

Determinants of self-driven referral among clients seeking outpatient services at Bungoma County Referral Hospital, Kenya

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ABSTRACT

Self-referred cases, where patients do not visit primary healthcare (PHC) facilities and instead consider visiting higher-level hospitals, create a negative burden on the healthcare system and jeopardise the attainment of the universal health coverage (UHC) requirements of the Sustainable Development Goal (SDG) 3.8. The prevalence of self-referral has been estimated at 84.3% in Kenya, and Bungoma County Referral Hospital (BCRH) has overutilisation, which is explained by systemic PHC gaps; however, there is a paucity of empirical studies that explain the determinants of overutilisation. This research evaluated the factors that have an impact on self-referrals in outpatient clientele visiting BCRH. Using the Health Belief Model (HBM), the research operationalised the concept of self-referral by the severity of perceived illness and mistrust in PHC and perceived benefits of care at a higher-level facility. An analytical cross-sectional design was used. The study population was 1,880, with a prevalence of 84.3%, which has a sample size of 201 patients in the Outpatient Department, Antenatal Care, Mother and Child Health, and Family Planning clinics. Purposive sampling identified key informants and systematic random sampling patients. Information was obtained through a pre-test validity structured questionnaire and key informant interview (KII) guide; quantitative data were analysed with chi-square tests and odds ratios ($p < 0.05$) using Statistical Package for Social Sciences version 27, and qualitative data were done through thematic analyses. Findings showed that self-driven referral rate in BCRH was 51.7%. Out of the 201 respondents, 71.6% were female, 73.2% were below 32 years of age and 60.2% were secondary education holders. Propensity toward self-referral was stronger among male clients (Odds Ratio [OR] = 4.418, $p = 0.040$) as well as those having tertiary education (OR = 0.094, $p = 0.006$). This study concludes that the factor of self-motivated referral in Bungoma County can be highly influenced by the systemic inadequacy of PHC, especially the insufficiency of diagnostics and the availability of medication and is also exacerbated by gender and educational gaps. This study recommends strengthening of PHC infrastructure, the guaranteeing of continuous medication availability, the coordination of insurance requirements with referral policies and the building of trust in communities as the necessary steps in reducing unnecessary self-referrals and promoting UHC.

Keywords: Bungoma County Referral, Primary Health Care, Self-Referral, Outpatient Services

I. INTRODUCTION

The client-made referral, where patients bypass the lower-level health institutions and go to the higher-level facilities, is majorly a challenge to the rationality of healthcare systems all around the world as well as its fairness. This practise is also in opposition to the principles of primary health care (PHC) as stipulated by the Alma-Ata Declaration issue of 1978 and once again by the Abuja Declaration issue of 2006, neither of whom failed to highlight the universal access to affordable and effective healthcare in their majority get-list (World Health Organisation [WHO], 2020). The self-referral practises reveal the systemic discrepancies between patient efficiencies and the service provisions, thus creating the inefficiencies, inequities, and increase in workloads to the higher-level facilities (Escamilla *et al.*, 2018; Yao, 2018). The phenomenon has great impact on achieving Sustainable Development Goal (SDG) 3.8 that seeks to achieve universal health coverage (UHC) by ensuring everyone has equitable access to quality healthcare services without fear of not affording them (WHO, 2020). Empirical data collected in different geographical settings show a significant difference in self-referral rates as it reflects the differences in healthcare organisation, its accessibility, and the patient trust towards the lower-level services (Abere *et al.*, 2021; Bell *et al.*, 2020).

Health declarations in Sub-Saharan Africa have been uneven, and several countries have been unable to operationalize PHC because of a lack of infrastructures, financial inaccessibility, and sociocultural fences (WHO, 2020). Even though the Abuja Declaration proposed a need to allocate more resources in the health sector, the distribution of

resources remains unequal between the various parts of the region so that there would be an uneven access to healthcare services of high quality (Larson *et al.*, 2019). Self-referral has become specifically widespread in African locations, as patients tend to lack confidence in primary-level establishments because of perceived shortcomings in diagnostic abilities, availability of medication, and staffing (Mubiri *et al.*, 2020). The self-referral rate is reported to be 29% in Uganda and more than 60 per cent in Nigeria and Ethiopia, which represents weakness in the system in terms of PHC delivery (Abera *et al.*, 2021; Okoli *et al.*, 2017). Such patterns vary health inequities, put the pressure on referral hospitals, and make the quality of care, creating the necessity to adopt region-specific strategies to empower PHC infrastructure and the fact that more people believe in the frontline services.

The policy frameworks and the provisions of the Kenyan constitution are directing its health system with consideration of the fact that health is a fundamental human right. The right of the highest attainable standard of health is guaranteed in article 43(1) of the Constitution of Kenya (2010) and the Kenya Health Policy (2014-2030) and the Vision 2030 provide the focus on universal coverage to quality healthcare on all levels of service delivery (Ministry of Health, 2014). Nevertheless, Kenya still reports one of the highest self-referral rates in Sub-Saharan Africa and research shows that as high as 84.3% of patients engage in bypass lower-level facilities as their initial choice to acquiring care in higher-level hospitals (Escamilla *et al.*, 2018). Distance, waiting time, access to diagnostic services, and patient opinion about the quality are among the factors that influence this trend (Bell *et al.*, 2020). The consequence and excessive use of referral hospitals negatively affects the functionality of healthcare system and defies national and worldwide aims to fulfil SDG 3.8 by the UHC.

The issue of the client-driven referral is most severe in Bungoma County where patients are at the Bungoma County Referral Hospital (BCRH), more so in other secondary healthcare facilities in Kanduyi and Webuye West sub-counties (Ministry of Health [MOH], 2022). This focus of healthcare usage is an indication of systemic imbalances in the distribution and perceived quality of primary-level services, which then result in bypassing of local facilities. Furthermore, the overuse of BCRH according to the study not only spreads the resources but also affects the referral system's intention at the national level to enhance patient flow and maximise service delivery to all levels of treatment (MOH, 2022). Despite the high-wide spread of self-referral in the county, there has been little empirical research to identify the underlying socio-demographic and system factors that create or drive this behaviour. These dynamics are important for informing interventions aimed towards strengthening PHC delivery to reduce inequities in service-seeking behaviour and bring Bungoma County health systems more broadly aligned with Kenya's UHC agenda.

1.1 Statement of the Problem

The principles of self-driven referral, when patients do not use primary health facilities to address the issue and refer directly to hospitals of a higher level, negate the effectiveness of referencing in Kenya and offers an added load on already limited resources (World Health Organisation, 2020). In the Sub-Saharan Africa, self-referral rates are high because of inadequate infrastructure, undermined trust in the services of lower level and perceptions to gaps in objectivity (Mubiri *et al.*, 2020; Bell *et al.*, 2020). One of the highest is 84.3% in Kenya ranking among the world (Abera *et al.*, 2021). System-wide weaknesses are highlighted by the over-use of the Bungoma County Referral Hospital (Ministry of Health, 2022) at county level, and very few empirical studies have been conducted in the subject to date, thus indicating a promising approach for this study. This study endeavoured to evaluate the determinants of self-driven referral among clients seeking outpatients' services such as outpatient department (OPD) antenatal care (ANC), child welfare clinics (CWC), mother and child health (MCH), and family planning (FP), at Bungoma County Referral Hospital.

1.2 Research Objective

To evaluate the determinants of self-driven referral among clients seeking outpatient services at Bungoma County Referral Hospital, Kenya

II LITERATURE REVIEW

2.1 Theoretical Review

2.1.1 Health belief Model

In the early 1950s the social psychologists Irwin M. Rosenstock, Godfrey Hochbaum, S. Stephen Kegeles, and Howard Leventhal (at that time serving the U.S. Public Health Service) tested the characteristics of this Health Belief Model [HBM] (Rosenstock, 1974). The model was first meant to make sense of the failure of people to engage in preventive health services like tuberculosis screening. It assumes health-related behaviours to be affected by perceptions of the people regarding susceptibility, severity, benefits and barriers and cues to action and self-effects. The HBM has over the years been utilised worldwide to examine the human behaviours like vaccination, testing, life service use (mothers), and treatment adherence (Champion & Skinner, 2008).

Self-referral behaviours have been explained through the HBM in the research of healthcare utilisation. As an illustration, studies in Ethiopia and Ghana utilised the model to demonstrate that the perception of disease severity and the distrust of the patients in the facilities of lower tiers was the strongest predictor of going around primary care (Mubiri *et al.*, 2020; Bell *et al.*, 2020). When applied to the situation at the Bungoma County, the HBM is used to investigate how

customers' perceptions of the seriousness of illnesses, perceived insufficiency of primary facilities, and perceived benefits of visiting BCRH can affect their self-referral intentions. All determinants in this study (including socio-demographic factors, and perceived quality of care) would be assigned to the categories of the HBM constructs, thus determining individual and structural power of self-driven referral and deciding how to interfere in the primary healthcare system and decrease the unwarranted crowding at the referral hospital.

2.2 Empirical Review

Self-driven referral, in which patients circumvent the primary care and go directly to higher level hospitals is a recurrent challenge in the world. A cross-sectional study conducted on 822 patients in Bangladesh revealed that 59% of them preferred to bypass primary facilities due to inadequate care (28%), or inadequate facilities (23%) (Hasan *et al.*, 2024). Such studies indicate that even customers are dissatisfied with their diagnostic ability, shortage of medicine, and wait times cause patients to go to third tier hospitals (WHO, 2020). Such actions are counterproductive to the ethics of primary health care (PHC) as envisaged in the Alma-Ata Declaration and are counterproductive to advancing universal health coverage (UHC) in SDG 3.8 (WHO, 2020). The outcome is that there will be congestion in the referral hospitals, an increase in costs and uneven access to services.

The cross-sectional hospital-based design is available in most studies in the world since 2018 that utilises structured questionnaires in the procedure of capturing patient experiences and determinants (Hasan *et al.*, 2024). Although such approaches offer prevalence estimates and related factors, they are prone to self-report bias, and their use focuses on causal inference. Results are regularly consistent with the conclusion that perceived severity of the illness, closeness to the tertiary hospitals as well as distrust in the field of primary care is the predominant reason behind bypassing (Escamilla *et al.*, 2018). Nevertheless, little interventional/longitudinal studies are while investing measures to diminish bypass, and there is a deficiency in proof of effective system-level adjustment. This disjunction is especially applicable in the areas of outpatient services, where the role of determinants other than maternal health is not much explored.

The prevalence of self-referral in Sub-Saharan Africa has a wide range of 35 percent in Uganda to more than 80 percent in Ethiopia and Kenya (Mubiri *et al.*, 2020; Abere *et al.*, 2021). In a multi-centre study developing in Ethiopia (n=446), 70.4% were self-referred, and both higher education (Adjusted Odds Ratio [AOR] = 0.35, 95% Confidence Interval [CI] 0.101 – 0.950), and knowledge of referral systems (AOR=0.31, 95% CI 0.16 – 0.68) decreased the likelihood, whereas perceived illness severity increased the likelihood (Alemu *et al.*, 2025). Those results state the fact that individual and systemic factors do interfere with the decisions surrounding referrals. However, despite the proposal by the Abuja Declaration to invest in PHC, there are still way too many countries in Africa with insufficient infrastructure, lack of medicine supply, and insufficient diagnostic services, and they continue to support bypassing behaviours (WHO, 2020).

There is debate between scholars that make self-referral irrational and a rational outcome to poor PHC systems. The lack of trust in the lower-levels facilities, inefficient staffing, and low quality of service is provided as the reasons why patients avoid going through (Bell *et al.*, 2020). Some believe that this behaviour indicates a misperception of the patients, others believe it is a reasonable response to the shortcomings the patient sees in the entire system (Mubiri *et al.*, 2020). Nevertheless, limited literature evaluates the PHC capacity rigorously in conjunction with patient decision-making and attributing this versus that makes attribution disputable. Besides, other types of interventions like the implementation of referral guidelines or community education are not evaluated sufficiently. This creates a gap on research on scalable strategies supporting PHC and lessening disparities in healthcare access in the region.

This is because Kenya is one of the few countries with the highest self-referral rates in Sub-Saharan Africa with estimates indicating 86% percent (Adoyo *et al.*, 2021). A hospital-based cross-sectional study of 161 women seeking skilled birth attendance in Marsabit County involved 47.2 percent not using the facilities at a lower level (Adoyo *et al.*, 2021). Some of the predictors were age (2539 years, AOR=5.17, p=0.048), previous delivery at the hospital where participants enrolled in the scheme (AOR=5.40, p=0.014) and willingness to receive more ANC services (AOR=4.06, p=0.010). Perceived privacy and confidentiality on the other hand decreased self-referral (AOR=0.37, p=0.048). This was a narrow study as it was limited to maternal health and cannot be generalised to outpatient.

As an example, policy-oriented studies in the Kenyatta National Hospital (KNH) demonstrate how enforced referral guidelines can affect the hospital. An intervention study revealed that orthopaedic walk-in admissions reduced to 45.1% down to 54.9% (p=0.013) whereas facility referrals went up to 53.4% up to 46.6% (Omondi *et al.*, 2024). A different analysis found that there were significant decreases in level 23-facility referrals (p=0.002), including more so in those in the private facilities (Omondi *et al.*, 2024). After all, there were still openings, including the fact that formal referral letters continued to be under-utilised. These results could outline the prospects and weaknesses of enforcing policies. However, there is no previous peer-reviewed article after 2018 investigating outpatient self-referral determinants in county referral hospitals beyond Nairobi, and the gap in evidence is thus critical that the research covers.

The population of the Bungoma County (located in Kenya) served 1.7 million people with 143 public health facilities, but the population presents an unequal distribution of patients to the Bungoma County Referral Hospital (BCRH) (County Government of Bungoma, 2024). Recording of self-care pilot programmes have shown problems in things such as uncertainty of policy frameworks, challenges in reporting, and shortages of commodities that can make the patients go

to the higher-level hospitals to secure services. Such results indicate a weakness of PHC, although, they are only qualitative, which do not provide the prevalence or determinants of outpatient self-referral.

There is little quantitative evidence of Bungoma. In a descriptive analysis of 137 diabetic outpatients at BCRH, 60% of the customers were content with service quality, and 88.3% said they received glycemetic control services whereas 80.8% reported receiving complication management services (Amoro *et al.*, 2021). Despite being useful, this research was not an original peer-reviewed study but specific to its condition, so the results could not be generalised. Since 2018 no research has been published comprehensive to investigate the determinants of outpatient self-referral in Bungoma County. The given gap implies the significance of the current research that aims at assessing socio-demographic and systemic factors affecting self-driven referral at BCRH, thus affecting the county and national strategies of the UHC.

III. METHODOLOGY

In this study, a cross-sectional analytical design was used to explore the factors of the self-driven referrals among the outpatient client at the Bungoma County Referral Hospital (BCRH). Quantitative method was used while the qualitative was used to give insights to the quantitative data. Self-driven referral was the dependent variable, socio-demographic issues (age, sex, marital status, education, income) were the independent independently published factors, and perceived severity of illness was a mediating factor.

BCRH was considered based on criteria of low facility density, (1.4 per 10,000) compared to the national level (2.4 per 10,000), and the high use of outpatient (220% in 2021/2022). A total of 1,880 outpatient clients visited BCRH per week, which made the target population, which was also considered based on the utilisation of outpatient services at the clinics [antenatal care (ANC), mother and child health (MCH) and family planning (FP)] clients. Clients whose age was lower than 18 years and too weak to cooperate or those with psychotic illnesses were not included.

The sample size adopted was 201 respondents was calculated using Cochran formulae, with self-referral prevalence of 84.3%. The purposive sampling was used to select the facilities in-charge to conduct the key informant interviews (KIIs), whereas systematic random sampling identified the clients across the clinics (OPD: 147, ANC: 16, CWC: 30, FP: 8). Data collection was done employing structured questionnaire and KII guide. Webuye County Hospital was selected for pre-testing of questionnaire from 21 clients to improve on the validity and reliability. Data collection was achieved using trained four research assistants. Data analysis was done by the aid of Statistical Package for Social Sciences version 27. This generate both descriptive and inferential (Odds Ratio). Data was presented in frequency tables. The thematic analysis of qualitative data was done to complement quantitative results and was reported in narration and verbatim. Ethical approval was obtained from Kenyatta University and research permit obtained from National Commission for Science, Technology and Innovation (NACOSTI) and the county government of Bungoma, Department of Health Bungoma County. This ensured that this study upheld ethical conduct during data collection

IV. RESULTS & DISCUSSION

4.1 Results

4.1.1 Socio Demographic Characteristics of the Study Population

The study sought to establish the sociodemographic characteristics of the respondents in terms of age, gender, education, marital status, occupation and average household income.

Most of young adults (43.3%) participants were aged 25-31 years and 29.9% were aged 18-24 year. This means that almost three-quarters (73.2%) of participants were under 32 years. The proportion of over 39 years of age was at only 11.4%, which indicates that younger individual has the most frequent cases to Bungoma County Referral Hospital. Gender wise, most of the respondents were females (71.6%) as compared to the male population (28.4%), which was perhaps a resultant indication of health seeking behaviour among women or the character of services received (ANC, MCH, FP clinics). In terms of education, most of the respondents were well-educated as 60.2% had secondary level education, 25.9% had college level education, and 6.5% university education. The proportion of individuals possessing the first or non-basic education was very low, only 7.5%.

Concerning marital status, most of them were married (59.7%), and 37.8% were single, widows or divorced were 2.5%. This distribution denotes that family responsibilities could impact on the family health-seeking patterns. Occupation wise, self-employment (34.8%) and formal employment (25.4%) were the predominant. Farming constated 19.9% and the unemployed individuals were 12.9%. Others 7% were students. Household incomes had a diversity where the highest in earnings ranged between KES 5,000 -9,999 according to 26.9% of the respondents. Approximately 36.3% were earning under KES 5,000 per month, and 36.7% were earning over KES 10,000. This indicates a mixed-income population with many people found in low and middle-income incomes. Table 1 presents the findings.



Table 1
Social Demographic Characteristics of the Respondents

Variable	Categories	Frequency	Proportion	Variable	Categories	Frequency	Proportion
Age (Years)	18-24	60	29.9%	Occupation	Employed	51	25.4%
	25- 31	87	43.3%		Self-employed	70	34.8%
	32-38	31	15.4%		Farmers	40	19.9%
	<39	23	11.4%		Unemployed	26	12.9%
Gender	Male	57	28.4%		Students	14	7.0%
	Female	144	71.6%	Average monthly income (Kes)	≤ 1000	35	17.4%
Education level	No formal education	4	2.0%		≥1000- ≤ 4999	38	18.9%
	Primary	11	5.5%		≥5000 ≤ 9999	54	26.9%
	Secondary	121	60.2%		≥10000 ≤ 14999	26	12.9%
	College	52	25.9%		≥15000 ≤ 19999	23	11.4%
	University	13	6.5%		≥ 20,000	25	12.4%
Marital status	Married	120	59.7%				
	Single	76	37.8%				
	Widowed/Divorced	5	2.5%				

Source: Researcher (2024)

4.1.2 Proportion of self-driven clients at the Bungoma County Referral Hospital

In this study, the dependent variable was those who self-referred. According to this study, 51.7% (n=104) sort medical services at the BCRH before seeking services in their nearest health facility. Figure 4-1 summarizes the proportion of self-referred and referred clients visiting BCRH at the time the study was conducted.

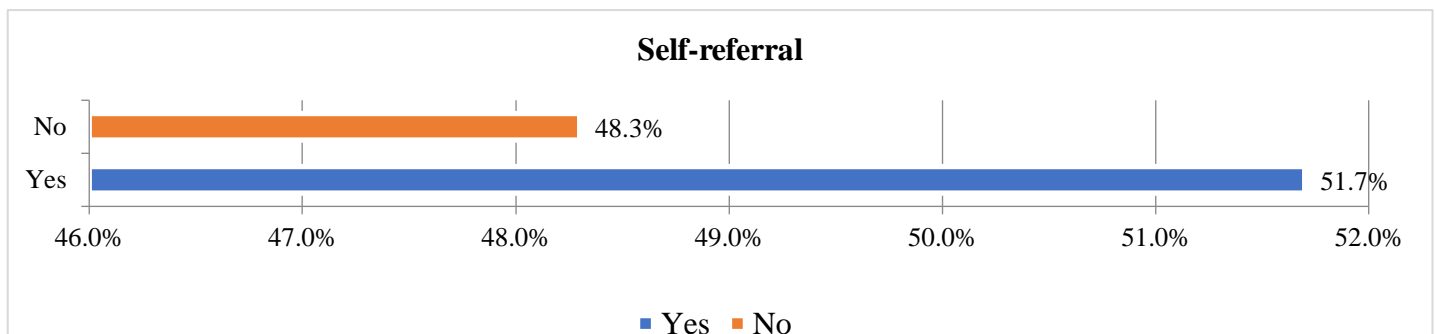


Figure 1
Proportion of self-driven clients at BCRH

4.1.3 Association between Self-Driven Referral and Socio - Demographic Factors

Table 2 presents socio-demographic factors associated with self-driven referral, showing odds ratios, confidence intervals, and significance levels.

Table 2
Socio-Demographic Factors Influencing Self-Driven Referral

Variable	Categories	Self-referral		OR	95% CI		P-value
		Yes	No		Lower	Upper	
Age (Years)	≤ 35	42	3	3.387	.923	12.428	0.054
	> 35	62	15				
Gender	Male	37	2	4.418	.963	20.277	0.040
	Female	67	16				
Education level	Primary-secondary	64	17	0.094	.012	.735	0.006
	Post-secondary	40	1				
Marital status	Married	69	14	0.563	.173	1.839	0.337
	Not Married	35	4				
Occupation	Formal employment	37	4	1.933	.593	6.300	0.268
	Informal employment	67	14				
Average Income (Kshs)	≤ Kes 23,670	90	17	0.378	.047	3.069	0.346
	> Kes 23,670	14	1				

Source: Researcher (2024)



In this study, bivariate analysis showed that gender and educational level were significantly associated with self-driven referral (p value = 0.040; OR 4.418) and (p value = 0.006; OR 0.094), respectively. Therefore, this study notes that according to gender, male clients are four times more likely to self-refer to BCRH for health care services as compared to female clients. Additionally, this study notes that clients with primary and secondary education are 90.6% less likely to self-refer to BCRH for health care services as compared to clients with tertiary education.

4.1.4 Health System Factors Influencing Self-Driven Referral

When clients were asked to rate the significant cause that made them to visit BCRH other than their nearest primary health care facility, the finding of this study showed that participants agreed that; availability of laboratory services, availability of medicine, and hospital reputation significantly contributed to their self-referral at 89.5% (n=91), 83.6% (n=87) and 74.1 % (n=87) respectively.

Table 3
Health System Factors Influencing Self-Driven Referral

Costs of Services	5	4	3	2	1
Affordability of services	2 (1.9%)	1 (1.0%)	1 (1.0%)	2 (1.9%)	98 (94.3%)
Insurance cover	63 (60.6%)	26 (25.0%)	6 (5.8%)	4 (3.9%)	5 (4.8%)
Deposit requirement	10 (9.6%)	5 (4.8%)	2 (1.9%)	25 (24.0%)	62 (59.6%)
Quality of Care	5	4	3	2	1
HCW competency	21 (20.2%)	4 (3.9%)	5 (4.8%)	33 (31.7%)	41 (39.4%)
HCW attitude	15 (14.4%)	5(4.8%)	3(2.9%)	30 (28.9%)	51 (49.0%)
Time spent on queues	12 (11.5%)	6 (5.8%)	3 (2.9%)	16 (15.4%)	67 (64.4%)
Opening hours	8 (7.7%)	3(2.9%)	3(2.9%)	22 (21.2%)	68 (65.4%)
Availability of lab services	62 (59.6%)	29 (29.9%)	5 (4.8%)	1 (1.0%)	7 (6.7%)
Availability of medicine	68 (65.4%)	9 (8.7%)	1 (1.0%)	6 (5.8%)	20 (19.2%)
Hospital reputation	67 (64.4%)	20 (19.2%)	5 (4.8%)	5 (4.8%)	(6.7%)

Source: Researcher (2024)

The results indicate that affordability of services was rated as least contributory by most respondents (94.3%), while insurance cover was identified as greatly contributory by 60.6% of participants. Deposit requirements were considered least contributory by 59.6% of respondents. With respect to quality of care, health care worker (HCW) competency was rated least contributory by 39.4%, and HCW attitude by 49.0%. Time spent on queues and opening hours were also largely considered least contributory, at 64.4% and 65.4% respectively. In contrast, availability of laboratory services (59.6%), availability of medicines (65.4%), and hospital reputation (64.4%) were rated as greatly contributory by most respondents.

4.1.5 Association between Health Systems Factors Interaction with Household Average Income Impacting Self-Referral to Bungoma County Referral Hospital

Table 4 also shows the association between household average income and the chosen health system variables, and how they have co-experience to affect self-referral behaviour to Bungoma County Referral Hospital using odds ratios, confidence and significant levels in relation to respondent data.

Concerning an Odds Ratio between health system factors and household income, less possibility of self-referral and nonsignificant association was observed to be associated with affordability of service (OR=0.860, p=0.486), insurance policy ownership (OR=0.545, p=0.475) and affordability of deposits (OR=0.962, p=0.962). Lower-income individuals were more likely to be influenced by perceptions of provider competency (OR= 1.571, p=0.492), attitude (OR= 3.042, p=0.071) and waiting time (OR= 2.086, p=0.257), though it was not statistically significant. Equally, lower-income individuals were more likely to be influenced by the supply of medicine (OR=1.278, p= 0.724), lab services (OR=1.182, p=0.231), cleanliness (OR= 1.543, p=0.545), and privacy (OR=3.625, p=0.278), but this had significance in their influence.

Table 4
Health Systems Factors and Household Average Income Impacting Self-Referral to Bungoma County Referral Hospital

Health system factors	Household average income		OR	95 CI		P value
	<= Kes 23,670	> Kes 23,670		Lower	Upper	
Affordability of service	Disagree	86	0.860	0.795	.931	0.486
	Agree	3				
Insurance policy	Disagree	7	0.545	0.101	2.942	0.475
	Agree	77				
Affordability of the deposit requirement for clients	Disagree	75	0.962	0.192	4.804	0.962
	Agree	13				



Competency of the healthcare providers	Disagree	66	8	1.571	0.430	5.748	0.492
	Agree	21	4				
Attitude of the healthcare providers	Disagree	73	8	3.042	0.873	10.594	0.071
	Agree	15	5				
Time spent in queues	Disagree	73	10	2.086	0.572	7.599	0.257
	Agree	14	4				
Time of operation	Disagree	79	11	2.693	0.620	11.704	0.173
	Agree	8	3				
Cleanliness of the hospital	Disagree	72	10	1.543	0.376	6.329	0.545
	Agree	14	3				
Availability of lab services	Disagree	8	0	1.182	1.083	1.290	0.231
	Agree	77	14				
Availability of medicine	Disagree	23	3	1.278	0.327	4.988	0.724
	Agree	66	11				
Privacy during examination.	Disagree	87	12	3.625	0.305	43.078	0.278
	Agree	2	1				
Reputation of the hospital	Disagree	11	1	1.932	0.230	16.266	0.538
	Agree	74	13				

Source: Researcher (2024)

4.2 Discussion

The study found a 51.7% self-referral rate (n=104), which is a significant number of patients who skipped the primary healthcare centres. This observation points to a structural issue in the Kenyan healthcare referral system where primary health centres (PHCs) are supposed to be used as the first point of contact point. The rate observed is also consistent with the data provided by Oladimeji *et al.* (2021) who noted a rate of 55.3% in a similar setting, which leads to believing that self-referral is not an isolated event and is instead a regular occurrence in the region of Sub-Saharan Africa. On the other hand, the present study gives a lower percentage compared to those of Escamilla *et al.* (2018) in Kakamega which was a high as 84.3%. this might be attributed to variable study design and sampling frames, especially the addition of urban populations with more facilities choice. The current findings are also higher than the ones reported by Mubiri *et al.* (2018) in Uganda (29%), during which their population sample was limited to acute and maternal care cases, which hinders the generalisability of bypass behaviour. Key informant observed that:

“The majority of referral cases that we have received in the facility was because there were no supportive health systems to address health complications like maternity related care, blood transfusion and complex complication like meningitis, albeit infrequently.”

This finding shows how the existence of infrastructural gaps in lower-level facilities is a direct contributor to a bypass behaviour and therefore quantitative data that self-referral is motivated by a lack of perceived sufficiency with PHC services is echoed.

The sense of technical superiority in BCRH was found to be an influential factor of self-referral. Customers consider BCRH as a healthcare centre, which provides specific services, which PHCs do not. This view is aligned with the results of Yao (2018) in Ghana, when the extent and quality of services in tertiary plants influenced the choice of clients. The reasons given to avoid PHCs include preventive care, pain management, and gynaecological services, which is indicative of the tendency of patients to find all round solutions to their routine and complex needs.

“... BCRH is known for upscale services that are not accessible to other health facilities in Bungoma County. Even health promoters are known to help guide clients to BCRH.”

This observation serves to strengthen bypass behaviour by community actors, but also it is concerning that a lack of trust in PHC diagnosing capacity, reported by Debsarma and Choudhary (2025). The inability to provide X-ray and laboratory services is further supported by Bell *et al.* (2020) and serves as one more indication of the gaps in the chain of infrastructures that transfers clients to facilities of a higher tier.

Insurance cover was found as an enabler of bypass behaviour, which allowed clients to focus on quality and privacy (private wards) rather than proximity. This observation is not foreign to Roh and Moon (2005) in Korea where insurance-access led to more people going to hospitals in cities. Key informant said this concerning self-referral and insurance cover.

“Clients who have National Health Insurance cover would not simply skip PHCs to save money but rather enjoy the perks like having their own wards in BCRH.”

This demonstrates that even without making direct use of monetary expenses, insurance plays a role in raising standards of care quality. Kenyan context is opposed to Putri *et al.* (2021) in Indonesia, where insurance did not have a visible effect, which indicates that the correlation between insurance and self-referral is very situational and relies on the infrastructure of the local healthcare. The low risk that deposit is insured, which additionally implies that financial impediments at PHCs are not as related to initial payments but rather to the perceived quality of the service, which demonstrates more resource inequalities in the devolved healthcare environment in Kenya.

As indicated by quantitative analysis, male clients tended to self-refer, which confirms the results by Rajman and Mahomed (2019) in South Africa who stated that men tended to bypass PHCs. This trend is supported by patriarchal traditions in the Bungoma County, and the increased financial mobility and control of men.

“Men struggle with accessing conventional primary care services because when compared to the number of services, one can find, rather, rather targeted services that specifically cater to men.”

This observation brings about the gendered aspects of accessing healthcare in that, a man considers referral hospitals to be better placed in terms of treating complex conditions. But this is contrary to Okoli *et al.* (2017) in Nigeria, who presented statistics of greater self-referral in female clients highlighting the significance of local socio-cultural attributes in determining referral behaviour.

Education was also a predictor of self-referral, which can be attributed to the findings of Abere *et al.* (2021), who concluded that informed clients do not use PHCs, as reflected by a higher understanding of the services offered. Tertiary educated clients had high expectations of PHC gap and chose specialised care at BCRH, especially when dealing with complex cases.

“The customers who have tertiary education would most likely be culturally critical of PHC constraints and would want the specialised treatment of BCRH.”

This is contrary to Yao (2018) who stated that there is no significant connection between education and self-referral and this effect is mediated by local PHC quality. Clients having primary or secondary education, unable to get PHC because of the lack of awareness or financial capacity, often had to accept the PHC despite the perceived inadequacy, as it happened in Abere *et al.* (2021). Earnings of households were not significant, even though richer households were slightly more inclined to self-refer, which was also the case in Abere *et al.* (2021), where the purchasing power determined care preferences.

Financial access is often mentioned as a motivator of self-referral, but this researcher was not in agreement with it since income and deposit requirements were not a major predictor (Roh and Moon, 2005). This supports Putri *et al.* (2021) in Indonesia, who propose that in the Kenyan devolved healthcare system, the perceived quality of the services is more important than direct financial expenditures.

“Within the health system, we have got drugs that we can store as health centre; but then there are some drugs that we cannot be in a position to order them at KEMSA.”

These include the observation of inequalities in systemic resources between PHC and tertiary facilities that underpin the quantitative observation that, it is the structural inequalities that drive bypass behaviour, and not affordability. The implication here is that healthcare reforms that will enhance PHC infrastructure can be more successful in decreasing self-referral compared to financial interventions that work on their own.

V. CONCLUSION & RECOMMENDATIONS

5.1 Conclusion

The study concludes that at least 51.7% of outpatients at Bungoma County Referral Hospital are self-referred. These referrals were occasioned by the scarcity of specialised equipment and the availability of insurance cover at their primary facilities. Moreover, male was more likely to self-refer as compared to women. Lastly, those with lower education, i.e., primary and secondary school were skewed towards using primary care services as compared to those with tertiary. This leans towards financial capacity which leads to choice of the facility with most opting for self-referral. Both financial aspects and attitudes towards quality-of-service influence self-referral patterns. Strategic interventions need to be initiated to address the insurance policy guidelines, while consolidating strengths in diagnostic facilities and drug availability.

5.2 Recommendation

The study recommends decentralisation of specialised care and in order to lower increasing cases of referrals to BCRH. This could be achieved through initiatives aimed at sensitizing the community members in Bungoma County on service available at their primary care facilities.

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