

BUNGOMA COUNTY
DEPARTMENT OF HEALTH AND SANITATION

HEALTH AND SANITATION REFERRAL POLICY 2026-2031

JULY 2026

FOREWORD

The role of the Bungoma County Health Department is to provide equitable, affordable, accessible and quality health care services to the whole of its population. This is very clear in the constitution of Kenya (2010) which guarantees all citizens the right to the highest attainable standards of health including the right to health care services. This desired goal has not yet been realized due to certain hindrances. Like most other Counties in Kenya, Bungoma has more of its healthcare facilities concentrated in the urban areas leaving the rural areas with fewer scattered facilities. The available categories of specialized staffs and equipment are also found in the bigger facilities in the urban areas. The Health Department is under obligation to ensure that all people of this County enjoy easy access to quality healthcare services equally regardless of their locality.

The department is committed to the establishment and operationalize of a fully functional referral Policy in line with the Kenya Health Sector Referral Policy. The existence of a well-functioning referral system will enable management of client health needs in a comprehensive manner with locally available resources.

This Policy will highly consider the four categories of elements which are client movement, specimen movement, expertise movement and client parameter as informed by the Kenya Health Sector Referral Policy. This will ensure continuity of care, appropriate response to the needs of the clients and it will also improve linkage across different levels of care.

The successful implementation of this Policy will require combined effort of various sectors and participation of all stakeholders in health; however, monitoring will be closely done through the Department of Health at County and Sub County levels.

I wish to appreciate the financial and technical support from County Health Management Team, Sub County Health Management Team and stakeholders for the development of this Policy

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ACKNOWLEDGMENTS

The Department of Health and Sanitation, Bungoma County would like to express appreciation to the Governor H.E. Hon. Kennedy Makelo Lusaka, EGH for his support in the process of development of this policy document.

This policy document was successfully developed through the full support of the county government of Bungoma, with enormous contributions from the office of the CECM–Health, the Chief Officer Health services and Director Health and Sanitation, Bungoma County. We appreciate the technical input from the County Health Management Team, Sub-county Health Management Teams and Hospital Management Teams, Bungoma County. Special thanks to all partners and stakeholders who participated in the process of development of this policy.

We wish to recognize the Policy and Monitoring and Evaluation Team from Department of Health for technical support offered.

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EXECUTIVE SUMMARY

The **Bungoma County Referral Policy 2026–2031** provides a comprehensive framework for strengthening and coordinating referral services across all levels of care within the county. The Policy aligns with the Constitution of Kenya (2010), which guarantees the right to the highest attainable standard of health, and is guided by the Kenya Health Sector Referral Policy and Implementation Guidelines. It responds to persistent systemic challenges that limit equitable access to quality healthcare services, particularly in rural and hard-to-reach areas.

Bungoma County covers approximately 3,032.4 km² and hosts 326 health facilities, including 182 public facilities, one Level 5 referral hospital, ten Level 4 hospitals, 58 health centers, and 113 dispensaries, alongside private and faith-based facilities. Despite this network, disparities in infrastructure, specialized human resources, equipment distribution, ambulance coordination, and ICT connectivity have resulted in inefficient referral pathways. Self-referrals to higher-level facilities, delays in emergency transfers, weak counter-referral systems, and limited specimen and expert movement have contributed to congestion at referral hospitals and sub optimal service utilization at lower levels of care.

The Policy establishes a structured and coordinated referral system built on four core components:

Client Movement – Timely and appropriate transfer of clients between levels of care to ensure access to specialized services while promoting service utilization at lower-level facilities.

Specimen Movement – Strengthening laboratory networks to facilitate safe, efficient transport of specimens for diagnostic purposes, minimizing unnecessary patient transfers.

Expertise Movement – Deploying specialists and skilled health workers to lower-level facilities through scheduled outreach, reverse referral, mentorship, and telemedicine.

Client Parameter Movement (E-Referral) – Leveraging ICT and digital health systems to transmit patient information securely across facilities to enhance continuity of care and clinical decision-making.

To operationalize these components, the Policy introduces a centralized County Referral Coordination Unit supported by zonal command centers. This structure will enhance ambulance dispatch coordination, communication systems, emergency response management, and referral tracking. A reverse referral mechanism will facilitate periodic deployment of specialists to underserved areas, strengthen capacity at primary and secondary levels, and reduce unnecessary referrals.

The overall goal of the Policy is to establish a functional, efficient, and equitable referral network that improves health outcomes and reverses poor health indicators. By 2030, the County aims to:

a) Increase appropriate client movement from 20% to 80%.

b) Increase expert services provision from 20% to 80%.

c) Improve specimen transportation coverage from 10% to 90%.

d) Expand client parameter (ICT-enabled) access from 30% to 90%.

e) Strengthen infrastructure readiness from 45% to 90%.

f) Improve referral communication systems from 15% to 100%.

Implementation will be supported through structured coordination mechanisms at county, sub-county, facility, and community levels, clearly defined roles and responsibilities, standardized referral tools, ambulance policies, training programs, stakeholder engagement, and dedicated budgetary allocations. The Policy emphasizes emergency preparedness, equitable access regardless of ability to pay, improved counter-referral systems, and strengthened monitoring and evaluation.

A robust Monitoring and Evaluation framework outlines measurable outcome and process indicators to track performance across client movement, specimen handling, expert outreach, emergency services, ICT integration, and system coordination. Regular audits, referral review forums, and performance reporting will ensure accountability and continuous quality improvement.

The Bungoma County Referral Policy 2026–2031 therefore represents a strategic investment in health system strengthening. By enhancing coordination, leveraging technology, optimizing resource utilization, and reinforcing service linkages across all tiers of care, the Policy seeks to ensure that every resident of Bungoma County receives timely, appropriate, and quality health services at the right level of care.

LIST OF ACRONYMS AND ABBREVIATIONS

ACSM	Advocacy Communication and Social Mobilization
AIDS	Acquired Immune-Deficiency Syndrome
APDK	Association of People with Disability
CBR	Crude Birth Rate
CDH	County Director of Health
CDR	Crude Death Rate
CECM	County Executive Committee member
CHA	Community Health Assistant
CHEW	Community Health Extension worker
CHIS	Community Health Information System
CHMT	County Health Management Team
CHRIO	County Health Records and Information officer
CHV	Community Health Volunteer
CIDP	County Integrated Development Plan
CIDP	County Integrated Development Plan
CLC	County Laboratory Coordinator
COH	Chief Officer Health
CPSB	County Public Service Board
CRSP	County Referral Strategic Plan
CSO	Civil Society Organization
CT	Computerized Tomography
CUs	Community Units
DBS	Dry Blood Spot
EHRIS	Electronic Health Record Information System
EMR	Electronic Medical Records
ENT	Ear Nose and Throat
ERCS	Emergency and Referral Service Coordinator
FBO	Faith Based Organization
FIF	Facility Improvement Fund
HDU	High Dependency Unit

HIV	Human Immune Virus
HMIS	Health Management Information System
HR	Human resources
HRIO	Health Records Information Officer
HRT	Health Records Technician
ICT	Information Communication Technology
ICU	Intensive Care Unit
KECN	Kenya Enrolled community Nurse
KEM	Kenya Enrolled Mid-wife
KRCS	Kenya Red Cross Society
MCH	Maternal Child Health
Med Supt	Medical superintendent
MO	Medical Officer
MOH	Ministry Of Health
MOU	Memorandum of understanding
MRI	Magnetic Resonance Imaging
NBTS	National Blood Transfusion Services
NBU	Newborn Unit
NCPD	National Council for population and Development
NGO	Non-Governmental Organization
NHIF	National Health Insurance Fund
NO	Nursing Officer
OVC	Orphans and Vulnerable Child
PACS	Picture archiving and communication system
PHC	Primary Health Care
PHO	Public Health Officer
PHT	Public Health Technician
PSK	Population Services Kenya
PWD	People with Disability
RCO	Registered Clinical Office
RH	Reproductive Health
RMNCH	Reproductive Maternal Newborn Child Health

SCH	Sub-County Hospital
SOP	Standard Operating procedure
TB	Tuberculosis
UNFPA	United Nations Population Fund
WHO	World Health Organization

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CHAPTER 1: INTRODUCTION

The World Health Organization (WHO) defines referral as a process in which a health worker at a one level of the health system, the referring facility, not having sufficient resources, i.e. drugs, equipment, skills to manage a clinical condition, seeks the assistance of a better or differently resourced facility at the same or higher level to assist in, or take over the management of, the client's case. Key reasons for deciding to refer either an emergency or routine case include:

- to seek expert opinion regarding the client
- to seek additional or different services for the client
- to seek admission and management of the client
- to seek use of diagnostic and therapeutic tools

An effective referral system ensures a close relationship between all levels of the health system for continuity in care and helps to ensure people receive the best possible care closest to home at the lowest cost without compromising quality. It also assists in making cost-effective use of hospitals and primary health care services. It is comparable to well-greased cogs and wheels that keep the system running.

Referral system also include support to lower level facilities including community units during outreaches by experienced staff from the hospital or county health department. These outreaches also help build capacity while enhancing access to better quality care.

Without a proper referral system in place, patients tend to over crowd tertiary and secondary level facilities owing to self-referrals. Consequently, this results to a vicious cycle of longer waiting time, staff overworking, sub optimal care with poor health outcomes and client dissatisfaction. On the other hand, peripheral health facility staff skills remain untapped and equipment underutilized.

CHAPTER 2: RATIONALE AND METHODOLOGY

2.1. RATIONALE

Bungoma County faces a high and diverse disease burden that includes communicable diseases (such as malaria, HIV, tuberculosis, and recurrent outbreaks), rising non-communicable diseases (hypertension, diabetes, cancers), maternal and neonatal complications, trauma cases, and childhood illnesses. The increasing prevalence of both infectious and chronic conditions has placed significant pressure on the county's health system, particularly on higher-level facilities that provide specialized and emergency services.

Although Bungoma County has an established network of community units, dispensaries, health Centre's, sub-county hospitals, and a county referral hospital, service availability and capacity are unevenly distributed. Many lower-level facilities lack adequate diagnostic equipment, skilled personnel, essential medicines, and emergency obstetric care services. As a result, conditions that could be managed at primary care level are frequently referred to higher-level hospitals, leading to congestion, long waiting times, and strain on limited specialized resources.

Geographical features further compound these challenges. Bungoma County has both urban and rural settings, with some areas characterized by poor road infrastructure, long travel distances to referral facilities and limited ambulance coverage. These geographical barriers contribute to delayed referrals, especially during emergencies such as maternal complications, trauma, and severe childhood illnesses. In some cases, patients self-refer to distant facilities, bypassing closer health Centres, which disrupts coordinated patient flow within the health system.

Additionally, the absence of a structured and standardized referral framework has led to inconsistent referral practices, weak communication between facilities, limited feedback mechanisms, and inadequate tracking of patient movement. This fragmentation undermines continuity of care, compromises patient safety, and limits effective planning and resource allocation based on referral trends.

Given the high disease burden, uneven distribution of health services, and geographical access challenges, there is a critical need to develop and implement a comprehensive Referral Policy in Bungoma County. Such a policy will provide clear referral pathways, strengthen primary health care, improve emergency coordination, optimize resource utilization, and enhance equitable access to quality health services across the county.

2.2 METHODOLOGY

The process entailed a desk review of key documents including but not limited to: the draft policy on emergency care policy, health strategic plan and integrated development plan for Bungoma County; the Kenya Health Sector Referral Implementation Guidelines and the Kenya Health Sector Referral Policy.
Two stakeholder meetings were convened under the leadership of County Health Management Team (CHMT). The meeting gathered the national government, county government, technical partners, Faith Based Organization (FBO), civil society organizations (CSO) and non – governmental organizations (NGOs).

The initial stakeholder meeting undertook an in-depth situational analysis, gap analysis on human resources and infrastructure, problem analysis and prioritization of interventions.

Key informant interviews were conducted to gain an in-depth understanding of the current situation. The challenges in service delivery and referral services in general at the higher tier hospitals stem from financial constraints arising from centralized budgeting and allocation of resources at the county level which were not in line with hospital priorities, prone to political interference and inadequate to run day to day activities such as purchase of supplies and equipment. The majority of the catchment population is not registered in SHA, thus unable to meet healthcare costs due to high levels of poverty, while others are unwilling to pay. In addition, referral services suffer from poor attraction and retention of staff, lack of supportive bills in procurement and health financing and lack of supportive supervision from county level.

The second stakeholders meeting involved the validation of a draft County referral Policy and investment plan.

CHAPTER 3: REFERRAL POLICY GOAL, OBJECTIVES AND DIRECTIONS

3.1 Policy Goal

The overall goal of this Policy is to have an efficient referral system with linkages across all levels of care in the County.

3.2 Policy Objectives

The objectives aim to ensure the implementation of an effective referral Policy, they include:

1. Ensuring patients are referred to the correct level of care promptly based on clinical need.
2. Facilitating smooth transfer of patients between community, primary, secondary, and tertiary levels with proper documentation and feedback mechanisms.
3. To enhance the system's ability to transfer clients, specimens, services, and client parameters between the different levels of the health care system
4. Establishing clear referral criteria, stabilization protocols, and safe transport procedures that reduce delays, complications, and preventable deaths.
5. Strengthening Primary Health Care by reducing unnecessary self-referrals to higher-level hospitals.
6. Preventing overcrowding at referral hospitals and ensure efficient use of specialists, diagnostic services, and hospital beds.
7. Standardizing referral forms, communication channels, and feedback systems between referring and receiving facilities.
8. Ensuring proper documentation and tracking of referrals for monitoring, evaluation, and health planning.
9. Promoting equitable access to appropriate health services based on need.

3.3 Policy Directions

Referral Policy Directions provide strategic guidance on how the referral system should operate within the health system to ensure efficiency, quality, and equity.

3.3.1. Establish a Structured Referral Pathway

Define clear levels of care (Community Units, Dispensaries, Health Centre, Sub-County Hospitals, County Referral Hospitals and Ensure referrals follow an upward and downward pathway unless in emergencies.

3.3.2. Strengthen Primary Health Care Level

Reinforce the role of primary care facilities as the first point of contact and Discourage unnecessary self-referrals to higher-level facilities.

3.3. 3. Standardize Referral Procedures

Use standardized referral forms and registers, clearly outline clinical criteria for referral and
Ensure proper documentation and feedback from receiving facilities.

3.3. 4. Ensure Patient Stabilization Before Referral

All referring facilities must stabilize patients before transfer and Provide essential emergency care and proper referral notes.

3.3.5. Improve Communication and Feedback Mechanisms

Establish direct communication channels (phone, digital systems) between facilities and Ensure back-referral and feedback to promote continuity of care.

3.3.6. Strengthen Referral Transport Systems

Ensure availability and proper management of ambulances, Prioritize emergency and maternal referrals and Maintain referral transport protocols and tracking systems.

3.3.7. Enhance Capacity at Lower-Level Facilities

Equip primary facilities with essential medicines, diagnostics, and trained staff and Reduce avoidable referrals by improving service delivery capacity.

3.3.8. Promote Community Awareness

Educate communities on appropriate use of health facilities and Encourage use of nearby facilities before seeking higher-level care.

3.3.9. Integrate Digital Health Systems

Promote electronic referral tracking and reporting systems and Improve data collection for monitoring and planning.

3.3.10. Monitoring, Evaluation, and Accountability

Regularly review referral trends and performance indicators and Conduct supportive supervision and audits.

CHAPTER 4: STRATEGIC THRUST AND PRIORITY INTERVENTIONS

4.1 STRATEGIC THRUST

The Strategic Thrust and Focus of the County Referral Services include:

1. **Client movement**: the transfer of clients to access appropriate level of care where their health needs can be addressed in the most efficient and cost-effective way.
2. **Services and expert movement**: the transfer of a service provider (mainly from a higher to a lower level of care) to provide (mainly specialized) services that might not otherwise be available or not routinely offered at the lower level; and where there is a pool of clients who many need the services within the county.
3. **Specimen movement**: the transfer of patient's specimen to specialized facilities, usually for diagnostic purposes. This avoids the need to move the client in the health services system within the county and beyond.
4. **Client parameter movement**: the transfer of client information to appropriate levels of the health system for supportive diagnosis or management guidance. This would often involve innovative information and communication technology (ICT) in the health i.e. e-health.

5. **Coordination and management of referral services**: The effective management and coordination of the county referral networks to provide linkages across the different levels of the health system across the county.

4.2 PRIORITY INTERVENTIONS PER SERVICES

	Priority Investment/Activities	**Year of Implementation**				
1	**Client Movement**	**2026**	**2027**	**2028**	**2029**	**2030**
1.1	Develop structures at facility, sub county & county such as referral committees and point persons					
1.2	Mapping of all available ambulance services including private					
1.3	Empowering communities to acquire comprehensive medical cover e.g. SHA.					
1.4	Training of health care providers on referral best practices (e.g. referral checklists) and ,basic					

	emergencies management to reduce unnecessary referrals.					
1.5	Procurement and training on referral tools					
1.6	Develop a county directory with participation of all stakeholders					
1.7	Increase capacity of sub-county health facilities and other facility to handle some referrals e.g. caesarean section.					
1.8	Community sensitisation on specialised services.					
1.9	Develop M&E plans for Bungoma county referral strategic plan					
1.10	Equipping of ambulances					
1.11	Purchase additional ambulances					
1.12	Advocacy with stakeholders to support referral policy and Guidelines					
1.13	Budgetary allocation to support referral of patients					
2	**Service/Expert Movement**					
2.1	Develop guidelines and SOP for expert outreach programs including remuneration and transport.					
2.2	Schedule specialist outreaches					
2.3	Provide enabling environment such as attractive scheme of service and working conditions.					
2.4	Mapping the experts/ General staffs and collaboration with private/FBOs					
2.5	Allocate budget to facilitate specialist/expert movement on outreach program					
3	**Specimen Movement**					
3.1	Develop SOPs for specimens' collection, packaging and transportation movement, feedback of results, payment of courier and processing fee.					
3.2	Disseminate guidelines policy ,protocols and SOPs					
3.3	Establish means /mechanism of transporting specimen such as courier services					

3.4	Upgrade County referral laboratories to reference level					
3.5	Allocate budget for referral of specimens					
3.6	Train personnel on handling and transport/movement of specimen.					
3.7	Establish and equip sub county hospitals to handle referrals from primary facilities					
3.8	Strengthen support supervision and M&E at all levels					
4	**Client Parameter Movement**					
4.1	Develop policy for client parameter movement including cost, privacy issues, IT security among others					
4.2	Automation of primary care facilities and inter-operability of electronic medical records					
4.3	Establish a central control centre to manage the data movement and offer support in linkage.					
4.4	Build capacity of county and sub county personnel to offer support lower level facilities by telemedicine.					
4.5	Map specialist and their contacts who will be consulted by lower level hospitals					
4.6	Allocate budget to meet the cost of communication and consultation					
5	**Coordination and Management of Referral Services**					
5.1	Develop policies for ambulance services in the county					
5.2	Establish a Central coordinating unit					
5.3	Establish a training unit at the county to help build capacity of staff on referrals					
5.4	Conduct Monitoring and evaluation of ambulance services					
5.5	Establish / set up emergency toll number					
5.6	Install GPS tracking on all ambulances					
5.7	County to invest in two utility cars annually					
5.8	Sensitization and advocacy of County					

	Assembly Members and other politicians on county referral services and emergency services					
5.9	Assess and equip all ambulances to preferred standards					
5.91	Scheduled quarterly maintenance of equipment on board and ambulances					

CHAPTER 5: BUNGOMA COUNTY REFERRAL POLICY IMPLEMENTATION GUIDELINES

5.1 IMPLEMENTATION GUIDELINE

These implementation guidelines ensure that the Referral Policy functions effectively by promoting Governance and coordination, accountability, proper documentation, safe transport, and continuous monitoring — ultimately improving patient outcomes and health system efficiency.

5.1.1 Governance and Coordination

Establish a County Referral Coordination Committee to oversee implementation, Designate referral focal persons at county, sub-county, and facility levels and Align county referral procedures with national referral strategy and legal frameworks

To ensure adequate linkages with the delivery of health services, the county will have four zones, as follow: Zone 1(Cheptais , Sirisia and Kabuchai) Zone 2 (Bumula and Kanduyi), Zone 3 (Kimilili, Mt Elgon and Tongaren) Zone 4 (Webuye West and East). Each Zone will have a coordinating team with a sub command Centre.

5.1.2. Defined Referral Pathways

Clearly outline levels of care (Community Units → Dispensaries → Health Centres → Sub-County Hospitals → County Referral Hospital → National Referral Facilities), Ensure referrals follow established pathways except in emergencies and Promote both upward and downward (back-referral) systems.

5.1.3. Standardized Referral Tools

Use approved referral forms and registers in all facilities, maintain referral documentation including: Patient clinical summary, Treatment given before referral, Reason for referral and Ensure receiving facilities provide feedback to referring facilities.

5.1.4. Clinical Criteria and Protocols

Develop and disseminate clear clinical referral criteria for major conditions (maternal health, pediatric emergencies, trauma, chronic diseases, etc.), Ensure stabilization of patients prior to transfer and Implement emergency referral protocols for life-threatening cases.

5.1.5. Referral Transport System

Maintain functional ambulances with essential equipment and trained personnel, establish communication between ambulance teams and receiving facilities before transfer and Prioritize emergency, maternal, neonatal, and trauma cases.

5.1.6. Communication and Feedback Mechanisms

Establish official communication channels (phone, digital systems, referral coordination desks), Implement feedback systems for continuity of care and Encourage regular case review meetings between facilities.

5.1.7. Capacity Building

Train healthcare workers on referral procedures and documentation, strengthen skills in triage, emergency stabilization, and communication and Provide ongoing supportive supervision.

5.1.8. Community Engagement

Sensitize communities on appropriate use of referral systems, promote first contact at primary health care facilities and engage Community Health Promoters (CHPs) in referral tracking and follow-up.

5.1.9. Monitoring and Evaluation

Track key indicators such as: Number of referrals per facility, Referral turnaround time, Proportion of completed referrals, Emergency referral outcomes, conduct quarterly referral audits and performance reviews and Use data to improve service delivery and planning.

5.1.10. Resource Mobilization

Allocate budget for referral transport, communication systems, and training and Strengthen partnerships with stakeholders and development partners.

5.2 REVERSE REFERRAL OF HEALTH WORKERS

(1) The Department of Health and Sanitation shall implement a reverse referral mechanism to facilitate the periodic deployment of health workers, including medical specialists and other skilled personnel, from higher-level facilities to lower-level health facilities for the purpose of:

(a) Enhancing access to specialist services at the primary and secondary care levels;

(b) Strengthening clinical mentorship, supervision, and capacity-building of lower cadre staff;

(c) Reducing unnecessary referrals and decongesting higher-level facilities; and

(d) Improving service equity, patient outcomes, and continuity of care at the community level.

(2) The reverse referral of health workers shall be guided by a structured deployment plan approved by the County Chief Officer for Health and Sanitation and shall:

(a) Be based on identified service delivery gaps and facility needs assessments;

(b) Align with the county human resource for health strategy and service delivery priorities; and

(c) Be implemented through scheduled outreach, clinical rotations, or temporary postings.

(3) Health workers deployed under the reverse referral mechanism shall be entitled to facilitation and allowances commensurate with:

(a) The duration and location of deployment;

(b) The level of expertise required;

(c) Any additional workload, hardship, or travel incurred during the assignment; and

(d) Any applicable guidelines in existence.

(4) The Department shall ensure that:

(a) Adequate logistical and administrative support is provided to enable effective service delivery during reverse referral deployments;

(b) Facilities receiving reverse-referred staff are prepared to support the visiting personnel with necessary equipment, supplies, and space; and

(c) Monitoring and evaluation systems are in place to assess the impact of the reverse referral mechanism on service delivery and workforce performance.

(5) The reverse referral arrangement shall not disrupt critical services at the originating facility and shall be implemented in a manner that ensures continuity of care at all levels.

5.3 ROLES AND RESPONSIBILITIES

5.3.1 COUNTY ASSEMBLY

- Consider this policy for approval
- Enactment of relevant legislative for efficient delivery the referral services
- Appropriate resources for efficient delivery the referral services

5.3.2 DEPARTMENT OF HEALTH

- Implement the county referral Policy or approach based on the county health system's capabilities, clients, and context
- Ensure collaboration between service providers at the county level through referral forums, memoranda of understanding for referral services, and establishment and maintenance of referral networks
- Undertake the referral system performance monitoring and evaluation at the county level
- Ensure the availability of standard referral tools, such as referral forms, registers and other relevant forms for referrals at the facility level
- Develop the necessary infrastructure to support the county referral system.
- Ensure the availability of financial, human, and other resources to support the county referral system
- Ensure continuous supportive supervision and capacity building of county facilities in the referral system
- Ensure the availability of accessible and high-quality health services in the county.
- Coordinate the flow of referral information from community units and facilities to the health management in the county

5.3.3 CLIENT OR NEXT OF KIN

The client or the client's next of kin shall be responsible for the following actions:

- Provide consent for referral
- Provide the right information
- Facilitate the referral
- Assume responsibility for the security of the client's belongings.
- Consent to be transferred back to the initiating facility after treatment.

5.3.4 REFERRING HEALTH WORKER

The referring health worker shall:

- Know what, whom, when, and where to refer as guided by the Clinical management and Referral Guidelines, Health Sector Referral Guidelines and the directory of health services
- Complete the standard referral form (see annex) with all the necessary information and attach the relevant documents
- Explain to the client the need for referral, reasons for choice of doctor or facility, preparation, expected cost, and possible outcome of referral
- Answer queries from the referral coordinator or receiving facility about the referral, if necessary
- Ensure counseling of the clients on the need for referral and maintenance of confidentiality
- Obtain informed consent from the client being referred
- Ensure patient is fully prepared for the referral
- Improve preparedness and response to emergencies and disasters

5.3.5 REFERRING FACILITY

The referring facility shall:

- Perform continuous monitoring of the process of referral in the facility, and institute corrective measures if necessary
- Ensure that staff members are adequately trained on the referral process
- Ensure the continuous supply of standardized referral forms and registers to the health care providers
- Keep the directory of health services and facilities in a defined geographic area or referral network
- Ensure proper recording of all referrals
- Develop and maintain mechanisms to track referrals in and out of the facility.
- Ensure the availability of transportation for emergency referrals.
- Assign a referral coordinator with clear roles and responsibilities.

5.3.6 THE RECEIVING HEALTH TEAM/HEALTH WORKER

The receiving health team has the following responsibilities:

- Respond promptly to referral consultation requests.
- Adequately prepare to receive the referrals and provide appropriate management.
- Report in detail all pertinent findings and recommendations to the referring health worker and, if necessary, the client, on opinions that affect his or her health care.
- Provide feedback with all required information and recommendations to the referring health facility and the client.
- Communicate with the client or the client's family.
- Ensure that the role of the referring health worker is not undermined by communication or action.
- Attend to the emergency referred clients, specimens or parameters regardless of socio-economic status or referring county/ facility.
- Work with the client to determine subsequent care and treatment needed.

- Improve preparedness and response to emergencies and disasters.
- Involve client in his/ her management.

5.3. 7.THE RECEIVING FACILITY

The receiving facility has the following responsibilities:

- Continuously monitor the facility's referral processes to identify gaps and strengths and put in place corrective measures where necessary.
- Assign a referral coordinator with clear roles and responsibilities.
- Devise follow-up plans and ensure that the plans are communicated to the referring facility and experts.
- Ensure that staff members are adequately trained on the referral process.
- Ensure that there is a continuous supply of registers and forms to record referrals.
- Provide patient education to clients on the referral processes and appropriate referral behavior.
- Keep and continually update a directory of services.
- Ensure that referred clients are seen by appropriate experts or are provided with expected services.
- Ensure that all investigations and documents accompanying the referral from the referring facility protect clients from unnecessary cost.
- Ensure that all scheduled referrals are processed without undue delay.
- Develop and maintain a mechanism to track referrals in and out of the facility.
- Provide feedback on referrals to the referring facility.
- Improve preparedness and response to emergencies and disasters.

5.3. 8. THE REFERRING COMMUNITY UNIT

The referring community unit shall have the following responsibilities:

- Perform continuous monitoring of the process of referral in the community unit, and institute corrective measures if necessary.
- Ensure that CHPs and CHAs/CHOs/PHO are adequately trained on the referral process.
- Ensure the continuous supply of standardized referral forms and registers to the CHPs.
- Ensure proper recording of all referrals.
- Assign a referral coordinator with clear roles and responsibilities.
- Create awareness on preparedness and response to emergencies and disasters.

5.4 REFERRAL COMPONENTS

5.4.1 GUIDELINES FOR CLIENT MOVEMENT

Client movements are referrals from one level to another level that are initiated by a Health care worker or by the clients themselves.

Any client examined by a health care worker or at an emergency care unit, in a public or private institution, who is deemed to need specialized consultation or treatment or requires care and procedures that cannot be provided at the initial level of care, shall be referred to the specialist or institution capable of continuing or providing the level of care required.

The attending health worker will fill out a client referral form in a legible manner (printed if necessary) in English and with all the required information. If an e-referral system is in place, the form will be completed electronically with all the necessary information included.

The referral information must be complete and accurate and contain the following minimum information:

- Full name of the client being referred
- Unique identifier number.
- Client date of birth, age, and gender
- Client address and phone number
- Date and hour of referral
- Client medical history
- Diagnosis, if known
- Reason for referral
- Treatment given, diagnostic work-ups done, client's vital signs
- Name and contact of Health care worker (Avoid initials)
- Signature of the referring health care worker
- Name and contact of the referring clinic or unit or facility
- Next of kin (name, address, and phone number)
- Name of the receiving clinic or unit or facility

In the case of an unknown patient, the receiving Health facility shall try to identify the patient, and record name and contact of person(s) who accompanied the patient and after their treatment or discharge arrange for repatriation of the client in dignified and lawful manner

The following shall apply: -

1. All relevant diagnostic results (laboratory, radiological studies and previous referral information) should accompany the client referral form
2. For emergency referrals, the referring health care worker will communicate directly by phone or any other means of communication available to the receiving health care worker to ensure that advance notice of the referral is given to allow for adequate preparation
3. All referrals shall be governed by the Bungoma County and health sector referral guidelines
4. A toll-free ambulance service telephone number will be in place and connected to other emergency services across the county
5. All emergency referrals shall be accompanied by a trained staff to the receiving health facility
6. Referred clients will receive priority attention at the receiving health facility.

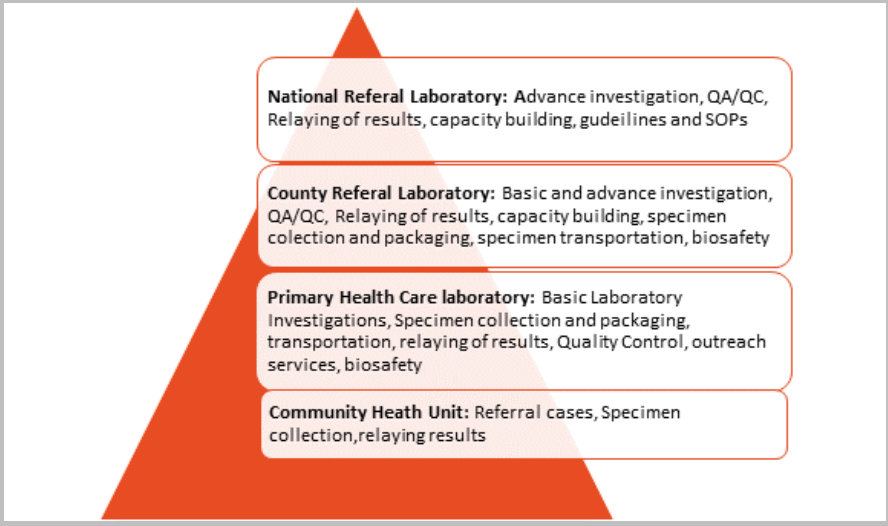
7. Emergency referred clients will be attended to regardless of the socio-economic status or referring county/ facility.
8. All health facilities receiving referral services will function for 24 hours to be able to manage referrals.
9. For primary care health facilities that do not function 24 hours, the officer in charge and community health workers will share contact details with the community for consultation.
10. All health facilities will have a standard designated area for receipt and management of emergency cases
11. All health facilities will have an emergency operation plan and a dedicated emergency response team; it also will provide equipment for management of emergency cases

5.4.2 GUIDELINE FOR SPECIMEN MOVEMENT

Specimen movement is an indirect referral mechanism for patients to ensure access to laboratory services from other facilities for investigative purposes. Specimen movement functions under a defined laboratory network.

In the laboratory referral network, the referring facility (satellite site) collects and refers the specimens to the receiving facility which analyses and issues a report. Figure 1 below illustrates the proposed Bungoma County integrated laboratory network for specimen movement, an adoption of the national network.

Figure 1: Bungoma County Integrated Laboratory Network



5.4.3 GUIDELINES FOR CLIENT PARAMETER MOVEMENT

Guidelines for movement of client parameters include the following:

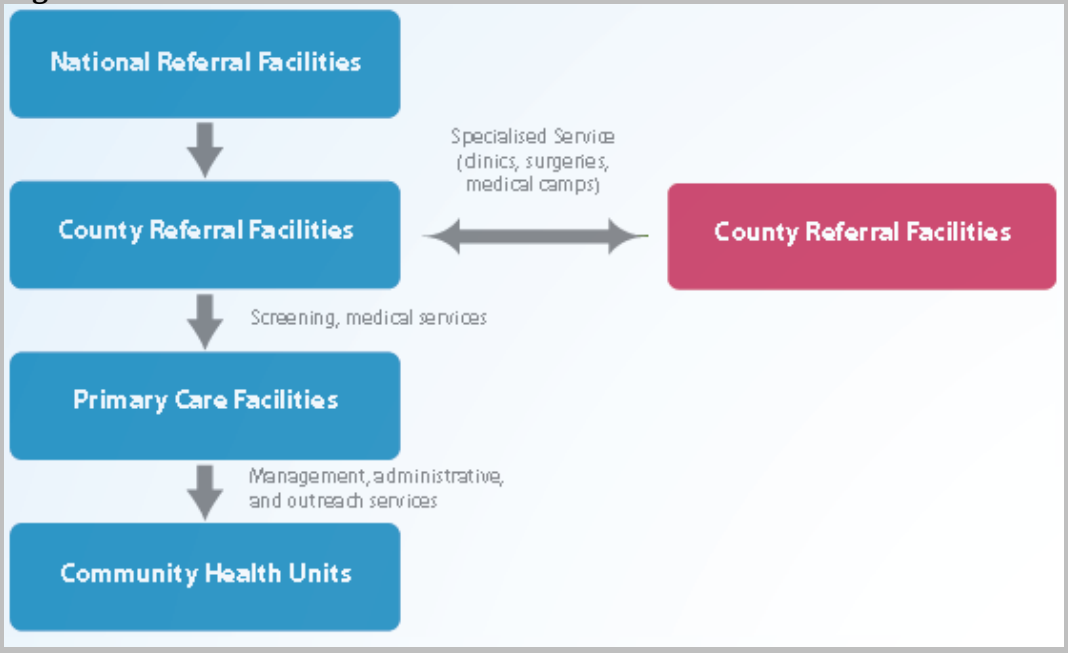
- The e-referral system will be implemented in accordance with the Bungoma County Referral Policy

- The County will establish a web portal and software module; call centers, referral guidelines, and standard operating procedures. The e-referral system will use the ICT backbone infrastructure established or use existing ICT platforms.
- The e-referral system will ensure that client privacy and confidentiality
- The health care workers shall be trained and updated in the use of information and communication technology (ICT), e-referral tools, and guidelines.
- A system of vetting experts at each level to provide support will be put in place, and this will be done regardless of whether the expert works in the public or private sector.
- Adequate training will be provided to facilitate capacity building at the different levels in the use of the e-referral services.
- The e-referral system will be linked to the ambulance services for the transportation and coordination of referred clients to the appropriate level.

5.4.4 GUIDELINE FOR MOVEMENT HEALTH CARE WORKERS

Movement of Health care worker to ensures that specialized services are accessible and affordable by being moved around to areas where their services are required. They can be drawn from public, private, faith-based, or external facilities.

Figure 2: Health Care worker Movement



The county will maintain an inventory of health Care worker from the public, private sectors and FBOs as a source for specialized services

5.5 COORDINATION

5.5.1 COUNTY LEVEL

The County referral services will be coordinated by the county referral coordination team at the county health department or the county referral facility. The county will appoint an Emergency and Referral Service Coordinator.
The roles and responsibilities of the coordinating team include:

- Coordinate resource mobilization and resource distribution at the county level to facilitate movement of clients, specialized services, specimens, and client parameters.
- Implement the referral system policy, guidelines, and protocols developed at the national and county levels.
- Ensure adherence to ethical standards pertaining to referrals.
- Conduct performance monitoring and evaluation of the referral system at county levels to ensure accountability and enhance performance.
- Sensitize and train the county teams on the referral system.
- Convene regular referral coordination and audit forums with relevant stakeholders to coordinate and discuss performance of the referral system.
- Ensure proper documentation.
- Uphold public relations on referral Policy.
- Ensure regular supportive supervision on referral services at all levels.
- Improve counter referral and referral feedback information system.
- Strengthen and supports out-reach systems for provision of referral health services to marginalized and vulnerable populations to minimize referrals

5.5.2 SUB COUNTY LEVEL

The sub-county-level Emergency and Referral Services Coordinator will ensure reinforcement of the referral system among the different levels of care. The roles and responsibilities of the Emergency and Referral Services Coordinator are:

- Provide resource mobilization and referral coordination at the sub-county level.
- Conduct referral system performance monitoring and quality assurance.
- Support supervision and capacity building of the sub-county facilities and community units.
- Receive, compile, and analyze referral data and provide feedback to facilities and the coordination units in the sub-county to improve the referral system.
- Ensure that the health facilities and coordination units comply with the referral guidelines.
- Convene regular meetings to coordinate and discuss the performance and challenges of the referral system.
- Ensure proper documentation
- Maintain public relations on referral Policy
- Improve counter referral and referral feedback information system

5.5.3. FACILITY LEVEL

The referral coordinator at the facility level will ensure the proper functioning of the referral system at the facility and community unit level. The roles and responsibilities of the facility Emergency and Referral Services coordinator are:

- Coordinate client, specimen, specialized services, and client parameter referrals in and out of the facility.
- Facilitate scheduling of referrals based on the level of priority for consultation; specifically: emergency, urgent, and routine cases.
- Use the following communication methods: letter, telephone and fax, email, e-health, delivery of photocopied reports, and personal contacts to ensure that referrals are communicated effectively.
- Confirm the availability of expertise at the receiving health facility before referrals are made.
- Facilitate transportation of emergency referrals.
- Ensure that health care workers in the facility adhere to the referral guidelines and protocols.
- Coordinate referral data collection, analysis, and interpretation for referral system performance monitoring and quality assurance.
- Ensure feedback to the referring facilities.
- Coordinate referral forums at the facility level.
- Coordinate sensitization and training of health care workers on the referral system at the facility level.
- Coordinate community or client education on the referral system at the facility level.
- Coordinate preparedness and response to emergencies and disasters.
- Ensure proper documentation.
- Maintain regular tracking of the progress of referral services.
- Maintain public relations on referral Policy.
- Regular supportive supervision on referral services.
- Improve counter referral and referral feedback information system.
- Strengthen out-reach systems for provision of referral health services to marginalized and vulnerable populations.
- Provide quality emergency health services at the point of need, regardless of ability to pay.

5.5.4 COMMUNITY UNIT LEVEL

The referral services at the community unit will be coordinated by CHA/CHO/PHO to ensure the proper functioning of the referral system at the community unit level. The roles and responsibilities of the CHA/CHO/PHO include:

- Coordinate client, specimen, specialized services and client parameter referrals in and out of the community unit.
- Use the following communication methods: letter, telephone, email, e-health, delivery of photocopied reports, and personal contacts to ensure that referrals are communicated effectively.
- Ensure adherence to the referral guidelines and protocols.
- Coordinate referral data collection, analysis, and interpretation for referral system performance monitoring and quality assurance.
- Coordinate referral forums at the community level.

- Coordinate sensitization and training of community health volunteers on the referral system at the community level.
- Coordinate community or client education on the referral system at the community level.

CHAPTER 6: MONITORING OF THE REFERRAL SYSTEM

6.0 INTRODUCTION

Adequate referral monitoring involves all aspects of the referral framework. This includes: client and client parameter movement; specimen movement; and specialized service movement. The monitoring involves a continuous audit of the system to ensure of its conformity with: the client rights as enshrined in the Constitution; the referral policies, guidelines, and protocols; and to assess the effectiveness of the referral system. The roles of national and county governments and the various levels of care, and their inter-relationship with the various sectors and players in the health sector, are primary to a functional referral service. As part of ensuring the efficiency and effectiveness of the system, various tools will be developed to inform the level and performance of client referrals, client parameter movement, specimen and specialized services movement. The list of the referral tools is enumerated below:

- Intra-facility client referral form.
- Standard referral forms for client movement, client parameter movement, specialized service movement and specimen movement.
- In-transit client monitoring form for emergency referrals
- Client counter-referral form.
- Client and referral registers.

The following are some
of the performance indicators that will be monitored in five Years:

a) Increase appropriate client movement from 20% to 80%.

b) Increase expert services provision from 20% to 80%.

c) Improve specimen transportation coverage from 10% to 90%.

d) Expand client parameter (ICT-enabled) access from 30% to 90%.

e) Strengthen infrastructure readiness from 45% to 90%.

f) Improve referral communication systems from 15% to 100%.

ANNEXES

ANNEX 1: CLIENT REFERRAL FORM

M.O.H

MINISTRY OF HEALTH

Client Referral Form

☐ Emergency ☐ Urgent ☐ Routine *(Tick as appropriate)*

☐ Local ☐ Inter-county ☐ Overseas *(Tick as appropriate)*

Date..... Time..... Facility code.....

Client Details:

Name ..... Age ..... Sex: Male ☐ Female ☐

IP/OP number:..... ID number:.....

NHIF Number:..... Telephone Number(s).....

Physical Address..... County.....

Sub County..... Sub Location.....

Assistant Chief..... Telephone Number(s).....

Next of Kin Details:

Name ..... Relationship to client .....

Telephone Number.....

Referring from Facility/Department .....

Referral to Facility/Department .....

History/Investigations.....

.....

.....

Diagnosis:.....

Reasons for Referral:

.....

.....

Referring Officer Details:

Name.....Telephone Number.....

Designation..... Signature.....

Referral Back Details (Tracking Slip):

Name of the Facility or Department.....

Date Client Registered..... Referred from Facility/Department .....

Clinical Details:.....

.....

Clinician Name.....Telephone Number.....

Designation.....

Signature.....Date.....

ANNEX 2: SAMPLE SPECIMEN REFERRAL FORM

MOH 240H

MINISTRY OF HEALTH

Specimen Ref No.....

SAMPLE AND SPECIMEN REFERRAL FORM

Note: Incompletely filled forms will not be processed

I. Patient and Specimen details

IP/OP No:.....

Patient's Name..... Age(yrs/months).....Sex: M ☐ F ☐

Residence.....Postal address.....

Sample / specimen and description.....Source.....

Collection date (dd/mm/yyyy) ___/___/_____ Time (24hrs).....

Date of preservation.....Method of preservation.....

II. Referring Lab (name and address).....

Reasons for Referral.....

III. Details of Person Referring sample

Name.....Designation.....Mobile.....

Email..... Signature.....

IV. Investigations Requested.....

V. Lab referred to (name and address).....

VI. Details of the Person Receiving sample

Name.....Designation.....Mobile No. .....

Email.....Signature.....

VII. Condition of Sample

Accepted ☐ Rejected ☐ (specify reason)_____

ANNEX 3: CLIENT CONSULTATION REQUEST FORM

M.O.H



MINISTRY OF HEALTH

Client Consultation Request Form

☐ Emergency ☐ Urgent ☐ Routine (*Tick as appropriate)

Date..... Time.....

The opinion of DR/MR/PROF/MS/MRS.....
in the .....Consultant
Clinic/Department would be appreciated in the case of:

Client Details:

Name:..... Age:..... Sex: .....
Ward/Clinic: ..... Bed Number (if IP): .....
Current IP/OP Number: .....
Previous IP/O P Number (s) : a) ..... b) ..... c).....
Specify if IP/OP

Diagnosis : .....
Investigations :
.....
.....
.....

Reasons for Consultation request:
.....
.....
.....
.....

Requesting Officer Details:
Name.....Telephone Number.....
Designation.....Department.....
Facility.....
Signature.....Date.....

ANNEX 4: CLIENT TRANSIT MONITORING FORM

ANNEX 4: Client in Transit Monitoring Form

Referring facility name	Service area	Vehicle No . . . . .

Client	Incident	Transit times
Name:	Date: __/__/____ (dd/mm/yyyy)	Call received: __:__
Age (Yrs):	Time: __:__	Dispatched: __:__
Sex: M ☐ F ☐	Location of incident (Mark as appropriate)	Arrived at scene: __:__
Mobile No:	☐ Home ☐ Medical Facility	Departed: __:__
Next of Kin	☐ School ☐ Work	Arrived at hospital: __:__
Name:	☐ Public	Hand over time: __:__
Mobile No:	☐ Other (Specify)	

History of illness/injury:

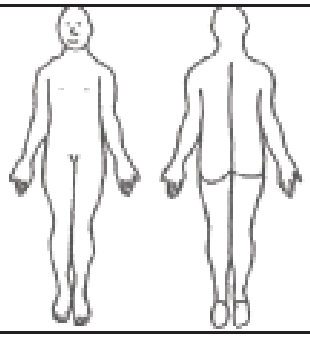
Medication client is using:

Allergies:

Observations	Time	Time	Time
	__:__	__:__	__:__
S/Os: Abdr			
Describe/elaborate			
Pulse: Abdr			
Describe/elaborate			
Breathing: Abdr			
Describe/elaborate			
Blood Pressure			
Temperature			

Actual observations

Abrasion
Burn
Contusion
Deformity
Fracture
Haemorrhage
Laceration
Pain
Rigidity
Swelling
Tenderness



Lung sounds (Mark as appropriate)

Left	Right
☐ Clear	☐
☐ Sonder	☐
☐ Diminished	☐
☐ Wheezes	☐
☐ Hyperresonance	☐
☐ Rhonchi	☐

Glasgow coma scale (circle as appropriate)

Eye opening	Motor response	Verbal response
4 Spontaneously	6 Obeys commands	5 Oriented
3 To voice	5 Localizes pain	4 Confused
2 To pain	4 Withdraws from pain	3 Inappropriate words
1 No response	3 Flexion to pain	2 Incomprehensible sounds
	2 Extension to pain	1 No response
	1 No response	

Personal medical history:

Client complaint:

Assessment/General impression:

Treatment/Interventions:

Receiving Facility	Ambulance Personnel
Name	Crew 1 (Name): . . . . . Sign: . . . . .
Staff handed over to (Name):	Crew 2 (Name): . . . . . Sign: . . . . .
Signature: . . . . . Time: __:__	Crew 3 (Name): . . . . . Sign: . . . . .

ANNEX 5: FACILITY MONTHLY REFERRAL SUMMARY FORM

M.O.H

MINISTRY OF HEALTH

Facility Monthly Referral Summary Form

COUNTY: ..... SUB-COUNTY: .....

FACILITY NAME: .....

YEAR: ..... MONTH: .....

		Total Number
1.	Number of clients seen	
2.	Number of clients referred	
3.	Number of counter referrals	
4.	Number of clients who completed referral	
5.	Number of clients who took more than 30 minutes to be referred	
6.	Number of clients who took less than 30 minutes to be referred	
7.	Number of days taken to completed a referral (reported Bi-annually)	

Completing Officer Details:

Name.....Telephone Number.....

Designation.....

Signature..... Date.....