HEALTH DEPARTMENT
GOVERNMENT OF KHYBER PAKHTUNKHWA

REFERRAL GUIDELINES AND STRATEGY FOR EMERGENCY OBSTETRIC AND NEWBORN CARE (EmONC)

Developed by Health Department
Govt. of Khyber Pakhtunkhwa

ABBREVIATIONS & ACRONYMS

BEmONC	Basic Emergency Obstetric & Newborn care
BHU	Basic Health Unit
CDs	Civil Dispensaries
CEmONC	Comprehensive Emergency Obstetric & Newborn care
CMWs	Community Mid Wives
DHQ	District Headquarter Hospital
DHO	District Health officer
DRC	District Referral Coordinator
DLIs	Disbursement Linked Indicators
DLRs	Disbursement Linked Results
EmONC	Emergency Obstetric & Newborn Care
EPHS	Essential Package for Health Services
HIE	Hypoxic Ischemic Encephalopathy
KMC	Kangaroo mother Care
LCG	Labor Care Guide
LHWs	Lady Health Workers
M&E	Monitoring and Evaluation
MNCH	Maternal, Newborn and Child Health
MVA	Manual Vacuum Aspiration
NHSP	National Health Support Program
PFM	Public Financial Management
PHC	Primary Health Care
PPH	Post-Partum Hemorrhage
PPROM	Preterm Premature Rupture of Membrane
PROM	Premature Rupture of Membrane
RMNCH	Reproductive, Maternal, Newborn, and Child Health
THQ	Tehsil Headquarter Hospital
UHC	Universal Health coverage
WHO	World Health Organization

CONTENTS

1. INTRODUCTION (NHSP with related DLIs, DLI3; Referral Guidelines)

The National Health Support Program Khyber Pakhtunkhwa (NHSP-KP) is a World Bank-funded initiative aimed at strengthening Primary Health Care (PHC) and promoting Universal Health Coverage (UHC). It operates in coordination with MNHSR&C and provincial governments to enhance health systems and improve health and nutrition outcomes.

A. KEY FOCUS AREAS

The NHSP-KP is structured to achieve sustainable improvements in PHC services through:

1. **Strengthening Primary Health Care (PHC):** Ensuring the effective delivery of essential services aligned with basic primary health care services directed towards Essential Package of Health Services (EPHS) and UHC goals.
2. **Strengthening Health system:** Strengthening Health system through utilizing information systems and provision of supplies.
3. **Public Financial Management (PFM):** Enhancing financial sustainability and accountability in healthcare by addressing inadequate PHC funding.

B. DISBURSEMENT LINKED INDICATORS (DLIs)

The program operates through 9 Disbursement Linked Indicators (DLIs), each with specific yearly targets, known as Disbursement Linked Results (DLRs). One of the key indicators, DLI-3, focuses on optimizing referral systems to ensure timely and appropriate referral from Primary Health Care (PHC) facilities to higher-level healthcare centers, particularly in lagging areas.

C. YEARLY MILESTONES FOR DLI-3 (Referral Guidelines)[1]:

YEAR 1: CEmONC referral and monitoring system and guidelines developed.

YEAR 3: 30% of women and newborn with (or at risk of) complications during pre-term period successfully referred by CMWs, BHUs, RHCs to CEmONC, of which at least 20% are from lagging area.

[1] The World Bank, International Development Association PAD. DLI 3 Referral guidelines on timely & appropriate referral between PHC level & higher levels of care, including in lagging areas. 2022 May 16;38.

2. MATERNAL & NEONATAL WELL BEING: A PRIORITY

Maternal and neonatal mortality are critical public health concerns. The WHO launched the Safe Motherhood Initiative in 1987, introducing strategies such as improved family planning, quality antenatal care, skilled birth attendants, and emergency obstetric care (EmONC). In 2005, the "Make Every Mother and Every Child Count" report emphasized a continuum of care, leading to the formation of the MNCH Partnership.

A. CHALLENGES IN KHYBER PAKHTUNKHWA PAKISTAN'S MATERNAL & NEONATAL HEALTH SYSTEM

Pakistan's especially Khyber Pakhtunkhwa health indicators remain concerning despite various services. Facility-based childbirth is key to improving intrapartum care, especially in low-resource settings. A study titled "A Prospective Study of Maternal, Fetal, and Neonatal Deaths in Low- and Middle-Income Countries" found that most maternal, fetal, and neonatal deaths occur around delivery due to preventable causes. Maternal death also raises the risk of perinatal and neonatal mortality, highlighting the need for better obstetric and neonatal care at birth[2].

B. NHSP COMMITMENT TO ENHANCING EmONC

The NHSP Khyber Pakhtunkhwa prioritizes a well-coordinated referral system to strengthen the EmONC network, particularly in underserved districts. Based on WHO recommendations and national guidelines, these protocols will be regularly updated through M&E outcomes and the National EmONC Framework, ensuring a responsive and evidence-based approach to maternal and neonatal health.

3. THE IMPORTANCE OF AN EFFECTIVE REFERRAL SYSTEM

A well-structured referral system is crucial for ensuring timely and specialized care by transferring patients from lower-level facilities to higher-tier institutions with the necessary expertise and resources. It functions within a coordinated framework, enabling seamless communication and continuity of care across healthcare levels.

[2] A prospective study of maternal, fetal and neonatal deaths in low- and middle-income countries. Bull World Health Organ. 2014 Aug 1;92(8):605-12.

A. ROLE OF THE REFERRAL SYSTEM IN MATERNAL & NEONATAL CARE

In maternal and neonatal health, an effective referral system facilitates access to Emergency Obstetric & Newborn Care (EmONC) and other critical services. Primary healthcare facilities often lack sufficient staff, medical supplies, and specialized care, making referrals essential for managing high-risk cases. Particularly in obstetric and neonatal emergencies, swift and well-coordinated interventions are vital to preventing complications and saving lives.

B. ENSURING TIMELY AND APPROPRIATE REFERRALS

Timely and well-managed referrals are essential in reducing maternal and neonatal mortality. A strong referral system in Primary Health Care (PHC) enables early risk detection, ensures swift transfers to advanced facilities, and prevents critical complications during pregnancy, childbirth, and postpartum. Additionally, it optimizes healthcare resources and reduces the burden on lower-tier facilities, playing a key role in safeguarding maternal and newborn health. In maternal and neonatal healthcare, referrals are classified based on several factors **(Table 1)**.

Table 3.1 REFERRAL TYPES[3]

S.No	BASIS	TYPE	DESCRIPTION
1	Timing	Antenatal	Referrals made during pregnancy for conditions like high-risk pregnancies.
		Intrapartum	Referrals made during labor or delivery for complications like fetal distress.
		Postnatal	Referrals after delivery for postpartum issues like postpartum hemorrhage, sepsis etc. or newborn care.
2	Pathway	Institutional	Initiated by healthcare providers within the system, often with formal documentation.
3	Urgency	Elective	Planned referrals for non-urgent cases like routine consultations or procedures.
		Emergency	Immediate referrals for life-threatening conditions requiring urgent care.

[3] World Health Organization. Standards for Improving Quality of Maternal and Newborn Care in Health Facilities. 2016.

4. STRATEGIC APPROACH TO REFERRAL CARE

The Government of Khyber Pakhtunkhwa is implementing a comprehensive and patient-centered referral system to address both emergency and non-emergency cases efficiently. This initiative focuses on bridging critical gaps in healthcare affecting the management of both maternal and neonatal emergencies.

A. ENHANCING EMERGENCY RESPONSE

A well-coordinated and structured referral mechanism is being established to ensure timely transfers of critical cases from under-resourced facilities to higher-level healthcare centers. This approach aims to significantly reduce maternal and neonatal mortality by facilitating urgent interventions[4].

B. FREE EMERGENCY REFERRAL SERVICES

The government has introduced free emergency referral services, ensuring seamless patient transportation between different levels of care via public sector ambulances. This initiative improves healthcare accessibility, financial sustainability, and equity, particularly benefiting vulnerable and underserved communities.

[4] World Health Organization. WHO recommendations on health promotion interventions for maternal and newborn health 2015. World Health Organization; 2015.

5. LEVELS OF HEALTHCARE REFERRAL SYSTEM

Community Based Healthcare Delivery System

- Lady Health Workers (LHWs) and Community Midwives (CMWs) provide early intervention, health education, and referral guidance at the community level.
- They ensure essential maternal and child healthcare services.
- Following the UN Newborn Action Plan, CMWs identify danger signs during pregnancy.
- They refer cases to Primary Level Health Care for further care.

Primary Healthcare Centre Level Health System

- Civil Dispensaries, BHUs, and RHCs form the primary healthcare network.
- They offer preventive care, antenatal/postnatal services, child healthcare, first aid, and treatment for common illnesses.
- BHUs and RHCs operate 24/7, providing Basic Emergency Obstetric & Newborn Care (BEmONC).
- These facilities serve as first-level referral points, directing complex cases to Category A, B, C, & D Hospitals as needed.

Category A, B, C & D Secondary Care Hospitals

- Category A, B, C and D (previously named as Tehsil Headquarters Hospitals and District Headquarters Hospitals) provide specialized care, diagnostics, and surgical services for moderate to severe conditions (Categorization attached as Annex A).
- A key function of these hospitals is Comprehensive Emergency Obstetric & Newborn Care (CEmONC).
- CEmONC ensures high-risk maternal and neonatal cases receive timely intervention.

Tertiary/Specialized Hospitals

- Teaching Hospitals and Specialized Centers (Particularly Women & Children Hospitals) act as advanced referral hubs.
- They offer highly specialized care, expert consultations, & cutting-edge diagnostics.
- These facilities manage complex conditions, perform advanced surgeries, & contribute to medical education and research.

6. REFERRAL PATHWAYS[5]

Community to PHC

- Patients with danger signs are referred to nearby PHC facilities for appropriate management.
- Community referrals also include consultations for:
  - Routine checkups, such as:
    - Antenatal care, Postnatal care, Newborn care
  - Family planning
  - Basic laboratory tests
  - Routine ultrasonography

PHC to Category A, B, C & D Hospitals

- Patients with complications/complex health issues identified through the Labor Care Guide (LCG) at the primary healthcare level are referred to Category A, B, C or D.
- **Purpose of referral:**
  - Further evaluation
  - Advanced treatment

Category A, B, C & D to Tertiary/Specialized Hospitals

- Cases requiring specialized care or advanced medical interventions are referred from Category A, B, C & D to tertiary and specialized hospitals (particularly Women & Children Hospital) for specialized care treatment.
- Conditions requiring referral include:
  - Hysterectomy
  - Eclampsia
  - Ruptured uterus
  - Maternal sepsis
  - Congenital anomalies
  - Abruptio Placenta
  - Ruptured Bladder
  - Vesicovaginal Fistula
  - Respiratory Distress Syndrome (RDS)
  - Meningitis
  - Obstructed Labor, Fetal Distress, APH, PPH And other Hish Risk Cases

[5] World Health Organization. Networks of care for maternal and newborn health: implementation guidance. World Health Organization; 2024 Sep 24.

7. OBSTETRIC AND NEWBORN REFERRAL SYSTEM

A. PREVENTIVE OBSTETRICS & NEWBORN CARE

Preventive obstetrics and newborn care delivered at the community level by LHWs & CMWs, focusing on the distribution of Iron, Folic Acid, calcium and Vitamin D Supplements, and safe usage of misoprostol for advanced antenatal care (CMWs), and identifying danger signs during antepartum, postpartum, and newborn stages.

B. BASIC OBSTETRIC & NEWBORN CARE

Provided at primary health centers, including routine antenatal care, normal deliveries, postnatal care, and immunization at CDs, and BHUs.

C. BASIC EMERGENCY OBSTETRIC & NEWBORN CARE (BEmONC)

Offered 24/7 at BHU and RHCs, covering all seven signal functions of BEmONC, including:

1. Use of Uterotonics,
2. Use of Parenteral anticonvulsants (Magnesium Sulphate),
3. Use of parenteral Antibiotics,
4. Manual removal of Placenta,
5. Manual vacuum aspiration (MVA) of retained products of conception,
6. Assisted vaginal delivery,
7. Newborn resuscitation of asphyxiated babies through helping babies breathe (HBB).

D. COMPREHENSIVE EMERGENCY OBSTETRIC & NEONATAL CARE (CEmONC)

District Headquarters and Tehsil Headquarters hospitals provide 24/7 CEmONC services, including caesarean sections and blood transfusions, alongside BEmONC's seven signal functions.

8. SPECIALIZED OBSTETRIC CARE

Tertiary hospitals offer specialized care for high-risk pregnancies, cardiac complications, and neonatal intensive care with CPAP and ventilators for newborns.

9. REFERRAL SYSTEM

Effective communication and coordination across different levels of the healthcare system are essential for ensuring seamless referrals, timely interventions, and optimal patient outcomes. This collaboration involves sharing patient information, ensuring that necessary resources are available during referrals such as the Labor Care Guide (LCG) for laboring women, and completed referral forms and fostering teamwork among healthcare providers at various levels.

In an optimal system, primary healthcare activities at the community level are reinforced through successive levels of referrals. Our referral services operate at two levels:

- **Horizontal Referral**: This occurs within the same level of care, such as from one PHC (e.g., CD, MCHC, BHU etc.) to another BHU for services like laboratory tests, ultrasound, or 24/7 labor room service.
- **Vertical Referral**: This involves transferring patients from primary healthcare to nearby secondary or tertiary or specialized Hospitals, shifting from lower to higher-level services.

10. SELECTION OF PATIENTS

The process of selecting patients for referrals in obstetric and newborn care is vital for effective healthcare management. It requires careful evaluation of conditions that demand immediate intervention to prevent further complications. However, the decision to refer must be deliberate and well-considered, aimed at reducing the condition's severity before initiating referral. While complications are unpredictable, timely intervention can manage most cases, with an efficient referral system playing a key role.

Before proceeding with a referral, healthcare providers must first attempt to stabilize the patient's condition through appropriate interventions. This proactive approach not only ensures effective patient care but also ensures referrals are made only when truly necessary. One notable situation requiring careful consideration is high-risk pregnancies, where various contributing factors should be thoroughly assessed before referral (Detailed overview of maternal and newborn complications are provided in Table 11.1, including their signs and symptoms, along with the initial emergency treatment administered at the health center prior to referral).

11. OBSTETRIC AND NEWBORN COMPLICATIONS

A detailed table is provided below to guide healthcare providers in identifying obstetric and newborn complications that necessitate immediate referral to higher-level healthcare facilities:

Table 11.1 Obstetric and Newborn complications

OBSTETRIC COMPLICATIONS		
Complication	**Definition**	**Referral Protocol**
ECTOPIC PREGNANCY (RUPTURED & UNRUPTURED)	A pregnancy in which implantation occurs outside the uterine cavity. **MOST COMMON SITE:** Fallopian tube **(> 90%).** **EARLY SYMPTOMS:** • Irregular spotting/bleeding • 6-8 weeks amenorrhea • Softening of cervix • Cervical motion tenderness • Lower abdominal pain • Slight uterine enlargement • Increased urinary frequency **SEVERE SYMPTOMS:** • Acute abdominal/pelvic pain • Collapse, weakness, shock • Tachycardia (Fast, weak pulse 110/min) • Hypotension, hypovolemia • Abdominal distension, rebound tenderness	• **IMMEDIATE MANAGEMENT (if in shock):** • Stabilize first • Pass IV Line • Start IV Fluids • Catheterize • **Refer:** • Secondary/Tertiary Care level with Treatment slip for Laparotomy, Salpingectomy, or Salpingostomy based on tubal damage and blood transfusion if required.
ANTEPARTUM HEMORRHAGE (APH)	• Bleeding after 24 weeks of pregnancy but before birth. **CAUSES:** • Placental Abruption • Placenta Previa • Rupture of Uterus. • Obstructed/Prolonged Labor Requires vigilant monitoring and timely intervention to prevent complications.	**Urgently mobilize personnel & resources.** **Rapid evaluation:** Vital signs, consciousness, anxiety, blood loss, pain, skin color/temp. **If shock suspected:** Pass IV line Start treatment & monitor. **Refer:** Secondary/Tertiary Care level with Treatment slip
CHORIOAMNIONITIS	• Infection of amnion, chorion & amniotic fluid due to ascending bacteria.	• Pass IV line & administer antipyretics and antibiotics (oral or IV) to reduce neonatal infection risk.

	• Requires prompt treatment to prevent maternal & fetal complications.	**Refer:** Secondary/Tertiary Care level with Treatment slip
PREECLAMPSIA, SEVERE PRE-ECLAMPSIA & ECLAMPSIA	Hypertensive Disorders (BP > 140/90)in Pregnancy • **Preeclampsia:** SBP 140-160 mmHg, DBP 90-110 mmHg, Proteinuria 2+ • **Severe Preeclampsia:** SBP ≥160 mmHg, DBP ≥110 mmHg, Proteinuria 2+, Headache, stomach pain and blurred vision. • **Eclampsia:** Convulsions with SBP ≥140, DBP ≥90 mmHg, or Trismus in absence of other disease	• **Stabilize:** • Clear airway • Pass IV line • Catheterize, • Keep warm • **ADMINISTER** Antihypertensive, $MgSO_4$ (4g IV + 10g IM) 5g IM each buttock. **Refer:** Secondary/Tertiary Care level with Treatment slip
SEVERE ANEMIA	**Definition:** • Low Hb (>11 g/dl), often due to iron deficiency. **Severe Anemia:** • Hb <7 g/dL, require special care. **Complications:** • Respiratory distress, cardiac failure, fetal growth issues, increased maternal & fetal risks.	• **Check:** Vital signs, fetal condition, signs of cardiac failure. • **Manage:** Pass IV line, Stabilize and treat shock if present. • **Refer:** To a secondary facility for blood transfusion.
CHRONIC CO-MORBID INFECTIONS LIKE HEPATITIS OR LIVER CIRRHOSIS	**Pregnancy with Chronic Co-morbid Infections** • Conditions like **Hepatitis & Liver Cirrhosis** require specialized care. • **Increased risks:** Exacerbated anemia & pregnancy complications. • **Management:** Multidisciplinary approach to treat anemia/infections	• **Essential:** Close monitoring, timely interventions, specialist coordination. • **Action:** Pass IV line Stabilize the patient **Refer:** Secondary/Tertiary Care level with Treatment slip
BLOOD AND BLEEDING DISORDERS	• Conditions like **Thalassemia, DIC, HELLP & bleeding disorders** need specialized care.	**Urgent Care for Blood Disorders in Pregnancy**

	• **Risks:** Impact on maternal & fetal health. • **Key Measures:** Regular Hb monitoring, hematologist coordination, proactive management.	• **Essential:** Close monitoring, timely intervention, specialist coordination. • **Refer:** Secondary/Tertiary Care level with Treatment slip for specialized care.
POSTPARTUM HEMORRHAGE (PPH)	**Primary PPH:** Blood loss >500 mL within 24 hours (Severe: ≥1000 mL). **Secondary PPH:** Same blood loss after 24 hours. **Causes: Uterine atony, trauma, thrombin, retained tissue.** **Risk:** Slow bleeding may lead to sudden shock. **Management (PPH Bundle - MOTIVE):** ○ **M:** Uterine Massage ○ **O:** Oxytocic Drugs ○ **T:** Tranexamic Acid ○ **I:** IV Fluids ○ **V:** Examination (Find Cause & Escalate)	**PPH Management & Referral** • **Monitor:** Uterine tone, bleeding, vitals, hemodynamic changes. • **Key Intervention:** Immediate **uterotonic** within 1 min of birth (IM injection or oral misoprostol). • **Manage:** Shock & PPH per protocol. • **Control Bleeding:** Balloon tamponade if available. • **Refer:** Secondary/Tertiary Level facility with proper documentation.
PLANNED CESAREAN SECTION	• **Requires:** Careful coordination & preparation. • **Indication:** Medically necessary surgical delivery by antenatal plan, **Absolute Indication:** Previous 2 C/Sections, Contracted Pelvis, Malpresentation, Previa Type IV	• **Provide:** Psychological support, birth preparedness, complication readiness. • **Refer:** Secondary level health facility for delivery.

MACROSOMIA FETUS	**Fetus Larger Than Expected**
	• **Fetal weight >4kg at 36 weeks** or >95th percentile after 36 weeks (e.g., 3.7kg at 37 weeks, 3.9kg at 38 weeks).
	• **Risks for mother/baby:**
	  • $3^{rd}/4^{th}$ degree perineal tears
	  • Shoulder dystocia
	  • Perinatal death, HIE
	  • Brachial plexus injury
	  • Increased likelihood of C/S
		Management of Macrosomia
		• **Check:** Fasting blood sugar, OGTT for gestational diabetes, manage if needed.
		• **Provide:** Counseling, psychological support, birth preparedness, complication readiness.
		• **Refer:** To Secondary/Tertiary level health facility.

UNCONTROLLED HYPERTENSION AND DIABETES DURING PREGNANCY	**Uncontrolled Hypertension & Diabetes in Pregnancy** **Risks:** • Preeclampsia, • Preterm birth, • Macrosomia.	• **Hypertension:** Give antihypertensive, stabilize. • **Diabetes:** Check blood glucose. • **Refer:** Secondary/Tertiary Care level with Treatment slip
SHOCK	**Definition:** • Inadequate perfusion of vital organs, life-threatening. **Cause:** Complications like APH, Rupture Uterus, PPH, sepsis, ectopic pregnancy.	• Mobilize personnel/resources • Establish double IV line • Administer fluids • Insert urine catheter • Provide oxygen **Refer:** Secondary/Tertiary Care level with Treatment slip
PRETERM BIRTH / LABOR	• **Definition:** Birth before 37 weeks of gestation. • **Impact:** Major determinant of adverse infant outcomes (survival & quality of life). • **Maternal Interventions:** Aim to improve preterm infant outcomes when birth is inevitable.	**Antenatal Corticosteroids:** For fetal lung maturation (24-34 weeks). **MgSO4:** To prevent neurologic complications (up to 32 weeks). **Antibiotics:** For women with PPROM/infection signs. **Refer:** To a secondary/Tertiary level health facility.
POSTPARTUM PSYCHOSIS	• **Timing:** Occurs around childbirth, within first two weeks postpartum. • **Prevalence:** Affects less than 1%. • **Severe Symptoms:** Delusions, hallucinations, sleep disturbances Obsessive thoughts about the baby Severe depression, anxiety, despair Suicidal or infanticidal impulses	• **Newborn Care:** Ensure supplemental care for the safety of the infant. • **Action:** Woman with active psychosis should not care for the infant. • **Refer:** Seek immediate psychiatric and medical care, refer to a secondary/Tertiary level health facility for hospitalization.
NEWBORN COMPLICATIONS		
CYANOSIS OR BREATHING DIFFICULTY	• **Symptoms:** ○ Cyanosis or difficulty breathing ○ Breathing rate <30 or >60/min ○ Severe chest wall in-drawing ○ Grunting ○ Low APGAR Score usually	• **Immediate Care:** Clear airway, administer oxygen. • **Note:** Keep the baby warm during transportation. • **Refer:** Transfer baby to secondary level health facility for sick newborn care.

NEONATAL SEPSIS	Systemic infection in newborns, usually within the first 28 days of life. **Symptoms:** Lethargy, poor feeding, fever/ hypothermia, breathing difficulty, abnormal heart rate, vomiting, seizures etc.	**Usually Low APGAR Score** **Supportive care**: warmth, oxygen, Pass IV line, IV fluids, and early antibiotics. **Refer:** To a secondary/Tertiary level health facility for specialized management.
LOW BIRTH / VERY LOW BIRTH WEIGHT OR PRETERM BABY	• **Low Birth Weight:** <2.5 kg at birth • **Very Low Birth Weight:** ≤1.5 kg at birth • **Preterm:** Born before 37 weeks • **Health Risks:** Difficulty breathing, feeding issues, severe jaundice, infections. Low APGAR score due to immature lung & weak muscle.	• **Transfer:** Keep the baby warm, provide breastfeeding. • **Transfer:** Baby can be transferred in skin-to-skin contact with the mother. • **Refer:** To secondary/Tertiary Level, having Kangaroo Mother Care (KMC).
LETHARGY	• **Symptoms:** o Low muscular tone o Drowsiness o Lack of spontaneous movement or response to stimulation • **APGAR Score:** Low APGAR score indicates Birth Asphyxia	• **Airway:** Maintain baby's airway, Administer oxygen • **Ventilation:** Use bag and mask if cyanosed/distress/hypoxaemic. • **Other Care:** IV antibiotics /check RBS/keep warm. •. **Refer:** To a secondary/Tertiary level health facility.
NEWBORN HYPOTHERMIA	• **Normal Body Temperature:** Below 37°C. • **Severe Hypothermia:** Axillary temperature below 32°C. • **APGAR Score:** Usually low in hypothermia	• Warm the baby with dressing, ensure skin to skin contact. • Administer first dose of antibiotics as per protocol. • **Refer:** To a secondary/Tertiary level health facility for management.
CONVULSIONS	**Causes:** • Asphyxia, Birth injury, Hypoglycemia, Hypocalcemia **Signs of Neurological Issues:** • Hypoxic-ischemic encephalopathy • Intracranial hemorrhage	• **Warm the Baby:** • **Check APGAR Score** • **Anti-convulsions:** Administer first dose as per protocol. • **Refer:** To a secondary/Tertiary level health facility for management.

References[6],[7]:

[6] Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC).
[7] Integrated Management of Pregnancy and Childbirth (IMPAC).

12. REFERRAL PROTOCOLS

A. REFERRAL DIRECTORY

Ensuring a smooth referral process begins with disseminating crucial information to all health facilities in the district. The Department of Health aims to achieve this by developing displaying, regularly updating, and widely sharing a directory of designated referral health facilities, blood banks, and Regional Blood Centers (RBCs) along with lists and contact details of transport available at that facility. In districts where Government transport system is not available, alternate mechanisms will be made by district authority. The related information will be made available at all health facilities. This proactive approach enhances awareness among healthcare providers and facilitates informed decision-making in the event of a necessary referral.

B. REFERRAL COMMUNICATION & COORDINATION

Efficient coordination at the district level is crucial for the success of the referral strategy. Districts must have information regarding mapping (coordinator/focal person) mapping of health facilities (CDs, BHUs, RHCs, DHQs)

a) Nomination and Role of District Referral Coordinators (DRCs)

DHO in each district will nominate District Referral Coordinator (DRC) at the district level and Referral Focal Person (RFP) at health facility levels having sound knowledge of BEmONC and CEmONC facility. This includes maintaining a supply of patient records including the referral letter/slip and indications for referrals, keeping an up-to-date referral directory & registers including review of a volume of activity, source, and appropriateness of referrals and adverse events, mapping available transportation vehicles for referral purposes and other partners and fostering coordination with referral health facilities. These efforts at the district level form the foundation for a well-organized referral system.

b) Timely Communication and Preparedness

The Department of Health emphasizes establishing regular communication channels with referral health facilities to confirm the ongoing availability of emergency services. A monthly duty roster, signed by the in-charge of the referral facility, serves as a guide for shift-wise

preparedness, ensuring facilities are well-informed and equipped for emergencies.

C. RECORD KEEPING, MONITORING & EVALUATION

Maintaining accurate records is vital for tracking and evaluating referral effectiveness. The Department of Health mandates thorough documentation using designated referral slips, and patient information forms (Annex B, C, and D). This ensures transparency and accountability.

c) Collaboration and Coordination

Effective coordination between the District Referral Coordinator (DRC) and Referral Health Facility staff is essential. Key aspects include:

- Regular meetings to discuss referral cases.
- District progress review forums for performance evaluation.
- Formal invitations from DHOs to engage referral facility staff.
- Feedback sharing to improve the referral process.
- Issue resolution through structured discussions.

DHOs will initiate collaboration via formal communications.

d) Data-Driven System Improvement

To enhance the referral system, DRCs, along with RMNCH and MNCH coordinators, analyze referral data and lead monthly or quarterly review meetings. Data insights guide improvements, ensuring an efficient and responsive referral system. The DHO and DRCs will conduct meetings, ensuring a mechanism for referral audit and quality control measures to assess case management and response time.

D. ROLES AND RESPONSIBILITIES IN THE REFERRAL PROCESS

A snapshot of the roles of responsibilities of the referring point, transport/ambulance, and referral point is annexed in annexure E.

E. REFERRAL FEEDBACK MECHANISM

Feedback mechanism is a very critical step of the referral mechanism to close the loop of care provided to women & newborns at different levels of health facilities. Feedback mechanism involves feedback forms, feedback registers filling & feedback coordination mechanism by

holding regular (Monthly, Quarterly, or Biannually) based on the quality of referrals to troubleshoot any related issue. (feedback register for the number of referrals, should be reflected in DHIS 2). The District Referral Coordinator should examine the feedback register on regular intervals. The Health Department of Khyber Pakhtunkhwa is progressing towards digitalization. Once the Command-and-Control Center is established and relevant indicators are integrated into DHIS-2, the referral system will also be fully digitalized. Until then, manual referral slips will remain in practice.

A feedback loop driven by data analysis and continuous improvement is a key component of the referral strategy. The DGHS Khyber Pakhtunkhwa oversees regular analysis of referral data, offering feedback and guidance to the field. The RMNCH wing at DGHSS closely coordinates EmONC-related referrals. This ongoing process helps identify gaps and implement targeted improvements, ensuring the system's effectiveness.

13. ANNEXURE A

Table 1: Summary of the Criterion for Categorisation of Secondary Care Hospitals

		CATEGORY A	CATEGORY B	CATEGORY C	CATEGORY D
INPATIENT BEDS	SURGERY	40 beds	30 beds	20 beds	8 beds
	MEDICINE	40 beds	30 beds	20 beds	8 beds
	GYNAE/OBS	40 beds	20 beds	15 beds	10 beds
	PAEDIATRICS	40 beds	20 beds	10 beds	10 beds
	EYE	30 beds	20 beds	10 beds	0
	ENT	30 beds	20 beds	10 beds	0
	ORTHOPAEDICS	20 beds	10 beds	10 beds	0
	CARDIOLOGY	15 beds	10 beds	0	0
	PSYCHIATRY	15 beds	10 beds	0	0
	CHEST/TB	10 beds	10 beds	0	0
	DIALYSIS UNIT	6 U	4 U	0	0
	DENTISTRY UNIT	6 U	4 U	2 U	1 U
	PAEDS SURGERY	10 beds	0	0	0
	NEUROSURGERY	10 beds	0	0	0
	DERMATOLOGY	10 beds	0	0	0
	ACCIDENT AND EMERGENCY (Casualty)	10 beds	10 beds	5 beds	4 beds
	LABOR ROOM	10 beds	5 beds	5 beds	2
	ICU/CCU	10 beds	10 beds	5 beds	0
	NURSERY PEADS/ICU	10 beds	5 beds	0	0
	TOTAL BEDS	350 Beds + 6 Dialysis Units + 6 Dentistry Units	210 Beds + 6 Dialysis Units + 6 Dentistry Units	110 Beds + 2 Dentistry Units	42 Beds + 1 Dentistry Unit

14. ANNEXURE B

REFERRAL SLIP

LADY HEALTH WORKER (COMMUNITY OUTREACH) PROGRAM

Referral ID _____ Date: _____

Patient name: _____ Gender: ☐ Male ☐ Female

Date of Birth/Age: _____ Patient/Attendant CNIC: _____

Address: _____Village/town: _____ District: _____

Primary complaint: _____

_____

Previous History (Medical/Surgical/Drug Allergy: _____

_____

B.P: _____ Pulse: _____ Respiratory Rate: _____ Temperature: _____

Any treatment given: ☐ Yes ☐ No ☐ Not applicable

What treatment was given _____

_____

_____

Referred Facility: _____ Referred Facility ID: _____

Health Worker Name _____

Health Worker Designation _____

Signature: _____

15. ANNEXURE C

PATIENT REFERRAL FORM

PRIMARY LEVEL HEALTH CARE

Date _____ Referring Facility Name_____

Time _____ Name of staff_____

Patient ID_____ Designation of staff_____

Name _____ Contact No (mobile) _____

Family/CNIC _____ Facility Telephone number _____

DOB/Age _____ Clinical Diagnosis _____

Gender: ☐Male. ☐Female Treatment provide ☐ Yes ☐ No

Phone number _____ Nationality: ☐ Pakistan ☐ Other _____

Reason for Referral _____

Any special Care required during Transport _____

Transport provided? ☐ Yes ☐ No (if no, why? _____)

Signature: _____ Date: _____

To be filled by the receiving facility staff

Health Facility Staff Name: _____

Health Facility Staff ID: _____

Health Facility Staff Designation: _____

Patient shifted to unit: _____

Date: _____ Time:_____ Signature & Stamp: _____

16. ANNEXURE D

PATIENT INFORMATION FORM

Presenting Complaint:

_____

_____

Vital Signs (Optional):

Temperature:	BP:
Pulse	Respiratory Rate:
Other important Signs depending upon case:	

Reason for Referral:

_____

_____

_____

_____

_____

Physical Examination:

_____

_____

_____

_____

_____

Patient History & Current Medications (Optional):

_____

_____

_____

_____

_____

Treatment Provided:

_____

_____

_____

_____

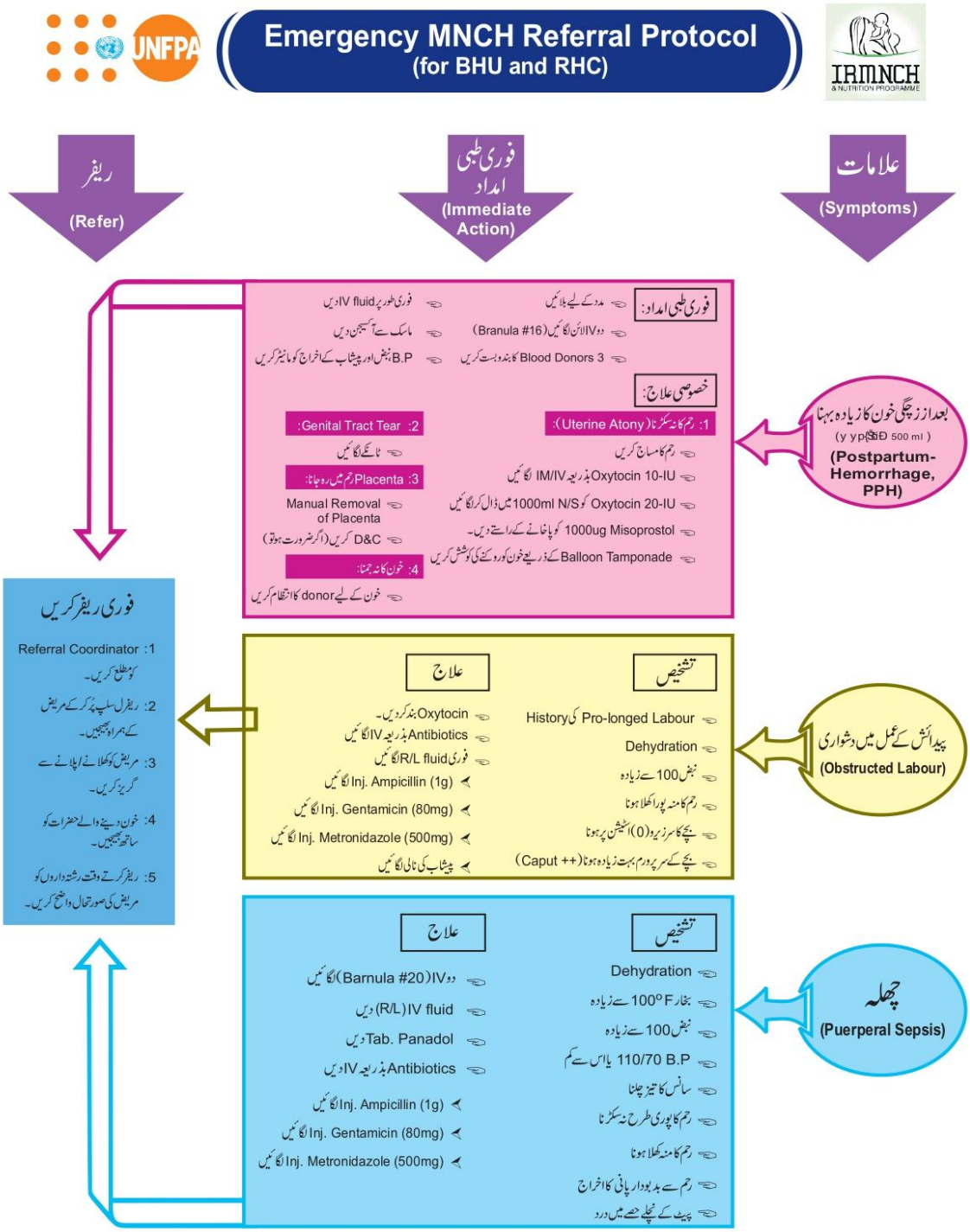
_____

17. ANNEXURE E

ROLES AND RESPONSIBILITIES IN THE REFERRAL PROCESS

STAGE	ROLE	RESPONSIBILITY
REFERRING FACILITY	Skilled birth attendant	• Promptly and precisely recognize complex cases requiring advanced care. • Apply appropriate stabilization protocols to ensure patient safety before transfer. • Accurately document all necessary details on the patient's referral slip. • Coordinate and facilitate a suitable transfer mechanism for seamless patient transportation.
PATIENT TRANSFER VIA AMBULANCE	Caller (Health Facility Official)	• Record essential data for the patient • Prepare the optimal referral health facility for the incoming patient through coordination with the Referral Coordinator/ Duty Administrator/ Medical Superintendent/Hospital referral Point.
	Rescue 1122 and/or Relevant Ambulance Official	• Stabilize the complicated case while transferring • Timely transfer of the patient to the most optimal facility
REFERRAL HEALTH FACILITY	Medical Superintendent/ Duty Administrator/ Hospital Referral Point	• Respond promptly to ambulance call center requests. • Ensure timely treatment for incoming patients. • Monitor and track referred cases. • Provide feedback to the referring facility. • Document maternal cases in the referral register.
	Specialized staff (i.e. gynecologist, etc.)	Provide required treatment to the referred case

18. ANNEXURE F



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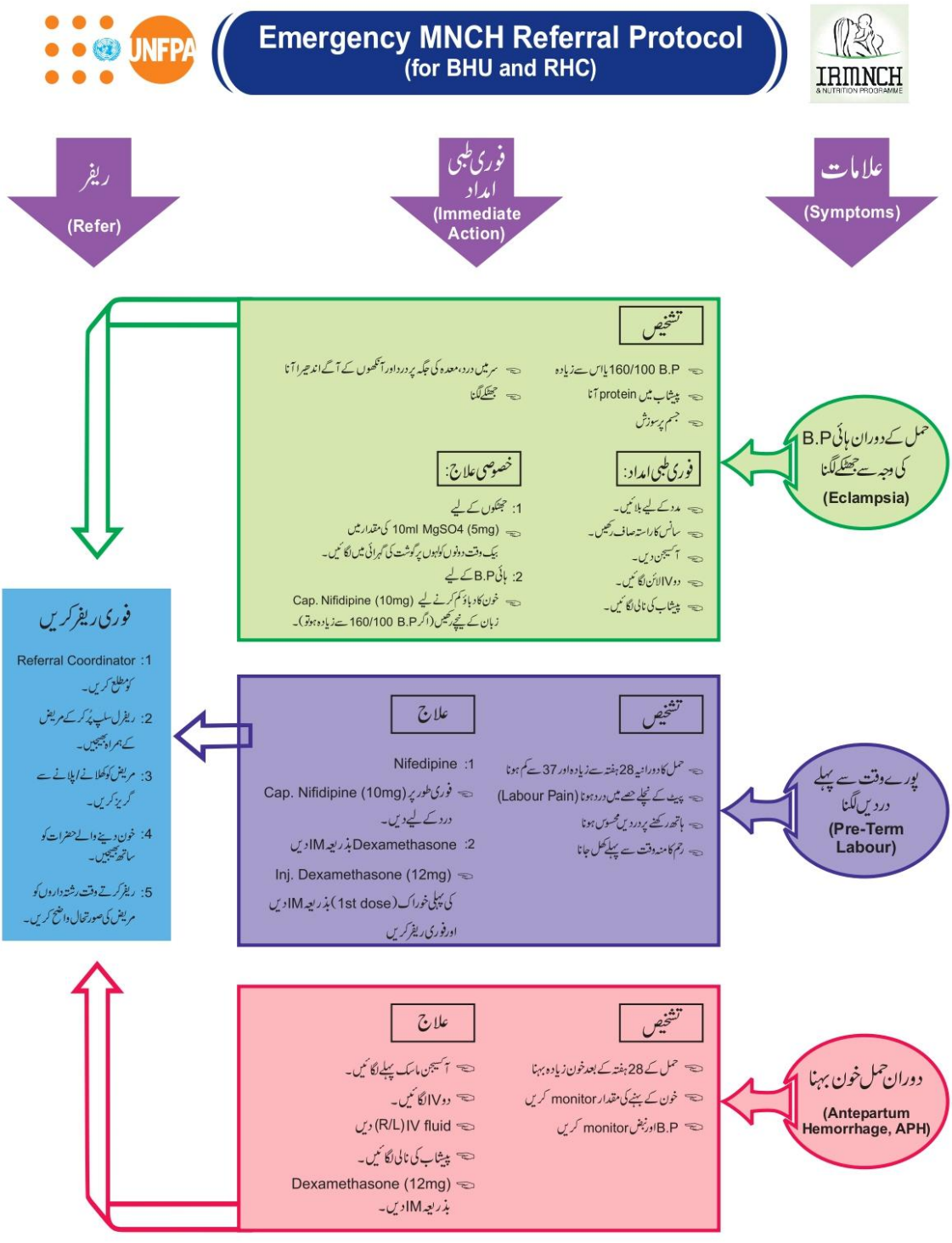

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