ amounts (54.5%), non-adherence to BQ (9.1%) and repairs (9.1%) as key ways in which contracts are often varied. This group of respondents as presented in Figure 26 also provided additional ways for fraudulent variations of contracts.

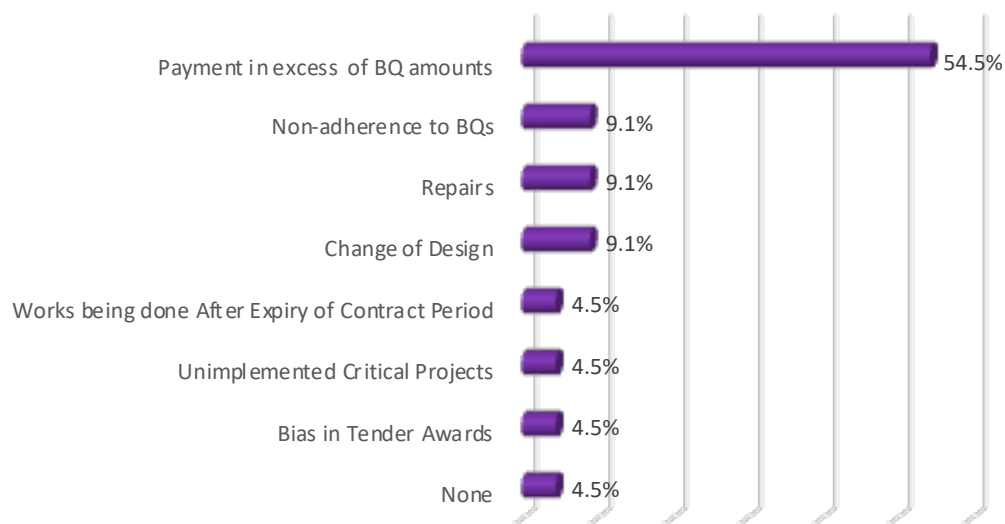


Figure 26: Fraudulent Variations in Tenders

Fourteen percent (13.7%) of the health staff who acknowledged awareness of fraudulent variation, explained that there were cases where such variations had been witnessed in as high as three times in one tender as shown in Figure 27.

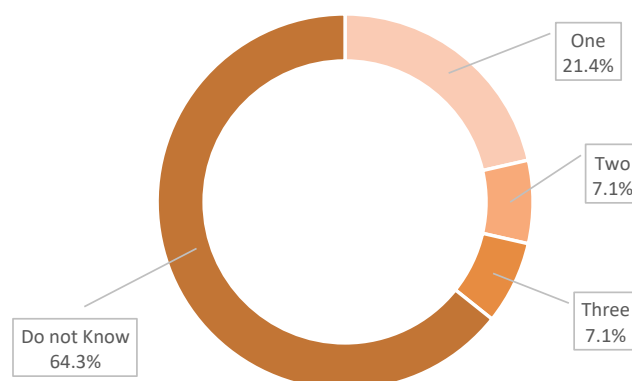


Figure 27: Number of Fraudulent Variations in Tenders

With regard to fraudulent tender variations, Kajiado, Meru and Machakos had the highest levels of awareness on instances of fraudulent variations in tenders as revealed by the respondents. Health staff indicated that they were not aware of instances of fraudulent variations in tenders in Kitui, Makueni, Uasin-Gishu, Nakuru, Narok, Bungoma and Kisii counties as shown in Figure 28.

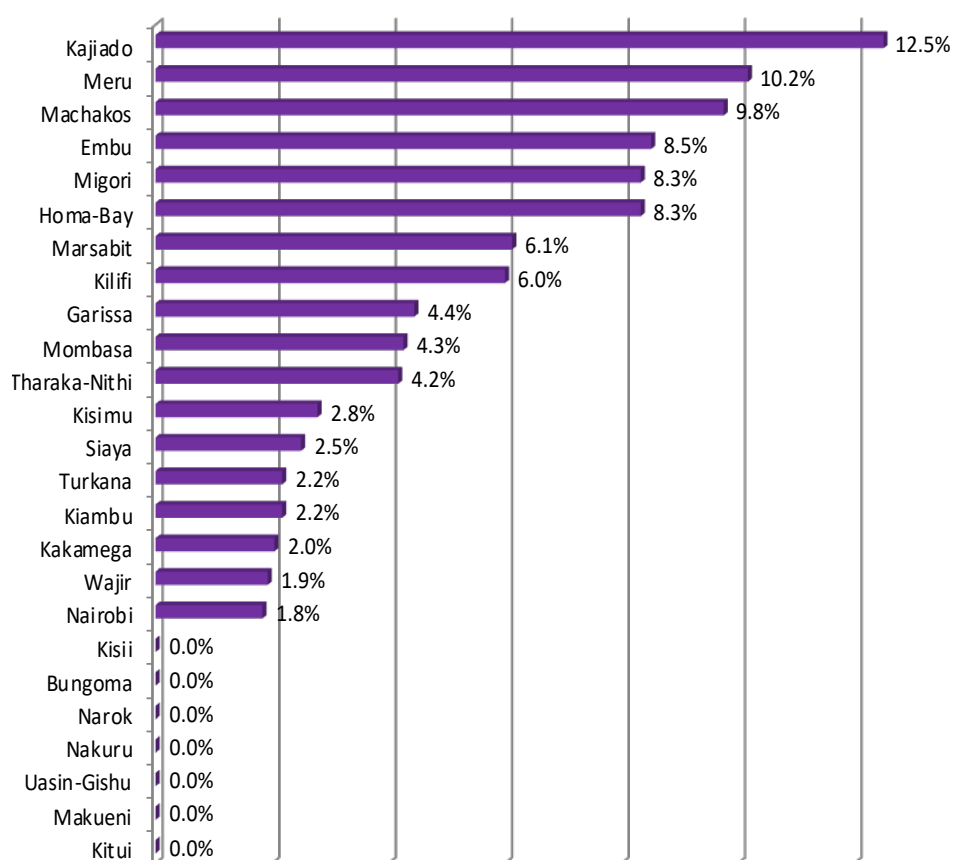


Figure 28: Health Staff Awareness of Fraudulent Variations in Tenders

3.2.7. Undue Influence in Procurement and Ownership of Companies

The study examined instances of undue influence by external actors in procurement processes in health care projects. Thirteen percent (13.3%) of health staff indicated that there were instances of undue influence by external actors in procurement processes. Similarly, 12.9 percent of contractors interviewed, pointed out to cases of undue influence. In addition, 22.5 percent of the members of public acknowledged instances of undue influence. Wajir, Embu and Machakos counties had the highest levels of undue influence in procurement processes while Makueni, Kisii and Narok had the lowest levels as shown in Table 15.

Table 15: Undue Influence in Procurement Processes in Counties

County	Yes	No	Do not Know
Wajir	32.7%	26.9%	40.4%
Embu	29.8%	34.0%	36.2%
Machakos	24.4%	29.3%	46.3%
Kilifi	24.0%	52.0%	24.0%

County	Yes	No	Do not Know
Homa-Bay	22.9%	52.1%	25.0%
Garissa	20.0%	35.6%	44.4%
Nakuru	19.0%	54.8%	26.2%
Migori	18.8%	45.8%	35.4%
Kisumu	16.7%	61.1%	22.2%
Bungoma	15.4%	57.7%	26.9%
Meru	15.3%	37.3%	47.5%
Kakamega	14.3%	57.1%	28.6%
Marsabit	14.3%	38.8%	46.9%
Turkana	13.0%	43.5%	43.5%
Kajiado	12.5%	45.0%	42.5%
Kiambu	10.9%	37.0%	52.2%
Siaya	7.5%	50.0%	42.5%
Tharaka-Nithi	6.3%	31.3%	62.5%
Nairobi	5.5%	60.6%	33.9%
Mombasa	4.3%	72.3%	23.4%
Kitui	4.1%	67.3%	28.6%
Uasin-Gishu	2.6%	84.2%	13.2%
Narok	2.5%	40.0%	57.5%
Kisii	2.1%	80.9%	17.0%
Makueni	0.0%	89.4%	10.6%

The health staff indicated that procurement processes were mostly influenced by governors (30.9%), followed by MCAs (25.5%) and MPs (12.1%) as presented in Figure 29.

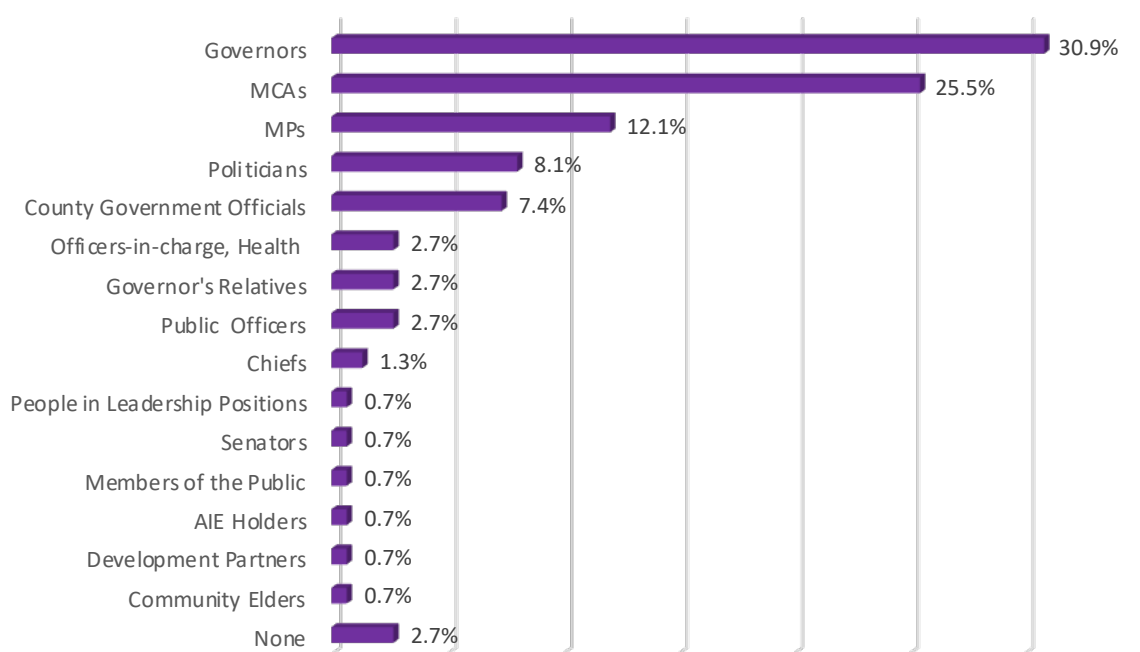


Figure 29: Persons Influencing Procurement Processes

Further, contractors indicated that county governments officers and politicians influenced procurement processes the most. Likewise, members of the public identified politicians (84.2%), public officers (7.5%) and contractors (5.8%) as key persons influencing procurement processes. Half of the members of public (49.7%) indicated that award of contracts were not fair and transparent. In addition, they identified instances of favouritism (49.0%), bribery (9.2%), political influence (8.4%), corrupt leaders (8.0%), lack of public participation (4.4%), collusion (4.0%) and conflict of interest (1.6%) as key reasons for their response. Figure 30 presents the nature of influence by external actors on procurement processes.

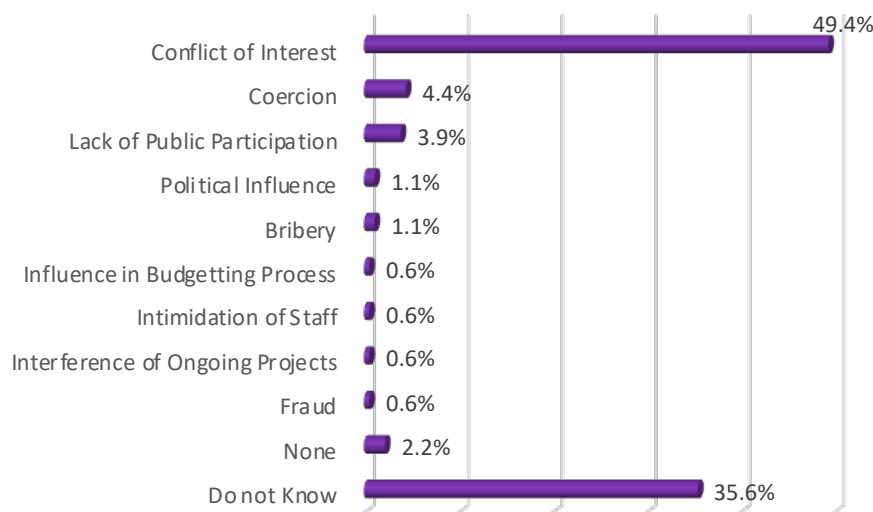


Figure 30: Nature of Influence by External Actors on Procurement Processes

Contractors pointed out that external actors influenced procurement processes by leaking information, favouring specific contractors, terminating and re-advertising of tenders. When asked to indicate whether they had ever sought for a clarification on a tender they had participated, 27.4 percent stated that they had. Contractors who indicated that they were satisfied with clarifications stated that queries were clarified (23.1%), processes were clear (23.1%) and processes were fair (15.4%) among other reasons. However, those who were dissatisfied reported that they had lost the bid (50.0%), there were inconsistencies in tender numbers (25.0%) and that tendering processes were unfair (25.0%).

The study sought to establish whether companies seeking to participate in procurement of health care projects were owned by public officers; either directly or indirectly. Eight percent (8.4%) of health staff indicated that public officers owned companies that participated in procurement of health care projects. Twelve percent (12.0%) indicated that public officers owned companies through proxies as presented in Figure 31.

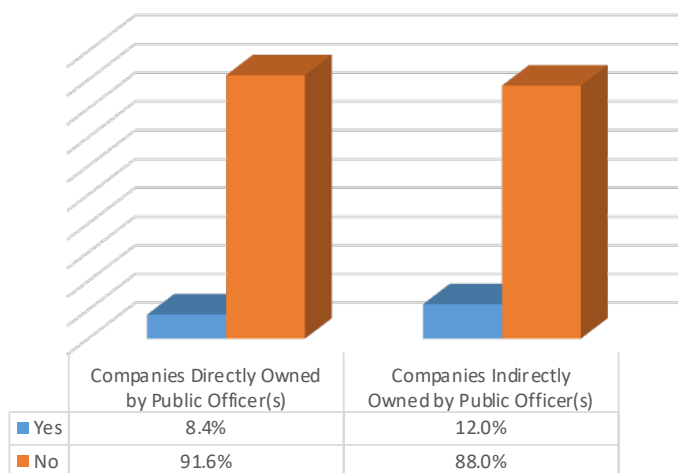


Figure 31: Companies Owned by Public Officers

Eighteen percent (17.8%) of contractors indicated that they were aware of companies owned by public officers that were undertaking health care projects. The cadre of public officers that mostly owned companies that sought procurement opportunities in health care projects were, as indicated by health staff, MCAs (10.8%), COs (10.8%) and CECMs health (9.8%). In addition, governors (20.5%), MCAs (11.2%) and county government officials (10.5%) were other public officers mostly associated with companies seeking procurement opportunities as detailed in Table 16. Moreover, contractors stated that county (50.0%) and national (16.7%) government officers owned companies that participated in health care projects.

Table 16: Public Officers Ownership of Companies Seeking Procurement Opportunities

Public Officer's Ownership of Companies Seeking Procurement Opportunities	%	Public Officer's Association with Companies Seeking Procurement Opportunities	%
MCAs	10.8%	Governors	20.5%
Chief officers	10.8%	MCAs	11.2%
CECMs health	9.8%	County government officials	10.5%
County government officials	8.9%	CECMs health	5.9%
Governors	8.9%	MPs	5.9%
Accounting officers	3.9%	Health workers	4.6%
Administrators at hospital	3.9%	Procurement officers	4.0%
Health workers	3.9%	Politicians	3.3%
Politicians	3.0%	Accounting officers	3.2%
MPs	3.0%	Chief officers	1.9%
Procurement officers	3.0%	Medical superintendents	1.9%
Doctors	2.9%	Deputy governors	1.3%
Medical superintendents	1.9%	Governor's relatives	1.3%
County pharmacists	1.9%	Nurses	0.6%
Laboratory managers	1.0%	Cabinet secretaries	0.6%
County secretaries	1.0%	Clerical officers	0.6%
CS/CECMs health	1.0%	Doctors	0.6%
Nurses	1.0%	CS/CECMs health	0.6%
Principal secretaries	1.0%	Principal secretaries	0.6%

Public Officer's Ownership of Companies Seeking Procurement Opportunities	%	Public Officer's Association with Companies Seeking Procurement Opportunities	%
Engineers	1.0%	Engineers	0.6%
Other public officers	1.9%	Other public officers	0.6%
Do not know	15.7%	Do not know	19.2%

The study sought to establish how conflict of interest was addressed in procurement processes. Health staff observed that public officers did not disclose their interest. Therefore, their companies participated in tenders and were even awarded (31.4%). There were instances where public officers disclosed their interest in certain tenders but their companies were nonetheless awarded (4.6%) as presented in Table 17.

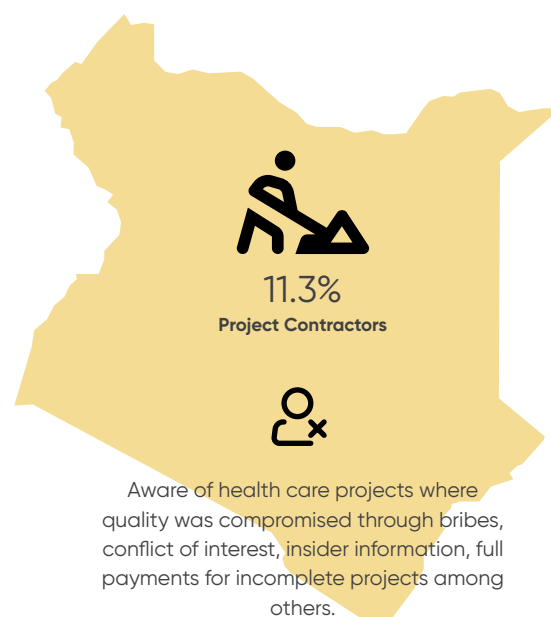
Table 17: Resolution of Conflict of Interest

How Conflict of Interest Was Addressed	%
A public officer did not disclose an interest in a tender yet the company was awarded	31.4%
A public officer disclosed an interest but the company was nonetheless awarded	4.6%
A public officer did not disclose an interest and the company was not awarded	2.8%
A public officer disclosed an interest and the company participated the tender but was not awarded	1.8%
A public officer did not disclose an interest and the company was disqualified on that basis	0.9%
Disciplinary action was instituted against a public officer	0.7%
Legal proceedings were instituted against a public officer	0.3%
No action was taken	4.5%
Do not know what happened	53.0%

Eleven percent (11.3%) of contractors were aware of health care projects where quality was compromised through impropriety. The impropriety took the manner of offering bribes, conflict of interest, insider information, full payments for incomplete projects among others. Most contractors (77.4%) stated that there were mechanisms to ensure delivery of quality goods, works and services contrary to 22.6 percent who observed that there were no mechanisms. Contractors also pointed out various malpractices in procurement process as illustrated in Table 18.

Table 18: Malpractices in Procurement Processes

Malpractices	Always	Sometimes	Never	Do not know
Bid rigging	16.1%	19.4%	12.9%	51.6%
Disqualification of a qualified bidder	16.1%	25.8%	12.9%	45.2%
Skewed specifications	21.0%	21.0%	14.5%	43.5%
Collusion	9.7%	24.2%	21.0%	45.2%
Bribery of staff	24.2%	25.8%	24.2%	25.8%
Bribery of judicial officers	1.6%	12.9%	21.0%	64.5%
Delay of projects and variations	4.8%	14.5%	41.9%	38.7%
Termination of procurement proceedings	3.2%	27.4%	27.4%	41.9%



3.2.8. Termination of Health Care Projects Before Completion

The study sought to establish whether there were health care projects which had been terminated before completion. Sixteen percent (16.4%) of health staff were aware of projects that had been terminated before completion. About 46.0 percent of the same respondents identified one to three projects which had been terminated before completion while 10.0 percent identified more than three projects that had been terminated as shown Figure 32. In addition, 8.1 percent of contractors indicated that projects that were being undertaken by their firms were terminated before completion.

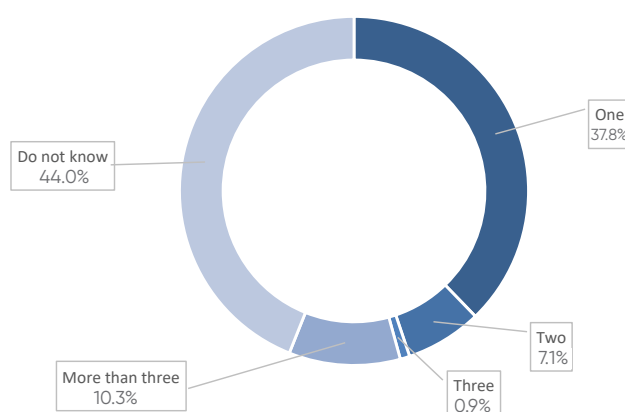


Figure 32: Number of Health Care Projects Terminated Before Completion

Embu, Kitui and Meru counties had the highest levels of health care projects terminated before completion as indicated by respondents. On the other hand, Kisii, Marsabit and Mombasa counties had the lowest levels of projects terminated before completion as shown in Figure 33.

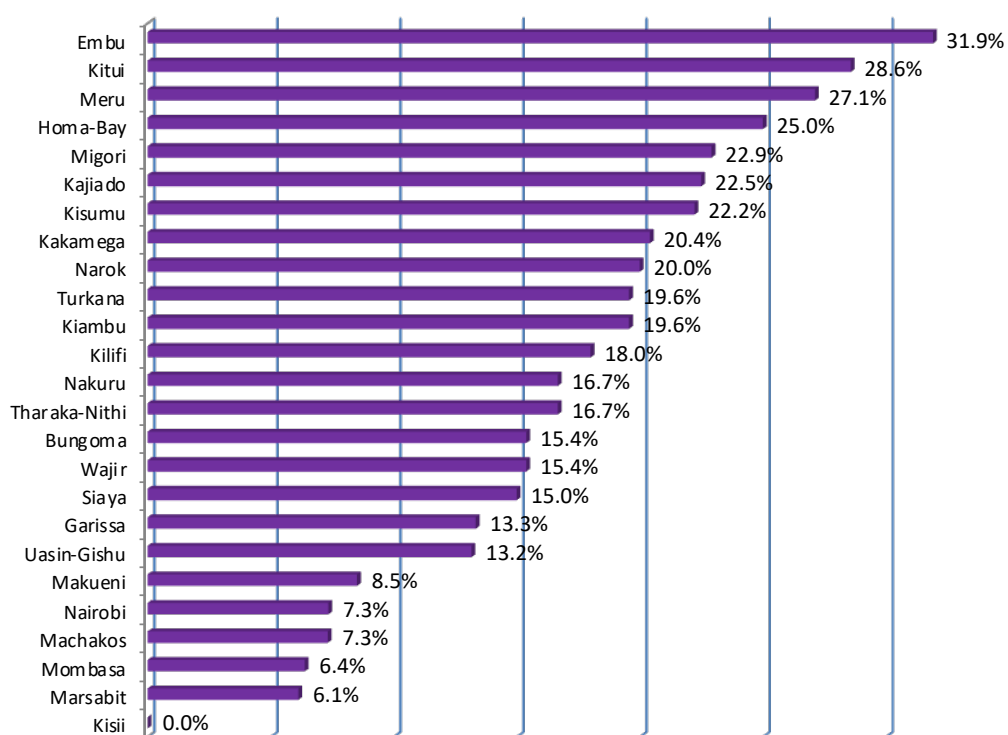


Figure 33: Levels of Health Care Projects Termination before Completion

Further, Kajiado (35.7%), Nakuru (30.0%), Kiambu (25.0%) and Bungoma (25.0%) counties had the most number of respondents reporting more than three projects that were terminated before completion. Detailed findings are presented in Table 19.

Table 19: Number of Health Care Projects Terminated before Completion

County	One	Two	Three	More Than Three	Do not Know
Kajiado	7.1%	21.4%	0.0%	35.7%	35.7%
Nakuru	40.0%	0.0%	0.0%	30.0%	30.0%
Kiambu	50.0%	0.0%	0.0%	25.0%	25.0%
Bungoma	75.0%	0.0%	0.0%	25.0%	0.0%
Kilifi	38.5%	7.7%	0.0%	23.1%	30.8%
Narok	23.1%	15.4%	0.0%	23.1%	38.5%
Siaya	33.3%	11.1%	0.0%	22.2%	33.3%
Embu	29.6%	7.4%	0.0%	18.5%	44.4%
Homa-Bay	66.7%	0.0%	8.3%	16.7%	8.3%
Garissa	16.7%	5.6%	0.0%	11.1%	66.7%
Tharaka-Nithi	17.4%	8.7%	0.0%	8.7%	65.2%
Turkana	53.8%	7.7%	0.0%	7.7%	30.8%
Kakamega	53.8%	7.7%	7.7%	7.7%	23.1%
Kitui	70.6%	5.9%	0.0%	5.9%	17.6%
Meru	57.1%	9.5%	0.0%	4.8%	28.6%
Mombasa	60.0%	0.0%	0.0%	0.0%	40.0%
Wajir	30.4%	4.3%	0.0%	0.0%	65.2%
Marsabit	22.2%	11.1%	0.0%	0.0%	66.7%
Machakos	14.3%	7.1%	0.0%	0.0%	78.6%
Makueni	50.0%	0.0%	0.0%	0.0%	50.0%
Uasin-Gishu	80.0%	20.0%	0.0%	0.0%	0.0%

County	One	Two	Three	More Than Three	Do not Know
Kisumu	63.6%	9.1%	0.0%	0.0%	27.3%
Migori	44.4%	0.0%	5.6%	0.0%	50.0%
Kisii	0.0%	0.0%	0.0%	0.0%	100.0%
Nairobi	22.2%	7.4%	0.0%	0.0%	70.4%

Health staff who had knowledge of termination of projects before completion, identified lack of capacity by contractors (16.5%), contractors abandoning the project (16.5%) and insufficient funds (16.0%) as key reasons for project termination as summarized in Table 20. On the other hand, contractors pointed out falsification of regulatory certificates, lack of financial capacity and budgetary constraints in the MoH as reasons for project termination.

Table 20: Reasons for Termination of Projects before Completion

Reasons for Termination	%
Lack of capacity by contractors	16.5%
Contractors abandoning the project	16.5%
Insufficient funds	16.0%
Change in Leadership	13.2%
Failure to meet projects timelines	8.0%
Political influence	7.4%
Contract variations	4.3%
Embezzlement of project funds	4.3%
Legal proceedings	3.1%
Abandonment by national and county governments	2.7%
Lack of prioritization	2.7%
Irregular procurement	1.0%
Others	4.3%

The study looked into whether oversight institutions were notified by procuring entities on termination of projects. It was established that PPRA (3.9%) and contractors (3.7%) were among institutions notified as shown in Figure 34.

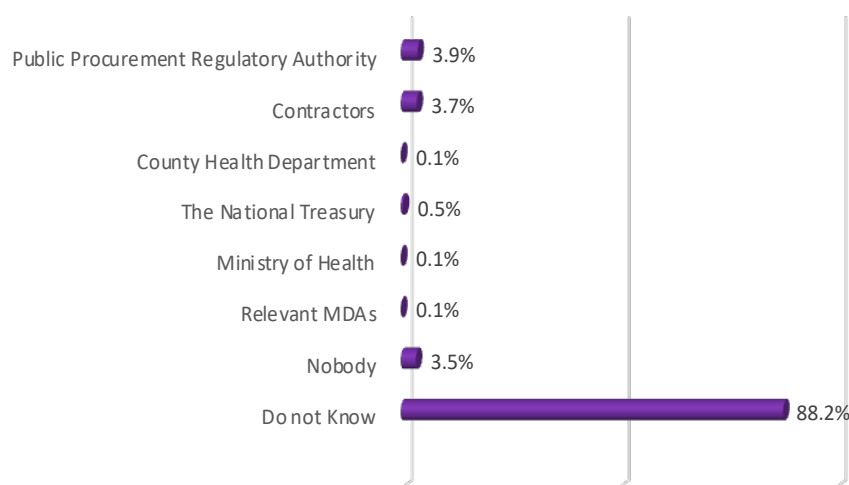


Figure 34: Institutions Notified of Project Termination

3.2.9. Delay, Overpayment and Payment for Incomplete Projects

The study inquired into whether there were cases of delay, overpayment and payment for incomplete projects. Sixty-five percent (64.6%) of health staff acknowledged that there were instances of delayed payments to contractors. In addition, 80.7 percent of contractors indicated that payments were delayed while 19.4 percent stated that payments were made on time. Further, 95.3 percent of health staff observed that there were one or more instances where payments were delayed. Detailed information on instances of delayed payments is summarized in Figure 35.

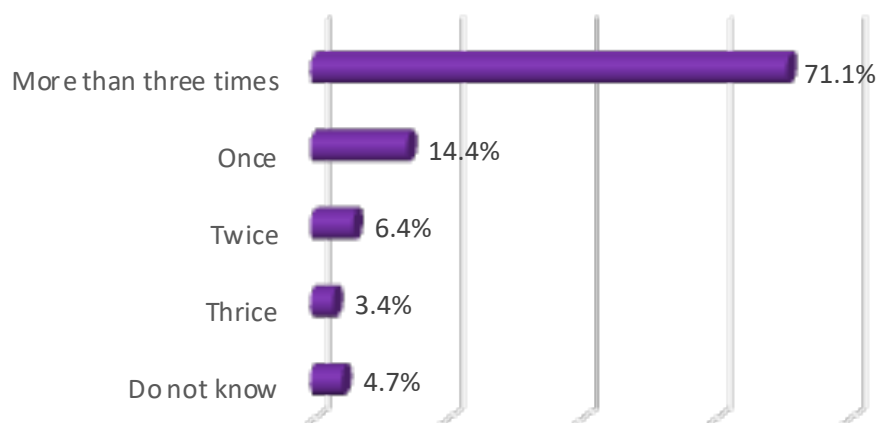


Figure 35: Instances of Delayed Payments to Contractors

Awareness of delayed payments among health staff in counties was high in Homa-Bay, Embu and Meru and low in Kiambu, Mombasa and Makueni as shown Figure 36.

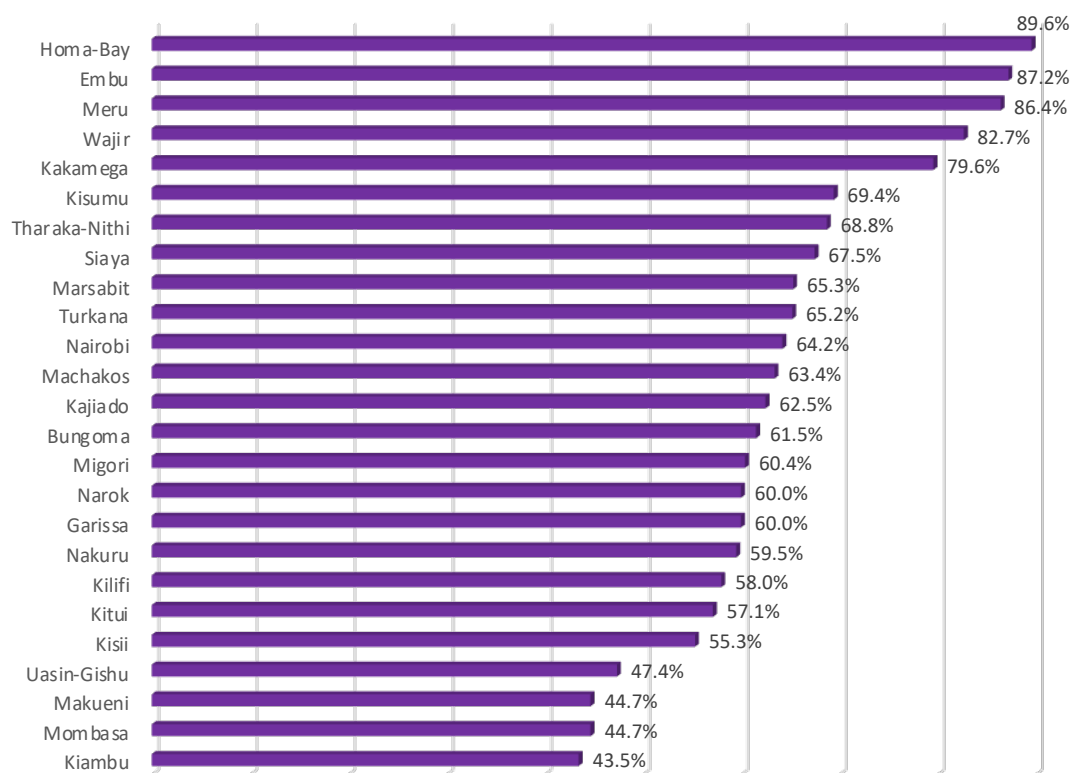


Figure 36: Awareness on Instances of Delayed Payments to Contractors

The main causes of delays in payment as cited by health staff were untimely release of funds from the national treasury (43.3%), inadequate budget allocation (27.6%), corruption (4.8%) and diversion of funds (3.2%) among others as detailed in Figure 37.

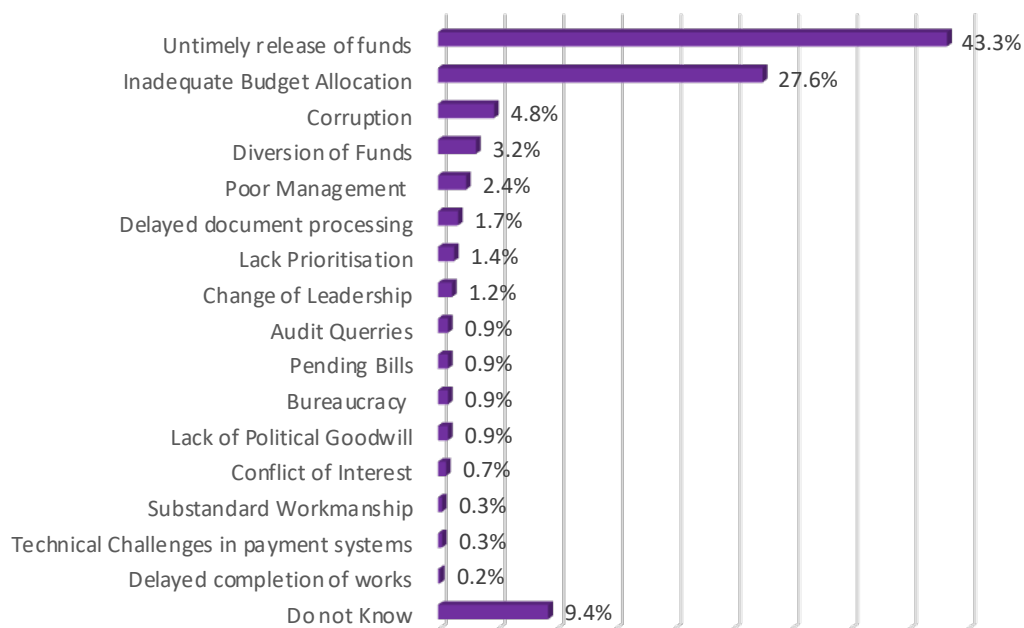


Figure 37: Causes of Delayed Payments

According to contractors, the main causes of delayed payments included untimely disbursement of funds from the National Treasury (51.7%), delays at the Controller of Budget (17.2%), technical challenges of online payment systems (13.8%), bribery demands (6.9%), misappropriation of funds (3.4%), payments in instalments (3.4%) and change in leadership at counties (3.4%).

Five percent (4.7%) of health staff acknowledged awareness of overpayment while 4.8 percent indicated instances of payments for incomplete projects as shown in Figure 38.

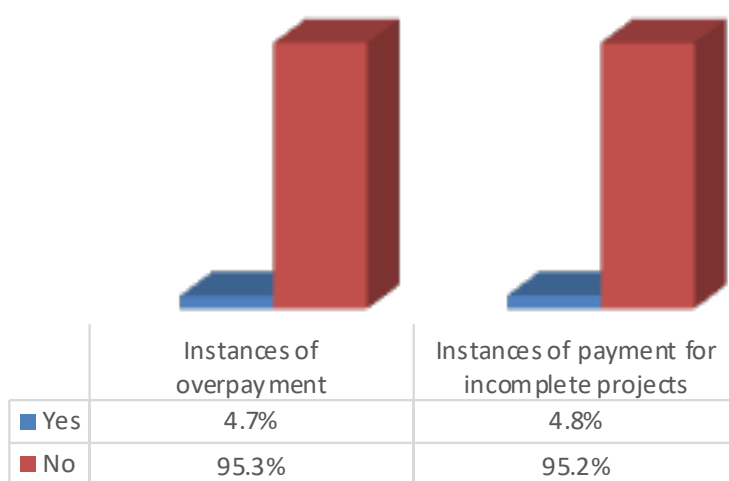


Figure 38: Instances of Irregular Payments

The highest amount of overpayment for a project was over KES 20 Million. Twenty nine percent (28.6%) of health staff stated that no action was taken by the relevant procuring entity to remedy the overpayment as depicted in Figure 39.

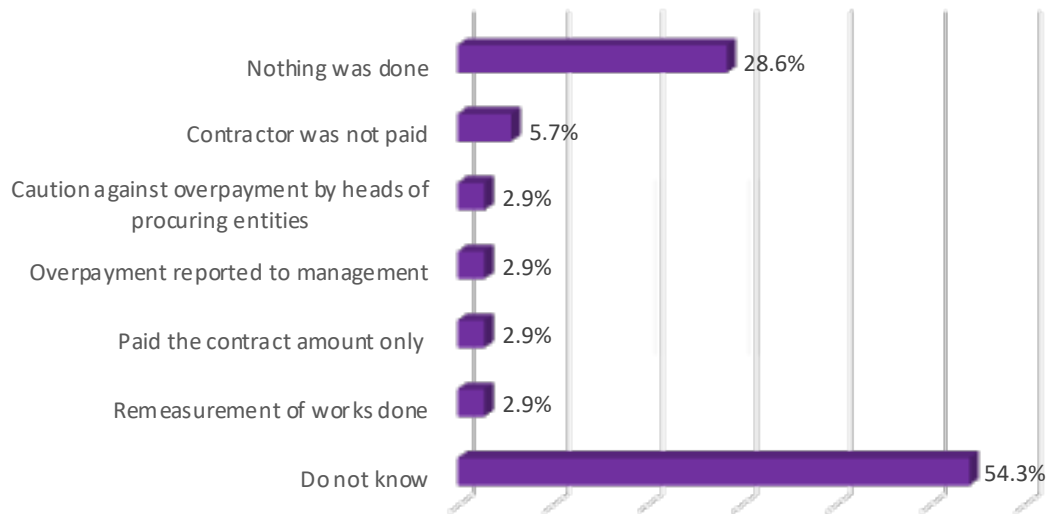


Figure 39: Actions Taken on Overpayment

Homa-Bay, Wajir and Migori counties had the highest cases of payment for incomplete projects as indicated by the respondents while Kitui, Kiambu, Turkana, Kajiado, Bungoma and Siaya had the least as shown in Figure 40.

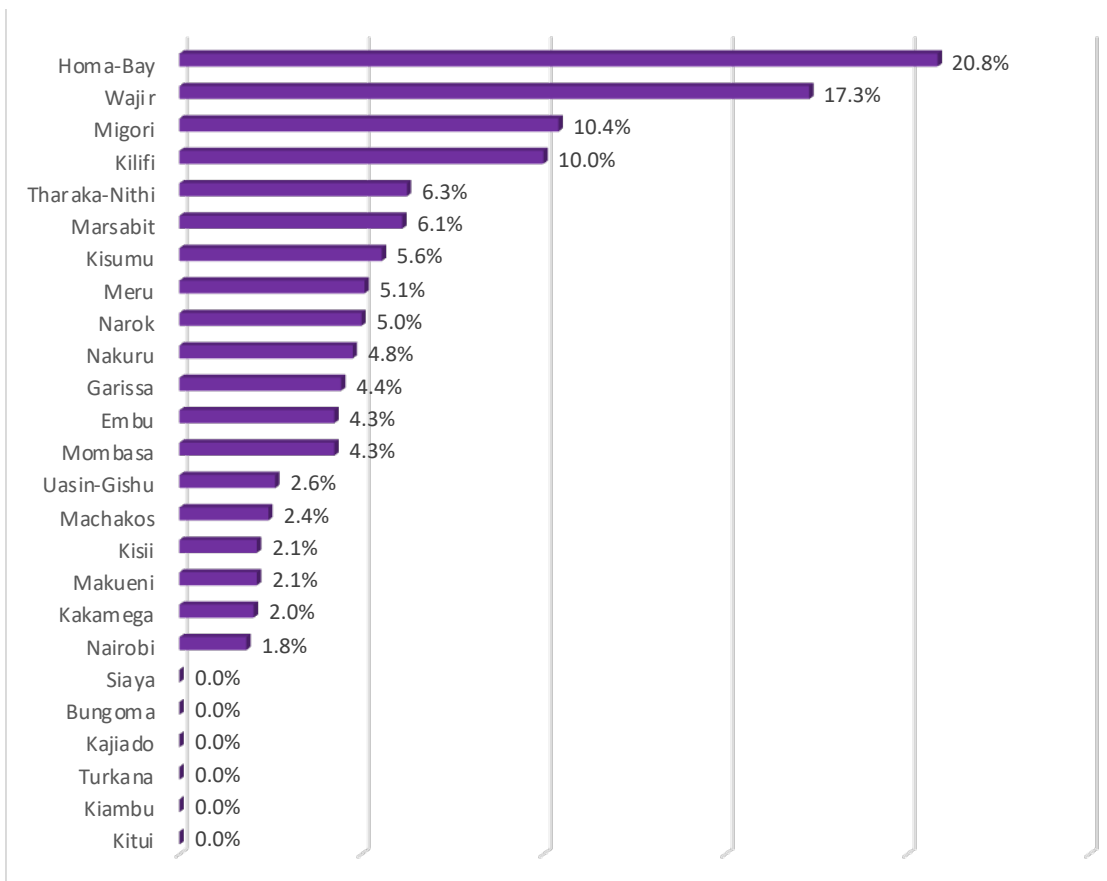


Figure 40: Awareness on Instances of Payments for Incomplete Projects

Majority of health staff (97.6%) did not know how the issues of payment for incomplete projects were addressed as detailed in Figure 41.

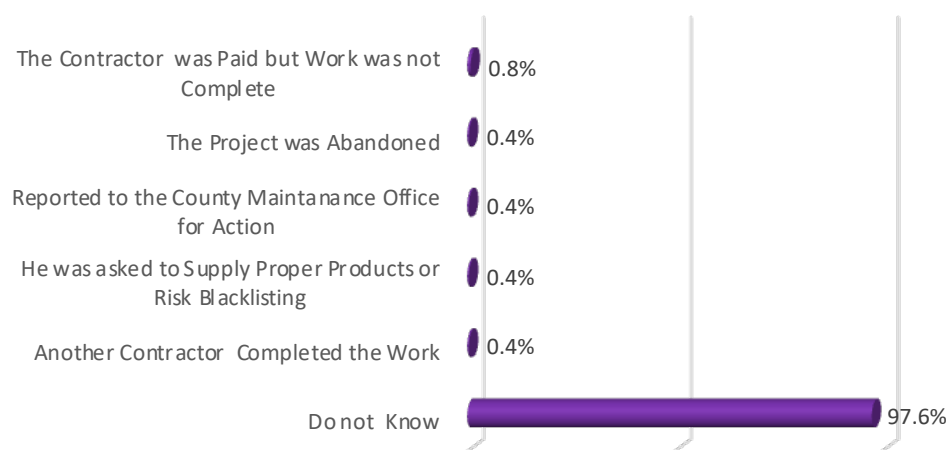


Figure 41: Actions Taken on Payments for Incomplete Projects

Prevalence of payment malpractices identified by contractors are as summarized in Table 21.

Table 21: Malpractices in Payments

Malpractices	Always	Sometimes	Never	Do not Know
Use of fake receipts as accounting documents	3.2%	17.7%	29.0%	50.0%
Payment for goods and services not offered	4.8%	16.1%	35.5%	43.5%
Full payment for faulty/poor quality works, goods and services	3.2%	29.0%	29.0%	38.7%
Money for official use deposited in staff personal accounts	3.2%	6.5%	27.4%	62.9%

3.2.10. Effectiveness of Information Management System

The study assessed whether health facilities were making use of Information Management Systems (IMSs) in procurement and financial management of health care projects. In addition, it sought to establish the effectiveness of the systems in enhancing transparency in procurement and payment of projects. Health staff (61.6%) observed that the IMSs were being used while 38.4 percent stated that they were not in use.

Those who indicated that IMSs were in use, listed Integrated Financial Management Information System (75.8%), Fun Soft (2.8%), JUMO Soft (0.1%) and Care Soft (0.1%) as some of the systems that were in use in procurement and financial management as shown Figure 42.

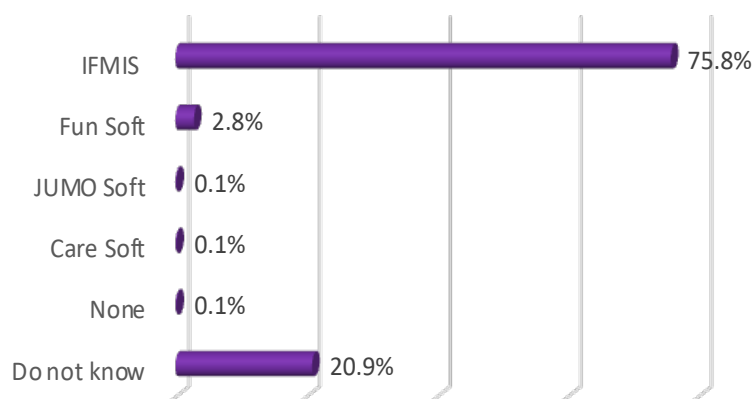


Figure 42: Information Management Systems in Use

The usage of IMSs was high in Nakuru, Uasin-Gishu and Bungoma counties as indicated by the respondents while it was low in Kisumu, Narok and Garissa as indicated in Figure 43.

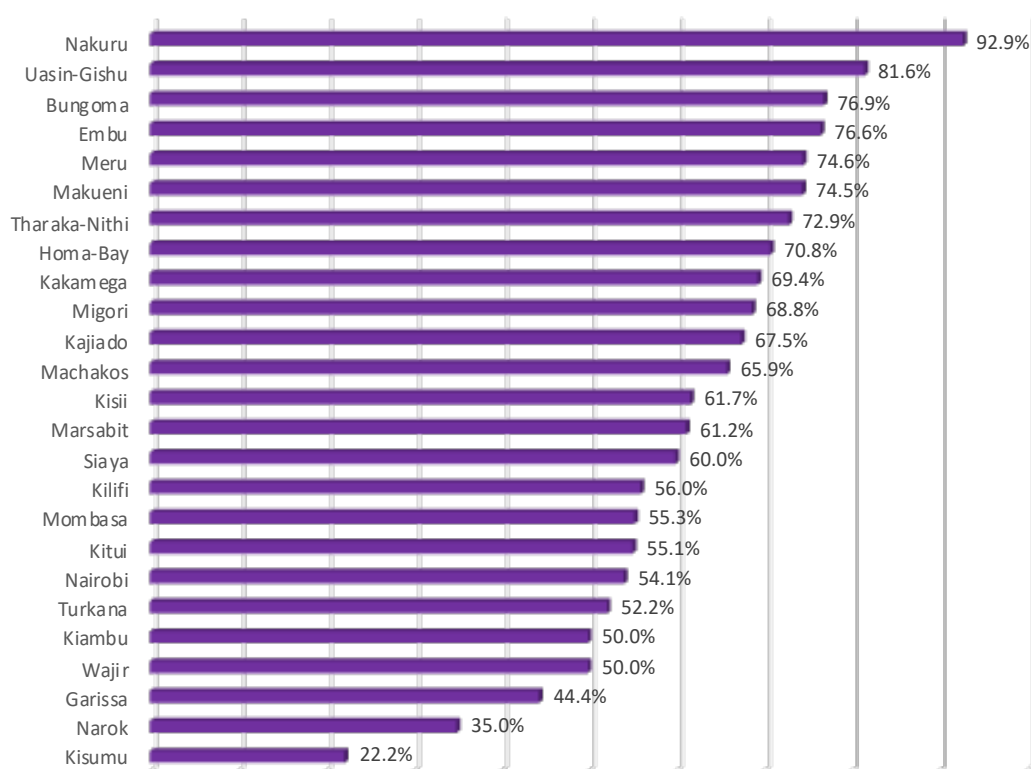


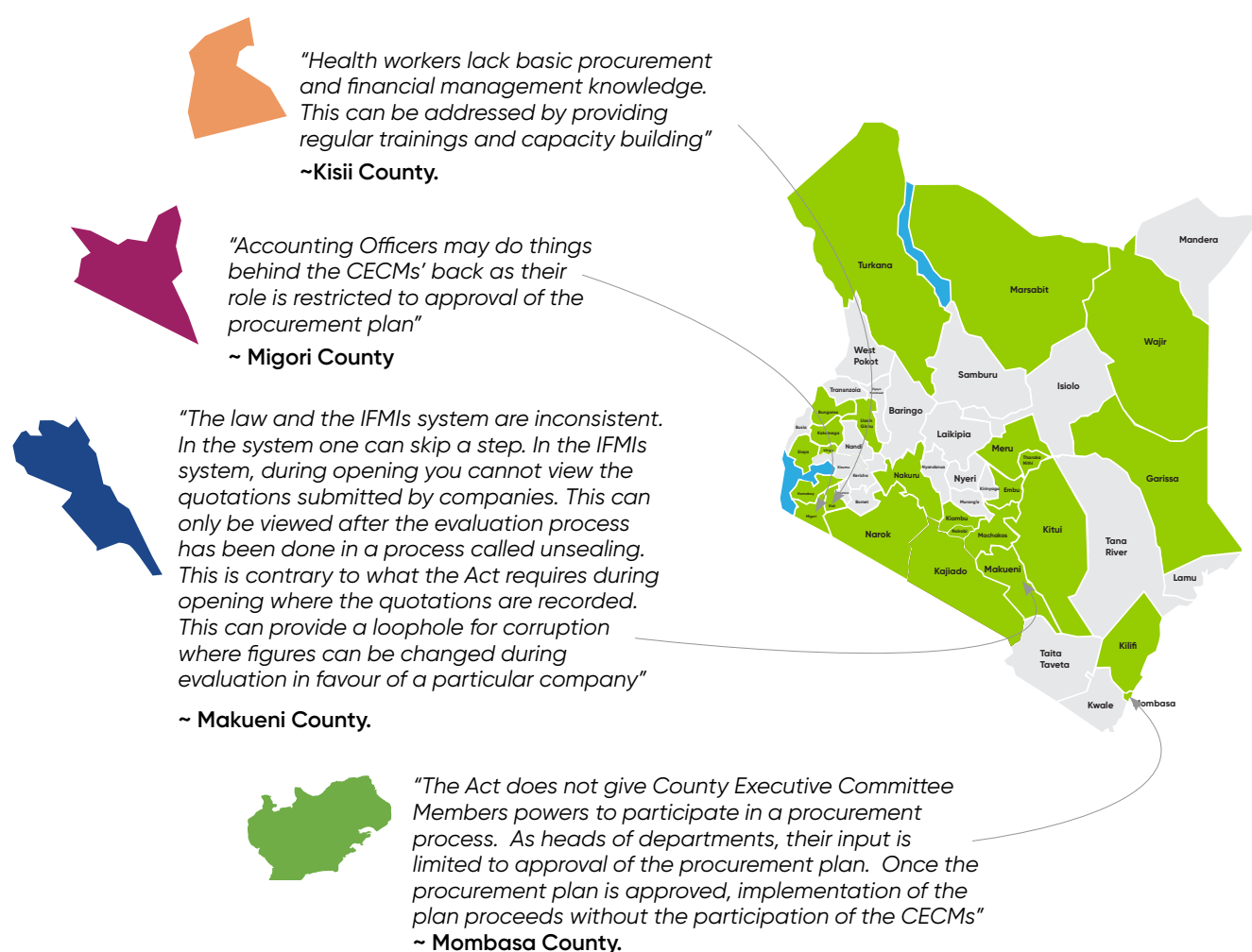
Figure 43: Use of Information Management Systems

Sixty-eight percent (68.3%) of health staff stated that the IMSs were effective while 12.9 percent stated they were not. The health staff, who indicated that the systems were effective, provided a number of reasons, which included ability to enhance information sharing (21.0%), ability to track tendering processes (19.6%) and ability to safeguard information (19.3%) among others as summarized in Table 22. The table also illustrates reasons given for ineffectiveness of IMSs.

Table 22: Effectiveness of Information Management Systems

Reasons for Effectiveness and Ineffectiveness of IMSs			
Reasons for Effectiveness		Reasons for Ineffectiveness	
	%		%
Able to share information	21.0%	Easy manipulation of information	58.9%
Able to track tendering processes	19.6%	Bureaucracy	7.8%
Safeguard information	19.3%	System inefficiency and failure	4.0%
Enhanced efficiency	6.0%	Delays in approvals	3.0%
Information accuracy	4.3%	Usage errors	1.9%
Real time feedback	3.6%	Prone to cyber crime	1.9%
Enhances accountability	3.0%	Inadequate user capacity	1.9%
Convenient to use	2.6%	Requires regular updates	1.0%
Promotes fairness	1.9%	Needs for infrastructural improvement	1.0%
Limits human interactions	1.7%	Limitation in information processing	1.0%
Ease of information management	1.3%	Internet downtime	1.0%
None	0.4%	None	1.0%
Do not know	15.3%	Do not know	15.7%

Key informants identified different challenges in the implementation of Public Procurement Assets and Disposal Act (PPADA), 2015 and the IFMIs System are as highlighted herein:



3.3. ASSESSMENT OF SELECT HEALTH CARE PROJECTS

3.3.1. Status of the Select Projects

The study assessed the implementation status of randomly selected health care projects in different counties as well as national health facilities. As part of the assessment, relevant project files were reviewed to obtain data related to procurement and financial aspects. In addition, site visits conducted to ascertain the existence and corroborate information extracted from the relevant files. The assessment covered projects initiated in the period 2013 to 2021.

These projects included new constructions (46.4%), installation of medical equipment (17.9%), expansion of health facilities (14.3%), refurbishment of health facilities (12.5%) and others (8.9%) as summarized in Figure 44.

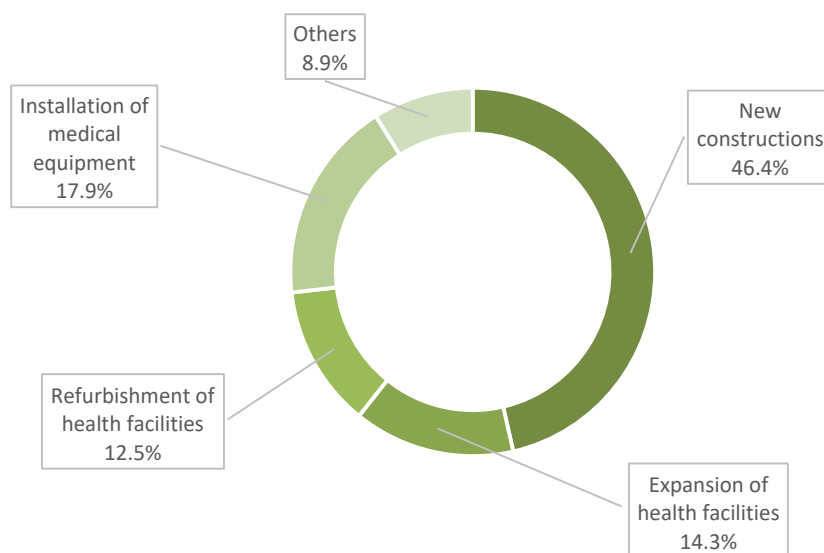


Figure 44: Types of Health Care Projects Assessed

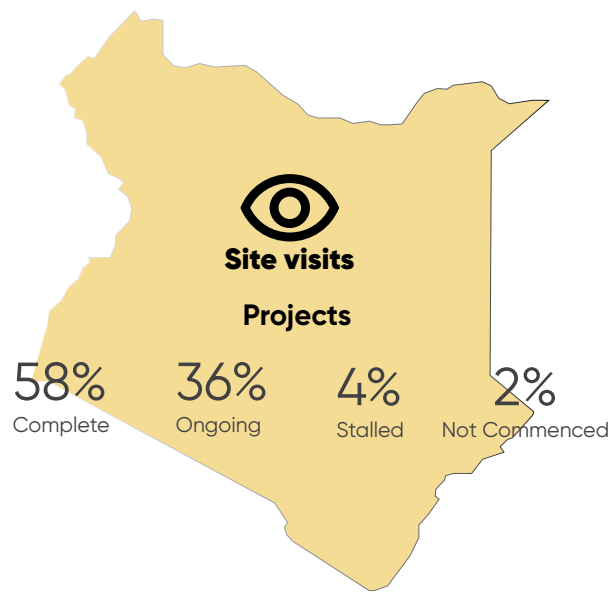
Sixty-four percent (64.3%) of the projects were funded by county governments, 16.1 percent by national government, 14.3 percent by development partners and 5.4 percent by others such as religious organizations.

Thirty-six percent (35.7%) were level 4 hospitals, 28.6 percent level 5 hospitals, 12.5 percent level 2 hospitals, 10.7 percent level 3 hospitals, 8.9 percent level 6 hospitals and 3.6 percent level 1 hospitals.

At the time of the site visits, 58.0 percent of the projects were complete, 36.0 percent were ongoing, 4.0 percent had stalled while 2.0 percent had not commenced.

The assessment established that implementation period for certain projects were inordinately long. In some cases, the tender sum of the winning bidder, the budgeted amount and the engineer's estimate were the same. Additionally, there were instances of completed projects, which were not in operation. In most of the projects record keeping was poor where some critical documents

were missing in the project files. The assessment revealed that some contractors acquired bidding documents but did not submit them indicating possibility of collusion.



The study established instances where bidders who failed in preliminary and/or technical evaluation proceeded to the financial evaluation stage and were awarded the contract. In addition, in 10.7 percent of the projects assessed, the tender sum of the winning bidder and the contract sum were different. The study further established instances of irregular application of restricted tendering. In particular, requirements relating to restricted tendering set out in the procurement law and regulations were not adhered to. During the study, it was noted that funds allocated for dealing with the Covid-19 pandemic were misappropriated.

Figure 46 presents findings on the status of project files with regard to availability of project documents. Over 92 percent had evaluation report among other compliance issues, 83.9 percent had contract documents and 78.6 had bill of quantities.

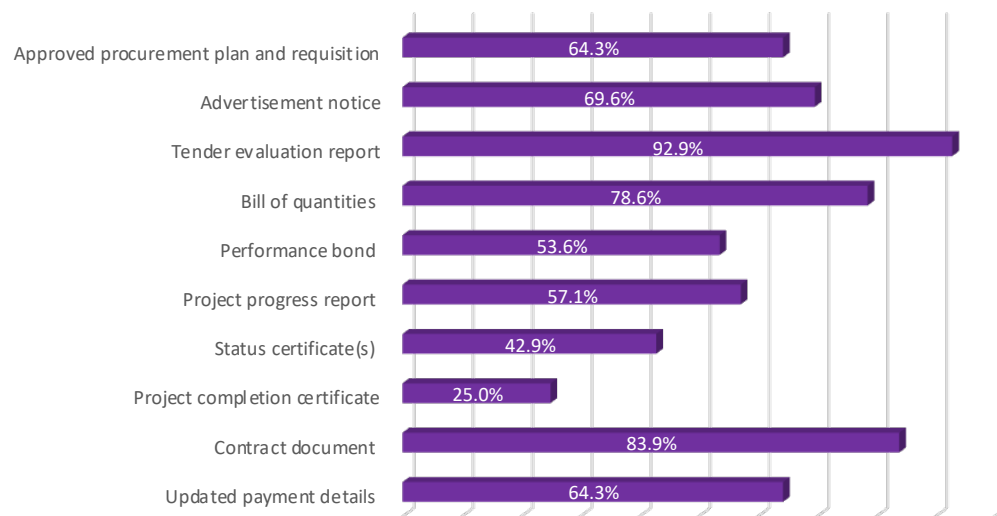


Figure 45: Availability of Procurement and Financial Management Related Documents in Project Files

3.3.2. Highlights of Select Projects

Most of the projects assessed were beneficial to communities because they met their needs, addressed emergencies, reduced congestion at hospitals, enhanced efficiency and solved health awareness among others. However, the level of public participation and involvement in the selection of projects was rated as low (42.0%) during the site visit in response to awareness. Key issues observed during the site visits and data extraction are presented in Figure 46 to 56.

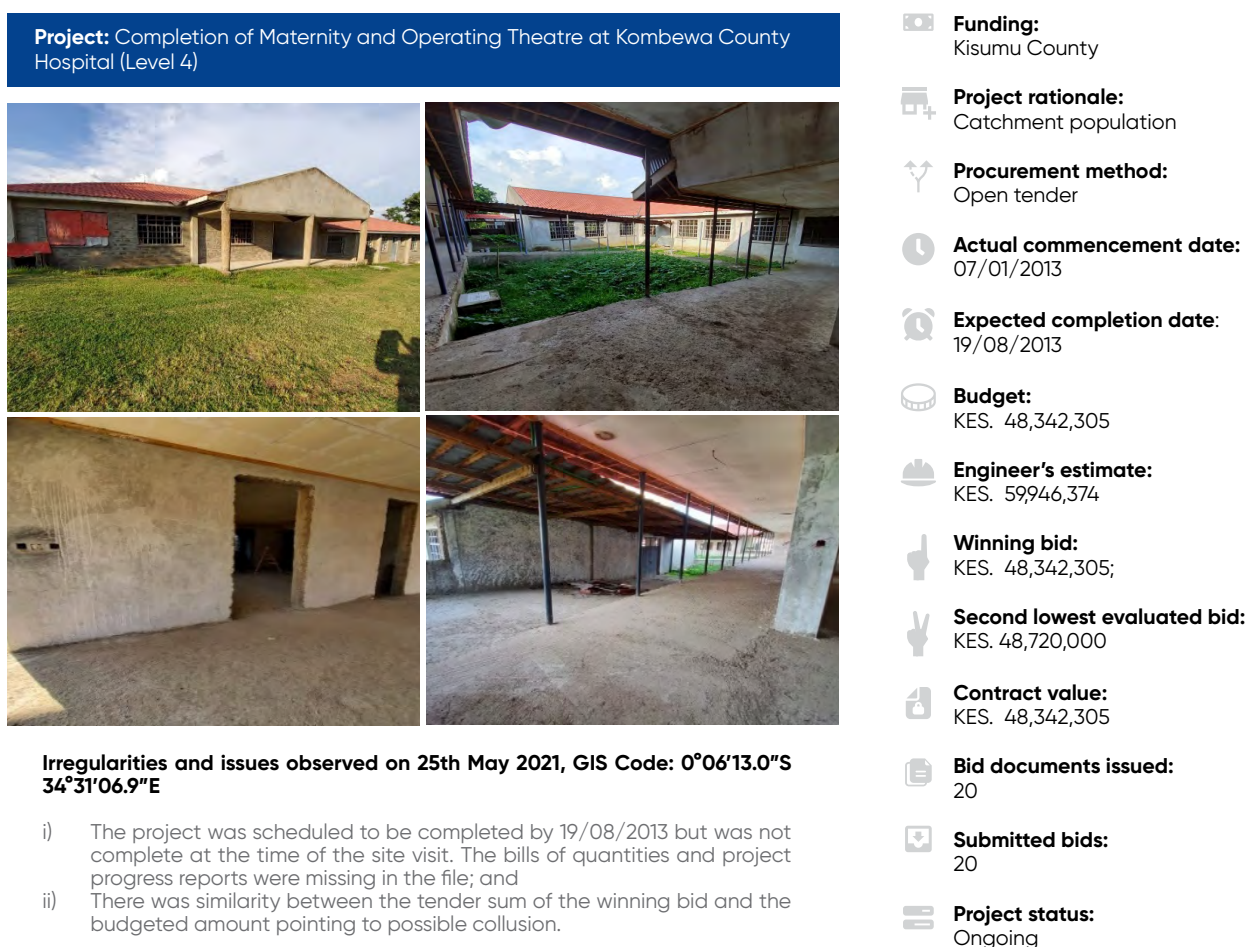


Figure 46: Construction of Maternity and Operating Theatre at Kombewa County Hospital, Kisumu County Hospital (Level 4)

Project: Construction of 45 Bed Maternity Ward and Twin Operation Theatre at Rabai Ward, Mariakani



Issues observed on 27th May 2021, GIS Code: 3°56'43.4"S 39°33'31.9"E:

- i) Approved procurement plan, requisition, advertisement notice, evaluation report, performance bond, and project progress report were missing in the project file;
- ii) One year after the project was completed it had not been put to use by the procuring entity.

	Funding: Kilifi County
	Project rationale: Distance
	Procurement method: Open tender
	Actual commencement date: 30/06/2015
	Actual completion date: 24/05/2020
	Budget: KES. 48,342,305
	Engineer's estimate: KES. 59,946,374
	Winning bid: KES. 63,178,011.50
	Contract value: KES. 63,178,011.50
	Bid documents issued: 25
	Submitted bids: 8
	Project status: Complete

Figure 47: Construction of 45 Bed Maternity Ward and Twin Operation Theatre at Rabai Ward, Mariakani

Project: Construction of Perimeter Wall Phase II at Kisii Teaching and Referral Hospital



Irregularities and issues observed on 30th May 2021, GIS Code: 8QHC+PJ Kisii

- The budget, engineer's estimates and tender sum of the winning bid were the same pointing to possible collusion; and
- Approved procurement plan, requisition and performance bond were missing in the project file.















	Funding: Kisii County
	Project rationale: Security
	Procurement method: Open tender
	Actual commencement date: 24/02/2019
	Expected completion date: 20/08/2019
	Budget: KES. 29,177,000
	Engineer's estimate: KES. 29,177,000
	Winning bid: KES. 29,177,000
	Second lowest evaluated bid: KES. 18,991,730
	Contract value: KES. 29,177,000
	Fully paid at KES. 29,177,000
	Bid documents issued: 3
	Submitted bids: 3
	Project status: Complete

Figure 48: Construction of Perimeter Wall Phase II at Kisii Teaching and Referral Hospital

Project: Construction of the Proposed Kakamega Teaching and Referral Hospital (Level 5)



Issues observed on 31st May 2021, GIS Code: 0°16'20"N 34°45'46"E

- i) Approved requisition, budget, evaluation report, bills of quantities, project progress reports, engineer's estimate and updated payment details were missing in the project file; and
- ii) The project completion period had expired but the project was yet to be completed.

Figure 49: Construction of the Proposed Kakamega Teaching and Referral Hospital (Level 5)

	Funding: Kakamega County
	Project rationale: Increased demand for health care services
	Procurement method: Open tender
	Actual commencement date: 25/09/2016
	Expected completion date: 16/05/2021
	Budget: KES. 48,342,305
	Winning bid: KES. 6,126,817,414.15
	Contract value: KES. 6,126,817,414.15
	Bid documents issued: 1
	Submitted bids: 1 re-advertised and only the same bidder bought and won
	Project status: Stalled
	Amount paid: KES. 2,229,811,466

Project: Supply, Delivery, Installation, Commissioning and Testing of an Incinerator at TB Manyatta, Wajir



Issues observed on 8th June 2021, GIS Code: 1°44'14.8"N 40°03'16.2"E

- i) The contract was not awarded to the lowest bidder;
- ii) Approved requisition, budget, engineer's estimate, contract document, progress report and contract completion certificate were missing in the project file; and
- iii) The project is complete but not in use;













	Funding: Wajir County
	Procurement method: Open tender
	Actual commencement date: 15/11/2019
	Actual completion date: Could not be determined
	Budget: Not in file
	Engineer's estimate: Not in file
	Winning Bid: KES. 14,234,910
	Second lowest evaluated bid: KES. 13,719,500
	Bid documents issued: 7
	Submitted bids: 7
	Project status: Complete but not in use
	Paid Amount: KES. 14,234,910

Figure 50: Supply, Delivery, Installation, Commissioning and Testing of an Incinerator at TB Manyatta, Wajir

Project: Construction of Maternity Unit at Modogashe Hospital Garissa County



Irregularities and issues observed on 4th June 2021, GIS Code: 0°43'52.1"N 39°10'31.2"E

- i) The budget and the tender sum of the winning bidder were the same pointing to possible collusion;
- ii) Approved requisition, budget, engineer's estimates, advertisement notice and project progress report were missing in the project file; and
- iii) Delayed payments despite project completion.

	Funding: Garissa County
	Project rationale: Needs based
	Procurement method: Open tender
	Actual commencement date: 26/6/2015
	Actual completion date: 26/10/2016
	Budget: KES. 24,560,076
	Engineer's estimate: Not available in the file
	Winning Bid: KES. 24,560,076
	Second lowest evaluated bid: KES. 22,887,301
	Contract value: KES. 24,560,076.8
	Bid opening date: 26/05/2015
	Site mobilization date: 10/04/2015
	Bid documents issued: Not in file
	Submitted bids: Not in file
	Project status: Complete

Figure 51: Construction of Maternity Unit at Modogashe Hospital Garissa County

Project: Supply, Delivery, Installation and Commissioning of Computed Tomography CT Scan Machine at Kitui County Referral Hospital (KCRH)



Irregularities observed on 10th June 2021, GIS Code: 1°16'50.0"S 37°54'56.0"E

The budget, the tender sum of the winning bidder and engineer's estimate were all the same pointing to possible collusion.
















	Funding: Kisumu County
	Procurement method: Open tender
	Actual commencement date: 28/01/2018
	Actual completion date: 30/08/2018
	Budget: KES. 80,000,000
	Engineer's estimate: KES. 80,000,000
	Winning Bid: KES. 80,000,000
	Second lowest evaluated bid: KES. 110,220,000
	Bid opening date: 10/03/2018
	Contract signed date: 23/03/2018
	Site mobilization date: 23/03/2018
	Bid documents issued: 5
	Submitted bids: 5
	Project status: Complete
	Actual amount paid: KES. 80,000,000 dated 10/05/2019

Figure 52: Supply, Delivery, Installation and Commissioning of Computed Tomography CT Scan Machine at Kitui County Referral Hospital (KCRH)

Project: Proposed Construction of Outpatient Department (ODP) at Eldas, Wajir County



Irregularities and issues Observed on 9th June 2021, GIS Code: 2°29'22.2"N 39°34'01.5"E











- i) During the site visit evidence of poor workmanship was noted in the project;
- ii) The approved requisition and budget were not available in the project file; and
- iii) The project was not in use despite being complete.

	Funding: Wajir County
	Procurement method: Open tender
	Actual commencement date: Could not be determined
	Actual completion date: 30/9/2019
	Budget: Not in the file
	Engineer's estimate: KES. 15,196,986
	Winning Bid: KES. 15,162,336
	Second lowest evaluated bid: KES. 17,393,400
	Contract value: KES. 15,196,986
	Bid opening date: 7/12/2018
	Site mobilization date: 22/01/2019
	Bid documents issued: Not in file
	Submitted bids: 3
	Project status: Complete
	Actual amount paid: KES. 15,196,986 dated 12/11/2020

Figure 53: Proposed Construction of Outpatient Department (ODP) at Eldas, Wajir County

Project: Proposed Completion of Kosawo Dispensary Phase II, Kisumu County



	Funding: Kisumu County
	Project rationale: Needs based
	Procurement method: Restricted tendering
	Budget: Not available in the file
	Engineer's estimate: KES 20,315,190
	Winning bid: 19,922,750
	Contract value: KES. 48,342,305
	Bid documents issued: 11
	Submitted bids: 3
	Project status: Not yet started

Issues observed on 27th May 2021, GIS Code: 0°05'21.0"S 34°46'53.4"E

- Approved requisition, budget, advertisement notice and performance bond not in the project file; and
- There was no evidence of justification to use restricted tendering.

Figure 54: Proposed Completion of Kosawo Dispensary Phase II, Kisumu County

Project: Proposed Construction of Tulu Magunga Dispensary in Migori County



	Funding: Migori County
	Procurement method: Open tender
	Actual commencement date: 5/06/2020
	Actual completion date: 23/03/2021
	Budget: KES. 4,500,000
	Engineer's estimate: KES. 4,500,000
	Winning Bid: KES. 4,220,000
	Contract value: KES. 4,220,000
	Bid documents issued: 1
	Submitted bids: 1
	Project status: Complete
	Actual amount paid: KES. 4,220,000 dated 31/05/2021

Issues observed on 5th June 2021, GIS Code: 0°58'00.4"S 34°09'50.8"E

- Performance bond was missing in the project file; and
- The project status was indicated as complete, however, the toilets shows incomplete and poor workmanship

Figure 55: Proposed Construction of Tulu Magunga Dispensary in Migori County

Project: Proposed Female Ward at Kauwi Sub-County in Kitui County



	Funding: Kitui County
	Procurement method: Request for quotation
	Actual commencement date: 10/04/2016
	Actual completion date: 10/06/2021
	Budget: KES. 4,000,000
	Engineer's estimate: KES. 4,000,000
	Winning bid: KES. 3,977,564.6
	Second lowest evaluated bid: KES 4,173,152.2
	Contract value: KES. 3,977,564.6
	Bid documents issued: 4
	Submitted bids: 4
	Project status: Complete

Issues observed on 9th June 2021, GIS Code: 1°16'50.0"S 37°54'56.0"E

- i) Certificate of project completion, updated payment details, the approved requisition, budget, the advertisement notice, performance bond, project progress reports and the contract were missing in the project file; and
- ii) The project was complete but not in use.

Figure 56: Proposed Female Ward at Kauwi Sub-County in Kitui County

Some Statistics

500

Members of the public sampled



1280

No. of Staff from County Health and Finance Departments sampled

56

Key informants sampled

150

No. of Contractors sampled



3.4. ANTI-CORRUPTION MEASURES IN PROCUREMENT AND FINANCIAL MANAGEMENT

Anti-corruption interventions are initiatives taken by institutions to prevent and mitigate the negative impact of corruption and unethical conduct. The study assessed whether counties and national health facilities had integrated anti-corruption measures and their effectiveness in health care projects.

3.4.1. Anti-Corruption Measures

Thirty four percent (33.6%) of health staff acknowledged existence of anti-corruption measures to ensure the integrity of contractors, 49.9 percent were not aware while 16.5 percent indicated none. Forty two percent (42.2%) of health staff stated that anti-corruption measures to monitor implementation of health care projects were in place, 14.3 percent indicated that there were none while 43.5 percent pointed out that they were not aware as shown in Figure 57.

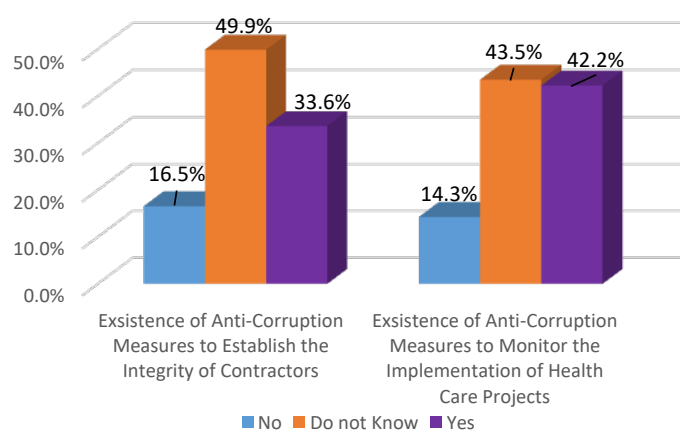


Figure 57: Anti-Corruption Measures in the Health Sector

Some of the anti-corruption measures identified in monitoring and evaluation of health care projects included: inspection of projects by monitoring and evaluation officers (34.0%), auditing and inspection by engineers (15.7%), appointment of project management committees (12.6%) among others as presented in Table 23.

Table 23: Anti-Corruption Measures in Health Care Projects

Monitoring Measures	%
M&E officers monitor projects from start to end	34.0%
Auditing and inspection by engineers	15.7%
Appointment of project management committee	12.6%
Integrity assurance officers and anti-corruption reporting boxes	9.5%
Requirement for compliance certificates (KRA, EACC, CR12, and performance bond)	7.7%
Sensitizations and provision of clear guidelines on tendering processes	3.9%
Pre-qualification and registration of bidders	2.6%
Segregation of duties	2.5%
Guidance on corruption reporting channels	1.8%

Monitoring Measures	%
Debarment of contractors	1.5%
Due diligence	1.5%
Use of Information Management Systems	1.3%
Others	5.4%

Thirty nine percent (39.0%) of the health staff noted that counties and national health facilities sought authorization from Controller of Budget before payment to contractors for projects undertaken, 6.5% did not seek authorization while 54.5 percent were not aware. Makueni, Bungoma and Migori Counties had the highest awareness of authorization requests to the Controller of Budget before payment to contractors, while Tharaka-Nithi, Kisumu and Garissa Counties had the least awareness as presented in Table 24.

Table 24: Authority to Pay Contractors

County	Yes	No	Do not know
Makueni	59.6%	6.4%	34.0%
Bungoma	57.7%	0.0%	42.3%
Migori	56.3%	2.1%	41.7%
Nakuru	54.8%	0.0%	45.2%
Kakamega	53.1%	6.1%	40.8%
Meru	49.2%	6.8%	44.1%
Mombasa	46.8%	8.5%	44.7%
Kilifi	46.0%	18.0%	36.0%
Kisii	44.7%	0.0%	55.3%
Kiambu	43.5%	8.7%	47.8%
Kitui	42.9%	0.0%	57.1%
Siaya	40.0%	5.0%	55.0%
Marsabit	38.8%	0.0%	61.2%
Nairobi	36.7%	12.8%	50.5%
Homa-Bay	35.4%	6.3%	58.3%
Machakos	34.1%	0.0%	65.9%
Wajir	32.7%	7.7%	59.6%
Embu	31.9%	6.4%	61.7%
Turkana	30.4%	8.7%	60.9%
Uasin-Gishu	28.9%	23.7%	47.4%
Narok	25.0%	0.0%	75.0%
Kajiado	25.0%	2.5%	72.5%
Garissa	22.2%	6.7%	71.1%
Kisumu	19.4%	11.1%	69.4%
Tharaka-Nithi	16.7%	6.3%	77.1%

3.4.2. Effectiveness of Anti-Corruption Measures

Forty one percent (41.2%) of the health staff indicated effectiveness of anti-corruption measures while 4.5 percent disagreed. Forty three percent (42.9%) did not know whether the measures were effective or not. Table 25 highlights proposals to enhance anti-corruption measures in projects.

Table 25: Proposals to Enhance Anti-Corruption Measures

Suggestions to Improve Anti-Corruption Measures for Health Care Projects	%
Frequent monitoring and evaluation of projects	23.7%
Appointment of project management committees	19.5%
Building capacity of staff	13.3%
Ensure adherence to regulatory frameworks	10.5%
Experts representation in committees	5.5%
Enhance public participation and awareness	5.0%
Use of IMs	3.8%
Appoint officers with integrity in evaluation teams	3.1%
Delegation of roles	2.2%
Information sharing of debarred contractors	2.1%
Adequate Allocation of resources	2.1%
Avail corruption reporting channels	2.1%
Undertake due diligence of contractors	2.2%
Timely payment of contractors	1.6%
Others	3.3%

3.5. CHALLENGES IN IMPLEMENTATION OF HEALTH CARE PROJECTS

Key challenges highlighted in implementation of health care projects included financial constraints (27.8%), delay in approval of finances (14.7%), corruption (8.8%), understaffing (8.7%) and political interference (6.0%) as presented in Figure 58.

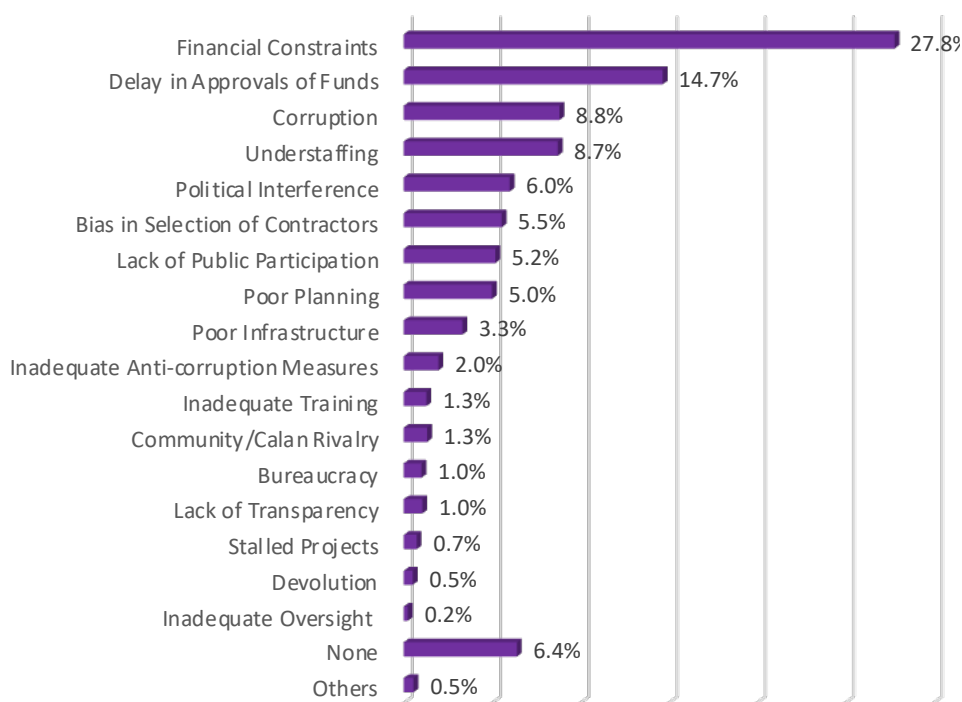


Figure 58: Challenges in Implementation of Health Care Project

In addition, experts' opinion on some of the key challenges in the health sector included inadequate human resource, inadequate funding, insufficient drugs and delay in funds disbursement from the National Treasury as highlighted:



"The medical specialists like oncologists are inadequate, we need at least 4, but we have none"

~ Kisii County.



"There are few health workers especially Nurses and Doctors. Oncologist are very few. Funds are inadequate making health care provision expensive, since it takes 30% of our budget. There is need for more funding."

~ Makueni County.

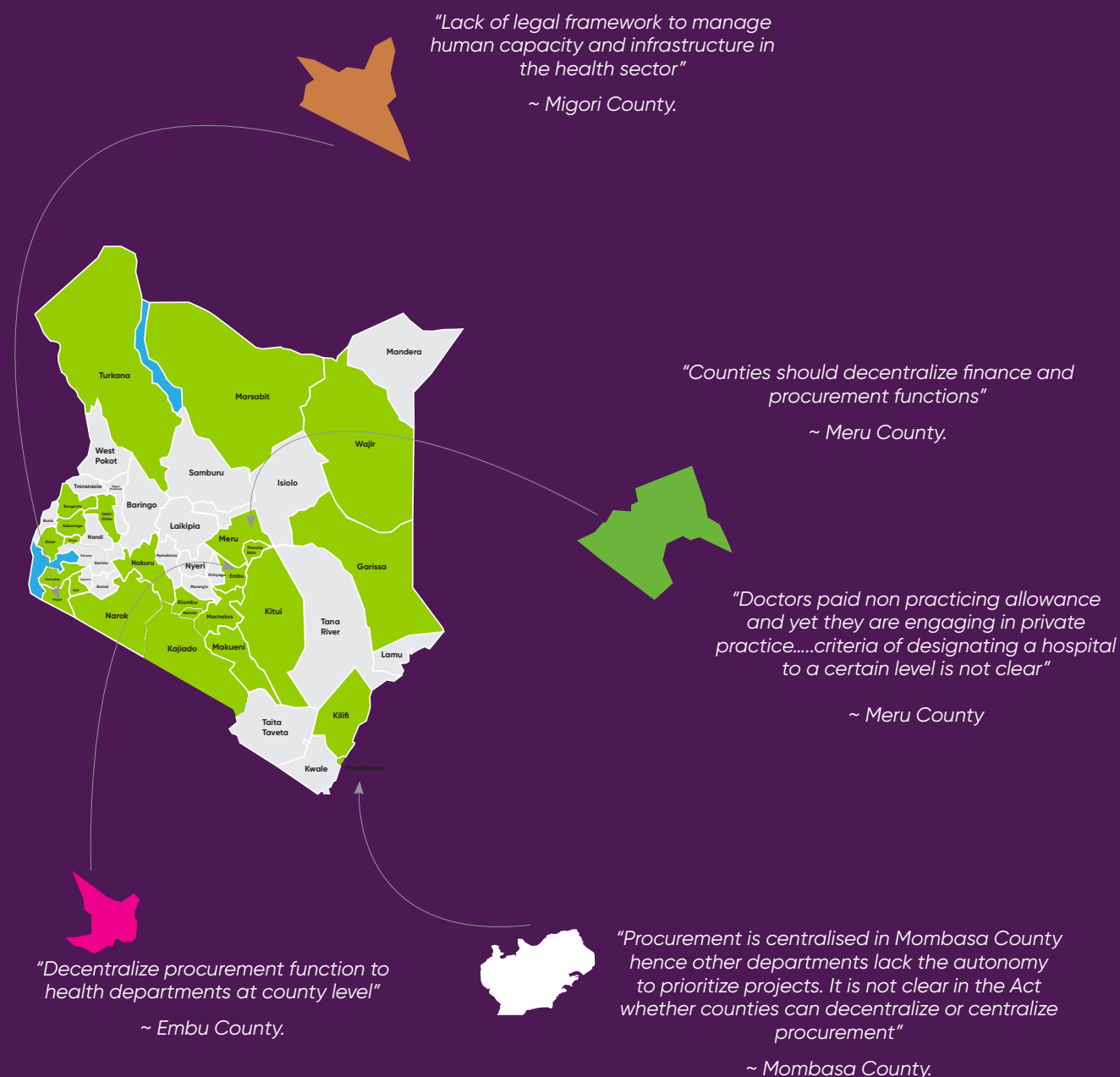


"Counties are not receiving funds from the national government on time, for instance as of this interview we have not received allocations from the national government for the past 3 months, neither have we received the second tranche of the conditional grant for level 5 hospitals."

~ Mombasa County.



In addition, centralised procurement processes and weak policies in the health sector were identified as other challenges as underscored:



Key recommendations to address challenges in implementation of health care projects included allocation of more resources (20.8%), proper planning and budgeting (13.8%), preventing delays in payments (10.3%), enhancing public participation (8.9%) and employing qualified personnel (8.9%) as shown Figure 59.

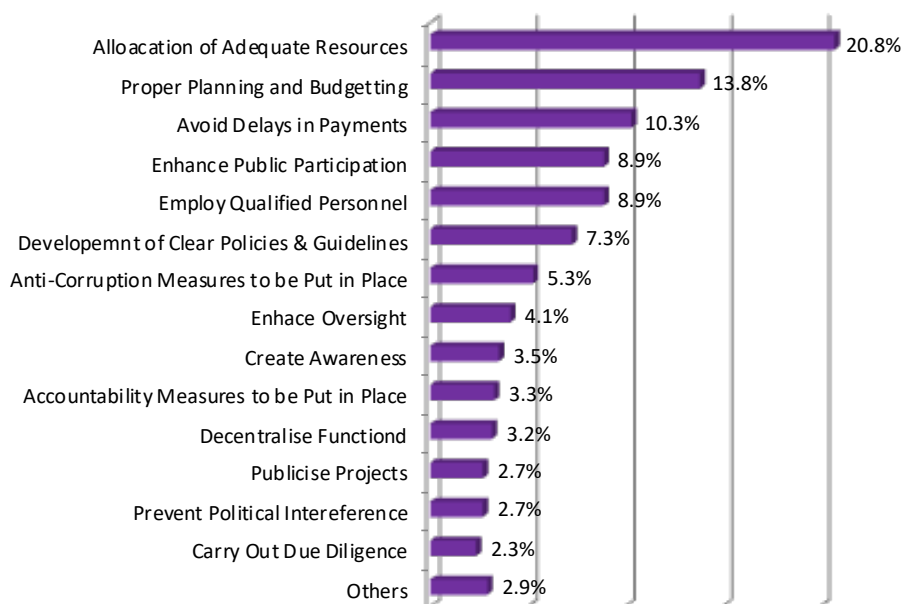


Figure 59: Measures to Address Challenges in the Implementation of Health Care Projects

The study sought to establish the institutions or persons to be charged with the implementation of proposed measures to address challenges identified in the implementation of health care projects. Forty three percent (42.9%) of the health staff proposed county governments, 15.3 percent national government, 4.9 percent MoH and 4.7 percent National Treasury as presented in Figure 60.

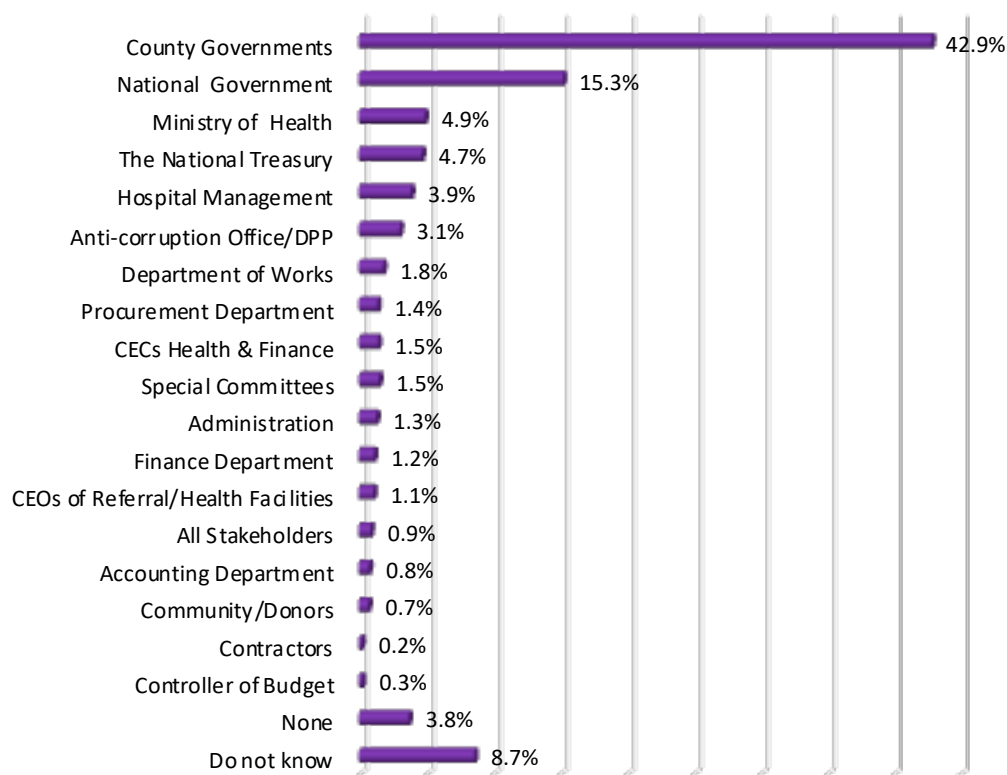


Figure 60: Institutions/Persons to Implement Proposed Measures to Address the Challenges


4

Conclusion and Recommendations



4. CHAPTER FOUR: CONCLUSION AND RECOMMENDATIONS

INTRODUCTION



As detailed in the objectives, the study sought to establish the nature, magnitude and extent of corruption in the health care projects with emphasis on procurement and financial management practices as they relate to identification, design and implementation. Further, it sought to establish causes and processes prone to corruption and unethical conduct especially in procurement and financial management of health care projects; assess the extent of adherence to public procurement and financial management laws and regulations; identify and evaluate effectiveness of measures being implemented by different procuring entities to combat corruption and unethical conduct; identify challenges in the implementation of health care projects; and propose measures and strategies for addressing corruption and unethical conduct in procurement and financial management.

4.1. CONCLUSION

The study established that favoritism, conflict of interest, bribery, manipulation of costs, distortion of procurement plans, manipulation of tender application, tribalism, nepotism, making payment on substandard works, alteration of bill of quantities (BQs) and delayed payments with regard to project completion dates as the main forms of corruption and unethical conduct that are encountered in the procurement of health care projects. The study also identified costs inflation, political influence, conflict of interest, greed, collusion, fraud, bribery, embezzlement, misappropriation of funds, acceptance of substandard items, favoritism, price inflation, non-adherence to laws and regulations, delayed and excess payments as the main forms of corruption and unethical conduct experienced in the financial management of health care projects.

Bribery was frequent in every phase of procurement and financial management of health care projects. The study established that bribes were mostly received by county government employees in relation to the implementation of health care projects. Bribery payments were mainly in the form of cash with the highest amount of bribe paid being KES 3,000,000. The average bribe paid for health care projects was approximately KES 395,909.

On the extent of corruption, the study showed high prevalence of corruption and unethical conduct in procurement and financial management of health care projects at the national and county level. Besides, the study identified greed, low and delay in salary payment, selfishness, high cost of living and delay in payments as the main causes of corruption and unethical conduct in the procurement and financial management of health care projects.

The study showed that tendering was the procurement phase where corruption and unethical conduct was most likely to occur while tender evaluation and award were the project procurement stages with high prevalence of corruption and unethical conduct. On the other hand, it was established that corruption and unethical conduct were most likely to occur at the budgeting phase of financial management.

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Bribery was prevalent in every phase of procurement and financial management of health care projects.”

The study established that project costing was the financial management procedure with high levels of corruption and unethical conduct.

The study revealed instances of non-adherence to most procurement and financial management laws, regulations and procedures in implementation of health care projects. Procurement processes in projects are mostly influenced by governors, MCAs and MPs, Members of the County Assemblies (MCAs), COs, and CECMs health are public officers mostly owning companies seeking procurement opportunities. On the other hand, governors, MCAs and county government officials are public officials mostly associated with companies seeking procurement opportunities through proxies.

It was established that IMSs were being used in procurement and financial management of health care projects in all procuring entities. However, instances of low and non-utilization of the system were also evident in a number of procuring entities. The most utilized system was IFMIS. Its effectiveness in enhancing transparency in procurement and financial management was underscored by most respondents. Its ability to enhance information sharing, tracking tendering processes and safeguarding information was also highlighted. In addition, its ineffectiveness was also noted especially in the case of manipulation of information, bureaucracy, and system inefficiency and failure.

About half of the respondents were not aware whether anti-corruption measures existed to ensure the integrity of contractors and monitor the implementation of health care projects. Majority of health staff were not aware whether counties or national health facilities sought authorization from the Controller of Budget before paying contractors for projects undertaken. Most of health staff interviewed were aware about the existence of the anticorruption measures.

Challenges were documented in the implementation of health care projects, which included financial constraints, delay in approval of finances, corruption, understaffing and political interference. In order to address these challenges, it was proposed that more resources be allocated to the health sector, proper planning and budgeting be done, avoid delay in payment, employment of qualified personnel and enhancement of public participation. County governments were identified as the most responsible institutions to implement the proposals followed by the national government. Equally, MoH and the National Treasury have a bigger role to play in the implementation of the stated suggestions.

From the assessment of the select health care projects it was observed that record keeping was poor for most of the projects, project period for certain projects was inordinately long and there was delayed payments to contractors. In addition, there were instances where the tender sum of the winning bidder, the budgeted amount as well as engineers' estimates were similar, indicating possible collusion. There were cases of significant difference between contractors that acquired bid documents and those that submitted them.

Further, although majority of the projects were relevant to the communities, the level of public participation and involvement was minimal. It was noted that funds allocated to Covid-19 pandemic were misappropriated.

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...although majority of the projects were relevant to the communities, the level of public participation and involvement was minimal."

RECOMMENDATIONS

- ✚ Debarment of contractors and government officers
- ✚ Ensure proper planning, prioritization and execution of projects
- ✚ Enhance public participation in project implementation
- ✚ Timely disbursement of funds to procuring entities
- ✚ Prompt payments to contractors during and after project completion
- ✚ Establishment of anti-corruption measures by institutions
- ✚ Build capacity of staff
- ✚ Implementation of Information Management Systems
- ✚ Allocation of more resources to the health sector
- ✚ Appointment of contract implementation teams



4.2. RECOMMENDATIONS

This section is based on the study's findings and it proposes anti-corruption policies and strategies with regard to procurement and financial management of health care projects.

i) Debarment of contractors and government officers

The Public Procurement Regulatory Board debar contractors who mismanage projects and engage in corruption and unethical conduct during project implementation. Debarment from practice and where applicable practicing licenses withdrawn of government officers who collude with contractors in committing procurement and financial malpractices.

ii) Ensure proper planning, prioritization and execution of projects

Procuring entities for health care projects ensure transparency and accountability in their planning processes, prioritization and execution of projects that address community needs. Health care projects be identified, prioritized and implemented based on community needs. Further, align the initiated projects to the budget allocations to avoid unnecessary cost and schedule variations.

iii) Enhance public participation in project implementation

Procuring entities ensure there is robust public participation before and during project implementation to enhance transparency, accountability and efficient implementation of health care projects. This can be attained by sensitizing communities within the project area on bill of quantities, scope, schedule and its impact. The public will in turn enhance social audit of projects for improved project performance and completion.

iv) Timely disbursement of funds to procuring entities

The National Treasury to ensure timely disbursement of funds to counties and national health institutions for efficient implementation of projects. Delay in disbursement of funds remained a factor that contributed to late completion and increased cost of health care projects. Low pay and delayed salary payments were other key factors identified by the respondents as reasons why public officers engage in corruption and unethical conduct.

v) Prompt payments to contractors during and after project completion

Counties and national institutions ensure prompt payments to contractors for health care projects delivered in strict adherence to the terms and conditions of the contract. This will eliminate incidents of bribery arising from delayed payments.

vi) Establishment of anti-corruption measures by institutions

Counties and national procuring entities establish and implement anti-corruption measures such as anti-corruption committees, internal control mechanism, automation of revenue collection and procurement processes, anti-corruption codes of conduct and ethics, Conflict of interest, gift and donations policies and registers, declaration of income, assets and liabilities and procedures for prevention of bribery.

vii) Build capacity of staff

Build capacity of officers in National and County health units responsible for the management of finance and procurement functions to ensure compliance with Laws, Regulations, Policies and Codes of Conduct. There is need for continuous training for staff on emerging issues in procurement and finance management, technological changes and innovations in implementation of projects.

viii) Implementation of Information Management Systems

Enact a law to compel national and county institutions to fully implement and use Information Management Systems in all procurement and financial management process and procedures. They take measures to prevent manipulation, tampering or delaying processes and loss of data in these processes. There is also a need to build the capacity of human resources to ensure optimal utilization of automated systems in finance and procurement management.

ix) Allocation of more resources to the health sector

The study findings revealed a huge gap in human, infrastructure and financial resource allocation in the health sector. In this regard, both levels of government increase funding to this sector to guarantee service delivery and value for money.

x) Appointment of contract implementation teams

In order to ensure contract obligations are satisfactorily met, counties and national procuring entities establish contract implementation teams (CIT) for works projects as provided in section 151 of the PPADA 2015. Professionals in respect to projects being undertaken appointed to CIT for ease of quality monitoring during project implementation.

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APPENDICES

Appendix 1: Distribution of Health Facilities in Counties (2019)

County	Population 2019	No. of hospitals Levels 4-6	Hospitals per 100,000 population	No. of health centres and dispensaries (Levels 2-3)	Health centres and dispensaries per 100,000 population
Kenya	47,564,296	512	1.3	8,104	19.9
Baringo	666,763	6	1.0	182	30.6
Bomet	875,689	5	0.6	113	14.4
Bungoma	1,670,570	12	0.8	134	9.1
Busia	893,681	7	0.9	74	9.3
Elgeyo - Marakwet	454,480	8	2.0	113	28.5
Embu	608,599	8	1.5	131	23.8
Garissa	841,353	14	3.1	105	23.0
Homa Bay	1,131,950	14	1.4	201	19.4
Isiolo	268,002	5	2.4	42	20.4
Kajiado	1,117,840	14	1.9	224	30.6
Kakamega	1,867,579	17	1.0	232	13.0
Kericho	901,777	14	1.8	162	20.3
Kiambu	2,417,735	27	1.6	391	22.5
Kilifi	1,453,787	10	0.8	227	19.2
Kirinyaga	610,411	5	0.9	239	42.4
Kisii	1,266,860	20	1.6	137	11.1
Kisumu	1,155,574	21	2.0	145	14.1
Kitui	1,136,187	15	1.4	290	27.3
Kwale	866,820	3	0.4	96	13.8
Laikipia	518,560	7	1.7	96	23.0
Lamu	143,920	3	2.8	41	38.4
Machakos	1,421,932	8	0.7	293	24.9
Makueni	987,653	13	1.4	175	18.5
Mandera	867,457	6	0.6	73	7.3
Marsabit	459,785	4	1.3	83	26.6
Meru	1,545,714	24	1.7	369	25.5
Migori	1,116,436	15	1.5	170	17.3
Mombasa	1,208,333	15	1.5	275	27.6
Murang'a	1,056,640	8	0.8	299	29.5
Nairobi	4,397,073	54	1.6	599	18.0
Nakuru	2,162,202	21	1.2	318	18.8
Nandi	885,711	6	0.7	169	21.1
Narok	1,157,873	6	0.7	147	16.2
Nyamira	605,576	7	1.1	126	19.7
Nyandarua	638,289	3	0.5	119	18.9
Nyeri	759,164	10	1.2	401	48.1
Samburu	310,327	3	1.3	70	29.2
Siaya	993,183	11	1.2	154	17.1
Taita Taveta	340,671	7	2.4	72	24.2
Tana River	315,943	2	0.8	62	24.0
Tharaka - Nithi	393,177	8	2.1	96	24.6

County	Population 2019	No. of hospitals Levels 4-6	Hospitals per 100,000 population	No. of health centres and dispensaries (Levels 2-3)	Health centres and dispensaries per 100,000 population
Trans Nzoia	990,341	7	0.8	91	10.4
Turkana	926,976	6	0.7	139	16.0
Uasin Gishu	1,163,186	12	1.3	165	17.6
Vihiga	590,013	6	1.0	75	12.6
Wajir	781,263	10	1.8	102	18.0
West Pokot	621,241	5	1.0	87	16.5

Source: Kenya Health Policy (2014-2030)

Appendix 2: Sample Size

1.	SAMPLING FOR HOSPITAL EMPLOYEES					
	Hospital Facility	No of facilities per county	No of employees per facility	Total per county	No. of counties	Total
	National Referral	1	20	20	4	80
	County Referral/Staff	1	20	20	25	500
	County Hospitals	3	7	21	25	525
	Health Centres	2	2	4	25	100
	Dispensaries	1	2	2	25	50
	Community Health Facilities	1	1	1	25	25
				60		1,280
Sub Total						1,280
2. SAMPLING FOR MEMBERS OF PUBLIC						
		No of projects per county	No of members per project	Total per county		
	Members of public	2	10	20	25	500
Sub Total						500
3. SAMPLING FOR CONTRACTORS						
		No of projects per county	No. of contractors per project	No. of employees per company	Total per county	
		2	3	1	6	25
Sub Total						150
4. KEY INFORMANTS						
	County Experts			Experts per county		
	CECMs Health and Finance, Chief Officers, Head of Procurement			2	25	50
	National Experts					
	PPRA					1
	PPRB					1
	Ministry of Health					1
	Ministry of Public Works					1
	Office of the Auditor General					1
	Office of Controller of Budget					1
Sub Total						6
Sub Total						56

5.	SAMPLING FOR DATA EXTRACTION FILES	Proj- ects per county		Total per county		
	Files	2	1	2	25	50
	Sub Total					
6	SAMPLING FOR SITE VISIT					
	Site visit and project as- sessment	2	1	2	25	50
	Sub Total					100
	GRAND TOTAL					2,180

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