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REPUBLIC OF KENYA

THIRTEENTH PARLIAMENT

THE SENATE

THE STANDING COMMITTEE ON HEALTH

REPORT ON THE COUNTY OVERSIGHT AND NETWORKING ENGAGEMENTS TO BUNGOMA AND KAKAMEGA COUNTIES

02/04/26

PAPERS LAID
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TABLED BY Sen. Olekina
COMMITTEE Health
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Rt. Hon. Speaker
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Clerk of the senate/ secretary, PSC
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(4) Mr. Chanzu (MP)
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(5) Ms. Machana.
For tabling.
D. Chanzu.
13/04/26.

(6) Mr. Abdirahman
For tabling.
A. Machana
13/4/2026

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LIST OF ABBREVIATIONS

AIA	Annual Investment Allowance
CECM	County Executive Committee Member
CHP	Community Health Promoter
CPSB	County Public Service Board
EMR	Electronic Management Records
FIF	Facilities Improvement Financing
FY	Financial Year
HMIS	Health Management Information System
HPTs	Health Products and Technologies
HRH	Human Resource for Health
SHIF	Social Health Insurance Fund
SHA	Social Health Authority
OSR	Own Source Revenues
ICU	Intensive Care Unit
KEMSA	Kenya Medical Supplies Agency
KMPDU	Kenya Medical Practitioners and Dentist Union
MEDS	Mission for Essential Drugs Supplies
MoH	Ministry of Health
NG	National Government
NHIF	National Health Insurance Fund
PSC	Public Service Commission
UHC	Universal Health Coverage
WHO	World Health Organization
MAT	Medically Assisted-Therapy

PRELIMINARIES

Establishment and Mandate of the Committee

The Standing Committee on Health is established pursuant to standing order 228 (3) and the Fourth Schedule of the Senate Standing Orders and is mandated to *consider all matters relating to medical services, public health and sanitation.*

Pursuant to Standing Order 228(4), the Committee is specifically mandated to-

1) *investigate, inquire into, and report on all matters relating to the mandate, management, activities, administration and operations of the Ministry of Health and its departments;*
2) *study the programme and policy objectives of the Ministry of Health and its departments, and the effectiveness of the implementation thereof;*
3) *study and review all legislation referred to it;*
4) *study, assess and analyze the success of the Ministry of Health and departments assigned to it as measured by the results obtained as compared with their stated objectives;*
5) *consider the Budget Policy Statement in line with the Committee's mandate;*
6) *report on all appointments where the Constitution or any law requires the Senate to approve;*
7) *make reports and recommendations to the Senate as often as possible, including recommendations for proposed legislation;*
8) *consider reports of Commissions and Independent Offices submitted to the Senate pursuant to the provisions of Article 254 of the Constitution;*
9) *examine any statements raised by Senators on a matter within its mandate; and*
10) *follow up and report on the status of implementation of resolution within its mandate;* and
11) *follow up and report on the status of commitments made by the Cabinet Secretaries in their response to questions under Standing Order 51C.*

Committee Membership

The Committee is comprised of the following members-

1. Sen. Jackson K. Mandago, EGH, MP - **Chairperson**
2. Sen. Mariam Sheikh Omar, MP - **Vice-Chairperson**
3. Sen. Justice (Rtd.) Stewart Madzayo, EGH, MP - Member
4. Sen. Ledama Olekina, CBS, MP - Member
5. Sen. Richard Onyonka, MP - Member
6. Sen. Tabitha Mutinda, CBS, MP - Member
7. Sen. Hamida Kibwana, MP - Member
8. Sen. Joseph Githuku, MP - Member
9. Sen. Vincent Kiprono Chemitei Cheburet, MP - Member

CHAIRPERSON'S FOREWORD

At its Sitting held on 4th November, 2025 the Standing Committee on Health deliberated on the state of provision of healthcare services at health facilities country-wide and resolved to conduct an oversight visit to Bungoma and Kakamega Counties to acquaint itself with the provision of healthcare services as part of its oversight function.

The oversight visits which took place on 14th and 15th November, 2025 were designed to provide crucial firsthand insights into the state of health infrastructure, service delivery quality and the urgent challenges affecting medical staff and local communities they serve.

The Committee engagements involved site visits and direct interactions with healthcare workers and members of the public at Bungoma County Referral Hospital and Kimaeti Health Centre in Bungoma County and Kakamega County Referral Hospital in Kakamega County. Through these interactions, the Committee gathered critical evidence and noted widespread deterioration of health infrastructure and safety standards across the two counties, including cracked floors, leaking roofs, damaged ceilings, broken doors and windows, exposed electrical wiring and dilapidated furniture.

The Committee noted widespread overcrowding in wards and maternity units, stalled or poorly executed capital projects and obsolete or non-functional medical, diagnostic and ambulance equipment which further undermine service delivery and patient safety in these healthcare facilities. In several facilities, kitchens, laundries, sanitation facilities and waste-management areas were found to be substandard with inadequate laundry capacity, firewood-based cooking, poor food-handling surfaces and open burning of mixed biomedical waste posing serious infection-prevention, environmental and occupational health risks.

The Committee also observed persistent human resource and service-delivery challenges, including understaffing of critical cadres such as nurses, clinical officers, radiographers and morticians, heavy workloads in emergency and maternity units and reliance on long-serving casual and contract staff without regularization. Weaknesses in patient-centred care were evident in the detention of patients over unpaid bills, congestion and lack of privacy in maternity and newborn units, inadequate sanitary facilities and insufficient waiting areas for clients and caregivers.

At the same time, the facilities struggled with delayed Social Health Authority (SHA) reimbursements and dependence on internally generated funds, which constrained their ability to maintain infrastructure, recruit staff, procure supplies and sustain essential services. The persistent delays in SHA reimbursements should be treated as a systemic risk to the implementation of Universal Health Coverage (UHC) implementation and that SHA and National Treasury should be compelled to submit biannual status reports.

Further, the Committee identified significant governance, health information and pharmaceutical management gaps, including malfunctioning or absent electronic health information systems, inconsistencies in patient data between admissions and ward records and inadequate deployment of SHA verification devices that forced patient movement for biometric authentication. Pharmacy and supply-chain weaknesses manifested through near-expiry and expired medicines on shelves, poor stock control and reports of patients being directed to purchase medicines externally despite evidence of available stock.

The Committee recommends that the County Governments of Bungoma and Kakamega, in collaboration with the relevant regulatory agencies, urgently prioritize the rehabilitation and upgrading of health infrastructure, safety systems and critical equipment in the visited facilities. This should include comprehensive structural repairs, completion and rational planning of capital projects, restoration or replacement of non-functional diagnostic and treatment equipment, and modernization of kitchens, laundries, sanitation and waste-management systems in line with national infection-prevention, occupational health and environmental standards.

The Committee further urges the development and implementation of facility master plans aligned to county development plans, with ring-fenced budgetary allocations and clear timelines for addressing identified gaps.

To strengthen service delivery and safeguard patient welfare, the Committee recommends accelerated recruitment and rational deployment of essential health workers, including nurses, clinical officers, radiographers, morticians and support staff, guided by Ministry of Health staffing norms. County Public Service Boards should regularize long-serving contract and casual staff and ensure adequate staffing of high-volume emergency and maternity units to reduce unsafe workloads and improve quality of care. At the same time, hospital managements should enhance patient-centred care by eliminating the detention of patients over unpaid bills, improving privacy and sanitation in wards, expanding waiting and sanitary facilities, and enforcing professional accountability through visible staff identification and functional feedback mechanisms.

The Committee further calls upon the Social Health Authority, the Ministry of Health and County Governments to address systemic financing, health-information and pharmaceutical-management weaknesses that undermine service delivery. This includes clearing outstanding reimbursement arrears and instituting predictable payment cycles, fully deploying functional electronic health information systems and adequate SHA verification devices, and tightening pharmaceutical and supply-chain controls to prevent wastage, stock-outs and misuse of medicines. The Committee recommends that the County Assemblies intensify structured oversight of these interventions, require regular progress reporting from duty bearers and ensure sustained compliance with legal, regulatory and policy frameworks governing the health sector.

Acknowledgements

The Committee sincerely thanks Sen. David Wafula Wakoli, CBS, MP, Senator for Bungoma County and Sen. Dr. Boni Khalwale, CBS, MP, Senator for Kakamega County for their warm welcome and the invaluable support extended to the Committee by their offices during our oversight visits. The contributions and input from their teams greatly facilitated the effective discharge of the Committee's oversight mandate and functions in the two counties.

The Committee further wishes to extend its appreciation to Hon. Kenneth M. Lusaka, EGH, Governor of Bungoma County; and Hon. (FCPA.) Fernandes Barasa, OGW, Governor of Kakamega County and the respective Executive Committee Members for their input and submissions during the oversight tours.

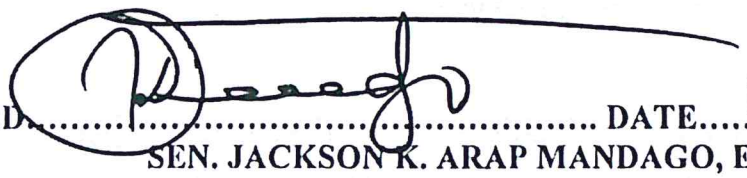
Further, the Committee extends its sincere gratitude and appreciation to the Speakers of Bungoma County Assembly and Kakamega County Assembly and the County Assembly Members of the respective County Assembly Committees on Health for their facilitation.

The Committee is also grateful to the members of staff and other stakeholders in the healthcare facilities visited during the tour for their submissions, which have greatly enhanced the evidence analyzed during processing of this report.

Finally, I acknowledge and appreciate the Members of the Committee for their dedication and commitment throughout the process of gathering of evidence, drafting of this report and setting out conclusions and recommendations.

Further appreciation goes to the Office of the Speaker of the Senate and the Office of the Clerk of the Senate for their continuous support to the Committee during execution of its mandate.

It is now my pleasant duty and privilege to present this report of the Standing Committee on Health, for consideration and approval by the House pursuant to Standing Order No. 223 (6) of the Senate Standing Orders.

SIGNED.....  **DATE**.....17/3/2026.....

SEN. JACKSON K. ARAP MANDAGO, EGH, MP
(CHAIRPERSON, COMMITTEE ON HEALTH)

CHAPTER ONE

1. INTRODUCTION

1. The Standing Committee on Health is established pursuant to Standing Order 228 (3) and the Fourth Schedule of the Senate Standing Orders and is mandated to *consider all matters relating to Medical Services, Public Health and Sanitation.*

2. To execute its mandate, the Committee has adopted different modes of operation which include County Oversight and Networking Engagements. Through these engagements, the Committee is able to augment the evidence gathered within the precincts of Parliament with site visits.

3. At its Siting held on Tuesday, 4th November 2025, the Committee deliberate on the healthcare provision in the counties and resolved to undertake a County Oversight and Networking Engagements (CONE) in Bungoma and Kakamega Counties to acquaint itself with the provision of Healthcare Services in the Counties as part of its oversight function.

Purpose and Objectives

4. The specific objective of the visit was to-

   a) assess the state and quality of the infrastructure, facilities, hospital equipment and provision of emergency services;

   b) asses the automation of healthcare provision systems for patients, drugs and commodity management;

   c) assess the availability of requisite healthcare personnel, the gaps and challenges, if any, these counties face in regard to healthcare workers;

   d) assess the availability of training and capacity building programs and avenues for healthcare workers in emergency healthcare, specialized services and referrals;

   e) assess the availability of drug and medical supplies in healthcare facilities in the counties; and

   f) obtain information on the Social Health Authority (SHA) reimbursements, facility accreditations and pending bills with the Kenya Medical Supplies Agency (KEMSA).

Scope of the Engagements

5. The Committee selected the following facilities Counties for assessment-

   1. Bungoma County Referral Hospital (BCRH), and Kimaeti Health Centre in Bungoma County, and
   2. Kakamega County Referral Hospital (KCRH) in Kakamega County.

Methodology

6. On 14th and 15th November, 2025, the Committee conducted site visits to the identified facilities. During these visits, Members engaged with pertinent county government officials, hospital management and other stakeholders in order to gather submissions and evidence. The Committee also conducted physical inspections of the premises, reviewed documentation and observed working conditions and challenges affecting healthcare provision and delivery firsthand.

7. The findings, analyses and recommendations set out in this Report are based on evidence collected during these engagements and aim to support the improvement of health sector governance, accountability and service delivery within the context of devolved governance framework.

1.1. COUNTY PROFILES

1.1.1 BUNGOMA COUNTY

8. Bungoma County is located in Western Kenya within the Lake Victoria Basin, covering an area of approximately 3,032.2 square kilometers. According to the 2019 Kenya Population and Housing Census, it has a population of about 1,670,570 people, making it a relatively densely populated County. This relatively dense population places significant demand on health services in the county.

9. According to the Ministry of Health, Bungoma County has a total of approximately 275 Health facilities distributed across its nine sub-counties. Of these, 154 are government-operated health centers, making up the majority of public healthcare provision in the County, the remainder includes faith-based facilities (around 22), private facilities (approximately 95), and a small number under NGOs (about 4).

10. According to the Office of the Controller of Budget Kenya, The County Gross Approved FY 2024/25 Budget was Kshs.15.59 billion. It comprised Kshs.4.97 billion (32 percent) and Kshs.10.62 billion (68 per cent) allocation for development and recurrent programmes, respectively. The budget estimates represented an increase of Kshs.1.56 billion (11 per cent) from the FY 2023/24. The increase was attributed to a rise in its own-source revenue projection and equitable share of revenue raised Nationally.

11. Further, Bungoma County's Gross Approved Budget for the financial year 2024/25 was Kshs. 15.59 billion. The budget comprised Kshs. 4.97 billion (32 percent) allocated to development programs and Kshs. 10.62 billion (68 percent) allocated to recurrent programs. The budget estimate represented an increase of Kshs. 1.56 billion (11 percent) from the FY 2023/24 budget. The increase was attributed to a rise in the county's own-source revenue projections alongside its equitable share revenue raised Nationally.

12. During the period under review, the County reported a collection of Kshs.441.40 million as Facilities Improvement Financing (FIF), which was 42 percent of the annual target of Kshs.1.06 billion. The collected amount was retained and utilized at source in line with the Facility Improvement Financing Act, 2023.

1.1.2 KAKAMEGA COUNTY

13. Kakamega County is located in Western Kenya and borders Vihiga County to the South, Siaya County to the West, Bungoma and Trans Nzoia Counties to the North, and Nandi and Uasin Gishu. The County covers an area of approximately 3,033.8 km^2.The county has an estimated population of about 1,867,579 people according to the 2019 census, with a population density of 618 people per square kilometer, projecting considerable Healthcare provision needs linked to its population size, density, and geographic spread.

14. The County has at least 374 Health facilities including Public Hospitals, Faith-Based Institutions, Private Clinics, and NGO-run centers. Public Facilities account for over half of the county's Health centers, with the rest divided between private providers (approximately 40%), faith-based groups (7.2%), and NGOs (1.3%) representing about 2.6% of all Health facilities in Kenya.

15. Kakamega County Gross Approved Supplementary I Budget for FY 2024/25 was Kshs.17.93 billion. The Budget comprised Kshs.5.93 billion (33 per cent) and Kshs.12 billion (67 per cent) allocation for development and recurrent programmes, respectively. The budget estimates represented an increase of Kshs.1.38 billion (8.4 per cent) from the FY 2023/24 budget, which comprised a development budget of Kshs.5.24 billion and a recurrent budget of Kshs.11.31 billion. The increase in the budget was attributed to the rise in conditional grants and balances brought forward.

16. During the review period, the County received Kshs.11.35 billion in revenues to fund its development and recurrent activities. The total revenue consisted of Kshs.8.56 billion from the equitable share of revenue raised Nationally, additional allocations from the Government and Development Partners of Kshs.22.93 billion, and its Own-Source Revenue (OSR) collection of Kshs.1.23 billion including Facilities Improvement Financing (FIF) of Kshs.593.75 million and Kshs.640.55 million from other OSR sources such as Annual Investment Allowance (AIA).

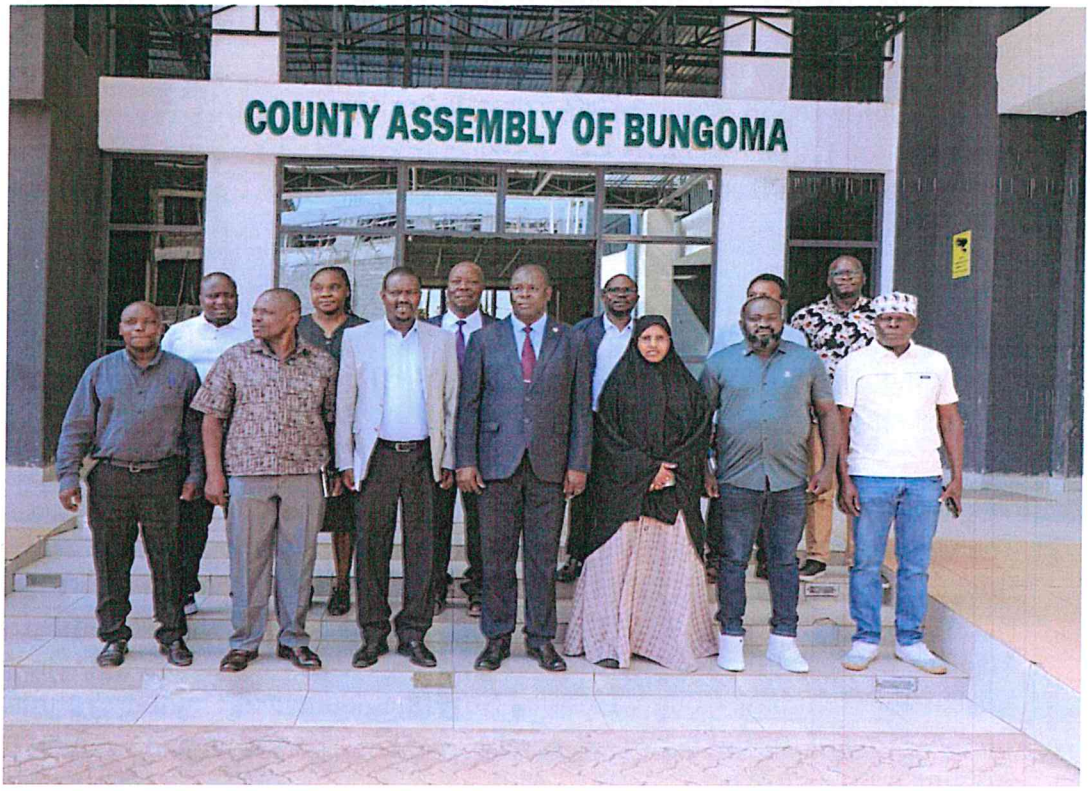
CHAPTER TWO

2. COMMITTEE OBSERVATIONS AND STAKEHOLDER SUBMISSIONS

2.1. Meeting with the County Assembly

17. The Committee paid a courtesy call to the County Assembly of Bungoma on 14th November, 2025 where it was received by the Speaker, Hon. Emmanuel Situma. The Speaker was accompanied by Hon. George Makari, Chairperson Committee on Health Services alongside other members of the Committee on Health Services. The Chairperson briefed the Speaker and the Members of the County Assembly present about the objectives of the oversight visit.

18. On his part, the Speaker thanked the Committee on its role in mentoring the County Assembly and Committee Members with an aim to improving oversight. The Speaker assured the Committee that the Members of the County Assembly will work closely with the Senate during and after the oversight visit and follow-up on the implementation status of the Senate resolutions.



Picture 1: The Committee on Health during a courtesy call on the Speaker of the County Assembly of Bungoma.

2.2. Meeting with the Governor, Bungoma County

19. The Committee paid a courtesy call on the Governor, Bungoma County Government on Friday, 14th November, 2025 and briefed him about the objective of the oversight visit.

20. During the courtesy call, the Committee was informed that-

a) Bungoma County operates approximately two hundred and seventy-five (275) healthcare facilities distributed across its nine sub-counties. Of these, one hundred and fifty-four (154) are government-operated health centres, which constitute the majority of public healthcare provision in the County. The remainder comprises around twenty-two (22) faith-based facilities, approximately ninety-five (95) private facilities and four (4) facilities operated by Non-Governmental Organizations (NGOs);

b) The County's Gross Approved budget for FY 2024/25 totaled Kshs 15.59 billion, comprising Kshs 4.97 billion (32%) for development programmes and Kshs 10.62 billion (68%) for recurrent programmes. These estimates represented an increase of Kshs 1.56 billion (11%) from FY 2023/24, attributed to higher projected own-source revenue and an increased equitable share of nationally raised revenue;

c) The County reported a collection of Kshs.441.40 million as FIF, which was 42 percent of the annual target of Kshs.1.06 billion. The collected amount was retained and utilized at source in line with the Facility Improvement Financing Act, 2023; and

d) The conversion and confirmation of the Universal Health Coverage (UHC) staff, totaling up to two hundred and forty-five (245) across all cadres, was still pending due to financial constraints. Further the list of the affected members of staff was being validated.

2.3. Oversight Visit to Bungoma County Referral Hospital (BCRH)

21. The Committee conducted an oversight visit to the Bungoma Level 5 Hospital in Bungoma County on Friday 14th November, 2025 accompanied Mr. Chrispinus Barasa, the County Executive Committee Member for Health and Sanitation; Dr. Magrina Mayama, the County Chief Officer for Health and Sanitation; Dr. Simon Kisaka, the Bungoma County Hospital Superintendent; Mr. Humphrey Silungi, the County Director of Public Works and Mr. Robert Mose, Bungoma County Health Administrative Officer.

22. During the Committee was informed that:

a) The hospital had a bed capacity of three hundred and eleven (311) beds including thirty-one (31) maternity beds. Additionally, the Newborn Unit accommodated a total of thirty-one (31) cots and ten (10) Kangaroo Mother Care (KMC) beds;

b) The facility employed a total of twenty-two (22) consultants, including eleven (11) medical officers nine (9) on Permanent and Pensionable (PNP) terms and two (2) on contract terms. Additionally, the facility employed thirty-six (36) registered clinical officers, comprising twenty-six (26) on PNP terms, seven (7(on Bungoma County Government contracts, and 3 on Universal Health Coverage (UHC) terms. These included twenty (20) general clinical officers and sixteen (16) specialists;

c) Nursing staff totaled to one hundred and eight one (181), made up of one hundred and thirty-five (135) on PNP, thirty-five (35) on Bungoma County Contract, nine (9) on UHC.one (1) Dumisha and one (1) on MOH COVID 19 Fund contract. These includes one hundred and forty-three (143) general nurses and thirty-eight (38) specialist nurses;

d) The pharmacy department had two (2) General pharmacists employed on PNP terms with one (1) on Bungoma county contract, pharmaceutical technologist was seven (7) on PNP, Seven (7) on Bungoma County contract and two (2) on UHC. Further the Radiography services were supported by nine (9) radiographers, of whom four (4) were on PNP terms and one (1) on Bungoma county Government contract and four (4) on Universal Health Coverage (UHC);

e) The Nutrition staff included 9 nutritionists three (3) on PNP terms and six (6) officers on Bungoma county Government contract. However, the facility did not have a psychologist on permanent and pensionable terms and therefore relied on locum psychologist;

f) The hospital employed eight (8) anesthetists, comprising four (4) clinical officer anesthetists on permanent and pensionable (PNP) terms, two (2) on locum terms, and two (2) nurse anesthetists. The facility also employed nine (9) physiotherapy staff (6 on PNP terms and 3 on contract); 7 occupational therapists (5 on PNP terms, 2 on locum terms, and 1 on Bungoma County Government contract); and 5 orthopedic trauma staff (2 on PNP terms, 2 on contract, and 1 on UHC terms); The hospital was equipped with two (2) dialysis machines that were operational and three (3) that were defective;

23. The Committee was further informed that the hospital faced challenges related to delayed SHA reimbursements amounting to two hundred and fourteen million eight hundred and ninety-four thousand, four hundred and seventeen shillings (214,894,417) which had adversely affected the delivery of effective services. Further, in the FY 2023/2024, the facility collected - 284,017,917 Facility Improvement Fund (FIF) revenues.

24. During the visit at the Bungoma County Referral Hospital, the Committee made the following observations-

a) That the health management system deployed by *JumboSoft* System was not providing the intended services to the hospital and experienced frequent downtime, despite the substantial investment made in its acquisition;

b) The Hospital faced significant challenges stemming from deteriorating infrastructure and overcrowding. The physical environment was in poor condition, with broken furniture in consultation rooms, cracked floors, faded and peeling wall paint and damaged ceilings. Wards were congested, forcing some in-patients to occupy verandahs improvised as wards furnished with old, rusty beds, unclean linen, and inadequate working surfaces and equipment, conditions that collectively compromised patient comfort and quality of care;

c) There were loose electrical sockets and exposed wiring in the laboratory, alongside a shortage of essential reagents, while the hospital kitchen was old, poorly maintained, inadequately equipped and lacked modern equipment and essential tools necessary for efficient operation;

Picture 2: The cracked floor at the main corridors and common areas of the Bungoma County Referral Hospital.

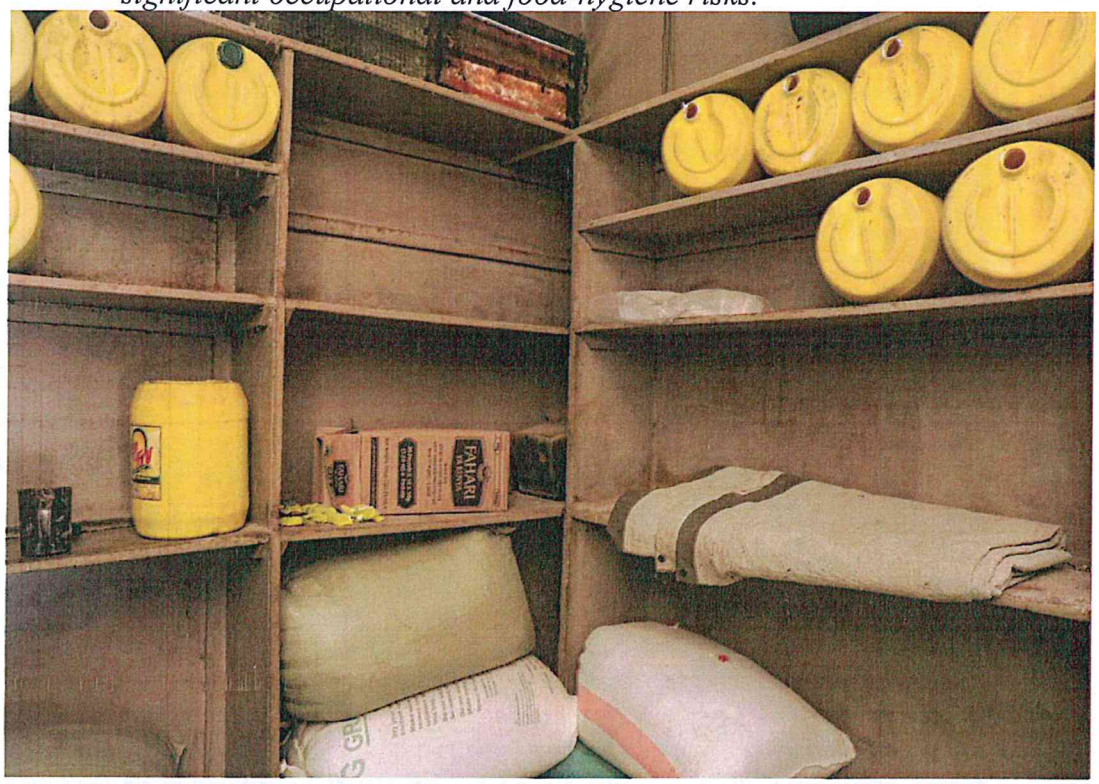
Picture 3 & 4 *Damaged roof at Bungoma County Referral Hospital with damaged ceilings and loose electrical wires.*

Picture 5 & 6: *Severely damp and mould-infested corridor ceiling with corroded exposed pipework, highlighting chronic water leakage and poor maintenance and smoke-stained kitchen wall with extensive tile loss and exposed, deteriorated plaster demonstrating longstanding neglect of basic maintenance in the kitchen.*

Picture 7: *Piles of obsolete desktop computers, printers and other ICT equipment heaped in a hospital room, underscoring poor e-waste management and the need for structured disposal of condemned assets.*

Picture 8: *Severely worn kitchen worktop with potholes, stagnant wastewater and cracked surface where vegetables are being prepared, illustrating poor food-handling and infection-prevention standards.*

Picture 9: Old firewood-fueled hospital kitchen with large, soot-stained cooking pots and wet, slippery floor, highlighting outdated equipment and significant occupational and food-hygiene risks.



Picture 10: Poorly ventilated and cramped dry-store with cooking oil jerrycans and bulk food sacks stacked on dusty wooden shelves and floor, falling short of recommended food-safety and hospital nutrition standards.

Picture 11: *The Committee Members inspecting the congested fresh-produce store, noting poor ventilation and cramped storage conditions for vegetables and other food items.*

d) There was variance in patient data between the admissions office and the wards, particularly between the admission office and the New Mother and Child Wing, where the recorded number of births also differed from the main hospital, raising concerns about data accuracy. The New Mother and Child Facility was well set out and efficiently run; however, it required re-design to facilitate easy access for stretchers and wheelchairs. During the visit to the New Mother and Child Unit, the Committee was also alarmed by the high number of teenage mothers;

Picture 12: *The Mother and Baby Hospital main entrance block, showing the newly constructed maternity wing where the oversight team noted improved infrastructure compared to the old hospital buildings.*

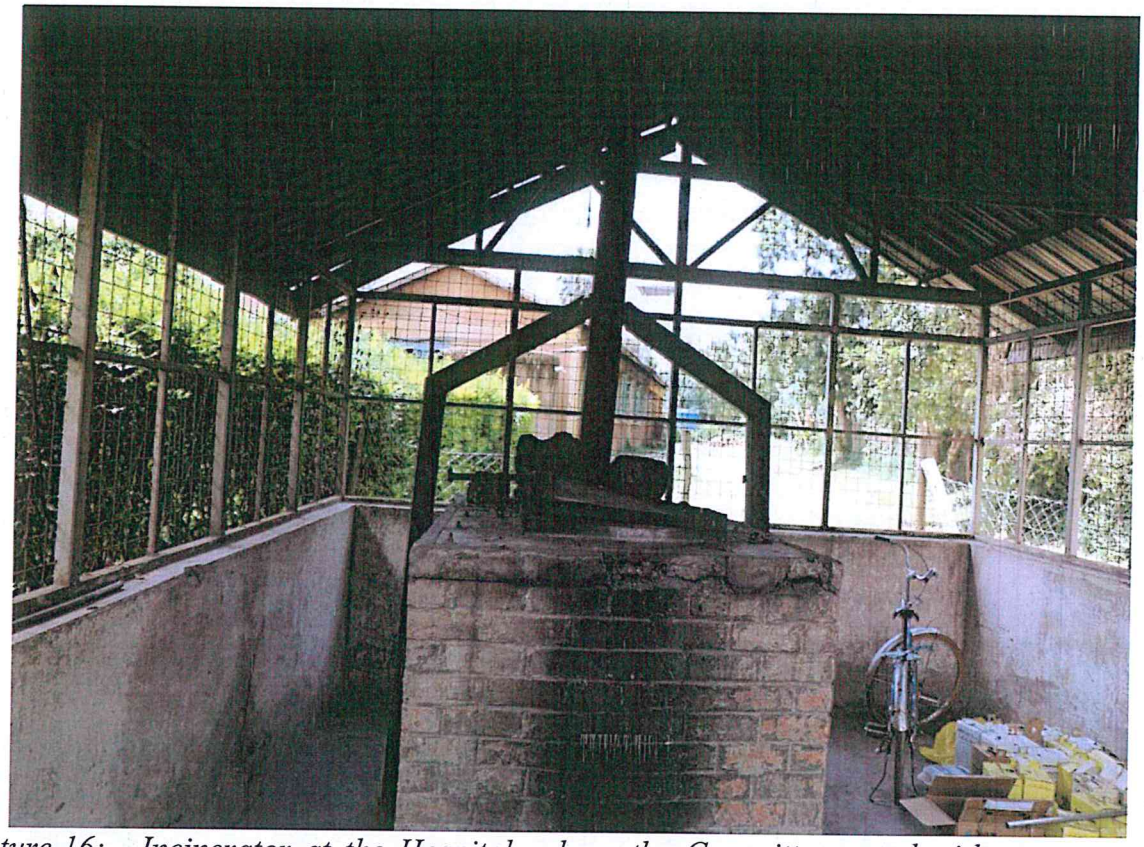
e) There was only one laundry machine serving the Hospital out of four observed at the laundry unit, with the other machines appearing to have been nonfunctional for an inordinate long period, resulting in a large pile of dirty linen from the medical wards. The Committee observed piles of surgically soiled linen being washed alongside other hospital garments and linen, contrary to the normal practice of separate cleaning and further noted that electronic waste was being dumped in the laundry store. In addition, there were only three laundry staff members who were serving as casual labourers at the unit since 2019;

Picture 13 & 14: *Congested hospital laundry room with ageing industrial machines and a heap of soiled linen on the floor and an abandoned washing machine lying outside the laundry section, symbolizing reflecting inadequate workflow, poor hygiene and limited capacity for safe linen management.*

Picture 15: *Cluttered hospital store room filled with bulging gunny bags, scrap metal and old records, reflecting poor waste segregation, fire risk and inadequate space management at Bungoma County Referral Hospital.*

f) Some patients informed the Members that they were asked to purchase prescribed medicines from outside the hospital, yet the Committee's inspection of the pharmacy confirmed that the same medicines were in stock and it was further noted that there was no record for controlled opioid (narcotic) analgesic and regulated medicine and drugs such as morphine;

g) That the waste disposal point was well maintained but it was located adjacent to staff quarters and lacked proper segregation, while the mortuary, though well maintained, was overcrowded and did not have adequate arrangements for managing bereaved families collecting bodies;



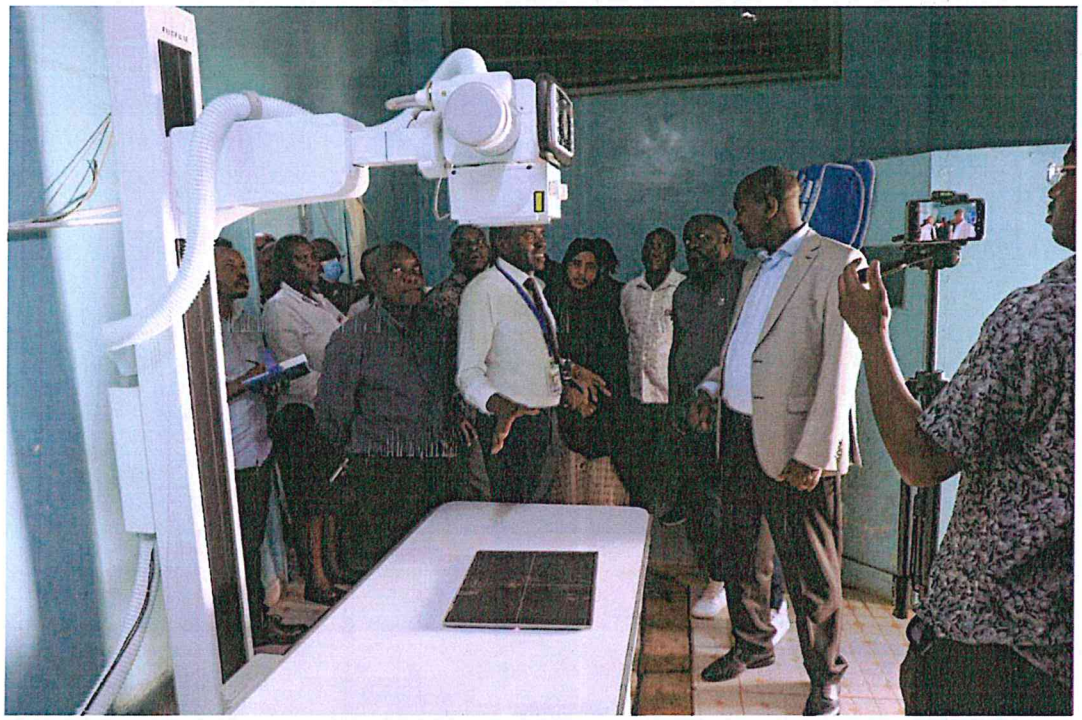
Picture 16: Incinerator at the Hospital, where the Committee noted with concern that it is situated adjacent to staff quarters and lacks proper segregation of waste.

Picture 17: Service Delivery Charter at the Mortuary of Bungoma County Referral Hospital.

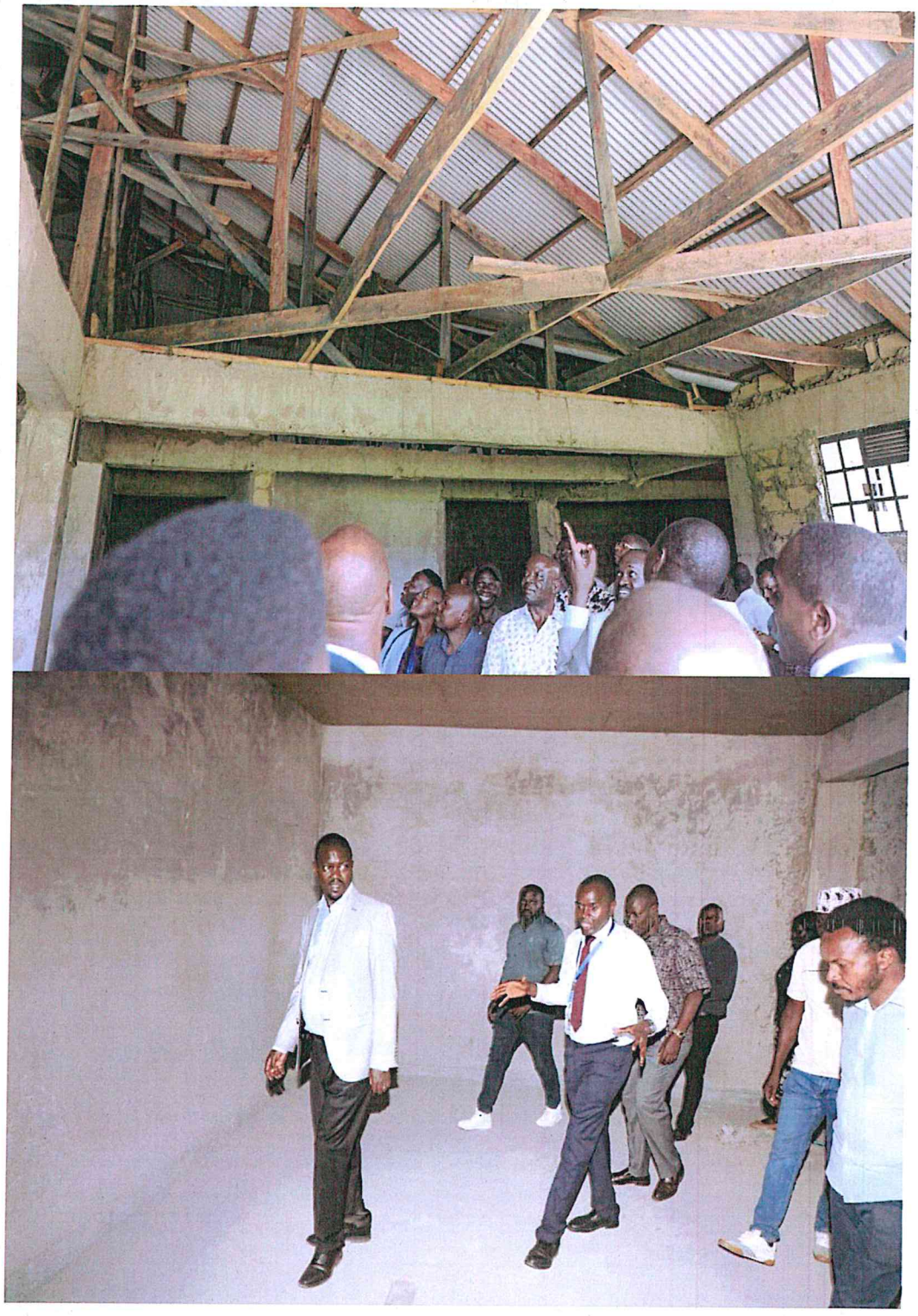
h) The Committee noted that the Emergency Department, staffed by two medical officers, six clinical officers and twelve nurses, manages a heavy workload from neighbouring counties such as Kakamega and Trans Nzoia, as well as patients from neighbouring Uganda, resulting in significant strain on the already limited resources. It was reported that in some shifts, only one nurse was on duty, further exacerbating the heavy workload and potentially compromising the quality and timeliness of emergency care;

i) The Committee noted that a Radiography Complex was under construction but expressed concern over the poor workmanship, and further emphasized the need for a comprehensive hospital master plan to consolidate the facility layout and adequately provide for future expansion; and

j) The Committee observed that the facility had only eight radiographers against an estimated requirement of 16 to 20, resulting in understaffing in the Radiology Department. Moreover, the MES equipment were non-functional, with only one X-ray machine operational, serving approximately 60 patients per day, and there was no functional CT scan available at the facility.



Picture 18: Committee being taken through a demonstration of X-ray equipment at Bungoma County Referral Hospital.

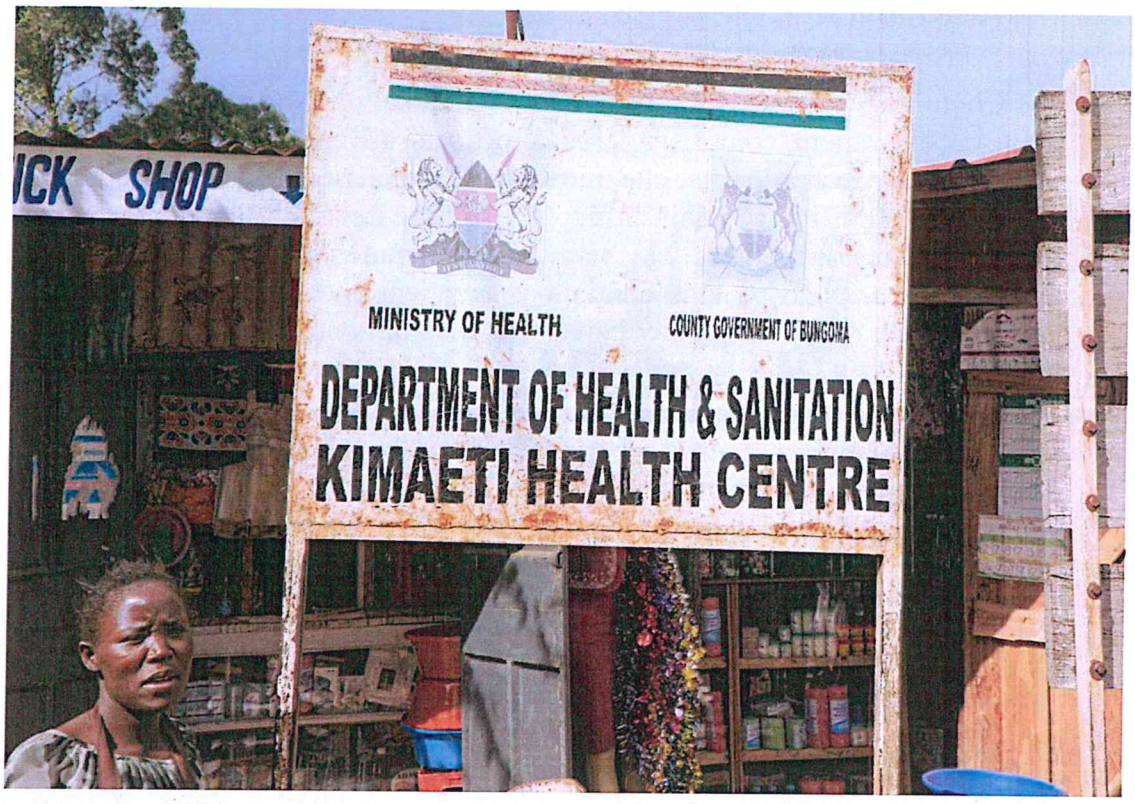


Picture 19: *Internal view of the Radiography Complex under construction at Bungoma County Referral Hospital, where the Committee expressed concern over the poor workmanship.*

Picture 20: *External view of the Radiography Complex where the Committee underscored the importance of a comprehensive hospital master plan to consolidate the facility layout and make adequate provision for future expansion*

2.4. County Oversight Visit to Kimaeti Health Centre

25. The Committee conducted an oversight visit to Kimaeti Health Centre on 14th November, 2025.The Committee was received by Mr. Paul Wamalwa, Clinical Officer in Charge of the Kimaeti Health Centre, a level III health facility.



Picture 21: Signage at the entrance of Kimaeti Health Centre in Bungoma County, under the Department of Health and Sanitation.

26. During the oversight visit, the Committee was informed that the Hospital operated on a 24-hour basis, with the Health Records Unit managed by four contracted employees, two engaged directly by the Hospital and two under a partnership arrangement, who were further supported by students on attachment.

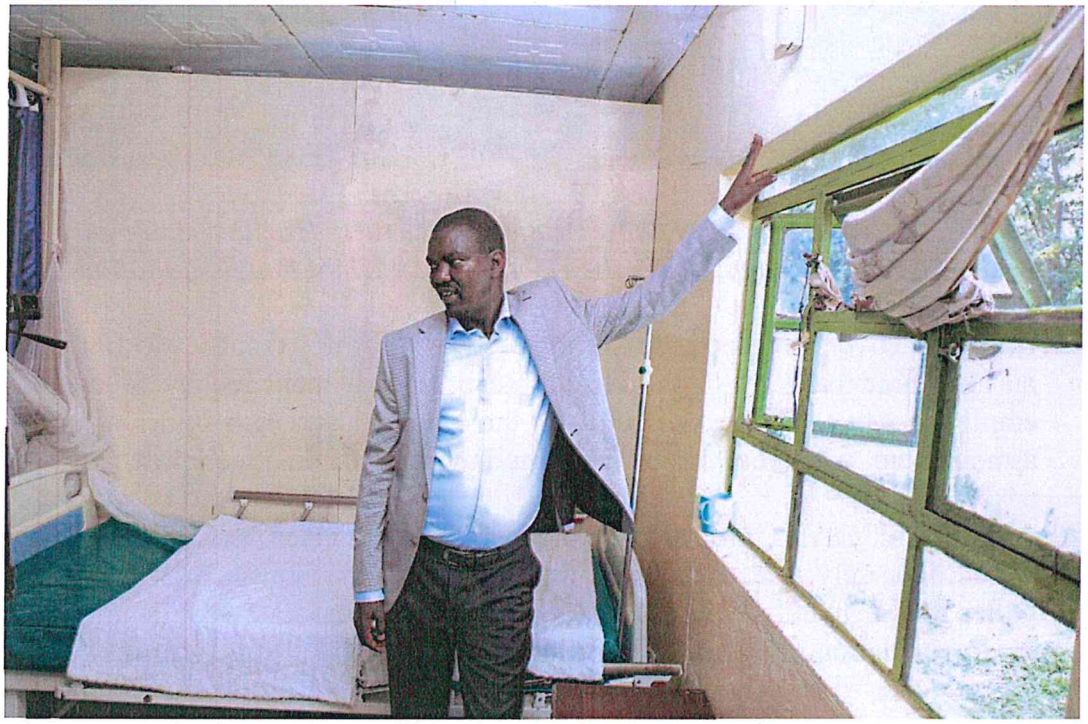
27. The Committee was informed that the facility experienced persistent understaffing, which adversely affected service delivery and compromised the quality of care, with a total of twenty-two (22) casual employees on the staff establishment drawing a combined monthly wage bill of Kshs. 266,000.

28. The Committee was further informed that the facility experiences challenges arising from delayed Social Health Authority (SHA) reimbursements, which have led to arrears in the payment of wages to casual employees. The Committee noted that Kimaeti Health Centre increasingly relies on internally generated resources to sustain operations.

29. The Committee was further informed that the facility comprises a laboratory, pharmacy, Maternal and Child Health (MCH) unit, records office, administration block, male and female wards and a maternity ward, and has a bed capacity of thirty-five (35). At the time of the visit, the Committee also observed a long-stalled building project within the facility. The maternity ward had no curtains or mosquito nets, was not clean and appeared unusually deserted, with some rooms being used to store obsolete materials and documents;

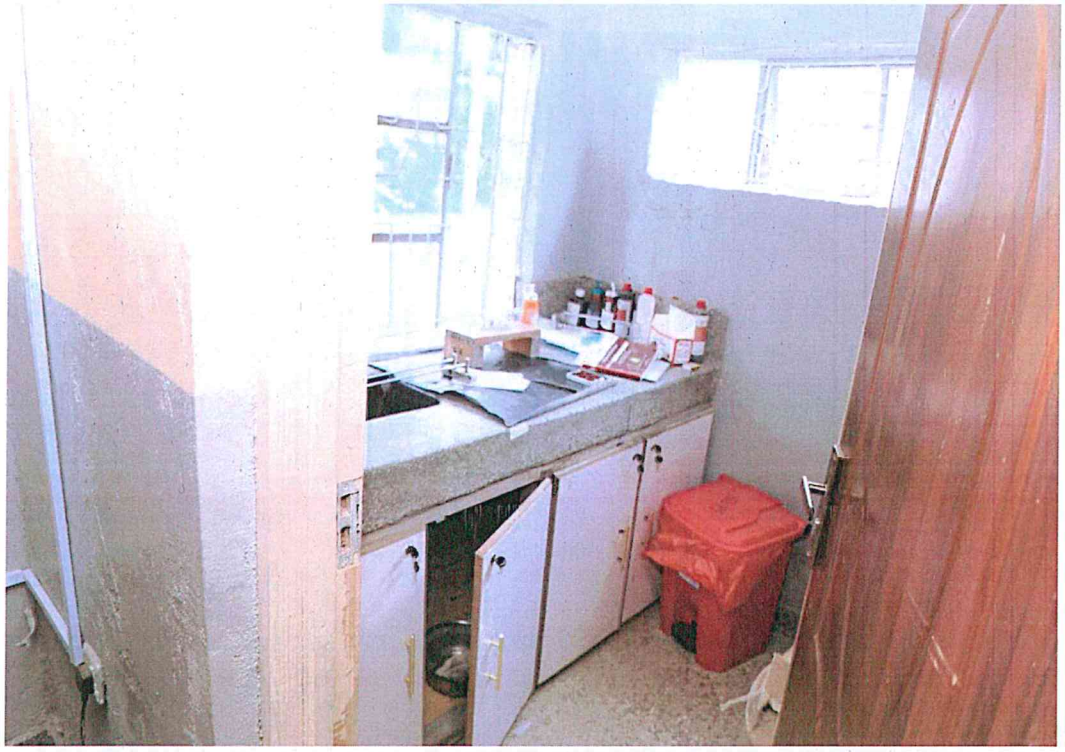
30. The Committee observed that the facility had a total of fourteen staff posted by the County Government, comprising clinical officers, a Health Administrative Officer, two laboratory technologists, one nutritionist, one clerical officer and eight nurses. Against the Ministry of Health staffing norms for a Level 3A facility, the number of clinical officers and nurses was below the recommended minimum, limiting the facility's capacity to provide continuous inpatient and maternity services, while laboratory and nutrition services barely met the minimum staffing requirements;

31. The Committee observed that the health centre infrastructure was in a poor state; the kitchen was a semi-permanent, poorly maintained structure that relied on firewood; the facility depended on inadequate manual sterilization of medical kits; the male wards were poorly maintained, with curtains falling; and there was a stalled building that required completion to decongest the already limited facility space.



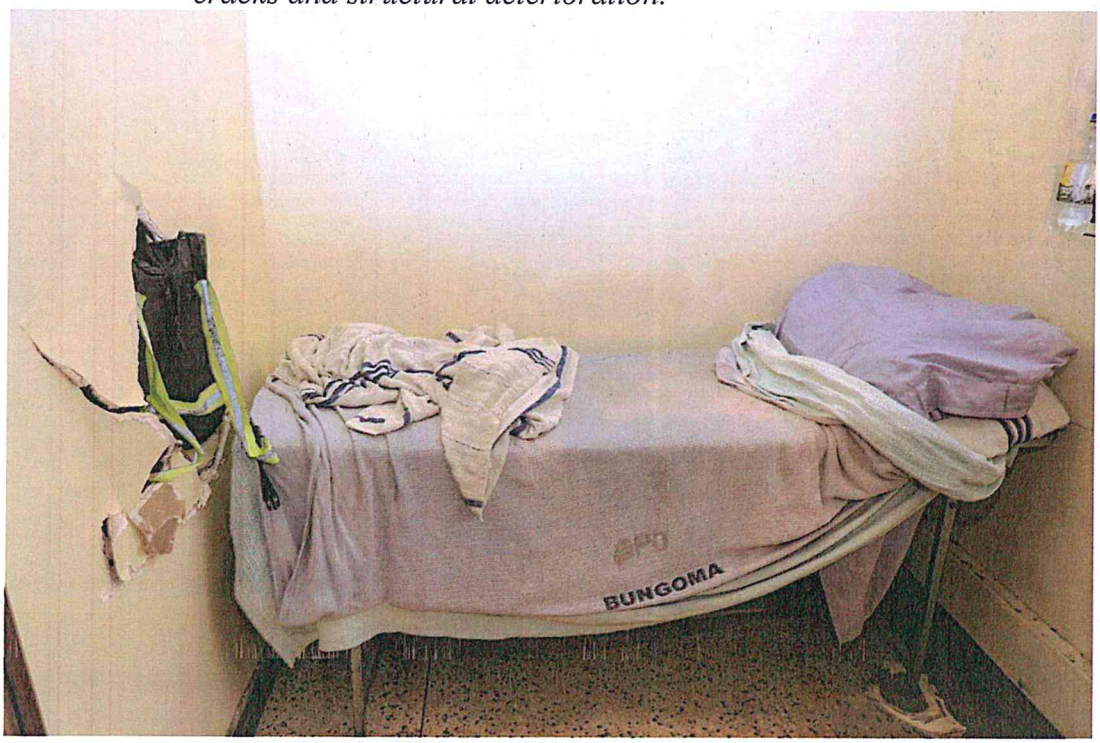
Picture 22: *The Committee Chairperson inspects a patient ward at Kimaeti Health Centre in Bungoma County, highlighting concerns about the state of the infrastructure and general ward conditions.*

Picture 23: Obsolete materials stored in one of the rooms at Kimaeti Health Centre.

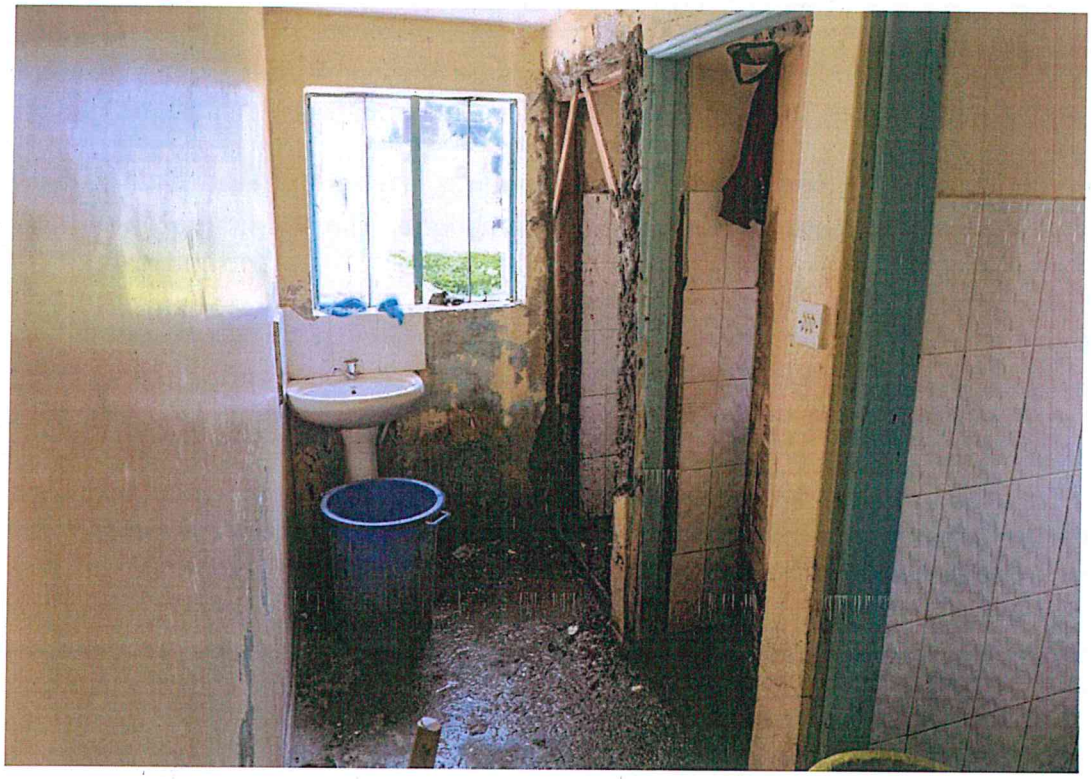


Picture 24: The Laboratory workspace at Kimaeti Health Centre, Bungoma County.

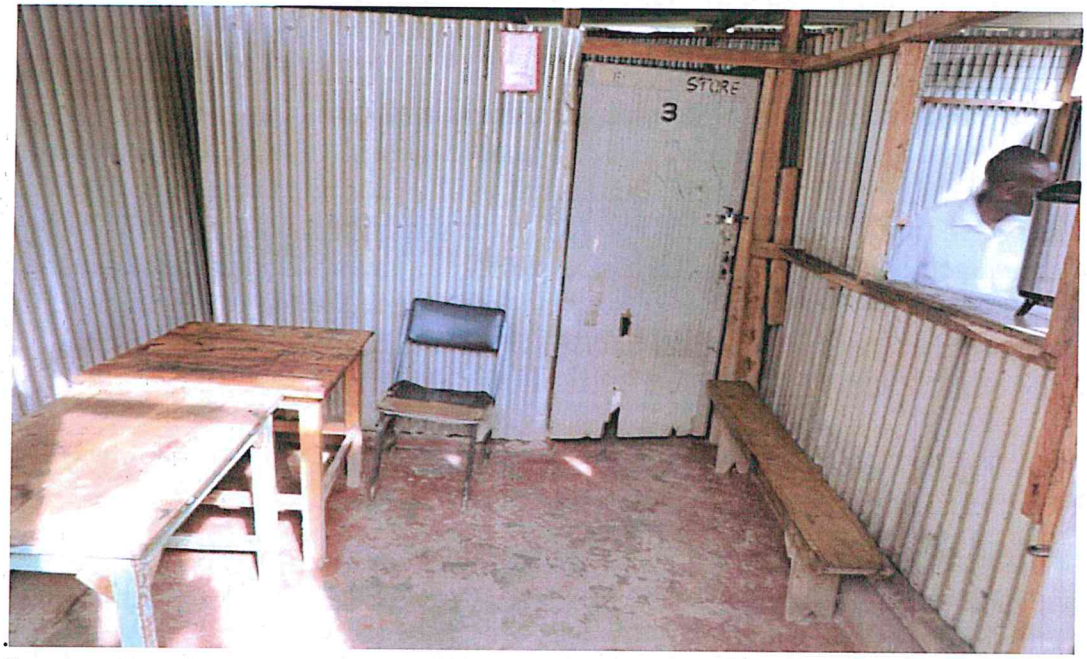
Picture 25: Ceiling damage at Kimaeti Health Centre with visible water stains, cracks and structural deterioration.



Picture 26: Patient ward at Kimaeti Health Centre, showing inadequate maintenance, with damaged wall structures and worn beddings,



Picture 27: Sanitation facilities and washroom area showing visible structural deterioration, peeling walls, and inadequate maintenance at Kimaeti Health Centre.



Picture 28: Kitchen facilities at Kimaeti Health Centre; modest infrastructure with visible wear and limited amenities, underscoring the need for investment in improved food preparation and storage areas.

2.5. Oversight Visit to Kakamega County Referral Hospital

32. The Committee conducted an oversight visit to the Kakamega County Referral Hospital on Saturday 15th November, 2025 accompanied Mr. Livingstone Imbayi, the County Executive Committee Member for Health Services; Dr. David Alilah, the County Chief Officer for Medical Services; Dr. Dixon Mchana, the Kakamega County Hospital Acting Medical Superintendent. The Committee was also accompanied by the Members of the County Assembly Committee on Health

33. During the oversight visit, the Committee was informed that the facility maintains a total bed capacity of 384. This capacity is distributed across various general and specialized wards to accommodate diverse patient needs. The general wards include Ward 1 with 20 beds, Ward 2 with 19 beds, Ward 3 with 22 beds, Ward 4 with 21 beds, and the largest section, Wards 5A & 5B, which provides 51 beds. Additional general inpatient space is found in Ward 6A (21 beds), Ward 7A (18 beds), Ward 7B (8 beds), Ward 8 (13 beds), and Ward 9 (22 beds).

34. The Committee was informed that specialized care units at the hospital are comprised of a 14-bed Oncology unit, a 10-bed Burns Unit and an Intensive Care Unit (ICU) equipped with 6 beds. Maternal and neonatal care are significant components of the hospital's infrastructure, featuring a Newborn Unit (NBU) with 38 beds, a Post-Natal Ward (PNW) with 45 beds, an Ante-Natal Ward (ANW) with 14 beds and a Labour Ward (LW) with 7 beds. The facility also provides 6 beds for Kangaroo Mother Care (KMC) and 6 beds for the High Dependency Unit (HDU), alongside an Amenity ward containing 23 beds. Beyond active patient care, the hospital's mortuary is noted to have a capacity of 112 bodies.

35. The Committee was further informed that the Hospital's human resources are divided into three primary categories; Permanent and Pensionable (P&P), Locum, and Universal Health Coverage (UHC). The Medical and Clinical Staff consists of 35 consultants, all of whom are on Permanent and Pensionable terms and 51 medical officers consisting of 33 P&P staff and 18 Locum staff. There is a total of 62 Clinical Officers, including 35 P&P, 26 Locum, and 1 UHC. There are 9 specialized clinical officers, all on P&P terms. The nursing staff constitute the largest segment of the workforce. There are 347 general nurses (231 P&P, 112 Locum, and 4 UHC) and 38 specialized nurses (37 P&P and 1 Locum).

36. During the visit at the Kakamega County Referral Hospital, the Committee made the following observations -

    a) The National Health Information Management System (NHIMS) had not been deployed at the Hospital. The existing reporting system was observed to be user-unfriendly, with patient information not easily retrievable. Furthermore, the facility had an inadequate number of Social Health Authority (SHA) verification machines, compelling patients to be transferred from hospital wards to the admissions area to access SHA services;

b) The Outpatient Department (OPD) operated only during daytime hours, attending to approximately 120 patients per day and about 45 patients over the weekend. It was further observed that there was no duty rota in place, resulting in delays in service delivery. Additionally, staff members did not wear name tags or uniforms bearing their names, hindering ease of identification and accountability;

c) The Committee observed that some patients were being detained at the facility due to unsettled hospital bills. The Labour Ward was found to be congested, with 65 mothers occupying only 45 available beds, thereby compromising patient privacy. Similarly, eight incubators were being used to accommodate 15 infants, raising concerns about neonatal safety and the quality of care provided;

d) The Committee further noted the lack of waiting bays or benches for patients' visitors and the absence of curtains or blinders in some wards, particularly within the maternity section, which affected patient privacy and comfort. Additionally, only two toilets were available for use by over 20 patients and caregivers, highlighting inadequate sanitation facilities in the wards;

e) The hospital received medical supplies from KEMSA and MEDS; however, a significant portion of the stock had short expiry periods, raising concerns about inventory control and wastage. Further, The Committee observed inconsistencies in the pharmaceutical records, with expired drugs found stocked on the shelves. Patients were further required to obtain prescribed medicines directly from the central drug store due to stock management challenges;

f) The Emergency Unit lacked essential protective equipment, including hand gloves, which health personnel reported that there were instances where patients were required to purchase medical supplies such as gloves and syringes prior to receiving medical attention. It was further noted that the hospital did not have a functional ambulance, despite substantial budgetary provisions by the County Assembly for the same. Additionally, the designated ambulance driver had not undergone the requisite training. The Committee also noted with concern the dilapidated condition of seats and the deteriorating ceiling within the Accident and Emergency Department;

g) The Hospital infrastructure was in a dilapidated state. Several window panes were broken and temporarily blocked with cartons. Electrical cables were exposed, posing safety risks, while seats and stretchers were extensively worn out, reflecting poor maintenance of the facility;

Picture 27: *The dilapidated interior of the ambulance at Kakamega County Referral Hospital, including worn seating, rusted surfaces, and inadequate emergency equipment, reflects systemic neglect of critical emergency services.*

Picture 28: The deteriorated state of infrastructure at Kakamega County Referral Hospital, exemplified by weathered and damaged entry doors.

Picture 28: A Committee Member points out a damaged signage at the Outpatient Department, highlighting systemic gaps in facility maintenance at Kakamega County Referral Hospital.

Picture 29: The worn and damaged furniture at Kakamega County Referral Hospital in a patient service area.

Picture 30: Improvised coverings affixed to clinical areas at Kakamega County Referral Hospital.

Picture 31: Exposed and poorly secured electrical wiring at Kakamega County Referral Hospital.

Picture 32: The water-damaged and deteriorating ceiling at Kakamega County Referral Hospital.

Picture 33: A section of dilapidated infrastructure at Kakamega County Referral Hospital.

Picture 33: A patient being wheeled from the wards to the main admissions section to authenticate SHA biometrics.

Picture 34: Kakamega County Referral Hospital Pharmacy Store.

Picture 35: Members of the Committee inspect the pharmacy store at Kakamega County Referral Hospital, where they noted a significant portion of the stock had short expiry periods, raising concerns over inventory control and potential wastage.

h) The Radiology Unit lacked essential consumables required for its efficient operation. The mammogram and MRI machines had been non-functional for the past five months, while the ultrasound equipment was not operating optimally. Additionally, the laboratory was found to be equipped with obsolete and aging machines, which adversely affected the quality and timeliness of diagnostic services;

i) The hospital waste was being poorly managed, with waste from the dumpsite burnt in an open field. Staff assigned to handle and burn the waste were not provided with appropriate protective clothing, thereby exposing them to health and safety risks;

j) The facility's roofing structure was made of asbestos, in contravention of the Environmental Management and Coordination (Waste Management) Regulations, 2006. Although the Hospital had a secured plot designated for the disposal of replaced asbestos roofing, pieces of asbestos were still visible on the grounds, and some asbestos materials had been buried in an open area used as an incinerator, posing serious environmental and occupational health hazards;

Picture 34: Accumulated bio medical waste at Kakamega County Referral Hospital, where the Committee observed poor waste management practices, including the burning of refuse including medical wastes in an open field.

Picture 35: Accumulated mixed waste at Kakamega County Referral Hospital.

Picture 36: Members of the Committee inspect the open hospital dumpsite at Kakamega County Referral Hospital, where they observed that waste from the facility was being burnt in the open exposing patients, staff and the surrounding community to serious health and safety risks.


DANGER
ASBESTOS
DISPOSAL SITE
CANCER & LUNGS
DECEASE HAZARD
AUTHORIZED
PERSONNEL ONLY


DANGER
ASBESTOS
DISPOSAL SITE
CANCER & LUNGS
DECEASE HAZARD
AUTHORIZED
PERSONNEL ONLY

Picture 37& 38: *The Committee visit to the area designated for the disposal of replaced asbestos roofing where pieces of asbestos were still visible on the hospital grounds, and some asbestos materials had been buried in an open area used as an incinerator.*

k) The mortuary was well maintained and efficiently managed. It had a private wing that generated own-source revenue for the hospital. The unit had nine morticians—three permanent and six on contract—one of whom had served for nine years without confirmation. The Committee further noted concerns regarding staff who had served for extended periods without being confirmed as permanent and pensionable employees.

Picture 40: The Kakamega County Referral Hospital Mortuary which was observed to be well maintained and efficiently managed.

Picture 41: The 'private wing' of the Kakamega County Referral Hospital.

CHAPTER THREE

3. COMMITTEE OBSERVATIONS

37. The Committee made the following observations from the visit to the healthcare facilities in the two counties.

3.1. Infrastructure and Physical Facilities

a) Structural deterioration and maintenance deficits

38. The Committee observed widespread infrastructure deterioration across the visited facilities. At Bungoma County Referral Hospital (BCRH), the physical environment was in poor condition with broken furniture in consultation rooms, cracked floors, faded and peeling wall paint and damaged ceilings. Wards were congested forcing some in-patients to occupy verandahs improvised as wards furnished with old, rusty beds, unclean linen and inadequate working surfaces and equipment.

39. At Kimaeti Health Centre, the infrastructure was similarly in a poor state. The facility depended on a semi-permanent, poorly maintained kitchen structure that relied on firewood. Male wards were poorly maintained with curtains falling and there was visible ceiling damage with water stains, cracks and structural deterioration. Sanitation facilities showed visible structural deterioration, peeling walls and inadequate maintenance.

40. Kakamega County Referral Hospital (KCRH) exhibited equally concerning conditions. The hospital infrastructure was in a dilapidated state with several broken window panes temporarily blocked with cartons. Electrical cables were exposed, posing safety risks, while seats and stretchers were extensively worn out. The Committee observed water-damaged and deteriorating ceilings, damaged entry doors and worn furniture in patient service areas.

b) Occupational Health and Safety Hazards

41. Another critical cross-cutting deficiency is the lack of safe disposal mechanisms, particularly functional incinerators across the counties. At BCRH, the Committee noted loose electrical sockets and exposed wiring in the laboratory. The hospital kitchen was old, poorly maintained, inadequately equipped and lacked modern equipment and essential tools necessary for efficient operation.

42. At KCRH exposed electrical cables posed immediate safety risks. Most alarmingly, the facility's roofing structure was made of asbestos, in contravention of the Environmental Management and Coordination (Waste Management) Regulations, 2006. Although the Hospital had a secured plot designated for disposal of replaced asbestos roofing, pieces of asbestos were still visible on the grounds, and some asbestos materials had been buried in an open area used as an incinerator, posing serious environmental and occupational health hazards.

*c) **Inadequate Capacity and Overcrowding***

43. Both referral hospitals demonstrated severe overcrowding. At BCRH, wards were congested with patients occupying verandahs as improvised wards. The Emergency Department, staffed by two medical officers, six clinical officers and twelve nurses, manages a heavy workload from neighbouring counties such as Kakamega and Trans Nzoia, as well as patients from neighbouring Uganda, resulting in significant strain on already limited resources. It was reported that in some shifts, only one nurse was on duty.

44. At KCRH, the Labour Ward was found to be congested with 65 mothers occupying only 45 available beds, thereby compromising patient privacy. Similarly, eight incubators were being used to accommodate 15 infants, raising concerns about neonatal safety and the quality of care provided. The Committee further noted the lack of waiting bays or benches for patients' visitors and the absence of curtains or blinders in some wards, particularly within the maternity section.

*d) **Incomplete and Stalled Development Projects***

45. The Committee observed evidence of stalled construction projects. At BCRH, a Radiography Complex was under construction but the Committee expressed concern over the poor workmanship and emphasized the need for a comprehensive hospital master plan to consolidate the facility layout and adequately provide for future expansion.

46. At Kimaeti Health Centre, the Committee observed a long-stalled building project within the facility that required completion to decongest the already limited facility space. The maternity ward appeared unusually deserted with some rooms being used to store obsolete materials and documents.

3.2. Human Resources for Health

*a) **Chronic Understaffing***

47. Understaffing emerged as a critical challenge across all visited facilities. At Kimaeti Health Centre, the Committee was informed that the facility experienced persistent understaffing which adversely affected service delivery and compromised the quality of care. The facility had a total of fourteen staff posted by the County Government. Against the Ministry of Health staffing norms for a Level 3A facility. The number of clinical officers and nurses was below the recommended minimum, limiting the facility's capacity to provide continuous inpatient and maternity services.

48. At BCRH, the facility had only eight radiographers against an estimated requirement of 16 to 20, resulting in understaffing in the Radiology Department. The hospital did not have a psychologist on permanent and pensionable terms and therefore relied on locum psychologists.

*b) **Employment Terms and Job Security Issues***

49. The Committee observed concerning patterns regarding employment terms. At Bungoma County Referral Hospital, the conversion and confirmation of Universal Health Coverage (UHC) staff totaling up to 245 across all cadres was still pending due to financial constraints, with the list of affected staff said to be undergoing validation.

50. At Kimaeti Health Centre, the facility had a total of 22 casual employees on the staff establishment drawing a combined monthly wage bill of Kshs 266,000. The facility experienced challenges arising from delayed Social Health Authority (SHA) reimbursements, which had led to arrears in the payment of wages to casual employees. Three laundry staff members at BCRH had been serving as casual labourers since 2019.

51. At Kakamega County Referral Hospital, the Committee noted with concern staff who had served for extended periods without being confirmed as permanent and pensionable employees. One mortician had served for nine years without confirmation.

*c) **Staff Identification and Accountability***

52. At Kakamega County Referral Hospital, the Committee observed that staff members did not wear name tags or uniforms bearing their names, hindering ease of identification and accountability. Additionally, there was no duty *rota* in place in the Outpatient Department, resulting in delays in service delivery.

3.3. Medical Equipment and Technology

*a) **Non-Functional and Inadequate Technology***

53. The Committee found numerous instances of non-functional critical medical equipment. The BCRH was equipped with two dialysis machines that were operational and three that were defective. The MES equipment were non-functional, with only one X-ray machine operational serving approximately 60 patients per day, and there was no functional CT scan available at the facility. At Kimaeti Health Centre, the facility depended on inadequate manual sterilization of medical kits, indicating lack of modern sterilization equipment.

54. At Kakamega County Referral Hospital, the mammogram and MRI machines had been non-functional for the past five months, while the ultrasound equipment was not operating optimally. The laboratory was found to be equipped with obsolete and aging machines which adversely affected the quality and timeliness of diagnostic services. The hospital did not have a functional ambulance despite substantial budgetary provision for the same. Further the designated ambulance driver had not undergone the requisite training.

b) Laundry and Sanitation Equipment

55. At Bungoma County Referral Hospital, there was only one laundry machine serving the Hospital out of four observed at the laundry unit, with the other machines appearing to have been nonfunctional for an inordinate long period, resulting in a large pile of dirty linen from the medical wards.

c) Electronic Waste Management

56. The Committee observed poor management of obsolete equipment. At Bungoma County Referral Hospital, piles of obsolete desktop computers, printers and other ICT equipment were heaped in a hospital room underscoring poor e-waste management and the need for structured disposal of condemned assets. Electronic waste was also being dumped in the laundry store.

3.4. Health Information Systems and Data Management

a) System Performance and Downtime

57. At Bungoma County Referral Hospital, the Committee observed that the health management system deployed by *JumboSoft* System was not providing the intended services to the hospital and experienced frequent downtime, despite the substantial investment made in its acquisition.

b) Data Accuracy and Consistency

58. The Committee identified significant data integrity issues. At Bungoma County Referral Hospital, there was variance in patient data between the admissions office and the wards, particularly between the admission office and the New Mother and Child Wing where the recorded number of births also differed from the main hospital, raising concerns about data accuracy.

c) System Deployment Gaps

59. At Kakamega County Referral Hospital, the National Health Information Management System (NHIMS) had not been deployed. The existing reporting system was observed to be user-unfriendly, with patient information not easily retrievable. Furthermore, the facility had an inadequate number of Social Health Authority (SHA) verification machines compelling patients to be transferred from hospital wards to the admissions area to access SHA services.

3.5. Pharmaceutical Services and Supply Chain Management

a) Stock Management Deficiencies

60. Kakamega County Referral Hospital had received medical supplies from KEMSA and MEDS; however, a significant portion of the stock had short expiry periods, raising concerns about inventory control and wastage. The Committee observed inconsistencies in the pharmaceutical records, with expired drugs found stocked on the shelves. Patients were required to obtain prescribed medicines directly from the central drug store due to stock management challenges.

b) Patient Access to Medicines

61. At Bungoma County Referral Hospital, patients informed Members that they were asked to purchase prescribed medicines from outside the hospital, yet the Committee's inspection of the pharmacy confirmed that the same medicines were in stock.

c) Controlled Substances Management

62. At Bungoma County Referral Hospital, it was noted that there was no record for controlled opioid (narcotic) analgesic and regulated medicine and drugs such as morphine.

d) Shortage of Essential Supplies

63. At Kakamega County Referral Hospital, the Emergency Unit lacked essential protective equipment, including hand gloves. Health personnel reported instances where patients were required to purchase medical supplies such as gloves and syringes prior to receiving medical attention. The Radiology Unit lacked essential consumables required for its efficient operation.

3.6. Infection Prevention and Control

a) Laundry and Linen Management

64. At BCRH the Committee observed piles of surgically soiled linen being washed alongside other hospital garments and linen, contrary to the normal practice of separate cleaning. There was a large pile of dirty linen from the medical wards due to insufficient functional laundry machines.

b) Kitchen and Food Safety

65. The Committee identified serious food safety concerns. At BCRH, the hospital kitchen exhibited smoke-stained walls with extensive tile loss and exposed, deteriorated plaster demonstrating longstanding neglect of basic maintenance. The Committee observed a severely worn kitchen worktop with potholes, stagnant wastewater and cracked surface where vegetables were being prepared, illustrating poor food-handling and infection-prevention standards. The old firewood-fueled hospital kitchen had large, soot-stained cooking pots and wet, slippery floors. The dry-store was poorly ventilated and cramped with cooking oil jerrycans and bulk food sacks stacked on dusty wooden shelves and floor.

66. At Kimaeti Health Centre, the kitchen was a semi-permanent, poorly maintained structure that relied on firewood with visible wear and limited amenities.

c) Sanitation Facilities

67. At Kakamega County Referral Hospital, only two toilets were available for use by over 20 patients and caregivers, highlighting inadequate sanitation facilities in the wards. At Kimaeti Health Centre, sanitation facilities and washroom areas showed visible structural deterioration, peeling walls, and inadequate maintenance.

d) Waste Management Practices

68. Critical waste management failures were also observed. At BCRH, the waste disposal point was well maintained but was located adjacent to staff quarters and lacked proper segregation. At KCRH waste was being poorly managed, with waste from the dumpsite burnt in an open field. Staff assigned to handle and burn the waste were not provided with appropriate protective clothing, thereby exposing them to health and safety risks. The Committee observed accumulated biomedical waste and mixed waste being burnt in the open, exposing patients, staff and the surrounding community to serious health and safety risks.

3.7. Financial Management and Sustainability

a) Social Health Authority (SHA) Reimbursement Challenges

69. Both referral hospitals reported significant challenges with SHA reimbursements. At Bungoma County Referral Hospital, the hospital faced challenges related to delayed Social Health Authority (SHA) reimbursements amounting to Kshs 214,894,417 which had adversely affected the delivery of effective services. At Kakamega County Referral Hospital, the Committee observed that some patients were being detained at the facility due to unsettled hospital bills.

70. At Kimaeti Health Centre, the facility experienced challenges arising from delayed Social Health Authority (SHA) reimbursements, which had led to arrears in the payment of wages to casual employees. The Committee was informed that Kimaeti Health Centre increasingly relies on internally generated resources to sustain operations.

b) Facility Improvement Financing

71. In Financial Year 2023/2024, the Bungoma County Referral Hospital collected Kshs 284,017,917 in Facility Improvement Fund (FIF) revenues. During the visit, the County reported a collection of Kshs 441.40 million as FIF in FY 2024 2025, which was 42 percent of the annual target of Kshs 1.06 billion, retained and utilized at source in line with the Facility Improvement Financing Act, 2023.

3.8. Specialized Services and Emergency Care

a) Emergency Department Operations

72. At Kakamega County Referral Hospital, the Outpatient Department operated only during daytime hours, attending to approximately 120 patients per day and about 45 patients over the weekend. At Bungoma County Referral Hospital, the Emergency Department manages a heavy workload from neighbouring counties and neighbouring Uganda, with reports that in some shifts only one nurse was on duty, further exacerbating the heavy workload and potentially compromising the quality and timeliness of emergency care.

b) Mortuary Services

73. At Bungoma County Referral Hospital, the mortuary, though well maintained, was overcrowded and did not have adequate arrangements for managing bereaved families collecting bodies. In contrast, the Kakamega County Referral Hospital mortuary was well maintained and efficiently managed with a private wing that generated own-source revenue for the hospital.

c) Maternity and Neonatal Care

74. At Bungoma County Referral Hospital, the New Mother and Child Facility was well set out and efficiently run; however, it required re-design to facilitate easy access for stretchers and wheelchairs. During the visit to the New Mother and Child Unit, the Committee was alarmed by the high number of teenage mothers. At Kimaeti Health Centre, the maternity ward had no curtains or mosquito nets, was not clean and appeared unusually deserted.

3.9. Quality Assurance and Service Delivery

a) Patient Privacy and Dignity

75. Patient privacy concerns were noted at multiple facilities. At KCRH the lack of curtains or blinders in some wards particularly within the maternity section affected patient privacy and comfort. The Labour Ward congestion with 65 mothers occupying only 45 beds compromised patient privacy. At Kimaeti Health Centre, the maternity ward lacked curtains or mosquito nets.

b) Patient Experience and Access

76. At Kakamega County Referral Hospital, patients were required to obtain prescribed medicines directly from the central drug store due to stock management challenges, and were compelled to be transferred from hospital wards to the admissions area to access SHA services due to inadequate verification machines. At Bungoma County Referral Hospital, patients reported being asked to purchase prescribed medicines from outside the hospital despite the same medicines being in stock.

CHAPTER FOUR

4. COMMITTEE RECOMMENDATIONS

77. With the foregoing, the Committee makes the following recommendations -

4.1. Cabinet Secretary, Ministry of Health

78. The Committee makes the following recommendations to the Cabinet Secretary, Ministry of Health-

1) To fast-track the conclusion and financing of the conversion of UHC staff to permanent and pensionable terms with clear timelines and present an implementation report to the Senate within sixty (60) days from the date of adoption of this report; and

2) To prioritize deployment and integration of the National Health Information Management System at all county referral hospitals and ensure full functionality of these digital systems, accompanied by user training and change-management.

4.2. Chief Executive of Social Health Authority (SHA

79. The Committee makes the following recommendations to the Chief Executive Officer of Social Health Authority-

1) To ensure that the National Health Information Management System and SHA verification infrastructure, including biometric and claims-processing equipment, are fully deployed and functional at all public healthcare facilities so that patients are not moved from wards to admissions areas merely to access SHA services;

2) To develop and implement a time-bound plan to clear outstanding reimbursement backlogs to all public healthcare facilities and ensure predictable disbursement cycles to prevent service disruption and wage arrears;

3) To establish clear turnaround time standards for claim processing and reimbursement to county healthcare facilities and file with the Senate an annual performance report comparing actual reimbursement times against the approved standards for each Level 3, Level 4 and Level 5 healthcare facilities

4) To provide an implementation status to the aforementioned recommendations within sixty (60) days from the date of adoption of this report.

4.3. Governor, Bungoma County Government

80. The Committee makes the following recommendations to the Governor, Bungoma County Government-

1) To provide adequate budgetary provision in the Financial Year 2026/2027 for phased absorption, harmonization of remuneration and settlement of related healthcare staff obligations;

2) To undertake a comprehensive structural audit and phased rehabilitation of cracked floors, leaking roofs, broken ceilings, damaged doors and windows and unsafe electrical installations prioritizing high-risk clinical areas;

3) To ring-fence and programme part of the development budgets and FIF collections to complete stalled buildings, including the Kimaeti Health Centre block and Bungoma radiography complex and decongest overcrowded wards and maternity units;

4) To review the contract and performance of the *JumboSoft* Hospital Information System and either enforce service-level agreements to ensure uptime, functionality and user support or competitively procure an alternative interoperable system within a defined timeline;

5) To allocate dedicated funds to repair or replace non-functional dialysis, MES radiology equipment, mammogram, MRI and obsolete laboratory machines and ensure preventive maintenance schedules are implemented and reported quarterly to the County Assembly and the Senate;

6) To enforce strict pharmacy accountability measures, including daily stock reconciliations, prohibition of directing patients to purchase medicines externally where stock exists in-house and proper controlled-drug registers for opioids and other regulated medicines;

7) To urgently procure additional functional laundry machines, employ adequate laundry staff on formal terms and enforce segregation and separate processing of surgically soiled linen, in line with the National Infection Prevention and Control (IPC) Guidelines;

8) To provide sufficient resources to upgrade kitchen infrastructure from firewood-based, poorly ventilated units to safer, energy-efficient systems, replace damaged worktops, and enforce food-handling standards, including proper dry and fresh-produce storage and pest control;

9) To strengthen financial management of FIF by ensuring timely remittance and transparent utilization at facility level, with public disclosure of collections and expenditures;

10) To allocate sufficient resources to provide curtains, blinders and adequate toilets and visitor waiting areas in all wards, particularly maternity units, to guarantee patient privacy, dignity and comfort; and

11) To establish and enforce a transparent human resource management framework in the health sector, including clear duty rosters, staff identification, promotion guidelines, grievance redress mechanisms, and periodic review of staffing levels against Ministry of Health norms, so as to reduce staff demotivation, improve accountability and support continuity of care.

81. The Governor, Bungoma County submits an implementation status to the aforementioned recommendations within sixty (60) days from the date of adoption of this report.

4.4. Governor, Kakamega County Government

82. The Committee makes the following recommendations to the Governor, Kakamega County Government-

1) To ensure that long serving officers who meet the applicable legal and administrative requirements are considered for confirmation to permanent and pensionable terms, promotion, or placement into equivalent secure terms of service in accordance with Article 41 of the Constitution, the County Governments Act and the principles of fair labour practices in public service;

2) To strengthen inventory management to minimize receipt of near-expiry medicines, ensure timely redistribution of short-dated stock and eliminate storage of expired medicines on dispensing shelves;

3) To immediately cease open-field burning of mixed and biomedical waste, operationalize or upgrade compliant incineration and waste-segregation systems and provide appropriate PPE to all waste-handling staff;

4) To increase staffing and on-call coverage in Emergency Departments and maternity units and enforce duty *rotas* that guarantee minimum nurse and clinician numbers per shift, especially in high-volume facilities;

5) To expeditiously procure and operationalize a fully equipped ambulance for Kakamega County Referral Hospital and ensure that drivers receive accredited Emergency Driving & Basic Life Support (BLS) Training;

6) To immediately stop the detention of patients over unpaid bills and develop social-protection and indigent-care protocols in line with national policy for handling financially constrained patients;

7) To develop and implement a compliant plan for safe removal, handling, transport and disposal of asbestos roofing materials from Kakamega CRH, including remediation of areas where asbestos has been buried or exposed;

8) To conduct regular occupational safety audits in hospitals, focusing on exposed electrical wiring, unsafe floors, lack of PPE and unsafe waste-handling practices and implement corrective measures with clear timelines;

9) To undertake a comprehensive structural audit and phased rehabilitation of cracked floors, leaking roofs, broken ceilings, damaged doors and windows and unsafe electrical installations prioritizing high-risk clinical areas;

10) To develop and implement disposal plans for obsolete ICT and medical equipment, in line with e-waste and hazardous waste regulations, and report compliance to National Environment and Management Authority (NEMA) and the Senate within sixty days (60) of adoption of this report;

11) To enforce strict pharmacy accountability measures, including daily stock reconciliations, prohibition of directing patients to purchase medicines externally where stock exists in-house, and proper controlled-drug registers for opioids and other regulated medicines; and

12) To enforce staff identification and accountability by requiring visible name tags and uniforms for all frontline health workers and establishing functional complaints and feedback mechanisms for patients.

83. The Committee further recommends that the Governor, Kakamega County submits an implementation status to the aforementioned recommendations within sixty (60) days from the date of adoption of this report.

4.5. County Public Service Boards of Bungoma and Kakamega

84. The Committee makes the following recommendations to the County Public Service Boards of Bungoma and Kakamega Counties-

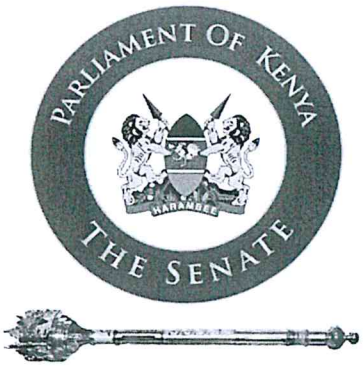
1) To undertake a comprehensive audit of all long serving staff in the county health departments and county referral hospitals, indicating cadre, date of first appointment, current terms of service, station, source of emoluments and whether the officer serves against an approved establishment;

2) To develop and implement a time-bound regularization plan for healthcare worker who have served for prolonged periods on locum, casual, contract or other insecure terms while discharging continuous and core health functions, with priority accorded to critical cadres in referral hospitals and high-volume primary care facilities.

3) To submit progress reports on the status of validation, confirmation, deployment, promotion and retention of long serving staff, including officers who have served for extended periods without confirmation within sixty (60) days from the date of tabling this report.

Annex 1:

Minutes of the Committee Sittings



13TH PARLIAMENT |5TH SESSION

MINUTES OF THE SIXTEENTH (16TH) SITTING OF THE STANDING COMMITTEE ON HEALTH HELD ON, THURDAY 26TH MARCH, 2026 AT 11.00 PM AT GLEE HOTEL, KIAMBU COUNTY

MEMBERS PRESENT

1. Sen. Jackson K. Arap Mandago, EGH, MP - **Chairperson**
2. Sen. Mariam Sheikh Omar, MP - **Vice-Chairperson**
3. Sen. Justice (Rtd) Stewart Madzayo, EGH, MP - Member
4. Sen. Richard Onyonka, MP - Member
5. Sen. Tabitha Mutinda, CBS, MP - Member
6. Sen. Hamida Kibwana, MP - Member
7. Sen. Vincent Kiprono Chemitei Cheburet, MP - Member

ABSENT WITH APOLOGY

1. Sen. Ledama Olekina, CBS, MP - Member
2. Sen. Joseph Githuku Kamau, MP - Member

SENATE SECRETARIAT

1. Mr. Humphrey Ringera - Senior Research Officer
2. Mr. Amos Kiangwe - Senior Clerk Assistant
3. Mr. David Ngamate - Clerk Assistant
4. Mr. Gilbert Juma - Legal Counsel
5. Mr. Ian Otieno - Audio Recording Officer
6. Mr. Stanley Gekore - Media Relations Officer
7. Ms. Yvonne Momanyi - Legal Intern (DLS)
8. Mr. Ham Juma - Legal Intern (DLS)

MIN/SEN/SCH/077/2026 PRELIMINARIES

The Chairperson called the meeting to order at twenty-six minutes past eleven o'clock and the proceedings commenced with a word of prayer followed by brief introduction of those present.

MIN/SEN/SCH/078/2026 **ADOPTION OF THE AGENDA**

The agenda of the meeting was adopted as listed below upon being proposed by Sen. Tabitha Mutinda, CBS, MP and seconded by Sen. Richard Onyonka, MP.

1. Preliminaries;
   a) Prayer
   b) Introductions
2. Adoption of the Agenda;
3. Confirmation of the Minutes;
4. Matters arising;
5. Consideration and Adoption of Committee Report on Oversight Visit to Bungoma and Kakamega Counties (*Committee Paper No.169*);
6. Any other Business; and
7. Adjournment/Date of the Next Meeting

MIN/SEN/SCH/079/2026 **CONFIRMATION OF THE MINUTES**

1. The Minutes of the 64th meeting held on Friday, 14th November, 2025 were confirmed as a true record of the proceedings having been proposed by Sen. Mariam Omar, MP and seconded by Sen. Richard Onyonka, MP;
2. The Minutes of the 65th meeting held on Friday, 14th November, 2025 were confirmed as a true record of the proceedings having been proposed by Sen. Mariam Omar, MP and seconded by Sen. Richard Onyonka, MP;
3. The Minutes of the 66th meeting held on Saturday, 15th November, 2025 were confirmed as a true record of the proceedings having been proposed by Sen. Richard Onyonka, MP and seconded by Sen. Mariam Omar, MP;
4. The Minutes of the 67th meeting held on Saturday, 15th November, 2025 were confirmed as a true record of the proceedings having been proposed by Sen. Mariam Omar, MP and seconded by Sen. Richard Onyonka, MP;
5. The Minutes of the 6th meeting held on Thursday, 12th March, 2026 were confirmed as a true record of the proceedings having been proposed by Sen. Tabitha Mutinda, CBS, MP and seconded by Sen. Justice (Rtd) Stewart Madzayo, EGH, MP;
6. The Minutes of the 11th meeting held on Monday, 16th March, 2026 were confirmed as a true record of the proceedings having been proposed by Sen. Tabitha Mutinda, CBS, MP and seconded by Sen. Hamida Kibwana, MP;
7. The Minutes of the 12th meeting held on Monday, 16th March, 2026 were confirmed as a true record of the proceedings having been proposed by Sen. Tabitha Mutinda, CBS, MP and seconded by Sen. Hamida Kibwana, MP;
8. The Minutes of the 14th meeting held on Monday, 23rd March, 2026 were confirmed as a true record of the proceedings having been proposed by Sen. Hamida Kibwana, MP and seconded by Sen. Richard Onyonka, MP; and

9. The Minutes of the 15th meeting held on Monday 23rd March, 2026 were confirmed as a true record of the proceedings having been proposed by, Sen. Tabitha Mutinda, CBS, MP and seconded by Sen. Justice (Rtd) Stewart Madzayo, EGH, MP;

MIN/SEN/SCH/080/2026 **MATTERS ARISING FROM PREVIOUS MINUTES**

There were no matters arising.

MIN/SEN/SCH/081/2026 **CONSIDERATION AND ADOPTION OF COMMITTEE REPORT ON OVERSIGHT VISIT TO BUNGOMA AND KAKAMEGA COUNTIES (COMMITTEE PAPER NO.169);**

1. The Secretariat presented the Committee Report on the oversight visits to Bungoma and Kakamega counties as contained in *Committee Paper No. 169* for consideration and adoption.
2. Following deliberations, the Committee adopted the report with amendments after being proposed by Sen. Mariam Sheikh Omar, MP and seconded by Sen. Tabitha Mutinda, CBS, MP.

MIN/SEN/SCH/082/2026 **ANY OTHER BUSINESS**

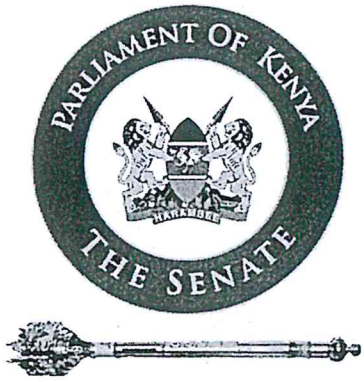
1. The Committee resolved to invite the Chief Executive Officer of the Social Health Authority to the meeting of the Committee scheduled to take place on Thursday 23rd April, 2026 to present the operational report on SHA and respond to issues raised in Statements pending before the Committee. The Committee further resolved that at the said meeting, all Members of the Senate should be invited; and
2. Members were informed that an approval had been granted to undertake oversight visits to Nakuru, Baringo, Elgeyo Marakwet, Uasin Gishu and Nandi Counties from Sunday 13th April to Saturday, 18th April, 2026. Consequently, Members were requested to confirm their attendance for logistical planning.

MIN/SEN/SCH/083/2026 **ADJOURNMENT**

There being no other business, the meeting ended at thirty minutes past ten minutes past one o'clock. The next meeting shall be held twelve noon at the same venue.

SIGNED..... **DATE**.....17/3/2026.....

SEN. JACKSON K. ARAP MANDAGO, EGH, MP
(CHAIRPERSON, COMMITTEE ON HEALTH)



13TH PARLIAMENT |4TH SESSION

MINUTES OF THE SIXTY-SEVENTH (67TH) SITTING OF THE STANDING COMMITTEE ON HEALTH HELD ON SATURDAY, 15TH NOVEMBER, 2025 AT KAKAMEGA COUNTY REFERRAL HOSPITAL AT 11.00 AM

MEMBERS PRESENT

1. **Sen. Jackson K. Arap Mandago, EGH, MP** - **Chairperson**
2. Sen. Mariam Sheikh Omar, MP - Vice-Chairperson
3. Sen. David Wakoli,CBS, MP - Member
4. Sen. Richard Onyonka, MP - Member
5. Sen. Joseph Githuku Kamau, MP - Member

ABSENT WITH APOLOGY

1. Sen. Justice (Rtd) Stewart Madzayo, EGH, MP - Member
2. Sen. Ledama Olekina,CBS, MP - Member
3. Sen. Tabitha Mutinda,CBS, MP - Member
4. Sen. Hamida Kibwana, MP - Member

SENATE SECRETARIAT

1. Mr. Humphrey Ringera - Senior Research Officer
2. Mr. David Ngamate - Clerk Assistant
3. Mr. Gilbert Juma - Legal Counsel
4. Mr. Ian Otieno - Audio Assistant
5. Mr. Jack Lemeteki - Media Relations Officer
6. Mr. Ibrahim Odindo - Serjeant – at- Arms

IN ATTENDANCE

1) Dr. Livingstone Imbayi - County Executive Committee Member, Health Services
2) Dr. David Alilah - Chief Officer, Medical Services
3) Ms. Rose Muhanda - Chief Officer, Public Health
4) Dr. Dixon Mchana - Ag. Medical Superintendent.

MIN/SEN/SCH/338/2025 **PRELIMINARIES**

The meeting was called to order at eleven o'clock and the proceedings commenced with a word of prayer and brief introductions of those present.

MIN/SEN/SCH/339/2025 **OVERSIGHT VISIT AT KAKAMEGA COUNTY REFERRAL HOSPITAL**

1. The Committee conducted an oversight visit to the Kakamega County Referral Hospital on Saturday 15th November, 2025 accompanied Mr. Livingstone Imbayi, the County Executive Committee Member for Health Services, Dr. David Alilah, the County Chief Officer for Medical Services, Dr. Dixon Mchana, the Kakamega County Hospital Acting Medical Superintendent. The Committee was accompanied by the Members of the County Assembly counterpart committee on health led by the Vice Chairperson Mr. Bonface Mabuka

2. During the oversight visit, the Committee was informed that Kakamega County Referral Hospital the facility maintains a total bed capacity of 384. This capacity is distributed across various general and specialized wards to accommodate diverse patient needs. The general wards include Ward 1 with 20 beds, Ward 2 with 19 beds, Ward 3 with 22 beds, Ward 4 with 21 beds, and the largest section, Wards 5A & 5B, which provides 51 beds. Additional general inpatient space is found in Ward 6A (21 beds), Ward 7A (18 beds), Ward 7B (8 beds), Ward 8 (13 beds), and Ward 9 (22 beds);

3. Specialized care units at the hospital are comprised of a 14-bed Oncology unit, a 10-bed Burns Unit, and an Intensive Care Unit (ICU) equipped with 6 beds. Maternal and neonatal care are significant components of the hospital's infrastructure, featuring a Newborn Unit (NBU) with 38 beds, a Post-Natal Ward (PNW) with 45 beds, an Ante-Natal Ward (ANW) with 14 beds, and a Labour Ward (LW) with 7 beds. The facility also provides 6 beds for Kangaroo Mother Care (KMC) and 6 beds for the High Dependency Unit (HDU), alongside an Amenity ward containing 23 beds. Beyond active patient care, the hospital's mortuary is noted to have a capacity of 112

4. The Committee was further informed that the Hospital's human resources are divided into three primary categories; Permanent and Pensionable (P&P), Locum, and Universal Health Coverage (UHC). The Medical and Clinical Staff consists of 35 consultants, all of whom are on Permanent and Pensionable terms and 51 medical officers consisting of 33 P&P staff and 18 Locum staff. There is a total of 62 Clinical Officers, including 35 P&P, 26 Locum, and 1 UHC. There are 9 specialized clinical officers, all on P&P terms;

5. The Committee was informed that the nursing staff constitute the largest segment of the workforce. There are 347 general nurses (231 P&P, 112 Locum, and 4 UHC) and 38 specialized nurses (37 P&P and 1 Locum).

6. During the visit the Committee made the following observations at the Kakamega County Referral Hospital-

a) The Emergency Unit lacked essential protective equipment, including hand gloves, which health personnel reported that there were instances where patients were required to purchase medical supplies such as gloves and syringes prior to receiving medical attention. It was further noted that the hospital did not have a functional ambulance, despite substantial budgetary provisions by the County Assembly for the same. Additionally, the designated ambulance driver had not undergone the requisite training. The Committee also noted with concern the dilapidated condition of seats and the deteriorating ceiling within the Accident and Emergency Department;

b) The National Health Information Management System (NHIMS) had not been deployed at the Hospital. The existing reporting system was observed to be user-unfriendly, with patient information not easily retrievable. Furthermore, the facility had an inadequate number of Social Health Authority (SHA) verification machines, compelling patients to be transferred from hospital wards to the admissions area to access SHA services;

c) The Hospital infrastructure was in a dilapidated state. Several window panes were broken and temporarily blocked with cartons. Electrical cables were exposed, posing safety risks, while seats and stretchers were extensively worn out, reflecting poor maintenance of the facility;

d) The Outpatient Department (OPD) operated only during daytime hours, attending to approximately 120 patients per day and about 45 patients over the weekend. It was further observed that there was no duty rota in place, resulting in delays in service delivery. Additionally, staff members did not wear name tags or uniforms bearing their names, hindering ease of identification and accountability;

e) The hospital received medical supplies from KEMSA and MEDS; however, a significant portion of the stock had short expiry periods, raising concerns about inventory control and wastage. Further, The Committee observed inconsistencies in the pharmaceutical records, with expired drugs found stocked on the shelves. Patients were further required to obtain prescribed medicines directly from the central drug store due to stock management challenges;

f) The hospital waste was being poorly managed, with waste from the dumpsite burnt in an open field. Staff assigned to handle and burn the waste were not provided with appropriate protective clothing, thereby exposing them to health and safety risks;

g) The facility's roofing structure was made of asbestos, in contravention o Environmental Management and Coordination (Waste Managen Regulations, 2006. Although the Hospital had a secured plot designated fo disposal of replaced asbestos roofing, pieces of asbestos were still visible o grounds, and some asbestos materials had been buried in an open area used a incinerator, posing serious environmental and occupational health hazards;

h) The Radiology Unit lacked essential consumables required for its effi operation. The mammogram and MRI machines had been non-functional fo past five months, while the ultrasound equipment was not operating optim Additionally, the laboratory was found to be equipped with obsolete and a machines, which adversely affected the quality and timeliness of diagno services;

i) The Committee observed that some patients were being detained at the fac due to unsettled hospital bills. The Labour Ward was found to be congested, w 65 mothers occupying only 45 available beds, thereby compromising pati privacy. Similarly, eight incubators were being used to accommodate 15 infan raising concerns about neonatal safety and the quality of care provided;

j) The Committee further noted the lack of waiting bays or benches for patien visitors and the absence of curtains or blinders in some wards, particularly with the maternity section, which affected patient privacy and comfort. Additionall only two toilets were available for use by over 20 patients and caregiver highlighting inadequate sanitation facilities in the wards;

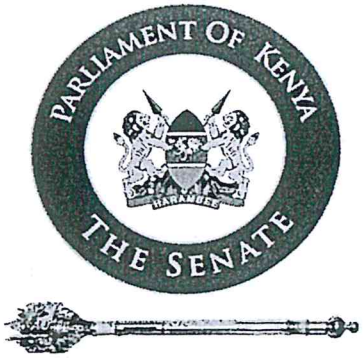
k) The mortuary was well maintained and efficiently managed. It had a private wi that generated own-source revenue for the hospital. The unit had nin morticians—three permanent and six on contract—one of whom had served fo nine years without confirmation. The Committee further noted concern regarding staff who had served for extended periods without being confirmed a permanent and pensionable employees.

MIN/SEN/SCH/340/2025 ADJOURNMENT

There being no other business, the meeting ended at forty minutes past one o'clock. The next meeting shall be held on notice.

SIGNED.....**DATE**.....4/3/2026

SEN. JACKSON K. ARAP MANDAGO, EGH, MP
(CHAIRPERSON, COMMITTEE ON HEALTH)



13TH PARLIAMENT |4TH SESSION

MINUTES OF THE SIXTY-FIFTH (65TH) SITTING OF THE STANDING COMMITTEE ON HEALTH HELD ON FRIDAY, 14TH NOVEMBER, 2025 AT 12.00 NOON IN BUNGOMA COUNTY REFERRAL HOSPITAL AND KIMAETI HEALTH CENTER

MEMBERS PRESENT

1. **Sen. Jackson K. Arap Mandago, EGH, MP** - **Chairperson**
2. Sen. Mariam Sheikh Omar, MP - Vice-Chairperson
3. Sen. David Wakoli, MP - Member
4. Sen. Richard Onyonka, MP - Member
5. Sen. Joseph Githuku Kamau, MP - Member

ABSENT WITH APOLOGY

1. Sen. Justice (Rtd) Stewart Madzayo, EGH, MP - Member
2. Sen. Ledama Olekina, CBS, MP - Member
3. Sen. Tabitha Mutinda, CBS, MP - Member
4. Sen. Hamida Kibwana, MP - Member

SENATE SECRETARIAT

1. Mr. Humphrey Ringera - Senior Research Officer
2. Mr. David Ngamate - Clerk Assistant
3. Mr. Gilbert Juma - Legal Counsel
4. Mr. Ian Otieno - Audio Assistant
5. Mr. Jack Lemeteki - Media Relations Officer
6. Mr. Ibrahim Odindo - Serjeant – At – Arms

IN ATTENDANCE

1. Mr. Chrispinus Barasa - County Executive Committee Member Health and Sanitation Department
2. Dr. Magrina Mayama - Chief Officer, Health and Sanitation
3. Dr. Caleb Watta - County Director, Health and Sanitation
4. Dr. Simon Kisaka - Medical Superintendent

5. Dr. Emma Nyaboke - Deputy Director -Health and Sanitation
6. Ms. Phoebe Wanjala - Senior Nursing Officer

MIN/SEN/SCH/329/2025 **PRELIMINARIES**

The Committee commenced the tour of the Bungoma County Referral Hospital at five minutes past one o'clock with brief introductions of the Members present, the accompanying members of the County Assembly and the Executive and the host hospital management.

MIN/SEN/SCH/330/2025 **OVERSIGHT VISIT TO BUNGOMA COUNTY REFERRAL HOSPITAL**

1. The Committee conducted an oversight visit to the Bungoma Level 5 Hospital in Bungoma County on Friday 14th November, 2025 accompanied Mr. Chrispinus Barasa, the County Executive Committee Member in charge of Health and Sanitation Department, Dr. Magrina Mayama, the County Chief Officer for Health and Sanitation, Dr. Simon Kisaka, the Bungoma County Hospital Superintendent alongside Mr. Humphrey Silungi, the County Director of Public Works;

2. During the oversight visit, the Committee was informed that:
   a) Bungoma County Referral Hospital has a bed capacity of 311 beds, including 31 maternity beds. Additionally, the Newborn Unit accommodated a total of 31 cots and 10 Kangaroo Mother Care (KMC) beds;
   b) The facility had employed a total of twenty-two (22) consultants; with Eleven (11) medical officers comprising nine (9) PNP and two (2) Bungoma County contract. In addition, there are thirty-six (36) registered clinical officers, twenty-six (26) on PNP, seven (7) on Bungoma county Government contract and Three (3) on UHC, including twenty 2O general clinical officers and sixteen (16) specialists;
   c) Nursing staff totaled to one hundred and eighty-one (181), made up of one hundred and thirty-five (135) nurses employed on Permanent basis, thirty-five (35) nurses contracted by the County Public Service Board, nine (9) on UHC staff, one (1) nurse from Dumisha Program and one (1) nurse on MOH COVID 19 Fund contract. Consequently, there are one hundred and forty-three (143) general nurses and thirty-eight (38) specialist nurses;
   d) The pharmacy department had two (2) pharmacists employed on permanent basis and one (1) contracted by the County Public Service Board. There were seven (7), pharmaceutical technologist on permanent basis, seven on contracts and a further two (2) from the UHC Staff compliment;
   e) Radiography services were supported by nine (9) radiographers, of whom four (4) were employed on permanent basis, one (1) was contracted by the County Public Service Board and the other four were UHC Staff.

3. During the visit the Committee made the following observations at the Bungoma County Referral Hospital:

a) The Hospital faced significant challenges stemming from deteriorating infrastructure and overcrowding. The physical environment was in poor condition, with broken furniture in consultation rooms, cracked floors, faded and peeling wall paint, and damaged ceilings. Wards were congested, forcing some in-patients to occupy verandahs improvised as wards furnished with old, rusty beds, unclean linen, and inadequate working surfaces and equipment, conditions that collectively compromised patient comfort and quality of care;

b) There were loose electrical sockets and exposed wiring in the laboratory, alongside a shortage of essential reagents, while the hospital kitchen was old, poorly maintained, inadequately equipped and lacked modern equipment and essential tools necessary for efficient operation;

c) There was variance in patient data between the admissions office and the wards, particularly between the admission office and the New Mother and Child Wing, where the recorded number of births also differed from the main hospital, raising concerns about data accuracy. The New Mother and Child Facility was well set out and efficiently run; however, it required re-design to facilitate easy access for stretchers and wheelchairs. During the visit to the New Mother and Child Unit, the Committee was also alarmed by the high number of teenage mothers;

d) There was only one laundry machine serving the Hospital out of four observed at the laundry unit, with the other machines appearing to have been nonfunctional for an inordinate long period, resulting in a large pile of dirty linen from the medical wards. The Committee observed piles of surgically soiled linen being washed alongside other hospital garments and linen, contrary to the normal practice of separate cleaning and further noted that electronic waste was being dumped in the laundry store. In addition, there were only three laundry staff members who were serving as casual labourers at the unit since 2019;

e) The Committee observed that the health management system deployed by *JumboSoft* System was not providing the intended services to the hospital and experienced frequent downtime, despite the substantial investment made in its acquisition;

f) Patients informed Members that they were asked to purchase prescribed medicines from outside the hospital, yet the Committee's inspection of the pharmacy confirmed that the same medicines were in stock, and it was further noted that there was no record for controlled opioid (narcotic) analgesic and regulated medicine and drugs such as morphine;

g) The Committee observed that the waste disposal point was well maintained, but noted that it was located adjacent to staff quarters and lacked proper segregation, while the mortuary, though well maintained, was overcrowded and did not have adequate arrangements for managing bereaved families collecting bodies;

h) The Committee noted that a Radiography Complex was under construction but expressed concern over the poor workmanship, and further emphasized the need for a comprehensive hospital master plan to consolidate the facility layout and adequately provide for future expansion;

i) The Committee observed that the facility had only eight radiographers against an estimated requirement of 16 to 20, resulting in understaffing in the Radiology Department. Moreover, the MES equipment were non-functional, with only one X-ray machine operational, serving approximately 60 patients per day, and there was no functional CT scan available at the facility;

j) The Committee noted that the Emergency Department, staffed by two medical officers, six clinical officers and twelve nurses, manages a heavy workload from neighbouring counties such as Kakamega and Trans Nzoia, as well as patients from neighbouring Uganda, resulting in significant strain on the already limited resources. It was reported that in some shifts, only one nurse was on duty, further exacerbating the heavy workload and potentially compromising the quality and timeliness of emergency care.

MIN/SEN/SCH/331/2025 **OVERSIGHT VISIT TO KIMAETI HEALTH CENTER**

1. The Committee was received by Mr. Paul Wamalwa, Clinical Officer in Charge of the Kimaeti Health Centre, a level III health facility. During the oversight visit, the Committee was informed that the Hospital operated on a 24-hour basis, with the Health Records Unit managed by four contracted employees, two engaged directly by the Hospital and two under a partnership arrangement, who were further supported by students on attachment;

2. The Committee was informed that the facility experienced persistent understaffing, which adversely affected service delivery and compromised the quality of care, with a total of twenty-two (22) casual employees on the staff establishment drawing a combined monthly wage bill of Kshs 266,000;

3. The Committee was further informed that the facility experiences challenges arising from delayed Social Health Authority (SHA) reimbursements, which have led to arrears in the payment of wages to casual employees. The Committee was informed that Kimaeti Health Centre increasingly relies on internally generated resources to sustain operations;

4. The Committee was further informed that the facility comprises a laboratory, pharmacy, Maternal and Child Health (MCH) unit, records office, administration block, male and female wards and a maternity ward, and has a bed capacity of thirty-five (35). At the time of the visit, the Committee also observed a long-stalled building project within the facility. The maternity ward had no curtains or mosquito nets, was not clean and appeared unusually deserted, with some rooms being used to store obsolete materials and documents;

5. The Committee observed that the facility had a total of fourteen staff posted by the County Government, comprising clinical officers, a Health Administrative Officer, two laboratory technologists, one nutritionist, one clerical officer and eight nurses. Against the Ministry of Health staffing norms for a Level 3A facility, the number of clinical officers and nurses was below the recommended minimum, limiting the facility's capacity to provide continuous inpatient and maternity services, while laboratory and nutrition services barely met the minimum staffing requirements;

6. The Committee observed that the health centre infrastructure was in a poor state; the kitchen was a semi-permanent, poorly maintained structure that relied on firewood; the facility depended on inadequate manual sterilization of medical kits; the male wards were poorly maintained, with curtains falling; and there was a stalled building that required completion to decongest the already limited facility space.

MIN/SEN/SCH/332/2025 THE EXIT MEETING WITH THE EXECUTIVE

1. The Committee held an exit meeting with the Governor, County Government of Bungoma County to present its preliminary report and informed the Governor that during the oversight visit to the healthcare facilities in the County;
2. The Committee recommended that the County Executive urgently reviews and addresses the challenges associated with the hospital information management system, with a view to ensuring its full functionality, reliability and integration across all service delivery points. In this regard, the Committee advised the Executive to consider benchmarking in other counties to learn best practices in the design, deployment and management of a robust hospital information system, with particular emphasis on strengthening the pharmacy module to enhance medicines management, accountability and service efficiency;
3. The Committee underscored the need to liaise with the National Police Service to establish a police mortuary for the preservation of bodies that are either unidentified or subject to ongoing court disputes;
4. The Committee observed that the visited healthcare facilities were in dire need of general repairs and therefore recommended the establishment of functional maintenance units to undertake day-to-day repair works. The Committee further recommended that the County Government urgently address the status of laundry machines, particularly at Bungoma Level V Hospital, where the existing machines required replacement. Additionally, the Committee underscored the need to install incinerators at sub-county Level 4 hospitals to ensure proper medical waste management;
5. The Committee observed that the healthcare facilities faced significant challenges in record keeping and health information management, with notable discrepancies and inconsistencies identified at the sub-county hospitals, thereby undermining the accuracy and reliability of health data for decision-making and service delivery;

6. The Committee recommended that the County Government give due consideration to long-serving contract staff, particularly those in the laundry and kitchen units, with a view to improving their terms of engagement in order to enhance motivation and retention.

7. The Committee recommended that the County Government liaise with the Kenya Power Company to install a functional transformer to facilitate effective water pumping at Kimaeti Health Centre.

8. The Governor informed the Committee that the County had intended the information management system to integrate all county health facilities to facilitate efficient management reporting. He regretted the system's downtime and assured the Committee that the County Government would address the matter.

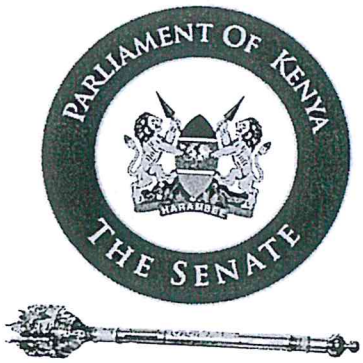
9. The Committee was further informed that the County Government accepted the Committee's overall recommendations and committed to initiating reforms on the basis of the exit report, pending the final report to facilitate comprehensive implementation of all the Committee's recommendations.

MIN/SEN/SCH/333/2025 **ADJOURNMENT**

There being no other business, the meeting ended at forty minutes past seven o'clock. The next meeting shall be held on notice.

SIGNED..... **DATE**..24/3/2026.....

SEN. JACKSON K. ARAP MANDAGO, EGH, MP
(CHAIRPERSON, COMMITTEE ON HEALTH)



13TH PARLIAMENT |4TH SESSION

MINUTES OF THE SIXTY-FOURTH (64TH) SITTING OF THE STANDING COMMITTEE ON HEALTH HELD ON FRIDAY, 14TH NOVEMBER, 2025 AT THE OFFICE OF THE GOVERNOR, BUNGOMA COUNTY AND COUNTY ASSEMBLY OF BUNGOMA

MEMBERS PRESENT

1. **Sen. Jackson K. Arap Mandago, EGH, MP** - **Chairperson**
2. Sen. Mariam Sheikh Omar, MP - **Vice-Chairperson**
3. Sen. David Wakoli, MP - Member
4. Sen. Richard Onyonka, MP - Member
5. Sen. Joseph Githuku Kamau, MP - Member

ABSENT WITH APOLOGY

1. Sen. Justice (Rtd) Stewart Madzayo, EGH, MP - Member
2. Sen. Ledama Olekina, CBS, MP - Member
3. Sen. Tabitha Mutinda, CBS, MP - Member
4. Sen. Hamida Kibwana, MP - Member

SENATE SECRETARIAT

1. Mr. Humphrey Ringera - Senior Research Officer
2. Mr. David Ngamate - Clerk Assistant
3. Mr. Gilbert Juma - Legal Counsel
4. Mr. Ian Otieno - Audio Assistant
5. Mr. Jack Lemeteki - Media Relations Officer
6. Mr. Ibrahim Odindo - Serjeant – At – Arms

IN ATTENDANCE - BUNGOMA COUNTY EXECUTIVE

1. Mr. Kenneth Lusaka - Governor
2. Mr. Chrispinus Barasa - County Executive Committee Member, Health and Sanitation Department
3. Dr. Magrina Mayama - Chief Officer Health and Sanitation

4. Dr. Caleb Watta - County Director – Health and Sanitation
5. Dr. Simon Kisaka - Medical Superintendent, Bungoma Referral Hospital
6. Dr. Emma Nyaboke - Deputy Director -Health
7. Mr. Humphrey Silungi - Director Public Works

COUNTY ASSEMBLY OF BUNGOMA

1. Mr. Emmanuel Situma - Speaker
2. Mr. George Makari - Chairperson, Committee on Health Services
3. Mr. Tony Barasa - Member, Committee on Health Services
4. Mr. Jacob Psero - Member, Committee on Health Services
5. Ms. Dorcas Nandasaba - Member, Committee on Health Services
6. Mr. Orize Kundu - Member Committee Health Services

MIN/SEN/SCH/324/2025 **PRELIMINARIES**

The meeting was called to order at thirty minutes past ten o'clock and the proceedings commenced with a word of prayer and brief introductions of those present.

MIN/SEN/SCH/325/2025 **ADOPTION OF THE AGENDA**

The agenda of the meeting was adopted with amendments after being proposed by Sen. David Wakoli, MP and seconded by Sen. Mariam Sheikh Omar, MP, as listed below-

1. Preliminaries;
   i. *Prayer*
   ii. *Introductions*
2. Adoption of the Agenda;
3. Courtesy call to the Speaker, Bungoma County Assembly;
4. Courtesy call to the Governor, Bungoma County Government;
5. Any other Business; and
6. Adjournment/Date of the Next Meeting

MIN/SEN/SCH/326/2025 **COURTESY CALL VISIT TO BUNGOMA COUNTY ASSEMBLY**

1. The Committee paid a courtesy call on the Speaker and briefed him about the objective of the oversight visit.
2. The Committee outlined the specific objective of this engagement was to visit select Healthcare facilities in the County in order to-
   a) assess the state and quality of the infrastructure, facilities, hospital equipment and provision of emergency services;

b) assess the automation of healthcare provision systems for patient, drugs and commodity management;
c) assess the availability of requisite healthcare personnel, the gaps and challenges, if any, Healthcare workers face in the county;
d) assess the availability of training and capacity building programs and avenues for healthcare workers in emergency Healthcare and specialized services;
e) assess the availability of drug and medical supplies in Health-care facilities in the Counties and pending bills with the Kenya Medical Supplies Agency; and
f) seek information on the Social Health Authority (SHA) reimbursements claimed and accreditation for County Health facilities with SHA.

3. On his part the Speaker thanked the Committee in its role in mentoring the County Assembly and Committee Members with an aim to improve on oversight. The Speaker assured the Committee that the Members of the County Assembly will work closely with the Senate during and after the oversight visit and follow-up on the implementation status of the Senate resolutions.

MIN/SEN/SCH/327/2025 **COURTESY CALL VISIT TO THE GOVERNOR**

4. The Committee paid a courtesy call on the Governor, Bungoma County Government on Friday, 14th November, 2025 and briefed him about the objective of the oversight visit.

5. The Governor informed the Committee that-

a) Bungoma County has a total of approximately 275 Health facilities distributed across its nine sub-counties. Of these, including 154 government-operated Health Centers, making up the majority of public healthcare provision in the County, the remainder includes faith-based facilities (around 22), private facilities (approximately 95), and a small number under NGOs (about 4);

b) the County Gross Approved FY 2024/25 Budget was Kshs.15.59 billion. It comprised Kshs.4.97 billion (32 percent) and Kshs.10.62 billion (68 per cent) allocation for development and recurrent programmes, respectively. The budget estimates represented an increase of Kshs.1.56 billion (11 per cent) from the FY 2023/24. The increase was attributed to a rise in its own-source revenue projection and equitable share of revenue raised Nationally;

c) the County reported a collection of Kshs.441.40 million as FIF, which was 42 percent of the annual target of Kshs.1.06 billion. The collected amount was retained and utilized at source in line with the Facility Improvement Financing Act, 2023.

6. The Committee was further informed that conversion and confirmation of the Universal Health Coverage (UHC) staff, totaling up to 245 across all cadres, was still pending due to financial constraints. Further the list of the affected members of staff was being validated.

MIN/SEN/SCH/328/2025 **ADJOURNMENT**

There being no other business, the meeting ended at forty minutes past eleven o'clock and the Committee proceeded to undertake oversight visits in the healthcare facilities.

SIGNED..... **DATE**.....24/3/2026.....

SEN. JACKSON K. ARAP MANDAGO, EGH, MP
(CHAIRPERSON, COMMITTEE ON HEALTH)

6. During the visit the Committee made the following observations at the Kakamega County Referral Hospital-

a) The Emergency Unit lacked essential protective equipment, including hand gloves, which health personnel reported that there were instances where patients were required to purchase medical supplies such as gloves and syringes prior to receiving medical attention. It was further noted that the hospital did not have a functional ambulance, despite substantial budgetary provisions by the County Assembly for the same. Additionally, the designated ambulance driver had not undergone the requisite training. The Committee also noted with concern the dilapidated condition of seats and the deteriorating ceiling within the Accident and Emergency Department;

b) The National Health Information Management System (NHIMS) had not been deployed at the Hospital. The existing reporting system was observed to be user-unfriendly, with patient information not easily retrievable. Furthermore, the facility had an inadequate number of Social Health Authority (SHA) verification machines, compelling patients to be transferred from hospital wards to the admissions area to access SHA services;

c) The Hospital infrastructure was in a dilapidated state. Several window panes were broken and temporarily blocked with cartons. Electrical cables were exposed, posing safety risks, while seats and stretchers were extensively worn out, reflecting poor maintenance of the facility;

d) The Outpatient Department (OPD) operated only during daytime hours, attending to approximately 120 patients per day and about 45 patients over the weekend. It was further observed that there was no duty rota in place, resulting in delays in service delivery. Additionally, staff members did not wear name tags or uniforms bearing their names, hindering ease of identification and accountability;

e) The hospital received medical supplies from KEMSA and MEDS; however, a significant portion of the stock had short expiry periods, raising concerns about inventory control and wastage. Further, The Committee observed inconsistencies in the pharmaceutical records, with expired drugs found stocked on the shelves. Patients were further required to obtain prescribed medicines directly from the central drug store due to stock management challenges;

f) The hospital waste was being poorly managed, with waste from the dumpsite burnt in an open field. Staff assigned to handle and burn the waste were not provided with appropriate protective clothing, thereby exposing them to health and safety risks;

g) The facility's roofing structure was made of asbestos, in contravention of the Environmental Management and Coordination (Waste Management) Regulations, 2006. Although the Hospital had a secured plot designated for the disposal of replaced asbestos roofing, pieces of asbestos were still visible on the grounds, and some asbestos materials had been buried in an open area used as an incinerator, posing serious environmental and occupational health hazards;

h) The Radiology Unit lacked essential consumables required for its efficient operation. The mammogram and MRI machines had been non-functional for the past five months, while the ultrasound equipment was not operating optimally. Additionally, the laboratory was found to be equipped with obsolete and aging machines, which adversely affected the quality and timeliness of diagnostic services;

i) The Committee observed that some patients were being detained at the facility due to unsettled hospital bills. The Labour Ward was found to be congested, with 65 mothers occupying only 45 available beds, thereby compromising patient privacy. Similarly, eight incubators were being used to accommodate 15 infants, raising concerns about neonatal safety and the quality of care provided;

j) The Committee further noted the lack of waiting bays or benches for patients' visitors and the absence of curtains or blinders in some wards, particularly within the maternity section, which affected patient privacy and comfort. Additionally, only two toilets were available for use by over 20 patients and caregivers, highlighting inadequate sanitation facilities in the wards;

k) The mortuary was well maintained and efficiently managed. It had a private wing that generated own-source revenue for the hospital. The unit had nine morticians—three permanent and six on contract—one of whom had served for nine years without confirmation. The Committee further noted concerns regarding staff who had served for extended periods without being confirmed as permanent and pensionable employees.

MIN/SEN/SCH/340/2025 ADJOURNMENT

There being no other business, the meeting ended at forty minutes past one o'clock. The next meeting shall be held on notice.

SIGNED.....**DATE**.....14/3/2026

SEN. JACKSON K. ARAP MANDAGO, EGH, MP
(CHAIRPERSON, COMMITTEE ON HEALTH)