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THE REFERRAL SYSTEM REVISED

DISCLAIMER
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PREFACE

Due to financial constraints, healthcare programs are seeking the most effective and efficient ways to provide health care for its citizens. As part of the health sector reform initiatives, countries are exploring ways of making care more efficient while maintaining the quality and continuum of care that is needed to achieve optimal health outcomes. Similarly, the Iraqi Ministry of Health (MoH) is also working on its health sector reform agenda that includes many strategic initiatives to ensure greater equity, accessibility and quality. USAID has designed its Primary Health Care Project in Iraq (PHCPI) to help MoH in its reform agenda particularly one that focuses on strengthening of the primary health service delivery in the country.

Since all health care required cannot be obtained at any given level of the system, an effective referral mechanism is a key element in the delivery of care. As a result, the USAID/PHCPI and the MoH have worked together to develop this document that details the protocol for a Referral System. The contents of this manual will serve as an essential guide to health planners, managers and practitioners and will constitute one of the planks on which the MoH can build its regulatory responsibilities for healthcare in Iraq, insofar as they relate to referral practices.

In this document a referral strategy is outlined that covers health system issues as well as roles and responsibilities of both the referral initiating and referral receiving facilities. In addition, the document also lays out strategies that are needed for supervision and capacity building that are critical for making the referral mechanism fully functional. The document also highlights the importance of continuous quality improvement including patient safety and rights within the referral system.

1. INTRODUCTION

In many developing countries, a high proportion of clients seen at the outpatient clinics of secondary facilities (hospitals) could be appropriately looked after at primary health care centers to lower the overall cost both to the client and the health system. In many countries, however, patients often bypass the primary care system and visit secondary/tertiary care facilities directly. In part, this is done due to the perceived quality available at the secondary care sites and partly due to the fact that the primary care facilities often do not have skilled staff or drugs available for the patients.

An effective referral system ensures a close relationship between all levels of the health system and helps people receive the best possible care closest to home. It also assists in making cost-effective use of hospitals and primary health care services. Support to health centers and outreach services by experienced staff from the hospital or district health office helps build capacity and enhance access to better quality care.

The health care system in Iraq has been based on a hospital-oriented and capital-intensive model that has limited efficiency and does not ensure equitable access. The MoH is the main provider of health care, both curative and preventive. The private sector provides curative services to only a limited population on a fee-for-service basis. In addition, access to health care has been further affected by years of conflict, sanctions and then ongoing military operations[1].

The MoH has established as one of its main objectives the improvement of the quality of care. As such, one of the national priorities is to implement a comprehensive, accessible and adequate model of health care with emphasis on the development and implementation of standardized norms, procedures and management protocols.

One of the major concerns is the lack of standard procedures and protocols for the referral of patients between the different levels of the health care delivery system. The key problem being the acceptance of referred patients by the reference centers, the counter-referral of patients from the higher levels to the primary care providers, and the quality of the information reflected on the referral forms. All of these factors have a direct impact on the continuity of care.

With the restructuring of the healthcare delivery system, the MoH is now faced with the added responsibility of regulating and supervising the delivery of care both in the public and private sector. This will require standardized norms and procedures to ensure high quality in the delivery of services to the population.

In order to support the MOH in these major changes the USAID/PHCPI is working closely with the government to develop an effective, standardized approach to a referral system beginning with the Primary Health Care Centers.

[1] Basic Health Service Package (BHSP, 2009)

1.1. Current Situation of Referral System in Iraq

Some Observations about the Referral System[2]

- Most referred cases are due to the preference of clients because they are not satisfied with the quality of services received at PHC centers.
- Due to a stock out of referral forms in the PHCs, staff are forced to utilize any available paper for referral. The Kirkuk Committee Team reported that "they need five months of paper work to obtain approval to print new forms".
- There is no clear list of "criteria or indication for referral" available that can be followed by staff at the level of PHC centers.
- The medical record system in the PHCs is weak; when a patient returns from a referral, PHC staff either do not have or cannot locate the patient's record to know why the patient was referred in the first place.
- There is contradiction and overlap in the instructions issued by different authorities when making or documenting a referral.
- There is no follow up to the referral system at the level of the MOH; only three DOHs have continued working within the system while other DOH have stopped.
- A lack of awareness exists concerning the basis and application of the referral system among both health care providers and health care receivers.
- In most cases full details about the patient are lacking on the referral form and sometimes even the name of the PHC center requesting the referral is missing. The reason for the referral is also usually missing.
- There is weak coordination between different offices that are directly concerned with the implementation and application of the referral system.
- There is weak compliance of the PHC centers and the hospitals in terms of data and its relationship to the referral system. A secondary issue is the incompleteness of information in the referral form.
- There is no policy that directs the PHC staff where to keep the feedback documents and for how long.
- There was a copy of an order signed by previous Minster of Health, stating that "health provider staff needs to offer services to any clients who attend the PHC or hospital even if he/she doesn't have a referral paper". Providers perceive that this order enable patients to bypass the referral system.

PHCPI Recommendations

1. There should be a modification of the table of the referral sheet used by the health offices in order to include all the needed information and to make it more applicable and understandable.

[2] These observations and recommendations were drawn from PHCPI team meetings with PHC medical staff from health centers all over Iraq, they do not represent the formal views of the MOH.

2. In order to organize the feedback from the hospitals to the PHCs, the timing and scheduling of the feedback should be restricted to the previous month only in order to prevent any misunderstanding and overlapping of data that are related to different months.
3. There is an acute and urgent need for a nationwide health education campaign in order to explain to both the people and the health workers the nature and the benefits of the referral system. This need is being addressed in the Referral System Orientation Guide that has been developed in conjunction with the MOH and now being translated in English. The Guide will be rolled out nationwide under PHCPI Component 3 Community Outreach and Engagement.
4. All required information listed in the referral form needs to be completed by both the PHC center and the personnel of the hospitals.

1.2. Characteristics of a Referral System:

Linking the different levels of care is an essential element of primary health care. The referral system complements the PHC principle of treating patients as close to their homes as possible at the lowest level of care with the needed expertise[3]. As emphasized by the WHO, this back-up function of referral is of particular importance in pregnancy and childbirth, as a range of potentially life-threatening complications requires management and skills that are only available at higher levels of care[4]. The following levels of care have been identified: (1) PHC sub-centers, (2) health centers (sub district) and (3) district hospital.

Health facilities allocated at the sub-district level are linked to those at the district level usually; practically speaking, health facilities functioning at the sub district level are mainly PHC centers, some of which are providing more advanced services in terms of delivery care, emergency obstetric care, and emergency care.

Health facilities located at the sub-district level are to be linked to the district hospital. This means that patients with unsolved health problems at the sub district level will be referred to the district level (district hospital) for more advanced health care and services. At the same time patients seeking care at the PHC center at the district level whose problems were unsolved or need more advanced care are to be referred to the district hospital for the completion of care and management.

Patients whose health problems are not fully resolved at the district hospital and are in need of more specialized and advanced care are to be referred to the provincial level, where more advanced health services are usually available. In some cases, patients or clinical conditions fail to find the proper care and services at the provincial level may be referred to the tertiary care level in Baghdad where highly specialized centers are available.

A referral system is a two-way system, i.e. patients and conditions referred from primary health care center with a special completed form and in compliance with certain rules and instructions are to be received at the referral level in an appropriate manner and provided with the necessary care or services needed. The referring PHC center should be informed about all the details of the patient's condition, investigation done for the patient and their findings and procedures and interventions.

[3] King M (1966). Medical Care in Developing Countries, Oxford University Press, Oxford.
[4] WHO (1996). Care in Normal Birth: a practical guide, Maternal and Newborn Health/Safe Motherhood Unit, Family and Reproductive Health, WHO, Geneva.

All health facilities, institutions, and centers who are receiving the referred patients and conditions should and must be prepared to show the proper concern to the patient referred to them from a lower level facility. At the same time the lower level health facility should be informed of all procedures, tests, and interventions conducted for the patients in a timely manner. This will enable the health facility to be prepared and able to follow up that patient's condition when he/she returns to receive health care at that level.

1.3. Objectives of the Referral Strategy

- Clients receive optimal care at the appropriate level and at an affordable cost.
- Hospital facilities are used optimally and cost-effectively by improving the continuum of care for patients.
- Clients in need of specialized services can access them in a timely way.
- Primary health services are well utilized and their role in both prevention and curative aspects is enhanced.

2. BACKGROUND AND RATIONALE

2.1. Health Infrastructure

The MoH is the main provider of health care in Iraq. Primary health care is provided through PHC sub-centers and PHC main centers. PHC centers provide preventive, promotive, and basic curative services, along with simple diagnostic investigations free of charge. PHC centers are positioned to refer to the second or tertiary level of care at MoH district and general hospitals.[5]

Other health service providers include private sector and semi-private sector (public clinics operating at a PHC center in the afternoon with a lower fee than in the private sector). Semi- private clinics provide curative services and follow-up for patients with chronic diseases. There is also an informal sector (traditional and unqualified healers) providing their services. They include traditional birth attendants (TBAs), bone setters and herbal medicine dispensers. Efforts to strengthen the PHC system through community-based initiatives (CBI) are ongoing and have had many successful experiences. The PHCPI will build upon these CBI successes in Component 3 through operationalization of the Community Health Partnership program.

2.2. Types of Health Facilities

2.2.1. PHC Centers

There are 6 types of PHC centers in Iraq:

1. **PHC Main centers (Category A):** These are the centers that deliver all the primary health care services and are managed by medical doctor. There are approximately 1,100 centers in

[5] BHSP, 2009, MoH reports

Iraq.

2. **Model PHC:** A Primary Health Care facility with an x-ray unit, ultra sound, and lecture hall. Based on the current definition, there are approximately 142 facilities in Iraq.
3. **Family Medicine Center:** a PHC Main Health Center that follows the family medical approach. The medical staff includes a physician trained/specialized in Family Medicine. There are approximately 40 centers in Iraq.
4. **PHC Training Center (Category B):** These centers offer the same services as category (A) plus provide training activities for medical, paramedical, nursing, and undergraduate students. There are 22 centers – on average one per directorate.
5. **Main PHC with labor and emergency room (Category C):** These centers deliver the same services as Category A facilities in addition to emergency care services and services for normal labor. This type of PHC facility is established in remote areas where there are no nearby hospitals (over 25 km). They provide 24 hour medical services. There are approximately 114 centers in Iraq; however many of them are not fully functioning due to lack of qualified staff or equipment/supplies.
6. **Main PHC at university compounds:** These facilities provide PHC services to teaching staff their families, students and staff working in the compound in addition to food inspection of canteens providing food for these compounds.

2.2.2. PHC Sub-centers

Primary health care sub-centers (Category D): These sub-centers deliver simple maternal and child health services, immunization activities and simple curative services. There are two types of Sub centers with approximately 1,231 in Iraq. These sub-centers are managed by:

- **Medical staff** (e.g. dentist) that provide medical services to population with more than 10,000 persons.
- **Paramedical staff** who provide PHC services to 3,000 to 7,000 populations.

2.2.3. Healthy Home:

A medical center that provides simple, essential medical services to less than 3,000 populations. Approximately 160.

2.2.4. Hospitals:

Secondary and tertiary care is provided by 229 public hospitals (49 in the Kurdistan region) and 92 private hospitals, two thirds of which are located in Baghdad. These hospitals provide out- patient and in-patient care that is primarily obstetrical and surgical services.

2.3. Challenges of PHC services

PHC facilities are inequitably distributed with large differences both between and within governorates. Large disparities also exist between urban and rural populations, particularly in their ability to access health services. In suburban and rural areas 29% and 26% of people respectively are required to travel approximately 30 km to the nearest PHC center. In comparison, only 5.4% of urban dwellers travel the same distance. Access to health facilities has also been negatively impacted by the poor security environment.

The past two decades have witnessed a progressive deterioration in the quality of care. Health facilities and hospitals lack proper maintenance and are short of supplies, drugs and equipment. Many buildings still lack electricity and proper sanitary amenities and are in dire need of rehabilitation and/or expansion. Human resources are inadequate in number and unevenly distributed. In addition, there is a high turnover of staff at all levels, which has a negative impact on continuity and the delivery of PHC services.

This situation has forced patients to seek services directly at the tertiary care level bypassing primary health care. According to the MoH/PHCPI Baseline Survey of the Primary Health Care Facilities conducted in 19 districts, the percentage of population attendance at PHCs varies from

3% - 26%. These variations also occur within the same districts and have been attributed to the following:

- Catchment areas and populations are not allocated for PHCs.
- The size of the catchment areas/population served by the PHC facility varies.
- Variability of supply of drug supplies to the PHC centers.
- People are not satisfied with the services provided by the PHC level.

The private sector has the capacity to supplement weaknesses in the public sector, especially in provision of curative services. In general, there is an uncoordinated network of a large number of clinics nationwide and small private hospitals, mostly located in Baghdad.

2.4. Current Status of Referral System[6]

Findings from the PHCPI baseline survey revealed that all primary health care facilities surveyed use a referral form; however only 25% of these facilities use the standard mechanisms of referral between primary and secondary level of care in comparison to 91% of health facilities in Baghdad. In addition, although PHCs refer patients to secondary care for advanced care, only

33% of these facilities recorded receiving feedback from the referral hospitals. Results showed that there is minimal coordination between the PHC level and the hospitals within district health systems apart from communicable disease surveillance as well as no official or formal mechanisms for public-private collaboration and partnership.

[6] USAID/PHCPI Baseline Assessment Report 2011

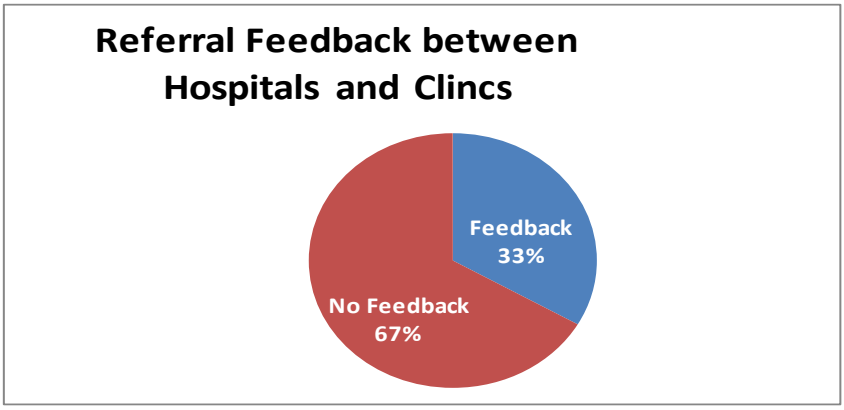


Figure 1: Percentage of referral feedback between the hospitals and PHCs
Source: PHCPI Baseline Assessment Survey 2011, unpublished

3. DEFINITIONS

3.1. Referral System

A process in which a health worker at one level of the health system, having insufficient resources (drugs, equipment, skills) to manage a clinical condition, seeks the assistance of a differently resourced facility at the same or higher level to assist in, or to take over, the management of the client's case. Key reasons for deciding to refer either an emergency or routine case include:

- To seek expert opinion regarding the client.
- To seek additional or different services for the client.
- To seek admission and management of the client.
- To seek use of diagnostic and therapeutic tools.
- To meet the client's expectation to be seen by specialist.

The process of directing, re-directing or transferring a patient to an appropriate specialist or agency should use a systemic process. Usually the referral is done from a unit of lower complexity to a unit with a higher resolution capacity. The Referral is Horizontal when it occurs between units of the same institution; and Vertical when it is between units of different institutions.

The first facility that starts the referral process is called the initiating facility and at that level; an outward referral should be prepared to communicate the client‘s condition and status.

3.2. Receiving Facility

The facility that accepts the referred case is called the receiving facility; at the end of their involvement, they should prepare a back referral on the lower part of the referral forms to let the initiating facility know what has been done. This completes the referral loop between the 2 facilities.

3.3. Referral Registers

It is a means of maintaining a list of all outward and internal referrals for one facility or service provider. Information registered includes client referred, to where, when and why, whether the case is closed or continuing (the retuning referral form has been received with any necessary rehabilitation or follow-up), and whether it was an appropriate referral or if there were any issues.

3.4. Directory of Services

It is a list that documents all organizations providing specialist care. Such a directory can facilitate the search for the most appropriate service provider for a particular referral. Where such a directory is used, it is important that the contact information is kept up-to-date.

3.5. Counter-Referral or Return-Referral

It is the process of re-directing the referred patient back to the originating unit once the reason for referral has been resolved.

4. COMPONENTS OF A REFERRAL SYSTEM

A referral system requires consideration of all its important components that can be then adjusted to the local situation. The design and functioning of a referral system in any individual country will be influenced by:

4.1. Health Systems Determinants:

Factors that affect the functioning of a referral system include: capabilities of first level (PHC); availability of skilled medical and assisting staff; training capacity; organizational arrangements; cultural issues, political issues, and traditions. For a referral system to work efficiently, relationships between service providers must be formalized and referral procedures agreed upon. At all levels of the health system, primary health care services need to be functioning appropriately.

4.1.1. Policy &Organization

This includes all implementing health facilities (both public and private) having:

- Clear responsibilities and limitations for each level.
- Protocols and referral guidelines set for clinical conditions and available at PHC level.
- Communication and transportation aids affordable to the client; in general communication be by the referral form, but may in addition be by phone, fax and E-mail.
- When public sector is unable to provide an ambulance for health centers, a community-based system may organize transportation.

4.1.2. Service providers (public and private) and quality of care:

Improvement in resource availability and quality of care at the primary level is the first priority. It is essential to strengthen primary health care services to make them attractive and credible to the clients that meet their need, demands and ensure their satisfaction.

4.1.3. Factors affecting quality of care:

- The bypassing of primary level services by clients is a common problem that leads to overcrowding of facilities at the secondary and sometimes tertiary level.
- For overcrowded (out-patient) hospital departments, queuing systems can be designed to separate and fast-track referred clients, while those who bypass their primary services have to wait longer.
- Emergencies and very serious cases should always be seen promptly.
- Penalty fees may be charged to those who arrive at higher level facilities without a referral letter or other clear indication of necessity may also help to curb or limit unnecessary use of these expensive facilities.
- In urban areas, having primary and secondary services in separate (but proximate) locations enables rigorous enforcement of the referral only policy at the secondary facilities.

Intensive public communication and education is essential to inform the public how, where, and when they should seek health care at different levels and to build their confidence that primary level facilities really can offer acceptable quality care when needed.

4.2. General Determinants

Some of the general factors affecting a referral system include: population size and density; terrain and distances between urban centers& hospitals; pattern and burden of disease; demand for and ability to pay for referral care. Other factors affecting the successful use of a referral system include:

- All service providers should adhere to the referral discipline.
- Clear and agreed referral protocols and guidelines for all clinical cases managed by PHC.
- Supportive supervision at all levels (facility supervisors, health directorate, and ministry level).
- Monitoring and evaluation through referral statistics and feedback.
- Progressively improvement at the national health authorities (e.g. Ministry of Health) to ensure supportive feedback to the referral system.
- Active and continuous professional performance assessment regarding referral protocols in addition to appropriate education at medical and nursing schools and involvement of medical and nursing professional associations in setting standards for the referral processes.

5. REFERRAL SYSTEM FLOW

5.1. Initiating facility

- When a client visits the health center, it is important that the health worker attends to them promptly, treats them with respect, privacy and confidentiality, acknowledging their cultural beliefs, and identify their needs.
- Protocols of care are used: the health workers need to have ready access to and be very familiar with the agreed regional or national protocols for that level of facility. Protocols need to include likely circumstances for referral and details of the information and documents that should be sent with the client.
- The health workers assess the client, gather relevant information and provide any necessary care possible at that facility.
- The health worker in an emergency situation must maintain all vital functions and minimize any further damage.
- Making the decision to refer the client comes after the health worker has gathered and analyzed the relevant information using the protocol of care as a guide.
- Deciding to refer does not mean that the health worker is inadequate or bad.
- Health workers must be ready to receive clients when they return from a referred facility

A number of early WHO publications including Health for All[7] reported on the availability and appropriateness of the referral process, but the literature is limited about a description of the essential components of a referral system or what makes a referral system appropriate and quality of care components linked to functionality of referral systems. WHO[8] (1987 & 1991) describes the functions of a referral hospital and key elements that constitute a referral system. Examples of inward and outward flow of patients, instructions, demands and problems of patient referral systems are documented.

The development of a conceptual framework (Figure 2. below) provides a clear picture of the service delivery and movement of patients through the different levels of the system. The framework depicts the interface between the three levels of a referral system and influencing factors that determine the directional flow and outcomes for a patient. As reflected in the framework, the issues surrounding referral are complex. There are no clear criteria established regarding what precisely constitutes a quality referral system, what referral rates should be or what constitutes best practices for health personnel. For example, should referral rates increase or decrease from primary to secondary level is a much debated issue in the literature. There is limited standardization concerning the quality of referral judgments and monitoring of referral systems with a more ad hoc approach adopted by many public health facilities.

[7] WHO (1981).Health for All Series No. 3. Geneva, Switzerland

[8] WHO (2004). Road Map for Accelerating the Attainment of the MDGs related to Maternal and Newborn Health in Africa

Figure 2: Conceptual Framework for Referral from Primary to Secondary Level

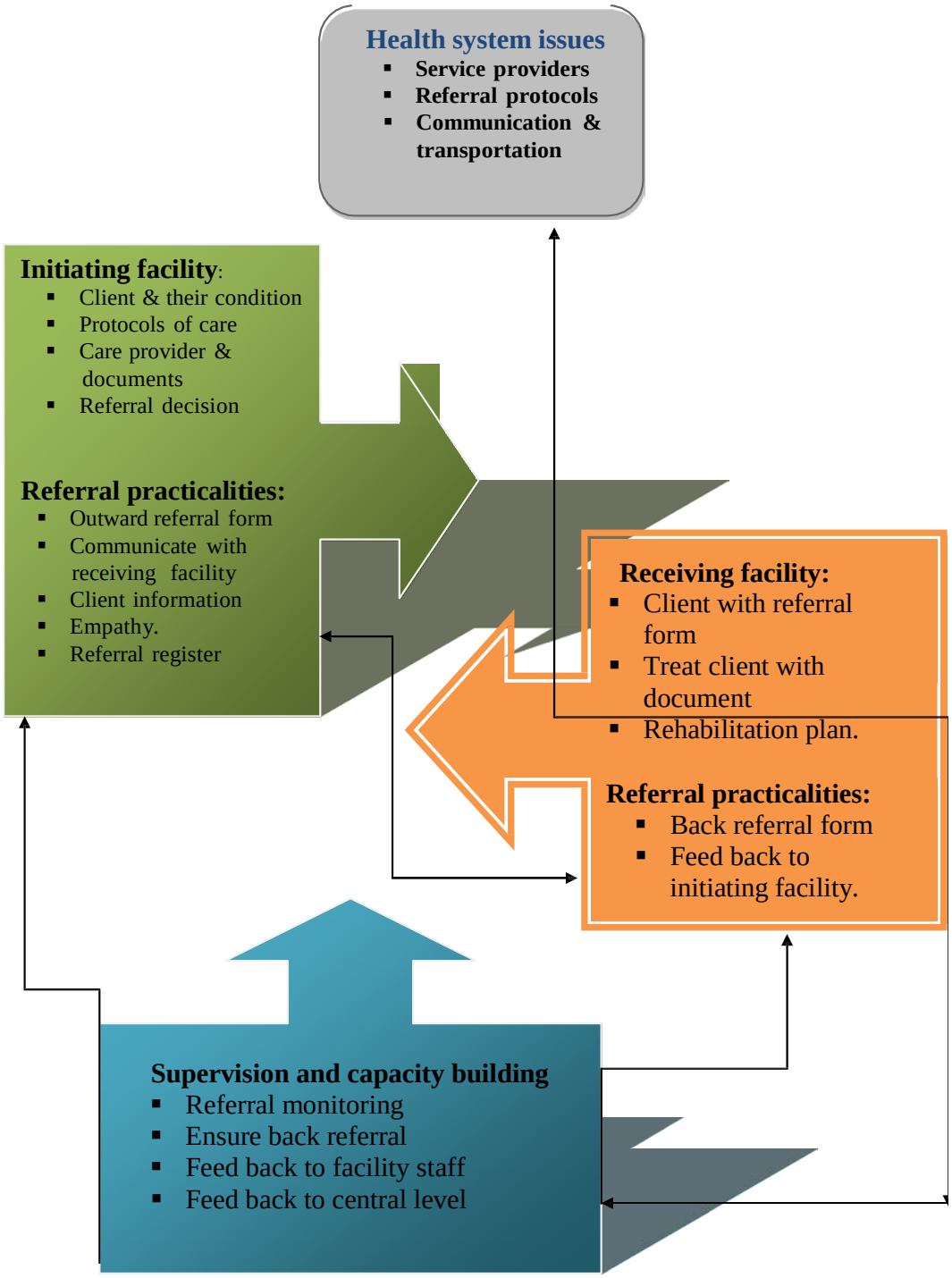
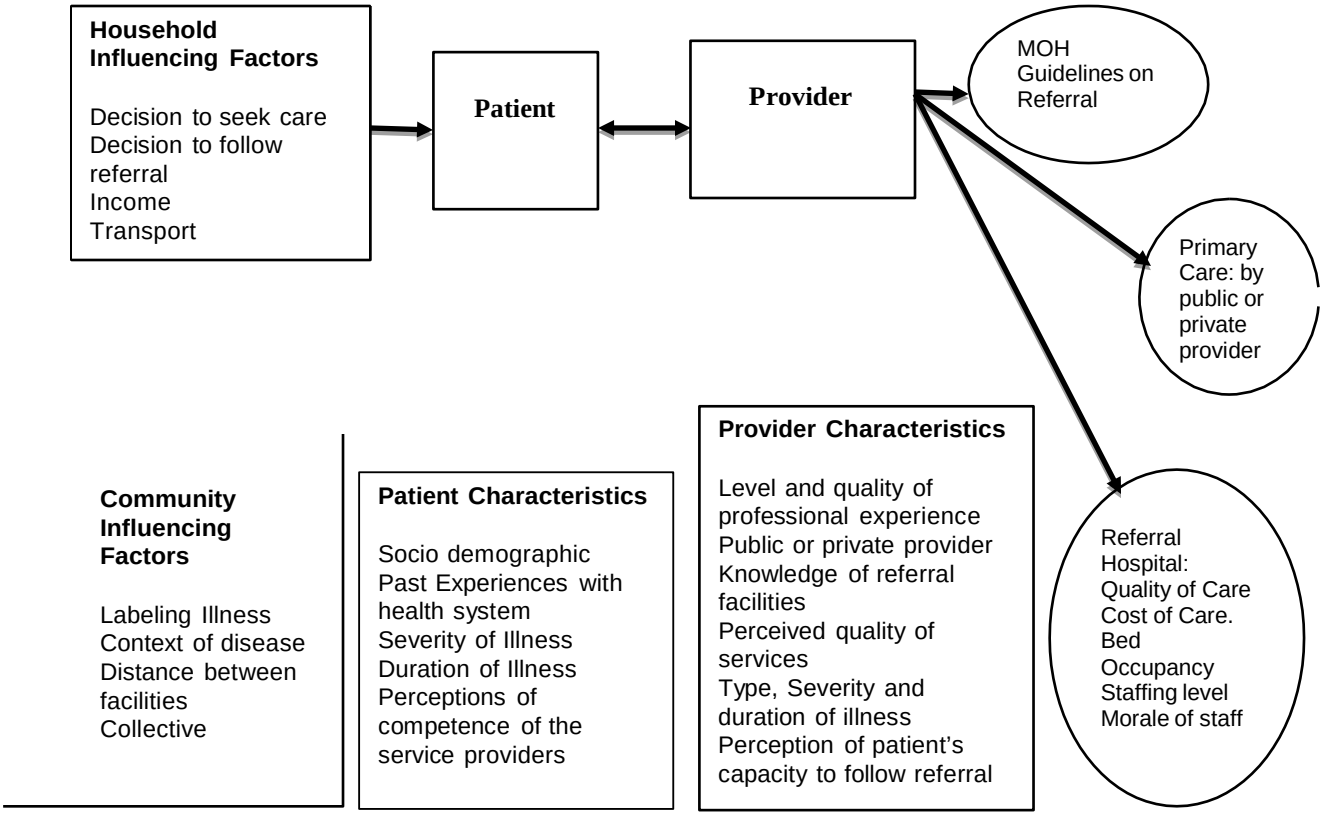


Figure 3: Community Interface Patient–Provider Interface Institutional Interface[7]



5.2. Referral Practicalities

- A referral form that is standardized throughout the network of service providers ensures that the same essential information is provided whenever a referral is initiated.
- The referral form is designed to facilitate communication in both directions; the initiating facility completes the top part or the outward referral.
- Every patient referred out should be accompanied by a written record of the clinical findings, any treatment given before referral and specific reasons for making the referral.
- The referral form should accompany the client (often carried by them) and give a clear designation of to which facility the patient is being sent. A carefully filled referral card cab help the client get timely attention at the receiving facility.
- In some situations it will be possible and necessary to communicate with the receiving facility to make an appointment or other arrangements for the referral, or to let them know of the pending arrival of an emergency case.
- If the client is very ill, it might be necessary for a health worker to accompany them to the receiving facility.
- The decision to refer might be frightening or distressing for the client and their family so it is important that the health workers have empathy and give the client relevant information such as:
    - Reasons and importance of the referral, risks associated with refusal of referral.
    - How to get to the receiving facility – location and transport
    - Who to see and what is likely to happen
    - The process of follow-up on their return
- Health workers can show empathy in understanding the implications of referral for the client and their family or support network. The client may be:
    - Frightened of the unknown, frightened of becoming more ill or even dying.
    - Concerned about meeting the costs of transport, treatment and family accommodation.
    - Concerned about leaving work that needs to be done.
- Each facility in the network should have a referral register to keep track of all the referrals made and received. Information from the register is used to monitor referral patterns and trends.
- A standardized referral register used throughout the network of service providers can facilitate this.

5.3. Receiving Facility

- The receiving facility must be prepared for the arrival and receive the client with their referral form. They will use the information sent on the referral form to begin a thorough assessment of the client and begin management of the case.
- The receiving facility will use its particular resources to provide the client high quality care and maintain documentation according to agreed standards.
- As the client progresses the receiving facility will plan the rehabilitation or follow-up program with client and their family or support network.
- When the client's care has finished at the higher level facility, back referral to the original facility is important. The receiving facility completes the lower part of the referral form.
- This communication contains information on special investigations, findings, diagnosis and treatment given by the higher level facility as well as follow up expected from the lower level facility.
- The back referral can be delivered by the client to the initiating facility, but may also be sent by fax or post or E-mail.
- This communication not only assures proper patient care and follow up, but also provides continuing education to the initiating facility and their staff.
- The supervisor should check that back referral is received and, in its absence, pursue the relevant staff at the higher level facility to provide proper back referral information.
- The receiving facility can also give feedback to the initiating facility on the appropriateness of referral. If there are any issues regarding the need for referral, timing, speed or information sent.
- The higher level facility provides specific feedback to the initiating facility, if there is any issue related to referring technical issue. This will assist the lower level facility to be surer of referral processes in the future.
- The receiving facility completes its own register of referrals in and out, from their perspective.

5.4. Supervision and Capacity Building

- Facility managers and supervisors at all levels should monitor all referrals made to and from facilities in their area each month. Usually between 5% and 10% of clients seen in a primary health care facility will be referred to a higher level for diagnostic services or more specialized care[9].
- Supervisors should discuss referred cases.
- Identify those which should have been properly treated at the facility itself

[9] WHO. (2004). Road Map for Accelerating the Attainment of the MDGS related to Maternal and Newborn Health in Africa.

without referral.

- Identify cases which should have been referred but were handled locally.
- Check the back referrals received to determine whether the information is adequate and being acted upon by the facility.
- Follow up cases that have been referred but no feedback yet received to assure that the client has arrived at the higher level.
- Identify any issues regarding timing, promptness and completeness of information sent.
- Results of this analysis can be covered at meetings with hospital and clinic staff together.
- As the issues are discussed, staff will identify what is needed to improve things this might include clinical training or strengthening of particular parts of the referral system or its procedures.
- Facility managers and supervisors need to ensure that such items are followed-up and acted on.
- In-service education and capacity strengthening can be reinforced by good supervision.
- Long-term treatment of chronic illnesses such as diabetes, hypertension, epilepsy and psychiatric illness can be managed at suitably resourced health centers - this assures not only high quality of care for the client, but also greater convenience and less burden on the client and the higher levels of the health system.

5.5. Continuous Quality Improvement

- The referral system must be open to revision in the light of practical experience in order to meet the goals of the overall health system.
- Periodically, there may be a need to analyze the functioning of the referral system in addition to looking at statistical patterns and trends.
- The rapid appraisal methodology has been used to assess the status of and constraints to referral of severely ill children from first-level care to secondary and tertiary levels of care in many countries.

This methodology can be adapted to varying circumstances to examine the whole referral system for an entire region or country, or to focus in or particular specialties or locations of concern.

5.6. Referral & Patient Safety

- Set up clear guidelines and standards for medical staff when referring medical condition managed with in PHC.
- The referral form at the medical record unit (MRU) should be completed accurately & all necessary information listed so that the risk of a miscommunication that could result in patient harm will be decreased.

- All necessary medical interventions administered during the trip should be noted when the patient is referred/transported to another health facility; e.g. amount of fluid (ORS) given to dehydrated child during trip ,diuretics to pregnant women with PET, 1st dose of antibiotics to child with a very severe disease, etc.].

5.7. Referral &Patient Rights

- The patient has the right to know (why, where, when) to be referred.
- The patient has the right to discuss referral options and alternatives.
- The patient has the right to refuse referral unless it will be of a threat to his/her life.

5.8. Referral System Tools

There are five sample tools on the following pages:

1. *Sample Tool 1- Referral form:* Prepare four copies for each client,1st send with the client, 2nd kept as a copy in the client notes 3 and 4, sent to receiving facility, the 3rd kept in receiving facility records and the last sent to the referring facility.
2. *Sample Tool 2 – Register for Referral Out* The register has a page for referrals made out from a facility and referrals received into a facility.
3. *Sample Tool 3 - Register for Referral In*
4. *Sample Tool 4 – Back Referral* Information on back referral of clients referred out from the facility should be made on the same line as information regarding the original referral out. This facilitates follow-up (Sample tool 5, Follow-up Card).
5. *Sample Tool 5 – Follow-up Card for OPD*

Please also note that the two referral registers have a column to indicate whether there is any problem regarding the appropriateness of the referral. Keeping track of this information will help identify if there are problems with referrals from a particular facility, or problems with referral of clients with particular conditions. Knowing this can help focus in-service and continuing education of health workers.

Tool 1: Referral Form

Name of facility:								
Referred by:	**Name: Position:**							
Initiating Facility Name and Address:				**Date of referral:**				
Telephone arrangements	**YES** ☐	**NO** ☐	**Facility Tel No.**			**Fax No.**		
Referred to Facility Name and Address:	☐ **ER** ☐ **OPD**							
Client Name								
Identity Number				**Age:**		**Sex**	**M**	**F**
Client address								
Clinical history								
Vital Signs	**Temp.**	**PR**	**BP**	**RR**	**SPO2**	**Time**		
Findings								
Treatment given	☐ **IV Line** ☐ **IV Fluid** ☐ **Oxygen**							
Reason for referral								
Documents accompanying referral								
Print name, sign & date	**Name:**		**Signature:**			**Date:**		
Note to receiving facility: On completion of client management please fill in and detach the referral back slip below and send with patient or send by fax or mail.								

Tool 2: Register of Referrals Out

Date referral made	**Client Name(M or F)**	**Identity No.**	**Referred By** (Name of Physician)	**Referred to** ***(name of facility / specialty)***	**Referred for**	**Date Back referral received**	**Follow-up required YES / NO**	**Follow-up completed YES / NO**	**Appropriate referral YES / NO**

Tool 3: Register of Referrals In

Date referral received	**Client Name:(M or F)**	**Identity No.**	**Referred from** *(name of facility/specialty)*	**Referred for**	**Appropriate referral** **YES / NO**	**Summary of treatment provided**	**Date Back referral sent**

Tool 4: Back Referral Form

Facility Name		Tel No.		Fax No.	
Reply from (person completing form)	Name:			Date:	
	Position:	Specialty:			
To Initiating Facility: *(enter name and address)*					
Client Name					
Identity Number		Age:	Sex:	M	F
Client address					
This client was seen by: *(give name and specialty)*				on date:	
Patient history					
Special investigations and findings					
Diagnosis					
Treatment / operation					
Medication prescribed					
Please continue with: *(meds, Rx, follow-up, care)*					
Refer back to:				on date:	
Print name, sign & date	Name:	Signature:		Date:	

Tool 5: Follow-up Card For OPD

Card no:		**Date:**	
Name of facility:		**Department:**	
Physician name:			
Client name:	**Sex:** ☐ **Male** ☐ **Female**	**Age:** _____	**Phone no:**
Diagnosis :			

Date :	**Treatment:**	**Next appointment:**	**Notes**

6. ESTABLISHING A REFERRAL SYSTEM IN IRAQ

6.1. PROPOSED STRATEGY TO STRENGTHEN THE REFERRAL SYSTEM

6.1.1. Step 1: Mobilize stakeholders

Identify and bring together the various stakeholders to seek input on creating a formal referral network and generating "buy-in" for the activity. Stakeholders may include key MoH and DOH Managers, key staff from health facilities at all levels (from tertiary to community level), private sector health professionals, key staff from professional medical associations, community representatives/community leaders, and informal health sector representatives. There is a need to establish a bridge of communication between the private sector and public sector; such an effort will result in a better and more comprehensive use of healthcare facilities and providers in Iraq.

6.1.2. Step 2: Conduct an assessment of health services utilization pattern/facility mapping exercise

Conduct assessments or mapping to:

- define a catchment area with a defined population for each sub-center, PHC main center and hospital,
- define a group of PHC sub-centers to constitute as the catchment of a PHC main center for services, referrals and coordination,
- define a group of PHC centers to constitute as the catchment of a hospital for services, referrals and coordination,
- generate a list of all facilities providing services public and private services within the geographic area that might be included in the referral network.

The mapping should identify key entry points (that is, how a client gets into the referral network), potential barriers to access and how the network will be linked to existing services in health facilities. The mapping exercise should also identify community resources, including the private sector and informal structures that can be tapped to strengthen and expand the referral network. Community leaders could be an excellent resource in this activity and should play an active role.

6.1.3. Step 3: Put systems in place to develop and support the referral network

6.1.3.1. Determine the roles and responsibilities

- Determine the roles and responsibilities of each organization within the referral system, including potentially developing a formal/legal Memorandum of Understanding between organizations.
- Hold sensitization meetings with stakeholders and staff of participating facilities to

achieve consensus on operating principles, such as ensuring that all referrals are honored.

- Encourage and help providers at all levels to nurture personal contacts within the network to facilitate referrals and follow-up; and maximize community resources for referrals.
- Supervisors in the network's organizations should ensure that staff understands the referral network and how it works and support staff at all levels (hospital or clinic- or community-based) in providing referrals as necessary.

6.1.3.2. Develop standardized processes and tools

Outline an appropriate mechanism for referral, including referral tools to document the process for the referrals and follow-up.

Standardized tools and processes (how to make a successful referral) should be available to organizations in the referral network to maintain accuracy, efficiency and consistency.

The tools could include:

- Directory of services showing all health service agencies in the catchment area and updated regularly
- Referral forms
- Client tracking forms
- Referral registers

Create and distribute standardized forms, tools and procedures and train all organizations in the network to use them.

6.1.3.3. Establish referral coordinating unit in each referral network

A specific unit in the network located at the district level could serve as the locus of responsibility for the network and its performance (in addition to its regular duties). This coordinating function could be performed by a health facility, preferably a unit within the facility that is dedicated to this function.

The primary functions of the coordinating organization/unit include:

- Convening regular meetings of providers
- Working with providers to address gaps and other inefficiencies in the system
- Updating the directory
- Providing standardized tools and forms
- Performing quality assurance for the referral system.

At the coordinating/organization unit, a specific person is designated to fulfill the tasks listed above.

6.1.3.4. Provide support for improving quality of PHC centers

Improve efficiency of resources by promoting a better allocation of the health budget between primary and secondary level care and supporting a system with staff and training to ensure quality of care provided by PHC centers.

6.1.4. Step 4: Mobilize the community to use and support the referral network.

Promote public awareness regarding available services at PHC facilities to build demand for PHC services. Seek the support of education leaders, medical providers and local leaders/policymakers to use their influence to increase community support for the referral network. Under Component 3 the PHCPI will utilize the Community Councils to promote the use of referrals and encourage the use of the PHC rather than bypassing it and going directly to hospitals for initial care.

6.1.5. Step 5: Monitoring and Evaluation

Monitor the referral network's activities and use findings to improve the system.

Evaluating the referral networks provides feedback for quality assurance and for informing the planning, design and implementation of future services. Some illustrative indicators for monitoring and evaluating referral networks are as follows:

- Total number of referrals made,
- Number of follow-up referrals made,
- Number of referrals made to which services,
- Number or percent of referral services completed,
- Number or percent of clients who report their needs were met,
- Number/percent of clients who with feedback on effectiveness of referral process,
- Number/percent of clients with feedback on referral.

One proposed strategy to monitor quality of services is a quarterly review of the referral register maintained by each service provider within the network to identify missing information, incomplete service delivery and other service and documentation problems.

Findings from the review are discussed with the service providers, and organizations participating in the network meet monthly to share findings and develop solutions to cross-cutting issues.

6.1.6. Way Forward to develop a Referral System with MoH and PHCPI in Year 1 of the project

- Conduct preparatory workshop with MoH Referral System Committee to implement

new referral system policy & implementation. (Draft Referral System paper was distributed to members and feedback and discussion will occur during this meeting).

- Organize high-level policy makers' workshop to adopt new system.
- Provide all necessary technical assistance to MoH that will lead to accurate, proper, timely referral system including developing training materials and assisting with training.
- A timeline for the Way Forward with respect to pilot testing the referral system and developing the Referral policy is attached below as a guide for next steps.

Conduct preparatory workshop with MoH Referral System Committee

1. Conduct SWOT analyses for the current referral system (challenges, constraints and a vision to implement a revised referral system and subsequent referral policy).
2. Discuss the findings of Baseline Survey that relate to referral system in order to better understand the strengths and weaknesses of the current referral system.
3. Obtain feedback from the staff at PHC centers, district and provincial level.
4. Facilitate in-depth discussion of the new referral system and subsequent need for policy revision.
5. Prepare final remarks, conclusions, and recommendations that aim at strengthening the referral system.

Organize Higher MOH committee meeting to adopt the new referral policy

The 'Referral System Higher Committee' within the MOH consists of the Senior Deputy Minister (Chairman); DG of Public Health (also Head of the TAG and a member of this Committee) as well as the DGs of the MoH central level directorate. This Committee reports to the TAG with its findings and recommendations. The policy developed within the Higher Committee will be adopted through the following actions:

- Presentation of a SWOT analysis and Baseline Survey (BLS) findings related to referral to the Higher Committee.
- Present new policies with detailed action work plans and implementation.
- Define selection criteria for a pilot referral policy (PHCPI included, G.D. commitments, district & PHC staff awareness & commitments, workload, quality service for referral hospital, etc.
- Identify location of pilot facilities

Conduct Pilot referral system: allocation of essential resources

1. Identify health workers to conduct piloting for training/orientation of new referral system.
2. Identify community supportive groups (NGOs, medical & nursing syndicates, TB and

other associations).

3. Prepare essential stationery, communication, IT, registry books & sheet.
4. Conduct orientation workshop for stakeholders.

Supervision and Monitoring

1. Weekly supportive supervision for piloting the new referral system.
2. Stakeholders meet every 2 weeks to monitor, support, and facilitate effective use of new system. (PHCPI to participate and can provide assistance for bi-weekly meetings, if requested).
3. Monthly meeting for MOH referral system committee to monitor and provide necessary intervention to the new system.
4. Monthly reporting and feedback about changes in system and summary reports of how the system is functioning.

Assessment of a pilot referral system

1. Conduct MoH Higher Committee to present final pilot referral assessment. (PHCPI will facilitate the meeting if requested).
2. Remarks, conclusion, updating referral policy.
3. Final referral policy approved.

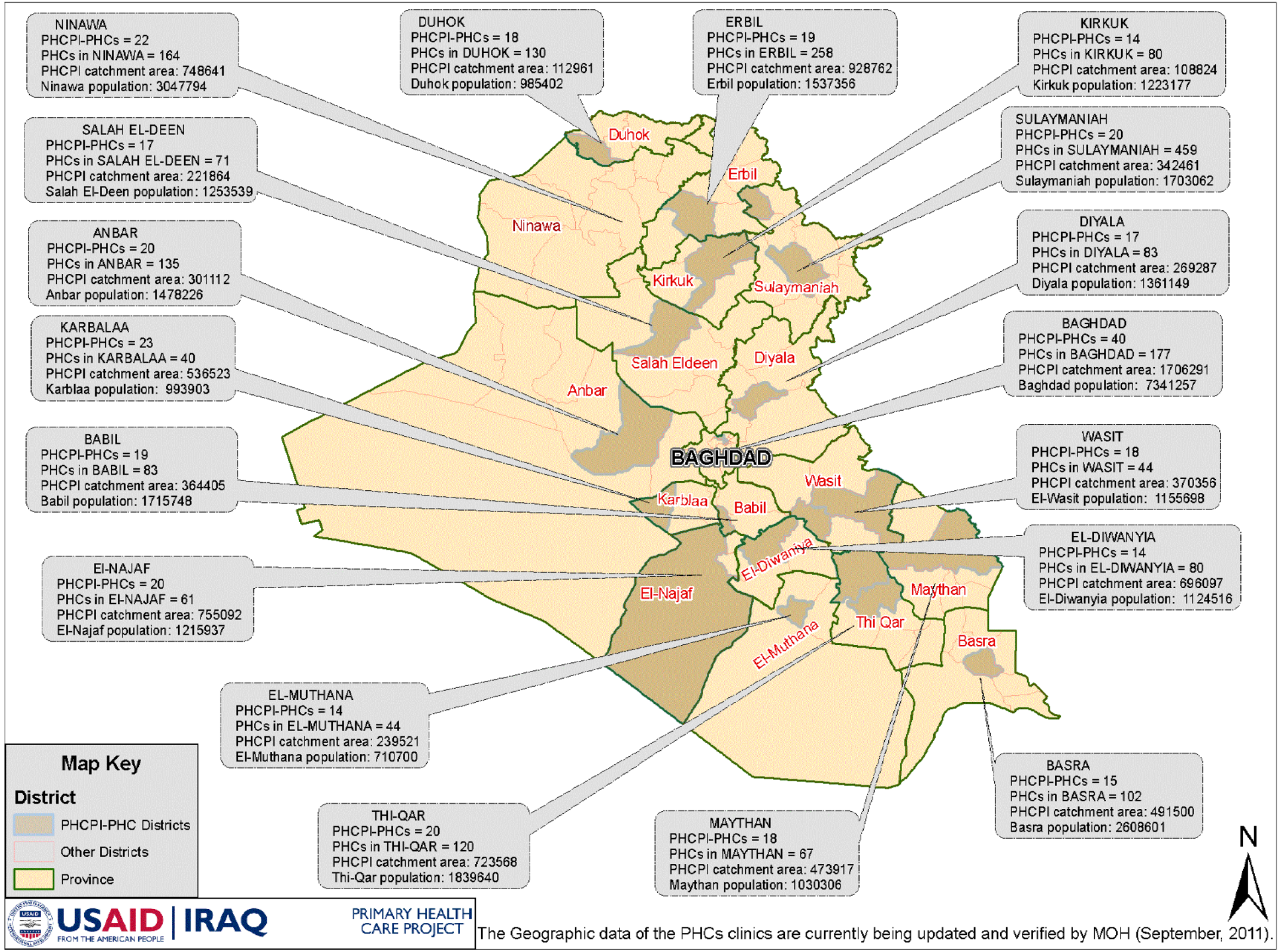
Country wide implementation of referral policy

4. Prepare essential stationery, communication, IT, registry books & sheet.
5. Conduct orientation at governorate level for supervisors.
6. Implement and track performance of referrals made and received between primary health care centers and hospitals.

Committee members involved in revising referral system :

- Dr. Raad Ahmed Sa'eed/ Anbar DoH
- Dr. Nadhim Nayef Salem/ Anbar DoH
- Dr. Nagham Hussein Abed Ali/ Diyala DoH
- Dr. Maher Saleh Hadi / Diyala DoH
- Dr. Haider Ibrahim Khalil / Karbala DoH
- Dr. Sahib Abdulredhda Saeed / Karbala DoH
- Dr. Abdulrasool Noor Swadi / Babel DoH
- Dr. Hussein Kadhim Abboud / Babel DoH
- Dr. Mohammed Ali Abdul-Hussein / Wasit DoH
- Dr. Ali Majeed Ali / Wasit DoH
- Dr. Amar Jaleel Sabahi/ Baghdad - Karkh DoH
- Dr. Ra’ad Jaleel Shaker / Baghdad - Karkh DoH
- Dr. Mayada Abdulwahab Sabe' / Baghdad - Rusafa DoH
- Dr. Sawsan Nahawi/ PHCPI

PHCPI-PHCs population mapped to IRAQ population



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PRIMARY HEALTH CARE PROJECT

The Geographic data of the PHCs clinics are currently being updated and verified by MOH (September, 2011).

U.S. Agency for International Development
Primary Health Care Project In Iraq
http://phciraq.org/
www.usaid.gov