Technical Guide for the Operationalization of a Referral Mechanism in a Service Delivery Network

(Family Planning/Maternal, Neonatal, Child Health and Nutrition)

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        - Dr. Jose N. Rodriguez Memorial Hospital
        - General Emilio Aguinaldo Memorial Hospital
        - Quezon Medical Center
        - Quirino Medical Center
        - San Lorenzo Ruiz Women's Hospital
        - Southern Isabela General Hospital
        - Tondo Medical Center
        - Valenzuela Medical Center
    - Provincial Health Offices of Albay, Batangas, Bulacan, Cagayan, Cavite, Isabela, and Quezon
    - City Health Offices of Caloocan, Malabon and Quezon City
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Acronyms and Abbreviations

AHDP	Adolescent Health and Development Program
AIDS	Acquired Immune Deficiency Syndrome
AJA	Adolescent Job Aid
ANC	Antenatal Care
AO	Administrative Order
AOG	Age of Gestation
A/Y	Adolescent and Youth
BEmONC	Basic Emergency Obstetric and Newborn Care
BHMC	Barangay Health Management Council
BHS	Barangay Health Station
BMI	Body Mass Index
BOW	Bag of Water
BP	Blood Pressure
BRTTH	Bicol Regional Training and Teaching Hospital
BTL	Bilateral Tubal Ligation
CBC	Complete Blood Count
CCHD	Caloocan City Health Department
CCT	Conditional Cash Transfer
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHC	City Health Center
CHO	City Health Officer
CHT	Community Health Team
CS	Caesarean Section
CVMC	Cagayan Valley Medical Center
D&C	Dilatation and Curettage
DJNRMH	Dr. Jose N. Rodriguez Memorial Hospital
DM	Department Memorandum
DMPA	Depot-Medroxyprogesterone Acetate
DOH	Department of Health
DOH RO	Department of Health Regional Office
DoSTiQCaSa	Dolores, San Antonio, Tiaong, Quezon Medical Center, Candelaria, Sariaya
EBF	Exclusive Breastfeeding
EINC	Essential Intrapartum Newborn Care
FBD	Facility-Based Delivery
FH	Fundic Height
FHT	Foetal Heart Tone
FP	Family Planning
FPCBT 1	Family Planning Competency-Based Training Level 1
FPCBT 2	Family Planning Competency-Based Training Level 2
HBsAg+	Hepatitis B surface Antigen positive
Hgb	Hemoglobin
HFEP	Health Facilities Enhancement Program
HIV	Human Immunodeficiency Virus
HP	Health Provider
HSP	Health Service Provider
IL	In Labor
ILHZ	Inter-Local Health Zone

IMAP	Integrated Midwives' Association of the Philippines
IRA	Internal Revenue Allotment
IRR	Implementing Rules and Regulations
IUD	Intrauterine Device
IUGR	Intrauterine Growth Retardation
IV	Intravenous
LAPM	Long-Acting Permanent Method
LARC	Long-Acting Reversible Contraception
LCE	Local Chief Executive
LGU	Local Government Unit
LIC	Lying-in clinic
LMP	Last Menstrual Period
LMT	Lactation Management Training
LTO	License to Operate
LuzonHealth	Integrated Maternal, Neonatal, Child Health and Nutrition/Family Planning Regional Project in Luzon
MCH	Maternal and Child Health
MCP	Maternity Care Package
MD	Doctor of Medicine
MDR	Maternal Death Review
M&E	Monitoring and Evaluation
MHC	Main Health Center
MLGU	Municipal Local Government Unit
MLLA	Mini-Laparotomy under Local Anesthesia
MmHg	Millimeter mercury
MNCHN	Maternal, Neonatal, Child Health and Nutrition
MOP	Manual of Procedures
NCP	Newborn Care Package
NIL	Not in Labor
NHIP	National Health Insurance Program
NHTS-PR	National Household Targeting System-Poverty Reduction
NSV	No-Scalpel Vasectomy
OB/GYN	Obstetrics and Gynecology Obstetrician-Gynecologist
OGTT	Oral Glucose Tolerance Test
PCB	Primary Care Benefit Package
PDO	Provincial DOH Office
PHIC	Philippine Health Insurance Corporation
PHO	Provincial Health Officer
PLGU	Provincial Local Government Unit
PPFP	Postpartum Family Planning
PPIUD	Postpartum Intrauterine Device
PPM	Private-Practice Midwives
PRISM2	Private Sector Mobilization for Family Health Project - Phase 2
PSI	Progestin-Only Subdermal Implant
PTB	Pulmonary Tuberculosis
QC	Quezon City
RA	Republic Act
RC	Referral Committee
RDS	Respiratory Distress Syndrome
RH-	Rhesus negative
RHU	Rural Health Unit

RM	Registered Midwife
RN	Registered Nurse
RPR	Rapid Plasma Reagin
RPRH	Responsible Parenthood and Reproductive Health
RTI	Research Triangle Institute
SBA	Skilled Birth Attendant
SDN	Service Delivery Network
SDN RC	Service Delivery Network Referral Committee
SIGH	Southern Isabela General Hospital
SPA	Service Providers' Agreement
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TA	Technical Assistance
TORCH	Toxoplasmosis, Other Agents, Rubella, Cytomegalovirus, Herpes Simplex
USAID	United States Agency for International Development
UTI	Urinary Tract Infection
UTZ	Ultrasound
VDRL Test	Venereal Disease Research Laboratory Test
ZFF	Zuellig Family Foundation

About This Guide

This technical guide was formulated in response to the need to establish a service delivery network (SDN) with a functional referral mechanism, particularly for family planning/maternal, neonatal, child health and nutrition (FP/MNCHN) services involving both public and private health service providers. This is in support to the strategy to rapidly reduce maternal and child mortality as mandated through Department of Health (DOH) Administrative Order 2008-0029 entitled "Implementing Health Reforms for the Rapid Reduction of Maternal and Neonatal Mortality." The guide also responds to the recent DOH memoranda pertaining to the operationalization of Responsible Parenthood and Reproductive Health (RPRH) Law and the Philippine Health Agenda.

The emphasis of this technical guide is the FP/MNHCN service line; however, the SDN operating documents can be systematically expanded to other service lines (non-communicable diseases, infectious diseases, trauma, and others) by defining and categorizing the conditions for referrals and mapping the appropriate health facilities and service providers accordingly.

The guide shows the three-phased approach in establishing or strengthening the referral mechanism of an SDN. It consists of: Phase 1 – Advocacy and Assessment; Phase 2 – Establishing the Operative Mechanisms of the SDN Referral System; and Phase 3 – Sustaining the SDN Operations**.** The guide provides a discussion of each of the phases, its milestones, and tools. In Phase 2, the guide also highlights the major operative documents that will operationalize the SDN's referral mechanism. These documents are: (a) the categorization of referrals to guide the referral decision makers; (b) the service providers' agreement, to formalize members' commitment; and (c) the referral guidelines to operationalize the system. In Phase 3, the monitoring and evaluation procedure to sustain SDN operations is discussed. The annex section contains copies of the tools in PDF format.

The guide discusses the lynch pin of the referral mechanism, which is the categorization of referrals, by referral conditions, into: Category A (conditions requiring subspecialist care and management); Category B (conditions requiring specialist care and management in obstetrics and pediatrics); or Category C (conditions requiring trained generalist care and management in obstetrics and pediatrics). Clients, through referrals, are matched with appropriate health facilities.

The guide is intended for the SDN coordinators and/or management teams of the DOH Regional Offices (ROs), Provincial DOH Offices (PDOs), Provincial Health Offices (PHOs), and Municipal/City Health Offices (M/CHOs) and relevant private health sector. Each phase has its milestones to guide the implementers in moving towards the operationalization of the SDN referral mechanism.

The processes demonstrated in the guide can be adopted easily by local government units (LGUs) in collaboration with partners, regardless of their stage in or approach to SDN development. The LGUs can enhance an already functional SDN referral mechanism by adopting some of the systems approach components or procedures prescribed in the guide.

The guide was developed based on actual experience in operationalizing the referral mechanism for FP/MNCHN services in 13 SDNs in seven provinces (Cagayan, Isabela, Cavite, Batangas, Quezon, Bulacan, and Albay) and three cities (Caloocan, Malabon, and Quezon).

I. Introduction

In accordance with the Implementing Rules and Regulations (IRR) of the RPRH Act of 2012, the DOH, through the Regional Offices, is mandated to integrate FP/MNCHN, obstetric and neonatal care services into established SDNs. In support of this, the DOH issued policies relative to SDN, namely: Department Memorandum 2014-0313, stating the general guidelines in establishing SDN; and DOH Administrative Order 2014-0046 which defined SDN for Universal Health Care. In 2016, the Philippine Health Agenda of the DOH, which builds on the gains of earlier reform policies, underscored the SDN as one of the three guarantees providing access to a continuum of health services.

The SDN is a strategic mechanism for expanding access to and strengthening of the continuum of care for families across political and geographical boundaries. The SDN seeks to ensure continuing provision of quality care by drawing the capacities of individual health service delivery points into a unified and tiered delivery system. Doing so helps in collectively managing recurrent issues brought about by the three-tiered health care delivery system and the uncoordinated referral practices among public and private health care facilities and providers. The referral network will help provide patients with services which other members of the network are unable to deliver thus ensuring access to a comprehensive and responsive continuum of quality care. It will identify the kind of assistance needed, and where it can be provided.

A SDN may consist of public and private primary care networks (PCN) linked to a level 3 hospital including specialty facilities. A PCN is a group of 5 to 10 RHUs and/or private out-patient clinics providing primary care services linked to either a Level 1 or 2 hospital for secondary and tertiary care services (*AO 2016-0038*). Preferably all hospitals and health facilities should be part of a referral network within a SDN. This will enable all families to access responsive, comprehensive quality health care services. The huge presence and capacities of the private health sector, especially in urban areas is an opportunity for strong public-private collaboration for FP/MNHCN services. However, the engagement of privately-owned health facilities and/or private skilled health professionals is on a voluntary basis and will be carried out through agreements or contracts, subject to DOH guidelines (IRR of RPRH Act of 2012, Section 5.06).

The importance of the referral system in a service delivery network cannot be underscored. The timely identification and safe transfer of patients across the three tiers of public-private health care delivery decreases the incidence of preventable maternal, neonatal, and child mortality. The effectiveness of this health care delivery system for FP/MNCHN services significantly depends on the strength of its referral system. This guide offers to improve the referral mechanism through the categorization of referrals, which the SDN members will find useful for FP/MNCHN services as well as for other program lines.

II. The Service Delivery Network for FP/MNCHN

The Service Delivery Network is a critical component of the FP/MNCHN program as this provides the mechanism for the continuum of care. An LGU with an organized SDN pools the capacities of health service organizations in its catchment area and manages them as a unified delivery system. This way, regardless of the point of entry of the patient/client in the system, he/she will be treated in the appropriate health facility.

To operationalize the SDN, there should be a set of guidelines that directs the operations of the system and a service providers' agreement that formalizes their commitment, or its equivalent.

The core services produced come as a result of the collaboration among the participating SDN facilities. The tangible results of the cooperation and collaboration of the SDN are the improvement of services and, subsequently, the health indicators. The intangible and equally important ones are the goodwill, trust and confidence generated by the availability of services beyond the capabilities of individual facilities.

Referral systems play a key role in the success of SDNs and in ensuring comprehensive coverage. The timely identification and safe transfer of patients through the three tiers decrease the incidence of preventable maternal, neonatal, and child mortality. It has been estimated that 73 percent of maternal mortality could be averted if all women received appropriate emergency obstetric care. Referral systems also facilitate the provision of FP and reproductive health services to cases needing the evaluation and management of trained physicians and/or specialists**.** The effectiveness of the three-tiered MNCHN system depends significantly on the strength of its referral system.

To assist the DOHROs in operationalizing the policy directive on SDN, USAID's LuzonHealth Project conducted a baseline assessment in its 21 partner provinces/cities in Luzon in 2015 to determine the needs and gaps, if any, of existing SDNs. Results of the baseline assessment showed that only 20 percent (4/21) of LuzonHealth Project sites (former USAID/PRISM Project sites) claimed to have written referral arrangements and agreements among the service delivery facilities, while 80 percent (18/21) of the LGUs had none at all.

An assessment of the FP/MNCHN SDN referral mechanism was done in one of the Project sites in 2015 which involved 27 key informant interviews, two focus group discussions, and one consultative workshop with health service providers (HSPs) from the three levels of care. Major findings included (1) lack of clear formal referral agreements or guidelines between referring and receiving facilities, (2) absence of advance arrangements for urgent/emergency situations, (3) absence of specialist services in common referral locations, and (4) low referral acceptance resulting from full capacity.

The results of the assessment highlighted the need to create a reference resource to assist frontline healthcare workers in making correct referral decisions (timely referral and appropriate referral facilities). Workshops were held by the respective SDNs where HSPs and MNCHN experts/specialists determined which health cases and conditions for referrals to include in the reference resource, including how to categorize the respective referrals and subsequently match the categorized conditions to appropriate health facilities within the network as agreed upon by the members of the SDN through the Service Providers' Agreement (SPA).

Improving the service delivery network and its referral mechanism is a component of various systems strengthening by the national government and the development partners. The table below describes the initiatives on SDN of previous and current USAID-assisted projects of the national government in different regions in the Philippines.

Implementing Partners	Various SDN Approaches
DOH/Private Sector Mobilization for Family Health-Phase 2 (USAID-PRISM2 Project)	Increasing the number of private health sector in the SDN was the focus. Local stewardship and building the capacities of public and private partners were instituted to facilitate integration of the private sector in the SDNs for FP-MCH. The following were the steps utilized in establishing an SDN. 1. Provider and Facility Mapping 2. Categorizing Potential Providers and Facilities for the SDN 3. DOHRO Recommendatory Technical Advisory on SDNs 4. LGU Rapid Assessment of Potential Providers and Facilities for the SDN 5. LGU-led DOHRO-supported "Operational Decision-Making" meetings 6. Local Policy Issuance Formalizing Creation of the SDN 7. Formal SDN Launching
DOH/USAID – MindanaoHealth Project	The SDNs are jointly managed by local health offices, DOH and PhilHealth ROs, Commission on Population, and private health care providers, corporations, and NGOs, with support from MindanaoHealth Project. LGUs and partners build on previous Interlocal Health Zones' service delivery network and from USAID supported projects such as the Private Sector Mobilization for Family Health Project-Phase 2 (PRISM 2) and HealthGov. The SDNs adopted a performance assessment system using 10 parameters of functionality, namely: 1. Community Health Teams (CHTs)/BHWs are functional 2. RHUs/BHS, health centers, and private clinics are providing MNCHN-FP services 3. Functional community-based transport and communication system 4. BEmONC-capable facilities have transport and communication system 5. CEmONC-capable facilities have transport and communication system 6. Public and private sectors actively participating 7. Referral mechanism initiated/established for each SDN 8. Blood services available and accessible 9. Organized MNCHN/ FP SDN Management structure and guidelines 10. Functional health systems instrumental for SDN
DOH/ USAID-VisayasHealth	The Tacloban City SDN was established to address challenges after Typhoon Haiyan (Yolanda) in November 2013. This involved the re-establishment of a functional service delivery network in Tacloban City with engagement of the Tacloban City Hospital (TCH), the District Health Centers (DHC) and the community health teams. It also includes the development and implementation of a hospital business plan with "Pantawid Pamilyang Pilipino Program" (4Ps beneficiaries) and other members of the National Household Targeting System as the priority clients.

Implementing Partners	Various SDN Approaches
The National TB Program of DOH/USAID's Innovations and Multi-sectoral Partnerships to Achieve Control of Tuberculosis (IMPACT)	LGU TB SDN involved public and private health care facilities and providers which render the entire spectrum of TB services (i.e., prevention, screening, diagnosis, and treatment). It includes the following components: • Expansion of service delivery points • Strengthening of health systems through policy development • Establishment of a coordinating body • Standardization of referral protocols • Institutionalization of a monitoring and evaluation system. TB Service Delivery Networks or TB-DOTS Networks have improved the provision of care for tuberculosis (TB) by coordinating efforts of relevant service providers.

III. Strengthening the Referral System of the SDN

The SDN systems approach in this guide emphasized the strengthening of the referral system and has features that can overcome the barriers to operationalizing a fully functional SDN.

First is its simplicity. There are only four operative parts: (a) the referral categories agreed upon by the participating providers; (b) service providers' agreement to formalize this commitment; (c) referral guidelines to operationalize the system; and (d) monitoring and evaluation procedure to sustain the SDN operations.

Second, it does not require a new structure. The SDN system builds on the existing health delivery system. It follows a three-tiered capability arrangement and does not require any changes in licensure or PhilHealth policy or procedures. The structures and processes also remain the same at the facility level. The three-tiered SDN system includes both the public and private sector. Its institutional home is the Provincial Health Office or the City Health Office with support from the DOH and the SDN member facilities. The support services can include support to operations, support to implementation of plans and policies, and support to development and dissemination of policy and standards.

The third strategic feature of the SDN systems approach is its flexibility. One major barrier to the establishment of a functional SDN is the variability of capabilities of participating facilities within the delivery system. Under this approach, the SDN can be built regardless of the capabilities of its facilities; likewise the limitations of the facilities are made known. Thus, the gaps and deficiencies can be solved through appropriate management mechanisms, slowly building up the optimum functionality of the SDN. In the existing three-tiered health care system in the public health sector, the second tier (district hospitals) was seen as the weakest link in spite of the health facility enhancement program of the national government. These deficiencies are brought into the open, discussed, and acted upon by the SDN management team during the process of operationalizing a SDN.

Fourth, there is no extra facility-level commitment other than what is mandated. The approach only defines the roles and responsibilities of the facility in relation to its function in the SDN. The SDN governance can be handled by the PHO/CHO with assistance from the DOHRO. As such, even at the level of a Service Providers' Agreement, the arrangements for the referral guidelines among members of the SDN can already be facilitated. However, as the SDN matures, further agreements and commitments among partners may be forged through a memorandum of agreement or the like.

Fifth, the SDN design can easily be adapted by the management regardless of the existing stage of development of the network. The approach can enhance an already functional SDN by adopting some of the systems approaches or procedures.

Sixth, it disaggregates different lines of services, such as FP/MNCHN services, Adolescent and Youth services, and others. The rationale for this is that these different preventive health programs have specific requirements in the different tiers of services, making it complex to operationalize and sustain them when done in one run. Thus, the systems approach proposes to establish one service line at a time to clearly define the role of each stakeholder in that line of service. The categorization of referrals introduced in the design facilitates the disaggregation of this service line. As more service lines are added, the SDN system grows to an SDN for All Life Stages (ALS).

Seventh, it has a huge potential for scale-up. This approach can be expanded by adding service lines (such as SDN for Non-communicable Diseases, among others), by increasing and fine-tuning facility-level commitments, by expanding geographically, by increasing the number and type of providers (e.g., in the private sector – birthing homes, hospitals, ambulance network, pharmacies, diagnostic facilities, etc.; and in other LGUs – cross-border referrals, LGU-DOH exchange programs).

Lastly, the SDN support units (C/PHO, PDOH, DOHRO, DOH-CO) can further strengthen their roles in the SDN by establishing or enhancing support mechanisms, such as planning and budgeting, quality assurance, technology transfer, communications network, recording and reporting systems, information system, diagnostic resource pooling, manpower, and others. Existing management structures may be involved and strengthened for SDN, such as the Inter Local Health Zone Technical Management Committee, Barangay Health Management Health Council, and other SDN management committees previously organized by the LGUs.

With sustained efforts, the SDN can be established within a three-month time frame using the three- phased approach.

Private Sector Involvement in the Service Delivery Network

Based on the IRR of Republic Act 10354, Sections 5.05-06, the DOH and/or the LGU may engage privately-owned hospitals and other health facilities, as well as private skilled health professionals, to become members of the SDN on a voluntary capacity through agreements or contracts, subject to DOH guidelines and standards. Based on the IRR, private facilities and skilled health professionals may receive referrals and patients from other facilities within the SDN; provided that these engaged private facilities and skilled health professionals will comply with the requirement to provide emergency obstetric and neonatal care and reproductive health care services in the context of the SDN referral network. This provision, however, is optional for non-maternity specialty hospitals and hospitals owned and operated by religious groups.

The private sector plays a critical role in improving the performance of the local health system and with the rapid expansion and dominance of private health facilities, especially in urban areas, it is vital to engage them in a collaborative relationship. Their participation in the network will contribute to the delivery of appropriate level of care at the appropriate provider/facility and enable highly burdened government facilities to decongest and consequently improve the quality of services. Likewise, the engagement of the private sector is expected to improve access and reach, and reduce out-of-pocket expense.

The engagement of the private health sector in the SDN is an opportunity that will ensure compliance of private practitioners with the DOH standards for FP/MNHCN programs, PhilHealth accreditation, and other government licensure requirements.

Financing

Financial viability of health care providers plays an increasingly critical role in strengthening the SDN. It is also important in ensuring financial risk protection of vulnerable groups, such as poor families identified under the National Household Targeting System for Poverty Reduction (NHTS-PR) and the Conditional Cash Transfer Program. Access to health services through the SDN (which can include promotion and communications, prevention and treatment) will not become truly universal without an effective and well-functioning health financing system. Consistent with the Philippine Health Agenda, 2016-2022, the government has been working

towards achieving universal health care coverage to ensure that “Filipinos, especially the poor, marginalized, and vulnerable are protected from high cost of health care.”

Achieving universal health care coverage, however, will be difficult if people, especially the poor, have to make out-of-pocket payments. They are most often torn between choosing to pay for health services (including spending for transportation and related costs) and spending for basic needs such as food or children’s education.

Universal health care under the current “All for Health towards Health for All Program” of the government means that essential health care services will be provided to the poorest Filipino families through a network of health service providers at different levels of health care. This aims to provide every Filipino with the highest possible quality of health care that is accessible, efficient, equitably distributed, adequately funded, fairly financed, and appropriately used by an informed and empowered public.

For an SDN to be successful in ensuring that clients are able to maximize their PhilHealth benefits, it should be able to help address existing barriers to benefit delivery through: coverage (particularly of the poorest population); accreditation of facilities; increased understanding of PhilHealth guidelines and circulars, including the process for claiming benefits and reimbursements; and increased LGU utilization of PhilHealth reimbursements for FP/MNCHN-related expense. This entails the following:

1. The SDN must ensure that all its member facilities are PhilHealth-accredited and have a license to operate.

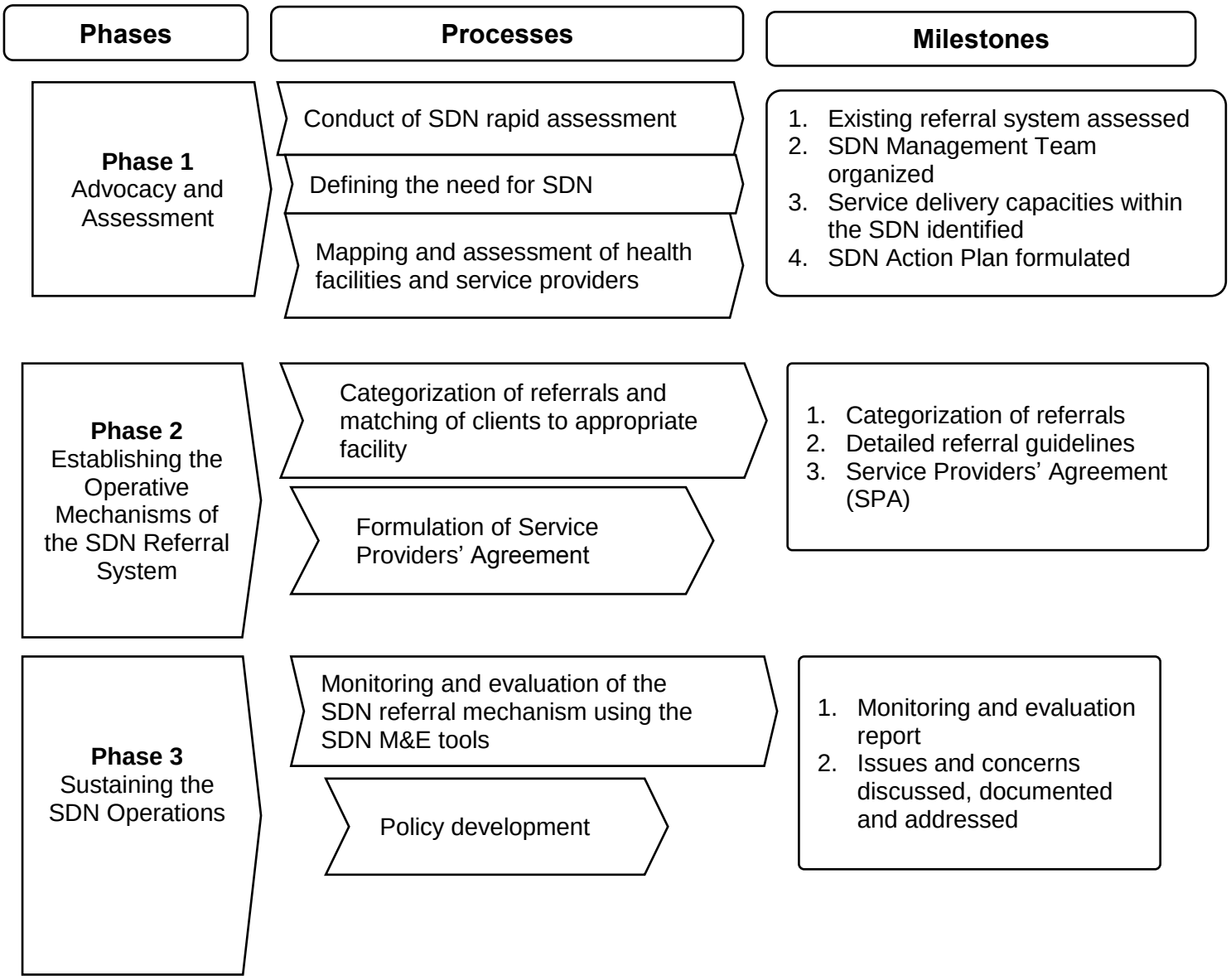
2. It must ensure that it has an existing mechanism for enrolling the poor who are not yet covered (e.g., through point-of-care/point of service or through an efficient basic system for means testing and financial capacity assessment for covered clients).

3. The SDN management team must ensure that all its member facilities are updated on PhilHealth policies, guidelines and circulars related to coverage, accreditation, claims and reimbursements.

4. The SDN management team must organize a monitoring and tracking team that will ensure that the first three conditions are met, and track whether LGUs are utilizing PhilHealth reimbursements for FP/MNCHN and other health expenses.

IV. The Three Phases in Operationalizing the SDN Referral Mechanism for FP/MNCHN Services

Figure 1: The Three Phases in Operationalizing a Service Delivery Network



Phase 1: Advocacy and Assessment

Phase 1 consists of preparatory activities, which include: (a) advocacy to secure buy-in from potential stakeholders who are the public and private health service providers; (b) conduct of rapid assessment of the status of the existing SDN, if there is already one; (c) defining the need and purpose of the SDN; and (d) mapping and assessment of the capacities of health facilities/providers that are potential members of the SDN.

Advocacy

The leadership of the P/CHO, which is the institutional home of the SDN, is critical in the establishment and operationalization of the SDN. The P/CHO heads the SDN Management Team and, together with the SDN Management Team, provides overall direction, oversees the operations, and monitors and evaluates the functionality and effectiveness of the SDN. If leadership is lacking or weak, the establishment of the SDN tends to be slow and the SDN will likely be unsustainable.

Initial activities would involve desk work for the review of the FP/MNHCN profile, and consultative meetings with potential members of the SDN from the private health sector and the public health sector, who by default will be automatic members of the SDN.

Assessment of the Environment

Another activity is the assessment of both the external and internal environment using the project-developed rapid assessment tool (*Annex A*) and SDN Mapping Tool (*Annex B*).

Assessing the external environment includes reviewing the past and/or existing SDN initiatives or management structures on which to build current SDN efforts. Examples of such management structures are: (a) the Barangay Health Management Council (BHMC) of the 3rd District of Quezon City, a functional community-driven health management structure; (b) the Technical Management Committee (TMC) of the Inter-Local Health Zone (ILHZ); and (c) the MNCHN Management Team.

The BHMC was regarded by the Quezon City District 3 Health Office as a potential arm in establishing and operationalizing the SDN at the district level. It is a grassroots health initiative that uses a Leadership-Management Model which was piloted in Barangay Payatas in District 2 and later expanded to the District 3. In 2012, the BHMC in QC District 3 started to be tapped for other health programs, including Maternal Health and Nutrition. The District 3 Health Office utilized the BHMCs towards the establishment of an MNCHN SDN in the district, in collaboration with the city and barangay LGUs, private health sector, and other stakeholders. BHMCs were organized in 2011 through the support of the USAID Systems Improved Access to Pharmaceuticals and Services (SIAPS) Project to provide a functional community-driven management structure for the then ongoing National Tuberculosis Program (NTP).

The Technical Management Committees of the ILHZs were used as entry points in the provinces of Albay, Cagayan and Cavite; the LGUs' MNCHN Management Team was used in Caloocan City; and the Health Leadership Governance Program team (HLGP) was used in Batangas. The past SDN initiatives of the USAID Private Sector Mobilization for Family Health Project-Phase 2 (PRISM2) were also revisited in the provinces of Cavite, Albay and Caloocan City. The existing local policies that were crafted were utilized as basis in strengthening the SDN in these sites.

In Caloocan City, the SDN discussion started with the need to improve the blood service delivery network. As a result of the mapping and series of meetings among SDN members, the Dr. Jose N. Rodriguez Memorial Hospital (DJNRMH) was developed to be licensed as a blood bank in District 2, in addition to the existing blood bank at the Valenzuela General Hospital which caters to the blood services needs of District 1. DJNRMH is now waiting for its license to operate as a blood bank from the DOH. The CHO discussed the referral guidelines with the private HSPs to ensure compliance with the referral mechanism prior to the signing of the Service Providers' Agreement. The Caloocan City SDN has the most number of private HSPs that voluntarily joined the SDN.

In Southern Isabela, FP services served as the entry point to SDN establishment. The partners – the Southern Isabela General Hospital (SIGH), the HSPs of the 3rd and 4th Congressional Districts of Isabela, two nearby LGUs in Nueva Vizcaya (Diadi) and Quirino (Diffun), and the Integrated Midwives Association of the Philippines (IMAP) Regional Chapter and Isabela Chapter – were engaged to respond to the urgent need of improving, strengthening and sustaining the delivery of FP services, particularly for long-acting reversible contraception (LARC) and long-acting permanent methods (LAPM). FP referrals to SIGH for LARC and LAPM have improved under the SDN referral mechanism.

The internal environment assessment consists of defining the need and purpose of SDN based on the results of Maternal Death Reviews, Program Implementation Reviews, and other similar activities. This process is essential as it enables the SDN to focus on issues that it can address, and to define the necessary elements of the referral mechanism that the SDN needs to establish. This process also includes the mapping and assessment of the service delivery capacities of available health care facilities and providers. The results of this assessment were utilized as reference in identifying the appropriate facilities that could be matched with clients with specific cases or conditions.

The evidence of completion of this phase is the accomplishment of the following milestones:

- Status of existing SDN in the province/city identified.
- SDN Management Team/Monitoring Team organized.
- Priorities and challenges identified.
- Health service delivery capacities within the SDN identified.
- SDN Core Team Action Plan formulated.

The Process

Activity	Timeline Month 1	Locus of Responsibility	Purpose	Milestones
Setting of meeting with the PHO/CHO	Week 1	DOHRO	To gather the leaders and decision-makers to advocate for the establishment of an SDN using the systems approach	Schedule of meeting confirmed
Conduct of the meeting	Week 2	DOHRO	To present the SDN concept, offer assistance to establish an SDN, and obtain their agreement on the process	• Buy-in of PHO/CHO secured • SDN Management Team/Monitoring Team organized • SDN Core Team Action Plan formulated
Gathering of data and submission of required documents: • SDN Rapid Assessment • Profile and priorities for	Week 3	PHO/CHO PDOH Office	To establish the need for a functional SDN	• Status of existing SDN in the province/city identified • External environment opportunities and challenges

Activity	Timeline Month 1	Locus of Responsibility	Purpose	Milestones
FP/MNCHN • Health facility mapping				identified • Priorities and challenges identified (FP/MNCHN) • Health service delivery capacities within the SDN identified
Setting of a one-day workshop with the Technical Team	Week 4	PHO/CHO PDOH Office	To discuss the SDN operative mechanisms, i.e., the referral categories, service providers' agreement, referral guidelines, and monitoring and evaluation procedure	Schedule of workshop confirmed
Consultative meetings with public and private health providers		PHO/CHO PDOH Office	To present the SDN design (FP/MNCHN), gather insights, and identify opportunities for collaboration	Available initial list of SDN members done

Phase 2: Establishing the Operative Mechanisms of the SDN Referral System

The second phase involves the drafting of the SDN operative documents, which are: the categories of referrals to match patients/clients conditions with appropriate health facilities and service providers *(Annex C)*; the referral guidelines; and the agreements within the Service Delivery Network for FP/MNCHN services.

Categorization of Referrals

The matching of clients with appropriate health facilities and service providers entails determining the referrals categories. The categorization of referrals is a unique feature of the USAID LuzonHealth Technical Assistance (TA) on SDN. Referral conditions are categorized into: Category A (maternal and neonatal conditions requiring subspecialist care and management); Category B (maternal and neonatal conditions requiring specialist care and management in obstetrics and pediatrics); or Category C (maternal and neonatal conditions requiring trained generalist care and management in obstetrics and pediatrics). *(See Annex C for a detailed listing of the categories and the subcategories under them.)*

In a workshop attended by HSPs composed of medical personnel (obstetrician/gynecologist, pediatrician, rural health physician, and general practitioner) and paramedical staff (nurses and midwives), the clear indicators (such as the recognizable signs and symptoms of certain conditions) are deliberated upon and negotiated by the SDN members, and accordingly categorized. This categorization of referrals is used to classify the cases that are referred (either for transfer of service, consultation, or diagnostics). The client with specific conditions is matched with the appropriate health facility. The current capacities of every SDN member facility are

made known to the other SDN members, and a directory of SDN members is made available. Referrals are guided by the referral guidelines and service providers' agreements.

The development of the categorization of referrals was based on the results of the assessment of the existing referral mechanism in one of the LuzonHealth sites. The assessment showed that a correct referral decision involves identifying the condition for referral, doing this in a timely manner, and knowing the correct facility where to send the referral. Thus, the categorization of referrals will begin with the referral decision, preparation by the referring facility regarding transfer/referral of the client, and acceptance by the recipient facility that has the required capacities.

The categorization of referrals was discussed during a one-day workshop with the SDN Technical Team using the results of the initial mapping of service delivery capacities of the three levels of care. The referrals of the conditions based on category are influenced by the clinical capacities of the facilities and medical practitioners within the SDN. The designation of facilities as referral units for specific conditions was validated in real time with the Chief of Hospital and/or obstetrician/gynecologists (OB/GYN) or pediatricians participating in the SDN workshop. Information on the actual availability of OB/GYN/pediatric subspecialist or OB/GYN/pediatric specialist are crucial requirements in designating the facility to attend to Category A and B conditions, respectively, as well as presence of blood services. The schedules of these health service providers are made known among SDN members and these become part of the referral guidelines and the service providers' agreement.

Service delivery capacities may change at some point in time due to the resignation or retirement of the ob-gyn from the designated facility, and this should be reported during the succeeding SDN meetings in order to update the SDN directory of health facilities and service providers. Further validation is done through on-site visits by the SDN Referral Team, review of the license to operate (LTO) and Maternal Care Package (MCP) accreditation status, and or discussion with either the Hospital Operations Cluster or the Licensing and Regulatory Division of the concerned DOH Regional Office.

Referral Guidelines and Service Providers' Agreement

Critical to the operationalization of an SDN is a functional referral mechanism. Thus, LuzonHealth ensured that the formulation of referral guidelines is an intrinsic component of the SDN initiative, formalized through a Service Providers' Agreement (SPA) signed by all participating facilities. Attached are sample referral guidelines *(Annex D*) and SPA *(Annex E*).

The referral guidelines systematically describe the five stages of the referral mechanism discussed and agreed upon by all the members of the SDN. These are:

1. **Pre-referral stage:** From the time the client/patient is seen to the point where a referral decision is made.

2. **Preparation for referral stage:** From the time the referral decision is made, to the completion of all the preparations and requirements for referral. This includes the referral communication and transport mechanism.

3. **Transfer stage:** From the time the preparations for referral are completed, to the arrival of the client/patient at the receiving facility.

4. **Receiving stage:** From the time the referring facility informed the receiving facility of the referral, to the arrival of the patient and acceptance of the referral and provision of initial treatment/management.

5. **Post-referral stage:** From the completion of service, to the discharge of the client/patient from the receiving facility.

The discussion process during the formulation of the referral guidelines and SPA firms up and validates the service delivery capacities of the SDN member health facilities and their commitment to receive referrals accordingly.

The Process

The specific activities involved in the formulation of the referral guidelines are shown in the table below. It is worth noting that at the forefront of these activities was the P/CHO and PDOH Office.

Activity	Timeline Month 2	Locus of Responsibility	Purpose	Milestones
Conduct of SDN technical meeting	Week 1	Technical Assistance provider	To draft the four operative documents namely: 1. Categorization of referrals 2. Detailed referral guidelines 3. Service Provider's Agreement 4. Monitoring and Evaluation (M&E) Mechanism and Indicators	Categorization of referrals Referral guidelines draft Draft service provider agreement M&E mechanism and list of indicators
Presentation and validation of the four operative documents, namely: 1. Categorization of referrals 2. Detailed referral guidelines 3. Service Provider's Agreement 4. M&E Mechanism and Indicators	Week 2	C/PHO Participating health facilities	To review and validate the draft referral guidelines and categorization of referrals	Referral categorization and guidelines reviewed and validated Service Providers' Agreement signed
Finalization and approval of the four SDN operative documents by the SDN Management Team	Weeks 3-4	SDN Management Team	To integrate comments/inputs and finalize the four SDN operative documents by the SDN Management Team	Finalized and adopted/approved: 1. Categorization of referrals 2. Detailed referral guidelines 3. Service Provider's Agreement

Activity	Timeline Month 2	Locus of Responsibility	Purpose	Milestones
				4. M&E Forms/Logbooks and SDN Indicators - Standard referral slip - Referral logbooks (incoming and outgoing) - Feedback Form - M&E data capture forms

The DOH-Retained Regional and Medical Centers were actively engaged as apex facilities for the SDN by the respective provinces/cities. For FP/MNCHN services, the lead discussants from the DOH-retained hospitals were the consultants/specialists from the Ob-gyn Department, with the active involvement of the Chiefs of Hospital, Medical Center Chiefs and or their representatives. These were demonstrated in the following DOH hospitals: Batangas Medical Center, Bicol Regional Training and Teaching Hospital (BRTTH), Cagayan Valley Medical Center; SIGH, Quirino Memorial Medical Center, Valenzuela General Hospital, Jose N. Rodriguez Memorial Hospital (JNRMH), Tondo General Hospital, and Jose Reyes Memorial Hospital. Together with the other SDN member facilities, these apex hospitals continuously provided information and guidance to improve the implementation of the referral mechanism within the network. For ease of referrals, all hospitals provided the network with a list of contact persons, actual specialists' schedules, hotlines and schedules for FP referrals and prenatal services for high-risk cases. In expanding the SDN referral mechanism to other service lines, the said process is followed with the active involvement of the concerned specialists.

Phase 3: Sustaining the SDN Operations

The monitoring and evaluation (M&E) system is one of the key components of a service delivery network. While the basic operative documents of an SDN (i.e., the categorization of referrals, the referral guidelines, and the Service Providers' Agreement) are essential to its establishment, without regular monitoring and evaluation, the SDN's development may not be sustained.

The monitoring and evaluation stage determines the functionality, performance, and areas for improvement of the referral system. As the SDN M&E develops and more data become available, time trend data can be made part of the evaluation, which makes it possible to make conclusions on effectiveness, efficiency, impact and sustainability.

The SDN Management Team or the SDN Referral Committee holds regular quarterly meetings to discuss the status of the indicators to ensure the functionality of the SDN and its referral mechanism using a set of M&E tools. For FP/MNHCN services, in the long run, this is the stage where the health outcomes and the role of the SDN in reducing the three delays leading to maternal and neonatal mortality and morbidity are discussed, using the results of the existing Maternal and Neonatal Death Reviews. Other areas for improvement in the process of operationalizing the SDN are also recorded and reported.

The M&E tools utilized include the following:

- Standard referral slip *(Annex F*), containing essential information on the client for referral, and the referral code. This also contains the services provided to the referred client both by

the referring and receiving facilities. This is developed by SDN member facilities during the M&E workshop based on their existing referral slips.

- Outgoing and incoming referral logbooks for all SDN member facilities which record the referrals made/received *(Annexes G and H*). All SDN members have outgoing and incoming referral logbooks in place in their respective facilities. In hospitals, the referral logbooks are maintained both at the outpatient department and emergency room. Religious recording of the referral transactions in these logbooks is important in tracking and evaluating the implementation of the referral mechanism.

- Manual and electronic data capture and consolidation forms used during the quarterly SDN M&E workshop (*Annex I*). These forms capture the data recorded in the outgoing and incoming referral logbooks. The extent and functionality of the referral mechanism can be analyzed using the data generated from these forms.

- Standard incident/feedback report identifying areas for improvement in the operations of the SDN referral mechanism *(Annex J).*

- Minutes of the meeting of the SDN Management Team and the SDN members.

Monitoring and Evaluation Design

Monitoring

The data are derived from the referral logbooks. There are two types of logbooks, the outgoing and incoming referral logbooks (*Annexes G and H).* These logbooks are filled out each time a referral is made. From the logbooks, data are gathered using a data capture form. The data capture is done by each SDN member facility on a quarterly/annual basis. The two data capture forms are submitted to the Provincial Health Office. The data are encoded in a spreadsheet in Excel format (*Annex I).* This aggregates the data of each facility to come up with a provincial/city SDN data.

The aggregated data should include the following:

1. Total number of outgoing referrals in the SDN (x = count of all outgoing referrals within the SDN)
2. Number and percentage of referrals sent by facilities within the SDN (y = count of all outgoing referrals per facility, percentage = y/x *100)
3. Total number of referrals received within the SDN (m = count of all incoming referrals)
4. Number and percentage of referrals received by the facility (n = count of all incoming referrals received by the facility, percentage = n/m * 100)
5. Number and percentage of unqualified referrals (p = count of all unqualified referrals, percentage = p/x * 100; unqualified referrals are cases that do not need to be referred or cases referred to the wrong facility)
6. Number and percentage of non-accepted referrals (q = count referrals that were not received either through phone or on-site rejection, percentage = q/x * 100)
7. Unclassified referrals – conditions not listed in Annex A (Code as U=unclassified)
8. Referrals coming from other SDN – referrals that are sent by facilities outside the defined catchment area of the receiving SDN or facilities that are within the catchment area but have not signed the Service Providers' Agreement

9. Number of referrals transferred to other facilities – referrals accepted by receiving facilities but eventually referred to another facility
10. Number of adolescent referrals – referrals within the age range of 10-19 years old
11. Number of referrals for FP services
12. Types of referrals (transfer, consultation, diagnostics)
13. Reasons for referral
14. Issues and concerns

To enable the province/city to determine if the SDN indeed had an impact on the health outcomes, the province/city needs to include the data on number of facility-based deliveries and number of maternal mortality for each reporting period. Similarly, indicators on youth and adolescents and family planning should also be collected for comparison. See sample tables below.

Maternal Mortality, Province/City of _____ Year: _____

Year	MMR		NMR		FBD		SBA	
	No.	Ratio	No.	Rate	No.	%	No.	%

Family Planning Indicators for SDN Referrals, Province/City of _____ Year: _____

Indicators	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Number of FP clients referred for BTL/ BTL-MLLA				
Number of FP clients referred for PPIUD				
Number of FP clients referred for Interval IUD				
Number of clients referred for FP services (pills/DMPA/condom/NFP)				

Adolescent Indicators for SDN Referrals, Province/City of _____ Year: _____

Indicators	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Total number of pregnant adolescents (10-19 y.o) referred to the hospital				
Total number of pregnant adolescents (10- 19 y.o) received by the hospital from referring facilities				
Total number of adolescent clients referred for FP services				
Total number of adolescents (10- 19 y.o) received by the hospital and provided FP services				

Evaluation

The evaluation will look at the degree of utilization of the referral system and some indirect indicators of the quality of referrals. It will also determine other issues and concerns related to the referral system.

1. Utilization

    a. Is there an increasing or decreasing rate of outgoing referrals? An increasing rate of correctly classified and categorized outgoing referrals shows ease of transferring patients to other health facilities. This means that facilities recognize capability levels and send cases to the appropriate facility. The referral procedure becomes part and parcel of the facility's daily operations. The delivery system becomes unified and reduces the fragmentation of services.

    b. Which facilities have the highest proportion of outgoing referrals? Facilities with consistently higher proportion of correctly classified and categorized referrals may mean that the facility is serving a population that is more ill than the rest. This may prompt a situational analysis to determine why clients have an illness that needs higher level of care.

    c. Are there facilities without outgoing referrals? If the facility consistently has no outgoing referrals, either it does not want to participate in the referral system or there are other reasons why patients are not referred.

    d. Is there an increasing/decreasing rate of incoming referrals? An increasing trend in correctly classified and categorized incoming referrals could mean that an increasing proportion of patients coming to the facility have been evaluated by a health provider at the lower tiers. This shows a better gatekeeping capability among the lower tiers.

    e. Which facilities have the highest proportion of incoming referrals? An increasing proportion of correctly classified and categorized incoming referrals could be an indication of confidence in the capability of the receiving facility and that services are consistently available here.

    f. Are there facilities without incoming referrals? This could indicate access or availability problems.

2. Quality of referrals

    a. How many referrals are unqualified? Unqualified referrals mean poor evaluation by the sending facility.

    b. What is the proportion of unqualified referrals to the total number of outgoing referrals? An increasing proportion of unqualified referrals vis-a-vis total outgoing referrals could indicate either capability problems at the lower tiers or a need to review and revise the categorization of conditions.

    c. How many referrals were not accepted? Each non-accepted referral should be investigated to determine the reason.

d. How many referrals were transferred to other facilities? Each transfer of referral should be investigated to determine the reason.

e. Are there referrals that are unclassified? Should these be included in the list? If so, the SDN must assign its classification.

f. Are there referrals coming from other SDNs? An increasing number of referrals from other SDNs will strain the resources of the accepting SDN unless they are covered by PhilHealth.

3. Family planning/adolescent services

a. Are there adolescent (10-19 years old) referrals? How many? An increasing number of adolescent referrals could mean that the adolescents are getting the appropriate services in the proper facility but it could also mean an increasing trend in teenage pregnancy.

b. Are there family planning referrals? How many? An increasing number of clients being referred to hospitals/birthing clinics for FP services could indicate an increasing proportion of clients utilizing FP services offered by the facilities.

4. Others

a. What are the top reasons for referral? An increasing number of referrals for consultation and diagnostics means more capable lower tier facilities and presence of coordination between specialists and generalists. This will open the possibility of the practice of telemedicine and the like.

b. What are the other Issues and concerns? There will always be issues and concerns and these have to be tackled at the SDN meetings for them to be resolved. Operational issues usually predominate when an SDN is just starting; later as the SDN matures, there will be more technical issues.

Monitoring and Evaluation Process

The monitoring and evaluation report will be presented in a meeting attended by relevant stakeholders (C/PHO, SDN Committee, and heads of member facilities) and presided by the C/PHO. After the presentation, a collegial discussion will follow. Agreements and commitment to address the gaps and deficiencies in the referral system will be made and documented.

As regards the SDN M&E presentation, the indicators for maternal mortality, family planning, and adolescent health should show positive trends or impact as the SDN matures.

Maternal mortality should decrease since early referrals mean that appropriate interventions were given at the appropriate facilities. There should also be a decline in the A1 category referrals, suggesting that the condition was evaluated at an early phase and not allowed to complicate. The reasons for maternal deaths should no longer be due to operational problems but rather due to the physiologic effect of the disease.

Family planning acceptance, especially for permanent methods not available in non-hospital facility, should increase as good coordination between the referring facilities and the provider facilities has already been established.

The table below summarizes the activities involved in monitoring and evaluation.

Activity	Timeline Month 3	Locus of Responsibility	Purpose	Milestones
Generation of data needed for the M&E	Weeks 1-2	Participating health facilities and the C/PHO	To collect and aggregate the M&E information requirements	M&E data of all participating SDN facilities submitted
Analysis of the aggregated data	Week 3	SDN Referral Committee and C/PHO	To understand the aggregated M&E data, generate descriptive statistics, and draw conclusions	M&E referral report prepared
Dissemination of the M&E report	Week 4	C/PHO	To provide feedback on the SDN referral system	Referral committee meetings regularly conducted and actions to be taken regarding issues and concerns related to the SDN referral system identified

SDN Implementation Challenges and Future Directions

The SDN M&E strategy was initially designed to determine the outputs generated by the newly installed referral system. The three (3) quarterly runs of the M&E system, confirmed the utilization of the referral system. Over time, however, as the SDN referral system progresses and the SDN sites conduct regular M&E continuously, it is expected that benefit and outcome data will be generated.

The SDN for the referral of maternity, newborn, and FP cases was started in 2015 in 13 sites in seven provinces (Cavite, Batangas, Quezon, Albay, Bulacan, Isabela, and Cagayan) and three cities (Caloocan, Malabon, and Quezon City) in Luzon. The referral practices followed guidelines composed of steps from referral decision-making to the transfer and acceptance of patients by the receiving facility.

Summarizing the experience of the project in operationalizing the SDN for FP/MNHCN, the LGUs and partners observed that the SDN referral system for the FP/MNCHN service line is implementable regardless of the site condition, and that it does not require complex arrangements to obtain commitment. It is sustainable with the regular implementation of an operational M&E system. It can be applied to other health service lines through the development of the categorization of conditions by facility level for the particular service line.

For an SDN to be fully functional, these are critical requirements: a computerized referral information system similar to the one used in District lll of Quezon City (rCHITS) or perhaps the Wireless Access for Health in Tarlac; strengthening of the second-tier facilities for them to be able to accept and manage Category B referrals; and provision of more critical equipment like incubators in Level II and III hospitals. There should be prioritization of the SDN in the agenda of regional and city/provincial health leaders in its initial stages and the PHO/CHO should have active roles in the proper implementation of action plans. The Health Facilities Enhancement Program of the DOH may be tapped by the LGUs to build the capacity of the second tier of the health care system purposively. Support mechanisms include: development of clinical protocols based on the categorization; costing of the conditions based on the protocols; use of evidence-based medicine in developing protocols; alignment of the PhilHealth payment system with the

categorization of conditions; and using all this information for the development of policies, plans and programs and for resource allocation.

Indicative guiding elements for SDN development

NOTE:

SDN ELEMENTs may be used as assessment checklist to evaluate or determine the status of SDN development or as agenda for SDN management meetings and reviews. The given set of criteria is only illustrative and may be changed or enhanced by the SDN Management team and members.

ELEMENTS	BASIC	√	INTERMEDIATE	√	ADVANCE	√
1. **SDN membership**	SDN consists only of all public facilities.		SDN consists of all public and 50% of private facilities.		SDN consists of all public and 75% of private facilities, community (e.g. *Barangay* officials, community volunteers, etc.) and other relevant sectors	
2. Utilization of the operative documents (Referral guidelines/SPA / Categorization/ M&E tools)	• SDN with referral guidelines/mechanisms and forms and referral categorization • All SDN service facility members oriented on SDN M&E tools • Less than 50% of SDN service facility members accomplish SDN M&E tools (e.g. logbooks, capture form, etc.)		• 50%-70% of SDN service facility members accomplish SDN M&E tools (e.g. logbooks, capture form, etc.)		More than 70% of SDN service facility members accomplish SDN M&E tools (e.g. logbooks, capture form, etc.)	
3. Utilities	• Transport providers already identified (e.g. *barangay*, health facility, other stakeholders, etc.) • With an SDN Directory of members (hotline) and list of available services that is regularly updated		• With formal transportation agreement (e.g. barangay, health facility, other stakeholders, etc.) • Electronic/digital SDN Directory (members and services) for easier access and updating		• With formal agreement and access to transportation services at "all times ensured" • Electronic/digital SDN Directory (members and services) and real-time E-referral two-way mechanism	
4. Leadership and governance	• Organized SDN Management Team • SDN with Service Providers' Agreement or similar instrument to formalize the		• Conducts SDN Management meetings regularly (discussions/ feedbacking/ planning/evaluation)		• Enacts local policy/ resolutions to strengthen implementation and institutionalize SDN	

ELEMENTS	BASIC	√	INTERMEDIATE	√	ADVANCE	√
	commitment of SDN members		• Conducts monitoring and evaluation regularly			
5. Health Outcomes	• Data on maternal / neonatal morbidity and mortality available • Other relevant health statistics		• Conducts M&E activities (e.g., Maternal and Neonatal Morbidity and Mortality reviews; Collaborating, Learning, Adapting workshops)		• SDN adapts measures to address identified issues/factors affecting maternal/ neonatal morbidity and mortality • SDN interventions attributed to prevention and reduction of maternal and neonatal mortality	
6. Financing	• Approved SDN plan (identified sources of fund, actual budget, meetings, transportation, capacity building, info dissemination, IEC materials, and other related SDN Activities)		• Budget commitments in the approved SDN plan incorporated in the approved Work and Financial Plan (WFP) of SDN members		• SDN budget institutionalized through local policies in respective organizations/institutions	
SCORING						
PERCENTAGE						

V. The Process of Expanding the SDN to Other Service Lines

Expansion of the FP/MNCHN SDN referral mechanism to Pediatrics, Medicine, and Surgery in Batangas Province

The Batangas Service Delivery Network led by the Batangas PHO and Batangas Medical Center as the apex facility, convened the specialists and consultants to draft the categorization of conditions in four non-MNCHN major specialties, i.e., Obstetrics, Pediatrics, Medicine, and Surgery. This resulted in the categorization of referrals for selected illnesses containing the following information to guide the referral mechanism: 1) Condition, 2) Indication for referral, 3) Signs and Symptoms, 4) Pre-transfer management, 5) General Management, and 6) Unit of Disposition (i.e., OPD, ER, or IPD).

The pre-transfer management, general management and the unit of disposition are new additions to the categorization list and helps the sending and receiving facilities in managing the patient before referral and upon receiving the referral. It is meant to act as a clinical practice guideline. This method starts the standardization of the clinical practice SDN facilities in Batangas.

The categorization of non-MNCHN conditions was validated and vetted in a general meeting attended by public and private facilities of the Batangas SDN. It was generally accepted and decided that the scale-up activity will follow the service line route and the agreed-upon referral guidelines. The following service lines chosen were:

Obstetrics and Gynecology: Maternal Hypertension and Diabetes Mellitus (in pregnant and non-pregnant women

Pediatrics: Pneumonia

Internal Medicine: Hypertension, Coronary Artery Disease, Cerebro-Vascular Accident

Surgery: Acute Abdomen and its differential diagnosis

The Batangas experience on expanding the SDN to other service lines was decided by the SDN management team based on identified need/s. Utilizing the existing referral guidelines, the SDN management team convened the consultant/specialist of prioritized service lines to develop the categorization of the additional conditions for referrals. Once the categorization of referrals was finalized by the specialists, consultative meeting with SDN members was done to present and discuss the developed categorization and when all members of the SDN agreed on the enhancement, the referral guidelines and Service Providers' Agreement were amended. Other SDN sites with existing referral guidelines and categorization of referrals may follow the same process in close coordination with the respective specialists of the chosen service lines.

The benefit of strengthening the SDN referral mechanism was noted and articulated by [redacted] a nurse at the Taysan RHU in Batangas:

> "Before the SDN became functional, we were already referring patients for specialist care to the other equipped hospitals but it was difficult because our referrals were not prioritized so I had to spend time convincing and sometimes even imploring other hospitals to accept our referrals. "Kanya-kanya" thinking was prevailing. With the SDN, referring high-risk patients to the district or other bigger hospitals has become easier, simpler and faster because each patient is the accountability of the whole network."

San Luis Municipality Mayor [redacted], a local official who attended one of the SDN meetings, said:

> "By having a network of highly collaborative health facilities, our constituents are assured that they will be treated in a facility that has the capacity to manage their condition."

Annexes

Annex A: SDN Rapid Assessment Tool

SDN Rapid Assessment Tool				
SDN Components	**1. Write existing SDN or potential areas for the establishment of SDN (e.g., SDN 1, SDN 2, SDN 3)** **2. Write (√) if SDN component is done or ongoing, (x) if not done or present**			
	SDN1	SDN2	SDN3	SDN4
A. Identifying needs of the population				
• MNCHN health profile of the area				
• Needs prioritization				
B. Mapping available health care facilities and providers				
• Mapping of health resources				
C. Designating priority population to facilities				
• Matching clients with health facilities				
D. Management, monitoring and evaluation				
• Existing SDN Management Team				
• Documented referral guidelines and agreements				
• Available SDN Work Plan				
• Available SDN recording and reporting tools (e.g., referral slip, referral logbook)				
• Existing SDN monitoring and evaluation activities				

Annex B: SDN Mapping Tool

Health Care Facilities and Providers for Maternal, Newborn, Child Health and Nutrition (MNCHN)

LGU: _____ District: _____ City/Province: _____

<table>
<tr><td colspan="8">SDN Mapping Tool for 1st Tier</td></tr>
<tr><td colspan="8">Health Care Facilities and Providers for Maternal, Newborn, Child Health and Nutrition (MNCHN)
LGU: _____District: _____ City/Province: _____</td></tr>
<tr><td colspan="8">1st Tier/ First contact that offers basic health services /NSD. Community-level service providers such as RHUs, health centers, lying-in, or similar private facilities and Barangay Health Teams/CHTs</td></tr>
<tr><td rowspan="2">Name/Address of Service Delivery Points (SDPs)</td><td rowspan="2">Type of Facility (birthing home, hospital)</td><td rowspan="2">Classification of Facility (public or private)</td><td rowspan="2">PHIC Accreditation (MCP, NCP, PCB/ PHIC)</td><td colspan="4">Current MNCHN Services Available
Refer to RH core package of services DOH Department Memo # 2014-0313
(Write services available)</td><td rowspan="2">Competencies of Health Service Providers (MDs, RNs, RMs)
*List of Trainings: FPCBT 1, FPCBT 2 (Interval IUD, PPIUD, BTL-MLLA, NSV, PSI), LMT</td></tr>
<tr><td>Pre-Pregnancy Services</td><td>Antenatal Care</td><td>Care during Labor/ Delivery</td><td>Postpartum and Postnatal Care/Newborn/ Child care</td></tr>
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<tr><td colspan="8">Name of FP/MNHCN Facility Staff /Position /Visiting consultant/Specialty/ Schedule (Full time or write specific schedule of duty/visit)</td></tr>
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SDN Mapping Tool for 2nd Tier

Health Care Facilities and Providers for Maternal, Newborn, Child Health and Nutrition (MNCHN)
LGU: _____District: _____

2nd Tier / Emergency/ Medical Surgical Intervention
Core district hospital or similar capable public or private facility assigned to serve an ILHZ or health district, densely populated areas/ GIDA. Birthing facilities capable of providing the six signal BEmONC functions.

Name/Address of Service Delivery Points (SDPs)	Type of Facility (birthing home, hospital)	Classification of Facility (public or private)	PHIC Accreditation (MCP, NCP, PCB/ PHIC)	Current MNCHN Services Available *Refer to RH core package of services DOH Department Memo # 2014-0313 (Write services available)*				Competencies of Health Service Providers (MDs, RNs, RMs) *List of Trainings: FPCBT 1, FPCBT 2 (Interval IUD, PPIUD, BTL-MLLA, NSV, PSI), LMT
				Pre-Pregnancy Services	Antenatal Care	Care during Labor/ Delivery	Postpartum and Postnatal Care/Newborn/ Child care	

Name of FP/MNHCN Facility Staff /Position /Visiting consultant/Specialty/ Schedule (Full time or write specific schedule of duty/visit)	

SDN Mapping Tool for 3rd Tier

Health Care Facilities and Providers for Maternal, Newborn, Child Health and Nutrition (MNCHN)
LGU: _____District: _____ City/Province: _____

3rd Tier/ Specialty Hospital
Public or private facilities designated as the end-referral facility for integrated FP/MNCHN services

Name/Address of Service Delivery Points (SDPs)	Type of Facility (birthing home, hospital)	Classification of Facility (public or private)	PHIC Accreditation (MCP, NCP, PCB/ PHIC)	Current MNCHN Services Available *Refer to RH core package of services DOH Department Memo # 2014-0313 (Write services available)*				Competencies of Health Service Providers (MDs, RNs, RMs) *List of Trainings: FPCBT 1, FPCBT 2 (Interval IUD, PPIUD, BTL-MLLA, NSV, PSI), LMT
				Pre-Pregnancy Services	Antenatal Care	Care during Labor/ Delivery	Postpartum and Postnatal Care/Newborn/ Child care	

Name of FP/MNHCN Facility Staff /Position /Visiting consultant/Specialty/ Schedule (Full time or write specific schedule of duty/visit)	

Annex C: Categorization of Referrals

The categorization of referrals will begin the decision, preparation by the referring facility regarding transfer/referral of the client, and the acceptance by the recipient facility which has the desired capacities.

The list of referral conditions should be made available and these conditions may be categorized into Category A, B or C. Clear indicators must be negotiated as basis for these types of referrals. Category A referral corresponds to maternal and neonatal conditions that require subspecialist care and management; Category B referral pertains to maternal and neonatal conditions that require general specialist care and management in obstetrics and pediatrics; and Category C referral pertains to maternal and neonatal conditions that require trained generalist care and management in obstetrics and pediatrics. The indicators must be carefully considered when making referrals for conditions under each category.

Group A Category (Subspecialist Level)

This referral category pertains to maternal and neonatal conditions that require subspecialist care and management. The health service provider will be a Level 3 hospital with the obstetrics and pediatrics departments providing perinatology and neonatology services, respectively. There will be a high-risk pregnancy unit and a neonatal intensive care unit that could provide for sustained life support and multi-specialty referral for preterm neonates or low birth weight of ≤1500 grams**.** The hospital must also have a staff specializing in reproductive health and family planning.

1. Group A1 subcategory – Emergency (life-threatening) conditions that require subspecialist evaluation and management

Condition	Indications	Recognizable Signs, Symptoms & History (To be validated by the health service provider)	Category
Maternal			
Hypertensive Cases			
Pregnant women, not in labor (NIL)	Eclampsia	Blood pressure exceeds 140 mm Hg systolic or 90 mm Hg diastolic; with active seizure/convulsion	A1
Pregnant women, NIL	Preeclampsia, severe	Blood pressure (BP): 160/110; difficulty of breathing; blurred vision, epigastric pain and severe headache; proteinuria	A1
Obstetric Hemorrhage			
Pregnant women, in active labor	Placenta previa	Vaginal bleeding after the 20th week of gestation. Usually, the bleeding is painless, but it can be associated with uterine contractions and abdominal pain. Bleeding may range in severity from light to severe.	A1
Pregnant women, in active labor	Placenta accreta	Ultrasound result; vaginal bleeding may be noted during the 3rd trimester	A1

Condition	Indications	Recognizable Signs, Symptoms & History (To be validated by the health service provider)	Category
Pregnant women, in active labor	Abruptio placenta	Severe abdominal pain; with tetanic contractions; vaginal bleeding during the 3rd trimester; hypertension	A1
Pregnant women, in active labor	Obstructed labor	Partograph: cervical dilatation cross over the alert line; malpresentation or malposition of the fetus	A1
Pregnant women, in active labor	Uterine rupture	History of uterus with a surgical scar from previous surgery; excessive vaginal bleeding; sudden pain between contractions; contractions become slower or less intense.	A1
Intrapartum bleeding	Uterine atony	Excessive and uncontrolled bleeding following the birth of the baby; decreased blood pressure; increased heart rate	A1
Intrapartum bleeding	Retained placenta	Placenta has not undergone placental expulsion within 30 minutes of the baby's birth	A1
Intrapartum bleeding	Retained products of conception	Prolonged uterine bleeding (>3 weeks); fever and/or pain	A1
Postpartum	Vaginal lacerations (3rd and 4th degree)	Vaginal lacerations (3rd and 4th degree); fetal head is oriented occiput posterior (face forward); primigravida; large fetus	A1
Postpartum	Uterine inversion	Uterus protrudes from the vagina; blood loss of >500 ml; mother's blood pressure drops (hypotension)	A1
Infectious Cases			
Postpartum	Puerperal fever – endometritis, pelvic abscess, septic, pelvic thrombophlebitis, wound infection	Lower abdominal pain; a low-grade fever, or foul-smelling lochia (signs of endometritis); a painful, hard, warm, red area (usually only on one breast); and fever, chills, muscle aches, fatigue, or a headache (signs of mastitis)	A1
Medical Cases			
Pregnant women, NIL	Heart disease (in failure)	History of heart disease	A1
Pregnant women, NIL	Bronchial asthma in acute exacerbation/status asthmaticus	History of bronchial asthma	A1
Pregnant women, NIL	Obstructive or restrictive pulmonary disease in respiratory failure or distress	History of chronic smoking; bronchitis; emphysema	A1
Pregnant women, NIL	Diabetes mellitus	Diagnosed as having diabetes	A1

Condition	Indications	Recognizable Signs, Symptoms & History (To be validated by the health service provider)	Category
		mellitus	
Pregnant women, NIL	Renal disease (acute renal failure)	History of kidney disease or injury	A1
Postpartum	Pulmonary embolism	Difficulty of breathing; chest pain; rapid breathing	A1
Neonatal			
Neonatal asphyxia	Neonatal asphyxia APGAR score: 0-3	Before birth, abnormal fetal heart rate and low pH levels, indicating too much acid; at birth, poor skin color, low heart rate, weak muscle tone, gasping or weak breathing, and meconium-stained amniotic fluid	A1
Respiratory distress syndrome (RDS)	Low birth weight babies	Low birth weight babies- <1,500 grams	A1
Preterm baby	Preterm baby	<32 weeks age of gestation (AOG)	A1
Neonatal sepsis	Neonatal sepsis	Diminished spontaneous activity; less vigorous sucking; apnea; bradycardia; temperature instability; respiratory distress; vomiting; diarrhea; abdominal distention; jitteriness; seizures; and jaundice	A1
Hemorrhagic disease of newborn		Active bleeding or severe pallor	A1
Fetal distress		Fetal heart tone (FHT) <120; thick meconium-stained amniotic fluid	A1

2. Group A2 subcategory – Urgent (non-life threatening but needs immediate care) and non-urgent conditions that require subspecialist evaluation and management

Condition	Indication/s	Recognizable Signs & Symptoms (To be filled out by the health service provider)	Category
Maternal			
Obstetric Hemorrhage			
Pregnant women, NIL	Iron deficiency anemia in 3rd trimester	Pallor; extreme fatigue; shortness of breath (Hgb <11 gms) during 3rd trimester	A2
Medical Cases			
Pregnant women, NIL	Heart disease	History of heart disease	A2
Pregnant women, NIL	Seizure disorder (within last 6 months)	Seizure disorder (within last 6 months)	A2
Postpartum	Pulmonary atelectasis		A2

Condition	Indication/s	Recognizable Signs & Symptoms (To be filled out by the health service provider)	Category
Infectious Cases			
Pregnant women, NIL	Infections (toxoplasmosis, other agents, rubella, cytomegalovirus, herpes simplex or TORCH; sexually transmitted disease or STD, acute and chronic hepatitis, and chickenpox)	TORCH, STD, acute and chronic hepatitis, chickenpox	A2
Pregnant women, NIL	Incompetent cervix	Backaches; pelvic pressure sensation; mild abdominal cramps; changes in vaginal discharge; mild vaginal bleeding	A2
Pregnant women, NIL	Intrauterine growth restriction (IUGR) or macrosomia	Abnormal fundic height; polyhydramnios for macrosomia	A2
Pregnant women, NIL	Unsure of last menstrual period (LMP); no ultrasound (UTZ)	Unsure of LMP; no UTZ	A2
Family Planning			
FP clients (Postpartum IUD)		Client with FP unmet need willing to accept long-acting reversible contraception after provision of counseling	A2/B2/Birthing facility with trained HSPs

Group B Category (Specialist Level)

This referral category pertains to maternal and neonatal conditions that require general specialist care and management in obstetrics and pediatrics. The health service provider will preferably be a Level 2 or at least Level 1 hospital with full CEmONC functionality. Their obstetrics and pediatrics services must have a trained specialist and these units must have capabilities for advanced neonatal resuscitation.

1. Group B1 subcategory – Emergency conditions that require specialist evaluation and management

Condition	Indications	Recognizable Signs & Symptoms (To be filled out by the health service providers)	Category
Maternal			
Infectious Cases			
Pre-pregnancy - postpartum stage	HIV/AIDS screening	History of risk factors for HIV infection (multiple sexual partner; intravenous drug user; sexually transmitted infection (STI)	B1/ Social Hygiene Clinic/ HIV/AIDS screening center/ treatment hub

Condition	Indications	Recognizable Signs & Symptoms (To be filled out by the health service providers)	Category
Hypertensive Cases			
Pregnant women, NIL	History of eclampsia	History of eclampsia (blood pressure exceeds 140 mm Hg systolic or 90 mm Hg diastolic and with active seizure/convulsion)	B1
Pregnant women, NIL	Preeclampsia (moderate)	BP: 140/90 - 150/100; blurred vision; epigastric pain and severe headache; proteinuria	B1

2. Group B2 subcategory – Urgent and non-urgent conditions that require specialist evaluation and management

Condition	Indications	Recognizable Signs & Symptoms (To be filled out by the health service providers)	Category
Maternal			
Hypertensive Cases			
Pregnant women, NIL	Chronic hypertension	Blood pressure ≥140 mm Hg systolic and/or 90 mm Hg diastolic before pregnancy	B2
Pregnant women, NIL	Gestational hypertension	Blood pressure ≥140 mm Hg systolic and/or 90 mm Hg diastolic after 20 weeks AOG without proteinuria or other signs and symptoms of preeclampsia	B2
Obstetric Hemorrhage			
Pregnant women, NIL	Tumor previa	Ultrasound result with positive report	B2
Pregnant women, NIL		History of two consecutive abortions with dissection and curettage (D&C)	B2
Pregnant women, NIL		History of uterine procedure (e.g., Caesarean section)	B2
Pregnant women, NIL		History of vaginal bleeding during the 1st and 2nd trimester	B2
Medical Cases			
Pregnant women, NIL		History of renal disease/injury	B2
Pregnant women, NIL		Hematologic disorders/ Hemoglobinopathy/RH connective tissue disorder	B2
Pregnant women, NIL		With history of seizure disorder	B2
Pregnant women, NIL		Alcohol and substance abuse	B2
Pregnant women, NIL		Diabetes mellitus	B2
Pregnant women, NIL		With bronchial asthma not in acute exacerbation	B2
Pregnant women, NIL		With psychiatric or mental retardation	B2
Pregnant women, NIL		Malnutrition (body mass index or BMI <18 or >25)	B2

Condition	Indications	Recognizable Signs & Symptoms (To be filled out by the health service providers)	Category
Pregnant women, NIL		Presence of genital and extra-genital mass	B2
Pregnant women, NIL	Hypokalemia (low potassium)	Morning sickness vomiting; muscular weakness; fatigue	B2
Infectious cases			
Postpartum women	Pyelonephritis	Positive urinalysis result for infection	B2
Pregnant women, NIL		HBsAg positive	B2
Other Risk Factors			
Pregnant women, NIL		History of preterm delivery	B2
Pregnant women, NIL		History of pregnancy with fetal or neonatal deaths	B2 Co-management with OB specialist
Pregnant women, NIL		History of previous birth with congenital anomaly	B2
Pregnant women, NIL		History of weight of 1st baby - 2.3 kg	B2
Pregnant women, NIL		Malpresentation (breech, transverse)	B2
Pregnant women, NIL	Oligohydramnios	Abnormal protuberance of fetal parts/ shorter symphysis-fundus height/ apparently smaller appearance of the belly than what should be at a certain gestational stage; Ultrasound Amniotic Fluid Index = 6-8 during term	B2
Pregnant women, NIL		Multiple gestation	B2
Pregnant women, NIL		Blood type: RH negative	B2
Pregnant women, NIL		Post-datism	B2
Family Planning			
FP clients (BTL-MLLA/NSV)	Normal history and physical exam	Client with FP unmet need willing to accept LAPM after provision of counseling	B2
IUD extraction		Detached filament	B2
IUD extraction	Impacted IUD	Lost string; ultrasound result	B2
Neonatal			
Pregnant women, NIL	Fetal congenital anomalies	Ultrasound results	B2
Pregnant women, NIL		No fetal heart sounds	B2

Group C Category (Generalist Level).

This referral category pertains to maternal and neonatal conditions that require trained generalist care and management in obstetrics and pediatrics. The health service provider will be a BEmONC-capable RHU or Level 1 hospital. There will be a team trained in essential maternal and newborn care.

1. Group C1 subcategory – Emergency conditions that require trained generalist evaluation and management

Condition	Indications	Recognizable Signs & Symptoms (To be filled out by the health service providers)	Category
Maternal			
Pregnant women, NIL	Hyperemesis gravidarum	Morning sickness vomiting	C1
Pregnant women, NIL	Inappropriate weight gain		C1
Pregnant women, NIL	Polyhydramnios without diabetes mellitus (DM)	Swelling in the lower extremities, vulva and abdominal wall; shortness of breath	C1
Pregnant women, in active labor	Leaking bag of water	Cervical dilatation 7 cm; 2nd stage of labor; effacement – 80%; amniotic fluid – clear; time of leaking is less than 8 hours; no fever	C1
Postpartum		1st degree lacerations	C1

2. Group C2 subcategory – both urgent and non-urgent conditions that require trained generalist evaluation and management.

Condition	Indication/s	Recognizable Signs & Symptoms (To be filled out by the health service provider)	Category
Maternal			
Hypertensive Cases			
Pregnant women, NIL		Lower extremities edema but with normal blood pressure (BP: less than 140/90)	C2
Pregnant women, NIL		Normal BP = 120/80 or BP not more than 30 mmHg systolic compared to **pre-pregnancy** BP	C2
Obstetric Hemorrhage			
Pregnant women, NIL		History of abortion with one D&C	C2
Medical Cases			
Pregnant women, NIL		With pulmonary tuberculosis (undergoing treatment for at least 12 weeks) and without other medical conditions (e.g., maternal malnutrition, etc.)	C2
Pregnant women, NIL	Urinary tract infection (UTI)	Positive urinary result for infection	C2
Pregnant women,		With Hgb >11 gms	C2

Condition	Indication/s	Recognizable Signs & Symptoms (To be filled out by the health service provider)	Category
NIL			
Pregnant women, NIL	Iron deficiency anemia	Hgb <11 gms during 1st and 2nd trimester	C2
Pregnant women, NIL		Weight of 1st baby - 2.3 kg (normal weight gain of mother all throughout pregnancy; no co-morbidities)	C2
Pregnant women, NIL		Unsure of LMP (with UTZ within 12 weeks)	C2
Pregnant women, NIL		With FHT 120-160	C2
Pregnant women, NIL		With disability (deaf and mute)	C2
Pregnant women, NIL		Height: 145 cms and gravida 2	C2
Pregnant women, NIL		Multiparity (up to 4 only); if imminent, deliver and refer immediately at discretion of service provider	C2
Pregnant women, NIL	Normal spontaneous delivery	Normal history and physical exam; can deliver in lying-in clinic (LIC) as long as not adolescent and elderly primi and not high-risk; can deliver patients only up to 4th pregnancy	C2
Pregnant women, NIL	Screening tests	Normal lab exam results: complete blood count (CBC), blood typing (RH+), urinalysis, venereal disease research laboratory (VDRL) or rapid plasma reagin (RPR), HbSAg, 75 gms oral glucose tolerance test (OGTT)	C2
Family Planning			
FP clients (oral contraceptive pills, DMPA, progestin-only subdermal implant, condom, natural family planning)		Client with FP unmet need willing to accept FP method of choice after provision of counseling	C2/B2/A2
FP clients (interval IUD)			C2/B2/A2
FP clients (postpartum IUD)			C2/B2/A2

Annex D: Sample SDN Referral Guidelines

1. **Pre-referral stage** – This is the stage from the time the client/patient is seen to the point where a referral decision is made.

    a. The appropriate health provider (HP) evaluates the client's condition.

    b. If needed, the HP orders laboratory tests to confirm assessment.

    c. If a condition is beyond the HP's expertise or the service needed is unavailable in the health facility, the HP will determine the category/subcategory of the condition and a referral decision is made.

    d. If the condition is not listed in the referral category list, this condition is noted as unclassified in the referral form and is noted for consideration in the next meeting of the referral committee.

2. **Preparation for referral stage** – From the time the referral decision is made to the completion of all preparations and requirements for referral.

    a. The HP explains to the client the reason for referral.

    b. The HP fills up the referral form completely and has the client sign the consent statement.

    c. The HP gives instructions to the client/patient or his relatives concerning the referral slip, the name of the receiving facility, the directions to the receiving facility's location, name of specific area to go to in the receiving facility, and the name and designation of the contact person or health provider to go to.

    d. The referring facility ensures the availability of transportation for the conduct of emergency and urgent cases to receiving facility.

    e. For nonemergency conditions:
        - The HP informs the client of the schedule or availability of the service or specialist in the receiving facility.
        - If required by the receiving facility to make an appointment, the HP makes the call or instructs the client to call the receiving HP.
        - The HP instructs the client on any preparations needed before going to the receiving facility.

    f. For emergency and urgent conditions:
        - The HP contacts and informs the primary receiving facility of the incoming referral.
        - The HP obtains the acceptance of the primary receiving facility.
        - If unable to get acceptance from the primary receiving facility for valid reasons, the HP calls the secondary receiving facility.
        - If still unable to get acceptance from the secondary receiving facility, the HP calls the primary receiving facility for assistance in resolving the referral.
        - The HP makes arrangements for transportation.

- The HP provides all necessary stabilization measures to keep patient's vital signs within acceptable range during transport.
- The HP packs medicines, IV fluids, and all things necessary for the safe transport of the patient.
- The HP informs the client of any charges or fees covering the materials and supplies used in the initial management or transportation cost and have them settle this if patient has the capacity to pay.

g. The HP fills out the outgoing referral logbook**.**

3. **Transfer stage** – From the time the preparations for referral are completed to the arrival of the client/patient at the receiving facility.

   a. For nonemergency and non-urgent conditions:
      - The patient/client proceeds to the receiving facility.
      - The patient/client presents the referral slip to the receiving facility.

   b. For emergency and urgent conditions:
      - The HP accompanies the patient during transport.
      - The HP monitors vital signs while on travel and institutes appropriate measures.
      - The HP continues recording management and medications given, including a record of the patient's condition.
      - The HP endorses the patient to the receiving facility.

4. **Receiving stage** – From the time the referring facility informed the receiving facility of the referral to the arrival of the patient and acceptance of the referral and provision of initial treatment/management.

   For emergency and urgent conditions:

   a. Upon receipt of the call of an incoming referral, the contact person:
      - Informs the appropriate ER staff on duty of the incoming referral, the patient's diagnosis and condition and its designated referral category. The ER staff on duty informs the specialist of the incoming referral and its details.
      - Informs the admitting section of the incoming referral and possible admission. The admitting section subsequently looks for a free bed in the designated ward.
      - Informs the OR/DR complex of arrival of the incoming referral and possible emergency procedure.
      - Informs the blood center of the blood type of the incoming referral.
      - Informs the security unit of the incoming referral to facilitate the entry.

   b. Upon arrival of the referral:
      - The security unit facilitates the entry of the referral to the ER.
      - The security unit informs the contact person of the arrival of the referral.
      - The patient is immediately transferred to the ER.
      - The ER staff receives the endorsement from the referring HP.
      - The ER staff makes an initial assessment and makes the admitting orders.
      - The ER staff fills out the return slip and returns this to the referring HP.
      - The ER staff attaches the referral slip to the patient's chart.
      - The ER staff fills out the incoming referral logbook**.**

5. **Post-referral stage** – From the completion of service to the discharge of the client/patient from the receiving facility.

   a. For non-admitted patients (diagnostic and consultation referral)
      - The receiving health provider gives the service and advices the patient to return to the referring health service provider.
      - The receiving health provider gives the diagnostic test results to the client (for diagnostic referrals).
      - The receiving health provider fills out the return slip and instructs the client to give it back to the referring health provider.

   b. For admitted patients:
      - The attending health provider orders the discharge of the patient.
      - The nurse on duty gives discharge instructions and encourages the patient to continue follow-up (if appropriate) in the referring facility.

6. **Monitoring and evaluation stage** – The activities to determine the functionality, performance, and areas for improvement of the referral system.

   a. The Provincial Health Office organizes the Provincial SDN Referral Committee (SDN RC).

   b. The SDN Management/Core Team can be designated as the SDN Referral Committee.

   c. The SDN Management/Core Team or RC will hold regular quarterly meetings to discuss:
      - Total number of referrals from SDN member facilities (x = total count of all outgoing referrals in the SDN;
      - Number and percentage of referrals from each SDN member facility (y = count of all outgoing referrals per facility; percentage = y/x *100)
      - Total number of referrals received by SDN member facilities (m = count of all incoming referrals)
      - Number and percentage of referrals received by each SDN member facility (n = count of all incoming referrals received per facility; percentage = n/m * 100)
      - Number and percentage of unqualified referrals (p = count of all unqualified referrals; unqualified referrals are cases that do not need to be referred or cases referred to the wrong facility; percentage = p/x * 100)
      - Number and percentage of non-accepted referrals (q = count of all referrals that were not accepted either through phone or on-site rejection; percentage = q/x *100)
      - Unclassified referrals – conditions not listed in the categorized referrals (code as U = unclassified)
      - Referrals coming from other SDNs – referrals that are sent by facilities outside the defined catchment area of the receiving SDN or facilities that are within the catchment area but have not signed the Service Providers' Agreement
      - Number of referrals transferred to other facilities – referrals accepted by receiving facilities but eventually referred to another facility
      - Number of adolescent and youth referrals (aged 10-24)
      - Number of referrals for FP services
      - Reasons for referral
      - Reasons for transfer of referrals and issues and concerns

d. For purposes of organizing the aggregated quarterly referral report, all facilities in the SDN will submit the following data to the P/CHO **one week after the end of each quarter**, preferably in Excel file for easier handling by the P/CHO staff:
   - Count of all outgoing referrals
   - Count of all incoming referrals
   - Count of all unqualified referrals
   - Count of all unclassified referrals
   - List of diagnosis of all unclassified referrals within the reporting period
   - Count of referrals that were not accepted by the designated receiving facility
   - Count of referrals received from and referred to facilities outside the SDN
   - Count of referrals transferred to other facilities (for receiving facilities only)
   - Count of adolescent and youth referrals (aged 10-24)
   - Count of referrals for FP services (BTL-MLLA; PPFP/PPIUD/Interval IUD, among others)
   - Reasons for referrals
   - Reasons for non-acceptance/transfer of referral

e. Report quarterly to the C/PHO/SDN Management Team the outcomes and decisions of the referral committee meetings.

Annex E: Sample Service Providers' Agreement

SERVICE PROVIDERS' AGREEMENT
ON PROVIDING FOR MNCHN-RPRH SERVICES WITHIN THE SERVICE DELIVERY NETWORK OF BATANGAS

By and Between

The *Batangas Medical Center*, with address at Kumintang Ibaba, Batangas City, represented by [redacted], Medical Center Chief II; the *Provincial Health Office*, with address at Kumintang Ibaba, Batangas City, represented by [redacted], Provincial Health Officer II; the *Batangas Provincial Hospital*, with address at Lemery, Batangas, represented by [redacted], Chief of Hospital; *Apacible Memorial District Hospital*, with address at Nasugbu, Batangas, represented by [redacted] Chief of Hospital; Calatagan Infirmary Hospital with address at Calatagan, Batangas, represented by [redacted], Chief of Hospital; *Don Manuel Lopez Memorial District Hospital* with address at Balayan, Batangas, represented by [redacted], Chief of Hospital; *Laurel Memorial District Hospital* with address at Tanauan City, Batangas, represented by [redacted] Chief of Hospital; *Laurel Municipal Hospital* with address at Laurel, Batangas, represented by [redacted], Chief of Hospital; Lipa City District Hospital with address at Lipa City, Batangas, represented by [redacted], Chief of Hospital; *Lobo District Hospital* with address at Lobo, Batangas, represented by [redacted], Chief of Hospital; *Martin Marasigan Memorial District Hospital* with address at Cuenca, Batangas, represented by [redacted], Chief of Hospital; *MVM Sto. Rosario District Hospital* with address at Rosario, Batangas, represented by [redacted], Chief of Hospital; *San Jose District Hospital* with address at San Jose, Batangas, represented by [redacted], Chief of Hospital; *San Juan District Hospital* with address at San Juan, Batangas, represented by [redacted], Chief of Hospital; *Bauan General Hospital* with address at Bauan, Batangas, represented by [redacted], Chief of Hospital; *Ospital ng Lipa* with address at Lipa City, Batangas, represented by [redacted], Chief of Hospital; *Fernando Airbase Hospital* with address at Lipa City, Batangas, represented by the Chief of Hospital**;** the *Batangas City Health Office* with address at Batangas City Batangas, represented by [redacted], City Health Officer; the *Lipa City Health Office* with address at Lipa City Batangas, represented by [redacted], City Health Officer; the *Tanauan City Health Office* with address at Tanauan City Batangas, represented by [redacted] City Health Officer; the *Agoncillo RHU* with address at Poblacion, Agoncillo, Batangas, represented by [redacted], Municipal Health Officer; the *Alitagtag RHU* with address at Poblacion East Alitagtag Batangas, represented by [redacted], Municipal Health Officer; the *Balayan RHU* with address at Plaza Mabini, Balayan, Batangas, represented by [redacted], Municipal Health Officer; the *Balete RHU* with address at Poblacion Balete, Batangas, represented by [redacted], Municipal Health Officer; the *Bauan RHU 1* with address at Brgy. 1 Poblacion, Bauan, Batangas, represented by [redacted] Municipal Health Officer; the *Bauan RHU 2* with address at Brgy. Aplaya, Bauan, Batangas, represented by [redacted], Municipal Health Officer; the *Calaca RHU* with address at Poblacion 3, Calaca, Batangas, represented by [redacted], Municipal Health Officer; the *Calatagan RHU* with address at Brgy. 2 Poblacion, Calatagan, Batangas, represented *by* [redacted], Municipal Health Officer; the *Cuenca RHU* with address at Brgy. 2 Poblacion Cuenca, Batangas, represented by [redacted], Municipal Health Officer; the *Ibaan RHU* with address at Don Pedro Subd. Talaibon, Ibaan, Batangas, represented by[redacted], Municipal Health Officer; the *Laurel RHU* with address at Brgy. 2 Poblacion Laurel, Batangas, represented by [redacted], Municipal Health Officer; the *Lemery RHU* with address at Poblacion, Lemery Batangas, represented by

[redacted], Municipal Health Officer; the *Lian RHU* with address at Brgy. 2 Lian, Batangas, represented by [redacted], Municipal Health Officer; the *Lobo RHU* with address at Poblacion, Lobo, Batangas, represented by [redacted], Municipal Health Officer; the *Mabini RHU* with address at Poblacion, Mabini, Batangas, represented by [redacted], Municipal Health Officer; the *Malvar RHU* with address at Municipal Compound San Pioquinto, Malvar, Batangas, represented by [redacted], Municipal Health Officer; the *Mataas na Kahoy RHU* with address at Brgy II-A Poblacion, Mataas na Kahoy, Batangas, represented by [redacted], Municipal Health Officer; the *Nasugbu RHU* with address at Poblacion 1 Nasugbu, Batangas, represented by [redacted], Municipal Health Officer; the *Padre Garcia RHU* with address at Poblacion, Padre Garcia, represented by [redacted], Municipal Health Officer; the *Rosario RHU* with address at Poblacion, Rosario, Batangas, represented by [redacted], Municipal Health Officer; the *San Jose RHU* with address at Brgy. Poblacion, San Jose, Batangas, represented by [redacted], Municipal Health Officer; the *San Juan RHU* with address at Poblacion, San Juan, Batangas, represented by [redacted], Municipal Health Officer; the *San Luis RHU* with address at Poblacion, San Luis, Batangas, represented by [redacted], Municipal Health Officer; the *San Nicolas RHU* with address at Poblacion, San Nicolas, Batangas, represented by [redacted], Municipal Health Officer; the *San Pascual RHU* with address at Poblacion, San Pascual, Batangas, represented by [redacted], Municipal Health Officer; the *Sta. Teresita RHU* with address at Poblacion 1, Sta. Teresita, Batangas, represented by [redacted], Municipal Health Officer; the *Sto. Tomas RHU* with address at Poblacion 2, Sto. Tomas, Batangas, represented by [redacted], Municipal Health Officer; the *Taal RHU* with address at Brgy. Tierra, Taal, Batangas, represented by [redacted], Municipal Health Officer; the *Talisay RHU* with address at Poblacion 5, Talisay, Batangas, represented by [redacted], Municipal Health Officer; the *Taysan RHU* with address at Brgy. Poblacion, West Taysan, Batangas, represented by [redacted], Municipal Health Officer; the *Tingloy RHU* with address at Brgy. 14, Poblacion 2, Tingloy, Batangas, represented by the Municipal Health Officer; the *Tuy RHU* with address at Luna Poblacion, Tuy Batangas, represented by [redacted] Municipal Health Officer; *Batangas Medicare Jesus of Nazareth Hospital* with address at *Batangas City*, represented by the Chief of Hospital; *Mary Mediatrix Medical Center* with address at Lipa City, represented by the Chief of Hospital; *Daniel Mercado Memorial Medical Center* with address at Tanauan City, represented by the Chief of Hospital; herein referred to as the Parties;

RECOGNIZING the need to improve maternal and neonatal health outcomes and the ability to address this effectively through the provision of comprehensive maternal and newborn and reproductive health services;

INTERNALIZING that no individual health facility can possibly provide all the MNCHN-RPRH services and that organizing into a unified health delivery system through a service delivery network is the most efficient way to carry out the goals of the health care system;

ACKNOWLEDGING the potential benefit of an organized referral system composed of all health facilities that provide MNCHN-RPRH services;

DESIRING to ensure the accessibility of services to women, newborn and children clients/patients and maximize the use of their PhilHealth benefits;

COMMITTED to decrease the maternal mortality rate, infant mortality rate, and under five mortality rate;

Operating under this Service Providers' Agreement, the parties hereto agree as follows:

PART I

The Parties hereby establish a working partnership in providing accessible MNCHN-RPRH services to women, newborn and children in the Province of Batangas.

PART II

1. The Parties agree to undertake this partnership based on the MNCHN-RPRH Referral Guidelines which will form part and parcel of this agreement;

2. The Parties appoint the Provincial Health Office as the caretaker of the MNCHN-RPRH SDN and as such will be the convener of the regular and special meetings. Hosting of these meetings can be shared by the different member facilities;

3. The Parties understand that the MNCHN-RPRH referral system is only an initial component to the full development of their SDN. As such, when additional SDN lines are added (i.e., systems planning, quality assurance, information system, technology transfer/sharing, diagnostic resource pooling, bulk procurement, health human resources planning and placement, other vertical health programs), corresponding guidelines will be developed;

4. The Parties will follow the technical guidelines issued by the Department of Health, the World Health Organization and other authorities recognized and agreed upon by consensus of its members. Examples of these technical guidelines are the MNCHN MOP, EINC Implementation Manual, and RPRH Clinical Standards Manual;

5. The Parties commit to undertake more formal and binding agreements upon successful implementation of this service providers' agreement.

PART III

The Service Providers' Agreement may be amended upon mutual agreement of the Parties.

PART IV

The parties mutually agree to the following referring and receiving referral arrangements:

EASTERN SECTOR		
Referring Facility (RHU) and C Referrals	**B Referrals**	**A Referrals**
Mataas na Kahoy	Lipa City District Hospital	Batangas Medical Center
Lipa City	Lipa City District Hospital	Batangas Medical Center
Malvar	Lipa City District Hospital/Laurel Memorial District Hospital	Batangas Medical Center
Balete	Lipa City District Hospital	Batangas Medical Center
Tanauan City	Laurel Memorial District Hospital	Lipa City District Hospital
San Jose	San Jose District Hospital	Lipa City District Hospital
Ibaan	San Jose District Hospital/ Mahal na Virgen Maria Sto. Rosario District Hospital	Lipa City District Hospital
Rosario	Mahal na Virgen Maria Sto. Rosario District Hospital	Lipa City District Hospital

EASTERN SECTOR		
Referring Facility (RHU) and C Referrals	**B Referrals**	**A Referrals**
Padre Garcia	Mahal na Virgen Maria Sto. Rosario District Hospital	Lipa City District Hospital
San Juan	San Juan District Hospital	Lipa City District Hospital
Lobo	Lobo District Hospital	Batangas Medical Center
Mabini	Batangas Provincial Hospital	Batangas Medical Center
Taysan	Mahal na Virgen Maria Sto. Rosario District Hospital	Lipa City District Hospital
Tingloy	Batangas Medical Center	
Sto. Tomas	Laurel Memorial District Hospital	Batangas Medical Center
Batangas City	Batangas Medical Center	

WESTERN SECTOR		
Referring Facility (RHU)/C Referrals	**B Referrals**	**A Referrals**
Alitagtag	Batangas Provincial Hospital	Batangas Medical Center
Agoncillo	Batangas Provincial Hospital	Batangas Medical Center
Balayan	Don Manuel Lopez Memorial District Hospital	Batangas Provincial Hospital
Bauan	Bauan General Hospital	Batangas Provincial Hospital
Calaca	Don Manuel Lopez Memorial District Hospital	Batangas Provincial Hospital
Calatagan	Calatagan Medicare Hospital	Don Manuel Lopez Memorial District Hospital/Batangas Provincial Hospital
Cuenca	Martin Marasigan Memorial District Hospital	Batangas Provincial Hospital
Laurel	Laurel Municipal Hospital	Batangas Provincial Hospital
Lemery	Batangas Provincial Hospital	Batangas Medical Center
Lian	Apacible Memorial District Hospital	Batangas Provincial Hospital
Nasugbu	Apacible Memorial District Hospital	Batangas Provincial Hospital
San Luis	Batangas Provincial Hospital	Batangas Medical Center
San Nicolas	Batangas Provincial Hospital	Batangas Medical Center
San Pascual	Batangas Medical Center	
Sta. Teresita	Batangas Provincial Hospital	Batangas Medical Center
Taal	Batangas Provincial Hospital	Batangas Medical Center
Talisay	Laurel Memorial District Hospital	Batangas Medical Center
Tuy	Don Manuel Lopez Memorial District Hospital	Batangas Provincial Hospital

PART V

This Service Providers' Agreement will take effect upon signature and will remain in force until terminated in writing by the Parties.

Signed at The Lake Hotel, Tagaytay this 10th day of August 2016

Annex F: Sample Referral Form for the SDN

(LOGO)

_____
Name of Facility

_____
Address of Facility

REFERRAL FORM

Referred to: _____ **Referred Date:** _____ **Time:** _____
Coordinated by phone call: Yes ___No____
Arrival Date: _____ **Time:** _____

REASON FOR REFERRAL
_____
_____

NAME OF PATIENT: _____**AGE:** _____ **SEX:** _____

ADDRESS: _____**CIVIL STATUS:** _____

BRIEF HISTORY
_____
_____
_____

MOTHER	BABY	
LMP: _____	**NAME:** _____	**SEX:** _____
EDC: _____	**BIRTH WEIGHT:** _____	**APGAR SCORE:** _____
AOG: _____	**TERM:** _____	**PRE-TERM:**_____
VITAL SIGNS: _____	**VITAL SIGNS:** _____	

__

LABORATORY RESULT:
_____
_____

MANAGEMENT/TREATMENT DONE/MEDICATION GIVEN AND TIME:
_____
_____

REMARKS: _____

_____
SIGNATURE OVER PRINTED NAME OF SERVICE PROVIDER

ACKNOWLEDGMENT SLIP

FROM REFERRAL UNIT: _____ **Referred Date:** _____ **Time:** _____

Received Date: _____ **Time:** _____

NAME OF PATIENT: _____ **AGE:** _____ **SEX:** _____

ADDRESS: _____**CIVIL STATUS:** _____

REMARKS: _____
_____

_____
SIGNATURE OVER PRINTED NAME OF SERVICE PROVIDER

Annex G: Referral Logbook for Outgoing Referrals

DATE/ TIME (1)	NAME OF PATIENT (2)	AGE (3)	SEX (4)	IMPRESSION (5)	REFERRED TO (6)	REASON FOR REFERRAL (7)	IMPRESSION (Given by Receiving Facility) (8)	OUTCOME OF REFERRAL (9)	REASON FOR NONACCEPTANCE/ TRANSFER (10)	NAME AND DESIGNATION OF RECEIVING / ACCEPTING PHYSICIAN (11)	OTHER ISSUES and CONCERNS (e.g., non-acknowledgment of referrals by receiving facility) (12)	REFERRAL CODE (13)

Instructions:

Column 1 – Indicate the date and time the referral was done.
Column 2 – Indicate the surname, given name, and middle initial of the patient.
Column 3 – Indicate the age in years.
Column 4 – Indicate the gender at birth (M or F).
Column 5 – Indicate clinical impression that prompted the referral.
Column 6 – Enter the name of the receiving facility.
Column 7 – Indicate whether: Consultation, Diagnostic Test, Transfer Service, or Family Planning (if FP, further specify whether BTL MLLA; NSV; PPFP/PPIUD/ Interval IUD, others), and others.
Column 8 – Indicate the impression given by the receiving facility (get information from the return slip).
Column 9 – Indicate whether the referral was accepted or not accepted.
Column 10 – Indicate whether full capacity, unavailability of service or provider, and if none of the preceding, please specify.
Column 11 – Indicate the complete name and designation of the receiving/accepting physician (get information from the return slip).
Column 12 – Indicate other issues and concerns. (e.g., non- acknowledgment of referrals by receiving facility either by phone call or SMS)
Column 13 – Indicate whether A1, A2, B1, B2, C1, C2, U – unclassified, UQ – Unqualified

Annex H: Referral Logbook for Incoming Referrals

DATE/ TIME (1)	NAME OF PATIENT (2)	AGE (3)	SEX (4)	IMPRESSION (Given by Receiving Facility) (5)	REFERRED FROM (6)	REASON FOR REFERRAL (7)	OUTCOME OF REFERRAL (8)	STATUS OF RETURN SLIP (9)	REASONS FOR TRANSFER (10)	REFERRAL CODE (11)	COORDINATED OR UNCOORDINATED (12)

Instructions:

Column 1 – Indicate the date and time the referral was received
Column 2 – Indicate the surname, given name, and middle initial of the patient
Column 3 – Indicate the age in years
Column 4 – Indicate the gender at birth (M or F)
Column 5 – Indicate initial clinical impression of the receiving facility
Column 6 – Enter the name of the referring facility and if an SDN member, add M after the name or if a non-SDN member - NM
Column 7 – Indicate whether: Consultation, Diagnostic Test, Transfer Service or Family Planning (if FP further specify whether BTL MLLA; NSV; PPFP/PPIUD/ Interval IUD, others), and others.
Column 8 – Indicate whether the referral was accepted, not accepted or transferred
Column 9 – Indicate if the return slip was returned or not returned
Column 10 – Indicate whether full capacity, unavailability of service or provider, and if none of the preceding please specify. Indicate other issues and concerns if there are any in this column
Column 11 – Indicate whether A1, A2, B1, B2, C1, C2, U – unclassified, UQ – Unqualified
Column 12 – Indicate whether the referral, especially A1 and B1 referrals, were coordinated (patient with referral slip and referral was acknowledged by receiving facility either by phone call or SMS)

Annex I: Data Capture Form (with Electronic Version)

Monitoring of the Service Delivery Network's Referral Mechanism

MUNICIPALITY/CITY: _____
NAME OF FACILITY: _____
FOR THE QUARTER: _____

A. OUTGOING REFERRALS

Instruction: Please provide the required data/information in the table or space provided. Please get information from the outgoing referral logbook

1. Count all the referrals sent within the SDN members (column 0)
1.1 Count all the referrals sent within the SDN members that were accepted (column 9)
1.2 Count all the referrals sent within the SDN that were not accepted either through phone or on-site rejection (column 9)
1.3 Write down the common reason for non-acceptance – whether full capacity, unavailability of service or provider, others (column 10)

2. Count all the referrals sent outside the SDN (referrals that are sent by facilities outside the defined catchment area of the receiving SDN or facilities that are within the catchment area but have not signed in the Service Providers' Agreement)(column 6)
2.1 Count all the referrals sent outside the SDN that were accepted (column 6)
2.2 Count all the referrals sent outside the SDN that were not accepted either through phone or on-site rejection (column 9)
2.3 Write down the common reason for non-acceptance – whether full capacity, unavailability of service or provider, others (column 10)

3. Write the reasons for referral (Column 7)
4. Count the number of referrals under each classification (Column 13)
5. Count the number of referrals for adolescent and youth – age range 10-24 (Column 3)
6. List down other issues/concerns **(**e.g., non-acknowledgment of referrals by receiving facility) (Column 12)

Outgoing Referral Tally Form

Outgoing Referral Data	Response
1. Total outgoing referrals **within the SDN members**	
1.1Total accepted	
1.2 Total not accepted	
1.3 Common reasons of non-acceptance of referral	
2. Total outgoing referrals to facilities **outside SDN (non-members)**	
2.1Total accepted	
2.2 Total not accepted	
2.3 Common reasons of non-acceptance of referral	
3. Reasons for referral	
3.1 Consultation	
3.2 Diagnostic Test	
3.3 Transfer Service	
3.4 FP Services	
- BTL MLLA	
- PPIUD	
- PPFP	
- Interval IIUD	
- Others, specify_____	
3.5 Others, please specify	
4. Classification of outgoing referrals	

Outgoing Referral Data	Response
4.1. Total A1	
4.2. Total A2	
4.3. Total B1	
4.4. Total B2	
4.5. Total C1	
4.6. Total C2	
4.7. Total U – Unclassified	
4.8. Total UQ – Unqualified	
5. Number of outgoing referrals for Adolescent and Youth	
5.1. 10-19 years old	
5.2. 20-24 years old	
6. Total outgoing referrals coordinated to receiving facilities	
6.1Total accepted	
6.2 Total not accepted	
7. Other Issues and Concerns (if any)	

B. INCOMING REFERRALS

Instruction: Please provide the required data/information in the table or space provided. Please get information from the incoming referral logbook

1. Count all the referrals sent within the SDN members (column 0)
1.1 Count all the referrals sent within the SDN members that were accepted (column 9)
1.2 Count all the referrals sent within the SDN that were not accepted either through phone or on-site rejection (column 9)
1.3 Write down the common reason for non-acceptance – whether full capacity, unavailability of service or provider, others (column 10)

2. Count all the referrals sent outside the SDN (referrals that are sent by facilities outside the defined catchment area of the receiving SDN or facilities that are within the catchment area but have not signed in the Service Providers' Agreement)(column 6)
2.1 Count all the referrals sent outside the SDN that were accepted (column 6)
2.2 Count all the referrals sent outside the SDN that were not accepted either through phone or on-site rejection (column 9)
2.3 Write down the common reason for non-acceptance – whether full capacity, unavailability of service or provider, others (column 10)

3. Write the reasons for referral (Column 7)
4. Count the number of referrals under each classification (Column 13)
5. Count the number of referrals for adolescent and youth – age range 10-24 (Column 3)
6. List down other issues/concerns **(**e.g., non-acknowledgment of referrals by receiving facility) (Column 12)

Incoming Referral Tally Form

Incoming Referral Data	Response
1. Total incoming referrals **within the SDN members**	
1.1Total accepted	
1.2 Total not accepted	
1.3 Common reasons of non-acceptance of referral	
2. Total incoming referrals to facilities **outside SDN (non-members)**	
2.1Total accepted	
2.2 Total not accepted	
2.3 Common reasons of non-acceptance of referral	
3. Reasons for referral	
3.1 Consultation	
3.2 Diagnostic Test	
3.3 Transfer Service	
3.4 FP Services	
- BTL MLLA	
- PPIUD	
- PPFP	
- Interval IIUD	
- Others, specify_____	
3.5 Others, please specify	
4. Classification of incoming referrals	
4.1. Total A1	
4.2. Total A2	
4.3. Total B1	
4.4. Total B2	
4.5. Total C1	
4.6. Total C2	
4.7. Total U – Unclassified	
4.8. Total UQ – Unqualified	
5. Number of incoming referrals for Adolescent and Youth	
5.1. 10-19 years old	
5.2. 20-24 years old	
6. Total incoming referrals coordinated to receiving facilities	
6.1Total accepted	
6.2 Total not accepted	
7. Other Issues and Concerns (if any)	

Prepared by: Certified by:

_____ _____

SDN Point Person Chief

Date: _____

Annex J: SDN Standard Incident/Feedback Report Form

FP/ MNCHN SERVICE DELIVERY NETWORK

Objective: To improve the SDN referral mechanism in the _____.

INCIDENT REPORT FORM

REPORTING FACILITY: _____ Contact No.: _____
Name of Reporting Health Staff: _____ Contact No.: _____
Position of Reporting Health Staff: _____

NAME OF PATIENT INVOLVED
Condition of Patient: _____
Category: _____

NAME OF KEY HEALTH FACILITY STAFF INVOLVED:

From Referring Facility:
1. _____ Contact No.: _____
2. _____ Contact No.: _____

From Receiving Facility:
1. _____ Contact No.: _____
2. _____ Contact No.: _____

DATE AND TIME PERIOD THAT THE INCIDENT OCCURRED:
_____

MAJOR ISSUE BEING RAISED:
_____
_____

NARRATIVE OF THE INCIDENT (Page ____ of ____)
_____

_____
_____
_____
_____
_____
_____
_____

_____
Signature of Reporting Health Staff, Designation, Contact Number and Email Address

Note: Attach additional page if needed

Annex K: Illustrative activity design for the SDN Monitoring and Evaluation workshop and Results

I. RATIONALE AND BACKGROUND

Family planning/maternal, newborn, and child health and nutrition (FP/MNCHN) services within the public health delivery system are organized as a three-tiered system: (1) at the lowest tier, City Health Centers (CHCs), Rural Health Units (RHUs), and *Barangay*/Village Health Stations provide support for basic maternal and child health (MCH) services; (2) at the mid-tier, District and Provincial Hospitals provide support for specialist care (general obstetricians/gynecologists and general pediatricians), and (3) at the highest tier, Regional Medical Centers provide support for subspecialist care (perinatologists and neonatologists).

A service delivery network (SDN) is a strategic mechanism for expanding access to and strengthening the continuum of care for families across political and geographical boundaries. It seeks to ensure the continuing provision of quality care by combining the capacities of individual health service delivery points into a unified delivery system. This facilitates the collective management of recurrent issues resulting from the three-tiered health care system and uncoordinated referral practices among health care system facilities.

In 2014, the Department of Health (DOH), through its Regional Offices (DOHROs), presented general guidelines for establishing SDNs [2]. The DOH also issued an administrative order defining SDNs for Universal Health Care [3]. In 2016, the Philippine Health Agenda (PHA) [4] of the DOH, which builds on the gains of earlier reform policies, underscored the SDN as one of the three guarantees providing access to a continuum of health services. The PHA policy states that the health system shall guarantee access to health interventions through functional SDNs.

The initial conduct of M and E activity aims to monitor and re-evaluate the implementation of the SDN referral system and the interventions done in improving the SDN referral system. Overtime as the SDN referral system progresses a benefit and outcome data will be generated as the SDN sites continuously conduct regular M and E which is imperative to sustain the SDN referral mechanism implementation.

II. OBJECTIVES

The activity seeks:

1. To monitor and evaluate the operations of the organized FP-MNCHN SDN and the implementation of the referral mechanism for FP/MNCHN services using the SDN M & E tools;
2. To identify gaps and challenges affecting SDN operations and address these gaps and challenges to further improve, strengthen and sustain its functionality/operation and referral mechanism

III. EXPECTED OUTPUTS

- Outputs generated by the referral system documented in the SDN M & E data capture tools
- Issues and concerns on the implementation of the FP-MNCHN referral mechanism discussed and documented and commitment for solution secured/obtained.

IV. METHODOLOGY:

- One day M and E Workshop and planning with all SDN members, presentation and discussion of results with the SDN members, DOH ROs, and PHOs.
- Health Facility Observation in specified areas (selected birthing facility; Hospital ER and Hospital OPD)
- Health Service Provider's Interview (from selected birthing facility; Hospital ER and Hospital OPD)

PROGRAM of ACTIVITIES
SDN M and E Workshop

Time	Topics	Person Responsible
Day 1		
8:00 – 9:00 AM	Arrival & Registration of Participants	**SDN Management Team**
9:00 – 9:20 AM	Opening program	
9:20 – 9:30AM	Overview of the SDN M&E workshop	PHO
9:30 – 10:00AM	Orientation/review of SDN Monitoring and Evaluation M&E Tools	**SDN Management Team**
10:00-12:00 NN	Workshop 1: Data Capture by facility	**Participants**
12:00-1:00PM	*Lunch Break*	
1:00-3:00 PM	Workshop 2: Gains, gaps, recommendations in the implementation of the FP/MNCHN SDN Referral Mechanism	**Participants and Facilitators**
	Preparation of presentation materials on the SDN M&E data	**SDN Management Team**
3:00-4:00 PM	Presentation of and discussion on the M&E data	**PHO SDN Focal person**
4:00-5:00 PM	Action Planning	**Participants and Facilitators**
Day 2		
Facility visit (by SDN Management Team)		
9:30-11:00 AM	Select SDN Member facilities Primary health care (RHU/ Public or private Lying in clinic) Level 2 and or Level 3 (apex facility)	**SDN Management Team**
11:00-12:00 NN	Processing of results of facility visit	**SDN Management Team**

Illustrative example of SDN M and E results conducted in 13 SDN project sites.

A total of 14,571 outgoing and 14,398 incoming referrals were recorded from respective facilities within the SDN from October 2017- June 2018 with a high acceptance rate at an average of 98.5%. Of the 14,571 recorded outgoing referrals, consultations, accounted for 45 percent of all referrals, with transfers representing the next largest proportion (41%). Transfer referrals were usually for emergency or urgent conditions. These findings may show that the referral system is in the process of maturing; in a developed SDN, the proportion of consultation referrals is expected to increase, whereas transfer referrals are expected to decrease, suggesting earlier

diagnosis and management of cases by the SDN. The counts of outgoing and incoming referrals demonstrated that the health facilities within the SDN operates as a functional health system showing gatekeeping activities with more medically evaluated referrals. Tracking referrals is one of the challenges being addressed by the SDN through the use of return slips, logbooks, and follow-up calls between referring and receiving facilities.

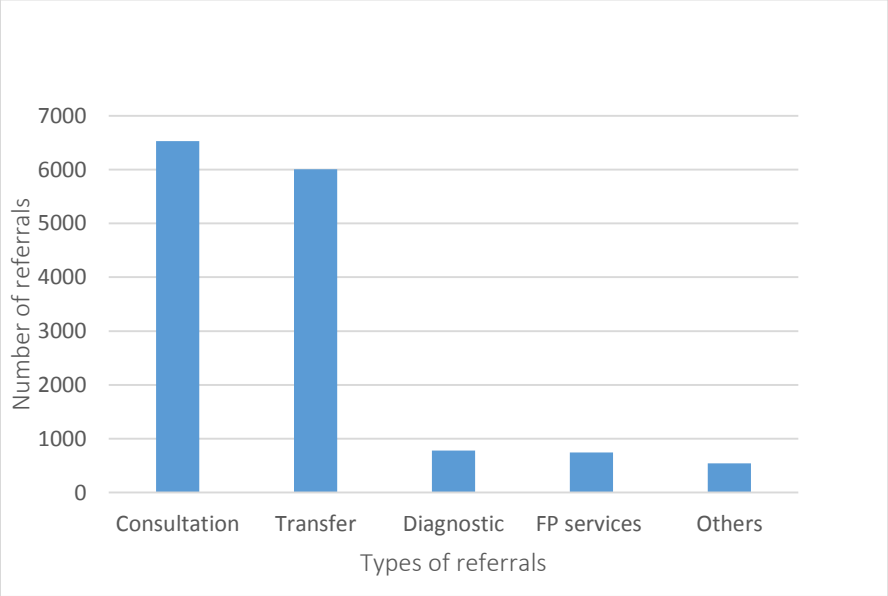


Figure 1. Outgoing referrals by type

Of the outgoing referrals with documentation on the classification of the referral, 26 percent were emergency cases or “must accept” referrals, and 35 percent were non-urgent conditions. As the SDN matures, the number of emergency or “must accept” referrals is expected to decrease, and non-emergency referrals are expected to increase. This is because emergencies will be prevented by improved MCH program performance. For example, a referred pregnant woman who is not in labor but is highly suspected of being pre-eclamptic will be categorized as urgent (non-life threatening), thereby preventing an emergency (life threatening) referral scenario. This patient will go directly to the appropriate tertiary hospital once she is in labor. A high referral rate for emergency and non-urgent cases and the continued existence of primary and secondary cases in hospitals lead to congestion in these hospitals. To address this situation, down referral of primary and secondary cases from higher- to lower-tier facilities is being encouraged to help decongest tertiary hospitals. Referrals that need to be improved were as well recorded, these are the Unqualified referrals (UQ) (i.e., those sent to the wrong facility) represented nine (9) percent of the total referrals and Unclassified referrals (UC) 29% were cases not initially included in the classification of FP/MNCHN referrals.

Classification of outgoing REFERRALS								
	Requiring a subspecialist		requiring a specialist		requiring a trained generalist		Unclassified referrals	Unqualified referrals
	Emergency (life-threatening)	Urgent (non-life threatening)	Emergency (life-threatening)	Urgent (non-life threatening)	Emergency (life-threatening)	Urgent (non-life threatening)		
Total	2,481	459	631	1,943	705	2,702	4,286	1364
Percent	17	3	4	13	5	19	29	9

Figure 2.

The categorization of referrals guided the HSPs to make appropriate referrals according to the condition and service delivery capacity of the receiving facility. Whenever primary cases are referred in the tertiary facility downward referral is being practiced. For example, as noted in Batangas Medical Center,, the uncomplicated non-spontaneous deliveries were referred to nearby SDN member birthing facilities and the practice of categorization was claimed to have contributed to decongesting the tertiary facility which would help them maximize the hospitals' mandate.

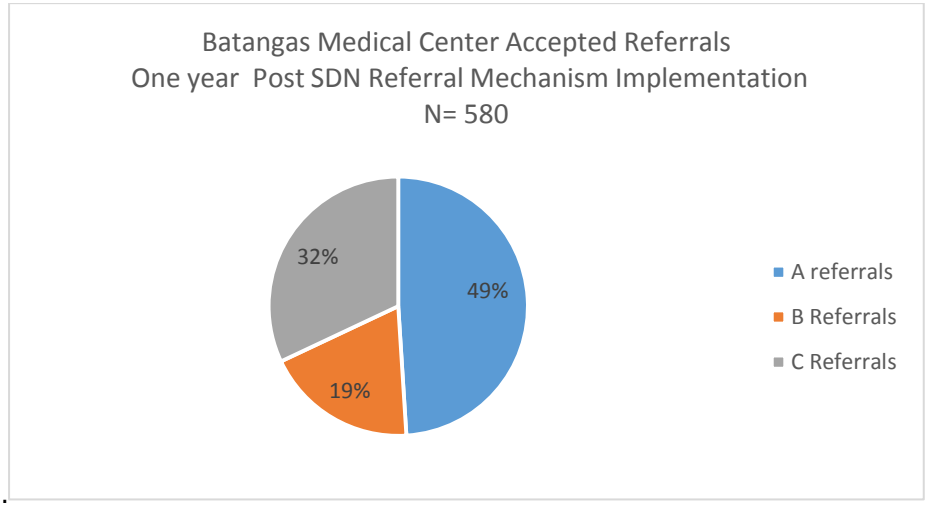
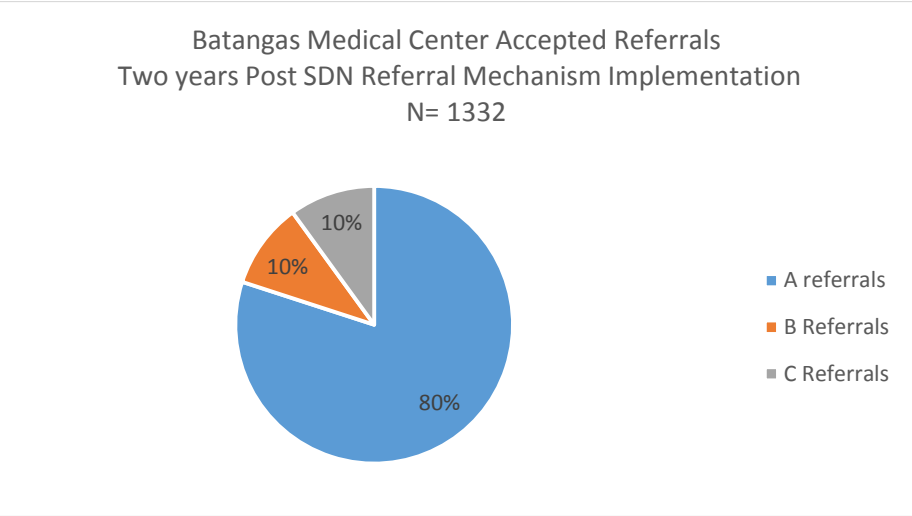


Figure 3:



Regarding Family Planning, 781 outgoing referrals were documented. Among the outgoing referrals, 32 percent were for bilateral tubal ligation by minilaparotomy under local anesthesia, 21percent for PSI insertion, 10 percent for postpartum intrauterine device insertion, 8 percent for Interval IUD insertion, and 29 percent for commodity-based methods. These data highlight the role of hospitals in the provision of long-acting reversible and permanent methods of contraception.

Referrals involving adolescents. There were 2346 outgoing referrals involving adolescents, mostly for maternity-related services. Of these, 45 percent belonged to the 10-14 age range. Ninety percent (2,122) of these were accounted for in the incoming logbooks of receiving facilities.

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