**SECTION A.**

**1). Hospital category/ classification.**

Initially it was Kakamega County General Hospital later on changed to Kakamega Teaching and Referral Hospital (K.T&R.H.) after it was gazetted on 1st July 2017.

It is a level 5 hospital.

**2). Functions of the hospital.**

The Kakamega Teaching and Referralhospital offers the following services;

* Curative services; this includes the admission of patients in the various wards depending on the diagnosis whether surgical or medical for further management. In the wards drugs are administered to the patient and other procedures necessary that promote healing.
* Preventive services; this involves Mother & Child Health ( MCH) services such as immunization, antenatal services, HIV testing and counselling, Family planning services.
* Promotive services; K.T&R.H offers services that aid in promotion of health such as nutrition services.
* Rehabilitative services; K.T&R.H has Psychiatric ward en clinic, the Comprehensive Care Centre that aid in rehabilitation of patients.
* Educational services; being a Teaching hospital it offers learning opportunities and training to students from various universities and medical training colleges. Research is also always carried out at the hospital.
* Diagnostic services; the hospital has laboratories, X-ray, Magnetic Resonance Imaging, Computed Tomography departments which aids in diagnostic findings of various diseases.

**3). Vision, Mission, Objectives, Values of the hospital.**

 Vision;

To be a leading regional centre of excellence in holistic health care delivery, medical research and education.

 Mission;

To provide accessible, acceptable, affordable and sustainable quality curative, preventive, promotive, rehabilitative and educational health care services of our clients.

 Values;

Develop, retain and motivate a high quality staff through teamwork, transparency, honesty, fairness, respect and humility to achieve our mission and vision.

**4) Hospital coverage area/ Target population.**

The target population for the hospital is 81,378 people.

The hospital coverage area has been calculated based on the new clients received at the facility divided by the total target population .i.e.

NEW CLIENTS= 69495

Target population= 81,378

69495/81378=0.854

0.854\*100%= 85.4%

Hence the hospital coverage area is 85.4%.

**5) Organogram/Staff establishment.**



Staff establishment.

 Medical consultants-18

* Medical officers – 44
* Medical officers interns- 20
* Clinical officers – 23
* Clinical officers interns- 45
* Nurses- 262
* Nutritionist- 3
* Physiotherapist-11
* Drivers- 6
* Housekeepers-17
*

**6) Subdivisions of the hospital and their functions.**

* Prime care unit; this includes the amenity and paediatric wards. This are units that require specialized and highly standard of care to the patients. Amenity involves those who can afford the specialized care and mostly they are always covered with insurance.
* Medical unit; the medical unit offers services to all medical conditions such as malaria, pneumonia etc. The hospital has the male medical (ward 1), female medical ward (ward3), and paediatric medical ward (5A).
* Surgical unit; the surgical unit involves all the invasive procedures. There is theatre where the operation takes place and later on the patients taken to the surgical wards .i.e. the male surgical ward ( ward 6) , female surgical ward (ward 7) and paediatrics surgical ward( ward 5B).
* Maternity/Obstetrics & Gynecological unit; this includes antenatal ward, Labor ward, and postnatal ward, gynecological ward. They offer comprehensive services to women.
* Out-patient department; this offers minor cases that treat patient and patient go back home under medication.
* Casualty & Disaster Preparedness department; this department handle all the emergencies and accidents.

**7) Bed capacity & patient turnovers.**

The bed capacity of K.T&R.H. is 500.

The patient turnover is 13 patients rotate on the same bed throughout the year with a duration of 4hours 48minutes each. The above calculation is based on the report from ward .i.e. patients discharge in and discharged out.

**8) Top 10 diseases of the entire hospital.**

1. Malaria (suspected and confirmed malaria)
2. Pneumonia.
3. Upper Respiratory Tract Infection.
4. Hypertension.
5. Injuries.
6. Urinary Tract Infections.
7. Arthritis, joint pains.
8. Diarrhoea
9. Typhoid fever.
10. Disease of the skin.

In-patient top 10 diseases.

1. Confirmed Malaria.
2. Pneumonia.
3. Anaemia.
4. Head injuries.
5. Diarrhoea.
6. Congestive Cardiac Failure.
7. Hypertension.
8. Hernia.
9. Cellulitis.
10. Peptic Ulcers Disease.
11. **Hospital committees and their functions.**
12. Hospital Management Team.

The chairperson is the medical superintended of the hospital.

Functions; - Preparation of hospital work plans.

 ; - Distribution of resources equally.

 ; - Ensures quality services are offered in the facility.

 ; - Ensures proper information and records are maintained.

 ; - Ensures there is proper finance maintained.

1. Hospital Advisory Committee.

The chairperson is the medical superintended.

Functions; - it deals with disciplinary issues.

 ; - Gives advice and punishment where and when necessary.

1. Executive Expenditure Committee.

It deals with finance issues .i.e. funding, distribution and utilization of money within the facility.

1. Hospital Transfusion Committee.

The chairperson is the Head of Department Surgery.

Ensures there is enough blood for transfusion within the facility.

1. Wavers committee.

Deals with waving the needy patients who cannot pay their bills on their own.

1. Medical Therapeutic Committee.

The chairperson is the Head of Department Medicine.

It ensures there is well commodity and supply management.

1. Emergency Response/ Disaster preparedness.

The chairperson is the orthopedic surgeon.

It ensures all emergencies and disaster are well managed.

1. Ethics and Research.

The chairperson is ophthalmologist.

Approves researches.

Ensures proper ethics are maintained.

1. Performance management Committee.

Headed by the medical superintended.

Appraisal of staffs.

1. Facility Improvement Funds committee.
2. Training committee.

Ensures well training of the students’ interns and nurses.

Organizes for training and seminars for nurses, medical officers.

**10) How does the hospital handles an emergencies.**

Emergencies are always managed by the emergency and accidents (Casualty) and Disaster preparedness department.

In case of an emergency the above department will receive the information about it through either one of the casualty from the scene or from the paramedics in rescue or a good Samaritan.

Once the information is on the facility the nurse in-charge or the nurse on duty will communicate to the covering nurse through hospital phone informing him/her about the accident .i.e. the type of accident, approximation number of people who might have been involved in the accident, and the place it has occurred.

The covering nurse will be the one to communicate to other departments in the hospital informing them about the accident so that departments such as theatre, surgical unit and X-rays can also prepare to receive the patients. Also the nurse covering is the one to mobilize other health practitioners to come to assist the nurses in casualty depending on the workforce.

In the casualty, as a unit in-charge or nurse on duty, after communicating to the hospital, you need to assemble all the necessary equipments both pharmaceutical and non-pharmaceuticals and place them at the central place where they are easily accessible. In this case the crush-box is always opened.

The nurse in-charge then delegates duties/allocation to the available nurses for example can assign those to be triaging patients, those arresting bleeding, those resuscitating the patients, those administering analgesics. When other nurses/ doctors arriving from the various departments arrive you as the nurse in-charge u just add them to the ones you had already delegated duty earlier on. This is always with the exception of the Theatre staffs and surgical staffs together with the Intensive care Unit.

As the care continues being given to the workers, assign one at most among the hospital casuals to record the names of the victims indicating their particulars including names, age, sex, and type of care/service given.

N/B; All casualties regardless of the pain score should be given intramuscular analgesics, though if the victim is conscious always ask if they are allergic to any drug.

After attending to all casualties and ensuring they are stable and those transferred to the wards have gone and those discharged home have gone, clearing of the work area is done.

During clearing one must be careful since infection prevention technique is always poor during the services.

For those staffs who will have pricked themselves with the sharps they are all given Post- Prophylaxis exposure (PEP).

During clearing is when you return the borrowed items.

After clearing the nurse in-charge writes the report of what happened capturing all the activities/ services given. Within the report the names of the victims and what was done to them is captured then one copy of the report remains in the casualty the other one is always taken to the administration block.

Finally as the nurse in-charge you need to replenish your stock by ordering from the hospital store the things (pharmaceuticals and non-pharmaceuticals).

**SECTION B.**

1. **Pillars of healthcare system.**
2. Leadership and Governance.

Good leadership and governance include

* Ensuring that health authorities take responsibilities for steering the entire health sector and for dealing with future challenges including un-anticipated events or disasters as well as the current problems.
* Defining, through transparent and inclusive processes, national health policies, strategy and plan that set a clear direction for the health sector with;

;A formulation of the country’s commitment to high level policy goals (health equity, people-centeredness, sound public health policies, effective and accountable governance.

 ; A strategy for transplanting these policy goals into its implications for financing, human resource, pharmaceuticals, technology, infrastructure and service delivery, with relevant guidelines, plans and targets.

 ; Mechanisms for accountability and adaptation to evolving needs.

; Effective regulation through a combination of guidelines, mandates, and incentives, backed up by the legal measures and enforcement mechanisms.

; Effective policy dialogue with other sectors.

; Mechanisms and institutional arrangements to channel donor funding and align it to country’s priority.

1. Health information system.

Good governance is possible with good information on health challenges, on the boarder environment in which the health system operates, and on the performance of the health system. This specifically includes timely intelligence on;

* Progress in meeting health challenges and social objectives ( particularly equity), including but not limited to household surveys, civil registration system and epidemiological surveillance
* Health financing, including through national health accounts and an analysis of financial catastrophes and of financial and other barriers to health services to the poor and vulnerable.
* Access to care and on the quality of service provided.
1. Health Financing.

This is a key policy to improve and reduce health inequalities if its primary objective is to facilitate universal coverage by removing financial barriers to access and preventing financial hardships and catastrophic expenditure. The following can facilitate these outcomes

 ; A system to raise sufficient funds for health fairly.

; A system to pool financial resources across population groups to share financial risks.

; A financing governance system supported by relevant legislation, financial audit and public expenditure reviews, and clear operational rules to ensure efficient use of funds.

1. Human Resource for Health.

A well performing workforce is responsive to the needs and expectations of people, is fair and efficient to achieve the best outcomes possible given available resources and circumstances. Some of the development of human resource include improving recruitment, education, training and distribution; enhancing productivity and performance and improving retention.

This requires;

* Arrangements for achieving sufficient numbers of the right mix in terms of numbers, diversity and competencies.
* Payment systems that produce the right kind of incentives.
* Regulatory mechanisms to ensure system wide deployment and distribution accordance with needs.
* Establishment of job related norms, deployment of support system and enabling work environments.
* Mechanisms to ensure cooperation of all stakeholders such as health worker advisory groups, donor coordination groups, private sector, professional associations, communities and client/consumer groups.
1. Essential Medical products and Technologies.

Universal access to health care depends on accessibility to affordable essential medicine, vaccines, diagnostics and health technologies of assured quality, which are used in scientifically sound and cost effective.

1. Service delivery.

The type of service delivered depends on;

* Network of close-to-client primary care, organized as health districts or local area networks with the back- up of specialized and hospital services, responsible for defined populations.
* Provision of package of benefits with a comprehensive and integrated range of clinical and public health interventions that respond to the full range of health problems of their populations including those targeted by the Millennium Development Goals.
* Standards, norms and guidance to ensure access and essential dimensions of quality, safety, effectiveness, integration, continuity and people-centeredness.
* Mechanisms to hold providers accountable for access and quality and to ensure consumer voice.
1. **Management of Health care systems at both the county and national level.**
2. National level management functions.
* Monitor quality and standards of performance of the national and county governments in the provision of health services.
* National planning and policy formulation.
* Enforcement of standards.
* Ensuring commodity security.
* Performance monitoring.
* Capacity strengthening.
* Resource mobilization.
* Operational and other research.
1. Management structure at the county level.

The constitution of Kenya 2010 assigned delivery of services to the counties with the exception of National Referral Services.

Governance units at county level include;

* County department responsible for health.
* Hospital boards.
* Primary care management committees.
* Community health committees.

County management functions.

* Planning, investment and asset ownership functions of public health facilities.
* Developing an investment plan to enable fulfilment of the highest attainable right to health and document, annually, progress on fulfilment as required by the constitution.
* Asset financing and ownership
* Channeling public and other funds to develop health facilities.
* Delivering county health services.
* Licensing and accrediting non state health service providers.
* Financing of county level health services.
* Maintaining, enhancing and regulating asset development and Health service providers.
* Approving county special partnership agreements for county health service providers.
* In collaboration with national government, gazette regulations for community manage health supplies to be implemented at the county level.
1. **Policies governing health care systems in Kenya.**
2. Eliminate communicable conditions.

This policy aims at reducing the burden of communicable diseases to a level that is not of major public health concerns.

* Promote provision and progressive realization of universal access to the preventive and promotive services addressing major causes of the disease burden due to communicable diseases.
* Improve nutrition and food safety throughout the life-course
* Control vaccine-preventable disease.
* Control entry of infectious conditions at national borders.
* Increase access to improved water safety and sanitation.
1. Halt and reverse the rising burden of non-communicable conditions and mental disorders.

This will be achieved through implementing strategies to address all of the identified non-communicable conditions and mental disorders.

* Promoting universal access to interventions addressing priority non-communicable conditions and mental disorders.
* Putting in place intersectoral programmes for non-communicable diseases prevention and control.
* Strengthening advocacy for health-promotion activities aimed at preventing increased burden of non-communicable conditions.
* Support optimal health and survival of children by improving technical guidance, regulation, and protection of children’s rights.
1. Reduce the burden of violence and injuries.

This will be achieved by putting in place strategies to address the causes of injuries and violence, with special consideration for gender, age, geographical distribution and other factors.

* Putting interventions directly addressing marginalized and indigent populations affected by the injuries and violence.
* Promote public health aspects of road safety.
* Promote corrective measures and intersectoral preventive interventions to addresses causes of injuries and violence.
* Enhance disaster risk management through disaster forecasting and emergency response.
1. Provide essential health care.

This aims at providing accessible, affordable and equitable healthcare that is responsive to client’s needs.

This will be achieved by strengthening the county and national planning and monitoring processes related to healthcare provision to ensure the demand-driven priorities are efficiently and effectively implemented.

1. Minimize exposure to health risk factors.

This can be achieved through strengthening health promotions interventions and facilitate the use of products and services that lead to healthy lifestyle in the population.

* Promoting healthy lifestyles across all life cycles.
* Reduce unsafe sexual practices among key populations.
* Ensure Health Impact Assessment is conducted for any major infrastructural development.
1. Strengthen collaboration with private and other sectors that have impact on health.

They include; economic growth and employment, security and justice, education and early life, agriculture and food, nutrition, infrastructure, planning and transport, environment and sustainability, housing, land and culture and population growth.

1. **Organization of health care system.**

Health systems are organized based on the government administrative levels.

The KHSSP III 2012-2017 defines the Kenya Essential Package for Health (KEPH) as consisting of the following cost-effective health services;

Type- promotive, preventive, curative and rehabilitative.

Target groups (cohorts -5+1).; Pregnancy and the new born (up to 28 days), early childhood (29 days-59months), late childhood and youths (5-19 years), adulthood (20-59 years), elderly (60 years and above)

Tiers/ levels.

 -Tier 1; Community level

 - Tier 2; Primary care level (health centers/dispensary)

 -Tier 3; County level (district/sub district hospitals)

 -Tier 4; National level.

1. **Role of county government in health care**
* County health facilities and pharmacies
* Ambulance services
* Promotion of primary health care;
* Licensing and control of undertakings that sell food to the public
* Veterinary services (excluding regulation of the profession);
* Cemeteries, funeral parlors and crematoria; and
* Refuse removal, refuse dumps and solid waste disposal.
1. **Partners of health care of Kakamega county referral Hospital**

 -Institutions (Masinde Muliro University of Science and Technology, Kakamega Medical Training College, Mukumu school of Nursing, Bondo medical training college.

 -Kenya Red Cross

 -United States Agency International Development (USAID)

 -AIDS Population and Health Integrated Assistance (APHIA plus)

 -Academic Model Providing Access to Healthcare (AMPATH)

 -Ministry of health

 -rotary

1. **Challenges faced by Kakamega County referral system.**
* Communication barrier between the paramedics and the hospital.
* Shortage of staffs.
* Inadequate equipments.
* Poor referral system.
* Poor Topography.
* Poverty among the patients hence many fear being referred due to lack of money to pay bills.
* More referrals in from the periphery.

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