Dolores Lagangilang San Juan (DOLASAN) Inter Local Health Zone MNCHN Referral Guideline

December 2012

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Foreword

The health referral system developed in this manual is intended to operationalize and strengthen the Inter Local Health Zone for Dolores, Lagangilang, and San Juan (DOLASAN). It will serve to create an efficient network between the Health Institutions of the 3 Municipalities as well as the Core Hospital which have all been functioning independently and separately because of the devolution brought about by the Local Government Code of 1991.

This manual was developed after extensive collaboration primarily with the municipal health officers, public health nurses, and hospital administrators of the 3 Municipalities taking into account the suggestions and concerns raised by physicians, nurses and midwives of other health agencies in Abra during the workshop. The inputs shared by Dr. Makoto Tobe of the Japan International Cooperation Agency also proved invaluable to the creation of this manual.

This manual is expected to act as a guide for the RHUs, BHWs, and hospital medical and paramedical staff of the DOLASAN Inter Local Health Zone to facilitate the implementation of the health referral system. It is expected to serve as a common agreed framework for the health workers and shall aid them in arriving at timely and correct decisions and appropriate action on patients' conditions.

Acknowledgment

The preparation and printing of a manual is a concerted effort between different agency officials, personnel and volunteers. For this manual, we sought the assistance and guidance of every supportive people who were with us every step of the way.

We are therefore very thankful to:

- The Japan International Cooperation Agency for facilitating the workshop for the Inter Local Health Zone that inspired the creation of this manual.
- Dr. Makoto Tobe of JICA, the resource speaker during the workshop, for his generous contribution of exemplary knowledge and experiences which is now adopted in many parts of this manual.
- The Department of Health and the Provincial Health Office for their unending and generous logistical support in endeavors to further improve the health system and the health status of the people.
- The Provincial Health Officers of the 3 Municipalities, the Hospital Administrator of Dolores Medicare and Community Hospital and everyone who participated in the workshop for their insights to strengthen the health referral system, and the proofreading of this manual.
- The Rural Health Nurses and Midwives for sharing their experiences in referring clients from their agencies.
- Existing Health Referral Guidelines presented during the workshop as well as other Referral Manuals available via the internet from which the template and some excerpts in this manual were lifted from.

Abbreviations

BHS	Barangay Health Station
BHW	Barangay Health Worker
CHT	Community Health Team
DOH	Department of Health
ER	Emergency Room
FHD	Family Health Diary
FHSIS	Field Health Service Information System
ILHZ	Inter Local Health Zone
MCH	Maternal and Child Health
MNCHN	Maternal Newborn Child Health and Nutrition
MHO	Municipal Health Officer
OPD	Out Patient Department
PHN	Public Health Nurse
PHO	Provincial Health Officer
RHM	Rural Health Midwife
RHU	Rural Health Unit
TCL	Target Client List
TT	Tetanus Toxoid

Glossary of Terms

Referral - refers to the process of linking a consumer with a health service resource, which is a participating health agency.

Community Health Team – Trained individuals serving as front liners in the barangay in giving information and guidance to those who want to access health services.

Contact Options – Mobile SMS, Mobile and Telephone Calls, E-mails, etc.

Referring Facility – the health agency making the referral.

Referred Health Facility – the facility that accepts referred patients.

Outcome of a referral – the result or manner of disposition of a referral. This is a function of the referred health facility.

Post-partum Care – encompasses management of the mother, newborn, and infant for 6 weeks after delivery. This includes monitoring of the mother and child for signs and symptoms of complications, breastfeeding, nutrition, hygiene, birth spacing and family planning counseling, and having the baby undergo newborn screening,

Prenatal Care – a package of services given to pregnant women that include check up, weight and vital signs monitoring, Tetanus Toxoid Administration, Vitamin A and Iron Supplementation, etc.

Risk Factors – Factors increasing the risk (to either the woman, the fetus/es, or both) which includes Adolescence, Old Age, Many Previous Pregnancies, Multiple Previous Fetuses, Obesity, Alcoholism, Low Height (less than 5 ft.), pre-existing conditions like Diabetes, Hypertension, etc.

Text Message - exchange of short text messages via mobile phone

Introduction

Referral is a set of activities undertaken by a health care provider or facility in response to its inability to provide the necessary intervention of patients' need, whether it is a real or just a perceived need. In its wider context, this includes referral from the community level to the highest level of care and back (***two-way referral system***). It also involves not only ***direct patient care*** but ***support services*** as well, such as knowing where to get a transport facility to move the patient from one facility to the other.

Within the Inter-Local Health Zone (ILHZ) concept, a referral system is often called a two-way relationship since it involves mainly the rural health facility, which provides primary medical care and a core referral hospital, which provides secondary care. A referral within the ILHZ will only be as strong as the weakest link in the chain of health facilities.

For the referral system to function, the lower levels especially the health centers must be operated by competent personnel whose roles and functions are clearly defined to avoid duplication. This is to ensure that the ranges of services that need to be delivered are in fact delivered. Self-referral by individuals to hospitals bypass the lower levels based on perceived inadequacy in the lower levels. This perpetuates the vicious cycle of over-burdened hospitals and under-utilized health centers. It is important for health centers to refer only those patients for whom secondary or tertiary care is essential. In general, referral from a health center to higher levels should occur in the following situations:

- When a patient needs expert advice;
- When a client identifies her birthing facility of choice
- When a patient needs a technical examination that is not available at the health centers;
- When a patient requires a technical intervention that is beyond the capabilities of the health center; or
- When a patient requires in-patient care.

These guidelines are important since they will govern the reason(s) why a patient needs to be referred. Outside of these guidelines, there should be a very strong reason for bypassing the lower links in the health care delivery system.

The hospital, on the other hand, will ensure that referrals coming from health centers will receive prompt attention. Referral back to the health center should also be done as soon as the reason for the referral to the hospital has been addressed. Indeed, referral is a 2-way process that involves **cooperation**, **coordination,** and **information transfer** between the health centers and the hospitals.

Ultimately, the hospital will benefit from its strong involvement and collaboration with the health centers especially in managing diseases who etiologies have bearings on the public health system. For the referral system to be truly functional, the different levels or components of health care delivery must adhere to a set of guidelines based on the ILHZ approaches to referrals.

1. Objectives of the MNCHN referral guideline

Overall objectives

MNCHN referral guideline aims

- To provide ***timely referral*** of pregnant/post-partum women and newborns in case of ***emergency***
- To enhance ***information sharing*** among health facilities and volunteers to provide ***continuous prenatal, delivery and post-partum care***
- To improve sharing of resources

Specific objectives

- To ensure that ALL pregnant women:

    a. Are registered in *Target Client List (TCL)*
    b. Receive *Family Health Diary*
    c. Receive prenatal care
    d. Make birth and emergency plan
    e. Are provided timely transportation to health facility in case of emergency
    f. Deliver at health facility attended by trained health professional
    g. Receive emergency obstetric care, if necessary
    h. Receive emergency newborn care for their children, if necessary
    i. Receive post-partum care
    j. Receive support from community health team

2. Standard operational procedure of MNCHN referral

2.1. Identification / master listing of pregnant women

Service providers	Actions to be taken
Community Health Team	- Register women in Pregnancy Tracking Record - Report to Rural Health Midwife (RHM) - Inform women on prenatal care and *Family Health Diary (FHD)*
Rural Health Midwife (in BHS and RHU)	- Issue Family Health Diary (FHD) and assist women to fill out FHD (pp. 1-4) - Register women in Target Client List - Provide prenatal care
Government / Private Hospital, Private clinic	- Inform women to go to BHS (to receive Family to receive Health Diary, to be registered in TCL, some prenatal care [Tetanus Toxoid, vitamin A] which is not provided by hospitals)

2.2. Birth and Emergency Plan

Service providers	Actions to be taken
Family member of the pregnant women	- Coordinate with transportation service provider and blood donors.
Community Health Team, OR health workers who provide prenatal care	- Assist women to make "Birth and emergency plan" - Encourage women (without risk factors) to receive prenatal care in the third trimester at facility where women plan to delivery. - Ensure women and their family to coordinate with transportation service provider and blood donors
Birthing facilities	- Provide prenatal care in the third trimester where the women plan to deliver - Prepare to provide services to women / newborns.
Transportation service providers	- Prepare to provide services to women

2.3. Pregnant women with identified risk factors

Service providers	Actions to be taken
Health workers who provide prenatal care	- Assess whether women are with risk factors based on; History of previous pregnancy, Status of present pregnancy, History of illness and prenatal checkup - If risk factors are identified: • Provide treatment, if applicable, and/or; • Refer to facilities for appropriate care, if necessary; and/or • The women with risk factors are recommended to receive prenatal care at the health facility where they plan to deliver. • Re-assess birth and emergency plan
Referred health facility	- Provide appropriate care/follow up, when necessary - Provide information back to facility/CHT which referred the women [Back Referral]

2.4. Obstetric / newborn emergency

Service providers	Actions to be taken
Referring facility or health worker/volunteer	In case of the patient needs higher level of care due to obstetric/ newborn emergency: - Consult to higher level facility / professionals (thru phone/text message or other mode of communication), if necessary - Provide care to the patient based on instruction from higher level professionals, if possible - Prepare means of transportation - Provide information to facility to which the patient is referred

	• e.g. referral form, Family Health Diary, accompanying patients, text message/phone - Transfer the patient to higher level facility - Record information on treatment and referral • e.g. referral logbook (out-going), carbon-copy of referral slip, patient record - Collect return slip by visiting house of the women (RHM)
Referred health facility	- Provide appropriate care to the patient - Provide information to facility which referred the patient (Back referral) • e.g. Referral slip (return form), Family Health Diary • Staple it to MCH book / Family Health diary - Record information on treatment and referral • e.g. referral logbook (in-coming), patient record, discharge summary - Refer the patient to higher level facility, if necessary

2.5. Post-partum care

Service providers	Actions to be taken
Health worker who attended delivery	- Inform Rural Health Midwife on status of post-partum women and newborns, if follow up care is needed by RHM. • Using referral form (out-going), Family Health Diary, phone, text message
Community Health Team	- Inform RHM on discharge of postpartum women and request for post-partum home visit - Record outcome of delivery on pregnancy track record. - Inform on health services available for mothers and children. (e.g. breast feeding, family planning, immunization)
Rural Health Midwife	- Provide post-partum care (home visit, if needed) - Record on Family Health Diary and Target Client Lists (prenatal, post-partum) as well as patient record - Inform the mothers on available MCH services (e.g. immunization, growth monitoring) - Inform CHT on status of the mothers and newborns - Inform results of post-partum care to referring health worker / facility (Back Referral) if follow up care is requested by health worker who attended delivery. • Using referral form (return slip), phone, text message, regular meeting

3. Recording of referral

3.1. Family Health Diary

- All pregnant women must possess a Family Health Diary. The Health worker attending to the client must issue a Family Health Diary to the client if the client does not have one.
- After issuing a Family Health Diary, all hospitals and clinics must instruct the client to proceed to the Rural Health Unit (of the Municipality of the Client) for listing in the Target Client List as well as to receive RHU MNCHN Health Packages which includes Tetanus Toxoid and Vitamin A. The Hospitals and Clinics must not include these packages in their prenatal care to ensure that the client conforms to the instruction.
- All health workers should record information on Family Health Diary when they provide MNCHN services.
- All women are informed to bring Family Health Diary every time they receive MNCHN services.
- Health workers should assist women and their family to fill out Family Health Diary,
  - Including past / present health problems and pregnancies as well as Birth and Emergency Plan.

3.2. Referral slip (ANNEX A)

- The Referral Slip has 2 parts
  - The Main Referral Slip which is filled out by the physician from the referring facility
  - The Return Slip which is filled out by the physician of the referred facility to inform results of referral and need for follow up

- The Return Slip going to the Rural Health Unit should be stapled to the Family Health Diary of the Client. The Client is instructed by the Physician from the referred facility to surrender the return slip to the Rural Health Unit.
- During barangay visits, the Rural Health Midwife collects the Return Slip stapled to the Family Health Diary from the clients (if the client still has not surrendered the return slip to the Rural Health Unit)

- Clients referred by hospitals to higher level facilities are instructed to obtain the return slips and surrender the slips to the referring hospital upon their discharge.

- For Hospitals, the ER nurse must officially receive incoming referrals. The Public Health Nurse will be the person to receive incoming referrals in the Rural Health Unit

- Format
  - (See Annex A)

3.3. Referral logbook (ANNEX B)

- There will be 2 logbooks. One for Outgoing Referral and another for Incoming Referral.
- The Public Health Nurse for Rural Health Units and the Emergency Room Nurse for Hospitals are tasked to ensure that the Referral Logbooks are updated.
- To keep the logbooks as updated as possible, the Public Health Nurse and Emergency Room Nurse must have contact options with the referred facility and/or the referred clients. If after a period of 1 month, the return slips have not been returned, the PHN and the ER Nurse must contact the referred facility and/or the referred clients to inquire for the necessary information to complete their data in the referral logbook.

- Format
  - (See Annex B)

3.4. Pregnancy tracking form (ANNEX C)

- Kept and updated by CHT member (BHW)
- The form must list ALL pregnant women in the catchment area
  - Regardless whether women are receiving services at BHS/RHU or hospitals (government /private) / clinics, or not receiving any services
- All pregnant women must be visited by CHT at least every three months (preferably monthly) for follow up
  - Complementing services among CHT, BHS, RHU, hospitals and/or clinics
- Information needs to be consolidated to Target Client List of Rural Health Midwife

- Format
  - (See Annex C)

3.5. Target Client List (FHSIS)

- Managed by Rural Health Midwife (RHM) / Public Health Nurse (PHN)
- List ALL pregnant women and postpartum women
  - Including women who receive MNCHN services from hospital / clinic (see User's guide for the FHSIS p14)
  - Should be MASTER LIST of pregnant women of catchment area
  - Sources of information:
    - Pregnancy tracking form of CHT members
    - Client list of pregnant women of hospitals / clinics

- Format
  - (See Annex D)

4. Monitoring of referral

Monitoring and evaluation reports shall be submitted by the Head of the Health Facility to the Chairman of the ILHZ Technical Working group for review.

The referral system shall be tracked down through records, such as checklists, logbooks, and reports. In particular, important information shall include the following:

- Number of Patients referred;
- Reason(s) for referral;
- Number and list of receiving hospitals;
- Leading Diagnosis;
- Return slips received;
- Number of referrals received;
- Reasons for referral;
- Number and list of referring hospitals;
- Leading diagnosis;
- Return slips sent back; and
- Source of referrals

4.1. Indicators

INDICATORS to gauge functional referral system include:

- Rate of referrals

Number of referrals
Total Consultations or Total Patients

- Case Mix

number of cause specific case/ total number of referred cases;

- Ten leading causes of referral; and

- Ratio of referrals with return slips

number of referrals with return slips
total number of referrals

4.2. Reporting

The ILHZ Technical Working Group Chairman shall prepare a consolidated report and submit it to the PHO.

Also, the efficiency of the referral system may be discussed during staff and ILHZ meetings.

Topics / items to be monitored	Organizations (meeting)
Reason of referral (by Sending facility) • Was it appropriate / necessary/per request? • Can some referral be reduced by upgrading function of service provider?	• RHU and BHS (monthly meeting) • Hospitals (census meeting [monthly / quarterly]) • ILHZ [quarterly]
Outcome of referral (by receiving facility) • Appropriate care given? • Return slip was issued? Received by referring facility? • Follow up care was given by referring facility, when necessary?	• RHU and BHS (monthly meeting) • Hospitals (census meeting [monthly / quarterly]) • ILHZ [quarterly]
Transportation (by sending facility) • Means of transportation available timely? • Provided as planned? • Any need for improvement?	• RHU and BHS (monthly meeting) • Hospitals (census meeting [monthly / quarterly]) • ILHZ [quarterly]
Information shared among health facilities • TCL covers all pregnant women, consolidating information of pregnancy tracking record, client lists of hospitals/clinics? • Family health diary provided to all pregnant women? • Did health worker fill up Family Health Diary properly? • Birth and emergency plan made? • Coordination with transportation provider and health facility made?	• RHU and BHS (monthly meeting) • Hospitals (census meeting [monthly / quarterly]) • ILHZ [quarterly]
Attainment of project goals • Facility-based delivery rate • Prenatal care / post-partum care coverage • MMR/IMR	• Program Implementation Review – PIR of the Province (annual)

5. Directories were deleted

Name of Province
Name of Facility
Address & Contact No.

REFERRAL SLIP

Referred to: Address:	Date:	
Patient's Name: Address:	Age:	Sex:
	Civil Status:	Occupation:
	Date Admitted/Seen:	
Brief Clinical History & Physical Examination		
Working Diagnosis:		
Management:		
Pertinent Laboratory/ Procedures Done:		
Reason for Referral / Services Requested:		
Referred by: Attending Health Worker	Noted by: Head of Department	

RETURN SLIP

Name of Facility: Address: Contact No:	Referred back to: (referring facility) Address:	
Patient's Name: Address:	Age:	Sex:
	Civil Status:	Occupation:
	Date Confined/Seen:	
Action(s) Taken / Recommendations:		
_____ Attending Health Worker		

Annex B

Referral Logbook

Line listing for Outgoing Referrals (logbook entries)

Date & Time Referred	Name of Patient	AGE	SEX	Address	Reason for referral	Referred to	Method of Transport	Return Slip Returned (Y/N)	Outcome of referral	Remarks

Line listing for Incoming Referrals (logbook entries)

Date & Time Received	Name of Patient	AGE	SEX	Address	Reason for referral	Referred from	Diagnosis / Actions taken / Recommendation	Return Slip issued (Check)	Remarks

Annex C

Pregnancy Tracking Form

Name of CHT member		Municipality	
Catchment area (Sitios, Purok)		Province	
		Name of Rural Health Midwife	
Barangay		Duty Station	

Name of Pregnant Women	Age	Address	LMP (dd/ mm/ yy)	EDC (dd/ mm/ yy)	Prenatal Care (put date/month)			Pregnancy Outcome	Place of Delivery (Name of health service provider)	Remarks
					1st trimester	2nd trimester	3rd trimester			

Annex D

Target Client List for Prenatal Care (page 1)

Date of Registration Mm/dd/yy (1)	Family Serial Number (2)	Name (3)	Address (4)	Age (5)	LMP / GP (6)	EDC (7)	Date Prenatal Visits (8)		
							First Trimester	Second Trimester	Third Trimester

Annex D

Target Client List for Prenatal Care (page 2)

Tetanus Status (9)	Date Tetanus Toxoid Vaccine Given (10)					Micronutrient Suppmentation (11)		Risk Code / Date Detected (12)	Pregnancy (13)		Livebirth (14)			Remarks
	TT 1	TT 2	TT 3	TT 4	TT 5	Date Given Vit. A	Date and Number Iron with Folic Acid was Given		Date Terminated	Outcome / Sex	Birth Weight (grams)	Place and Type of Delivery	Attended by	

Inter-Local Health Zone
MNCHN Referral Guideline
(VPP)

December 12, 2012

Villaviciosa

Pilar

Peñarrubia

Villaviciosa Medicare
&
Community Hospital

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Foreword

This MNCHN Referral Guideline was developed to serve as a guide in setting up and strengthen the referral system in the Villaviciosa, Pilar, Peñarrubia Inter-local Health Zone (VPP ILHZ).

This guideline was developed after extensive collaboration primarily with the municipal Health Officers, Public Health Nurses of the 3 Municipalities and the Chief of Hospital Villaviciosa Medicare and Community Hospital, taking into accounts the suggestions and concerns raised.

It is expected to serve as a common agreed structureandframework for the health workers and shall aid them in arriving at a timely and correct decisions and appropriate actions on clients' condition.

Acknowledgement

The Villaviciosa, Pilar, Peñarrubia Inter-local Health Zone (VPP ILHZ) Technical working group extends its appreciation to the participants and resource persons of the workshop for their valuable contribution in the development of the MNCHN referral guideline.

Recognition and appreciation is extended to the following:

- The Japan International Cooperation Agency (JICA) for facilitating the workshop for the Inter Local Health Zone that inspired the creation of this guideline.
- Dr. Makoto Tobe of JICA, the resource speaker during the workshop, for his generous contribution of exemplary knowledge and experiences which is now adopted in many parts of this guideline.
- Dr. Godofredo L. Gasa, Provincial Health officer of Abra, Provincial Technical staff and Mrs. Manuela Munar, Abra JICA project coordinator for their unending and generous logistical support in endeavors to further improve the health system and the health status of the people.
- The Municipal Health Officers Dr. Elsa Gonzales (MHO of Peñarrubia) and Dr. Adele Solang (MHO of Villaviciosa), and Dr. Manuela G. Fontanilla (COH-VMCH) who participated in the workshop for their insights to strengthen the health referral system and finalization of this guideline.
- The Public Health Nurses: Mrs. Emma Fe Cital (Villaviciosa), Antonio Japson Jr. (Peñarrubia), Marivic B. Somera (Pilar), and the Rural Health Midwives of the three Municipalities for sharing their experiences in referring clients from their agencies.
- The Local Chief Executive of the three municipalities; Mayor Marjorie L. Montalbo (Villaviciosa), Mayor Jaja Josephina Disono (Pilar), and Mayor Geraldine Balbuena (Peñarrubia) for giving their full support to the VPP ILHZ.
- Existing Health Referral Guideline presented during the workshop as well as the Local Health System Manual of the Department of Health, Bureau of Local Health Development from which the template and some excerpts in this manual were lifted from.

Abbreviations

BEmONC	Basic Emergency Obstetric Neonatal Care
BHS	Barangay Health Station
BHW	Barangay Health Worker
CEmONC	Comprehensive Emergency Obstetric Neonatal Care
CHT	Community Health Team
COH	Chief of Hospital
DOH	Department of Health
ER	Emergency Room
FHD	Family Health Diary
FHSIS	Field Health Service Information System
ILHZ	Inter Local Health Zone
JICA	Japan International Cooperation Agency
MCH	Maternal and Child Health
MMR/IMR	Maternal Mortality Rate/Infant Mortality Rate
MNCHN	Maternal Newborn Child Health and Nutrition
MHO	Municipal Health Officer
OPD	Out Patient Department
PHN	Public Health Nurse
PHO	Provincial Health Officer
RHM	Rural Health Midwife
RHU	Rural Health Unit
TCL	Target Client List
TT	Tetanus Toxoid
VPP	Villaviciosa Pilar Peñarrubia
VMCH	Villaviciosa Medicare and Community Hospital

Glossary of Term

Referral- refers to the process of linking a costumer with a health service resource, which is a participating health agency.

Community Health Team- trained individuals serving as front liners in the barangay in giving information and guidance to those who want to access health services.

Contact Options - Mobile SMS, Mobile and Telephone calls, E-mails, etc.

Referring Facility - the health agency making the referral.

Referred Health Facility - the facility that accepts referred patients.

Outcome of a referral - the result of manner of disposition of a referral. This is a function of the referred health facility.

Post-partum Care - Encompasses management of the mother, newborn, and infant for 6 weeks after delivery. This includes monitoring of the mother and child for signs and symptoms of complications, breastfeeding, nutrition, hygiene, birth spacing and family planning counseling, and having the baby undergo newborn screening.

Prenatal Care- a package of services given to pregnant women that include check-up, weight and vital signs monitoring, Tetanus Toxoid Administration, Vitamin A and Iron Supplementation, etc.

Risk Factors- factors increasing the risk (to either the women, the fetus/es, or both) which includes Adolescence, Old Age, Many Previous Pregnancies, Multiple Previous Fetuses, Obesity, Alcoholism, Low Height (less than 5 ft.), pre-existing conditions like Diabetes, Hypertension, etc.

Text Message- Exchange of short text messages via mobile.

Introduction

As part of the Japan International Cooperation Agency (JICA) Project for Cordillera-wide Strengthening of the Local Health System for Effective and Efficient Delivery of Maternal and Child Health Services, MNCHN Referral Guideline Development Workshop was held on October 2012. This workshop worked in the development of this MNCHN referral guideline to strengthen the referral system of Villaviciosa, Pilar, Peñarrubia Interlocal Health Zone (VPP ILHZ).

Strengthening the referral system would upgrade the health care facility's quality of health services, optimize the use of available funds, pharmaceutical supplies, medical supplies and equipment, and enhance its capabilities in health planning, decision-making, and monitoring.

Within the Inter Local Health Zone (ILHZ) concept, a referral system is often called a two-way relationship since it involves mainly the rural health facility, which provides primary medical care and a core referral hospital, which provides secondary care.

For the referral system to function, the lower levels especially the health centers must be operated by competent personnel whose roles and functions are clearly defined to avoid duplication. This is to ensure that the ranges of services that need to be delivered are in fact delivered. Self-referrals by individuals to hospitals bypass the lower levels, this perpetuates the vicious cycle of over-burdened hospitals and under-utilized health centers. It is important for health centers to refer only those patients for whom secondary or tertiary care is essential. In general, referral form from health center to higher levels should occur in the following situations:

- When a patient needs expert advice.
- When the client identifies her birthing facility of choice.
- When a patient needs a technical examinations that is available in the health centers.
- When a patient requires a technical intervention that is beyond the capabilities of the health center, or
- When a patient requires in-patient care.

This guideline is important since it will govern the reason(s) why a patient needs to be referred. Outside of this guideline, there should be a very strong reason(s) why a patient needs to be referred. Outside of these guidelines, there should be a very strong reason for bypassing the lower links in the health care delivery system.

The hospital, on the other hand, will ensure that referrals coming from health centers will receive prompt attention. Referral back to the health centers should be done as soon as the reason for referral to the hospital has been addressed. Indeed, referral is a 2 way process that involves cooperation, coordination and information transfer between the health centers and the hospitals who etiologies have bearings on the public health system. For the referral system to be truly functional, the different levels or components of health care delivery system must adhere to a set of guidelines based on the ILHZ approaches to referrals.

Ultimately, the hospital will benefit from its strong involvement and collaboration with the health Center especially in managing diseases.

1. Objectives of the MNCHN referral guideline

1.1 Overall objectives

- To provide ***timely referral*** of pregnant/post-partum women and newborns in case of ***emergency***
  - Reduction of MMR and IMR
- To enhance ***information sharing*** among health facilities and volunteers to provide ***continuous prenatal, delivery and post-partum care***
  - Increased facility-based deliveries
  - Increased utilization of prenatal and post-partum care

1.2 Specific objectives

- To guarantee that ALL pregnant women:
  a. Are registered in *Target Client List (TCL)*
  b. Receive *Family Health Diary*
  c. Receive prenatal care (at least 4 Prenatal visits)
  d. Make birth and emergency plan
     To provide timely transportation to health facility in case of emergency
  e. Deliver at health facility attended by trained health professional
  f. Receive emergency obstetric care, if necessary
  g. Receive emergency newborn care, if necessary
  h. Receive post-partum care
  i. Receive support from community health team

2. Standard operational procedure of MNCHN referral

2.1 Identification / master listing of pregnant women

Objectives:

a. To strengthen pregnancy tracking record/ master listing of all pregnant women at the community/barangay level.

b. To reinforce the two way referral system.

Procedure

Service providers	Actions to be taken
Community Health Team	- Register women in Pregnancy Tracking Record - Report to Rural Health Midwife (RHM) - Inform women on prenatal care and *Family Health Diary (FHD)*
Rural Health Midwife (in BHS and RHU)	- Issue *Family Health Diary (FHD)* and assist women to fill out FHD (pp. 1-4) - Register women in Target Client List - Provide prenatal care
Government / Private Hospital, Private clinic	• Encourage women to go to BHS (to receive Family Health Diary, to be registered in TCL) • Update BHS on women (thru client list, regular meeting, cell phone/text, etc.) • Issuance of • Family health diary.(for those who directly go to the hospitals with proper instructions to go back to the BHS

2.2 Birth and Emergency Plan

Objectives:

a. To assist pregnant women in making Birth and Emergency Plan.

b. To prepare birthing facilities and transportation services to pregnant women.

Procedure

Service providers	Actions to be taken
Family member of the pregnant women	- Coordinate with transport service providers and blood donors.
Community Health Team, OR health workers who provide	- Assist women to make "Birth and emergency plan" - Inform place(s) of delivery about the plan

prenatal care	(NSD, emergency) - Ensure the pregnant woman and the family to coordinate with the transportation service provider and blood donors. - Encourage pregnant women (without risk factors) to receive prenatal check-up for her last trimester at the facility where women plan to deliver
Birthing facilities **BEmONC** **CEmONC**	- Provide prenatal care or the last trimester. - Prepare to provide services to women/newborn
Transportation service providers	- Prepare to provide services to women

2.3 Pregnant women with identified risk factors

Objective:

a. To have an early detection and identification of risk factors.

Procedure

Service providers	Actions to be taken
Health workers who provide prenatal care	- Assess whether women are with risk factors based on - History of previous pregnancy - Status of present pregnancy - History of illness - Prenatal checkup - If risk factors are identified: - Provide treatment, if applicable, and/or; - Refer to facilities for appropriate care, if necessary; and/or - The women with risk factors are recommended to receive prenatal care at the health facility where they plan to deliver. - Re-assess birth and emergency plan
Referred to health facility	- Provide appropriate care/follow up, when necessary - Provide information back to facility/CHT which referred the women [Back Referral]

2.4 Obstetric / newborn emergency

Objectives:

- To ensure the provision of appropriate and timely quality of care to all mothers and newborn.

Procedure

Service providers	Actions to be taken
Referring facility or health worker/volunteer	- In case of the patient needs higher level of care due to obstetric/ newborn emergency: - Consult to higher level facility / professionals (thru phone/text message or other mode of communication), if necessary - Staple it to the MCH book - Provide care to the patient based on instruction from higher level professionals, if possible - Prepare means of transportation - Provide information to facility to which the patient is referred - e.g. referral form, (FHD) Family Health Diary, accompanying patients, text message/phone - Transfer the patient to higher level facility - Record information on treatment and referral - E.g. referral logbook (out-going), carbon-copy of referral slip, patient record -
Referred health facility	- Provide appropriate care to the patient - Provide information to facility which referred the patient (Back referral) - E.g. Referral slip (return form), Family Health Diary - Record information on treatment and referral - E.g. referral logbook (in-coming), patient record, discharge summary - Refer the patient to higher level facility, if necessary - Collect return slip by visiting house of the women (RHM)

2.5 Post-partum Care

Objective:

- Safeguard the lives of the mothers and newborns by making available, accessible and timely appropriate quality post-partum care.

Procedure

Service providers	Actions to be taken
Health worker who attended delivery	- Inform Rural Health Midwife on status of post-partum women and newborns - Using referral form (out-going), Family Health Diary, phone, text message - Inform RHM on discharge of Post-partum women and request for home visit.
Rural Health Midwife	- Provide post-partum care (home visit, if needed) - Record on Family Health Diary and Target Client List as well as patient record - Inform results of post-partum care to referring health worker / facility (Back Referral) if follow up care is requested by health worker who attended delivery - Using referral form (return slip), phone, text message, regular meeting - Inform the mothers on available MCH services (e.g. immunization, growth monitoring) - Inform CHT on status of the mothers and newborns
Community Health Team	- Record outcome of delivery on pregnancy track record. - Inform on health services available for mothers and children (breastfeeding, Family planning, immunization - If follow up need by the RHM

3. Recording of Referral

3.1 Family Health Diary

- All pregnant women must hold a Family Health Diary. The Health worker attending to the client must issue a Family Health Diary to the client if the client does not have one.
- After issuing a Family Health Diary, all hospitals and clinics must instruct the client to proceed to the Rural Health Unit (of the Municipality of the client) for the listing in the Target Client List as well as to receive RHU MNCHN Health Packages which includes Tetanus Toxoid. The hospitals and clinics must not include these packages in their prenatal care to ensure that the client conforms to the instruction.
- All health workers should record information on the Family Health Diary when they provide MNCHN services.

- All pregnant women are educated to bring their Family Health Diary every time they receive MNCHN services.
- Health workers should assist the pregnant women to fill out Family Health Diary.
  -including past and present health problems and pregnancies as well as birth and emergency plans.
- The Community Health Team should register all pregnant women in the Pregnancy Tracking Record.

3.2 Referral slip (Annex A)

1. The Referral Slip has 2 parts:
   - The Main Referral Slip which is filled out by the Physician from the referring facility.
   - The Return Slip which s filled out by the Physician from the referred facility to surrender the return slips of referral and need to follow up.

2. The Return Slip going to the Rural Health Unit should be stapled to the Family Health Diary of the client.
   - The client is instructed by the Physician from the referred facility to surrender the return slip to the Rural Health Unit.

3. During barangay visits, the Rural Health Midwife collects the Return Slip stapled to the Family Health Diary from the clients (if the client still has not surrendered and return slip to the Rural Health Unit).

4. Clients referred by hospitals to higher level facilities are instructed to obtain the return slips and surrender the slips to the referring hospital upon their discharge.

5. For hospitals, the resident on duty/nurse on duty must officially receive incoming referrals. The Municipal Health Officer/ Public Health Nurse will be the person to receive incoming referrals in the Rural Health Unit.

6. Format
   - (see attached Annex A)

3.3 Referral Logbook (Annex B)

1. There will be 2 log books. One for the outgoing Referral and another for the Incoming Referral.

2. The Public Health Nurse for Rural Health Units and the Nurse on Duty/ Nurse Attendant on Duty tasked to ensure that the Referral Logbooks are updated.

3. To keep the logbooks as updated as possible, the Public Health

Nurse and Hospital Nurse/Nursing Attendant must have contact options with the referred facility and/or the referred clients. If after a period of 1 month, the return slips have not been returned, the PHN and the Hospital Nurse/Nursing Attendant must contact the referred facility and/or the referred clients to inquire for the necessary information to complete their data in the referral logbook.

4. Format
   - (see attached Annex B)

3.4 Pregnancy Tracking Form (Annex C)

1. Accomplished and updated by CHT Member.

2. The Forms must list ALL Pregnant women in the catchment area
   - Regardless whether women are receiving services at BHS/RHU or hospitals (government/private) clinics, or not receiving any services.
3. All pregnant women must be visited by CHT preferably once a month for follow up.
   - Complementing services among CHT, BHS, RHU, hospitals and/or clinics
4. Information needs to be consolidated to Target Client List of the Rural Health Unit.

5. Format
   - (see attached Annex C)

3.5 Target Client List of Pregnant Women (FHSIS) (Annex D)

1. Managed by Rural Health Midwife (RHM)/ Public Health Nurse (PHN)

2. List All pregnant women and postpartum women,
   - Including women who received MNCHN services from the hospital/clinic (See Users Guide for the FHSIS p14)
   - Include MASTER LIST of pregnant women of catchment area
   - Sources of information:
     *Pregnancy Tracking Form of CHT Members
     *Client List of pregnant women of Hospitals/clinics
3. Format
   * (see attached Annex D)

4. Monitoring of referral

4.1 Objectives of monitoring on referral

1. To monitor whether referral activities attain objectives of referral;
   - Timely referral in case of obstetric/newborn emergency.
   - Continuous MNCHN services among various health service providers.

2. To monitor whether there is any need for improvement of referral/MNCHN services.
   - Improvement of means of transportation
   - Upgrading functions to reduce referral.

4.2 Monitoring Checklist

Topics/Items to be monitored	Organizations(Meetings)
Reasons of referral (by sending facility)	*RHU and BHS (Monthly Meeting)
*Was it Appropriate/necessary/per request? *Can some Referral be reduced by upgrading function of service provider?	*Hospitals (census meeting{monthly/quarterly} *ILHZ [Quarterly]
Outcome of referral(by sending facility)	
*Appropriate care given? *Return slip was issued? Received by referring facility? *Follow up care was given by referring facility, when necessary?	*RHU and BHS (Monthly Meeting) *Hospitals (census meeting{monthly/quarterly} *ILHZ [Quarterly]
Transportation (by sending facility)	
*Means of transportation available timely? *Provided as planned? *Any need for improvement?	*RHU and BHS (Monthly Meeting) *Hospitals (census meeting{monthly/quarterly} *ILHZ [Quarterly]
Information shared among health facilities	

*TCL covers all pregnant women, consolidating information of pregnancy tracking record, client lists of hospitals/clinics *Family health diary provided to all pregnant women? *Did health worker fill up Family Diary properly? *Birth and emergency plan made? *Coordination with transportation provider and health facility made?	*RHU and BHS (Monthly Meeting) *Hospitals(census meeting{monthly/quarterly} *ILHZ [Quarterly]
Attainment of project goals	
*Facility-based delivery rate *Prenatal care/post-partum care coverage *MMR/IMR	*Program Implementation Review -PIR of the province (annual)

5. Directories were deleted

ANNEX A

Republic of the Philippines
Province of Abra
Villaviciosa-Pilar-Penarubia ILHZ
Villaviciosa, Abra

Referred to: Address:	Date:	
Patient's name: Address:	Age:	Sex:
	Civil Status:	Occupation:
	Date Admitted/seen:	
Brief Clinical History & Physical Examination:		
Working Diagnosis:		
Management:		
Pertinent laboratory/Procedures done:		
Reason Of referral/Services Requested:		
Referred by: Attending Health Worker	Noted by: Head of the Department	

RETURN SLIP

Name of facility: Address: Contact no.	Referred Back to: (referring facility) Address:	
Patient's name: Address:	Age:	Sex:
	Civil Status:	Occupation:
	Date confined/seen:	
Action(s) taken/Recommendations:		
Attending Health Worker		

ANNEX B

Referral Logbook

Line Listing for Outgoing Referrals (Logbook entries)

Date & Time Referred	Name of Patient	Age	Sex	Address	Reason for Referral	Referred to	Method of Transport	Return Slip Returned (Y/N)	Outcome of Referral	Remarks

Line listing for Incoming Referrals (logbook entries)

Date & Time Referred	Name of Patient	Age	Sex	Address	Reason for Referral	Referred from	Diagnosis/ Actions taken Recommendation	Return Slip Issued (Check)	Remarks

ANNEX C

Pregnancy Tracking Form

Name of CHT Member: Catchment Area (Sitios/Purok Barangay								Municipality: Province: Name of Rural Health Midwife		
Name of Pregnant	Age	Address	LMP (dd/mm/yy	EDC (dd/mm/yy)	Prenatal Care (put date/month) 1st trimester	2nd trimester	3rd trimester	Pregnancy Outcome	Place of Delivery (name of health service)	Remarks

ANNEX D

Target Client List for Prenatal Care (page 1)

Date of Registration mm/dd/yy 1	Family Serial Number 2	Name 3	Address 4	Age 5	LMP/GP 6	EDC 7	Date of Prenatal Visits 8		
							First Trimester	Second Trimester	Third Trimester