REFERRAL MANUAL

Flora Sta. Marcela Inter Local Health Zone

December 2012

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INTRODUCTION

The Flora – Sta. Marcela Inter Local Health Zone was conceptualize and later developed as a competent organization with the following vision and mission: improving quality of life for all and a commitment to provide quality health care that is comprehensive, acceptable, affordable, readily available, community based and culture friendly.

To further advance and fulfill the promise of the organization a MNCHN Referral Guideline/ manual is developed. In this manual, detailed goal and intent, person responsible, procedures, policies, guidelines and logistics to be use are stated clearly. For this manual if followed rigorously, referral system operates smoothly and it shall save lives and reduce the burden of disease on the meager income of our constituents.

Through a series of meetings, workshops and consultations the referral manual is now user friendly. The detailed standard operational procedure (SOP) is adequately drawn highlighting information on the minimum health services available at the primary facilities and easy access to service providers exemplified by active community health teams, barangay health workers, and midwives.

Referral forms, slip, logbook and other logistics are mentioned and ready available when needed likewise the provision of transportation and communication which is essential in any referral system. Worth mentioning in this manual is the free provision of ambulance for the constituents of Sta. Marcela. This innovation shall increase health seeking behavior and likewise save the precious lives…

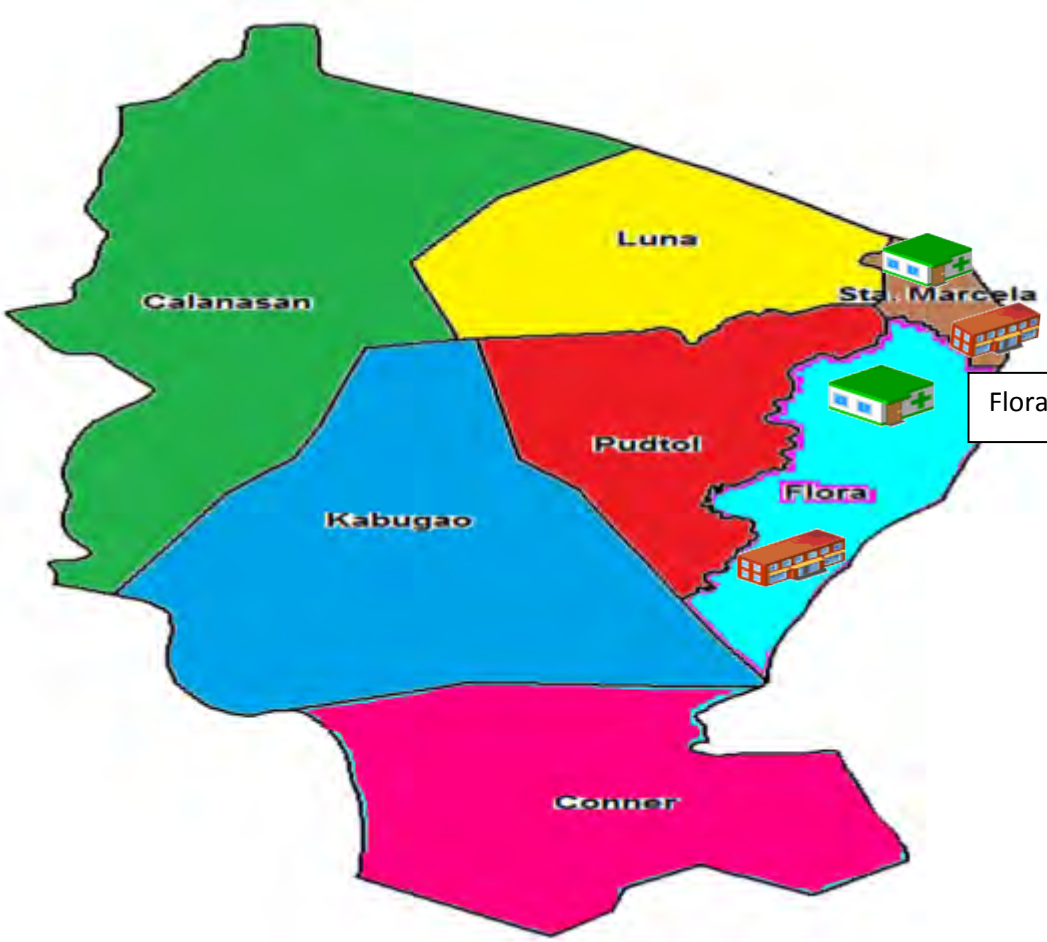
ACKNOWLEDGEMENT

The conceptualization and writing of this manual is a joined contribution of the participating officials and health workers of Flora – Sta. Marcela Inter Local Health Zone.

Thank you to the following for their support that made this manual made possible:

- Japan International Cooperation Agency who facilitated the Inter Local Health Zone Workshop at Las Palmas Resort, Tuguegarao City
- Dr. Makoto Tobe, Chief Advisor, who shared his exemplary knowledge and experiences during the Inter – Local Health Zone Referral System Workshop
- The Department of Health through the Provincial Health Team Office for their technical assistance
- The Technical Working Group of Flora – Sta. Marcela Interlocal Health Zone for their insights and contributions to strengthen their existing health referral system
- The two mayors: Mayor Rolly U. Guiang of the Municipality of Sta. Marcela and Mayor Efren U. de San Jose of the Municipality of Flora for their full support and commitment
- Hon. Elias C. Bulut, Jr, the Provincial Governor of Apayao and the Provincial Health Office of Apayao for their financial support and technical assistance to improve the health status of Iyapayao

MAP OF Flora – Sta. Marcela INTERLOCAL HEALTH ZONE



BeMONC Health Facilities

Hospital

Rural Health Unit

HEALTH FACILITIES

Municipality of Sta. Marcela

Sta. Marcela District Hospital

Sta. Marcela Rural Health Unit/ Rural Health birthing Clinic

Municipality of Flora

Flora District Hospital

Flora Maternal & Child Health Clinic

MESSAGE

At the commencement of this leadership endeavor, we have set all out effort to assess the health needs and gaps of our local residents. this does not only fulfill the promise to deliver better quality health services within my governance, but also to initiate a realistic achievable plan to address such health gaps.

One of the identified predicaments is the meager resources provided by the Local Government Unit, which basically affect our logistics, drugs and medicines and even health personnel. We recognize that to have a real progress and development, we must also uplift our constituents' status. Cognizant of the problem, I increased the budget for health requested and approved hiring of midwives and nurse through the RNheals program. And along this course we came upon and learned the advantages of joining with the Municipality of Flora in organizing the Inter - Local Health Zone and consequently sharing of resources will be a big plus to confront our problems in health.

The newly crafted Flora – Sta. Marcela Inter – Local Health Zone Referral Guideline or Manual is a tool to at least guide and monitor the progress we implement in alleviating the ever recurring problem of transporting, referring our patients to proper referral facility and follow-up of referred patients. With the guideline or manual, the policies, activities and logistics are now better stated, available at any time and more significantly, it is now secured and visible not only for the officials but also to our people to gaze upon. And since the manual is more concentrated to MNCHN, expectations are high that our mothers and children are in safe hands.

Anent to this, to show my support to our new organization, the following activities shall be followed: a yearly financial commitment shall be appropriated; commitment to share health personnel whenever there is a need; share health resources; continually support the technical working group of the Inter – Local Health Zone; support health policies and attend meetings to improve the organization.

Together then, with Flora, Sta. Marcela continues to be a dynamic partner of the Flora – Sta. Marcela Inter – Local Health Zone in bringing " Kalusugan Pangkalahatan " to our constituents.

ROLLY U. GUIANG
MUNICIPAL MAYOR

Republic of the Philippines

Province of Apayao

OFFICE OF THE MUNICIPAL MAYOR

My healthful greetings to all!

There is no better byword we can proudly parade to our people than to assure them that when their body ails, our health services are accessible and available, efficient and reliable.

With the establishment of the Flora-Sta. Marcela Inter-Local Health Zone, the enhancement of providing quality health care is now being recognized both by the people of Flora and Sta. Marcela. This is indeed a great pillar in the pursuance of excellence in addressing health problems by local leaders in line with the untiring support and initiative of the Department of Health and other non-governmental organizations.

Let us not waste this opportunity. With this Inter-local Health Zone, we can do much in improving our health facilities, enhancing the skills of our health personnel and also the way of approaching and/or attending the needs of our dear patients within the locality. Let us exert further efforts to establish a unique bonding not only by these two (2) municipalities but also sensible connections to different entities which can provide valuable assistance concerning health issues.

There is no better way of showing our utmost care and concern for the well-being of our people than to provide realistic programs that fit into their social and economic stratum. By supporting then this program, in one way or another we are reducing the apprehensions of our dear people with regard to the old fashioned way of dealing with health problems.

For all of us, particularly our dear people of Flora and Sta. Marcela, let us show our cooperation to this noble program. And to all individuals both in government and non-government organization who labor much in the improvement of our health services, my highest appreciation to all of you. Indeed, with the efforts of all leaders united as one, we are really ***"bringing health services closer to the people."***

EFREN U. DE SAN JOSE, DMD

Municipal Mayor

LIST OF ACRONYMS

BHS	Barangay Health Stations
BHW	Barangay Health Worker
CBC	Complete Blood Count
CHT	Community Health Team
DOH	Department of Health
DQC	Data Quality Check
ER	Emergency Room
FDH	Flora District Hospital
FHD	Family Health Diary
FHSIS	Field Health Service Information System
HBSAg	Hepatitis B Surface Antigen
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
RHU-MCHC	Rural Health Unit – Maternal and Child Clinic
SMMCH	Sta. Marcela Medicare and Community Hospital
TCL	Target Client List
TT	Tetanus Toxoid

1. Objectives of the MNCHN referral guideline

Overall Objectives

- 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 postpartum care

Specific Objectives

- To support that all pregnant women:
  a. Are registered in Target Client List (TCL)
  b. Receive, understand and use Family Health diary
  c. Receive essential and complete prenatal services
  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 postpartum services
  i. Receive support from community health team.
  j. With complications to be referred to higher level of care
  k. All delivered women to be referred back to CHT/BHS for continuity of care.

- To support that all newborn:
  a. Are registered in the local civil registrar
  b. Are registered in Target Client List.
  c. Receive essential newborn care
  d. Receive emergency newborn care, if necessary.
  e. With complications be referred to higher level of care
  f. Be referred back to CHT/BHS for regular immunization.

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
	- Submit pregnancy tracking record to birthing facilities
	- Follow up prenatal check up defaulters
	- Report to RHM
	- Inform women on prenatal care and Family Health Diary

Rural Health Midwife	- Issue Family Health Diary and assist to fill out FHD
	- Register women in target client list
	- - Provide essential and complete prenatal care - Prepare laboratory request for Urinalysis, CBC, Test for HBSAg, blood typing - Advise pregnant women for ultrasound preferably during third trimester. - Advise pregnant women for dental check -up at least twice during the period of pregnancy. - Advise pregnant women to consult doctors at least once in every trimester if normal or as advice of the attending physician in complicated cases. - Perform and teach women how to do self breast examination.

Service providers	Actions to be taken
Government/Private hospital, Private clinic	- The government facility (hospital or RHU) that catches the first prenatal check up of a pregnant woman will provide/issue Family Health Diary.
	- Government hospitals inform women to go to BHS (to be registered in TCL, receive some prenatal services like Tetanus Toxoid, deworming, iodized salt and treated mosquito net which are not provided by hospitals)
	- Private clinic inform women to go to BHS (to receive Family Health Diary, to be registered in TCL, receive some prenatal services like free Iron with folate tablets, iodized salt, Tetanus Toxoid immunization, deworming and treated mosquito net which are not provided by private clinics)

2.2. Birth and Emergency Plan

Service providers	Actions to be taken
Family member of pregnant women	- Coordinate with transportation service provider (neighbor and /or ambulance) 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 deliver. - Encourage relatives to donate blood during bloodletting activities.
	- Ensure women and their facility to coordinate with transportation service provider and blood donors
Birthing Facilities **Transportation service provider**	- Provide prenatal care in the third trimester at where the women plan to deliver - Hotlines (ambulance and birthing facilities) must be posted in front of the facility - Prepare to provide services to women - Local officials ensure the provision of transport service for referral

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 past and present illness and prenatal check up.
	- If risk factors are identified: • Provide treatment if applicable • Refer to physician 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
Referred health facility	- Provide appropriate care to the patient
	- Provide information to facility which referred the patient (Back Referral) • Referral slip (return form, Family Health Diary) with advice to return it to referring

	facility. • Staple it to MCH book/ Family Health Diary - Record information on treatment and referral • Referral logbook (in-coming), patient record, discharge summary - Refer patient to higher level facility, if necessary

2.5. Post-partum care

Service providers	Actions to be taken
Health worker who attended delivery	- Inform RHM on status of postpartum women and newborns (especially if follow up care is needed by RHM)
	- Also inform what kind of postpartum/ newborn care was given by hospital/ RHU before discharge.
	- Use referral form (out-going)/ discharge summary form and breastfeeding flier, Family Health Diary, phone, text message as back referral.
Community Health Team	- Inform RHM on discharge of postpartum women and request for postpartum home visit.
	- Record outcome of delivery on pregnancy track record.
	- Inform on health services available for mothers and children (breastfeeding, family planning, immunization)
Rural Health Midwife	- Provide postpartum care (home visit)
	- Record on Family Health Diary and Target Client Lists (prenatal, postpartum) as well as patient record
	- Inform the mothers on available MCH services (immunization, growth monitoring, family planning, exclusive breastfeeding, nutrition)
	- Inform CHT on status of the mothers and newborns
	- Inform results of postpartum care referring health worker/ facility (back referral if follow up care is requested by health worker who attended delivery.
	- Use referral form (return slip)/ discharge instruction, phone, text message, regular meeting as back referral.

3. Recording of referral

3.1. Family Health Diary (FHD)

The health facility (government hospital, BHS, RHU) that catches the first prenatal visit of the pregnant woman must issue FHD. Private hospitals/clinics on the other hand must advise pregnant to receive FHD in the RHJU. Hospitals (government and private) and private clinics instruct pregnant women to go to RHU/BHS for TCL registration and to receive some services not provided by hospitals and clinics. The Family Health Diary should be properly fill out by the pregnant women assisted by the health worker. All health workers should record information on FHD when they provide MNCHN.

All women are informed to bring FHD every time they receive MNCHN services either in the RHU/BHS, hospital or private clinics and when receiving laboratory services.

3.2. Referral slip (Annex A-1) and return slip (ANNEX A-2)

Adopt the referral form slip with minor changes. Fill out properly referral form with return slip and instructing them to return back to referring facility.

3.3. Referral logbook (ANNEX B-1 and Annex B-2)

Maintain the existing separate incoming and out-going referral logbook for the RHU.

Sta. Marcela Medicare and Community Hospital (SMMCH) and Flora District Hospital (FDH) will adopt outgoing and incoming referral logbook of the RHU.

3.4. Pregnancy tracking form (ANNEX C)

The Flora-Sta. Marcela ILHZ will adopt the format/matrix of pregnancy tracking form

in a logbook.

3.5. Client list of pregnant women of hospital and clinics (ANNEX D)

FDH and SMMCH will adopt the Client List of Pregnant Women matrix in a logbook.

The hospitals will submit monthly client list of pregnant women to RHU. Logbook will be maintained in hospitals.

3.6. Target Client List (FHSIS)

Daily updating of TCL by RHM and monthly DQC by PHN. Professionals who

are not submitting for prenatal check up at the RHU should be visited by the CHT monthly. Check- up dates at the private clinic must be updated in the TCL.

4. Monitoring of referral (Annex E)

4.1. Objectives of monitoring on referral

1. Timely referral in case of obstetric/ newborn emergency
2. Continuous MNCHN services among various health service providers

Reason for referral:

1. Complicated cases that our facility cannot offer.
2. For further evaluation and management.

Outcome of referral:

1. For continuity of care.
2. Return slip should be appropriately filled out and return to referring facility.
3. For follow up care will be given by referring facility when necessary.

Transportation:

1. Ambulance of hospitals, RHU and MCHC
2. Tricycle/kuliglig/jeep (private) in the barangay

4.2. Monitoring Checklist (Annex E)

- Information shared among health facilities
  -ILHZ meeting held regularly
  -minutes of ILHZ meetings, ILHZ resolution
  -TCL covers all pregnant women, consolidating information of pregnancy tracking record, client list of hospital and clinics
  -completeness of TCL and client list of health facilities.
  -FHD provided to all pregnant women
  -properly filled out FHD to all pregnant women
  -Updated list of transportation owners and drivers with contact numbers
- Attainment of project goals

5. Transportation and communication

The 2 hospitals have ambulance operating 24/7. The operation of the ambulance is guided by a provincial ordinance. Flora RHU have 2 ambulances, one is stationed at birthing center 24/7. Referral within the municipality is free of charge. The other ambulance is stationed at the municipal motor pool for referral outside the municipality and province. Relatives of patients referred outside the municipality are responsible for diesoline used to and fro.

Sta. Marcela RHU has one ambulance operating free of charge to any place of referral.

Trip tickets are signed by mayors or MHOs for RHU and Chief of Hospitals for FDH and SMMCH.

Referrals from the BHSs and/or patients from the community utilize public utility vehicles like tricycles and jeepneys). Hiring of private vehicles like "kuliglig" or elf is also available.

Hotlines are available in the RHUs and Hospitals (please see directories). The numbers are being communicated to all barangays and concerned offices.

6. Directories (include those outside the municipality) Deleted

6.1 Health service providers

Type of provider	Name	Address	Contact information	Operating hours	PhilHealth accreditation	BEmONC capability	Rates

Province of Apayao
FLORA – STA MARCELA INTERLOCAL HEALTH ZONE
_____Hospital/RHU/BHS
_____, Apayao

REFERRAL SLIP

<table>
<tr><td>Referred to:

Address:</td><td colspan="2">Date and time:</td></tr>
<tr><td rowspan="3">Patient's Name:

Address:</td><td>Age:</td><td>Sex:</td></tr>
<tr><td>Civil Status:</td><td>Occupation:</td></tr>
<tr><td colspan="2">Date Admitted/Seen:</td></tr>
<tr><td colspan="3">Brief Clinical History:</td></tr>
<tr><td colspan="3">Past Medical History: G___ P___ (___,___,___,___)
G1
G2
G3
G4
G5</td></tr>
<tr><td colspan="3">Physical Examination: Vital Signs: BP - _____ mm Hg CR-_____ bpm RR-_____/min Temp -_____°C Weight - _____kg
HEENT:
Chest/ Lungs:
Heart:
Abdomen:
IE: Cx:_____; _____cm dilated; ____% effaced; Station _____; _____(Presentation); BOW _____
Uterus: FH: _____cm; FHB: _____bpm; Adnexae: _____
Extremities:</td></tr>
<tr><td colspan="3">Working Diagnosis:</td></tr>
<tr><td colspan="3">Management:</td></tr>
<tr><td colspan="3">Pertinent Laboratory/ Procedures Done:</td></tr>
<tr><td colspan="3">Reason for Referral / Services Requested:</td></tr>
<tr><td colspan="2">Referred by:

_____
Signature over Printed Name</td><td>_____
Position/Designation</td></tr>
</table>

Annex A-2

RETURN SLIP

<table>
<tr><td>Name of Facility:

Address:

Contact No:</td><td colspan="2">Referred back to:

Address:</td></tr>
<tr><td rowspan="3">Patient’s Name:

Address:</td><td>Age:</td><td>Sex:</td></tr>
<tr><td>Civil Status:</td><td>Occupation:</td></tr>
<tr><td colspan="2">Date Confined/Seen:</td></tr>
<tr><td colspan="3">Action(s) Taken:</td></tr>
<tr><td colspan="3">Recommendations/Instructions:</td></tr>
<tr><td colspan="3">_____

Signature over Printed Name of Attending Health Worker/Position</td></tr>
</table>

ANNEX B-1

Referral Logbook

Line listing for Outgoing Referrals (logbook entries)

Date & Time Referred	Name of Patient	AGE	SEX	Address	Impression/Diagnosis/ Signs and Symptoms	Status of Patientbefore referral	Reason for referral	Referred to	Method of Transport	Return Slip Returned (Y/N)	Outcome of Referral

Annex B-2

Line listing for Incoming Referrals (logbook entries)

Date & Time Received	Name of Patient	A G E	S E X	Address	Impression or Diagnosis of referring Facility or Signs and Symptoms	Status of Patient upon arrival	Reason for referral	Referred from	Method of transport	Diagnosis / Actions taken / Recommendations/Instructions to Referring Facility	Return Slip issued (Check)

ANNEX C

Pregnancy Tracking Form

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

Client List of Pregnant Women

Name Health Facility		Address	

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

Annex E

Referral Monitoring Tool
Flora – Sta. Marcela Inter local Health Zone

Checklist (What to Monitor)	Monitoring Level		
	RHU	ILHZ	PHO
A. Reason of Referral			
1. Was it appropriate?			
2. Can some referral be reduced by upgrading function of service provider?			
B. Outcome of Referral			
1. Appropriate care given?			
2. Return slip was issued?			
3. Was return slip received by referring level?			
4. Follow – up care was given by referring facility, when necessary?			
C. Transportation			
1. Means of transportation available timely?			
2. Provided as planned?			
3. Any need for improvement?			
D. Information shared among health facilities			
1. ILHZ held regularly?			
2. TCL covers all pregnant women, consolidating information of pregnancy tracking record, client list of hospitals/clinics			
3. Family Health Diary provided to all pregnant women?			
4. Did health worker record Family Health Diary properly?			
5. Birth and emergency plan made?			
6. Coordination with transportation provider and health facility made?			
E. Attainment of project goals			
1. Facility-based delivery rate			
2. Prenatal care/post-partum care coverage			
3. Annual Maternal and Newborn Death Review			

The Rural Health Unit will monitor referrals on a quarterly basis during staff meeting. Flora - Sta. Marcela Inter local Health Zone Technical Management Committee , on the other hand will conduct monitoring of referrals bi-annually. The Provincial Health Office is requested to perform same activity annually.

Referral Manual

KABINNULIG INTER LOCAL HEALTH ZONE

January 2013

FOREWORD

This referral manual is formulated for use by the various stakeholders of the Kabinnulig Inter-local Health Zone. It is aimed at improving access to a more systematic maternal, neonatal care and child care with end in view of reducing maternal, early neonatal and under-five mortalities and morbidities.

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ANNEXES

ACRONYMS

APH	Apayao Provincial Hospital
BEMONC	Basic Emergency Mother & Neonatal Care
BHS	Barangay Health Station
BHW	Barangay Health Worker
BNS	Barangay Nutrition Scholar
CDH	Conner District Hospital
CEMONC	Comprehensive Emergency Mother & Neonatal Care
CHT	Community Health Team
EPI	Expanded Program of Immunization
IYCF	Infant & Young Child Feeding
KILHZ	Kabinnulig Interlocal Health Zone
MCB	Mother & Child Book
MCRA	Married Couples of Reproductive Age
MHC	Main Health Center
MNCHN	Maternal, Newborn, Child Health & Nutrition
MWRA	Married Women of Reproductive Age
OPT	Operation Timbang
PHIC	Philippine Health Insurance System
RHU	Rural Health Unit
TBA	Trained Birth Attendant
TCL	Target Client List

I. INTRODUCTION

The Kabinnulig Inter-Local Health Zone was established as one of endeavours to provide quality, equitable and accessible health care to the people of Kabugao and Conner. It is a response to the fragmentation of health services as a result of devolution wherein public health service became a responsibility of municipal/local government units and hospital services are basically maintained by the provincial and the national government through the provincial/ district hospitals and retained-hospitals, in this case, Conner District Hospital. Furthermore, it is recognized that the private sectors, particularly the Juan Maternity Clinic, is a strong partner in the provision of accessible and quality health care, thus its inclusion as one of the stakeholders for health in the health zone.

The Kabinnulig ILHZ is established between the municipalities of Conner and Kabugao, through their respective Rural Health Units, the province of Apayao, through the Apayao Provincial Hospital, and the Department of Health, through the Conner District Hospital, which is a national-retained hospital. It is a unique health zone in that one of its partners is Juan Maternity Clinic which is a privately owned facility. Both municipalities are located on the southernmost parts of the province of Apayao, bordered by the provinces of Cagayan Valley, Kalinga, Abra and the municipalities of Calanasan, Flora and Pudtol. The KILHZ has a combined land area of 908430 sq. km. with a generally mountainous topography. There are a total of 42 barangays in the zone. Among the 21 barangays of Kabugao, only 7 are accessible via rough or paved road while the rest are accessible through hiking or by a boat ride. Conner, on the other hand, has 4 barangays accessible only by hiking while the rest have a developed or partially developed road network. Communication facilities are available via 2 major networks; however, its coverage is limited only to a few barangays. Secured short wave radios are utilized by the Municipal Police Offices.

One of the systems that should be institutionalized in every health zone is a functional referral system. The referral system defines the hierarchy and relationship of services within the health zone, identifying the personnel and facility capability, thereby delineating the services that each personnel and facility can and should provide. The referral system generally aims to provide appropriate services to specific cases, thereby reducing the various delays in health service delivery which contribute to morbidities & mortalities. The process of institutionalizing a referral system in the KILHZ required the following aspects:

1. Identification of stakeholders
2. Role identification and delineation
3. Identification of the goals and objectives of the system
4. Identification of the referral flow according to facility capability
5. Consultation with various specialties on the referral process for specific disease conditions
6. Identification of the recording & reporting process &
7. Small group discussion among members of the TWG to finalize the system.

II. OBJECTIVES OF THE MNCHN REFERRAL GUIDELINES

A. GENERAL OBJECTIVE

To reduce maternal and under-five mortality in the municipalities of Conner and Kabugao through the institutionalization of a functional two-way referral system in the Kabinnulig Inter-Local Health Zone area.

B. SPECIFIC OBJECTIVES

1. To ensure timely referral of pregnant women, women in labor and post-partum women to reduce pregnancy related morbidities and mortalities.
2. To ensure a timely referral of newborn and sick children to reduce mortalities among the very young.
3. To enhance information sharing among the various health facilities and stakeholders for health in the health zone.
4. To increase facility based deliveries and deliveries assisted by skilled health professionals.
5. To improve health workers capability through seminars, trainings/ in-service trainings, and program implementation reviews.
6. To institutionalize a culturally-sensitive health service delivery.

III. THE KABINNULIG INTERLOCAL HEALTH ZONE AND ITS COMPONENT HEALTH FACILITIES

The KILHZ has 3 component hospitals, namely, Apayao Provincial Hospital, Conner District Hospital, Juan Maternity Clinic, 2 municipal health services from the municipalities of Kabugao and Conner, and 4 functional birthing homes in various barangays.

The Apayao Provincial Hospital (APH) was initially known as Kabugao Emergency Hospital created by virtue of Republic Act No. 4931 on June 1, 1967. It was made operational during the administration of then Governor Amado Alamazan. On August 22, 1995, by virtue of House Resolution No. 95-09 it was converted to a provincial hospital known as Apayao Provincial Hospital (APH). APH is a devolved hospital operated by the provincial government of Apayao. It is operating as a Level 1 referral hospital with a 25- bed capacity providing the following services: general medicine, general paediatrics, obstetrics and minor surgery. It is a PhilHealth accredited facility.

The Conner District Hospital is located in Barangay Ripang, Conner. It was created in 1992 by virtue of Republic Act 7850 sponsored by the Honorable Elias K. Bulut of the Lone Congressional District of Apayao. It became operational in 1999 with initial manpower and logistic augmentation from the Provincial Government of Apayao. It is a 25 bed capacity hospital catering the following health services: general medicine, general pediatrics, obstetrics, minor surgery and general dentistry. It is a PHILHEALTH accredited facility providing the NO BALANCE BILLING policy of the PHIC.

Juan Maternity Clinic is a privately owned clinic operated by a family of physicians headed by Dr. Janice Juan. It is strategically located in Ili, Conner, Apayao which makes it accessible to both Ikabugaos and the constituents of Conner. It provides services for general medicine, general pediatrics, minor surgery and obstetrics. The facility director, Dr. Janice Juan, is an accredited obstetrician/gynaecologist. The Conner District Hospital established a MOA for co-management of complicated obstetric cases. It is a Philhealth Accredited facility for obstetric cases.

The Conner RHU serves as a catchment of 21 barangays. Its facilities are composed of one (1) Main Health Center , eight (8) regular BHSs and three (3) BHS/birthing facilities. The following are the facilities, its location and the specific barangays served for each facility:

FACILITY	LOCATION	CATCHMENT BRGYS
Main Health Center/ Birthing Home	Malama	21 brgys
Paddaoan BHS	Paddaoan	Talifugo, Paddaoan,Katablangan
Ripang BHS	Ripang	Ripang, Nabbuangan,
Caglayan BHS	Caglayan	Caglayan, Cupis
Karikitan BHS	Karikitan	Calafug, Karikitan
Mawigue BHS	Mawigue	Mawigue, Allangigan
Puguin BHs	Puguin	Puguin, Mabiga
Daga BHS	Daga	Daga, Sacpil
Guinamgamman	Guinamgamman	Guinamgamman
Buluan BHS/ Birthing Home	Buluan	Banban, Buluan
Guina-angBHS/ Birthing Home	Guinaang	Guina-ang, Manag

The Kabugao Rural Health Unit is serving 21 barangays. It has one (1) Main Health Center, 1 functional birthing home, 7 BHSs and 2 sub-BHS. The following are the facilities, its location and its catchment areas:

FACILITY	LOCATION	CATCHMENT BRGYS
Main Health Center	Poblacion	21 brgys but spec Poblacion & Cabetayan
Lenneng BHS/ Birthing Home	Lenneng	Lenneng, Badduat
Karagawan BHS	Karagawan	Karagwan, Madduang, Luttuacan
Lucab BHS	Lucab	Nagbabalayan. Lucab, Musimut
Magabta BHS	Magabta	Magabta, Bulu, Waga
Kumao BHS	Kumao	Laco, Kumao, Baliwanan
Madatag BHS/ proposed Birthing Home in 2013	Madatag	Madatag, Dibagat, Tuyangan
Dagara BHS	Dagara	Dagara, Maragat

The following is a comparative table showing personnel and diagnostic complements of the various facilities:

	Apayao Provincial Hospital	Conner District Hospital	Juan Maternity Clinic	Conner RHU	Kabugao RHU
FACILITY PROFILE					
No. Of Facilities	1	1	1	1 MHC	1 MHC
No. Of Regular BHS	-	-	-	8	7
No. Of Birthing Home	-	-	-	3	1
Maternity Waiting Home	1	0	0	-	-
SERVICE CAPABILITIES					
General Medicine	/	/	/	/	/
General Pediatrics	/	/	/	/	/
Obstetrics	/	/	/	-	-
Minor Surgery	/	/	/	/	/
BEMONC teams	1	3	-	-	-
MHOs trained as BEMONC supervisors	-	-	-	0	0
# of midwives trained on harmonized BEMONC	-	-	-	0	0
PERSONNEL COMPLEMENT					
No. Of doctors	2 (permanent) 2(JO)	6 (incl COH)	3	1(MHO)	1(MHO)
No. Of Nurses	6	7	1	1 (casual)	1 (casual) 1(permanent)
No. Of midwives/ nurse attendants	4	4	3	11	8(permanent) 3(casual)
Medical Technologist	1 (w/ 1 lab aide)	1(Permanent) 1(JO)	1	1	1
Sanitary Inspector	-	-	-	1	1 (designate)
Dentist	1	1	0	1	0
Pharmacist	1	1(permanent) 1(JO)	0	-	-
Radiology technician	1	1	0	-	-
Administrative & auxiliary personnel	9	13 (permanent) 2 (JO)	-	1(JO)	1
Population Officers	-	-	-	2	-
DIAGNOSTIC & LABORATORY COMPLEMENT					
X-ray Machine	0	1	0	0	0
Ultrasound machine	1	1	0	0	0
Laboratory Tests:					
• CB C	/	/	/	/	/
• Urinalysis	/	/	/	/	/
• Fecal analysis	/	/	/	/	/
• Serologic Tests					
1. Hepatits A IgM IgG	X	X	X	X	/
2. Hepatitis B Ag	X	/	X	X	/

3. Dengueblot	X	/	X	/	/
4. Pregnancy Test	/	/	/	/	/
5. Typhidot	/	/	X	X	/
• Blood smear for Malarial Parasite	/	/	/	/	/
• Blood Typing	/	/	/	X	X
• Blood Chemistry					
1. Fasting Blood Sugar	/	/	x	/	/
2. Total cholesterol	X	/	X	X	X
3. HDL	X	/	X		
4. LDL	X	/	X		
5. BUN	X	/	X		
6. Creatinine	x	/	x		
NewBorn Screening	/	/	/	X	X
TRASPORT VEHICLES/ REFERRAL VEHICLES	1	2	0	1	1

The Conner District hospital has two (2) units x-ray machine operated by (1) radtech. The hospital established a MOA with a radiologist in Tuguegarao City for the official reading of all plates.

IV. ROLE IDENTIFICATION & DELINEATION AMONG THE STAKEHOLDERS OF THE HEALTH ZONE

To ensure that a holistic health care is provided by all tiers of the referral system, role identification and delineation is important. The following is a shortlist of expected minimum services that are to be provided by each facility in the health zone.

1. COMMUNITY

The community is represented by the auxiliary health workers and the barangay officials duly trained as members of the COMMUNITY HEALTH TEAM (CHT). The group are usually composed of Barangay Health workers, Barangay Nutrition Scholars, Trained Birth Attendants, and Kagawads for Health. Both municipalities have organized CHTs in each barangay with the midwife as the leader for each team. The expected function of the CHTs pertinent to MNCHN are as follows:

1.a. Pre-natal Care

1. a.1. Identification pregnant women in the community.

1.a.2. Refer ALL newly identified pregnant women to the respective midwife-in-charge

1.a.3. Conduct health education activities utilizing the Family Health Diary emphasizing importance of prenatal care and birth planning.

1.a.4. Assist the family in their “Birth and Emergency Plan”

1.a.5. Conduct home visits of pregnant women who fail/refuse to avail of pren-natal services

1.a.6. Recommend maternity waiting home for expectant mothers

1.a.7. Advocate for active participation of family members in the community blood donation activities

1.a.8. Observe for danger signs of pregnancy among the enlisted women and refer accordingly.

1.a.9. Encourage/facilitate enrolment of all pregnant non-members with PHIC.

1.b. Labor

1.b.1. Identify signs of true labor and refer client to a birthing facility or hospital.

1.b.2. Facilitate the client transport

1.c. Post-Partum Care

1.c.1. Identify all post-partum mothers in the community & refer to midwife in charge.

1.c.2. Conduct health education on IYCF with emphasis on exclusive breastfeeding and importance of vaccination.

1.c.3. Observe post-partum mothers for dangers signs and refer accordingly.

1.d. Newborn Care

1.d.1. Provision of basic newborn care (for home deliveries)

1.d.2. Facilitate effective breastfeeding (breastfeeding support group)

1.d.3. Educate mother on midwife's schedule of infant immunization

1.e. Child Care

1.e.1. Identify and refer all children 59 months old and below to midwife in charge for enlisting in the TCL

1.e.2. Participate in growth monitoring and other nutrition activities.

1.e.3.Conduct nutrition education activities especially on exclusive breastfeeding and complementary feeding.

1.e.4. Conduct home visitation activities for EPI and OPT defaulters.

2. BARANGAY HEALTH STATIONS

Kabugao has 7 barangay health stations while Conner has 11 BHSs. Each BHS is manned by a midwife, being the leader of the CHT, assisted by the BHW, BNS, TBAs and the Kagawad for Health. BHSs serve a cluster of 2-3 barangays each as a result of limited availability of health personnel. The midwife is expected to do the following:

2.a. Pre-pregnant

2.a.1. Identify and masterlist women and married women of reproductive age(MWRA/MCRA)

2.a.2. Identify families with unmet family planning needs.

2.a.3. Provide appropriate information and counselling on Family Planning and Responsible Parenthood

2.a.4. Ensure availability of family planning services and logistics

2.a.5. Micronutrient supplementation (Ferrous sulphate + folic acid) for women of reproductive age

2.a.6. Referral of suspected pregnant women for confirmation at the RHU or hospital

2.b. Pre-natal Care

2.b.1. Identify and masterlist all identified women who are pregnant.

2.b.2. Micronutrient supplementation and deworming

2.b.3. Refer patient to MHC/ hospital for Provision of Oral Health Services

2.b.4. Issuance of Pregnancy Package (Mother and Child Book, Mosquito Net, Albendazole); IEC on importance & use of the MCB

2.b.5. Facilitate Birth and Emergency Plan

2.b.6. Advocate on FP options post-partum

2.b.7. IEC on healthy lifestyle

2.b.8. Early detection and management of danger signs of pregnancy

2.b.9. Tetanus Toxoid Immunization

2..b.10. Refer to MHC or hospital for diagnostic and screening procedures: CBC, Urinalysis, Blood Typing, VDRL, HBSag, OGCT, AFB

2.b.11. Prevention and management of other health diseases

2.b.12. Orient patient on the availability of the maternity waiting home.

2.c. Delivery (Non- birthing facility)

2.c.1. Identification of early signs and symptoms of true labor

2.c.2. Facilitate transport and referral of client to a birthing facility

2.d. Delivery (Birthing facility)

2.d.1. Monitor progress of labor using partograph

2.d.2. Identify early signs and symptoms of abnormalities such as prolonged labor, hypertension, and other complications and **refer** accordingly.

2.d.3. For normal deliveries, facilitate controlled delivery of head and management of the third stage of labor.

2.d.4. Induction of antibiotics and parenteral oxytocin/methergine.

2.e. Post-partum (Birthing facility)

2.e.1. Monitoring of mother for early signs of complications.

2.e.2. Facilitate referral for cases with complications: hyper/hypotension, uncontrolled vaginal bleeding, uterine atony, altered sensorium, extreme maternal weakness

2.e.3. Provision of Vitamin A 200,000 iu and Ferrous Sulfate with folic acid

2.e.4. Enter mother in the TCL for Post-partum care

2.e.5. Provide a minimum of two (2) post-partum visits

2.e.6. Re-iterate FP options for mother

2.f. Early Neonatal Care (Birthing Facility)

2.f.1. Maintenance of appropriate body temperature through “skin-to-skin” technique for 90 min (11/2 hours); delay bathing until 6 hours after birth

2.f.2. Get infant body measurements ONLY 90 minutes after birth

2.f.3. Facilitate early latching on then provide Crede’s prophylaxis

2.f.4. Initiate immunization with BCG and Hepatitis B antigens and refer to specific BHS for subsequent doses

2.f.5. Observe for dangers signs of a newborn: difficult or rapid respiration, cyanosis, poor suck, poor reflexes, fever (>37.5), etc and refer accordingly.

2.f.6. Provide Vitamin K injection .5 ml @ right gluteal area

2.f.7. Enter infant in the Under-One TCL

2.f.8. Refer infant for Newborn Screening after 24 hours but within 72 hours after birth

2.f.9. Refer infant for hearing testing

2.g. Post-partum Care (Non-Birthing Facility)

2.g.1. Enlist mother in the TCL for Post-partum Care

2.g.2. Provide at least two (2) post-partum visits.

2.g.3. Observe for danger signs and refer accordingly.

2.g.4. Provide micronutrients: 1 cap Vitamin a 200,000 iu and 90 tabs Ferrous s ulfate w/ folic acid

2.g.5. Advice mother on FP services/options

2.f. Neonatal Care (Non-Birthing Facility)

2.f.1. Enlist infant in TCL for Under-Fiver Care

2.f.2. Evaluate child for danger signs and refer accordingly

2.f.3. Obtain and record infant's body measurements in the MCB/ ECCD Card.

2.f.4. Initiate immunization with BCG and Hepatitis B antigen.

2.f.5. Refer infant for NewBorn Screening

2.f.6. Refer infant for hearing testing

3. MAIN HEALTH CENTER

3.a. Pre-pregnant

3.a.1. Identify and masterlist women and married women of reproductive age; endorse women to specific catchment areas

3.a.2. Identify families with unmet family planning needs.

3.a.3. Provide appropriate information and counselling on Family Planning and Responsible Parenthood

3.a.4. Ensure availability of family planning services and logistics

3.a.5. Micronutrient supplementation (Ferrous sulphate + folic acid) for women of reproductive age

3.a.6. Conduct confirmatory tests for suspected pregnant women.

3.a.7. Initiate Tetanus Toxoid immunization for non-pregnant women 15 years old and above

3.b. Pre-natal Care

3.b.1. Identify and masterlist all identified women who are pregnant;endorse women to appropriate catchment BHS for entry into the TCL

3.b.2. Micronutrient supplementation and deworming

3.b.3. Provision of Oral Health Services

3.b.4. Issuance of Pregnancy Package (Mother and Child Book, Mosquito Net, Albendazole); Orient mother on use of MCB

3.b.5. Facilitate Birth and Emergency Plan

3.b.6. Advocate on FP options post-partum

3.b.7. IEC on healthy lifestyle

3.b.8. Early detection and management of danger signs of pregnancy

3.b.9. Tetanus Toxoid Immunization

3.b.10. Conduct diagnostic and screening procedures: CBC, Urinalysis, Blood Typing, VDRL, HBSag, FBS

3.b.11. Prevention and management of other health diseases

3.b.12. Orient patient on the availability of the maternity waiting home.

3.c. Delivery (Non- birthing facility)

3.c.1. Identification of early signs and symptoms of labor

3.c.2. Facilitate transport and referral of client to a birthing facility

3.d. Delivery (Birthing facility)

2.d.1. Monitor progress of labor using partograph

2.d.2. Identify early signs and symptoms of abnormalities such as prolonged labor, hypertension, and other complications and **refer** accordingly.

2.d.3. For normal deliveries, facilitate controlled delivery of head and management of the third stage of labor.

2.d.4. Induction of antibiotics and parenteral oxytocin/methergine.

3.e. Post-partum (Birthing facility)

2.e.1. Monitoring of mother for early signs of complications.

2.e.2. Facilitate referral for cases with complications: hyper/hypotension, uncontrolled vaginal bleeding, uterine atony, altered sensorium, extreme maternal weakness

2.e.3. Provision of Vitamin A 200,000 iu and Ferrous Sulfate with folic acid

2.e.4. Enter mother in the TCL for Post-partum care

2.e.5. Provide a minimum of two (2) post-partum visits

3.f. Early Neonatal Care (Birthing Facility)

3.f.1. Maintenance of appropriate body temperature through “skin-to-skin” technique

3.f.2. Get infant body measurements and record in MCB

3.f.3. Facilitate early latching on

3.f.4. Initiate immunization with BCG and Hepatitis B antigens and refer to specific BHS for subsequent doses

3.f.5. Observe for dangers signs of a newborn: difficult or rapid respiration, cyanosis, failure to suck, and refer accordingly.

3.f.6. Enter infant in the Under-Five TCL

3.g. Post-partum Care (Non-Birthing Facility)

2.g.1. Enlist mother in the TCL for Post-partum Care

2.g.2. Provide at least two (2) post-partum visits.

2.g.3. Observe for danger signs and refer accordingly.

2.g.4. Provide micronutrients: 1 cap Vitamin a 200,000 iu and 90 tabs Ferrous s ulfate w/ folic acid

2.g.5. Advice mother on FP services/options

3.f. Neonatal Care (Non-Birthing Facility)

2.f.1. Enlist infant in TCL for Under-Fiver Care

2.f.2. Evaluate child for danger signs and refer accordingly

2.f.3. Obtain and record infant's body measurements in the MCB/ ECCD Card.

2.f.4. Initiate immunization with BCG and Hepatitis A antigen.

2.f.5. Refer infant for New Born Screening

4. ***HOSPITALS***

The 2 government hospitals are BEMONC capable whereas the San Juan Maternity Clinic is manned by an Obstetrician/Gynecologist. At the current set-up, non-surgical obstetric cases are managed within the health zone while cases requiring C-section are immediately referred to tertiary hospitals in Tuguegarao City for appropriate management.

4.a. Pre-natal

4.a.1. Admit patient and provide initial evaluation

4.a.2. Conduct essential diagnostic procedures: Hemoglobin determination, Blood typing and urinalysis; FBS if there indications for its need

4.a.3. Fill up Mother and Child Book and orient mother on its use (CDH); for other hospitals refer mother to BHS for release of MCB

4.a.4. Initiate tetanus toxoid immunization (CDH/JMC); Advice mother to seek consult with midwife-in-charge of her barangay for initiation of the tetanus toxoid immunization and micronutrient supplementation and regular AP check-up (APH)

4.a.5. Evaluate for danger signs and manage or refer accordingly

4.b. Delivery

4.b.1. Monitor progress of labor using partograph

4.d.2. Identify early signs and symptoms of abnormalities such as prolonged labor, hypertension, and other complications and manage or **refer** accordingly.

4.d.3. For normal deliveries, facilitate controlled delivery of head and management of the third stage of labor.

4.d.4. Induction of antibiotics and parenteral oxytocin/methergine.

4.c. Post-partum

4.c.1. Monitoring of mother for early signs of complications.

4.c.2. Facilitate referral of cases with complications

4.c.3. Provision of Vitamin A 200,000 iu and Ferrous Sulfate with folic acid

4.c.4. Conduct post-partum evaluation within 24 hours and within 7 days thereafter; record all findings and medical actions in the MCB.

4.c.5. Advice client to seek consult with midwife-in-charge of her barangay for post-partum care

4.d. Early Neonatal Care

4.d.1. Maintenance of appropriate body temperature through "skin-to-skin" technique

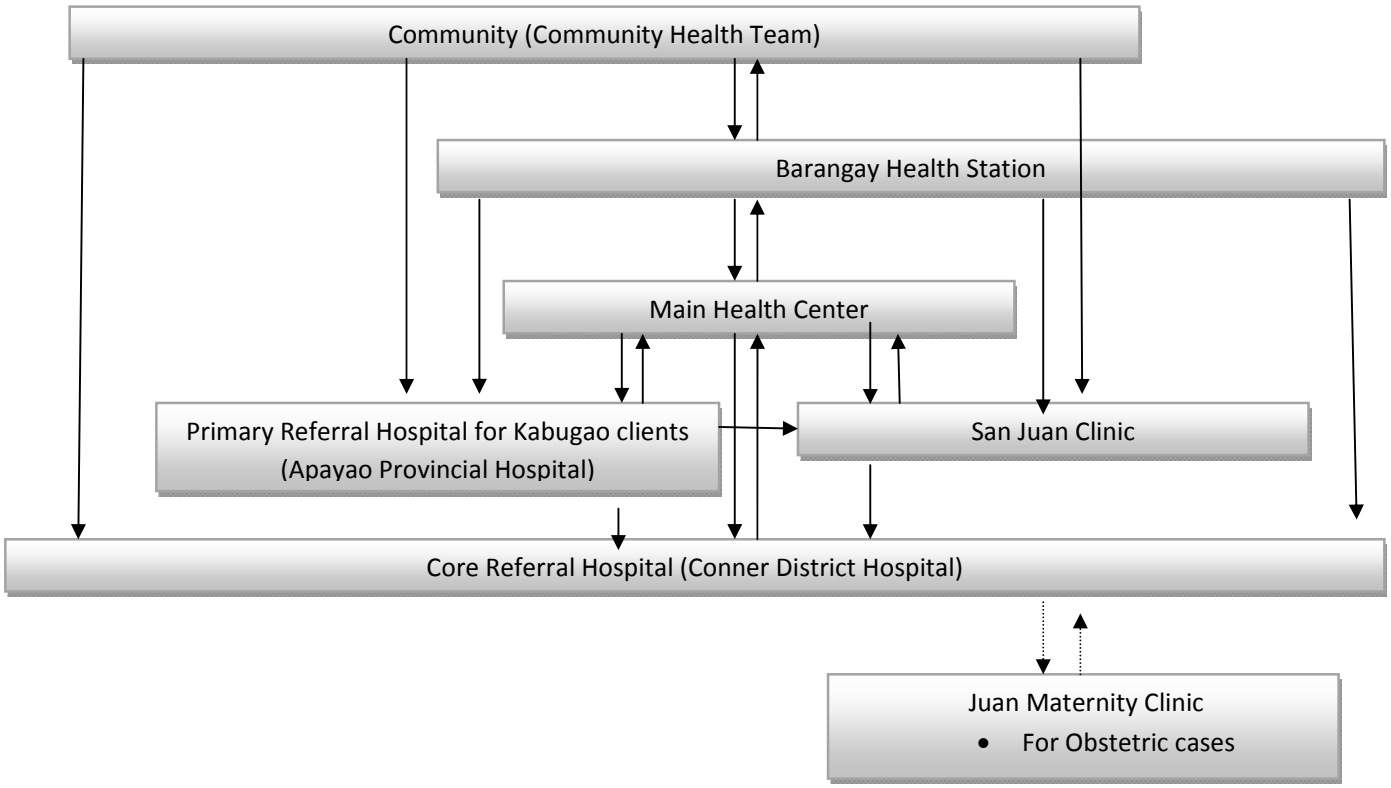
4.d.2. Get infant body measurements and record in MCB

4.d.3. Facilitate early latching on

4.d.4. For CDH and APH, all newborns shall be initiated on immunization with BCG and Hepatitis B antigens and enter all immunized child in the masterlist which shall be submitted for consolidation at the Main Health Center. For Juan Maternity Clinic, midwife-in-charge of Barangay ILI shall be responsible for retrieving the record.
4.d.5. Observe for dangers signs of a newborn such as difficult or rapid respiration, cyanosis, failure to suck, and refer accordingly.
4.d.6. Conduct Newborn Screening
4.e.7. Crede's Prophylaxis
4.e.8. Conduct Hearing test
4.e.9. Vitamin k injection
4.e.10. Delay bathing for 6 hours; avoid removal of vernix caseosa
4.e.11. Appropriate cord care

V. THE REFERRAL FLOWCHART

The following is a representation of the various tiers in the delivery of health services in the KILHZ and the referral and back-referral arrows to indicate directional flows of the referral flowchart:



VI. GENERAL REFERRAL GUIDELINES

1. All health workers shall be oriented on the referral manual.
2. A copy of the manual shall be made available to all facilities in the health zone.
3. All facilities and health workers in the KILHZ shall follow the agreed upon referral flow chart.
4. All clients referred to higher facilities should be given a duly accomplished referral form which should be presented to the facility she is being referred to.
5. Clients being referred back to primary referring facility should be given a duly accomplished refer-back slip which should be presented to the primary referring facility.
6. All facilities should maintain a logbook recording all referred out and referred back cases.
7. Clients evaluated to have danger signs should ALWAYS be accompanied by a health worker during transport to referral facility.
8. Major facilities, namely, hospitals and Main Health Centers, should ensure the availability of a referral transport system/ambulance. The ILHZ shall endeavour to provide transport vehicles for birthing facilities.
9. A quarterly report on referrals should be accomplished by all facilities.

VII. REFERRAL RECORDING & REPORTING

1. REFERRAL SLIP

   A common referral slip shall be utilized in the health zone at the level of the CHT, auxiliary health workers and the various institutional health facilities.

   a. CHT REFERRAL FORM

      This shall be utilized by the BHWs and BNSs and other members of the CHT to refer newly identified pregnant, post-partum and under-five year old children to their respective midwife-in-charge or CHT Team Leader. (Annex A)

   b. FACILITY REFERRAL SLIP

      This shall be utilized by all health workers to refer a client to a higher facility for evaluation and management; likewise the same form shall be utilized to refer back patients to the referring facility. (Annex B)

2. RECORDING

   A logbook shall be maintained by all major facilities (MHC, Hospitals) which shall record all referrals to and from their facility. Referral from and referrals to the facilities shall be recorded separately. The following shall be the expected data in the logbook (Annex C & D):

   a. Referral to other facilities:
      1. Name of Patient
      2. Age
      3. Sex
      4. Address
      5. Diagnosis
      6. Facility to which patient is being referred to
      7. Reason for referral

8. Transport vehicle
9. Status of the referral slip
10. Outcome of the Referral
11. Remarks

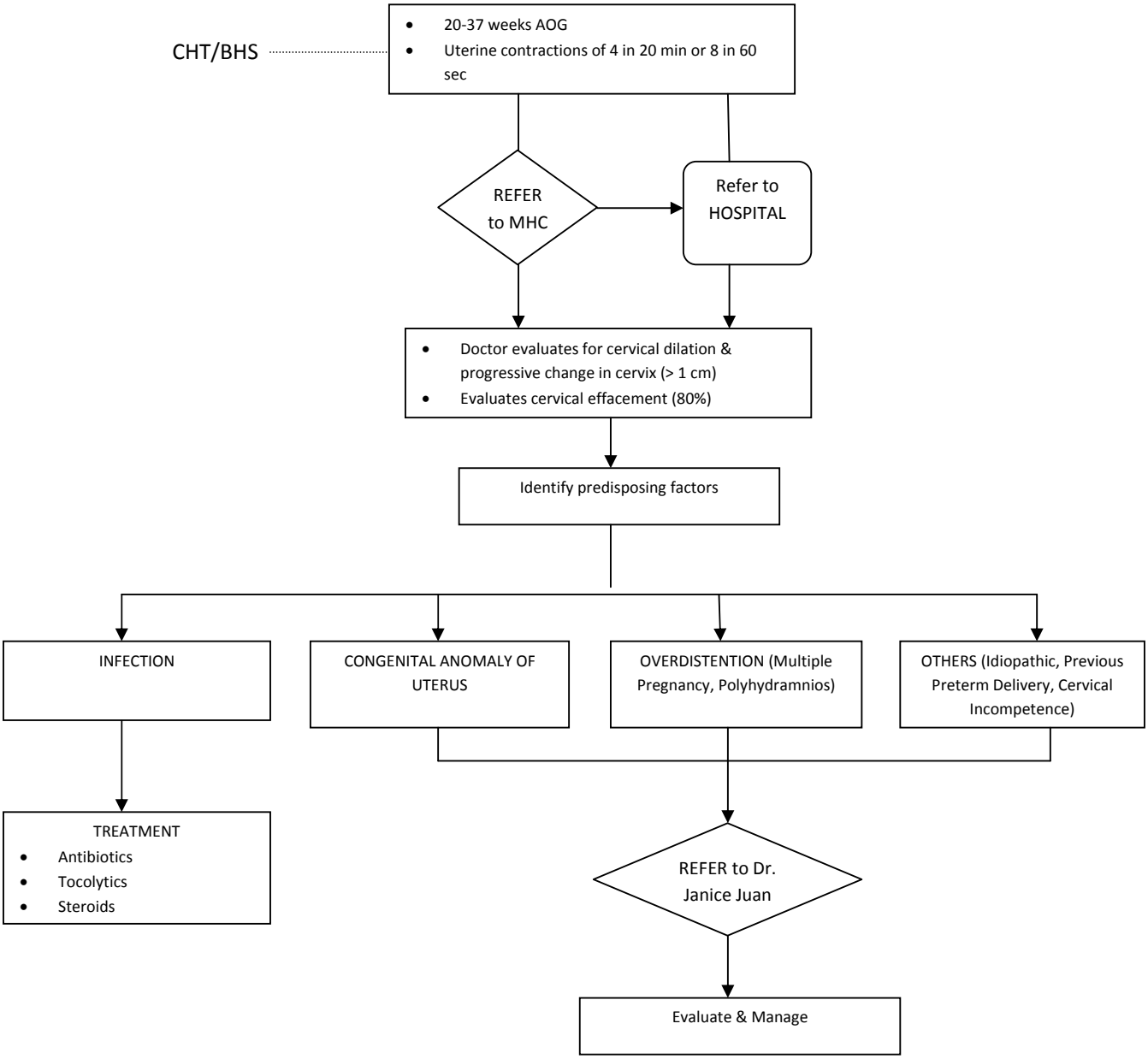
b. Refer- back other facilities
   1. Name of patient
   2. Age
   3. Sex
   4. Address
   5. Referring Facility or doctor
   6. Diagnosis
   7. Reason for referral

3. REPORTING

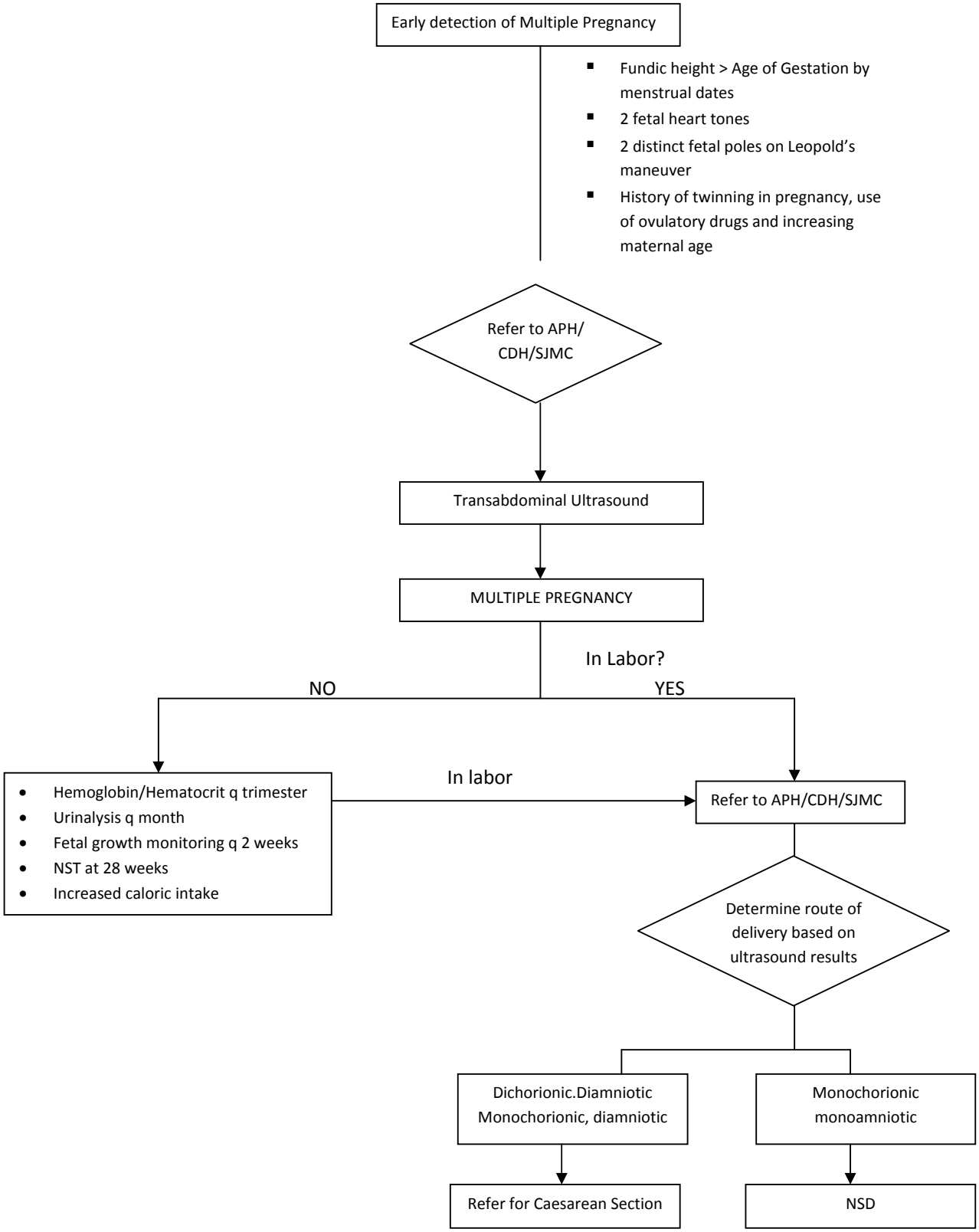
   Referral shall be consolidated in a quarterly report. The report shall be utilized to determine the referral rate as opposed to the over-all admission (hospital) or OPD cases (Hospital & Health Units), case diagnosis for referred cases, reasons for referrals and back-referral rates.(Annex E)

VIII. CASE MANAGEMENT ALGORITHMS FOR COMMON OBSTETRIC AND NEONATAL CONDITIONS

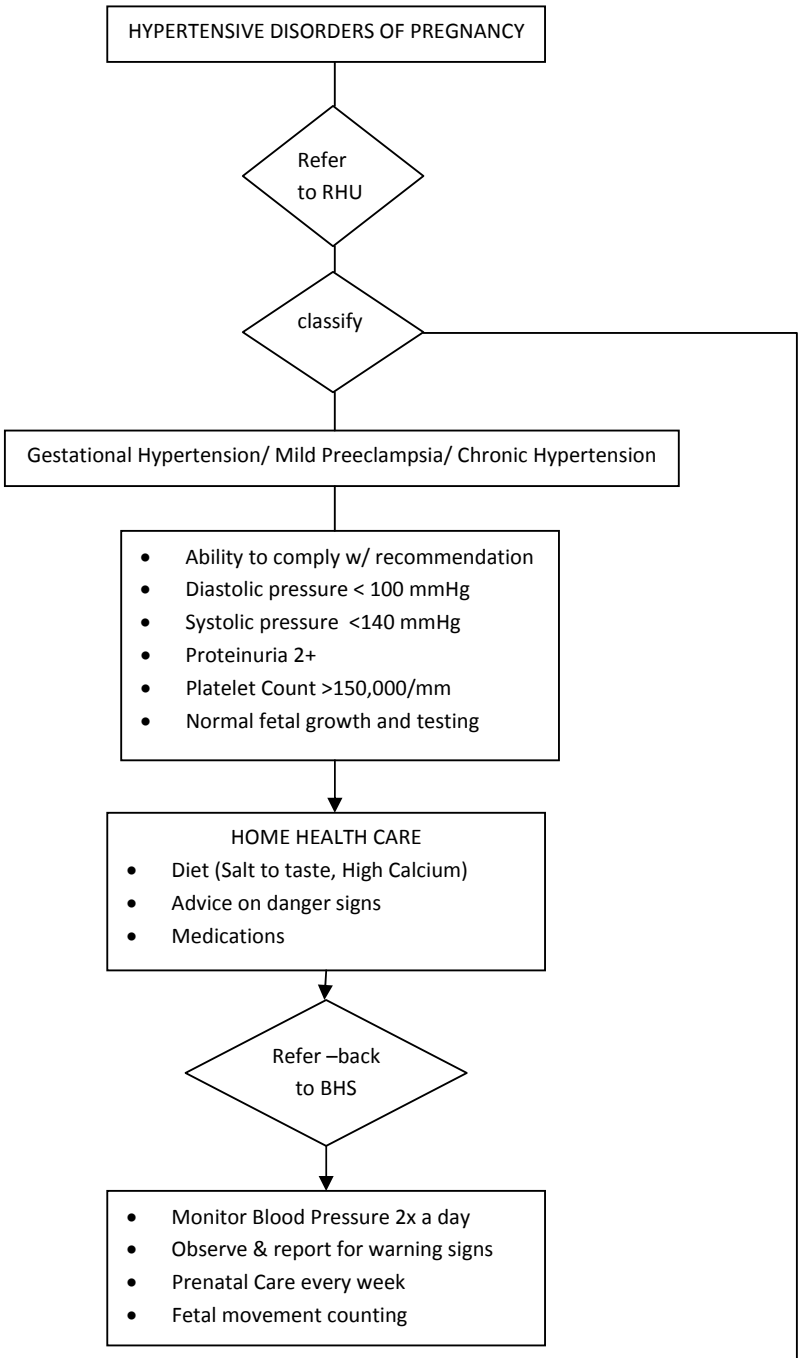
A. PRE-TERM LABOR



B. MULTI-FETAL PREGNANCY



C. **HYPERTENSIVE DISORDERS OF PREGNANCY**



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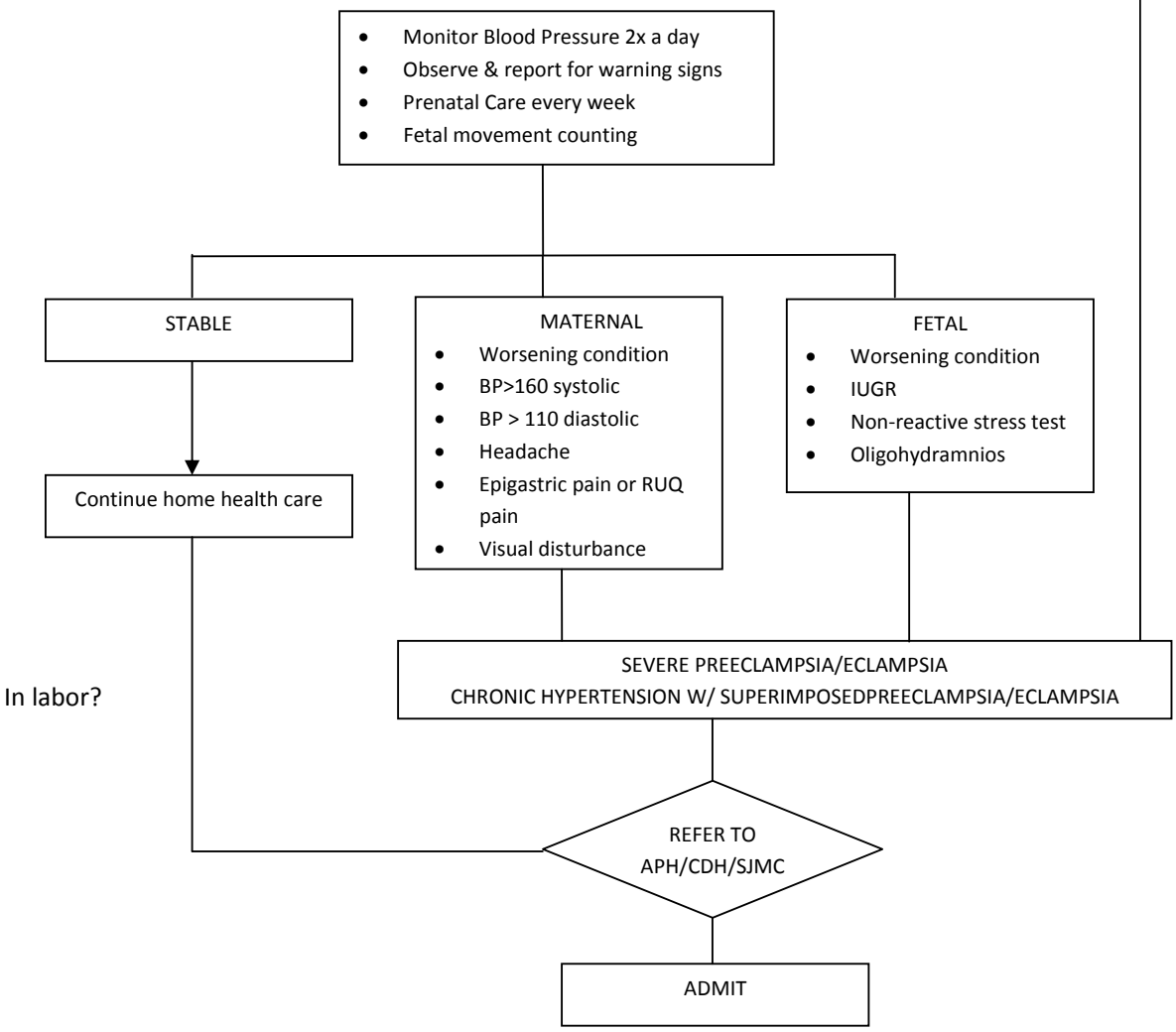
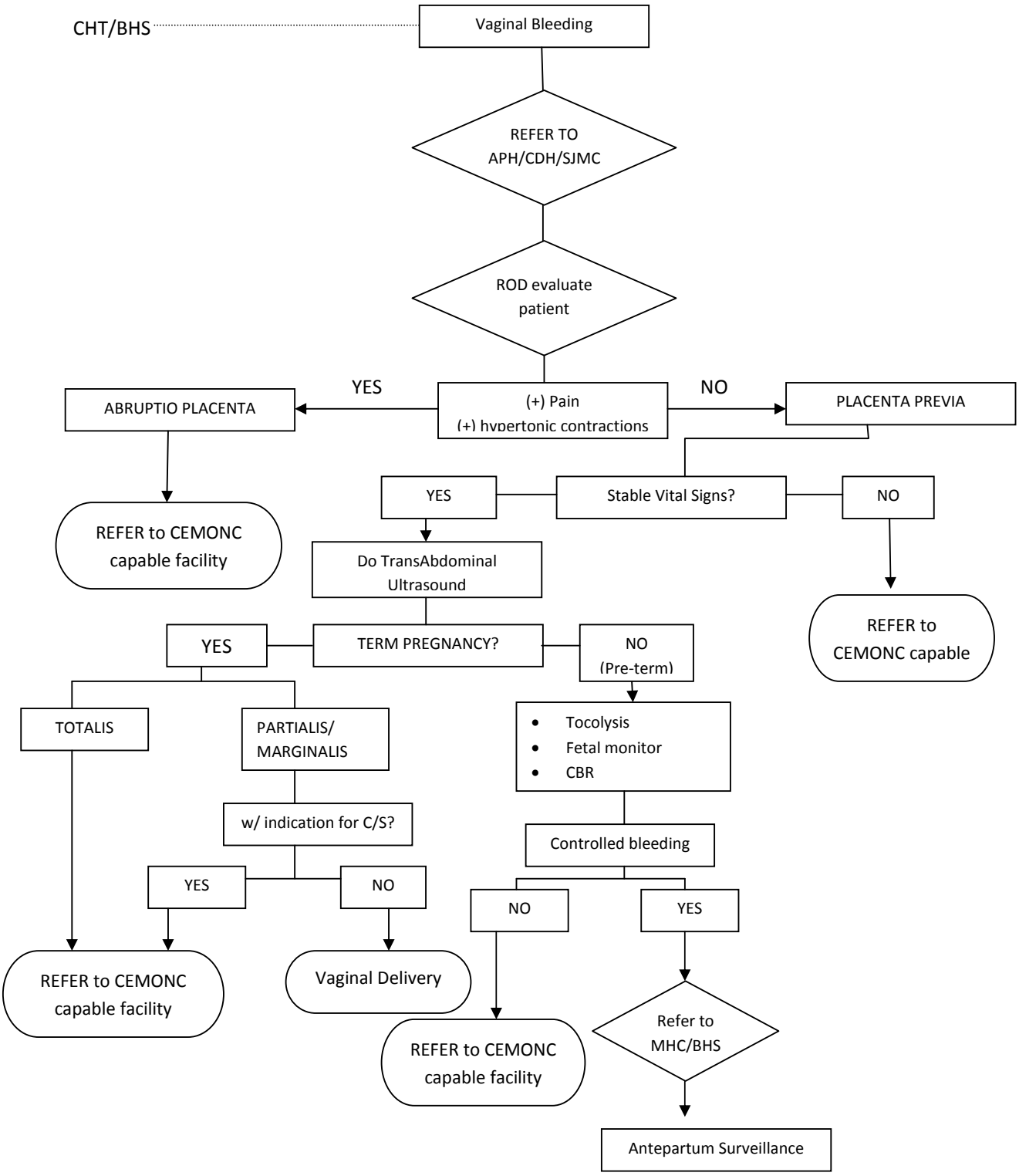
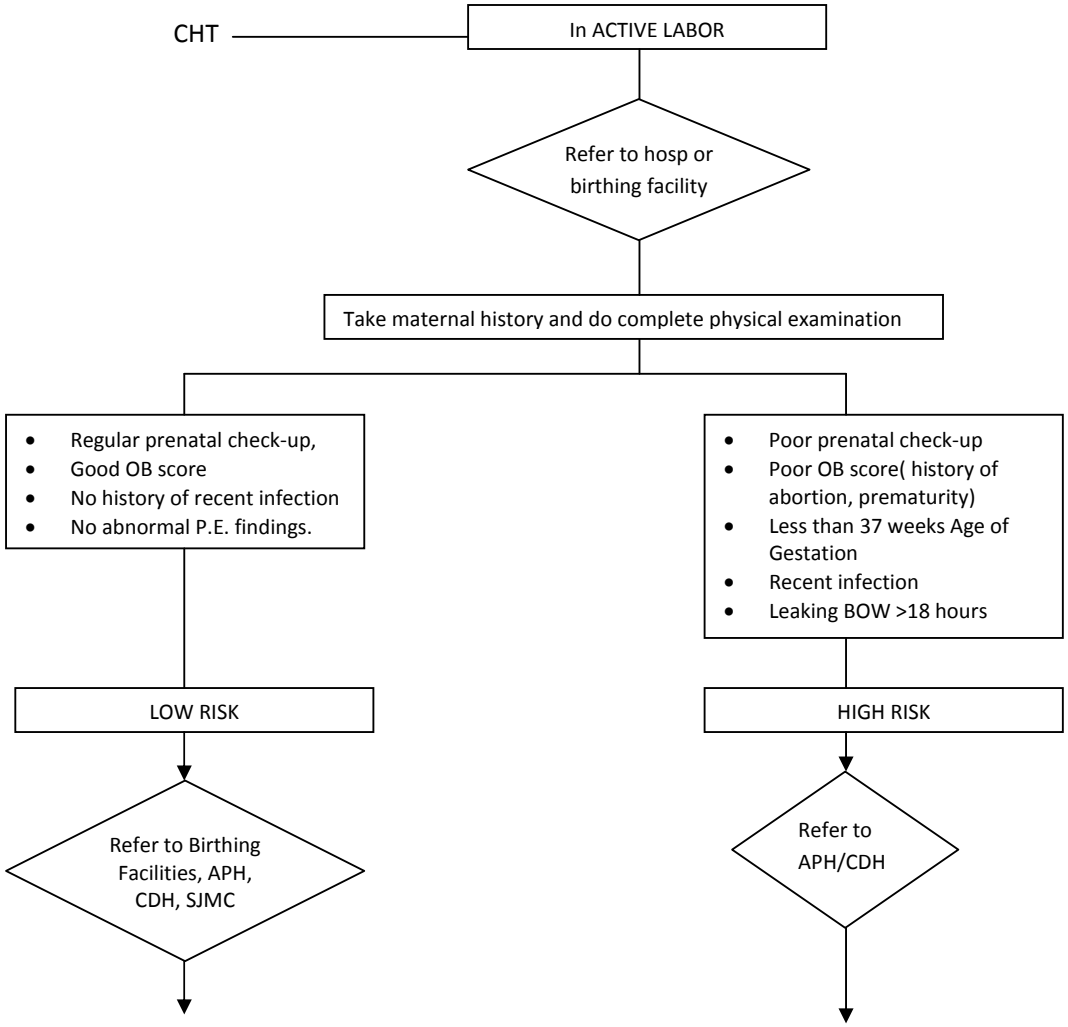

Monitor Blood Pressure 2x a day
Observe & report for warning signs
Prenatal Care every week
Fetal movement counting
STABLE
MATERNAL
Worsening condition
BP>160 systolic
BP > 110 diastolic
Headache
Epigastric pain or RUQ pain
Visual disturbance
FETAL
Worsening condition
IUGR
Non-reactive stress test
Oligohydramnios
Continue home health care
In labor?
SEVERE PREECLAMPSIA/ECLAMPSIA
CHRONIC HYPERTENSION W/ SUPERIMPOSEDPREECLAMPSIA/ECLAMPSIA
REFER TO
APH/CDH/SJMC
ADMIT

D. PRE-NATAL VAGINAL BLEEDING



E. ALGORITHM FOR THE OPTIMAL OUTCOME OF THE DELIVERY OF A NEWBORN



Approximate time	Birth	Appropriate action
30 seconds	Clear meconium? Breathing or crying? YES Good muscle tone? → Color pink? Term gestation	Routine care -Provide warmth -Clear airway -Dry -Follow BEMONC protocol
	NO → Re-evaluate ←	• Provide warmth • Position, clear airway as necessary* • Dry, stimulate, reposition • Give 02 as necessary
	Breathing Pink → HR >100	SUPPORTIVE CARE
30 seconds	Apnea or HR < 100 →	

	Re-evaluate ←	Positive Pressure Ventillation
	↓ Ventilating Pink HR > 100	SUPPORTIVE CARE
30 seconds	↓ HR < 60 →	Positive Pressure Ventillation Administer Chest Compression

ANNEXES

ANNEX A. CHT REFERRAL SLIP

KABINNULIG INTER-LOCAL HEALTH ZONE **CHT Referral Slip**	
Name of Patient:	Date Seen/Referred:
Barangay:	
Referred for: ( ) Child Care ( ) Prenatal Care ( ) Post-partum Care	
Referred to :	
Referring CHT:	

ANNEX B. CLINICAL REFERRAL SLIP

KABINNULIG INTERLOCAL HEALTH ZONE
CLINICAL REFERRAL SLIP

Date:_____

Name of Patient:_____Age/Sex:_____
Address:_____
__
Referring Unit:_____
Referring Personnel:_____
Referred to:_____
CHIEF COMPLAINT:_____
HISTORY:_____
_____
PHYSICAL EXAMINATION/ VITAL SIGNS:_____
_____
IMPRESSION:_____
ACTIONSTAKEN:_____
_____
_____
REASON FOR REFERRAL:_____

Signature

KABINNULIG INTERLOCAL HEALTH ZONE
REFER- BACK SLIP

Date:_____

Name of Patient:_____Age/Sex:_____
Address:_____
Referring Unit:_____
Referring Personnel:_____
Referred to:_____
DIAGNOSIS:_____
ACTIONS OF REFERRING FACILITY:_____
_____
_____
_____
INSTRUCTIONS:_____
_____
_____
_____
_____

ANNEX C. MATRIX FOR OUT-REFERRALS

Column 1- Date and time of referral
Column 2- Name of patient
Column 3- Age
Column 4-Sex
Column 5-Address
Column 6- Diagnosis
Column 7- Reason for referral
Column 8- Referred to?
Column 9-Method of Transport
Column 10- Refer back slip returned? Y/N
Column 11- Outcome of Referral (A-alive; B-Dead)
Column 12- remarks

Date & Time Referred	Name of Patient	Age	Sex	Address	Diagnosis	Reason for Referral	Referred to?	Method of transport	Refer back slip returned?	Outcome of referral	Remarks

ANNEX D. MATRIX FOR BACK-REFERRALS

Column 1- Date and time of referral
Column 2- Name of patient
Column 3- Age
Column 4-Sex
Column 5-Address
Column 6- Diagnosis
Column 7- Back-referring Unit
Column 9- Purpose of back-referral
Column 10-Remarks

Date & Time Referred	Name of Patient	Age	Sex	Address	Diagnosis	Reason for Referral	Referring facility	Refer back slip returned?	Remarks

ANNEX E. REFERRAL REPORTING FORM

ANNEX F. FACILITY MAPPING

LUNA-PUDTOL INTER LOCAL HEALTH ZONE

MNCHN REFERRAL MANUAL

(November 2012)

LUNA – PUDTOL ILHZ

MNCHN Referral Guideline

November 12, 2012

Far North Luzon General Hospital and Training Center
Amma Jadsac District Hospital
Luna Rural Health Unit
Pudtol Rural Health Unit

DR. MARLENE L. LUBO, FPPS
TWG Chairman

DR. AMELIA ABULENCIA *Member*

DR. MARY ELIZA GALLEON *Member*

DR. JONAH GRACE P. VERZOLA *Member*

TABLE OF CONTENTS

DEDICATION

To Him Who is

the way

the truth and

the life.

the Giver of life,

the Divine Healer,

the Father Almighty

To you we dedicate

This referral Manual.

Map of Luna – Pudtol Inter Local Health Zone

Foreword

The Luna-Pudtol Inter Local Health Zone was established in 2000 with the aim to strengthen the networking of referrals between the health facilities of Luna and Pudtol.

Driven forward by the ultimate goal of preventing maternal and neonatal and childhood deaths, the Luna-Pudtol ILHZ was founded and established by the Luna-Pudtol District Health Board.

Through the ICHSP project; the first Luna-Pudtol ILHZ referral was then published.

Last year; the Japan International Cooperation Agency (JICA); joined hands with the (CHD – CAR) Center for Health and Development – Cordillera Administrative Region with the Project for Cordillera-wide strengthening of the Local Health System for effective and efficient delivery of maternal and child health services.

When our friends from Japan saw the enthusiasm of our own Governor Elias C. Bulut, Jr. about the project; Japan extended their full support to our province, Apayao.

In November 2012; a referral manual workshop was held in Tuguegarao City for one week. It was chaired by Dr. Makoto Tobe with his members Ms. Fude Takayoshi and Ms. Marcelyn Dulnuan.

As a result of such workshop; the new Luna-Pudtol Inter Local Health Zone Referral Manual was published. This is a collaborative effort of the Hospital Administrators, Municipal Health Officers and Public Health Nurses of the two hospitals and the two Rural Health Units.

DR. MARLENE L. LUBO, FPPS
TWG Chairman

ACKNOWLEDGEMENT

The Luna-Pudtol ILHZ would like to thank and acknowledge the following for their generous contribution and support to the crafting and finalization of this manual.

Special thanks to the Local Executives of both towns, Luna and Pudtol; Mayor Betty C. Verzola and Mayor Batara Laoat respectively for immersing themselves to this project.

Special thanks to the assistance and guidance of Director Valeriano Jesus Lopez.

Heartfelt gratitude is also extended to the Hospital Administrators of both hospitals and the Municipal Health Officers of Pudtol and Luna Rural Health Units and all the members of the Technical Working Group who patiently encoded the outputs of the workshop last November 2012.

Particular acknowledgement is made to Dr. Makoto Tobe the JICA SSC Chief Advisor and Ms. Fude Takayoshi, deputy Chief Advisor for their valuable inputs during the Referral Manual training. Also to Miss Marcelyn M. Dulnuan,for the tireless efforts in facilitating meetings and activities so that this manual will be finished.

Also, we acknowledge the unending technical support from the Provincial Health Officer II, Dr. Thelma V. Dangao, MNCHN Coordinator Ms. Cheryl Reyes,PHTL Dr.Andrew Martin, and the DOH representatives Dr. Estella Nicolas and Charlyn Tagabing.

And above all, the Almighty Father who gave each and everyone wisdom and strength to finish this manual.

Dr. Marlene L. Lubo, FPPS
TWG-Chairman

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 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

Definition of Terms

Community Health Team – is composed of community health volunteers (e.g. Barangay Health Workers, Barangay Nutrition Scholar, other community members and others) led by a midwife that can provide community level care and services during the pre-pregnancy, pregnancy, delivery and post partum period.

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

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 – refers to the 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 counselling, 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, Iron Supplementation, counselling and etc.

Referral – is a process by which a health worker/facility transfers the responsibility of care to another health worker/facility or social worker .

Referring Facility – refers to the health facility making the referral.

Referred Health Facility – refers to the health facility that receives referred patients.

Text Message – exchange of short text messages via mobile phone.

LUNA-PUDTOL INTER LOCAL HEALTH ZONE OFFICERS & MEMBERS

LOCAL CHIEF EXECUTIVES

Hon. Betty C. Verzola	LGU, Luna
Hon. Batara Laoat	LGU, Pudtol

TECHNICAL WORKING GROUP

Chairman	Dr. Marlene L. Lubo, FPPS
Co-Chairman	Amparo Calaycay
Members	Miriam C. Danao
	Marthe Gorospe
	Femie Bragas
	Kathy Myer Paculan
	Roberto Caluducan
	Engr. Albert Martin
	Maribeth Agustin Micu
	Engr. Darlo Arnedo

CHIEF OF HOSPITALS AND MUNICIPAL HEALTH OFFICERS

Dr. Danilo A. Domingo, M.D., MHA	Far North Luzon General Hospital & Training Center
Dr. Mary Eliza Galleon	Amma Jadsac District Hospital
Dr. Amelia Abulencia	Pudtol Rural Health Unit
Dr. Jonah Grace Verzola	Luna Rural Health Unit

Introduction

A referral system within the Inter-Local Health Zone, (ILHZ) involves a two-way relationship, that is, it involves a rural health facility and a core referral hospital.

The rural health facility provides primary medical care and the core referral hospital provide a secondary care.

Some reasons why patients are to be referred to a referral hospital by a rural health unit include the following:

- When patient needs inpatient care;
- When client identifies her birthing facility of choice;
- When patient requires a technical examination that is not available at the health centers; and
- When a patient needs expert medical advice.

The hospital shall answer all the referred patients and give prompt care and medical attention. After the patient is being treated; the former should be referred back to the rural health facility. Hence, both facilities are benefited.

In our set-up, the Pudtol Inter local health zone, The Far North Luzon General Hospital & Training Center is the referral hospital which caters Medical, OB-Gynecology, Surgery and Pediatric, Neonatal Intensive Care Unit, Intensive Care Unit and Orthopedics.

AmmaJadsac District Hospital, Rural Health Unit of Pudtol and Luna refer problematic cases.

It is our hope that the Luna-Pudtol ILHZ two-way referral system be perfected so that we can attain our goal to reduce maternal, neonatal and childhood death.

1. Objectives of The MNCHN referral guideline

Overall objectives

- 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***

Specific objectives

- To ensure that ALL pregnant women/ post- partum and newborns:
    a. Are registered in *Target Client List (TCL)*
    b. Receive and understand the importance of *Family Health Diary*
    c. Receive the standard prenatal care
    d. Make a birth and an emergency plan
    e. Are provided timely transportation to health facility in case of emergency
    f. Delivered at health facility attended by trained health personnel
    g. Receive emergency obstetric care, if necessary
    h. Receive emergency newborn care for their babies, if necessary
    i. Receive the standard 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	- Tracking all pregnant women especially during the first trimester - Register women in the Pregnancy Tracking Record - Report to Rural Health Midwife (RHM) - Inform women on prenatal care and Family Health Diary (FHD) - advocacy on PHIC memberships
Midwives	- Pregnancy test-if positive register in the TCL - Issue Family Health Diary (FHD) and assist women to fill out FHD (pp. 1-4) - Register women in Target Client List - Provide prenatal care

2.2 Birth and Emergency Plan

Service providers	Actions to be taken
Midwives	- Discuss with the pregnant women the benefits of prenatal visit. (Family health diary) - Relatives of pregnant women are advised to donate blood prior to delivery.
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 at where the women plan to deliver -Prepare to provide services to women / newborns.
Transportation service providers	-Prepare to provide transportation services to women

2.3 Pregnant women with identified risk factors

Service providers	Actions to be taken
Midwives	- After identifying the pregnancy risk factors referred to MHO
MHO	- Gives proper counselling and possible referral to referral agencies.
Obstetricians	- Identified pregnant women with risk factors are seen by an OB. Blood typing of the mother is a necessity during her last visit in the facility. - Pregnant identified with risk factors are advised to have weekly prenatal visits prior to delivery for work up and monitoring.
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
ROD	- Performs and assess the case and referral is made to Obstetrician/ Pediatrician
Obstetrician/ Pediatrician	- Assesses and performs necessary procedures and "E" (emergency) Management.
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
ROD	- Performs post partum assessment- if complications noted referr to Obstetrician.
Obstetrician	- Performs adequate and pertinent management to the case referred.
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

The Inter Local Health Zone will follow the usual Luna – Pudtol ILHZ referral. The following are the records to be used by the ILHZ.

3.1 Family Health Diary

- All pregnant women are given Family Health Diary(FHD) in the facility where they are first seen.
- The PHO is responsible in giving out FHD to the private clinics.

3.2 Referral slip (ANNEX A)

- Each facility will use the format of the referral slip in Annex A. The return slip will be filled up by the referred facility to be given back to the referring facility.

3.3 Referral logbook (ANNEX B)

- The original referral logbook will be retained.

3.4 Pregnancy tracking form (ANNEX C)

- The Pregnancy Tracking form in Annex C will be used by the Rural Health Units.

3.4 Client list of pregnant women (ANNEX D)

- In the hospital set-up, the admission and referral logbook is utilized as the source of information.
- There will be a separate logbook for OPD pregnant women.(for MNCHN recording)

3.5 Target Client List (FHSIS)

- The ILHZ will retain the usual reporting and recording based on the FHSIS Guidelines.

4. Monitoring of Referral

- The ILHZ will ensure that referrals are seen and patients are managed accordingly.

5. The Monitoring Checklist

- The ILHZ will retain the original logbook for monitoring.
- The Provincial Health Office will monitor the Rural Health Units and the Municipal Health Officers will monitor the Public Health Nurses and midwives.

6. Directories

Type of provider	Name	Address	Contact #	Operating hours	PhilHealth accre-ditation	BEmONC /CEmONC capability	Rates

7. Transportation and communication

7.1 Transportation

- The two local Chief Executives together with the Technical Working Group will set policies regarding the sharing of the use of the ambulances of the two hospitals. Guidelines of which are not included in this manual.

7.2 Communication

- The Hospitals and the RHUs will make use of the hotlines of each facility. The referring hospital and RHUs will contact the hotline of Far North Hospital prior to referral. The referring resident on duty informs the resident on duty of Far North and describes the condition of the patient prior to transfer. The old policy of referral through phone call and text will still be practiced. The following are the hotline numbers of the facilities:

Name of Facility	Hotline Number

ANNEX A

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

Pregnancy Tracking Form

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

Date of registration (dd/mm/yy)	Name of Pregnant Women	Age	Address	LMP (dd/mm/yy)	EDC (dd/mm/yy)	Prenatal Care (put date/month)			Pregnancy Outcome
						1st trimester	2nd trimester	3rd trimester	

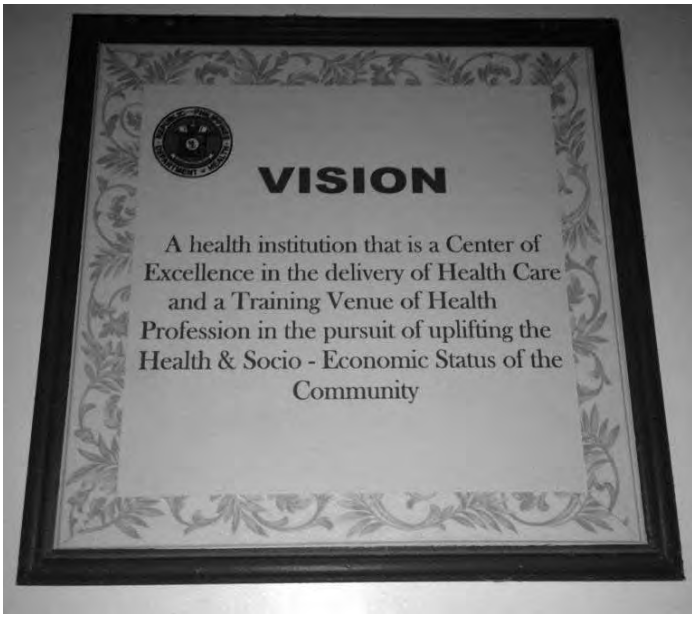
ANNEX D

Client List of Pregnant Women

Name Health Facility		Address	

Date of registration (dd/mm/yy)	Name of Pregnant Women	Age	Address	LMP (dd/mm/yy)	EDC (dd/mm/yy)	Prenatal Care (put date/month)			Pregnancy Outcome
						1st trimester	2nd trimester	3rd trimester	


FAR NORTH LUZON
GENERAL HOSPITAL
& TRAINING CENTER


VISION
A health institution that is a Center of Excellence in the delivery of Health Care and a Training Venue of Health Profession in the pursuit of uplifting the Health & Socio - Economic Status of the Community


MISSION
To provide an optimum health care services that is very accessible and affordable at least cost to every clientele, delivered by well-trained but humane, courteous, diligent, efficient health workers and complemented with adequate facilities and equipment.

Dr. Danilo Domingo,Chief of Hospital(FNLGHTC)

Dr. Marlene Lubo, Chief of Clinics (FNLGHTC)

Miriam C. Danao, Chief Nurse(FNLGHTC)

Brenda B. Bayani, Adm. Officer V (FNLGHTC)

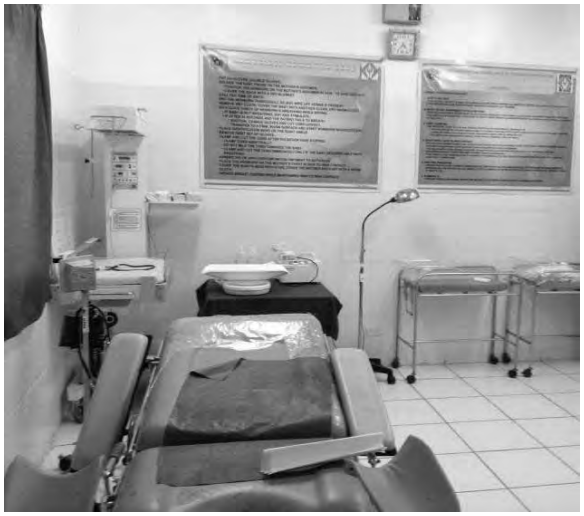
Medical Staff (FNLGHTC)

Eleanor S. San Mateo, Nurse III (FNLGHTC)

Medical and Nursing Staff (FNLGHTC)

Nursing Staff at the Emergency Room (FNLGHTC)

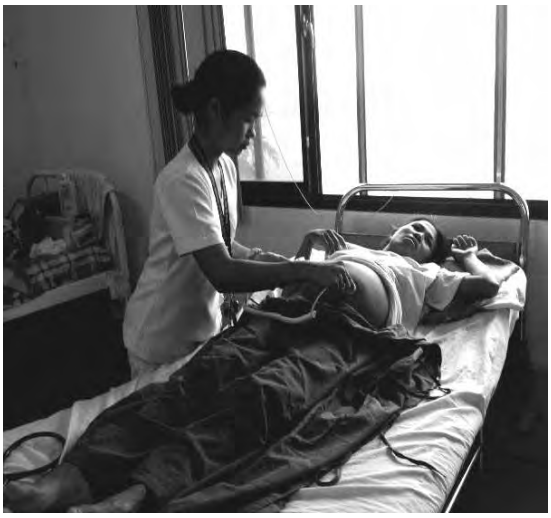
Emergency cart given by JICA (FNLGHTC)



Delivery Bed (FNLGHTC)

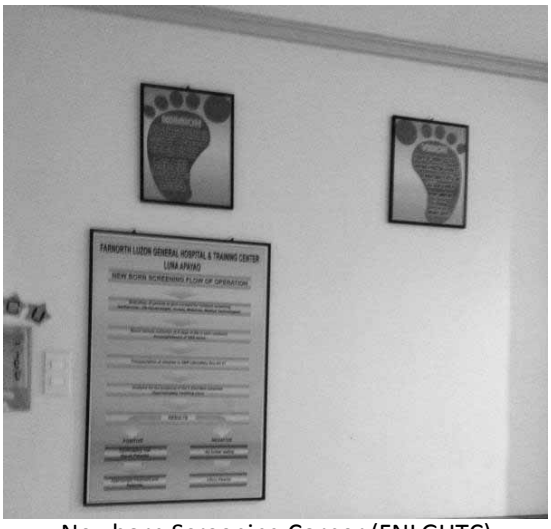
Entrance of the Emergency Room (FNLGHTC)

Nursing Attendant Sheryl Reyes at work (FNLGHTC)



Nurse Getting Fetal Heart Tone (FNLGHTC)

Nurse Assisting Patient to Breastfeed (FNLGHTC)



Newborn Screening Corner (FNLGHTC)

Medical Technologist Extracting Blood for Newborn Screening (FNLGHTC)


RHU-LUNA
POBLACION, LUNA, APAYAO

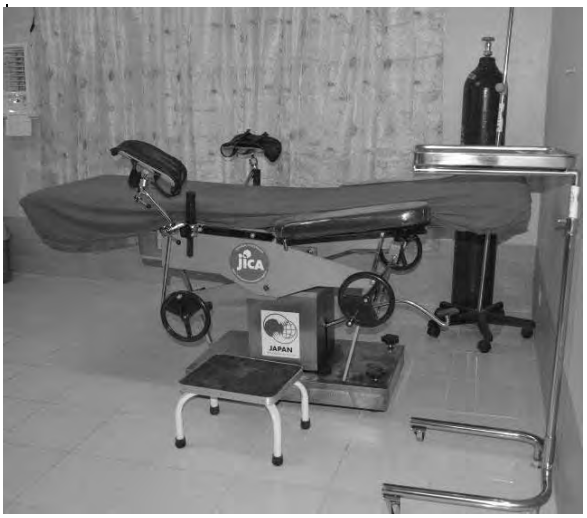

ANTI - FIXER CAMPAIGN
CIVIL SERVICE COMMISSION
FIX THE FIXER
TB DOTS CENTER

Meeting with the RHU & PHO staff by the MHO

Luna RHU Birthing Facility

Newly Renovated Delivery area of Luna RHU

The RHU staff w/ partners during the blessing



Delivery Bed Provided by JICA(Luna RHU)

The PHO II, MHO of Luna RHU & MHO of Pudtol RHU

Amma Jadsac District Hospital
Pudtol, Luna, Apayao

District Hospital Building (AJDH)

Side View of the District Hospital (AJDH)

Philhealth Ward (AJDH)

Delivery Room Complex (AJDH)

Labor Room (AJDH)

Recovery Room (AJDH)

PUDTOL RHU

PUDTOL, LUNA, APAYAO

Entrance of Pudtol Rural Health Unit

Dr. Amelia Abulencia,MHO of Pudtol RHU

Inside the Pudtol RHU

Working Area for RHU staff (Pudtol RHU)

Records Area (Pudtol RHU)

OPD Area (Pudtol RHU)

yMandaya ILHZ
MNCHN Referral Guideline

December 2012

Apayao District Hospital
Calanasan Rural Health Unit

TABLE OF CONTENTS

FOREWORD

The finishing of this referral manual will strengthen the Maternal, Child Health and Nutrition activities of the yMandaya Intra-Local Health Zone, which is composed of the Rural Health Unit of the Municipality of Calanasan and the Apayao District Hospital, which is located in the Municipality of Calanasan.

This manual is the product of years of research conducted by the Department of Health – CHD-CAR, Provincial Health Office of the Province of Apayao and JICA – SSC (especially Makoto Tobe-San and Ms. Marcelyn Dulnuan) in their implementation of their programs in various locations. Utilizing this research, the technical working group members of the various inter-local health zones (including doctors, nurses, midwives and other allied health personnel) met and discussed this research to come up with a MNCHN referral manual for use by the municipality.

With this manual, the aim of the yMandaya ILHZ is to streamline the flow of referral from the barangay levels to the municipal level and to the district hospital to the tertiary referrals hospitals. This referral manual will serve as a written codice on the referral system which will be utilized by the ILHZ for faster and more efficient referral of patients, which will ultimately improve the MNCHN status of the municipality.

Acknowledgement

This referral manual would not have been possible without the contributions of many persons and/or organizations.
Therefore, we are very thankful for the following:

To GOD almighty, for which all things are possible.

The Municipal government of Calanasan and the Provincial government of Apayo, for all the support they have given us in the formulation of this manual.

Dr. Makoto Tobe-San, Ms. Marcelyn Dulnuan and all other personnel of JICA, thank you for all the technical support you provided us.

The Department of Health, especially the CHD-CAR, for all the technical advice they gave us which is instrumental in the creation of this referral manual.

The Provincial Health Office of the province of Apayao, for the assistance they provided, especially in organizing meetings between the Interlocal Health Zones and JICA-SSC and CHD-CAR. They provided the avenue for the creation of the MNCHN referral manual.

The municipal health officers of the Rural Health Unit – Calanasan and the chief of ospital of the Apayao District hospital, for providing insights during the creation of this referral manual.

The nurses and midwives of the Rural Health Unit – Calanasan and the Apayao District Hospital, for providing their personal experiences and knowledge regarding MNCHN, which is integral to the finishing and polishing of this referral manual.

Abbreviations

BHS	Barangay Health Station
BNS	Barangay Nutrition Scholar
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 / Intra 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 Office
RHM	Rural Health Midwife
RHU	Rural Health Unit
TCL	Target Client List
TT	Tetanus Toxoid

Glossary of Terms

Community Health Team – a group of individuals who underwent training and act as front liners in the barangay level in providing health information and services to the community

Outcome of referral – the result or manner in which the referral was resolved

Postpartum Care – care package given to women and their babies immediately after delivery and up to 6 weeks after delivery; includes monitoring of the mother and child for signs and symptoms of complications, breast feeding, nutrition, hygiene, birth spacing and family planning counseling and newborn screening for the baby.

Prenatal Care – care package given to pregnant women to ensure adequate health during the pregnancy until delivery; includes check-up, weighting, monitoring of vital signs, Tetanus toxoid administration, Vitamin A and iron supplementation and other services necessary to ensure the health of the mother and the baby

Referral – to direct to a source for help or information

Referring Facility – the point of origin of the referral; otherwise known as the referrer

Referral Facility – the end acceptor of the referral; usually a tertiary or specialty facility

INTRODUCTION

The local health system of the municipality is a dynamic relationship between the health facilities of the municipality (which is the Rural Health Unit and the District Hospitals), the local government and the environment, including the people of the municipality.

A health system is only as excellent as the functionality of the facilities and its ability to deliver care to the population. It is important to note that delivery of healthcare not only means that the facilities should physically deliver the mentioned services but that health facilities should be able to properly assess patients on their needs and, if unable to provide those needed services, they should direct patients to facilities who are able to deliver these needed services. This situation led to the development of the referral system.

The referral system is a way to increase the efficiency of a local health system. It maximizes efficiency by directing patients where the appropriate method of care can be accessed, whether inside or outside the municipality/health system. With a proper referral system, patients are being directed to the BHS or the RHU of the municipality for common ailments while referring patients who need advanced levels of care either to the local hospital or a tertiary of specialty hospital outside of the municipality.

With the finishing of this referral manual, the local health system will boost its capability to deliver health services being able to efficiently assess patients whether they need a referral or not and have baseline knowledge on when and where to refer patients, depending on the current situation.

1. Objectives of the MNCHN referral guideline

Overall objectives

To improve the MNCHN status in the area

Specific objectives

- To support that ALL pregnant women:
  a. Are registered in *Target Client List (TCL)*
  b. Receive and completely fill up the *Family Health Diary*
  c. Receive complete prenatal and postnatal care services
  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
  k. Non-PHIC member indigent pregnant women will receive financial assistance
  l. Should accomplish and understand the agreement based on the appropriate management based on the patient's condition.
  m. Ensure birth registration by the local civil registrar
- To include all women of childbearing age (place in activities).
- To include health workers, facility and other on capabilities on referral.

2. Standard operational procedure of MNCHN referral

2.1. Identification / master listing of pregnant women

Procedure

Service providers	Actions to be taken
Community Health team	- Report to RHM the name of the suspected/confirmed pregnant women - Register women in Pregnancy Tracking Record - Inform women on prenatal care and *Family Health Diary (FHD)*
Rural Health Midwife	Issue *Family Health Diary (FHD)* and assist women to fill out FHD (pp. 1-4) Register women in Target Client List Providecomplete prenatal care/services
Government Hospital	- Provide Family Health Diary and prenatal services and refer to RHU to be registered in the TCL and receive other prenatal services (TT, provision of iron supplements)

2.2. Birth and Emergency Plan

Procedure

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 Assist in the provision on transportation services specially indigent patients
Birthing facilities	Provide prenatal care in the third trimester at where the women plan to deliver Prepare to provide services to womenduring delivery / newborns
Transportation service providers	Prepare to provide services to women

2.3. Pregnant women with identified 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 and prenatal checkup If risk factors are identified: 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

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 and • Provide care to the patientin the referring facility or provide the management based on the recommendation of the referral facility/professional • Prepare means of transportation • Provide information to facility to which the patient is referred • e.g. referral form, Family Health Diary, health workers/ relative accompanying the patients, text message/phone • Transfer the patient to higher level facility • Record information on treatment done by referring facility E.g. referral logbook (out-going), carbon-copy of referral slip, patient record • Collect return slipduring postpartum home visit (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

Procedure

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

Service providers	Actions to be taken
Community Health Team	• Aid the family in completing the birth and emergency plan.
Rural Health Midwife/Public Health Nurse	• Ensure that the family health diary is completely filled up.

3.2. Referral slip (ANNEX A)

Service providers	Actions to be taken
Community Health Team	• Refer patients to health workers for consult and possible referral.
Rural Health Midwife/Public Health Nurse	• Refers patient to higher facility (intra - facility) if appropriate care cannot be provided at the BHS.
Municipal Health Officer/Chief of Hospital/Resident Physician	• Refers patient to higher facility (inter – facility) if appropriate care cannot be provided at the RHU.

3.3. Referral logbook (ANNEX B)

Service providers	Actions to be taken
Rural Health Midwife/Public Health Nurse	• Ensures that the patient is registered at the referral logbook, and data should be updated as necessary.

3.4. Pregnancy tracking form (ANNEX C)

Service providers	Actions to be taken
Community Health Team	• Actively seek out patients who are suspected pregnant. Afterwards, report these cases to the RHM for confirmation • After confirmation of pregnancy, CHT members list the pregnant woman in the pregnancy tracking form
Rural Health Midwife	• Upon referral of the CHT member, RHMs investigate and confirm whether suspected cases are pregnant or not. • Together with the CHT members, ensure that the pregnancy tracking forms are completely filled up.
Public Health Nurse	• Reviews RHMs pregnancy tracking forms, as needed.

3.5. Client list of pregnant women (ANNEX D)

Service providers	Actions to be taken
Community Health Team	• Actively seek out patients who are suspected pregnant. Afterwards, report these cases to the RHM for confirmation • After confirmation of pregnancy, CHT members list the pregnant woman in the pregnancy tracking form
Rural Health Midwife	• Upon referral of the CHT member, RHMs

	investigate and confirm whether suspected cases are pregnant or not. • Together with the CHT members, ensure that the pregnancy tracking forms are completely filled up.
Public Health Nurse	• Reviews RHMs pregnancy tracking forms, as needed.

3.6. Target Client List (FHSIS)

Service providers	Actions to be taken
Community Health Team	• Actively seek out patients who are suspected pregnant. Afterwards, report these cases to the RHM for confirmation. • After confirmation of pregnancy, CHT members list the pregnant woman in the pregnancy tracking form
Rural Health Midwife	• Upon referral of the CHT member, RHMs investigate and confirm whether suspected cases are pregnant or not. • Together with the CHT members, ensure that the pregnancy tracking forms are completely filled up.
Public Health Nurse	• Reviews RHMs pregnancy tracking forms, as needed.

4. Monitoring of referral

4.1. Objectives of monitoring on referral

Timely referral in case of obstetric / newborn emergency
Continuous MNCHN services among various health service providers

4.2. Monitoring Checklist

Service providers	Actions to be taken
Community Health Team	• Assist in the implementation of referrals, especially those contained in the birth and emergency plan.
Rural Health Midwife	• Logs patients in the barangay referral logbook. • Brings barangay referral logbook to the MHC during meetings to discuss referrals.
Public Health Nurse	• Reviews RHMs referrals, especially on appropriateness and promptness.
Municipal Health Officer / Chief of Hospital	• Conducts reviews on referrals. • Conducts activities to improve the referral system in the ILHZ.

5. Transportation and communication

5.1. Transportation

The LGU has an ambulance which is used both by the RHU and ADH. In extreme cases, we use the service vehicle of the RHU, in case the ambulance is unusable.

The LGU currently has no policy governing ambulance and other service vehicle use for patients during emergencies. However, it has been established that the RHU, mandated to safeguard and improve the health of the constituents of the municipality, is fully supported by the LGU by providing both a service vehicle and an ambulance for RHU, both of which can be used for patient transport.

In emergency cases where a patient will be transported from the LGU to a referral hospital, the LGU shoulders the gasoline used in the travel.

5.2. Communication

The LGU uses mobile phones in communicating information. However, in barangays where there is no signal, we sometimes use runners.

There is an ongoing study on the feasibility of handheld short wave radios for use in the municipality.

6. Directories were deleted