RMNCH REFERRAL GUIDELINES

PARTICIPANTS MANUAL

KHYBER PAKHTUNKHWA – HUMAN CAPITAL INVESTMENTY PROJECT

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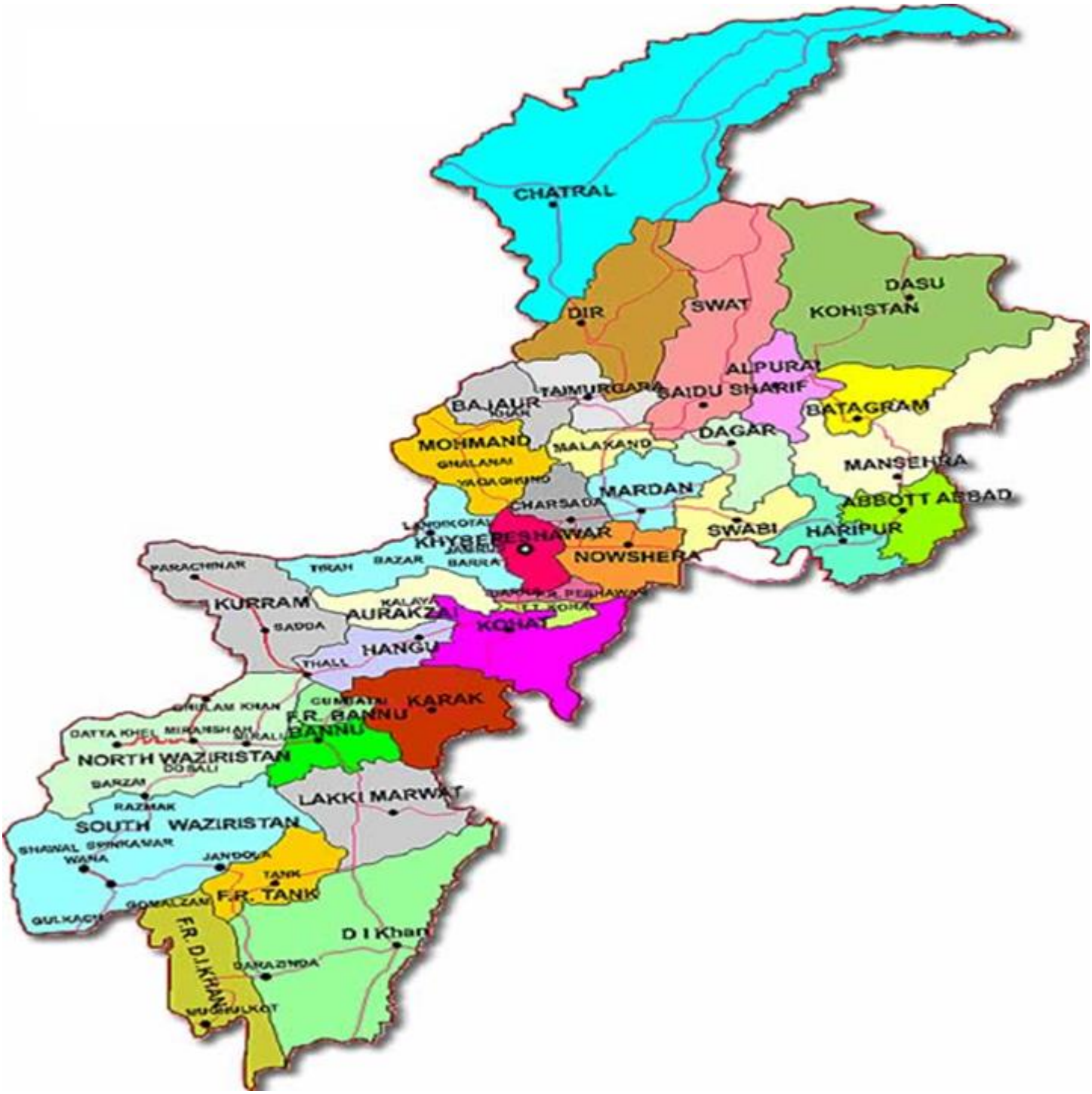
Map of Khyber Pakhtunkhwa



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Acknowledgement:

The *Referral Guidelines Manual for Reproductive, Maternal, Neonatal and Child Health (RMNCH)* has been meticulously developed as part of the Human Capital Investment Project in Khyber Pakhtunkhwa. This manual is designed to provide comprehensive, clear and actionable referral procedures for primary healthcare workers, ensuring a seamless and effective referral system across the region. The primary goal of this manual is to enhance the quality and accessibility of reproductive, maternal, neonatal and child health services by offering structured referral guidelines that are easy to follow. By adhering to these guidelines, primary healthcare providers can facilitate timely and appropriate referrals, ensuring that patients receive the necessary care without unnecessary delays, ultimately saving lives and improving health outcomes.

This manual outlines the roles and responsibilities of healthcare workers, the procedural steps involved in referrals, as well as the logistics and policies required for a smooth referral system. It includes detailed instructions on the minimum health services available at primary healthcare facilities and the referral pathways for cases requiring more advanced care. It emphasizes the importance of coordination between healthcare providers, active community health teams, midwives and other stakeholders in ensuring the effectiveness of the referral system.

In addition to the procedural components, the manual also provides guidance on the proper use of referral forms, slips, logbooks and other essential tools for documentation. Furthermore, it highlights the availability of transportation and communication resources, which are critical for ensuring timely referrals. Notably, the manual incorporates an innovative approach with the provision of free ambulance services to the constituents of Khyber Pakhtunkhwa, which is expected to encourage increased health-seeking behaviors and contribute to better health outcomes.

Through this well-structured and user-friendly manual, primary healthcare workers are equipped with the knowledge and tools necessary to operate the referral system effectively. This effort aims to enhance the overall healthcare delivery in Khyber Pakhtunkhwa and improve the well-being of mothers, children and families throughout the region.

Glossary:

- ANC – Ante Natal Clinic
- BHU – Basic Health Unit
- DoH – Department of Health
- GMP – Growth Monitoring and Promotion
- HCIP – Human Capital Investment Project
- IMNCI – Integrated Management of Neonatal & Childhood Illness
- IYCH – Infant and Young Child Feeding
- LHV – Lady Health Visitor
- LHW – Lady Health Worker
- M&E – Monitoring and Evaluation
- MOH – Ministry of Health
- NGO – Non-Governmental Organization
- PHC – Primary Health Care
- RHC – Rural Health Centre
- THQ – Tehsil Headquarter
- DHQ – District Headquarter
- UNICEF – United Nations Children's Fund
- WHO – World Health Organization

Message from Health Minister, Khyber Pakhtunkhwa

It is with great pleasure that I announce the launch of the *Referral Guidelines Manual for Reproductive, Maternal, Neonatal and Child Health (RMNCH)*, developed for primary healthcare workers across Khyber Pakhtunkhwa. This manual, which is a key component of the World Bank-supported Khyber Pakhtunkhwa Human Capital Investment Project (KP-HCIP), marks an important step forward in our collective efforts to strengthen the healthcare system and improve the health outcomes of mothers, infants and children in our province.

The RMNCH referral guidelines are designed to equip primary healthcare providers with the knowledge and tools necessary to manage referrals effectively, ensuring timely and appropriate care for those in need. This comprehensive resource will help streamline the referral process, reducing delays in care and improving the overall quality of healthcare services. This initiative reflects our continued commitment to achieving Universal Health Coverage (UHC) and aligns with the broader goals of the Sustainable Development Goals (SDGs), particularly in improving maternal, neonatal and child health outcomes.

I would like to express my sincere gratitude to the World Bank Pakistan for their steadfast support in making this project a reality, as well as to the technical experts, healthcare professionals and stakeholders who have contributed to the development of this manual. Your collective efforts are integral to ensuring that every individual in Khyber Pakhtunkhwa has access to the highest standard of care.

I encourage all primary healthcare workers, including clinicians, public health professionals and community health workers, to embrace the guidelines outlined in this manual. By working together, we can ensure that our referral systems are robust and responsive, ultimately improving health outcomes and ensuring a healthier future for the people of Khyber Pakhtunkhwa.

Mr. Ihtisham Ali

Health Minister, Khyber Pakhtunkhwa, Pakistan

Message from the Secretary of Health, Khyber Pakhtunkhwa

It is with immense pride to introduce the *Referral Guidelines Manual for Reproductive, Maternal, Neonatal and Child Health (RMNCH)*, a crucial resource for primary healthcare workers across Khyber Pakhtunkhwa. Developed as part of the World Bank-supported Khyber Pakhtunkhwa Human Capital Investment Project (KP-HCIP), this manual is a vital step in our ongoing efforts to improve healthcare services and outcomes for mothers, infants and children throughout the province.

The RMNCH referral manual is not only a practical tool for healthcare providers but also a reflection of our commitment to advancing Universal Health Coverage (UHC) and addressing the health needs of our most vulnerable populations. The manual offers clear, evidence-based guidelines on referral procedures, ensuring that healthcare workers are able to respond swiftly and accurately to the needs of mothers and children in urgent situations.

I encourage all healthcare professionals in the province, from clinicians to community health workers, to fully engage with this manual. Your active participation in following these guidelines will be essential in strengthening the referral system and ensuring that every mother and child receives the care and support they deserve.

Together, we can build a more responsive and effective healthcare system in Khyber Pakhtunkhwa, creating a future where all individuals, especially mothers and children, have access to the highest standards of care. I extend my gratitude to all those who have contributed to the development of this manual and I look forward to seeing its positive impact in our communities.

Mr. Shahid Ullah
Secretary of Health, Khyber Pakhtunkhwa, Pakistan

Message from the Director General Health Services, Khyber Pakhtunkhwa

As we continue to progress towards achieving Universal Health Coverage (UHC) in Khyber Pakhtunkhwa, it is imperative that we focus on strengthening the healthcare systems that serve our most vulnerable populations. Among the critical areas of concern are reproductive, maternal, neonatal and child health (RMNCH), where timely and effective referrals are vital to ensuring the best health outcomes for mothers and children.

It is with great pleasure that I announce the launch of the *Referral Guidelines Manual for RMNCH*, developed for primary healthcare workers in Khyber Pakhtunkhwa under the World Bank-supported Human Capital Investment Project (KP-HCIP). This manual provides a comprehensive and practical guide that will empower healthcare providers with the necessary tools to ensure a streamlined, efficient and effective referral process. This manual is designed to equip primary healthcare workers with the knowledge to identify cases that require referral, communicate effectively and facilitate access to higher levels of care, reducing delays and improving patient outcomes.

I would like to extend my heartfelt thanks to the World Bank for their invaluable support and to all stakeholders and technical consultants who contributed to the development of this important resource. Their collaboration has been crucial in ensuring that we have a system in place that prioritizes the health and well-being of our province's most vulnerable populations.

Together, we can make a meaningful impact on maternal and child health and work towards a healthier and more prosperous future for our communities. Let us continue to work together to ensure that every mother and child receives the care and support they deserve.

Dr. Shahid Yunis

Director General Health Services, Khyber Pakhtunkhwa, Pakistan

Message from Project Director, (KP-HCIP)

As the Project Director of the Khyber Pakhtunkhwa Human Capital Investment Project (KP-HCIP), I am proud to announce the launch of the *Referral Guidelines Manual for Reproductive, Maternal, Neonatal and Child Health (RMNCH)*, a crucial resource that aims to strengthen the referral system within our province's primary healthcare settings. This manual, developed under the World Bank-supported initiative, represents a significant step forward in enhancing the quality of healthcare services for mothers, infants and children, ensuring that they receive timely and appropriate care when needed.

The RMNCH referral guidelines are designed to empower primary healthcare workers with the knowledge and tools necessary to manage patient referrals efficiently. With clear, evidence-based procedures for identifying, documenting and referring cases that require higher-level medical attention, this manual will improve the overall functioning of our healthcare system, ensuring that critical cases are addressed promptly. This initiative is key to tackling the challenges that come with maternal and child health, where delays in referrals can have serious consequences.

I would like to extend my sincere appreciation to the World Bank for their continued support, as well as to the technical advisor Dr. Muhammad Imran Marwat and all stakeholders who contributed to the development of this manual. This collaborative effort marks a key milestone in our ongoing commitment to improving health outcomes in Khyber Pakhtunkhwa. I urge all primary healthcare workers, from clinicians to community health teams, to fully embrace these guidelines, which will play a vital role in delivering better, more coordinated care to those who need it most.

Dr. Muhammad Bilal
Project Director, KP-HCIP, Pakistan

Message from the Deputy Project Director

As part of our ongoing commitment to advancing healthcare services in Khyber Pakhtunkhwa and ensuring equitable access to quality care, I am pleased to announce the launch of the *Referral Guidelines Manual for Reproductive, Maternal, Neonatal and Child Health (RMNCH)*. This manual is a significant step in strengthening the referral system within our primary healthcare settings, ensuring that mothers, infants and young children receive the timely and appropriate care they need for optimal health outcomes. Developed under the World Bank-supported Khyber Pakhtunkhwa Human Capital Investment Project (KP-HCIP), this initiative reflects our dedication to improving healthcare delivery at all levels.

The RMNCH Referral Guidelines Manual is an essential resource that will guide primary healthcare workers in identifying, documenting and referring patients who require specialized care. With a clear set of evidence-based procedures and a focus on streamlining referrals, this manual ensures that critical cases are managed efficiently, reducing delays and improving health outcomes. By equipping healthcare workers with practical tools and knowledge, we are enhancing the quality of care provided to vulnerable populations, especially mothers and children, at the community level.

I would like to extend my deepest gratitude to all the stakeholders, including the Health Department, development partners and technical experts, who have contributed to the development of this manual. Their collective efforts are instrumental in ensuring the success of this initiative. I urge all primary healthcare workers to actively engage with these guidelines, as they are key to improving the effectiveness of our referral system and, ultimately, the health and well-being of mothers and children across Khyber Pakhtunkhwa. Together, we can create a healthcare system that is responsive, efficient and accessible to all.

Dr. Sumaira Saeed
Deputy Project Director, KP-HCIP, Pakistan

Introduction to the Manual

The Khyber Pakhtunkhwa department of health (DoH) is committed in improving the quality of life for all by providing comprehensive, affordable, culturally appropriate and accessible healthcare. In line with this commitment, a Referral Manual for Maternal and Child Health has been developed to ensure the smooth operation of the referral system. The manual outlines clear guidelines, goals, responsibilities, procedures and logistics to be followed, which, when implemented effectively, will not only save lives but also ease the financial burden on communities.

This referral manual has been designed from national and international guidelines to ensure, it is user-friendly. It includes comprehensive Standard Operating Procedures (SOPs), providing detailed information on the minimum health services available at primary healthcare facilities. This ensures easy access to health services, supported by LHVs, Midwives and LHWs, all of whom play vital roles in the referral process.

Essential documents, such as referral forms, slips, logbooks and other necessary logistics, are readily available when needed. Furthermore, provisions for transportation and communication are integral to the success of the referral system. A notable feature of this system is the free ambulance service provided by Rescue 1122 to the residents of Khyber Pakhtunkhwa, which will enhance health-seeking behavior and contribute to saving lives in the region.

This manual is a crucial tool for primary healthcare workers in Khyber Pakhtunkhwa, ensuring that they can effectively manage referrals and deliver timely, life-saving care to the community.

Purpose:

This training manual is designed to guide the establishment of an effective referral system within primary healthcare settings in Khyber Pakhtunkhwa province, Pakistan, under the HCIP project funded by the World Bank. It offers a thorough understanding of the importance and benefits of a well-functioning referral system and presents best practices for its development. The manual emphasizes how such a system can enhance healthcare delivery in urban areas, where primary healthcare services are often underutilized and higher-level facilities face overcrowding. It details the step-by-step process of implementing the referral mechanism, focusing on strengthening the existing referral network within the government framework. The goal is to improve the overall efficiency and accessibility of health services in the region.

Key Terms and Definitions

1. **Back Referral**: The process in which the receiving facility sends the client back to the initiating facility with information about the services provided and any required follow-up. This completes the referral loop between the two facilities.
2. **Counter-Referral**: The process where patients directly reach a facility, receive the necessary treatment and are then referred by the facility staff to their respective Primary Healthcare Facilities.
3. **Facilitated Referral**: A referral process where each beneficiary is guided through a specific protocol. This includes proper information transfer (referral slip, counseling), feedback and tracking (completion of the referral loop) and addressing barriers (such as geographical, financial, etc.).
4. **Initiating/Referring Facility**: The facility (e.g., organization, clinic) that initiates the referral process. It is where the referral is prepared to communicate the client's condition and status.
5. **Initiating/Referring Service**: The type of service from which the referral is initiated (e.g., family planning, antenatal care, or general primary care).
6. **Receiving Facility**: The facility (e.g., organization, clinic) that accepts the referred client's case and provides the necessary services.

7. **Receiving Service**: The type of service to which the client is referred (e.g., family planning, antenatal care, or HIV testing and counseling).
8. **Referral**: A process in which a health worker at one level of the health system, with insufficient resources (e.g., drugs, equipment, skills), manages a clinical condition and seeks assistance from a better-resourced facility at the same or higher level to either assist in or take over the management of a client's case.
9. **Referral Network**: The interconnected group of service providers among which referrals are made. Referral systems integrate networks of service providers to ensure efficient and coordinated care.
10. **Referral Protocols/Healthcare Pathways**: For each specific clinical condition or service, the referral system outlines multiple stages of management. This pathway provides a predefined map for beneficiaries and health providers, detailing what, where, whom and how to manage the condition within the spectrum of illness to health and well-being.

Objectives of the RMNCH Referral Guideline

The RMNCH referral guidelines aim to improve the overall care provided to pregnant women, postpartum mothers and newborns, especially in emergency situations. These guidelines are designed to ensure timely and effective referrals between health facilities, as well as continuous care throughout the prenatal, delivery and postpartum periods.

A. Overall Objectives:

- **Timely Referral in Emergencies**: Ensure the prompt referral of pregnant women, postpartum mothers and newborns in case of emergencies to appropriate health facilities.
- **Enhanced Information Sharing**: Improve the flow of information between health facilities and health workers to provide continuous and coordinated prenatal, delivery and postpartum care.

B. Specific Objectives for Pregnant Women:

- **Registration and Tracking**:
  - Ensure all pregnant women are registered with health facility.
- **Comprehensive Prenatal Care**:
  - Guarantee that every pregnant woman receives complete and essential prenatal services.
- **Birth and Emergency Planning**:
  - Encourage every pregnant woman to create a birth and emergency plan to ensure preparedness in case of complications.
- **Timely Transportation in Emergencies**:
  - Ensure that pregnant women have access to timely transportation to health facilities in emergencies.
- **Skilled Attendance at Delivery**:
  - Ensure that all deliveries take place at health facilities attended by trained health professionals.
- **Emergency Obstetric Care**:
  - Provide emergency obstetric care when necessary to manage complications during delivery.
- **Postpartum Services**:
  - Ensure that all women receive appropriate postpartum care following delivery.
- **Community Health Team Support**:
  - Provide continuous support from the community health team (LHW/Dai/) to ensure consistent care.
- **Referral for Complications**:
  - If complications arise, ensure the pregnant woman is referred to a higher level of care for further management.
- **Post-delivery Referral for Continuity of Care**:
  - After delivery, refer women back to primary healthcare facility for continuous follow-up care.

C. Specific Objectives for Newborns:

- **Essential Newborn Care**:
  - Provide every newborn with essential newborn care immediately after birth.
- **Emergency Newborn Care**:
  - Ensure that newborns receive emergency care if they experience health complications.
- **Referral for Complications**:
  - In cases of complications, ensure that newborns are referred to a higher level of care for specialized treatment.
- **Post-delivery Referral for Immunization**:
  - Ensure that newborns are referred back to the primary healthcare facility for regular immunizations and follow-up care.

Target audience:

The primary target audience for the MCH Referral Guidelines training includes frontline primary healthcare providers such as Medical Officers, Lady Health Visitors (LHVs) and Medical Technicians**.** These healthcare workers play a pivotal role in the early identification, initial management, stabilization, and timely referral of maternal and child health conditions at the primary care level. Medical Officers are responsible for clinical assessment, decision-making, and initiation of referrals, while LHVs and Medical Technicians provide essential frontline care, counselling, and follow-up support for mothers and children. Strengthening the capacity of these cadres is critical to improving the effectiveness of referral pathways, reducing delays in care, and ensuring alignment with national MCH policies and internationally accepted standards**.**

MODULE ONE

INTRODUCTION TO REFERRALS IN A PRIMARY HEALTHCARE SETTINGS

INTRODUCTION:

Referral in Health Systems

Referral is a process in which a health worker at one level of the health system, with limited resources (such as drugs, equipment, or skills), manages a clinical condition and seeks assistance from a more equipped facility, either at the same level or at a higher level, to either support or take over the management of the client's case. Key reasons for referring a patient, whether in an emergency or routine situation, include:

- Seeking expert opinion regarding the client's condition
- Requesting additional or specialized services for the client
- Arranging for admission and further management of the client
- Accessing diagnostic and therapeutic tools that may not be available at the referring facility

In Pakistan, like most countries, the health system follows a hierarchical structure, starting with primary healthcare facilities, moving to secondary care centers and progressing to tertiary care facilities that provide highly specialized services. However, in many developing countries, including Pakistan, health referral systems across various levels of care are often weak, which hampers the overall effectiveness and performance of the health system.

An effective referral system ensures strong connections between each level of healthcare delivery (primary, secondary and tertiary). It helps in the optimal use of health services by guiding patients to the appropriate facilities based on their preferences, proximity, or both.

To build a strong referral system in Pakistan, the following considerations are crucial:

- Patients should receive the right care, at the right time and at the right cost.
- Health resources should be utilized in an optimal and cost-efficient manner.
- Specialist services should be used appropriately and efficiently for patients who require them.
- Primary healthcare services should be maximally utilized to meet community health needs.

Current Situation of the Referral System in Khyber Pakhtunkhwa Province

The existing referral system in Khyber Pakhtunkhwa, like in many other regions, relies on patients first accessing primary health care services, after which they are referred to higher levels of care when their health needs surpass the capabilities of the primary care facility. However, this ideal system faces significant challenges that undermine its efficiency and effectiveness.

One of the primary issues is that many patients bypass the primary care level entirely. This is often due to a lack of awareness or understanding of the referral process. Patients may not fully comprehend the importance of seeking care at the first level or may be unaware of the appropriate steps to take. Furthermore, inadequate infrastructure and resources in primary health care facilities contribute to this issue. In some areas, the quality of care at the primary level is perceived as subpar, leading patients to seek care directly at higher-level facilities, such as district or tertiary hospitals. This results in overcrowding at these facilities and delays in care for those who truly need it.

Additional factors contributing to the inefficiency of the referral system include the absence of clear and standardized procedures for making referrals. Without a uniform protocol, referral processes can become inconsistent, leading to confusion and errors. The failure to use formal referral forms or documentation is another problem. These forms are vital for ensuring that relevant patient information, including medical history and current condition, is properly communicated to higher-level care providers, allowing for continuity of care and reducing the chances of misdiagnosis or delayed treatment.

Furthermore, referred patients often experience a negative perception of the referral system. They may view the referral process as bureaucratic, burdensome, or unnecessary, especially if they do not understand its purpose or are dissatisfied with the services at the receiving facility. This perception can reduce the willingness of patients to comply with referrals, further undermining the effectiveness of the system.

A major weakness in the referral system is the lack of feedback loops. Feedback from higher-level care facilities back to the primary care providers is often missing, making it difficult to track patient progress or ensure that patients receive appropriate follow-up care. Without feedback, primary

care providers may not know whether their referrals were successful, leaving them in the dark about the effectiveness of their interventions.

If these inefficiencies are not addressed, the broader health system will continue to suffer. For instance, the success of the Sehat Card Plus KP Insurance Scheme, which advocates for a mechanism to reduce unnecessary health care costs, depends heavily on an effective referral system. If patients are bypassing the primary care level and not adhering to referrals, the system will become overwhelmed with unnecessary visits to higher-level facilities, leading to increased healthcare costs. This, in turn, could strain mutual health schemes and ultimately, cause their collapse.

To address these challenges, there is an urgent need for comprehensive reform of the referral system in Khyber Pakhtunkhwa. This includes improving public awareness of the referral process, standardizing referral procedures, ensuring the use of proper documentation, enhancing the perception of primary care and establishing effective feedback mechanisms. Addressing these inefficiencies will not only enhance patient care but also contribute to the sustainability and success of health insurance programs.

Healthcare Referrals

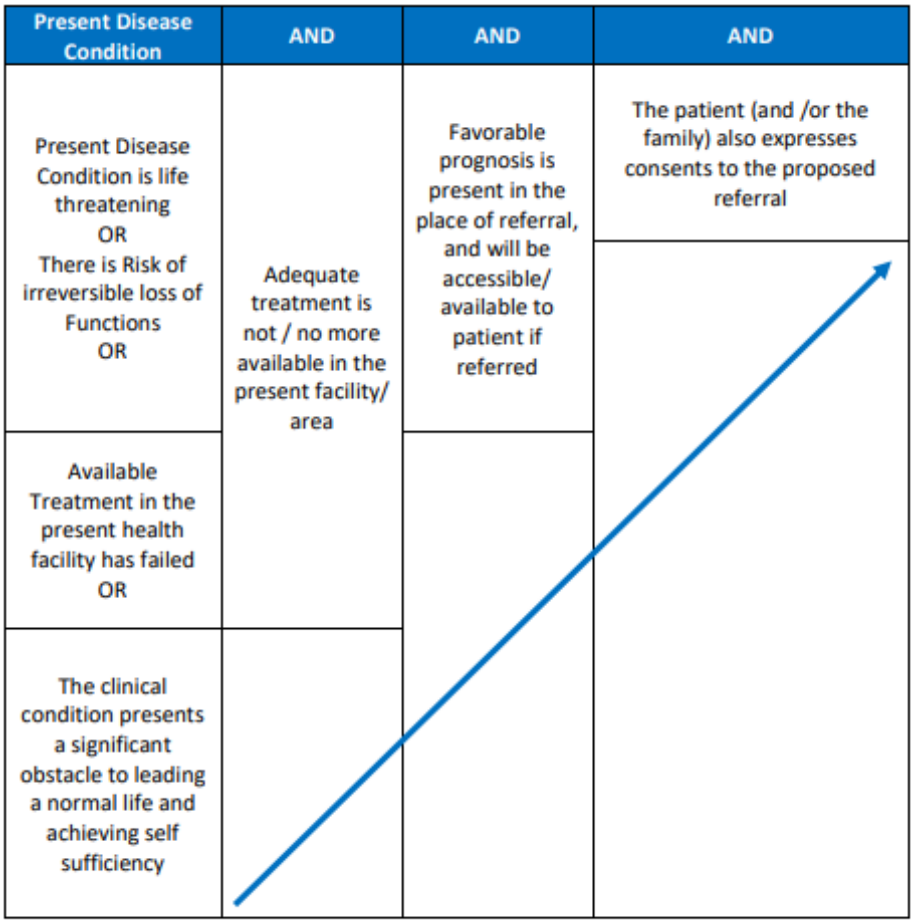
Referrals in healthcare involve the transfer of responsibility for a patient's care from one healthcare provider or facility to another, either temporarily or permanently and for a specific purpose. This purpose could range from investigations, consultations, specialized care, or further treatment that a patient may require. The referral process ensures that patients, initially seen at primary healthcare facilities (the first level of care) are promptly transferred to higher levels of care (secondary or tertiary), if necessary. Similarly, once a patient's condition has been addressed, they should be referred back to the primary facility for ongoing care or follow-up.

The referral system relies on cooperation, coordination and efficient transfer of information across various levels of service delivery. It is critical to maintain seamless communication between health providers to ensure that the patient receives the best possible care at every level.

A. Reasons for Referrals

Referrals serve several purposes, ensuring that patients receive appropriate and comprehensive care. Common reasons for making a referral include:

1. **Obtaining the opinion or advice of another healthcare provider** – For specialized or second opinions.
2. **Co-management of a case** – Collaboration between different specialists or departments to manage complex medical cases.
3. **Further management or specialized care** – When a patient's condition requires advanced treatment or specialized medical attention beyond the scope of the initial facility.



(Construed from Standard Operating Procedures of Medical referral of Persons of Concern in Ethiopia, UNHCR March, 2015)

Pre-Conditions for a Referral

B. Types of Referrals

Referrals can be categorized into three primary types:

Type of Referral	Description
External Referrals	Involve the transfer of patients from one health facility to another **outside the healthcare system** or **outside the local area**. May include referrals to higher-level facilities or specialists for specialized care.
Internal Referrals	Made **within the same health facility**, usually between departments or units. Includes referrals to different specialists or services not available in the initial department.
International Referrals	Occur when patients require care **unavailable within the country**. Patients are referred to **international facilities** for specialized treatment or surgeries.

a. External Referral System

External referrals are crucial for ensuring that patients receive the necessary care when their condition exceeds the capacity of the initial healthcare facility. External referrals include:

i. Pre-hospital Emergency Referrals

These are referrals initiated before a patient reaches a healthcare facility, typically in emergency situations. Pre-hospital referrals may involve:

- Ambulance Services (National, Private or other services)
- Community Field Workers etc. (LHWs or other community workers)

ii. Facility-to-Facility (Inter-facility) Referrals

These involve the transfer of patients between different healthcare institutions, ensuring that patients are referred from one facility to another based on the severity of their condition. Facility-to-facility referrals include transfers from:

- Teaching Hospitals
- Private Healthcare Providers (including private clinics and practitioners)
- Non-Government Hospitals
- National Ambulance Service (1122)
- Other healthcare institutions

b. Internal Referral System

Internal referrals occur within a single healthcare facility, ensuring that patients receive care from specialized departments or units. This internal transfer could involve:

i. **Referral between different departments:** For example, from general medicine to surgery or from obstetrics to gynecology unit.
ii. **Within the same department:** A patient may need to be referred for further tests or specific care within the same department.
iii. **Referral between units:** Within the same facility, a patient might need to move from one unit, such as the emergency department, to a specialized care unit, like intensive care.

C. General Principles for Referrals

a. Organizing for Referral

The effective implementation of a referral system requires clear guidelines and structures:

1. **Availability of Referral Policies and Guidelines:** All health facilities should have access to the National Referral Policy and Free Maternal Care Policy. These should be made available in all health units and departments to guide the referral process.
2. **Two-Way Referral System:** A robust referral system requires both upward (from lower to higher-level facilities) and downward referrals (from higher to lower-level facilities). This ensures continuity of care and appropriate management at every level.
3. **Facility Directory:** The Ministry of Health should prepare and distribute a directory of available healthcare facilities and services, ensuring all health providers are well-informed and that referrals are directed to facilities with the necessary capabilities. This directory should be updated annually.
4. **Monitoring and Evaluation:** Registers for tracking and evaluating both internal and external referrals should be maintained in all health facilities to monitor effectiveness and identify areas for improvement.

b. Referral Process

The process for referrals is critical for ensuring that all relevant information is communicated effectively:

1. **Standard Referral Form:** Every patient referred must be accompanied by a completed standard referral form. This form ensures the transferring facility provides all necessary patient details to the receiving facility, which helps ensure continuity of care.
2. **Information on the Referral Form:** The standard referral form must include vital patient information, including:
    - Personal details (name, age, sex, contact information)
    - Health insurance status (if applicable)
    - Clinical history and examination findings
    - Diagnosis, treatments given and results of relevant investigations

- Referring facility contact details (address and phone number)
- Date and time of the referral
- Urgency of the referral and the reason for it.

3. **Completion by Referring Practitioner:** The referring healthcare provider must fill out the referral form, including their name, signature and stamp (if available), ensuring the form is legally completed and comprehensive.
4. **Adherence to Policies:** All referrals must adhere to the National Health and Maternal Care Policies. All referrals, whether from public or private health institutions, must align with the Ministry of Health's Referral Policy Guidelines.

c. Communication of Patient Care and Transportation

Efficient communication and transportation are vital components of the referral process:

1. **Prior Communication:** Whenever possible, the referring facility should communicate directly with the receiving facility prior to the patient's transfer. This could be done via telephone, email, radiophone, or fax. The communication should include:
    - Patient identification (name, age, sex)
    - Presenting complaints and examination findings
    - Investigations carried out
    - Diagnosis and treatment provided
    - Date and time of referral
2. **Transporting Patients:** Patients should be transported using the most suitable means available, typically via an ambulance equipped to handle the patient's medical needs. If an ambulance is used, the referring facility must also arrange for the return of the healthcare provider involved in the transfer.

d. Feedback Mechanism

Feedback is a critical element of the referral process, ensuring that the referring facility is updated on the patient's progress:

1. **Feedback to Referring Facility:** The receiving facility must provide feedback to the referring facility. This feedback should include any additional treatment provided, further management plans and whether the referral was successful.
2. **Continuation of Care:** If appropriate, the attending healthcare provider at the receiving facility should refer the patient back to the original facility for ongoing care, particularly for follow-up treatments or monitoring.
3. **Clear Details on Feedback Forms:** Feedback forms must clearly specify ongoing management, required therapies and any necessary follow-up appointments. This ensures continuity of care and effective collaboration between healthcare providers.

Components of a Referral System

A well-structured referral system across all levels of healthcare helps ensure smooth patient referrals between government and private healthcare providers. When properly implemented, such systems contribute to high-quality care and the optimal use of medical services and resources. An effective referral system is essential to quality healthcare, as it helps reduce costs and enhances patient outcomes.

Key components of a referral system include:

- **Referral Decision**: This is the clinical decision made by healthcare providers (e.g., doctors, nurses) to determine if a referral is necessary and if so, which level of care the referral should be made to (e.g., primary, secondary, tertiary).
- **Referral Communication**: This refers to the interaction and exchange of information between the referring and receiving healthcare providers once the referral decision has been made. It ensures that the referral provider understands the patient's condition and needs.

For a referral system to function efficiently, both components—**Referral Decision** and **Referral Communication**—must be prioritized and implemented effectively. A strong referral system contributes to the provision of high-standard medical care, ensuring safety, efficiency and effectiveness in healthcare delivery.

Component	Description
Referral Decision	A clinical judgment made by healthcare providers about the need for a referral and its appropriate level.
Referral Communication	The exchange of information between referring and receiving healthcare providers to ensure seamless care.

By focusing on these components, a well-functioning referral system can optimize healthcare provision within a government health setup, improving both efficiency and patient outcomes.

The Global Scenario: Referral Systems in Developed vs. Developing Countries

Referral System in Developed Countries	Referral System in Developing Countries
Healthcare is mostly insurance-driven.	Healthcare is largely funded by the government or paid out-of-pocket by patients.
People primarily use public healthcare, making regulation easier.	People have almost equal access to both public and private healthcare, making regulation more difficult.
General Practitioners (GPs) act as gatekeepers and patients need a referral from their GP to access higher-level facilities.	Medical Officers at Primary Health Centers are responsible for referrals, but patients can often access higher-level facilities directly, weakening the referral process.
Referral guidelines are clearly defined, ensuring efficient implementation.	Referral guidelines exist but are weakly implemented due to various challenges.

Healthcare Facility Utilization

1. In developing countries, fewer than 40% of patients seeking care at tertiary level facilities are referred from lower-level facilities.
2. Over 60% of patients directly access higher-level facilities without a referral.
3. More than 50% of the patients being treated at the tertiary level could have received appropriate care at lower-level **facilities.**

Most health initiatives emphasize behavior change at the community level to encourage people to seek care. However, referral mechanisms focus on changing the behavior of caregivers and healthcare managers, ensuring that care is patient-centered, respectful, safe, appropriate and of high quality.

The referral system in rural Pakistan is formally organized. A Basic Health Unit (BHU) or Rural Health Centre (RHC) with a qualified Medical Officer serves as the first point of contact for the community. The Medical Officer can refer cases to rural hospitals based on medical needs. Cases from rural hospitals can then be referred to district hospitals or higher-level facilities as required. While the implementation of this system remains weak in rural areas, it is significant that the referral framework is clearly established within the rural health system.

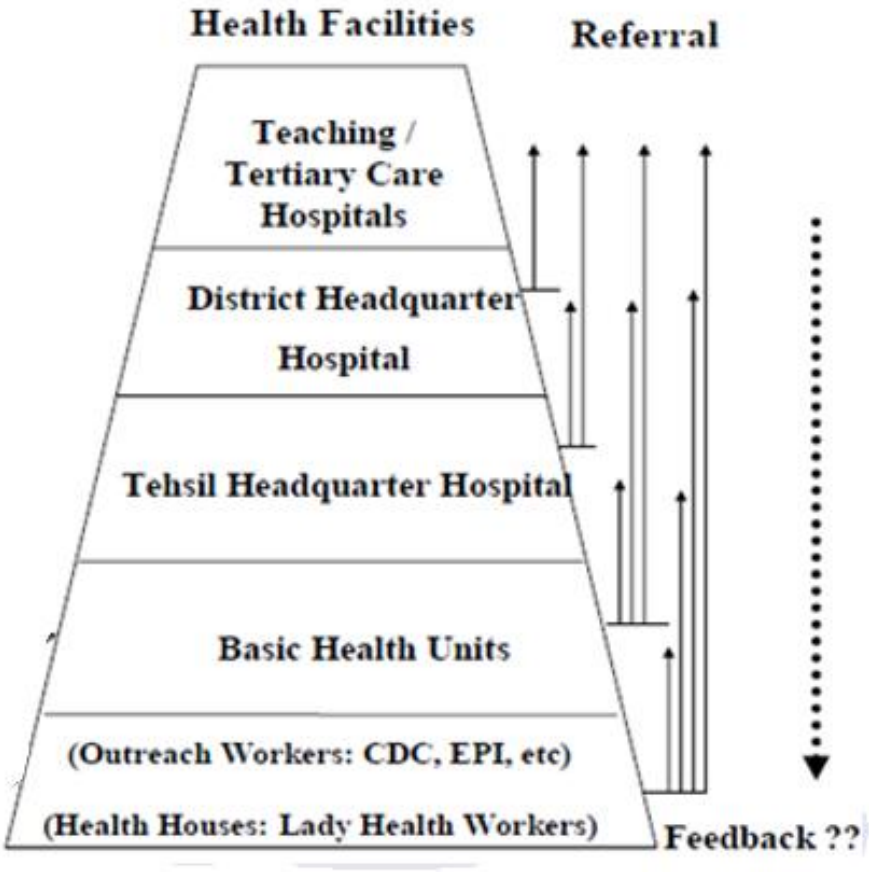


Figure: Pakistan's Healthcare Facilities and Referral System Structure

Minimum Service Delivery Standards of Khyber Pakhtunkhwa Health Care Commission:

The Minimum Service Delivery Standards (MSDS) prescribed by the KP Healthcare Commission, under its regulatory framework, provide clear mechanism and SOPs regarding referring any type of patients to other hospitals for specialized care. The following provisions are relevant and are to be followed mandatorily by the HCEs while making referrals of the patients:

Standard & Indicators	Relevant Provision
Care of Patients (COP-1): Standard 22 Indicator 79, 81	• Discharge to home or transfer to another organization must be documented. • The referral record must include advice and information for both the patient and the receiving clinician or facility, ensuring proper support, recovery, ongoing treatment and follow-up as clinically required.
Care of Patients (COP-3): Standard 24 Indicator 87, 88, 89	• The healthcare establishment (HCE) must define and display whether it can care for high-risk obstetric cases and their neonates can be cared for or not. • The hospital must inform obstetric patients of the risks and its ability to handle high-risk cases. • The hospital must inform practitioners and referring facilities about its capability to care for high-risk obstetric cases.
Information Management System (IMS-1): Standard 13 Indicator 40	• When a patient is transferred, the medical record must include the date of transfer, the reason for the transfer and the name of the receiving hospital. • The referral medical record must contain the results of any diagnostic investigations, treatments rendered before transfer and the clinical status of the patient.

Recognizing Maternal and Child Danger Signs for Immediate Referral

Introduction:

Referral is one of the most powerful, life-saving actions in Reproductive, Maternal, Newborn and Child Health (RMNCH). Across the continuum of care—from pregnancy to childbirth and the postnatal period—many maternal and newborn deaths occur because complications are not recognized early, referral decisions are delayed, or referrals are not completed (transport, communication and receiving-facility readiness). As frontline and managerial healthcare professionals, our responsibility is not only to provide care, but also to ensure that clients who require higher-level services reach the right facility immediately and safely.

Antenatal care (ANC) visits are not routine "tick-box" checkups; they are critical opportunities to detect danger signs, identify risk factors and prevent complications before they become fatal. A pregnancy may become "complicated" when the mother or baby is at increased risk due to past obstetric history, current medical conditions, or emerging warning signs. Such pregnancies require enhanced monitoring, timely counseling and often planned delivery at a facility capable of comprehensive emergency obstetric and newborn care. During history-taking and examination, providers should stay alert for risk factors that increase the likelihood of complications (e.g., previous stillbirth or early neonatal death, prior postpartum hemorrhage, previous assisted delivery, grand multiparity, suspected pelvic disproportion, significant pelvic deformities, or major obstetric trauma). Identifying these risks early allows appropriate birth planning and timely referral when needed.

However, risk factors alone are not enough. Most maternal and neonatal deaths occur around the time of delivery and in the first days after birth. Therefore, safe delivery practices—supported by skilled birth attendance, emergency preparedness and rapid identification of complications—are essential for reducing morbidity and mortality. In practical terms, this means: when a danger sign appears during pregnancy, labor, or postpartum, the client must be referred immediately to the nearest appropriate higher facility (e.g., THQ/DHQ/tertiary hospital depending on severity and

service availability). The goal is not simply “referral,” but effective referral: timely decision-making, initial stabilization, safe transport and clear communication with the receiving facility.

The neonatal period (first 28 days) is especially critical for child survival. Immediate newborn care—including thermal protection, early initiation of breastfeeding and rapid assessment of the newborn’s condition—can prevent many deaths. Yet, when newborn danger signs emerge (poor feeding, lethargy, fever/hypothermia, breathing difficulty, convulsions, or signs of infection), the window for action is extremely short. In such cases, the correct response is rapid assessment, urgent stabilization and immediate referral to a facility with newborn care capacity.

This session links maternal and newborn/child care into one integrated referral approach. Participants will learn how to recognize priority danger signs across the RMNCH continuum and apply structured decision-making to determine:

1. Who needs urgent referral?
2. Where should they be referred?
3. What pre-referral actions are essential to ensure safety?
4. How to communicate clearly and document effectively?

In addition, the session will reinforce patient counseling skills so that families understand danger signs and seek care promptly, especially for conditions that can worsen rapidly (e.g., severe bleeding, eclampsia, sepsis, obstructed labor and serious newborn infections).

Important note for participants: For detailed referral pathways, checklists and facility-level guidance, please read the RMNCH Participant Manual available on the Khyber Pakhtunkhwa Department of Health website:

Link: https://www.healthkp.gov.pk/downloads/view/7

1. Continuum of Care: When Referral Must Be Immediate

RMNCH referral is not limited to one stage of care. Referral decisions must be made promptly at each stage:

A. **Antenatal Period (Pregnancy)**

During ANC, danger signs may indicate hypertensive disorders, hemorrhage, infection, anemia complications, or threatened preterm labor—each requiring timely escalation. Referral is indicated when the condition requires diagnostics, monitoring, medications, or specialist care unavailable at the current facility. Providers must act immediately when warning signs suggest risk to maternal life (e.g., severe bleeding, convulsions, severe headache with visual changes, severe abdominal pain, high fever, breathlessness) or fetal compromise (e.g., reduced/absent fetal movements, suspected growth restriction, abnormal fetal heart rate, malpresentation close to term with additional risks).

B. **Intrapartum Period (Labor and Delivery)**

Safe delivery depends on preparedness for complications. Referral is urgent when labor becomes prolonged or obstructed, when there is suspected uterine rupture, severe pre-eclampsia/eclampsia, fetal distress, malpresentation requiring operative delivery, severe bleeding, or any situation where operative intervention or blood transfusion may be needed but is not available on site. Timely referral during labor prevents maternal shock, fetal hypoxia and avoidable stillbirths.

C. **Postnatal Period (Mother and Newborn)**

The postpartum period carries major risks such as postpartum hemorrhage, sepsis, hypertensive crises, thromboembolic events and postpartum depression with self-harm risk. For newborns, the highest-risk conditions include breathing difficulties, hypothermia, sepsis and feeding failure. Referral should be immediate for heavy bleeding, high fever with foul-smelling lochia, severe abdominal pain, convulsions, severe headache/visual disturbance, breathlessness, or collapse in the mother. For newborns, referral is urgent

when there is inability to feed, lethargy/unresponsiveness, fever or low temperature, fast or difficult breathing, chest indrawing, convulsions, jaundice in the first 24 hours or severe jaundice, or any signs of severe infection.

2. Brief Introduction to IMNCI and Referrals of Cases with Very Severe Disease

The Integrated Management of Neonatal and Childhood Illness (IMNCI) is a WHO/UNICEF-supported approach that combines preventive and curative strategies for common illnesses in newborns and young children. IMNCI provides a systematic "Assess–Classify–Treat/Counsel" framework to ensure that children receive appropriate care based on clinical severity and age group.

A core strength of IMNCI is its color-coded classification system, which guides decision-making quickly:

- Pink classification: Severe illness—urgent referral/admission required.
- Yellow classification: Needs specific treatment (often outpatient) plus caregiver counseling and follow-up.
- Green classification: No specific medical treatment needed; provide home care advice and counseling.

In referral practice, the Pink row is non-negotiable: it indicates that a child is at high risk of rapid deterioration and requires immediate referral to an inpatient-capable facility. Before referral, providers should focus on rapid stabilization (keeping the baby warm, preventing hypoglycemia, maintaining airway/breathing as needed and arranging safe transport) and ensuring the caregiver understands the urgency.

IMNCI also standardizes key clinical thresholds. For example, fast breathing varies by age:

- 0–59 days: ≥60 breaths/min
- 2–12 months: ≥50 breaths/min
- 12 months–5 years: ≥40 breaths/min

Recognizing these thresholds supports early detection of pneumonia and serious illness and strengthens appropriate referral decisions—particularly when combined with other danger signs (poor feeding, lethargy, fever/hypothermia, convulsions, severe chest indrawing).

Session Objectives (RMNCH Referral Guidelines)

By the end of this session, participants will be able to:

A. Maternal Referral Objectives

1. Identify maternal danger signs during antenatal, intrapartum and postnatal periods that require immediate referral to a higher facility.
2. Differentiate risk factors vs. emergency danger signs and apply referral decision-making based on severity and facility capability.
3. Initiate essential pre-referral actions (initial assessment, stabilization, documentation, communication and safe transfer arrangements).

B. Newborn & Child Referral Objectives

4. Recognize newborn and young infant danger signs (0–2 months) requiring urgent referral, including signs suggestive of possible serious bacterial infection/very severe disease.
5. Apply IMNCI classification principles and clearly explain that Pink classification requires urgent referral/admission, while Yellow/Green require treatment/counseling and follow-up.
6. Use age-specific respiratory thresholds to identify fast breathing and determine when referral is required

Section 1: Maternal Referral Guidelines as per PCPNC protocols

Table: Assessment of female with danger signs:

SIGNS	CLASSIFY	TREAT
If the woman is or has: ▪ unconscious does not answer ▪ convulsing ▪ bleeding ▪ severe abdominal pain or looks very ill ▪ headache and visual disturbance ▪ severe difficulty breathing ▪ fever ▪ severe vomiting.	**EMERGENCY FOR WOMAN**	▪ Transfer woman to a treatment room for Rapid ▪ Assessment and Management ▪ Call for help if needed. ▪ Reassure the woman that she will be taken care of immediately. ▪ Ask her companion to stay.
▪ imminent delivery or ▪ labour	**LABOUR**	▪ **Transfer the woman to the labour ward.** ▪ **Call for immediate assessment.**

Table: Assess, Classify and Hospital Referral of Pre-Eclampsia and Eclampsia

SIGNS	CLASSIFY	TREAT AND ADVISE
▪ Diastolic blood pressure more than or equal to 110 mmHg and 3+ proteinuria. OR ▪ Diastolic blood pressure more than or equal to 110 mmHg on two readings and 2+ proteinuria, and any of: → headache → blurred vision → epigastric pain	**SEVERE PRE-ECLAMPSIA**	▪ Give magnesium sulphate ▪ Give appropriate anti-hypertensives ▪ Revise the birth plan ▪ Refer urgently to hospital
▪ Diastolic blood pressure 90-110-mmhHg on two readings and 2+proteinuria.	**PRE-ECLAMPSIA**	▪ Revise the birth plan Refer to hospital.
▪ Diastolic blood pressure more than 90 mmHg on 2 Readings.	**HYPERTENSION**	▪ Advise to reduce workload and to rest. ▪ Advise on danger signs ▪ Reassess at the next antenatal visit / contact or in 1 week if more than 8 months pregnant. ▪ If hypertension persists after 1 week or at next visit, refer to hospital or discuss case with the doctor or midwife, if available. ▪ Advise on no added salt intake
▪ None of the above.	**NO HYPERTENSION**	▪ No treatment required. ▪ Routine antenatal care ▪ Advice to stop cola drinks and reduce intake of tea and coffee to reduce intake of caffeine

Table: Assessment, Management and Hospital Referral of Bleeding during Antenatal Period

SIGNS	CLASSIFY	TREAT AND ADVISE
▪ Vaginal bleeding and any of: → Foul-smelling vaginal discharge → Abortion with uterine manipulation → Abdominal pain/tenderness → Temperature >38°C.	**COMPLICATED ABORTION**	▪ Insert an IV line and give fluids ▪ Give paracetamol for pain ▪ Give appropriate IM/IV antibiotics ▪ Refer urgently to hospital
▪ **Light vaginal bleeding**	**THREATENED ABORTION**	▪ Observe bleeding for 4-6 hours: → If no decrease, **refer to hospital.** → If decrease, let the woman go home. → Advise the woman to return immediately if bleeding increases. ▪ Follow up in 2 days
▪ History of heavy bleeding but: → now decreasing, or → no bleeding at present.	**COMPLETE ABORTION**	▪ Check preventive measures ▪ Advise on self-care ▪ Advise and counsel on family planning ▪ Advise to return if bleeding dose not stop within 2 days
▪ Two or more of the following signs: → abdominal pain → fainting → pale → very weak	**ECTOPIC PREGNANCY**	▪ Insert an IV line and give fluids ▪ **Refer urgently to hospital**

Table: Assessment, Management and Referral of Anemia Cases

SIGNS	CLASSIFY	TREAT AND ADVISE
▪ Hemoglobin less than 7-g/dl. AND/OR ▪ Severe palmar and conjunctival pallor or ▪ Any pallor with any of → more than 30 breaths per minute → tires easily → breathlessness at rest	**SEVERE ANAEMIA**	▪ Revise birth plan so as to deliver in a facility with blood transfusion services ▪ Give double dose of iron (1 tablet twice daily) for 3 months ▪ Counsel on compliance with treatment ▪ Follow up in 2 weeks to check clinical progress, test results, and compliance with treatment. ▪ **Refer urgently to hospital**
▪ Hemoglobin 7-11-g/dl. OR ▪ Palmar or conjunctival pallor.	**MODERATE ANAEMIA**	▪ Give double dose of iron (1 tablet twice daily) for 3 months ▪ Counsel on compliance with treatment ▪ Give appropriate oral antimalarial if not given in the past month ▪ Reassess at next antenatal visit (4-6 weeks). If **anaemia persists, refer to hospital.**
▪ Haemoglobin more than 11-g/dl. ▪ No pallor.	**NO CLINICAL ANAEMIA**	▪ Give iron 1 tablet once daily for 3 months ▪ Counsel on compliance with treatment

Table: Check for Diabetes and Rh Factor

SIGNS	CLASSIFY	TREAT AND ADVISE
▪ RBS more than 200mg/dl	DIABETES	→ Refer to hospital
▪ RBS 150-200mg/dl	POSSIBLE DIABETES	→ Refer to Hospital
▪ RBS less than 150mg/dl	NO DIABETES	→ Reassure
▪ If mother Rh-negative ▪ Check husband blood group ▪ If husband Rh-postive	RH-INCOMPATIBILITY	→ Refer to hospital → Give information & explain reason for referral
▪ If mother Rh-postive	NO RI-I-INCOMPATIBILITY	→ Reassure
▪ If mother Rh-negetive ▪ If husband Rh-negetive	NO RH-INCOMPATIBILITY	→ Reassure

Table: Urgent Referral required if female presents with following signs and symptoms:

SIGNS	CLASSIFY	TREAT AND ADVISE
▪ Transverse lie ▪ Continuous contractions ▪ Constant pain between contractions. ▪ Sudden and severe abdominal pain ▪ Horizontal ridge across lower abdomen ▪ Labour more than.12 hours	**OBSTRUCTED LABOUR**	▪ If distressed, insert an IV line and give fluids ▪ If in labour more than 12 hours, give appropriate IM/IV antibiotics ▪ **Refer urgently to hospital**
▪ Rupture of membranes and any of: Fever more than 38°C Foul-smelling vaginal discharge	**UTERINE AND FETAL INFECTION**	▪ Give appropriate IM/IV antibiotics ▪ If late labour, deliver and refer to hospital after delivery ▪ Plan to treat newborn
▪ Rupture of membranes at less than 8-months of pregnancy.	**RISK OF UTERINE AND FETAL INFECTION**	▪ Give appropriate IM/IV antibiotics ▪ If late labour, deliver ▪ Discontinue antibiotic for mother after delivery if no signs of infection.
▪ Diastolic blood pressure more than 90 mmHg.	**PREECLAMPSIA**	▪ Plan to treat newborn ▪ Assess further and manage as on
▪ Severe palmar and conjunctival pallor and/or hemoglobin less than 7g/dl.	**SEVERE AMAEMIA**	▪ Manage as on

Table: Problems during Labor & Delivery

SIGNS	CLASSIFY	TREAT
▪ Transverse lie	**OBSTRUCTED LABOUR**	▪ Refer urgently to hospital
▪ Cord is pulsating	**FETUS ALIVE**	If early labour: ▪ Push the head or presenting part out of the pelvis and hold it above the brim/pelvis with your hand on the abdomen until caesarean section is performed. ▪ Instruct assistant (family, staff) to position the woman's buttocks higher than the shoulder ▪ Or pass a Foley's catheter and fill the urinary bladder with 300-500ml sterile saline. Clamp the catheter. This lifts the baby's head out of the pelvis. ▪ **Refer urgently to hospital** ▪ If transfer not possible, allow labour to continue. **If late labour:** ▪ Call for additional help if possible (for mother and baby). ▪ Prepare for Newborn resuscitation Ask the woman to assume an upright or squatting. position to help progress. ▪ Expedite delivery by encouraging woman to push with contraction.
▪ Cord is not pulsating	**FETUS PROBABLY DEAD**	▪ Explain to the parents that baby may not be well. ▪ Manage as for alive baby.

Table: If Breech Presentation

SIGN	TREAT
▪ If early labour	▪ **Refer urgently to hospital**
▪ If late labour	▪ Call for additional help. ▪ Confirm full dilatation of the cervix by vaginal examination ▪ Ensure bladder is empty. If unable to empty bladder see Empty bladder ▪ Prepare for newborn resuscitation ▪ Deliver the baby: → Assist the woman into a position that will allow the baby to hang down during delivery, for example, propped up with buttocks at edge of bed or onto her hands and knees (all fours position). → When baby's buttocks are distending the perineum make an episiotomy. → Allow buttocks, trunk and shoulders to deliver spontaneously during contractions. → After delivery of the shoulders allow the baby to hang until next contraction.
▪ If the head does not deliver after several contractions	▪ Place the baby astride your left forearm with limbs hanging on each side. ▪ Place the middle and index fingers of the left hand over the malar cheek bones on either side to apply gentle downwards pressure to aid flexion of head. ▪ Keeping the left hand as described, place the index and ring fingers of the right hand over the baby's shoulders and the middle finger on the baby's head to gently aid flexion until the hairline is visible. ▪ When the hairline is visible, raise the baby in upward and forward direction towards the mother's abdomen until the nose and mouth are free. The assistant gives supra pubic pressure during the period to maintain flexion.

Table: Postpartum Infections

SIGNS	CLASSIFY	TREAT AND ADVISE
▪ More than 1 pad soaked in 5 minutes.	**POSTPARTUM BLEEDING**	▪ Give syntocinon/misoprostol/0.2 mg ergometrine IM ▪ Give appropriate IM/IV antibiotics ▪ Manage as in Rapid assessment and management ▪ **Refer urgently to hospital**
▪ Temperature more than 38°C and any of: → very weak → abdominal tenderness → foul-smelling lochia → profuse lochia → uterus not well contracted → lower abdominal pain → history of heavy vaginal bleeding.	**UTERINE INFECTION**	▪ Insert an IV line and give fluids rapidly ▪ Give appropriate IM/IV antibiotics ▪ Refer urgently to hospital
▪ Fever more than 38°C and any of: → burning on urination → flank pain.	**UPPER URINARY TRACT INFECTION**	▪ Give appropriate IM/IV antibiotics ▪ **Refer urgently to hospital**
▪ Burning on urination.	**LOWER URINARY TRACT INFECTION**	▪ Give appropriate oral antibiotic ▪ Encourage her to drink more fluids. ▪ Follow up in 2 days. If no improvement, refer to hospital.

Table: Postpartum Problems

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	TREAT
IF DRIBBLING URINE				
		▪ Dribbling or leaking urine.	**URINARY INCONTINENCE**	▪ Check perineal trauma. ▪ Give appropriate oral antibiotics for lower urinary tract infection ▪ If conditions persists more than 1 week, refer the woman to hospital-
IF PUS OR PERINEAL PAIN				
		▪ Excessive swelling of vulva or perineum.	**PERINEAL TRAUMA**	▪ Refer the woman to hospital.
		▪ Pus in perineum. ▪ Pain in perineum.	**PERINEAL INFECTION OR PAIN**	▪ Remove sutures, if present. ▪ Clean wound. Counsel on care and hygiene ▪ Give paracetamol for pain ▪ Follow up in 2 days. If inprovement, refer to hßpital.-
IF FEELING UNHAPPY OR CRYING EASILY				
▪ How have you been feeling recently? ▪ Have you been in low spirits? ▪ Have you been able to enjoy the things you usually enjoy? ▪ Have you had your usual level of energy, or have you been feeling tired? ▪ How has your sleep been? ▪ Have you been able to concentrate (for example on newspaper articles or your favorite radio programers)?		Two or more of the following symptoms during the same 2 week period representing a change from normal: ▪ Inappropriate guilt or negative feeling towards self. ▪ Cries easily. ▪ Decreased interest or pleasure. ▪ Feels tired, agitated all the time. ▪ Disturbed sleep (sleeping too much or too little, waking early). ▪ Diminished ability to think or concentrate. ▪ Marked loss of appetite.	**POSTPARTUM DEPRESSION (USUALLY AFTER FIRST WEEK)**	▪ Provide emotional support. ▪ Refer urgently the woman to hospital
		▪ Any of the above, for less than 2 weeks.	**POSTPARTUM BLUES (USUALLY IN FIRST WEEK)**	▪ Assure the woman that this is very common. ▪ Listen to her concerns. Give emotional encouragement and support.

Table: Assess Pre-Term, LBW or Twins

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ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	TREAT AND ADVISE
▪ Baby just born. ▪ Birth weight → less than1500 g →1500 g to less than 2500 g. ▪ Preterm → less than 32 weeks →33-36 weeks. ▪ Twin.	▪ If this is repeated visit assess weight gain	▪ Birth weight less than 1500g. ▪ Very preterm less than 32 weeks or more than 2 months early).	VERY SMALL BABY	▪ Refer baby urgently to hospital ▪ Ensure extra warmth during referral.
		▪ Birth weight 1500g less than 2500g ▪ Preterm baby (32-36 weeks or 1-2 months early). ▪ Several days old and weight gain inadequate. ▪ Feeding difficulty.	SMALL BABY	▪ Give special support to breastfeed the small baby ▪ Assisted Breast milk feeding ▪ Ensure additional care for a small baby provide Kangaroo mother care ▪ Reassess daily ▪ Do not discharge before feeding well. Gaining weight and body temperature stable.
		▪ Twin	TWIN	▪ Give special support to the mother to breastfeed twins ▪ Do not discharge until both twins can go home.
		▪ Mother not able to breastfeed due to receiving special treatment. ▪ Mother transferred.	MOTHER NOT ABLE TO TAKE CARE FOR BABY	▪ Help the mother express breast milk ▪ Consider alternative feeding methods until mother is well ▪ Provide care for the baby ensure warmth ▪ Ensure mother can see the baby regularly. ▪ Transfer the baby with the mother if possible. ▪ Ensure care for the baby at home.

Table: Assess Breast Feeding

Assess breastfeeding in every baby as part of the examination.
If mother is complaining of nipple or breast pain, also assess the mother's breasts

ASK, CHECK RECORD	LOOK, LISTEN, FEEL	SIGNS	CLASSIFY	TREAT AND ADVISE
Ask the mother ▪ How is the breastfeeding going? ▪ Has your baby fed in the previous hour? ▪ Is there any difficulty? ▪ Is your baby satisfied with the feed? ▪ Have you fed your baby any other foods or drinks? ▪ How do your breasts feel? ▪ Do you have any concerns? **If baby more than one day old:** ▪ How many times has your baby fed in 24 hours?	▪ **Observe a breastfeed.** If the baby has not fed in the previous hour, ask the mother to put the baby on her breasts and observe breastfeeding for about 5 minutes. **Look** ▪ Is the baby able to attach correctly? ▪ Is the baby well-positioned? ▪ Is the baby suckling effectively? If mother has fed in the last hour, ask her to tell you when her baby is willing to feed again.	▪ Suckling effectively ▪ Breastfeeding 8 times in 24 hours on demand day and night	**FEEDING WELL**	▪ Encourage the mother to continue breast feeding on demand
		▪ Not yet breastfed (first hours of life). ▪ Not well attached. ▪ Not suckling effectively. ▪ Breastfeeding less than 8 times per 24 hours. ▪ Receiving other foods or drinks. ▪ Several days old and inadequate weight gain.	**FEEDING DIFFICULTY**	▪ Support exclusive breastfeeding ▪ Help the mother to initiate breastfeeding ▪ Teach correct positioning and attachment ▪ Advise to feed more frequently, day and night. ▪ Reassure her that she has enough milk. ▪ Advise the mother to stop feeding the baby other foods or drinks. ▪ Reassess at the next feed or follow-up visit in 2 days.
		▪ Not suckling (after 6 hours of age). ▪ Stopped feeding.	**NOT ABLE TO FEED**	▪ Refer baby urgently to hospital

Table: Assess, Classify & Treat the Sick Young Infant: Age Up To 2 Months

DO A RAPID APRAISAL OF ALL WAITING INFANTS

ASK THE MOTHER WHAT THE YOUNG INFANT'S PROBLEMS ARE

- Determine if this is an initial or follow-up visit for this problem.
  - If follow-up visit, use the follow-up instructions.
  - If initial visit, assess the young infant as follows:

USE ALL BOXES THAT MATCH INFANT'S SYMPTOMS AND PROBLEMS TO CLASSIFY THE ILLNESS.

CHECK FOR POSSIBLE SERIOUS BACTERIAL INFECTION OR VERY SEVERE DISEASE, PNEUMONIA AND LOCAL INFECTION

ASK:

- Is the infant having difficulty in feeding?
- Has the infant had convulsions (fits)?

LOOK AND FEEL:

- Count the breaths in one minute. Repeat the count if 60 or more breaths per minute. } YOUNG INFANT MUST BE CALM
- Look for severe chest indrawing
- Measure axillary temperature.
- Look at the young infant's movements. *If infant is sleeping, ask the mother to wake him/her.*
  - Does the infant move on his/her own? *If the infant is not moving, gently stimulate him/her.*
  - Does the infant move only when stimulated but then stops?
  - Does the infant not move at all?
- Look at the umbilicus. Is it red or draining pus?
- Look for skin pustules.

Classify ALL YOUNG INFANTS

SIGNS	CLASSIFY	IDENTIFY TREATMENT (Urgent pre-referral treatments are in bold print)
Any one or more of the following signs: • Not able to feed since birth, stopped feeding well or not feeding at all or • Convulsions or • Severe chest indrawing or • Fever (38°C* or above) or • Low body temperature (less than 35.5°C*) or • Movement only when stimulated or no movement at all, or • Fast breathing (60 breaths per minute or more) in infants less than 7 days old	**POSSIBLE SERIOUS BACTERIAL INFECTION OR VERY SEVERE DISEASE**	➢ ***Give first dose of intramuscular antibiotic.*** ➢ ***Treat to prevent low blood sugar.*** ➢ ***Refer URGENTLY to hospital.**** ➢ ***Teach the mother how to keep the infant warm on the way to the hospital.*** ➢ ***If referral is refused or not possible, further assess and classify the young infant (as on page 39) and treat accordingly.***
• Fast breathing (60 breaths per minute or more) in infants 7 to 59 days old	**PNEUMONIA**	➢ Give amoxicillin for 7 days. ➢ Advise mother to give home care for the young infant. ➢ Follow up on day 4 of treatment. ➢ Also treat per any other
• Umbilicus red or draining pus • Skin pustules	**LOCAL INFECTION**	➢ Give amoxicillin for 5 days. ➢ Teach mother to treat local infections at home. ➢ Advise mother to give home care for the young infant. ➢ Follow up on day 3.
• No signs of bacterial infection or very severe disease	**SEVERE DISEASE OR INFECTION UNLIKELY**	➢ Advise mother to give home care for the young infant.

* *These thresholds are based on axillary temperature.*
** *If referral is refused or not possible, see page 12.*

Table: Assess and Classify Jaundice and deciding when to Refer

THEN CHECK FOR JAUNDICE

ASK:

- When did jaundice first appear?

LOOK AND FEEL:

- Look for jaundice (yellow skin).
- Look at the young infant's palms and soles. Are they yellow?

Classify JAUNDICE

SIGNS	CLASSIFY	IDENTIFY TREATMENT (Urgent pre-referral treatments are in bold print)
• Any jaundice if age less than 24 hours or • Yellow palms or soles at any age	**SEVERE JAUNDICE**	➢ ***Treat to prevent low blood sugar.*** ➢ ***Refer URGENTLY to hospital.*** ➢ ***Teach the mother how to keep the infant warm on the way to the hospital.***
• Jaundice appearing after 24 hours of age and • Palms or soles not yellow	**JAUNDICE**	➢ Advise the mother to give home care for the young infant. ➢ Advise mother to return immediately if palms or soles appear yellow. ➢ If the young infant is older than 3 weeks, refer to a hospital for assessment. ➢ Follow-up on day 2.
• No jaundice	**NO JAUNDICE**	➢ Advise the mother to give home care for the young infant.

Table: Ask about Diarrhea in Young Infant and when to Refer

THEN ASK: Does the young infant have diarrhoea*?

IF YES, LOOK AND FEEL:

- Look at the young infant's general condition:

  Infant's movements
  - Does the infant move on his/her own?
  - Does the infant move only when stimulated but then stops?
  - Does the infant not move at all?

  - Is the infant restless and irritable?

- Look for sunken eyes.

- Pinch the skin of the abdomen.
  Does it go back:
  - Very slowly (longer than 2 seconds)?
  - or slowly?

Classify DIARRHOEA FOR DEHYDRATION

SIGNS	CLASSIFY	IDENTIFY TREATMENT (Urgent pre-referral treatments are in bold print)
Two of the following signs: • Movement only when stimulated or no movement at all • Sunken eyes • Skin pinch goes back very slowly.	**SEVERE DEHYDRATION**	➢ ***If infant has no other severe classification:*** ***- Follow Plan C to treat severe dehydration quickly. Start IV fluid immediately, or refer urgently for IV fluid. If that is not possible, start rehydration by NG tube.*** OR ➢ ***If infant also has another severe classification:*** ***- Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way.*** ***- Advise mother to continue breastfeeding.*** ➢ ***Teach the mother how to keep the infant warm on the way to the hospital.***
Two of the following signs: • Restless and irritable • Sunken eyes • Skin pinch goes back slowly.	**SOME DEHYDRATION**	➢ Give fluid and breast milk for some dehydration (Plan B). OR ➢ ***If infant also has another severe classification:*** ***- Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way.*** ***- Advise mother to continue breastfeeding.*** ➢ Advise mother when to return immediately ➢ Follow-up on day 3 if not improving
• Not enough signs to classify as some or severe dehydration.	**NO DEHYDRATION**	➢ Give fluids and breastmilk to treat for diarrhoea at home (Plan A) ➢ Advise mother when to return immediately

* ***What is diarrhoea in a young infant?***

A young infant has diarrhoea if the stools have changed from usual pattern and are many and watery (more water than fecal matter).

The normally frequent or semi-solid stools of a breastfed baby are not diarrhoea.

Table: Feeding Problems in Low Weight for Age Breastfed Infant & when to Refer

THEN CHECK FOR FEEDING PROBLEM OR LOW WEIGHT FOR AGE IN BREASTFED INFANTS

ASK:

- Is the infant breastfed? If yes,how many times in 24 hours?
- Does the infant usually receive any other foods or drinks?
  - If yes, how often?
  - If yes, what do you use to feed the infant?

LOOK AND FEEL:

- Determine weight for age.
  - Weight less than 1.5 kg?
  - Weight for age less than -3 Z score?
- Look for ulcers or white patches in the mouth (thrush).

ASSESS BREASTFEEDING:

- Has the infant breastfed in the previous hour?

If the infant has not fed in the previous hour, ask the mother to put her infant to the breast. Observe the breastfeed for 4 minutes.

(If the infant was fed during the last hour, ask the mother if she can wait and tell you when the infant is willing to feed again.)

- Is the infant well attached?

not well attached *good attachment*

TO CHECK ATTACHMENT, LOOK FOR:

- *More areola seen above infant's top lip than below bottom lip*
- *Mouth wide open*
- *Lower lip turned outwards*
- *Chin touching breast*

(All of these signs should be present if the attachment is good).

- Is the infant suckling effectively (that is, slow deep sucks, sometimes pausing)?

not suckling effectively *suckling effectively*

➢ Clear a blocked nose if it interferes with breastfeeding.

Classify FEEDING

SIGNS	CLASSIFY	IDENTIFY TREATMENT
• Weight < 1.5 kg, or • Weight < -3 Z score	**VERY LOW WEIGHT**	➢ ***Treat to prevent low blood sugar.*** ➢ ***Refer URGENTLY to hospital.*** ➢ ***Teach the mother to keep the young infant warm on the way to hospital.***
• Not well attached to breast or • Not suckling effectively, or • Less than 8 breastfeeds in 24 hours, or • Receives other foods or drinks, or • Low weight for age, or • Thrush (ulcers or white patches in mouth)	**FEEDING PROBLEM and/or LOW WEIGHT FOR AGE**	➢ If not well attached or not suckling effectively, teach correct positioning and attachment. • If not able to attach well immediately, teach the mother to express breast milk and feed by a cup ➢ If breastfeeding less than 8 times in 24 hours, advise to increase frequency of feeding. Advise her to breastfeed as often and for as long as the infant wants, day and night. ➢ If receiving other foods or drinks, counsel mother about breastfeeding more, reducing other foods or drinks, and using a cup. • If not breastfeeding at all: - Refer for breastfeeding counselling and possible relactation. - Advise about correctly preparing breast-milk substitutes and using a cup. ➢ Advise the mother how to feed and keep the low weight infant warm at home ➢ If thrush, teach the mother to treat thrush at home. ➢ Advise mother to give home care for the young infant. ➢ Follow up FEEDING PROBLEM or thrush on day 3. ➢ Follow up LOW WEIGHT FOR AGE on day 14.
• Not low weight for age and no other signs of inadequate feeding	**NO FEEDING PROBLEM**	➢ Advise mother to give home care for the young infant. ➢ Praise the mother for feeding the infant well.

Table: Feeding Problems or Low Weight for Age Infants receiving no Breast milk and deciding when to Refer

THEN CHECK FOR FEEDING PROBLEM OR LOW WEIGHT FOR AGE IN INFANTS RECEIVING NO BREASTMILK

ASK:

- What milk are you giving?
- How many times during the day and night?
- How much is given at each feed?
- How are you preparing the milk?
  - Let mother demonstrate or explain how a feed is prepared, and how it is given to the infant.
- How is the milk being given? Cup or bottle?
- How are you cleaning the feeding utensils?
- Are you giving any breastmilk at all?
- What foods and fluids in addition to replacement feeds are given?

LOOK, LISTEN, FEEL:

- Determine the weight for age.
  - Weight less than 1.5 kg?
  - Weight for age less than -3 Z score?
- Look for ulcers or white patches in the mouth (thrush).

Classify FEEDING

SIGNS	CLASSIFY	IDENTIFY TREATMENT
• Weight < 1.5 kg, or • Weight < –3 Z score	**VERY LOW WEIGHT**	➢ ***Treat to prevent low blood sugar.*** ➢ ***Refer URGENTLY to hospital.*** ➢ ***Teach the mother to keep the young infant warm on the way to the hospital.***
• Giving inappropriate replacement feeds, or • Giving insufficient replacement feeds, or • Milk incorrectly or unhygienically prepared, or • Using a feeding bottle, or • An HIV positive mother mixing breastmilk and other feeds before 6 months, or • Low weight for age, or • Thrush	**FEEDING PROBLEM and/or LOW WEIGHT FOR AGE**	➢ Counsel about feeding ➢ Explain the guidelines for safe replacement feeding ➢ Identify concerns of mother and family about feeding. ➢ If mother is using a bottle, teach cup feeding. ➢ If thrush, teach the mother to treat it at home. ➢ Follow-up FEEDING PROBLEM or thrush on day 3. ➢ Follow up LOW WEIGHT FOR AGE on day 7.
• Not low weight for age and no other signs of inadequate feeding	**NO FEEDING PROBLEM**	➢ Advise mother to continue feeding, and ensure good hygiene ➢ Praise the mother for feeding the infant well

Table: Child Presenting with Signs and Symptoms of Urgent Attention and Referral

ASSESS AND CLASSIFY THE SICK CHILD AGE 2 MONTHS UP TO 5 YEARS

ASSESS	CLASSIFY	IDENTITY TREATMENT
ASK THE MOTHER WHAT THE CHILD'S PROBLEMS ARE Determine if this is an initial or follow-up visit for this problem		USE ALL BOXES THAT MATCH THE CHILD'S SYMPTOMS AND PROBLEMS TO CLASSIFY THE ILLNESS

CHECK FOR GENERAL DANGER SIGNS

Ask:	*Look:*				
• Is the child able to drink or breastfeed? • Does the child vomit everything? • Has the child had convulsions?	• See if the child is lethargic or unconscious. • Is the child convulsing now?	**URGENT attention**	• Any general danger sign	**VERY SEVERE DISEASE**	▪ **Give diazepam if convulsing now** ▪ **Quickly complete the assessment** ▪ **Give any prereferral treatment immediately** ▪ **Treat to prevent low blood sugar** ▪ **Keep the child warm** ▪ **Refer URGENTLY.**

A child with any general danger sign needs *URGENT* attention; complete the assessment and any pre-referral treatment immediately so referral is not delayed.

Table: Classify Cough/Difficult Breathing and when to Refer:

THEN ASK ABOUT MAIN SYMPTOMS:

If yes, ask:

- For how long?

Look, listen, feel*:

- Count the breaths in one minute.
- Look for chest indrawing.
- Look and listen for stridor.
- Look and listen for wheezing.

CHILD MUST BE CALM

If wheezing with either fast breathing or chest indrawing:

Give a trial of rapid acting inhaled bronchodilator for up to three times 15-20 minutes apart. Count the breaths and look for chest indrawing again, and then classify.

If the child is:	***Fast breathing is:***
2 months up to 12 months	**50** breaths per minute or more
12 Months up to 5 years	**40** breaths per minute or more

Classify COUGH or DIFFICULT BREATHING

Does the child have cough or difficult breathing?

• Any general danger sign **or** • Stridor in calm child.	**SEVERE PNEUMONIA OR VERY SEVERE DISEASE**	▸ **Give first dose of an appropriate antibiotic** ▸ **Refer URGENTLY to hospital****
• Chest indrawing **or** • Fast breathing.	**PNEUMONIA**	▸ **Give oral Amoxicillin for 5 days***** ▸ If wheezing (or disappeared after rapidly acting bronchodilator) give an inhaled bronchodilator for 5 days****** ▸ If coughing for more than 14 days or recurrent wheeze, refer for possible TB or asthma assessment ▸ Advise mother when to return immediately ▸ Follow-up in 3 days
• No signs of pneumonia or very severe disease.	**NO PNEUMONIA: COUGH OR COLD**	▸ If wheezing (or disappeared after rapidly acting bronchodilator) give an inhaled bronchodilator for 5 days****** ▸ Soothe the throat and relieve the cough with a safe remedy ▸ If coughing for more than 14 days or recurrent wheezing, refer for possible TB or asthma assessment ▸ Advise mother when to return immediately ▸ Follow-up in 5 days if not improving

**If pulse oximeter is available, determine oxygen saturation and refer if < 90%.*

*** If referral is not possible, manage the child as described in the pneumonia section of the guidelines.*

****Oral Amoxicillin for 3 days could be used in patients with fast breathing but no chest indrawing.*

***** In settings where inhaled bronchodilator is not available, oral salbutamol may be tried but not recommended for treatment of severe acute wheeze.*

Table: Assess, Classify and when to refer Dehydration cases

Does the child have fever?
by history or feels hot or temperature 37.50C or above*

Does the child have diarrhea?

If yes, ask:
- For how long?
- Is there blood in the stool?

Look and feel:
- Look at the child's general condition. Is the child:
  - Lethargic or unconscious?
  - Restless and irritable?
- Look for sunken eyes.
- Offer the child fluid. Is the child:
  - Not able to drink or drinking poorly?
  - Drinking eagerly, thirsty?
- Pinch the skin of the abdomen. Does it go back:
  - Very slowly (longer than 2 seconds)?
  - Slowly?

Classify DIARRHOEA

for DEHYDRATION	Two of the following signs: ▪ Lethargic or unconscious ▪ Sunken eyes ▪ Not able to drink or drinking poorly ▪ Skin pinch goes back very slowly.	**SEVERE DEHYDRATION**	▸ If child has no other severe classification: Give fluid for severe dehydration (Plan C) OR **If child also has another severe classification:** – **Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way*** – **Advise the mother to continue breastfeeding** ▸ **If child is 2 years or older and there is cholera in your area, give antibiotic for cholera**
	Two of the following signs: ▪ Restless, irritable ▪ Sunken eyes ▪ Drinks eagerly, thirsty ▪ Skin pinch goes back slowly.	**SOME DEHYDRATION**	▸ Give fluid, zinc supplements, and food for some dehydration (Plan B) ▸ **If child also has a severe classification: Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way** ▸ **Advise the mother to continue breastfeeding** ▸ Advise mother when to return immediately ▸ Follow-up in 5 days if not improving
	Not enough signs to classify as some or severe dehydration.	**NO DEHYDRATION**	▸ Give fluid, zinc supplements, and food to treat diarrhea at home (Plan A) ▸ Advise mother when to return immediately ▸ Follow-up in 5 days if not improving
And If diarrhea 14daysor more	Dehydration present.	**SEVERE PERSISTENT DIARRHOEA**	▸ Treat dehydration before referral unless the child has another severe classification ▸ Refer to hospital
	No Dehydration present.	**PERSISTENT DIARRHOEA**	▸ Advise the mother on feeding a child who has PERSISTENT DIARRHOEA ▸ Give multivitamins and minerals (including zinc) for 14 days ▸ Follow-up in 5 days
and if blood in stool	Blood in the stool	**DYSENTERY**	▸ **Give ciprofloxacin for 3 days** ▸ Follow-up in 3 days

Table: When to refer Fever cases

If yes: Decide Malaria Risk: high or low ***Then ask:*** ▪ For how long? ▪ If more than 7 days, has fever been present every day? ▪ Has the child had measles within the last 3 months? ***Look and feel:*** ▪ Look or feel for stiff neck. ▪ Look for runny nose. ▪ Look for any bacterial cause of ▪ fever**. ▪ Look for signs of MEASLES: – Generalized rash and – One of these: – cough, runny nose, or red eyes. ***Do a malaria test***: If NO severe classification*** ▪ In all fever cases if High malaria risk. ▪ In Low malaria risk if no obvious cause of fever present. Decide Dengue Rik: High or Low Then Ask for: ▪ Headache ▪ Myalgia ▪ Rash ▪ Retro-orbital pain/ ocular pain ▪ Hemorrhagic manifestations (e.g. positive tourniquet test, purpura/ ecchymosis, epistaxis, gum bleeding) …… **If the child has measles now or within the last 3 months:** ▪ Look for mouth ulcers. ▪ Are they deep and extensive? ▪ Look for pus draining from the eye. ▪ Look for clouding of the cornea.	**CLASSIFY FEVER**	▪ Any general danger sign or ▪ Stiff neck.	**VERY SEVERE FEBRILE DISEASE**	▸ **Give first dose of artesunate or quinine for severe malaria** ▸ **Give first dose of an appropriate antibiotic** ▸ **Treat the child to prevent low blood sugar** ▸ **Give one dose of Paracetamol in clinic for high fever (38.5°C or above)** ▸ **Refer URGENTLY to hospital**
	High or Low malaria Risk	Malaria test POSITIVE.	**MALARIA**	▸ **Give one dose of Paracetamol in clinic for high fever (38.8°C or above)** ▸ Give appropriate antibiotic treatment for an identified bacteri5l cause of fever ▸ Advise mother when to return immediately ▸ Follow-up in 3 days if fever persists ▸ If fever is present every day for more than 7 days, refer for assessment
		▪ Malaria test NEGATIVE ▪ Other cause of fever PRESENT.	**FEVER:** **NO MALARIA**	▸ **Give recommended first line oral antimalarial** ▸ **Give one dose of Paracetamol in clinic for high fever (38.8°C or above)** ▸ **Give appropriate antibiotic treatment** for an identified bacterial cause of fever ▸ Advise mother when to return immediately ▸ Follow-up in 3 days if fever persists ▸ If fever is present every day for more than 7 days, refer for assessment
	No Malaria Risk and No travel to malaria Risk area	▪ Any general danger sign or ▪ Stiff neck.	**VERY SEVERE FEBRILE DISEASE**	▸ **Give first dose of an appropriate antibiotic.** ▸ **Treat the child to prevent low blood sugar.** ▸ **Give one dose of Paracetamol in clinic for high fever (38.5°C or above).** ▸ **Refer URGENTLY to hospital.**
		▪ No general danger signs ▪ No stiff neck.	**FEVER**	▸ **Give one dose of Paracetamol in clinic for high fever (38.5°C & or above)** ▸ **Give appropriate antibiotic treatment** for any identified bacterial cause of fever ▸ Advise mother when to return immediately ▸ Follow-up in 2 days if fever persists ▸ If fever is present every day for more than 7 days, refer for assessment
	Measles now or within 3 months	▪ Any general danger sign or ▪ Clouding of cornea or ▪ Deep or extensive mouth ulcers.	**SEVERE COMPLICATED MEASLES****	▸ **Give Vitamin A treatment** ▸ **Give first dose of an appropriate antibiotic** ▸ **If clouding of the cornea or pus draining from the eye, apply tetracycline eye ointment Refer URGENTLY to hospital**
		▪ Pus draining from the eye or ▪ Mouth ulcers.	**MEASLES WITH EYE OR MOUTH COMPLICATIONS****	▸ **Give Vitamin A treatment** ▸ **If pus draining from the eye, treat eye infection with tetracycline eye ointment** ▸ If mouth ulcers, treat with gentian violet ▸ Follow-up in 3 days
		▪ Measles now or ▪ within the last 3 months.	**MEASLES**	**Give Vitamin A treatment**
	Dengue	▪ Bleeding from the nose or gums ▪ Bleeding in the stool or vomits ▪ Black stool or vomitus ▪ Skin petechiae ▪ Slow capillary refill (more than 3 seconds) ▪ Persistent abdominal; pain ▪ Persistent vomiting ▪ Positive tourniquet test	**SEVERE DENGUE HEMORRHAGIC FEVER**	▸ ***If skin petechiae, peritent abdominal pain, persistent vomiting or positive tourniquet test are the only positive signs, then give ORS.*** ▸ ***If any other sign of bleeding is positive, give fluids rpidly as in Plan C.*** ▸ ***Treat the child to prevent low blood sugar.*** ▸ ***Refer URGENTLY to hospital.*** ▸ ***Do not give Aspirin.***
		▪ No sign of Dengue hemorrhagic fever	**FEVER ONLY: DENGUE HEMORRHAGIC FEVER UNLIKELY**	▸ Advise mother when to return immediately. ▸ **Follow up in 2 days if the fever persists or if the child shows signs of bleeding** ▸ **Do not give aspirin**

- **These temperatures are based on axillary temperatures.**

** Look for local tenderness; oral sores; refusal to use a limb; hot tender swelling; red tender skin or boils; lower abdominal pain or pain on passing urine in older children.

*** If no malaria test available: High malaria risk - classify as MALARIA; Low malaria risk AND NO obvious cause of fever - classify as MALARIA.

**** *Other important complications of measles - pneumonia, stridor, diarrhoea, ear infection, and acute malnutrition - are classified in other tables.*

Table: Management of Ear Infection

Does the child have an ear problem?

If yes, ask:
- Is there ear pain? Is
- there ear discharge?
  If yes, for how long?

Look and feel:
- Look for pus draining from the ear.
- Feel for tender swelling behind the ear.

Classify EAR PROBLEM

• Tender swelling behind the ear.	**MASTOIDITIS**	▪ **Give first dose of an appropriate antibiotic** ▪ **Give first dose of paracetamol for pain** ▪ **Refer URGENTLY to hospital**
• Pus is seen draining from the ear and discharge is reported for less than 14 days, or Ear • pain.	**ACUTE EAR INFECTION**	▪ **Give an antibiotic for 5 days** ▪ **Give paracetamol for pain** ▪ Dry the ear by wicking ▪ Follow-up in 5 days
• Pus is seen draining from the ear and discharge is reported for 14 days or more.	**CHRONIC EAR INFECTION**	▪ Dry the ear by wicking ▪ Treat with topical quinolone eardrops for 14 ▪ days Follow-up in 5 days
• No ear pain and No pus seen draining from the ear.	**NO EAR INFECTION**	▪ No treatment

Table: Management of Anemia

THEN CHECK FOR ANAEMIA

Check for anaemia
- Look for palmar pallor. Is it:
  - Severe palmar pallor*?
  - Some palmar pallor?

Classify ANAEMIA

• Severe palmar pallor	**SEVERE ANAEMIA**	▪ **Refer URGENTLY to hospital**
• Some pallor	**ANAEMIA**	▪ Give iron** ▪ Give mebendazole if child is 1 year or older and has not had a dose in the previous 6 ▪ months ▪ Advise mother when to return immediately Follow-up in 14 days
• No palmar pallor	**NO ANAEMIA**	If child is less than 2 years old, assess the child's feeding and counsel the mother according to the feeding recommendations If feeding problem, follow-up in 5 days

*Assess for sickle cell anaemia if common in your area.

**If child has severe acute malnutrition and is receiving RUTF, DO NOT give iron because there is already adequate amount of iron in RUTF.

Table: Management of Malnutrition:

THEN CHECK FOR ACUTE MALNUTRITION

CHECK FOR ACUTE MALNUTRITION

LOOK AND FEEL:

Look for signs of acute malnutrition

- Look for oedema of both feet.
- Determine WFH/L* ___ z-score.
- Measure MUAC**____ mm in a child 6 months or older.

If WFH/L less than -3 z-scores or MUAC less than 115 mm, then:

- **Check for any medical complication present:**
  - **Any general danger signs**
  - **Any severe classification**
  - **Pneumonia with chest indrawing**
- **If no medical complications present:**
  - **Child is 6 months or older, offer RUTF*** to eat. Is the child:**

    Not able to finish RUTF portion?

    Able to finish RUTF portion?
  - **Child is less than 6 months, assess breastfeeding:**

    Does the child have a breastfeeding problem?

Classify NUTRITIONAL STATUS

• Oedema of both feet **OR** • WFH/L less than -3 z-scores **OR** MUAC less than 115 mm **AND any one of the following:** ○ Medical complication present or ○ Not able to finish RUTF or ○ Breastfeeding problem.	***Pink:*** **COMPLICATED SEVERE ACUTE MALNUTRITION**	▪ **Give first dose appropriate antibiotic** ▪ **Treat the child to prevent low blood sugar** ▪ **Keep the child warm** ▪ **Refer URGENTLY to hospital**
• WFH/L less than -3 z-scores **OR** • MUAC less than 115 mm **AND** • Able to finish RUTF.	***Yellow:*** **UNCOMPLICATED SEVERE ACUTE MALNUTRITION**	▪ **Give oral antibiotics for 5 days** ▪ Give ready-to-use therapeutic food for a child aged 6 months or more ▪ Counsel the mother on how to feed the child. ▪ Assess for possible TB infection ▪ Advise mother when to return immediately ▪ Follow up in 7 days
• WFH/L between -3 and -2 z-scores **OR** • MUAC 115 up to 125 mm.	***Yellow:*** **MODERATE ACUTE MALNUTRITION**	▪ Assess the child's feeding and counsel the mother on the feeding recommendations ▪ If feeding problem, follow up in 7 days ▪ Assess for possible TB infection. ▪ Advise mother when to return immediately ▪ Follow-up in 30 days
• WFH/L - 2 z-scores or more **OR** • MUAC 125 mm or more.	***Green:*** **NO ACUTE MALNUTRITION**	▪ If child is less than 2 years old, assess the child's feeding and counsel the mother on feeding according to the feeding recommendations ▪ If feeding problem, follow-up in 7 days

*WFH/L is Weight-for-Height or Weight-for-Length determined by using the WHO growth standards charts.

** MUAC is Mid-Upper Arm Circumference measured using MUAC tape in all children 6 months or older.

***RUTF is Ready-to-Use Therapeutic Food for conducting the appetite test and feeding children with severe acute malanutrition.

Case Study: Zahida

Zahida Bibi, a 28-year-old woman in active labor, arrived at the Basic Health Unit (BHU) after experiencing labor pains that began 14 hours ago. She appears visibly exhausted and is complaining of severe lower abdominal pain, yet there has been minimal progress in labor. Upon examination, her blood pressure is elevated at 150/100 mmHg and the fetal heart rate is noted to be irregular, raising concerns about potential fetal distress. The BHU lacks essential diagnostic and emergency tools such as ultrasound or vacuum extraction equipment. The nearest facility equipped for emergency obstetric care is a Rural Health Centre (RHC) located 30 minutes away. Zahida's husband is present at the BHU and is visibly concerned about her condition.

Task for Group Discussion

As the healthcare team at the BHU, decide the following:

1. Should Zahida be referred to a higher facility? Why or why not?
2. If yes, what are the immediate steps to take before referral?
3. What information should be documented on the referral form?
4. How would you communicate with the receiving facility and Zahida's family?
5. What feedback would you expect from the referral hospital afterward?

MODULE THREE

REFERRAL RECORDING & STANDARD OPERATIONAL PROCEDURE (SOP) FOR MNCH

Section A: Referral Recording

a. Maternal Health Card (MHC)

The health facility (government hospital, BHU, RHC) that handles the first prenatal visit of a pregnant woman must issue the MHC. On the other hand, private hospitals or clinics must advise pregnant women to obtain the MHC from the RHC/BHU. Both government and private hospitals, as well as private clinics, must instruct pregnant women to visit the RHC/BHU for registration and to receive services that are not available at the hospitals or clinics. The Maternal Health Card should be accurately filled out by the pregnant woman, with assistance from the health worker. Health workers must ensure that all information is recorded in the MHC whenever they provide MNCH services. All women are required to bring their MHC every time they receive MNCH services, whether in the RHC/BHU, hospitals, private clinics or when undergoing laboratory services.

b. Referral Slip (Annex A-1) and Return Slip (Annex A-2)

Adopt the referral form slip with minor adjustments. Ensure that the referral form, along with the return slip, is properly filled out and provide clear instructions for the patient to return to the referring facility.

c. Referral Logbook (Annex B-1 and Annex B-2)

Maintain separate logbooks for incoming and outgoing referrals at the RHU, as currently required.

Section B: The role of Community Health Workers and Primary Health Care Facility

1: Community Health Workers

In Khyber Pakhtunkhwa, the community is represented by auxiliary health workers. This group typically includes Lady Health Workers (LHWs) and Trained Birth Attendants (Dais). The expected functions of these workers, particularly in relation to Maternal, Neonatal and Child Health (MNCH), are as follows:

a. During Prenatal Care

1. Identify pregnant women within the community.
2. Refer all newly identified pregnant women to the designated LHV or health facility.
3. Conduct health education sessions, focusing on the importance of prenatal care and birth planning.
4. Assist families in creating their "Birth and Emergency Plan."
5. Conduct home visits for pregnant women who fail or refuse to seek prenatal services.
6. Recommend maternity homes for expectant mothers in need.
7. Advocate for the active involvement of family members.
8. Monitor for danger signs during pregnancy and refer them as necessary.

b. During Labor

1. Identify signs of true labor and refer the client to a birthing facility or hospital.
2. Assist in arranging transportation for the client to the facility.

c. During Post-Partum Care

1. Identify all post-partum mothers in the community and refer them to the designated Lady Health Visitor (LHV).
2. Provide health education on Mother and Child Nutrition (MIYCN) focusing on exclusive breastfeeding and the importance of vaccination.
3. Monitor post-partum mothers for danger signs and make necessary referrals.

d. Newborn Care

1. Provide basic newborn care for home deliveries.
2. Promote early initiation and exclusive breastfeeding for 6 months.
3. Educate mothers on infant routine immunization.

e. Child Care

1. Identify and refer all children under 5 years old to the health facility in emergency situation.
2. Participate in growth monitoring and other nutrition-related activities.
3. Conduct nutrition education sessions, particularly focusing on exclusive breastfeeding and complementary feeding.

2: Primary Health Care Facilities

Each health facility is manned by Male or Female Medical Officer and Lady Health Visitor (LHV). The LHV is expected to perform the following tasks:

a. Pre-Pregnancy

1. Identify and create a list of women and married women of reproductive age.
2. Identify families with unmet family planning needs.
3. Provide relevant information and counseling on Family Planning and Responsible Parenthood.
4. Ensure the availability of family planning services and necessary logistics.
5. Provide multiple micronutrient supplementation (MMS) for women of reproductive age.
6. Refer women with suspected complicated pregnancies for confirmation at the Rural Health Centre (RHC) or higher nearby health facility including Tehsil or District Headquarter or Women and Child Hospital.

b. Prenatal Care

1. Identify and create a master list of all pregnant women.
2. Provide micronutrient supplementation and deworming.
3. Assist in creating a birth and emergency plan.
4. Advocate for family planning options after childbirth.
5. Provide information on maintaining a healthy lifestyle.
6. Monitor for and manage early signs of pregnancy complications.
7. Refer patients to the Rural Health Center (RHC), Maternal Health Center (MHC) or hospital for health services.
8. Administer Tetanus Toxoid immunization.
9. Refer for diagnostic and screening procedures, such as CBC, urinalysis, blood typing, VDRL, HBsAg/HCVAb and random/fasting blood sugar.
10. Provide prevention and management of other health conditions.
11. Inform the patient about the availability of the maternity homes.

c. Delivery (Non-Birthing Facility)

1. Identify early signs and symptoms of true labor.
2. Assist with transport and referral of the client to a birthing facility.

d. Post-Partum Care (Non-Birthing Facility)

1. **Enlist the Mother for Post-Partum Care**: After childbirth, the mother should be enrolled for Post-Partum services to ensure she receives appropriate follow-up care.
2. **Provide Two Post-Partum Visits**: The mother should receive at least two follow-up visits after giving birth to monitor her recovery and address any health concerns.
3. **Observe for Danger Signs and Refer as Needed**: During these visits, healthcare providers should monitor the mother for any danger signs such as excessive bleeding, infection, or other complications and refer her to a higher-level facility if necessary.
4. **Provide Micronutrients**: The mother should be given micronutrient supplements to support her postpartum recovery.

5. **Advise on Family Planning (FP) Services/Options**: Offer the mother information and counseling on family planning services and options, helping her make an informed decision regarding contraception and spacing of future pregnancies.

e. Neonatal Care (Non-Birthing Facility)

1. **Enlist the Infant for Under-Five Care**: The newborn should be registered in the for-under-five care, ensuring ongoing health monitoring and appropriate care.
2. **Evaluate for Danger Signs and Refer as Needed**: Healthcare providers should assess the infant for any danger signs, such as difficulty breathing, lethargy, or poor feeding and refer the infant to a higher facility if needed.
3. **Record Infant's Body Measurements**: The infant's body measurements (e.g., weight, length, head circumference) should be documented for tracking growth and development.
4. **Initiate Immunization**: The infant should receive their first immunizations, including the Bacillus Calmette–Guérin (BCG) vaccine and poliomyelitis, as part of the newborn immunization schedule.
5. **Refer for Newborn Screening**: The infant should be referred for newborn screening to check for any metabolic or genetic conditions that could require early intervention.

f. Delivery (Birthing Facility)

1. Monitor labor progress using a WHO Labor Care Guide (LCG).
2. Identify early signs of complications like prolonged labor, hypertension, or other issues and refer as needed.
3. For normal deliveries, assist in controlled delivery of the head and manage the third stage of labor.
4. Administer antibiotics and parenteral oxytocin/methergine as needed.

g. Post-Partum (Birthing Facility)

1. Monitor the mother for early signs of complications.
2. Refer cases with complications (e.g., hypertension, uncontrolled vaginal bleeding, uterine atony, altered sensorium, extreme maternal weakness).
3. Add the mother to the Target Client List (TCL) for post-partum care.
4. Provide at least two post-partum visits.
5. Reinforce family planning options for the mother.

h. Early Neonatal Care (Birthing Facility)

1. Maintain the infant's body temperature using skin-to-skin contact for 90 minutes (1.5 hours) and delay bathing for at least 24 hours after birth.
2. Measure the infant's body size only 90 minutes after birth.
3. Assist with early breastfeeding and provide Crede's prophylaxis.
4. Administer BCG and Oral Polio vaccinations and counsel the mother for subsequent vaccination doses.

Section 2: Standard Operational Procedure (SOP) for MNCH Referral

A: Identification / Master Listing of Pregnant Women by Healthcare Providers:

Service Providers	Actions to be Taken
Lady Health Worker	✓ **Register pregnant women** in the pregnancy tracking record. ✓ **Submit pregnancy tracking records** to the birthing facilities for proper documentation. ✓ **Follow up with prenatal check-up defaulters** to ensure consistent care. ✓ **Report findings to the Lady Health Supervisor (LHS) and Lady Health Visitor (LHV)** for further action and coordination. ✓ **Educate women** on the importance of prenatal care and provide them with a **registration card**.
Lady Health Visitor	✓ **Issue Health Cards** to each pregnant woman and assist in filling out relevant details. ✓ **Register women** in the target client list register for easy tracking and follow-up. ✓ **Provide essential and comprehensive prenatal care** services during regular visits. ✓ **Prepare laboratory requests** for essential tests, including Urinalysis, Complete Blood Count (CBC), HBsAg testing and blood typing. ✓ **Recommend ultrasound** examination during the **third trimester** for better monitoring of fetal development. ✓ **Advise dental check-ups** for pregnant women at least **twice during pregnancy** to ensure oral health and prevent complications. ✓ **Recommend regular consultations** with doctors, at least **once in 1st and 2nd trimester and twice in 3rd trimester** for normal pregnancies, or more frequently as advised in complicated cases. ✓ **Teach women how to perform self-breast examinations** as part of routine health education for early detection of issues.

Service Providers	Actions to be Taken
Government/Private Hospitals	✓ The **first government facility** (BHU, RHC or Hospital) where a pregnant woman attends her **initial prenatal check-up** will provide and issue a **Registration Card**. ✓ **The Private clinics** will also instruct women to visit **nearby government health facility** for **Registration Card issuance** and to receive other prenatal services such as **free Iron and folate tablets**, **Tetanus Toxoid immunization**, **deworming** and **treated mosquito nets (if available)** which are not offered at private clinics.

B: Birth and Emergency Plan

Service Providers	Actions to be Taken
Family Member of Pregnant Women	✓ **Coordinate with transportation providers** (e.g., neighbors, ambulance services) to ensure readiness in case of emergencies. ✓ **Arrange for blood donors** to be available during emergencies.
Community Health Team / Health Workers	✓ **Assist women in creating a "birth and emergency plan"** that includes identifying the nearest birthing facility, transportation and emergency contacts. ✓ **Encourage women (without identified risk factors)** to receive prenatal care in the **third trimester** at the facility where they plan to deliver. ✓ **Promote blood donation among relatives** during **bloodletting activities** to ensure availability of blood for emergency situations. ✓ **Ensure coordination between the woman, her chosen facility, transportation services and blood donors** to ensure seamless access in case of an emergency.
Birthing Facilities	✓ **Provide prenatal care in the third trimester** for women planning to deliver at the facility. ✓ **Display emergency contact numbers** (ambulance and birthing facility hotlines) prominently at the facility.
Transportation Service Provider	- **Ensure readiness** to provide services to pregnant women in need of transportation for delivery or emergencies. - **Coordinate with local officials** to ensure the availability and accessibility of transport services for referrals or emergencies.

C: Pregnant Women with Identified Risk Factors

Service Providers	Actions to be Taken
Health Workers Providing Prenatal Care	✓ **Assess risk factors** based on the woman's medical history, previous pregnancies, current pregnancy status and previous prenatal check-up results. ✓ **If risk factors are identified**, take the following actions: ✓ **Provide immediate treatment** if applicable to manage the condition. ✓ **Refer the woman to a physician** for specialized care if necessary. ✓ **Recommend facility-based prenatal care** for women with risk factors, ensuring they receive care at the facility where they plan to deliver. ✓ **Reassess and update the birth and emergency plan** based on the identified risk factors.
Referred Health Facility	✓ **Provide appropriate care and follow-up** for the pregnant woman as required. ✓ **Provide feedback to the referring facility/Community Health Workers (LHV/LHW)** to ensure continuous care, utilizing back referral methods. ✓ **Update referral documentation**, including referral slips, Mother Health registers, treatment records and referral logbooks to maintain a seamless information flow between facilities.

D: Obstetric / Newborn Emergency

Service Providers	Actions to be Taken
Referred Health Facility	✓ **Provide appropriate care** to the patient (either obstetric or newborn emergency care). ✓ **Return information to the referring facility** (back referral) to ensure continuity of care, including: ✓ **Referral slip** (return form, treatment card) advising the patient to return to the referring facility. ✓ **Document treatment and referral information** on the MCH book and patient record. ✓ **Maintain accurate records** in the referral logbook (in-coming), patient files and discharge summary. ✓ **Refer to a higher-level facility** if the patient's condition requires specialized care.

E: Post-partum Care

Service Providers	Actions to be Taken
Health Worker Who Attended Delivery	✓ **Inform the Healthcare Provider** about the status of postpartum women and newborns, especially if follow-up care is needed. ✓ **Communicate the type of postpartum and newborn care** that was provided by the hospital/RHU before discharge. ✓ **Use referral forms (out-going)**, **discharge summary forms** or communication methods (phone, text) for back referral.
Community Health Team (CHT)	✓ **Notify about the discharge** of postpartum women and request for a postpartum home visit to ensure proper recovery and care. ✓ **Record the outcome of the delivery** in the pregnancy tracking record for continuous monitoring. ✓ **Inform the family about available health services** for mothers and children, including breastfeeding support, family planning and immunization services.
Rural Health Midwife (RHM)	✓ **Provide postpartum care** through home visits, ensuring mothers and newborns are recovering well. ✓ **Update** both prenatal and postpartum records. ✓ **Educate mothers on available MCH services**, including **immunization**, **growth monitoring**, **exclusive breastfeeding**, **nutrition** and **family planning** options. ✓ **Inform the Community Health Workers (LHWs)** about the status of mothers and newborns after follow-up. ✓ **Provide feedback to referring health workers/facilities** through back referral using referral forms (return slip), discharge instructions and regular communication (phone, text, meetings).

PARTICIPANT'S HANDOUTS

Annexure 1-A: Referral Form

Referred to: Address:	Date and time:	
Patient's Name: Address:	Age:	Sex:
	Civil Status:	Occupation:
	Date Admitted/Seen:	
Brief Clinical History:		
Past Medical History: G___ P___ (___,___,___,___) G1 G2 G3 G4 G5		
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:		
Working Diagnosis:		
Management:		
Pertinent Laboratory/ Procedures Done:		
Reason for Referral / Services Requested:		
Referred by: _____ Signature over Printed Name	_____ Position/Designation	

Annex 1-B: Return Form

<table>
<tr><td colspan="2">Name of Facility:

Address:

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

Address:</td></tr>
<tr><td colspan="2" 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="4">Action(s) Taken:</td></tr>
<tr><td colspan="4">Recommendations/Instructions:</td></tr>
<tr><td colspan="4">_____

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

Annexure B: Referral Log Book

Annex B1: Line Listing for Outgoing Referrals

Date & Time Referred	Name of Patient	A G E	S E X	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:

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)

Annexure C: Registration Record 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 D: Referral Monitoring Checklist

Indicator	Health Facility		
	BHU	RHC	Hosp
A. Reason for Referral			
1. Was the referral appropriate?			
2. Can the referral be reduced by upgrading the function of the service provider?			
B. Outcome of Referral			
1. Was appropriate care provided?			
2. Was a return slip issued?			
3. Was the return slip received by the referring facility?			
4. Was follow-up care provided by the referring facility, if necessary?			
C. Transportation			
1. Was transportation available on time?			
2. Was transportation provided as planned?			
3. Is there any need for improvement in transportation?			
D. Information Sharing Among Health Facilities			
1. Were ILHZ meetings held regularly?			
2. Does TCL cover all pregnant women, consolidating pregnancy tracking records and client lists from hospitals/clinics?			
3. Was the Maternal Health Diary (MHD) provided to all pregnant women?			
4. Did the health worker properly record the Maternal Health Diary?			
5. Was a birth and emergency plan created?			
6. Was coordination with transportation providers and health facilities made?			
E. Attainment of Project Goals			
1. Facility-based delivery rate			
2. Prenatal care/postpartum care coverage			
3. Annual Maternal and Newborn Death Review			

Annex E: Referral Guidelines

Following guidelines need to be practiced by all healthcare facilities both, public and private in letter and spirit while referring the patients:

Serial No	Key Area	Details
1	**Referral Process**	The referral process includes stabilizing the patient, informing the family, arranging for a nursing escort (if needed), identifying a caregiver and preparing the patient for transport.
2	**Referral Documents**	Referral documents should contain the patient's identity, detailed medical history, ongoing treatment and the general health condition to ensure proper continuity of care.
3	**KP Emergency (Medical Aid) Act, 2014**	The Act defines "injured person" as someone who needs immediate treatment due to incidents like accidents or assaults. It permits shifting a patient only after stabilization or if necessary treatment isn't available.
4	**Record Maintenance**	Both referring and receiving hospitals are responsible for maintaining accurate and secure records, preventing tampering. The In-charge of the hospital ensures proper record custody.
5	**KP Emergency Rescue Service Act, 2012**	Act empowers the Rescue 1122 Service to arrange transportation for patients needing emergency medical treatment, ensuring timely transfer to the nearest healthcare facility.
6	**Life Safety Procedures**	The Act enables Emergency Officers or Rescuers to perform life-saving procedures within their level of training and competence, aiming to stabilize patients in critical conditions.
7	**Minimum Service Delivery Standards**	The Khyber Pakhtunkhwa Healthcare Commission's MSDS provides standardized procedures and SOPs for referring patients to hospitals that offer specialized care, ensuring systematic patient transfers.

Serial No	Key Area	Details
8	**MSDS Reference Manual**	This manual specifies that referral forms must include detailed medical history, treatments performed, reasons for referral and the name of the receiving hospital. It also mandates following SOPs for patient transfers. ✓ Ambulances used for transporting critically ill patients must be equipped with necessary life-support equipment and staff trained to manage the patient during transit, minimizing any risks. ✓ Ambulances and rescue vehicles must meet the standards outlined by the KP Emergency Service Act. Vehicles not meeting the standards can only be used for patient transport.
9	**Requirements for High-Risk Pregnancy Care**	High-risk pregnancy care facilities must have proper laboratory services, blood bank facilities (including rare blood groups) and intensive care units with a multidisciplinary team for managing critical cases.
10	**Referral in Case of Insufficient Resources**	If the available resources in a hospital are insufficient to provide necessary care, a referral must be made immediately to the nearest competent healthcare facility that can provide the required care.
11	**Professional Links with Referral Hospitals**	There should be strong professional connections with referral hospitals to ensure that emergency and specialized services, including maternity care, are accessible. A 24-hour roster of qualified staff should be available.
12	**Written Communication for Referral**	The referring hospital must provide written communication about the referral, which should be acknowledged by the receiving hospital, ensuring smooth transition and proper documentation.
13	**Consultation Procedures**	Written procedures must be established to ensure timely consultations with the necessary specialists (e.g., gynecologists,

Serial No	Key Area	Details
		physicians, surgeons and pediatricians) for patients requiring medical or surgical care.
14	**Emergency Treatment Regardless of Payment**	All patients presenting with an emergency medical condition must receive treatment aimed at stabilizing their condition, irrespective of their ability to pay, ensuring that emergency care is accessible to all.
15	**Conditions Where Referral is Not Justifiable**	Referral should not be recommended for conditions such as degenerative diseases, terminal illnesses, or chronic diseases where treatment will not benefit the patient, or if local resources are sufficient for rehabilitation.
16	**Responsibility of Receiving Hospital**	The receiving hospital must be informed of an impending referral, make necessary arrangements and be prepared to manage the patient. A health worker might accompany the patient if they are critically ill.
17	**Health Worker Accompaniment**	If the patient is critically ill, it may be necessary for a trained health worker to accompany the patient during the transfer to ensure continuous care and monitoring during transport.
18	**Preparatory Arrangements at Receiving Facility**	The receiving hospital's Emergency or OPD department must be prepared for the patient's arrival, ensuring that the necessary resources and staff are available to handle the referral.
19	**Separate Referral Counters**	The receiving facility should have designated counters for receiving referrals, where the necessary documents are processed and the patient is quickly directed to the appropriate care unit.
20	**Specialized Care and Documentation**	The receiving hospital must provide the required specialized care, documenting the treatment provided for continuity of care and ensuring proper follow-up.
21	**Rehabilitation/Follow-up**	The receiving hospital should plan for the patient's rehabilitation or refer back to the original health facility for follow-up care, ensuring that the patient's ongoing medical needs are addressed.

Serial No	Key Area	Details
22	**Feedback to Referring facility**	The receiving hospital should provide feedback to the referring facility, sharing details about the patient's care and recovery and update the central system if established.
23	**Maintenance of Records**	The receiving hospital must maintain updated records of patients received through referrals, ensuring the data is accurate and available for future reference or legal purposes.
24	**Compliance with Medico-Legal Requirements**	The receiving hospital must comply with relevant medico-legal requirements, ensuring that all legal aspects of patient care, including consent and documentation, are handled appropriately.