MINISTRY OF HEALTH

Kenya Health Sector Referral Implementation Guidelines

2014

1st Edition

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PUBLISHED BY:

Ministry of Health,
Division of Emergency and Disaster Risk Management
Afya House
P.O. Box 30016, General Post Office
Nairobi 00100, Kenya
http://www.health.go.ke

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Foreword

The Kenyan Constitution 2010 through the Bill of Rights puts a heavy responsibility on the health sector to ensure realization of the right to health. The goal for the health sector is to provide equitable, affordable and quality health care to all citizens.

Healthcare is essential for the socio-economic development of a nation and it has been at the top of public policy agenda since Kenya's independence. Making healthcare services accessible to everyone remains a great challenge to the existing healthcare system in the country.

Kenya, like other developing nations, has health facilities which are concentrated in the urban areas. Furthermore, throughout the country, some categories of health workers are more concentrated in urban and private sector services. But, with most of the population living in rural areas, creating equitable access to comprehensive health care services including for emergency care is one of the most important aspects in planning an effective health care system.

> "The Ministry of Health intends to improve on referral services as defined in the Kenya Health Sector Referral Strategy: 2014-2018.

The Ministry of Health intends to improve on referral services as defined in the Kenya Health Sector Referral Strategy: 2014-2018 by guiding the set-up of a fully functional referral system in the 47 counties in order to enhance delivery of health services at all levels. The services are based on the premise that, while capacity for health service delivery has to be rationalized around different levels of care, services received by clients should not be determined only by the services available where they access care, but rather by the full scope of care the health system is able to provide in the country.

I urge all stakeholders in health to use these referral guidelines to provide direction on offering effective management of referral services in order to ensure continuity of care and effective management of health needs of the population in Kenya.

Prof. Fred H.K. Segor | *Principal Secretary* | *Ministry of Health*

Acknowledgements

The development of the Kenya Health Sector Referral Implementation Guidelines involved the engagement of various stakeholders. The Ministry of Health wishes to acknowledge the USAID-funded MEASURE Evaluation-PIMA for the financial and technical support in the development of the guidelines.

The Ministry would further wish to acknowledge the commitment of the members of the Technical Working Group under whose stewardship the guidelines was developed. The members were drawn from various directorates of the Ministry of Health and County level, the World Health Organization, MEASURE Evaluation PIMA, Moi University and Kenyatta National Hospital. In particular, we would like to thank Dr. John Odondi, Dr. Simon Kibias, Mrs. Susan Otieno, Ms. Peninah Muteti, Mr. Aaron Kimeu, Dr. Wycliffe Mogoa, Dr. Wilson Gachari, Dr. David Kiima, Mr. Josephat Yundu, Mr. Geoffrey Kimani and Dr. Isabella Maina from MOH, Dr. Humphrey Karamagi from WHO and Dr. Caroline Gitonga, Ms. Kate Mbaire and Ms. Sarah Kedenge from MEASURE Evaluation PIMA for their leadership and contribution to the development of the referral guidelines. We also wish to thank the people listed in annex 4, who have contributed in various ways in the development of the strategy.

We wish to acknowledge the efforts and time the health sector partners and stakeholders put in the development of these guidelines. We further wish to appreciate the financial and technical support received from the World Health Organization and USAID-MEASURE Evaluation PIMA for the development and finalization of the guideline document.

Dr. Nicholas Muraguri | *Director of Medical Services* | *Ministry of Health*

List of Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CCS	Comprehensive Community Strategy
CHW	Community Health Worker
CU	Community Unit
DFID	Department for International Development
ECG	Electrocardiogram
EHRS	Electronic Health Record System
EHS	Essential Health Services
EMR	Electronic Medical Records
EMS	Emergency Medical Services
EOP	Emergency Operating Procedures
FBO	Faith-based Organizations
HIV	Human Immunodeficiency Virus
IATA	International Air Transport Association
ICT	Information and communication technology
IP	In-Patient
KEMRI	Kenya Medical Research Institute
KEPH	Kenya Essential Package for Health
KHP	Kenya Health Policy
KHSRS	Kenya Health Sector Referral Strategy
MDG	Millennium Development Goals
MEASURE	Monitoring and Evaluation to Assess and Use Results
MOH	Ministry of Health
MTP	Medium Term Plan
OP	Out-Patient
SOP	Standard Operating Procedures
TB	Tuberculosis

Definition of Terms

Client movement:
A process that follows the issuance of a referral for a client to seek additional care from an organization, service, or community unit.

Client parameters movement:
An indirect referral process used to move client information to seek supportive diagnosis and manage guidance to appropriate levels of the health system. This type of referral is benefitting from the scale-up of innovative information communication technology in health services, particularly in the context of e-health technology.

Consultation:
A process a client or health provider uses to seek specialized services.

Counter-referral:
A process used to redirect a referred client back to the originating unit for follow-up of the reason for referral.

Emergency referrals:
A referral process used for emergency conditions that threaten life, limb, or eye sight.

Expert:
A trained health care provider with expertise in a specific subject area.

Inappropriate referrals:
Referrals that incorrectly designate destination or necessity or that lack quality of communication, completed referral forms, or accompanying documentation.

Initiating facility:
An organization, service, or community unit that initiates a referral process by preparing an outward referral to communicate the client's condition and status; an initiating facility is also known as a "referring facility."

Level of care:
The Kenyan health system is divided into levels of care, defined as community, primary care, and county and national referral services.

Non-urgent or routine referral:
A referral process used to seek a second opinion, a higher level investigation, or for routine admissions and client management.

Receiving facility:
An organization, service, or community unit that accepts a referred client or specimen from an initiating facility.

Referral system:
A comprehensive health care system used to manage client health care needs by referring clients from an initiating facility to an organization, service, or community unit that can better provide the level of care needed.

Expertise referral:
The system of rotation and facilitation of healthcare providers' movement to reach patients in need of care in situations where it may be more efficient and cost-effective to do so. Expertise referrals are used most commonly for non-emergency (scheduled) cases and include out-reaches.

Specimen movement:
A referral process used to move a specimen to another organization, service, or community unit for analysis.

Tier of care:
The tiers of care in the Kenyan health systems are defined as community, primary care, county referral services, and national referral services.

Transfer:
A management process used to move a client from one facility to another.

Urgent referrals:
A referral process for conditions that may not threaten life, limb, or eyesight but require urgent attention to prevent them from becoming a serious risk to health.

CHAPTER 1
Introduction

1.1. Background

The Constitution of Kenya (2010) guarantees its citizens the right to the highest attainable standard of health, including the right to health care services such as reproductive health care. The Constitution further states that no person shall be denied emergency medical treatment. As a signatory to international declarations such as the Millennium Development Goals (MDG), the Government of Kenya is committed to reduce child mortality by two-thirds, reduce maternal mortality, and combat HIV/AIDs, Malaria, Tuberculosis (TB), and other diseases by 2015.

At the strategic level, the government's overall strategic plan, the Second Medium-Term Plan (MTP) of Vision 2030, elaborates policies, reform measures, projects, and programs for implementation during 2014–2018. This plan seeks to improve access to referral systems through the following strategies:

- Increase the use of services at lower levels of the health care system and reduce self-referral to higher levels of care.
- Develop service providers' capacity to offer services and appropriately refer at each level of the health care system.
- Improve the system's ability to transfer clients and specimens between the different levels of the health care system.
- Improve supportive supervision, thereby ensuring up-to-date management practices in use across the country.
- Improve the reverse (counter) referral and feedback information system.
- Improve preparedness and response to emergencies and disasters.
- Strengthen outreach systems for provision of health services to marginalized and vulnerable populations.
- Provide quality emergency health services at the point of need regardless of ability to pay.
- Establish full-fledged, low-cost diagnostic centres and provide adequate screening and treatment facilities for people with chronic or terminal conditions, including cancer, diabetes, and kidney failure, in every county.

The overall goal of the Kenya Health Policy (KHP) 2012–2030 is to guide the attainment of the highest possible standard of health that is responsive to the needs of the population by advocating for universal coverage of essential services. The strategic objectives of the policy include providing essential health care by making it affordable, equitable, accessible, and responsive to client needs. The health service delivery system in Kenya is organized across six levels of care, beginning at the community level and continuing through primary care services, which include dispensaries (level 2) and health centres (level 3), and county referral health services (level 4 & 5) all the way to the national referral health services (level 6). The strengthening of referral linkages across service delivery units is one of the elements in the health policy strategy to achieve an efficient health service delivery system that maximizes health outcomes. A comprehensive referral system in Kenya with effective linkages will ensure continuity of care across all levels.

To strengthen the referral system, the Ministry of Health (MOH) developed the Kenya Health Sector Referral Strategy 2014–2018. This strategy defines referral as a mechanism to comprehensively manage clients' health needs by using resources beyond those available where they access care. The scope of referral services defined in this strategy includes movement of clients, specimens, services and experts, and client parameters.

1.2 Rationale for a Well-Functioning Referral System

Most of the population of Kenya is rural and poor. An effective referral system will ensure health services to all people in Kenya in the following ways:

- Coordination and standardization of referral services
- Continuity of care across the different levels of care
- Cost-effectiveness of health services provided to Kenyan citizens
- Promotion of universal coverage and equity in provision of health services
- Health care planning through performance monitoring of the referral system

1.3 Benefits of a Well-Functioning Referral System

A well-functioning referral system will have the following benefits:

- Maximize efficiency of the health system by ensuring appropriate use of health services
- Strengthen lower-level facilities and improve capacity for decision-making by health workers at all levels
- Create opportunities for balanced distribution of funds, services, and human resources
- Promote linkages across the different levels of care and between public and private entities
- Ensure that care is provided at the lowest possible cost

1.4 The Goal and Objectives of the Referral Guidelines

1.4.1 The Goal

The goal of the referral guidelines is to guide the effective management of referral services to ensure continuity of care and effective management of the health needs of the population of Kenya.

1.4.2 Objectives

The referral guidelines have the following objectives:

- Increase the use of services at lower levels of the health care system.
- Reduce self-referral to the higher levels of care.
- Develop service providers' capacity to offer services and appropriately refer at each level of the health care system.
- Improve the health system's ability to transfer clients, client parameters, specimens and expertise between the different levels of the health care system.
- Improve supportive supervision, thereby ensuring up-to-date management practices in use across the country.
- Improve referral performance monitoring and coordination.
- Improve preparedness and response to emergencies and disasters.
- Improve counter referral and referral feedback information system and 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.

1.5 Target Audience

The referral guidelines are intended for all state and non-state actors in the health sector including health management teams at national, county, semi-autonomous government agencies in health, households, community units, primary care facilities, county referral facilities, national referral facilities, partners in health, and other sectors that have an impact on referrals, such as the Ministry of Interior and Coordination of National Government, Ministry of Education, and other line ministries.

CHAPTER 2

The Structure and Organization of the Health Referral System in Kenya

2.1 Structure of Integrated Health Referral Network in Kenya

The referral system includes six levels of health care:

Level 1 comprises community health services. This is the foundation of the health service delivery system. Referrals at this level are initiated by Community Health Workers (CHWs) in community units. Community units (CU) are linked to primary health care facilities to which majority of referrals from this level are made.

Level 2 health services provide primary care services and form the interface between the community and the rest of the health system. Level 2 facilities include dispensaries. Dispensaries are managed by a small number of staff, a large majority being nurses. Like the community level, dispensaries refer to level 3 facilities and in some cases level 4. Some dispensaries with larger capacity act as receiving points from other smaller facilities of the same level.

Level 3 facilities also provide primary care services but with additional support. They include health centres and maternity and nursing homes. Many are currently able to offer in-patient services, mostly maternity. These facilities mainly receive referrals from level 1 and 2 facilities.

Level 4 facilities are the first-level hospitals whose services complement the primary care level. Together with level 5 facilities, these form the county referral hospitals. Majority of the referrals to this level are from levels 2 & 3. Facilities at this level offer in- and out-patient services and have large laboratories that offer diagnostic services that otherwise would not be available at the primary care facilities. In emergency cases, referrals to this level may also come from Level 1.

Level 5 facilities are the secondary referral level and offer a broad spectrum of specialized curative services. At this level, facilities are able to offer advanced services and expertise both for curative and diagnostic services. Referrals at this level are mainly from level 4 facilities and in emergency cases lower level facilities.

Level 6 comprises the tertiary-level hospitals whose services are highly specialized. These are the ultimate referral points, mainly national teaching referral hospitals. The entire cascade and network of referrals in the Kenyan health system is to this level where very specialized skills, expertise and services are offered and linkages with local and international universities, facilities, and staff are forged and maintained.

2.2 The Health Referral Chain

The referral system links the different levels of care based on the expected services being provided through the system. The levels of care include all facilities—public and private, and Faith-Based Organizations (FBO). Figure 1 shows the linkages between the levels of care. In emergency cases though, there may be referrals from lower level facilities (Levels 1, 2 & 3) direct to county referral facilities (Levels 4 & 5).

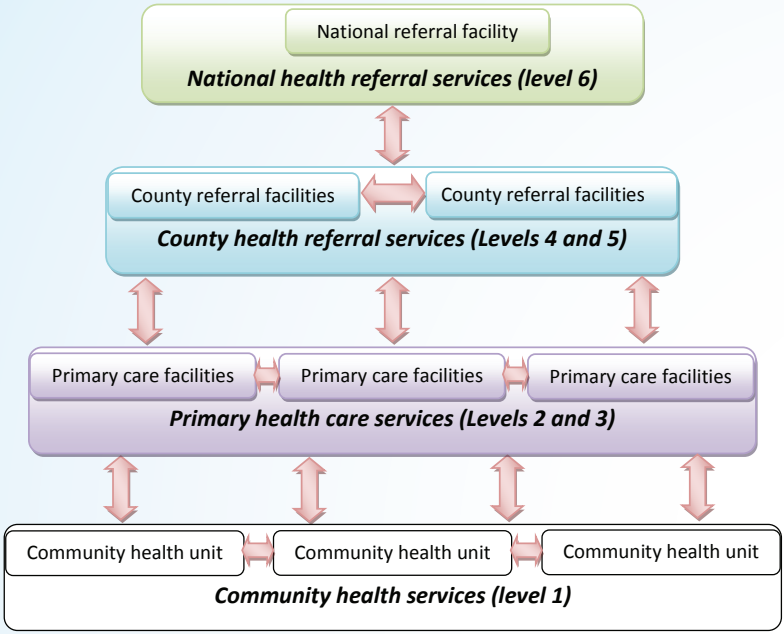

Figure 1: Referral linkages between different levels of care

The referral system has four levels of service: community, primary care, county referral services, and national referral services.

The ***Community Health Services (Level 1)*** which comprises all community-based health activities, organized around the Comprehensive Community Strategy (CCS). This is a non-facility based level.

The ***Primary Care Facilities (Levels 2 and 3)*** comprises all dispensaries, clinics, health centres, and maternity homes.

The ***County Referral Health Facilities (Levels 4 and 5)*** comprise all level 4 and 5 facilities operating in and managed by the county. All of the county-managed facilities form a county referral system, which shares specific services to form a virtual network. The county referral systems receive referrals from primary care facilities in its area of responsibility, from other county facilities in the county, and from facilities outside the county (horizontal referral) and community units.

The ***National Referral Health Facilities (Level 6)*** include the facilities that provide specialized health care services, such as hospitals, laboratories, blood banks, and research institutions. These facilities operate with a defined level of autonomy.

2.3 The Referral Services Framework

Kenya's referral services framework provides for movement of four categories of elements:

Client movement: A client or next of kin seeks an appropriate level of care where his/her or next of kin's health needs can be addressed in the most efficient and cost-effective way, taking into account the different choices of facilities available.

Expertise movement: Services that might not otherwise be available are offered to communities that need them, as they need them. Rather than moving clients to different levels of facilities, specialised service providers come to the client. Services can be provided in a number of ways, such as directly to clients, as out-reach, screening in a medical camp, or surgeries in remote areas. The movement of expert professionals is from higher levels to lower levels.

Specimen movement: Laboratory specimens are moved to specialized facilities, usually for diagnostic purposes, which avoids the need to move the client in the health services system (refer to *National Guidelines for Laboratory Specimen Referral Networks,* MOH, 2012).

Client parameter movement: Client information can be sent to appropriate levels of the health system for supportive diagnosis or management guidance. The scale-up of innovative information and communication technology (ICT) in the health services, particularly in the context of e-health, will facilitate this form of referral.

Figure 2 illustrates the full scope of referral services.

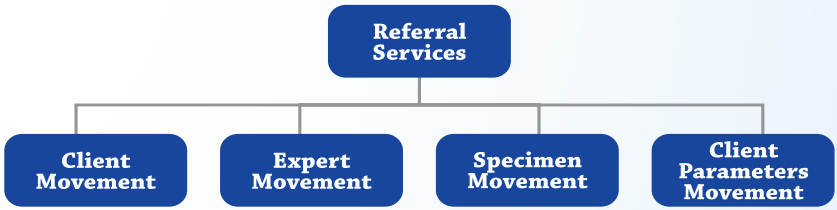

Figure 2: Kenya's referral services framework

2.4 Indications for Referral

The following is a list of some primary reasons for referring clients who seek emergency or routine care:

- To seek expert opinion and report on the client's condition or specimen
- To procure additional or different services for the client
- To seek admission and management of the client
- To request use of diagnostic and therapeutic tools
- To respond to mass incidents and disaster situations
- To send specimens for external quality assurance
- To address security issues
- To account for a lack of resources (financial, human, material)
- To meet a client's request

CHAPTER 3

Roles and Responsibilities

Key players in the referral process must fulfil their respective roles and responsibilities for the referral system to function well. This chapter describes the various roles and responsibilities of the key players in the referral system.

3.1 Responsibilities of the National Ministry of Health

MOH has the following responsibilities at the national level:

- Formulate overall referral policy, referral strategy, referral guidelines, and standard operating procedures (SOPs) for referrals.
- Support the dissemination and training health workers on the referral guidelines and referral SOPs.
- Design and disseminate standard referral tools, such referral forms and registers.
- Provide technical assistance and build capacity to strengthen the referral system at the county level.
- Undertake overall performance monitoring of the referral system in Kenya.
- Perform needs assessments for specialized services.
- Provide accreditation of specialists.

3.2 Responsibilities of the County Health Department

The county health departments have the following responsibilities at the county level:

- Implement the county referral strategy 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 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 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 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.

3.3 Responsibilities of the Client

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

- Provide consent for referral. Clients or next of kin who refuse consent for a referral or transfer should sign a form indicating that they are acting against medical advice.
- Facilitate the referral.
- Assume responsibility for the security of the client's belongings.
- Consent to be transferred back to the initiating facility after treatment.

3.4 Roles and Responsibilities of the Referring Health Worker

The referring health worker should meet the following responsibilities:

- 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 (refer to annex) with all the necessary information and attach relevant documentation.
- 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 counselling of the clients on the need for referral and maintenance of confidentiality.
- Obtain informed consent from the client being referred.

3.5 Roles and Responsibilities of the Referring Facility

The referring facility assumes the following responsibilities:

- 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 a 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.

3.6 Roles and Responsibilities of 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.

3.7 Responsibilities of 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 behaviour.
- 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 prescheduled 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.

CHAPTER 4

Management of Referrals

Effective referral networks should provide linkages across the different levels of the health system, from the community to the tertiary level. This thereby ensures that clients receive the full spectrum of care provided by the health system, regardless of the level at which they physically access health care.

The linkages among the various levels of care and the referral processes will be guided by the guidelines described in this chapter.

4.1 General Referral Implementation Guidelines

General referral guidelines include the following:

- Every person has the right to the highest attainable standard of health.
- Every person has the right to emergency medical treatment.
- The national and county governments will enhance access to referral services by all Kenyans.
- The national MOH will set guidelines for national and county referral systems.
- All clients examined by a health care provider and deemed in need of referral will be referred to a health service that is capable of continuing the care.
- The referral destination will be guided by the MOH Clinical Management and Referral Guidelines for each level of care and the availability of services in the facility receiving the referral.
- The MOH, at both national and county level, will enhance the capacity of service providers to offer appropriate referral services.
- A nation-wide, toll-free telephone number to facilitate communication in the referral system will be established.
- One national and 47 county command centres will be established to coordinate the referral system and interlink it with other relevant departments, such as fire, police, and other services.
- A financial system at the national and county levels will be established to support and ensure the sustainability of the referral system.
- A county ambulance service with appropriate means of transport and trained personnel will be established. Such service will have semi-autonomy and may -be outsourced as a public-private sector collaboration or partnership; however, the function and overall responsibility of the ambulance service will remain under the county health department.
- All referrals will have proper and relevant documentation that is complete, legible, and written in the national language(s) as provided.
- The MOH and scientific and research institutions will collaborate in research and innovative practices in the referral services.

4.2 Client Referral Guidelines

The following list outlines the client referral guidelines:

- Any client examined by a health care worker or at an emergency care unit, in a public or private institution, who is deemed to be in need of specialized consultation or

treatment or requires care and procedures that cannot be provided at the initial level of care, must 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 (see Annex 1) 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 (see the client referral form in Annex 1):
  - Full name of the client being referred
  - Unique identifier number (IP/OP)
  - Client address and phone number
  - Next of kin (name, address, and phone number)
  - Date and hour of referral
  - Client date of birth, age, and sex
  - Reason for referral
  - Diagnosis, if known
  - Treatment given, diagnostic work-ups done, client's vital signs
  - Name and relevant details of physician or provider making the referral
  - Signature of the referring health worker
  - Name of the referring clinic or unit or facility
  - Client medical history
  - Name of the receiving clinic or unit or facility
- All relevant diagnostic results (laboratory, radiological studies, electrocardiogram (ECG), and previous referral information) should accompany the client referral form.
- For emergency referrals, the referring health worker will communicate directly by phone or any other means of communication available to the receiving health worker to ensure that advance notice of the referral is given to allow adequate preparation.
- All referrals shall be governed by the health sector referral guidelines.
- The national and county MOH will appoint a team to periodically monitor and evaluate the performance of the referral system at the national and county levels. This team will make recommendations on how to improve the performance of individual units or of the system as a whole.
- All counter-referrals to the originating referral facility will be communicated appropriately by using standard counter-referral forms with all the necessary information completed.
- A toll-free ambulance service telephone number will be in place and connected to other emergency services across the country.
- For effective management of clients and efficiency of the referral systems, the counties will ensure the availability of health services according to the Health Sector Norms and Standards.
- All emergency referrals shall be accompanied by a trained staff to the receiving health facility.
- Referred clients will receive priority attention at the receiving health facility.
- The referral processes will include proper documentation, and client privacy and confidentiality will be ensured at all times.
- Emergency referred clients, specimens or parameters will be attended to regardless of socio-economic status or referring county/ facility.
- All health facilities receiving referral services will function for 24 hours to be able to manage referrals. 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.

- All health facilities will have a standard designated area for receipt and management of emergency cases.
- All health facilities will have an emergency operations plan and a dedicated emergency response team; it also will provide equipment for management of emergency cases.

4.3 Logistics for Client Movement

The following guidelines apply to the logistics for client movement:

- Basic logistics will be provided to facilitate client movement at different levels of care, including transport, communication, human resources, and commodities.
- A command, control, and coordination structure will be established at the national and county levels with linkages to other relevant departments. The command centre will have its own layout, infrastructure, and staff.
- Every county will appoint a coordinating team for ambulance services that will be answerable to the county health management team.

4.4 Guidelines for Specimen Movement

Guidelines for specimen movement include the following:

- A specimen will be referred to any of the referral laboratories in the network, depending on the availability of services.
- The established health care system management structures will be used to manage and coordinate laboratory referral networks, especially for tests used in support of diseases of public health importance.
- The roles and responsibilities of various actors in the specimen referral at each level will be well defined.
- The national reference laboratories will serve as centres for carrying out specialized tests. The main national reference laboratories in the referral chain will include the national reference laboratory network and the Kenya Medical Research Institute (KEMRI) laboratories, which are intended for research, but which also act as referral centres for diagnosis of diseases that require notification, such as polio, measles, and influenza.
- Primary care laboratory services will be provided at primary care facilities, providing basic laboratory diagnosis for clients coming to the facility. The primary care laboratories will coordinate collection of specimens for community events that require laboratory diagnosis, such as for notifiable diseases.
- The primary care laboratory services will be equipped with the necessary capacity to facilitate specimen packaging and transportation to higher level laboratories.
- A chain of horizontal laboratory networks, whether public or private, will be established to provide alternative testing sites in the same level of the hierarchy when such need arises.
- Clear service standards and operating procedures will be communicated to all facilities to guide them in appropriate referral of specimens collected, and they will be contained in the national guidelines for laboratory specimen referral networks.

- Standard measures will be put in place to ensure that the specimens collected are of good quality and that appropriate biosafety measures are used in handling them.
- The process of collecting and packaging laboratory specimens will be guided by Kenyan law and International Air Transport Association (IATA) Instruction 650-Diagnostic Specimens disease specification, including packaging of specimens to maintain integrity of specimens and safety of personnel at all times.
- All specimen referrals to and from outside the country must authorised by the Kenya Medical Laboratory Technicians and Technologist Board, in consultation with the Director of Medical Services.
- Appropriate packaging materials and biohazard labels will be provided at all levels.
- Minimum documentation requirements of the referring laboratory, courier, and receiving laboratory will be defined.
- The specimen referral form will be duly filled in, and further information on this will be contained in the national guidelines for laboratory specimen referral networks.
- Well-defined channels of communication in referral networks will be established to ensure completion of the referral and effective performance of various actors at each level.
- All facilities in the network will have a modern, effective means of communication with each other and with their respective health services management.
- A well-defined frequency of reporting will be established at all levels; that is, from facilities to county and national levels.
- Data obtained from the referral chain will be analysed at all levels of the referral chain and used to assess the gaps and performance of the networks at various levels for better management and service improvement by the MOH and supporting partners.
- All the laboratories participating in the referral network will adhere to good laboratory practices. The referral system will adhere to good internal and external quality assurance practices and maintain the system in a continuous quality improvement process for all the laboratories connected to the network.
- The quality assurance system will be supported by budgetary provisions at the national, county, and sub-county levels.

4.5 Guidelines for Movement of Client Parameters

Guidelines for movement of client parameters include the following:

- The e-referral system will be implemented in accordance with the country e-health strategy, including establishment of the web portal and software module, call centres, e-referral guidelines, and standard operating procedures.
- The health workers shall be trained and updated in the use of information and communication technology (ICT), e-referral tools, and guidelines.
- The e-referral system will use the ICT backbone infrastructure established by the government and provided by other stakeholders.
- The e-referral system will be implemented through the use of established e-referral (call) centres interlinked in the system and digitized clinical management and referral guidelines to support accessibility and decision support while carrying out e-referral services at all levels and geographical locations.

- 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.
- The e-referral system will be linked to the Electronic Medical Record (EMRs) and Electronic Health Record System (EHRS) and laboratory services at all levels.
- The community-level m-health (mobile phones) strategy will be used to collect health data for decision-making, and the community health extension workers, community-oriented resource personnel, and community health workers will be trained on referral mechanisms and how to identify complicated cases.
- The e-referral system will ensure that client privacy and confidentiality are maintained at all levels of care.

4.6 Guidelines for Expert Movement

Following are the guidelines for expertise movement in the health referral system:

- Expert specialists will be drawn from public, private, and faith-based facilities or foreign countries and will include medical, dentists, pharmacists, clinical, nursing, laboratory, nutrition experts, among other health specialists.
- Experts will support national or county facilities in the country by offering services at specialised clinics, surgeries, and out-reaches, as well as organizing medical camps, depending on the need in each area.
- The expert specialists will be required to promote screening services at primary care facilities in their areas of jurisdiction, guided and coordinated by the county health teams.
- An up-to-date inventory of teams of specialists from the public and private sectors and faith-based organizations at the national and county levels will be maintained and used to form the pool from which the expert services will be drawn.
- County health teams will periodically determine needs on the ground and liaise with the national MOH in identifying, accrediting, and prioritizing the types of experts and schedule for maximum benefit.
- On a needs basis, the national MOH, in consultation with counties and the national facilities, may recruit experts from out of the country. Such recruitment is encouraged to transfer skills to a larger group of local personnel. The accreditation of such facilities, however, will be guided by the Medical Practitioners and Dentists Act and other acts of Parliament that guide the registration of health practitioners.
- The recipient facility will be required to mobilise and screen clients before enrolling them for consultation by the visiting experts.
- All the facilities will be required to invest in basic information and communication technology to support consultations and ensure proper back-up.
- Individuals in charge of facilities will ensure that adequate support staff, necessary equipment, and resources are available to meet the needs of the expert mission.

CHAPTER 5

Coordination of Referral Services

A well-functioning referral system requires active collaboration and cooperation among the various stakeholders and health care providers in a referral network. This chapter details the coordination mechanisms at the national, county, sub-county, and facility levels.

5.1 Referral Coordination Structure

Referral coordination will be done at the different levels of health service delivery and include all four types of referrals according to the Kenya Health Sector Referral Strategy. The coordination of the referral system will be done at the national and county levels by a referral coordinating unit or team, and the sub-county and facility levels will have an appointed referral coordinator (Figure 3).

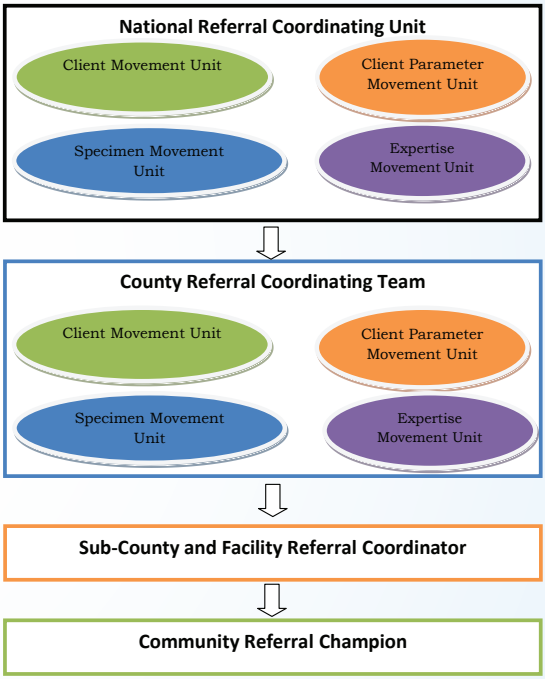

Figure 3: Coordination of the referral system

5.1.1. Coordination at the National Level

The national referral coordination unit will oversee coordination at all levels of care in the country and be expected to facilitate care when the situation requires mass evacuations, air ambulance, disaster response, or external expertise. The MOH, in consultation with national-level facilities, will establish this unit.

The unit will perform the following functions:

- Coordinate resource mobilization and distribution to facilitate movement of clients, experts and services, specimens, and client parameters.
- Design, develop, and disseminate referral policy, strategy, guidelines, and protocols.
- Align the referral strategy with other relevant policy documents.
- Develop the referral monitoring and evaluation framework.
- Coordinate capacity building of the referral system.
- Develop appropriate policies to govern ethical issues pertaining to referral.
- Ensure implementation of referral standards.

5.1.2. Coordination at the County Level

At the county level, 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 overall county referral coordinator.

Following is a list of the roles and responsibilities of the coordinating team:

- Coordinate resource mobilization and resource distribution at the county level to facilitate movement of clients, services and experts, 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 referral.
- Conduct performance monitoring and evaluation of the referral system at the national and 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.

5.1.3. Coordination at the Sub-County and Facility Levels

The sub-county-level referral coordinator will ensure reinforcement of the referral system among the different levels of care. The following is a list of the roles and responsibilities of the sub-county referral coordinator:

- 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 analyse 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.

5.1.4. Coordination at the 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 following is a list of the roles and responsibilities of the facility referral coordinator:

- Coordinate client, specimen, experts, and client parameter referrals in and out of the facility.
- Facilitate scheduling of referrals based on the level of priority for consultation; that is, 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 sensitisation 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.

CHAPTER 6

Monitoring of the Referral System

The health referral services require a performance monitoring system to ensure proper functioning of the system. The national and county health services will establish monitoring mechanisms to ensure that the health sector referral guidelines are followed.

6.1. Purpose of Referral System Monitoring

Adequate referral monitoring involves all aspects of the referral framework, which includes client and client parameter movement, specimen movement, and expertise movement. The national and county health referral networks function in an interdependent manner where all units, at different levels, depend on all other units for the harmonious performance of the referral system as a whole. The monitoring involves a continuous audit of the system to ensure 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 have been developed to inform the level and performance of client referrals, client parameter movement, specimen and expert movement. The following is a list of the referral tools:

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

6.2. Monthly Referral Summary Forms Monitoring Indicators

Table 1 below shows the minimum set of indicators that will be used to monitor and evaluate the performance of the referral system.

Table 1: Indicators used to monitor and evaluate the referral system

Monitoring Parameters	Indicators
Client movement	1. Service utilization rates (number of clients attended and population) 2. Referral rate from referring service (number of clients referred and number of clients seen) 3. Referral uptake rate (number of referred clients seen at receiving service/facility and number of clients referred) 4. Median delay in completion of referral (median time in days from referral to capture at receiving service/facility) 5. Median emergency referral waiting time (median time taken after referral decision was made to the actual transfer of the client from the referring facility) 6. Counter-referral rate (number of clients received back at original referring service/facility with adequate information from receiving service and number of clients referred) 7. Client satisfaction (number of clients satisfied with referral service and number of clients referred)
Client parameter movement	8. Number of counties with enabling ICT infrastructure to support referrals 9. Number of e-health hubs established (goal, 58 facilities) 10. Number of Web portals established (plus inventory) 11. Number of call centres to support e-referrals 12. Number of trained staff in client exchange parameters from county for e-referral
Specimen movement	*Network effectiveness* 13. Number of specimens sent from satellite sites 14. Number of new nodal or satellite sites established in support of care and treatment for priority diseases 15. Number of new tests added to the test menu in the nodal sites *Network efficiency* 16. Number of referral costs 17. Median turn-around time for results *Quality assurance* 18. The specimen rejection rate *Nodal site saturation* 19. The volume of specimens referred to the nodal site for testing per given period of time, usually one year versus the staff establishment in the facility

Monitoring Parameters	Indicators
Expertise movement	20. Number of out-reach and mission services from county and out of county 21. Number of foreign, national, and county out-reaches and missions per county per year
Referral System	22. Number of health facilities with Emergency Operating Procedures (EOPs) 23. Number of fully equipped ambulances and trained personnel in emergency procedures 24. Number of counties with integrated emergency preparedness plans 25. Number of staff trained in emergency care 26. Proportion of health facilities with referral guidelines and protocols 27. Number of counties with a central command and coordination centre 28. Number of complaints about client rights per facility 29. Number of counties with functional ambulances as per the ambulance norms and requirements (number, type: basic, intermediate, and advanced) 30. Proportion of facilities with focal person for referral 31. Accessibility of e-referral guidelines in counties
Referral Process	32. Proportion of referrals with completed referral forms 33. Number of self-referrals 34. Proportion of appropriate referrals as determined by receiving facilities (number of appropriate referrals and total number of referrals received) 35. Proportion of service providers that report satisfaction with referral services

References

1. Kenya Bureau of Standards. (2013). Minimum Ground Ambulance Requirements. Kenya Standard KS 2429: 2013.
2. World Health Organization. (2002). Draft: Human Resources for Health: Developing Policy Options for Change. Discussion paper. Geneva, Switzerland.
3. Deloitte. (2011). Strategic review of the national hospital insurance fund–Kenya.
4. United Nations. The Millennium Development Goals. Accessed at : http://www.un.org/millenniumgoals/
5. World Health Organization. The Six Major Health Sector Objectives.
6. Ministry of Health. (2012). National Guidelines for Laboratory Referral Networks. Nairobi: Republic of Kenya.
7. The Constitution of Kenya. (2010).
8. Ministry of Health. (2006). Norms and Standards for Health Services Delivery, June 2006. Nairobi: Kenya Ministry of Health.
9. Ministry of Health. (2013). Accelerating Attainment of Health Goals: The first Kenya Health Sector Strategic and Investment Plan. July 2013–June 2017.
10. The Kenya Vision 2030: The Second Medium-Term Plan 2013–2017.
11. Kenya Ministry of Health in collaboration with the World Health Organization. (2007). Service availability mapping.
12. Ministry of Health. (2013). Draft sector plan for health 2013–2017.
13. The State of the Health Referral System in Kenya:
14. Ministry of Health. (2013). Results from a Baseline Study on the Functionality of the Health Referral System in Eight Counties.
15. Ministry of Health–Belize. (2006). National referral strategy, policy and protocols. Pan American Health Organization, World Health Organization.
16. Ministry of Health–New Zealand (2002). Guidelines for Consultation with Obstetric and Related Medical Services (Referral Services). Accessed at: www.health.gvt.nz.
17. The Kenya Quality Model for Health. (2011). Quality standards for Kenya Essential Package for Health.
18. Jonathan Brotherton. (2008). Good Practices Guide for Ambulance Services and their Commissioners (UK).
19. Ministry of Health/Centres for Disease Control. (2013). Emergency Medical Services report.
20. Federal Democratic Republic of Ethiopia, Ministry of Health. (2010). Guidelines for implementation of a patient referral system. Addis Ababa, Ethiopia.
21. Ministry of Medical Services, Kenya. (2010). Facts and Figures.
22. The Kenya Demographic Health Survey. (2009).
23. Ministry of Medical Services and Ministry of Public Health and Sanitation. (2010). Devolution and Health in Kenya.
24. Service Availability and Readiness Assessment Mapping (SARAM) report. (2013).

ANNEX 1: Client Referral Form

M.O.H

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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 Reported..... Referred from Facility/Department .....

Clinical Details:.....

.....

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

Designation.....

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

ANNEX 2: Specimen Movement Form

MOH 240H

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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..... Signture.....

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 Form

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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/OP 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 in Transit Monitoring Form

Referring facility name……	**Service area**……	**Vehicle No**……

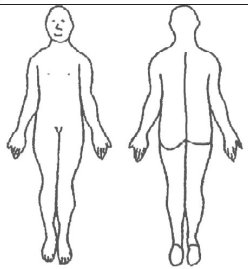
Client	**Incident**	**Transit times**
Name: ……	Date: __ __/__ __/__ __ __ __ [dd/mm/yyyy]	Call received: __ __: __ __
Age [Yrs]: _____	Time: __ __: __ __	Dispatched: __ __: __ __
Sex: M ☐ F ☐	Location of Incident: ***(tick as appropriate)***	Arrived at scene: __ __: __ __
Mobile No: ……	☐ Home ☐ Medical 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**
	__ __: __ __	__: __ __	__: __
SPO₂ *Rate*			
Description			
Pulse *Rate*			
Description			
Breathing *Rate*			
Description			
Blood Pressure			
Temperature			

Initial assessment

Abrasion
Burn
Contusion
Deformity
Fracture
Haemorrhage
Laceration
Pain
Rigidity
Swelling
Tenderness



Lung sounds ***(tick as appropriate)***

Left		**Right**
☐	Clear	☐
☐	Stridor	☐
☐	Diminished	☐
☐	Wet rales	☐
☐	Hyper-resonant	☐
☐	Rhonchi	☐

Glasgow coma scale ***(circle as appropriate)***

Eye opening	**Motor response**	**Verbal response**
4 Spontaneously	**6** Obeys commands	**5** Oriented
3 To voice	**5** Locates 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	

Pertinent medical history:

Chief 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

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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 complete 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 complete a referral (reported Bi-annually)	

Completing Officer Details:
Name.....Telephone Number.....
Designation.....
Signature..... Date.....

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Kenya Health Sector Referral Implementation Guidelines

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