THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

NATIONAL GUIDELINES FOR PATIENTS/CLIENTS REFERRAL AT ALL HEALTH FACILITY LEVELS

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NATIONAL GUIDELINES FOR REFERRAL OF PATIENTS/CLIENTS AT ALL HEALTH FACILITY LEVELS

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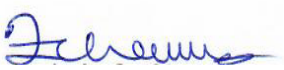
PREFACE

The Government of the United Republic of Tanzania through the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) is always working towards improving the quality of health care through health system strengthening. As the strategy to achieve this endeavor, in 2004, the Ministry developed the first National Guidelines and Procedure for Referral of Patients at all Levels. However, the Guidelines were not disseminated and hence were not put into use. This had a negative effect on the referral system. To improve the delivery of quality health services, the Ministry also has developed the Health Sector Strategic Plan IV (HSSP IV), which underscored the importance of effective and well-functioning referral system.

The non-use of the Guidelines added to other challenges affecting a systematic referral of patients at all levels in the country. Other challenges include; availability of adequate skilled and trained health personnel, availability of adequate medicines, supplies, equipment, communications and information infrastructures and technologies. Other challenges include availability of standardized and appropriate referral tools, proper ambulances with standardized equipment, health care financing for referred patients, referral guidelines, linkage between conventional and traditional and alternative medicine and accountability to referred patients.

In order to address the above challenges, the Ministry has reviewed the previous Guidelines so that they are in line with the HSSP IV and current situation.



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ACKNOWLEDGEMENT

To review the existing National Guidelines for Referral of Patients/Clients at all Health Facility Levels, the Ministry appointed a Working Group for this endeavour. This Working Group worked tirelessly to come up with this important Document. In this regard, the Ministry therefore would like to express its sincere appreciation to various individuals, institutions, Regional and Council Health Management Team members whose contributions made the review of these guidelines a success.

It is not possible to mention by name all those who contributed to the development of these Guidelines in one way or another. However, MOHCDGEC wishes to acknowledge the contribution of the following in initial development of these guidelines namely: Dr. Margareth E. Mhando, Dr. Dorothy Gwajima, Dr. Paulo P. Mhame, Dr. Edwin P. Mung'ong'o, Dr. Ally S. Uredi, Dr. Fatuma I. Makuka, Dr. Msafiri N. Kabulwa and Dr. Eliudi S. Eliakimu, Mr. Stephen H. Kitinya, Ms. Edith K. Bakari and Ms. Judith P. Matuli from the Ministry.

Others are: Dr. Raymond D. Mwenesano (Muhimbili National Hospital), Dr. Paul G. Marealle (Muhimbili Orthopaedic Institute), Dr. Sarah J. Urasa (KCMC Zonal Referral Hospital) Dr. Lazaro N. Mboma (Mbeya Zonal Referral Hospital, Dr. Leonard M. Subi, Regional Administrative Secretary (Former RMO Mwanza), Dr. Ntuli A. Kapologwe (Former RMO Shinyanga), Late Dr. Mohamed A. Gwao (Kitete Regional Referral Hospital Tabora), Dr. Baltazar J. Ngoli, (GIZ), Dr. Jacquiline J. Tesha (Mafiga Health Centre Morogoro MC) and Ms. Hadija M. Said, (Katoma Dispensary Bukoba DC).

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CHIEF MEDICAL OFFICER

ABBREVIATIONS AND ACRONYMS

Abbreviations	Acronyms
ADDO	Accredited Drug Dispensing Outlets
AHSPPR-HMIS	Annual Health Sector Performance Profile Report-Health Management Information System
AMO	Assistant Medical Officer
APHFTA	Association of Private Health Facilities in Tanzania
ART	Anti-Retroviral Therapy
BEmONC	Basic Emergency Obstetric and Neonatal Care
BMH	Benjamin Mkapa Hospital
BRN	Big Results Now
BSHSWFS	Basic Standard for Health Services and Social Welfare Facilities
CBO	Community Based Organization
CCBRT	Comprehensive Community Based Rehabilitation in Tanzania
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CSSC	Christian Social Services Commission
D-by-D	Decentralization by Devolution
DC	District Council
FBO	Faith Based Organization
GBV	Gender Based Violence
GIZ	Deutsche Gesellschaftfür Internationale Zusammenarbei
HFGC	Health Facility Governing Committee
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HRH	Human Resources for Health
HSR	Health Sector Reforms
HSSP	Health Sector Strategic Plan
IVD	Immunization & Vaccine Department
JKCI	Jakaya Kikwete Cardiac Institute
KCMC	Kilimanjaro Christian Medical Centre
MC	Municipal Council
MMAM	Mpango wa Maendeleo ya Afya ya Msingi
MNH	Muhimbili National Hospital
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MOI	Muhimbili Orthopedic Institute

MRDT	Malaria Rapid Diagnostic Test
NBS	National Bureau of Statistics
NGO	Non-Government Organization
OPD	Out Patient Department
ORCI	Ocean Road Cancer Institute
PHN A	Public Health Nurse A
PHN B	Public Health Nurse B
PHSDP	Primary Health Services Development Programme
PO-RALG	President's Office - Regional Administration and Local Government
RAS	Regional Administrative Secretary
RCH	Reproductive and Child Health
RHAB	Regional Hospital Advisory Board
SPD	Sentinel Panel of Districts
TB	Tuberculosis
TCM	Traditional Chinese Medicine
TDHS	Tanzania Demographic Health Survey
TFR	Total Fertility Rate
VAC	Violence Against Children
WHO	World Health Organization

DEFINITION OF TERMS

For the purposes of this National Guidelines for Referral of Patients at all Health Facility Levels, these terms and definitions will apply:

Terms	Applicable Definitions
Alternative Medicine	refers to any range of medical therapies that are not regarded as orthodox by the medical profession such as herbalism, homeopathy, Ayurveda, TCM and acupuncture.
Community Health Workers	refers to members of the community who are chosen by community members or organizations who have undergone formal training to provide basic medical care to their community
Conventional Medicine	refers to system in which medical doctors and other health care professionals (nurses, pharmacists and therapists) treat symptoms and disease using drugs, radiation or surgery
Cross consultation	refers to deliberation between two or more health care professionals of different health facilities within or outside the country about the diagnosis or treatment of a particular case
Medical emergency	refers to an acute injury or illness that poses an immediate risk to a person's life or long-term health.
Private for profit	refers to private health facilities (self-sustaining health facilities) which provide service for financial gain
Private not for profit	refers to private health facilities (subsidized health facilities) which provide service without financial gain.
Referral	refers to a process in which a health worker at one level of the health system, having insufficient resources (medicines, equipment and/or skills and infrastructure) to manage a clinical condition, seeks the assistance of a better or differently resourced facility at a higher or the same level to assist in, or take over the management of a patient/client.
Traditional Medicine	refers to the sum total of knowledge, skills and practices based on theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness

1. INTRODUCTION

1.1 Historical Background

Health care services in the country have been provided since time immemorial. The provision of health care services in the country can be divided into three main eras.

1.2 Pre-colonial era

During this era health services were provided by traditional medicine practitioners. Traditional Healers of different disciplines, which included general traditional health services, traditional midwifery, bone setting and mental health care, were the main providers of health services. The traditional medicine practitioners at that time were of high standing in their respective communities and were available to serve others whenever they needed health care services. More often there was no cost attached to services provided. People receiving such services felt duty bound to reward the providers after receiving the needed services. Health care provision was mainly practiced without a formal structure in place for referring patients. Referrals were mostly made by patients themselves from one practitioner to another.

1.3 Colonial era

During this era, traditional healers continued to practice, despite the introduction of modern medicine being provided. The modern medicine introduced in this era, was practiced in hospitals and clinics, which were built principally for the benefit of colonial administrators and settlers. A few elite Africans were allowed to use the modern facilities established for colonialists. Rural clinics were usually the product of missionary activities. Even during this time, there was no formal structure, which defined how patients should be referred from one level of health facility to another.

1.4 Post-colonial

a) **Immediately after independence**

After independence, health facilities for the provision of modern Medicine Health Services were built from grassroots to national level by adopting the British Health System, which was used during the colonial era. The Traditional and Conventional Medicines continued to run parallel. The referral of patients was from health post in the community to national level and was mostly characterized by cost sharing. A pyramid system of referral was in existence although not formalized.

b) **Arusha Declaration (1967) and Alma Ata Declaration (1978)**

Policy of Free Health Services to All, and adoption of Alma Ata Declaration of 1978 and nationalization of some Private Hospitals, facilitated accessibility to Primary Health Care and Referral Services for people in need. In 1977, the Government banned provision of health services for profit by private sector by an Act of Parliament (Private Hospitals Act Cap.151). The ban was removed in 1991[1] by amendment of 1977 Act. However, these events had no effect on the referral system.

c) **Health Sector Reforms**

Health Sector Reforms (HSR) which started in 1990s introduced User Fees in 1993/94[2], at the National, Zonal and, Regional Referral Hospitals, and Councils Hospitals. In 2004 Cost Sharing was rolled out to all public health centres and dispensaries. Through these reforms, the D-by-D approach was introduced with the aim to improve Health Care Delivery in Tanzania. Reforms in the delivery of health services went parallel with other reforms that took place in other sectors. Cost Sharing Guidelines are used to guide the payment of User Fees. The Guidelines specify the groups of people exempted from contributing in cost sharing. Health Service Providers who are also stakeholders in the referral system include the Government Health Facilities, Faith Based Organizations (FBO), Private Not for Profit (Subsidized Health Facilities), Private for Profit (Self Sustaining), Traditional and Alternative Medicine Practitioners. Traditional/Alternative and Conventional Health Services have continued to run parallel. There was no working linkage established to complement each other.

If the available National Guidelines and Procedure for Referral of Patients at all levels had been put into use it would have contributed to improve the performance of health sector as measured by key health indicators on population, morbidity, mortality, fertility, malaria and HIV/AIDS shown in **Table 1** below.

TABLE 1: HEALTH INDICATORS IN TANZANIA MAINLAND

Description	Figures	Sources
Total Population:	47.8 million (mainland)	NBS 2015 projection
Under 15 years old	44.2% (mainland)	NBS 2015 projection
15-64 years old	52.2% (mainland)	NBS Census 2012
65 years& above	3.9% (mainland)	NBS Census 2012

[1]White, James, Barbara O'Hanlon, Grace Chee, Emmanuel Malangalila, Adeline Kimambo, Jorge Coarasa, Sean Callahan, Ilana Ron Levey, and Kim McKeon. January 2013. *Tanzania Private Sector Assessment.* Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates Inc.

[2]Mujinja PGM and Kida TM. Iimplications of health Sector reforms in Tanzania: policies, Indicators and Accessibility to health Services. THDR 2014: Background Paper No. 8. ESRF Discussion Paper 62

Women of reproductive age (15-49)	24.3% (mainland)	NBS 2015 projection
Annual Population Growth rate	2.7%	NBS Census 2012
Life expectancy at birth (years)	61 (63 F, 60 M)	NBS Census 2012
Total Fertility Rate (TFR)	5.2	TDHS-MIS 2015-16[3]
Under 5 Mortality Rate /1,000 live births	67	TDHS-MIS 2015-16
Infant Mortality Rate / 1,000 live births	43	TDHS-MIS 2015-16
Neonatal Mortality/1,000 live births	25	TDHS-MIS 2015-16
Maternal Mortality Ratio/per 100,000 live birth	432	NBS Census 2012
Births in health facilities	60%	TDHS-MIS 2015-16
Skilled Birth Attendance	64%	TDHS-MIS 2015-16
Leading Cause Admission/Death in Hospitals	Malaria	SPD 2013
Prevalence of Malaria Parasitemia (6-59 months)	14.8% (MRDT)	TDHS-MIS 2015-16
HIV Prevalence, 15-49 years	5.3% (6.2% F, 3.9% M)	THMIS 2012
ART Coverage persons with advanced HIV	67%	AHSPPR HMIS 2013
Hospital admission per 100 persons per year	2.4	HMIS 2014
OPD visits for new cases per person per year	0.64	HMIS 2014

[3]Ministry of Health, Community Development, Gender, Elderly and Children [Tanzania Mainland], Ministry of Health [Zanzibar], national Bureau of Statistics(NBS), Office of the Chief Government Statistician(OCGS) and ICF International 2016. Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) 2015-16. Dar es Salaam, Tanzania and Rockville, Maryland, (MoHCDGEC) USA, MoHSW, MoH, NBS, OCGC and ICF International

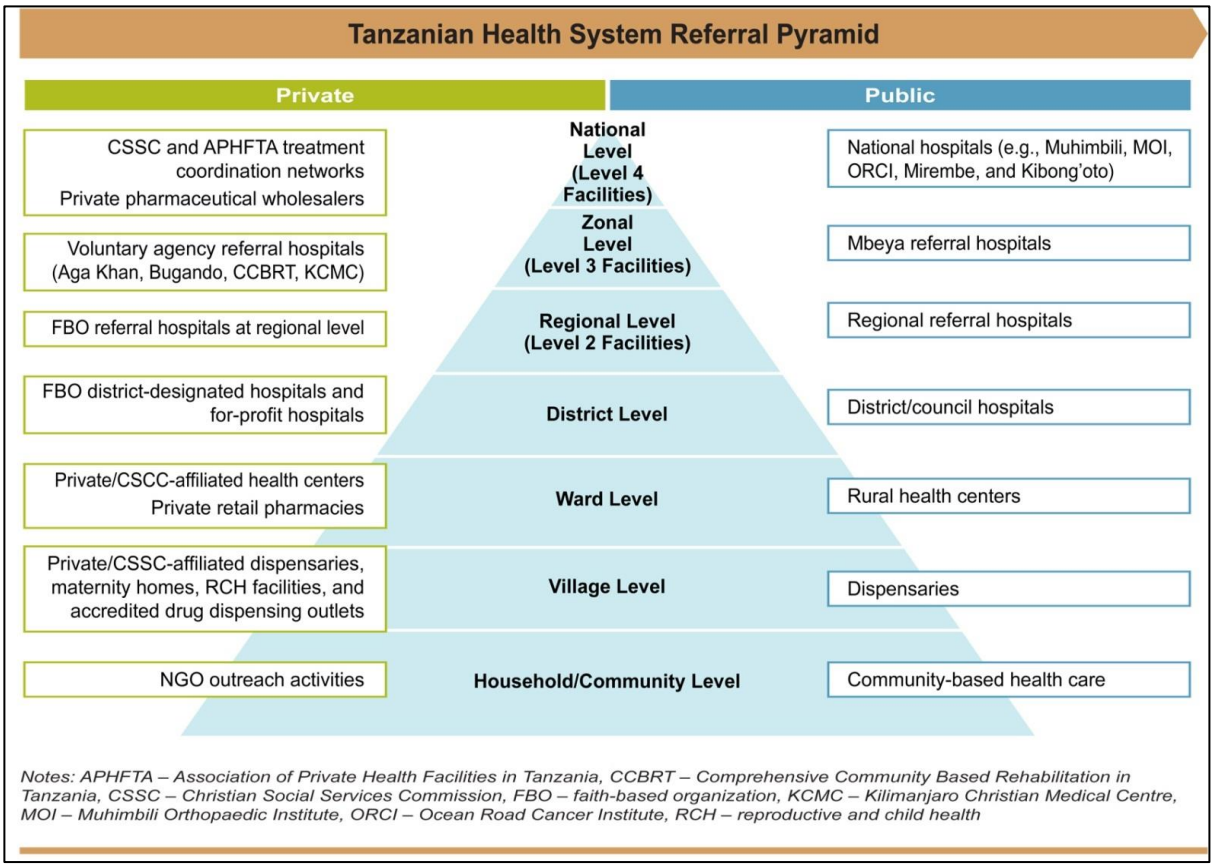


FIGURE 1: HEALTH CARE SYSTEM PYRAMID IN TANZANIA MAINLAND

NOTE 1: For both Public and Private

1.5 Current situation of the Health Facilities and Human Resource for Health

1.5.1 Health Facilities

There are about 8,571 health facilities of which, 6,748 (78.7%) are Dispensaries, 462 (5.4%) Others, 980 (11.4%) Health Centres, 331 (3.9%) Council level Hospitals, 38 (0.4%) Regional level Hospitals and 12 (0.1%) Zonal and National Level Hospitals (**Table 2** refers). Administratively, the health sector is divided into 8 zones as shown in **Figure 2**. Each zone is supposed to have a zonal referral hospital as referral center for a population in that catchment area. Currently only four (5) Zones have Zonal Referral Hospitals, namely: Lake zone - Bugando Medical Centre, Northern Zone - KCMC, South Western Highlands Zone - Mbeya Zonal Referral Hospital, Central Zone - Benjamin Mkapa Hospital and Eastern Zone - CCBRT and Lugalo Military Hospitals.

TABLE 2: HEALTH FACILITIES IN TANZANIA MAINLAND

Type of Facility	2017			2018			2019		
	Ownership			Ownership			Ownership		
	Govt	Pvt	Total	Govt	Pvt	Total	Govt	Pvt	Total
National Hospital	5	0	5	6	0	6	6	0	6
Zonal Hospital	3	3	6	3	3	6	3	3	6
Regional Referral Hospital	28	10	38	28	10	38	28	10	38
Council Hospital	37	31	68	63	90	153	145	186	331
Total Hospitals	73	44	117	100	103	203	182	199	381
Health Centre	489	22	711	505	208	713	701	279	980
Dispensary	4469	1444	5913	4523	1390	5913	5199	1549	6748
Others	10	79	89	24	379	403	20	442	462
TOTAL	4968	1545	6713	5052	1977	7029	5920	2270	8190
OVERALL TOTAL	5041	1589	6830	5152	2080	7232	6102	2469	8571

Sources: DHIS 2015 and HFR Portal

1.5.2 Human Resource for Health

Generally, there is still a shortage of Human Resource for Health (HRH) at all levels of Facilities. The shortage of HRH now stands at 48%. Human Resources for the provision of health services by 2019 were: Medical Specialist - 597, Medical Doctors 2,667, 182 Dental Specialists and Dental Officers - 143, Assistant Medical Officers - 1,275, Clinical Officers - 5,368 and Assistant Clinical Officers - 2,450, Assistant Dental Officers - 226 and Dental Therapists - 719. Pharmacists and Pharmaceutical Technicians were 1839, all cadres of Nurse were 21,552, Medical Laboratory Scientists, Technologists and Technicians were 2601, Optometrist, enrolled Optician and all Environmental Health Practitioners were 2,324 (HSSP IV 2015-2020). The shortage of HRH and infrastructure contribute to challenges facing referral of patients.

Similarly, it is estimated that Traditional and Alternative Health Practitioners' are about 75,000 who include 32,000 Traditional Birth Attendants and 43,000 general health practitioners, bone setters and mental health practitioners.

However, over 60% of people seeking medical services consult Traditional Health Practitioners before going to conventional health care systems and as a result often,

patients do delay to access conventional medical care and finally referral for further expertise.

FIGURE 2: MAP OF TANZANIA WITH REGIONS AND ZONES

1.6 Health Systems Building Blocks and the Current Referral System

The World Health Organization (WHO)[4] in 2007 came up with a health systems strengthening framework, which identified six building blocks namely: service delivery, health workforce, information, medical products, vaccines and technologies, financing, leadership and Governance.

[4]WHO. (2007). Everybody business: Strengthening health systems to improve health outcomes: WHO's framework for action. Geneva, Switzerland

Tanzanian Health system according to the WHO building blocks:

i. Financing of Public Health Services is mainly from the Central Government. Other sources are user fees in form of out of pocket payment and Community Health Fund and reimbursement from insurance schemes. Private health facilities are mainly self-financed (capital) loans; payment for services, insurance and service agreement reimbursement (operational costs);
ii. The Government established Health Management Information System (HMIS), which is used for management of health services provided by facilities at all levels. Working tool for HMIS are provided by Government for both public and private health facilities;
iii. Human Resource for Health in Public Facilities, follow the National Staffing Level Guidelines. For Public Health facilities recruitment and deployment depends on employment permit issued by the President's Office-Public Services Management and Good Governance (PO-PSM). For Private Health Facilities are required to follow National Staffing Level Guidelines;
iv. Service delivery at National, Zonal and Regional levels is under the supervision of the Ministry with involvement of respective Regional and LGA Management where the Hospital is located. Service delivery at primary health care level is under the supervision of PO-RALG. The Ministry provides technical support;
v. Leadership and Governance: The MOHCDGEC is responsible for policy development, technical supervision, monitoring and evaluation: PO-RALG is responsible for delivery and administrative issues through RHMT and CHMTs. Facilities have either Health Facility Governing Committee (HFGC) or Board. Dispensaries, Health Centres and Council Hospital have HFGC. Regional, Zonal and National Hospitals have Boards;
vi. Health technologies and medicines are regulated by Tanzania Medicines and Medical Devices Authority (TMDA). The Immunization and Vaccine Department (IVD) programme oversees supply and use of vaccine through cold chain control at the Regional and Council levels.

2. REFERRAL SYSTEM IN TANZANIA

2.1 Current Situation

The current referral chain begins from the Community to the Dispensary, Health Centre, Council Hospital, Regional Referral Hospital, Zonal Referral Hospital and ultimately the National hospitals (**Figure 4** refers). It considers only the conventional medicine in public health services. It leaves out the traditional and alternative health services. Recognizing the contribution of the private sector, referral between private and public services is now being encouraged so as to share the inadequate resources available on either side. This may lead to parallel referral lines. Therefore, there is a need to recognize the contribution of the private sector in the referral system. The classical referral system follows the health facilities hierarchy instead of professional

hierarchy. This situation might have an overall consequence in the accessibility; continuity and efficiency in health care services provision. To improve the current situation, there is a need to integrate both vertical and horizontal referral systems and take into consideration the contribution of the private health facilities at all levels.

Rationale for reviewing the National Guidelines and Procedures for referral of Patients at all Levels of 2004.

Referral Services are essential element of any functioning health system and are provided at different levels of health facilities. The personnel in these facilities must have the required qualifications which enable them to provide the required services at the respective levels. A patient needs to move smoothly from one level of health facility to another and receive the services needed. In turn, the referring facility should be informed of the outcome of the referral of that patient. There is a need for guidance to assist health facilities in referring patients. It is widely accepted that, substantial reduction in morbidities and mortalities of any population are impossible to be achieved without an effective referral system.

The Health Sector Strategic Plan IV (2015-2020), underscores the need for a functioning referral system. In order for quality health services to be delivered at various levels of health facilities, there is a need to ensure that referral system is operational and is continuously improved, hence the review of the existing Guidelines.

In order to ensure that there is a functional referral system that is in line with the current HSSP IV, the MOHCDGEC decided to develop these Guidelines. These guidelines are expected to facilitate the implementation of an effective referral system at all levels and hence contribute to the improved delivery of quality health care.

2.2 ROLES AND FUNCTIONS IN THE PROVISION OF REFERRAL SERVICES

Functionality of different levels of health services delivery depends upon performance of key players who are from both community and health facilities. Community representation is achieved through the HFGC and Boards, which have the responsibility for overseeing health services provision in these facilities including referral services.

2.2.1 Community level/Households

Health services provided at this level include:

i. Provision of preventive service through community health workers;
ii. Psycho-social support;
iii. Outreach services;
iv. Health promotion services;
v. Home based care;

vi. Rehabilitative health services;
vii. Services for Older People.

(For more details refer Basic Standards for Health Facility Volume I)

Traditional and Alternative Health Practitioners also provide curative services at this level.

At this level, Community Health Workers are the link between the Community Health Services at Village/Mtaa Level and the Formal Health Facility.

2.2.2 Dispensary

Provides Outpatient Care (OPD) for a catchment population within five kilometers. Staffing level and infrastructure are as per Basic Standard for Health Services and Social Welfare Facilities (BSHSWFS) and The Staffing Guidelines 2015.

Dispensary shall provide the following services:

i. OPD Services (diagnosis, treatment and dispensing);
ii. Basic laboratory investigations;
iii. Reproductive, Maternal, Neonatal, Child and Adolescent Health services including immunization, Antenatal care, family planning, normal deliveries, BEmONC (including Doppler and imaging), postnatal care;
iv. Counselling;
v. Primary eye care services;
vi. TB and HIV clinics;
vii. Care and treatment of HIV/AIDS;
viii. Management and referral of cases of Gender Based Violence and Violence Against Children;
ix. Health Education and Promotion;
x. Community Outreach Services within its catchment area;
xi. Services to Older People;
xii. Nutrition and social welfare services;
xiii. Follow up of returning referred patients;
xiv. Conducting operational research.

The facility in-charge is responsible for recommending all referrals to the next level.

2.2.3 Health Centre

Provides Outpatient and Inpatient Care for a catchment population of a ward

according to Primary Health Services Development Programme (PHSDP), which stipulates that each ward should have a health centre. Staffing level and infrastructure is as per BSHSWFs 2015 and the Staffing level.

The Health Centre provides all services provided at dispensary level and additionally provides:

i. Comprehensive Emergency Obstetric and New-born Care (CEmONC);
ii. Management of surgical and medical conditions;
iii. Basic diagnostic services (laboratory investigation, ultrasound imaging);
iv. In-patient services;
v. Mental health care;
vi. Dental services;
vii. Eye services;
viii. Management and referral of cases of GBV and VAC;
ix. Health Education and Promotion;
x. Mortuary services;
xi. Conduct community outreach Services within its catchment area;
xii. Referral Centre for dispensaries;
xiii. To collect, analyze and utilize HMIS data;
xiv. Receive and care of referred patients from Dispensaries;
xv. Provide feedback on referred patients from lower level;
xvi. Cascade supportive supervision to nearby dispensaries.

The Facility in -charge is responsible for all referrals.

2.2.4 Hospital at Council Level (level I Hospital)

Hospital at Council level is a level I Hospital with a capacity of providing all basic health care services to the catchment population. Staffing level and infrastructure as per Health Facility Standards Vol III.

The Council Hospital provides all services required at Health Centre level and in addition offers:

i. Casualty/emergency preparedness and response services;
ii. Diagnostic services (laboratory, radiology & imaging);
iii. Mortuary services;
iv. Emergency Medicine and critical care services;
v. Communicable and Non-Communicable;
vi. Mental health services;
vii. Management of cases of GBV and VAC;
viii. Services for older people;
ix. Health Education and Promotion;

x. Community Outreach Services within its catchment area;
xi. Referral centre for health centres;
xii. Dental services;
xiii. Eye care services;
xiv. Rehabilitative services;
xv. Teaching and training of middle and operational level health cadres;
xvi. Conducting operational research;
xvii. Collect, analyze and utilize HMIS data;
xviii. Provide feedback on referred patients from lower level;
xix. Conduct supportive supervision, mentoring and coaching on quality health services.

2.2.5 Referral Hospital at Regional Level (level II Hospital)

A Referral Hospital at Regional level is a Level II hospital, which provides specialized services including Pediatrics, Obstetrics and Gynaecology, Internal Medicine, General Surgery, Orthopedics, Mental Health services, Ophthalmology, Geriatrics, ENT, Dental and Laboratory. It is a referral centre for level I hospital and other level II Hospitals. Staffing Level and Infrastructure is as per the Standard Health Facility Guideline 2015 and Staffing Level Guidelines 2014-2019.

The Regional Referral Hospital provides all services required at Level I hospitals but with a higher level of expertise (major and specialized management of medical and surgical conditions) and additionally provides:

i. Emergency Medicine and critical care services;
ii. Preventive and promotive health services e.g. RCH, School Health;
iii. Operational research of health system in the region;
iv. Communication and transport system to facilitate referrals;
v. Referral of complicated conditions to level III hospitals;
vi. Outreach Services to District hospitals and offer specialized support services;
vii. Follow-up of returning referral patients from higher level hospitals;
viii. Provide safe blood transfusion services;
ix. Provide feedback on referred patients from level I hospitals;
x. Mentoring and coaching of level I facilities.

The Facility in charge is responsible for all referrals at the facility

2.2.6 Referral Hospital at Zonal level (level III Hospital)

i. This is a level III Hospital, which is a referral centre for level II hospitals and other referral hospitals at zonal level. It provides all services offered at level II but at a higher specialized level. Staffing level and Infrastructure is as per the Standard Health Facility Guideline 2015 and Staffing level 2014-2019;

ii. The Zonal Referral Hospital provides all services required at Level II hospitals but with a higher level of expertise (specialized and super specialised management of medical and surgical conditions) and additionally:

a) Provide level III hospital services;
b) Provide a mix of specialized and super specialized services;
c) Perform investigations using modern equipment in order to provide quality specialized and super specialized care;
d) Conduct training of high and middle level health personnel;
e) Conduct operational research;
f) Provide consultancy on various health issues to lower level hospitals through eHealth, clients and service providers;
g) Conduct outreach visits to hospitals level II in the zones and offer specialized support services;
h) Geriatric (elderly) referral services;
i) Follow up of patients from other referral centers;
j) Data collection, analysis and utilization;
k) Provide supportive supervision;
l) Mentorship and coaching to level II hospitals;
m) Provide feedback on referred patients from level II hospitals;
n) Nutrition and social welfare services.

The Facility in charge is responsible for all referrals at the facility

2.2.7 Specialized and National Hospital (level IV Hospital)

This is a level IV hospital and the highest level of hospital services in the country, which is a referral centre for level III hospitals. The level provides services, which are of the highest level in the country. Staffing level and infrastructure is as per the Standard Health Facility Guideline 2015 and Staffing level 2014-2019.

The Specialized and National Hospital (level IV Hospital) provides all services required at Level III hospitals but with a higher level of expertise (specialized and super specialised management of medical and surgical conditions) and additionally:

i. Provide a mix of specialized and super specialized services;
ii. Perform investigations using modern equipment in order to provide quality specialized and super specialized care;
iii. Provide all services offered at level III but at a higher specialized level;
iv. Conduct training of high and middle level health personnel;
v. Conduct operational research;
vi. Provide consultancy on various health issues to lower level hospitals through eHealth, clients and service providers;

vii. Conduct outreach visits to level III hospitals in the country and offer specialized and super specialized support services;
viii. Develop and produce treatment protocols for all levels of health facilities in collaboration with the Ministry;
ix. Conduct cross-consultation with other referral centers within the country and abroad.

2.3 Challenges affecting Current Referral Systems

Challenges in the referral system can be described using the WHO health system strengthening framework as follows:

i. Human resource for health;
ii. Health services delivery;
iii. Health financing;
iv. Information system and communication;
v. Leadership and governance;
vi. Supply chain for medicines and technologies.

2.3.1 Human Resources for Health

i. Availability of adequately trained and skilled human resources for health;
ii. An equitable distribution of skilled staff;
iii. An effective utilization and efficient management of the available staff;
iv. Attitude of staff and customer care skills;
v. Staff motivation;
vi. Communication among health staff;
vii. Managerial skills;
viii. Timely referral of patients.

2.3.2 Health Services Delivery

i. Accessibility to health facility;
ii. Adequate water supply and sanitation;
iii. Adequate power supply;
iv. Security at work place;
v. Availability of adequate medicines, supplies and equipment;
vi. Availability of required infrastructure;
vii. Organization of Clinical Services at the health facility.

2.3.3 Health Financing

i. Availability of adequate funds for referrals;
ii. Availability of funds for procurement of medicines, supplies and equipment;

iii. An effective Implementation of cost sharing, insurance scheme and exemption policy;
iv. Effective and efficient collection and utilization of available funds including timely disbursement, expenditure and reporting.

2.3.4 Leadership and Governance

i. Adequate knowledgeable and skilled leadership;
ii. Availability of facility plans that include referral services;
iii. Functioning Planned Preventive Maintenance system for facilities equipment and infrastructure;
iv. Adequate public health facility autonomy;
v. An effective implementation of good governance;
vi. Availability of Standard Operating Procedures at all points of service delivery in facilities.

2.3.5 Information and Communication System

i. Functional communication, coordination and means of transport between various health service facilities to maximize utilization of existing resources;
ii. Adequate and functioning information and communication equipment;
iii. Availability and analysis of data, and an effective sharing of information regarding services provided by facilities at all levels.

2.3.6 Access to Essential Medicines and technologies

A well-functioning health commodities supply chain system to ensure equitable access to essential medical products especially medicines, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.

3. PREREQUISITES FOR A FUNCTIONAL REFERRAL SYSTEM

For a fully functional referral system, challenges identified under the item 2.3 above must be addressed. This part outlines prerequisite actions to tackle the challenges under each category.

3.1 Human Resources for Health

The following must be done:

i. For Public and Private Health Facilities should employ required number of health care providers with knowledge and skills at all level as stipulated in the Staffing Level 2014-2019;
ii. Strengthen continuing education, professional code of conduct and ethics;

iii. Improve working environment and remunerations;
iv. Adequate management of the available staff;
v. Availability and adherence to clinical performance by Standard Operating Procedures;
vi. Improve coordination and communications between and among the health care providers;
vii. Raise awareness among health care providers in public health facilities on the importance of private health facilities, traditional and alternative healers in referral network.

3.2 Infrastructure, Medical Supplies and Equipment

The following must be done:

i. Rehabilitation and construction of health facility infrastructure according to laid down guidelines;
ii. Improve physical accessibility to health facilities;
iii. Provide clean and safe water and improve sanitation;
iv. Provide reliable constant power supply;
v. Improve security of health facilities;
vi. Provide adequate medicines, supplies and equipment;
vii. Ensure standard organization of the clinical services to avoid delays at the health facility;
viii. Timely planned preventive and corrective maintenance of infrastructure, equipment and instrument to ensure functional services.

3.3 Transport

The following must be done:

i. Provide appropriate and well equipped transport facilities (modern ambulances) and other means of transport available;
ii. Implement planned preventive maintenance system;
iii. Provide adequate funding for transport;
iv. Train drivers on safe operation of ambulance.

3.4 Information and Communication

The following must be done:

i. Establish effective communication and coordination, between various health service facilities to maximize utilization of existing resources and ensure effective feedback mechanism between referring facility and recipient facility;
ii. Provide information and communication equipment;
iii. Implement planned preventive maintenance system;

iv. Establish cross consultation with different health facilities using telemedicine;
v. Implement e-health strategy;
vi. Engage private health facilities, traditional and alternative healers in referral networks;
vii. Provide information on the services provided by health facilities to the public;
viii. Avail database for type of Health Facilities with service they provided at all levels together with Professionals available in Health Facilities;
ix. Acknowledge the existence of lower public and private health facilities with high capacity of skills and technology in referral networking;
x. Encourage private ambulatory services;
xi. A functional (electronic) referral documentation.

3.5 Patient Factors

The following must be done:

i. Raise public awareness on the referral services;
ii. Introduce gate pass fees to self-referring patients. However, the RHMT and the CHMT should be consulted before introducing the gate pass fees in Regional Referral, Council Hospitals and Health Centres. Special consideration shall be given to area, which do not have lower level facilities (Hard-to-reach area), where patients can make first contact with to get a referral to a higher-level facility. Gate pass shall not be applicable at any level of facility when a patient is in need of emergency services and no qualified staffs in the referring Facility;
iii. Improve health services so as to give maximum patient satisfaction.

3.6 Financing Referral Services

The following must be done:

i. Enough funds allocated for referral of patients at all levels Improve referral services to incorporate vulnerable groups; elderly, children, pregnant women and disabled;
ii. Universal health insurance to cover referral services at all levels;
iii. Strengthen management of financing from internal sources (insurance schemes, cost sharing etc.).

3.7 Components of Referral Services

Definition:

A referral is process in which a health worker at a one level of the health system, having insufficient resources (medicines, equipment, skills) to manage a clinical condition, seeks the assistance of a better or differently resourced facility at the same or higher level to assist in, or take over the management of, the client's case (WHO).

Key reasons for deciding to refer a patient/client are to seek:

i. Higher level therapeutic or diagnostic services not available at the initiating facility;
ii. More expert opinion regarding the patient/client health condition;
iii. Admission for better management of the patient/client;
iv. Additional or different services for the patient/client.

a) **Initiating Facility**

The facility that starts the referral process is called the initiating facility, and it prepares an outward referral to communicate the client condition and status to a receiving facility

b) **Receiving Facility**

The facility that accepts the referred patients/clients is called the receiving facility and after managing the patient/client prepares feedback to the initiating facility, this completes the referral loop between the two facilities.

c) **A Referral Register**

Is a means of maintaining a record of all outward and inward referrals in a facility. Information registered includes particulars of patient/client referred, to or from where, when and why (Annexes 3 and 4).

d) **Directory of Services**

Is a list of all facilities providing specialist care available in each level of health facilities. Such a directory can facilitate the search for the most appropriate service provider for a particular referral. It is important that the contact information is kept up-to-date regularly.

e) **Feedback Loop**

Feedback loop is made up of two elements: (1) an outward referral, which communicates the patient/client condition and status to the receiving facility, (2) a feedback from the receiving facility to the initiating facility indicates how the referred patient was managed and any continuity of care that the client should receive at the initiating facility.

This guideline incorporates WHO's recommended referral system components, while acknowledging community as the key element of the referral system.

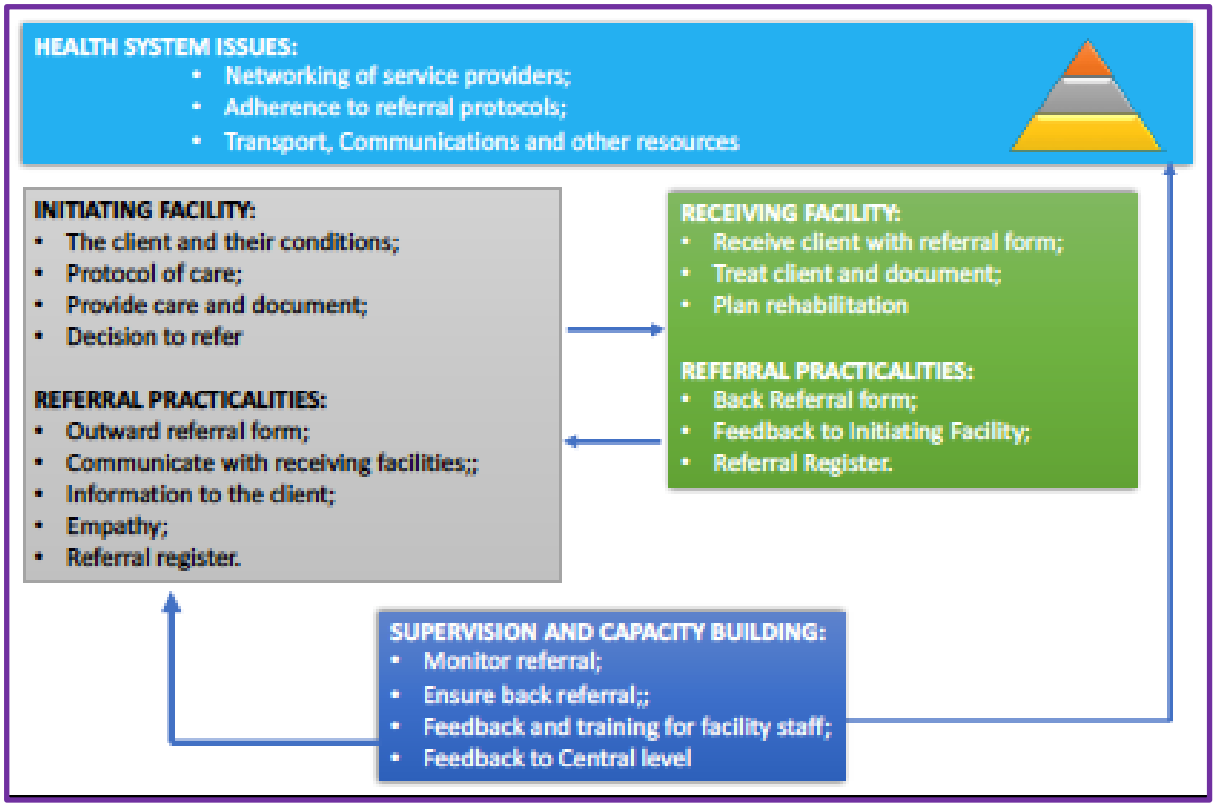


FIGURE 3: COMPONENTS OF REFERRAL SYSTEM

3.8 Referral Framework

In the HSSP IV: 2015-2020 the proposed referral system pattern is pyramidal. Patients are referred from dispensary and health centre to district and regional hospitals. The referral of patients from one level to another should be based on the skills and capacities that are required to address the problems of the patient. Since the government has established an open-door policy within the health sector reforms, the referral should not necessarily be vertical. Instead, patients from both public and private health facilities should access referral services nearest to their home based on skills and other resources needed to provide required services.

The entry point to the conventional health system for all patients from community should be the dispensary or nearby health facility as shown in **Figure 4** refers).

The basic flow should be community, dispensary to health centre to Level I Hospital to Level II Hospital to Level III Hospital to National hospital and finally if necessary cross consultation with other health facilities. Horizontal referrals should be considered when the required services or skills are available in the other facility within the same level or even lower level e.g. dispensary to dispensary or health centre to dispensary for both public and private health

facilities. Where payments are involved patients should be informed and a referral note should indicate clearly reasons for referral.

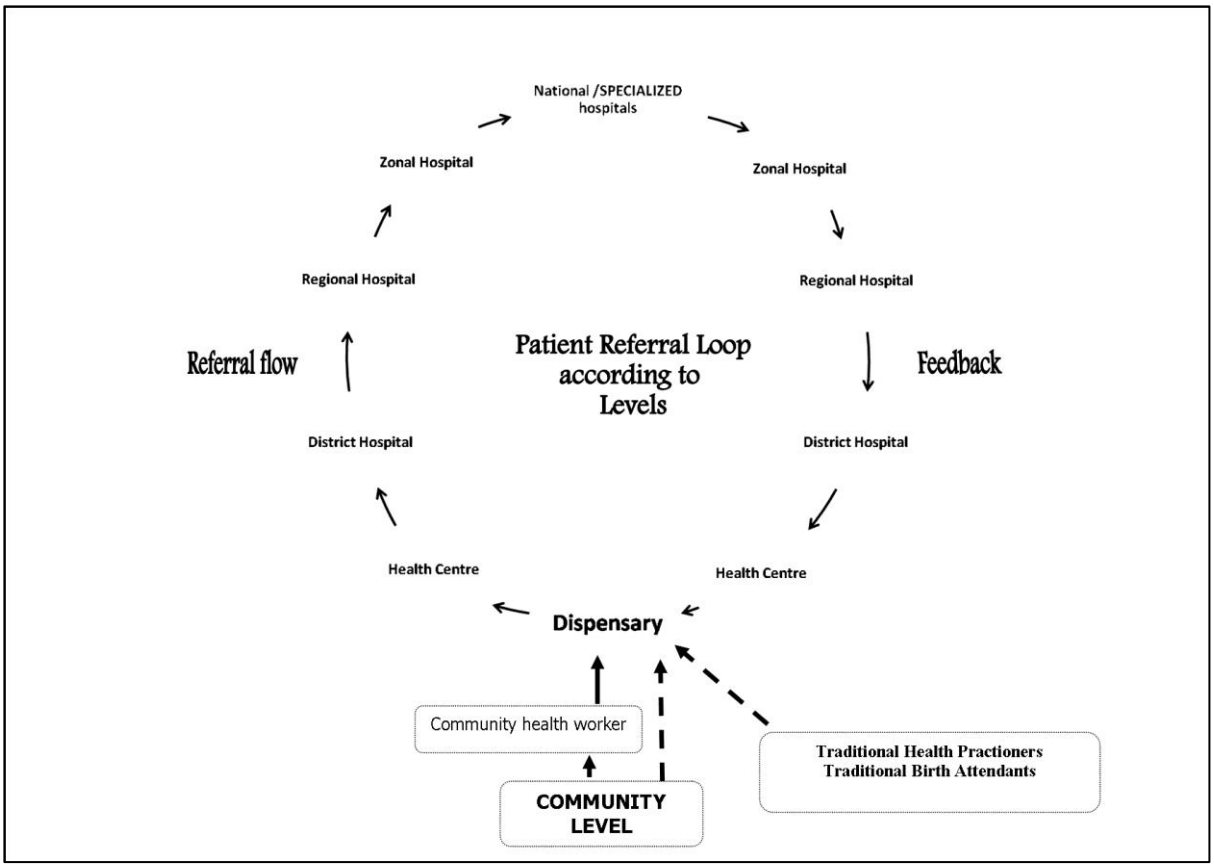


FIGURE 4: ILLUSTRATION OF INTEGRATED VERTICAL AND HORIZONTAL REFERRAL SYSTEM

3.9 Procedures for referral

The referral flow/chain will be complete if the procedures at various levels in the referral chain are duly followed by stakeholders in the referral cycle i.e. initiating and receiving facilities.

TABLE 3: REFERRAL ARRANGEMENTS

Responsibilities	Community	Dispensary	Health Centre	Level I Hospital	Level II Hospital	Level III & IV Hospitals
Who refers	Community Health Worker/ Traditional health practitioner or relative	Institution	Institution	Institution	Institution	Institution
Who arranges the referral	Community Health Worker/ Traditional health practitioner	Health facility in charge	Health facility in charge	Health facility in charge	Health facility in-charge	Health facility in-charge
Who accompanies the patients	Community Health Worker/ Traditional health practitioner	Nurse Midwives/PHN-B who has been caring for the patient. Relatives	Nursing Officer, PHN-A, PHN-B who has been caring for the patient. Relatives	Nurse Midwives/PHN-A, Relatives AMO, MO, Anesthetist) - who has been caring for the patient.	Nurse Midwives, Relatives, AMO, MO, Anesthetist- who has been caring for the patient.	Medical Officer/Nursing Officer, who has been caring for the patient, Relatives
Who incurs costs for referral	Self	- Insurance agencies - Personal costs - Employer - Cost sharingCost sharing	- Insurance agencies - Personal - Employer - Cost sharing	- Insurance agencies - Personal - Employer - Cost sharing	- Insurance agencies - Personal - Employer - Cost sharing	- MOH - Insurance agencies - Personal - Employer
Exempted groups cost		Health Facility (as per prevailing exemption Guidelines)	Health Facility (as per prevailing exemption Guidelines)	Health Facility (as per prevailing exemption Guidelines)	Health Facility (as per prevailing exemption Guidelines)	Health Facility (as per prevailing exemption Guidelines)

3.9.1 Responsibilities of the Initiating Facility

i. When a patient/client visits health facility, it is important that the providers attends to them promptly, treats them with respect, privacy and confidentiality, acknowledging their cultural beliefs, and identify their needs. All protocols should be adhered to by all providers;
ii. Providers should assess the client, gather relevant information and provide any necessary care possible at that facility. Moreover, in an emergency situation, providers must maintain all vital functions and minimize any further damage;
iii. Providers' decision to refer the client should come after the health worker has gathered and analyzed the relevant information using the protocol of care as a guide;
iv. Patient to be referred is the one whose condition cannot be managed at the centre due to unavailability of skills, equipment, medicines and supplies. All emergencies should be transferred to the next station as early as possible;
v. The referring level should communicate with receiving facility regarding the patient to be referred so that the recipient level confirms that the patient can be attended there or should be sent directly to the higher or other equivalent levels;
vi. Arrange transport if there is none at the referring facility (for public facilities or for private facilities in case there is an agreement with the public facility);
vii. The patient (or relatives in cases when the patient is unable to communicate) to be referred should be well informed of reasons for referral, the expected benefits from the highest or next level and the patient should give own consent;
viii. There should be an arrangement for an escort depending on the condition of the patient to be referred (ambulance or escort using public transport). Relevant skilled medical personnel should escort referred patient, whenever need arises;
ix. Patient who cannot afford completely to meet the referral costs and has no membership in health insurance scheme which covers referral costs, the referring unit should cover the referral cost e.g. through exemption criterion as per prevailing exemption guideline;
x. A referral form that explains the condition of the patient, management done and reasons for referral should be filled, signed and stamped by facility in-charge. A copy of the filled form should remain at the facility for review when needed.

3.9.2 Receiving Facility

i. Receiving facility should anticipate and prepare to receive the referred patient/client;
ii. Receiving facility should critically analyze the patient and information sent before beginning to manage the patient/client;
iii. The receiving facility should manage referred patients according to available protocols for relevant conditions;

iv. Before discharging the patient/client, the receiving facility should plan the rehabilitation or follow-up programme;
v. Receiving facility should provide feedback to the initiating facility regarding the referred patient/client on all information: investigations, findings, diagnosis and treatment given;
vi. Receiving facility should complete its own registers of incoming and outgoing referrals;
vii. Transferred patients from traditional health practitioners should be accepted;
viii. Where facilities of the same level have difference in skills and equipment, horizontal referral can be applicable.

3.9.3 Specific procedures for referral of level IV hospital

Level IV hospitals are the only facilities permitted to refer patients outside the country for services that are not available in the country. Before referring a patient outside the country, level IV hospitals have to follow the laid down procedures. These procedures are:

- Three (3) registered specialists should confirm the need for the referral abroad, fill the special referral form, ensure it is signed by all of them and the form be approved by the head of the hospital;
- The completed approved referral form should be submitted to the Ministry.

3.9.5 Referral Protocols at all facility levels

The referral process is guided by the following referral protocol at all facility levels

i. Application of appropriate referral tools (Referral registry and referral forms);
ii. Accountability of all referral at health facility;
iii. Standardized and appropriately equipped Ambulance;
iv. Skilled and trained Ambulance personnel;
v. Two-way feedback and follow-up of referral patients.

3.9.6 Specialist Outreach Services from higher to lower level health facilities

One of the objectives of the Primary Health Services Development Programme, commonly known as MMAM (2007-2017) is to ensure that referral system is operational. Where necessary, referral services can be provided as outreach services in different levels of health facilities so as to benefit more people, minimize unnecessary referrals, minimize costs of transporting referred patients, and minimizing inconveniencies to patients. All health facilities should prepare plans for the provision of outreach services.

In order to ensure the sustainability of specialized outreach services at lower level health facilities, the management of level III, Level II and level I hospitals should

include in their annual plans of action, costs of accommodation, subsistence allowances and transporting personnel providing outreach services to lower level health facilities at least once per quarter. It will be the responsibility of the Regional Health Management Team and the Regional Referral Hospital to accommodate and provide subsistence allowances for personnel providing outreach services at Regional Referral Hospitals. Furthermore, it will be the responsibility of the Council Health Management Team and Council Hospital to accommodate and provide subsistence allowances for personnel providing outreach services at Council Hospital, health centers and dispensaries in their Councils.

4. MONITORING PERFORMANCE OF REFERRAL SYSTEM IN TANZANIA

4.1 The aim of Monitoring System

For the referral system to function well and sustainably its implementation has to be regularly followed up and evaluated. The aim of monitoring the performance of referral system is to determine whether referral services are provided as per guidelines. This will inform the managers at various levels and decision makers to understand the flow of patients/clients through a network of health facilities particularly as to whether the referral loop is kept closed or open. The routine monitoring of referrals uses three indicators that reflect the three key processes – initiation, completion, and feedback of the referral as listed below[5]:

i. Referral Initiation: Proportion of patients/clients seen that is referred to another health facility;
ii. Referral Completion: Proportion of referred patients/clients that completed the referral;
iii. Referral Completion Feedback: Proportion of referred patients/clients seen at receiving facility that is seen back at referring facility with complete referral feedback form. Any significant changes whether an increase or decrease in proportion will require a close follow up.

4.2 Pre-requisite for the Monitoring System

It is important for every health services providers in health facilities to ensure that all the referral tools (referral register, referral forms) listed in these guidelines are completely and correctly filled and are well kept in order to generate and ensure availability of the required data elements for calculating the indicators. Each of the indicators is defined in the summary **Table 4** (M&E) refers.

[5] Measure Evaluation. (2013). *Referral Systems Assessment and Monitoring Toolkit*. PEPFAR, USAID, and Measure Evaluation, April 2013, MS-13-60.

4.3 Self-Referrals

There has been an undesirable increasing trend of self-referrals in all levels of referral facilities. This trend is more pronounced in patients who are members of the National Health Insurance Fund and other health insurance schemes. The effects of this is that many patients do not follow the referral system and as the result they go to higher level referral facilities thus putting more strain on the meager financial resources. The meager financial resources are used to pay for services provided at a higher level.

TABLE 4: DESCRIPTION OF MONITORING AND EVALUATION OF INDICATORS

Indicator Name	Description	Numerator / Denominator
Referral Initiation	• Proportion of patients/clients referred from initiating health facility	• Number of patients/clients referred from initiating facility • Number of patients/clients seen at initiating service
Referral Completion	• Proportion of referred patients/clients that complete referral at receiving health facility	• Number of referred patients/clients seen at receiving health facility • Number of patients/clients referred from initiating health facility
Referral Completion Feedback	• Proportion of referred patients/clients seen at receiving health facility that is seen back at referring health facility with referral feedback form	• Number of patients/clients seen at initiating health facility with feedback form from receiving facility • Number of referred patients/clients seen at receiving health facility

Source: Adapted from Measure Evaluation, 2013[1]

ANNEX 1: FOMU YA RUFAA NGAZI YA MHUDUMU WA AFYA YA JAMII

JAMHURI YA MUUNGANO WA TANZANIA
WIZARA YA AFYA, MAENDELEO YA JAMII, JINSIA, WAZEE NA WATOTO

FOMU YA RUFAA KWA MGONJWA

MKOA WA ……..**HALMASHAURI YA** ……

MTOA RUFAA MHUDUMU WA AFYA NGAZI YA JAMII
S L P ……..**SIMU**:……

KIJIJI/MTAA……
KUMB. Na……**TAREHE**……

MAELEZO YA RUFAA
JINA LA MGONJWA……..
UMRI……**ANWANI**……..……..……**SIMU** ……

MAELEZO YA MGONJWA
……..
……..
……..
……..
SABABU YA RUFAA
……..
……..
……..
JINA LA MHUDUMU WA AFYA NGAZI YA JAMII ……...
SAINI……

ANNEX 2: FEEDBACK FORM

THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

Receiving Facility Name		**Tel No.**		**Fax No.** **Email:**	
Reply from **(person completing form)**	**Name:**			**Date:**	
	Position:	**Department:**			
Initiating Facility: (enter name and address)	**Name:**..... **Address:**.....				
Client Name					
Referral Number		**Age:**	**Sex:**	**M**	**F**
Receiving facility Patient registration number					
Client address					
This client was attended by: **(give name and Department)**				**On date:**	
Patient history					
Investigations and findings					
Diagnosis					
Treatment / operation					

Medication prescribed			
Please continue with: (meds, Rx, follow-up, care)			
Refer back to:			**on date:**
Print name, sign & date	**Name:**	**Signature:**	**Date:**

ANNEX 3: REGISTER OF OUTWARD REFERRALS

THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

Name of facility:.....

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

ANNEX 4: REGISTER OF INWARD REFERRALS

THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

Name of facility: .....

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

ANNEX 5: REFERRAL FORM

THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

Receiving Facility Name		Tel No.: ……..	Fax No: …… Email: ……..		
Reply from (person completing form)	Name:		Date: ……Time: …….		
	Position:	Department: ……			
Initiating Facility: (enter name and address)	Name: ..... Address: …….....				
Client Name					
Referral Number		Age:	Sex:	M	F
Initiating facility Patient registration number					
Client address					
Next of Kin name and phone number					
Condition of the patient on arrival	Vital signs: …….. Any supportive appliances (IV-line, O2, orthotics): YES or NO				
Diagnosis on arrival					
On transit complications					
Accompanying documents and Investigations					
Escorting medical personnel (Name and Signature)	Name: ……	Signature: ……..			
Receiving Medical personnel	Name: ……	Signature: ……..			
Ambulance Driver	Name: ……	Signature: ……..			

ANNEX 6: RECEIVING FORM FOR REFERRED PATIENTS

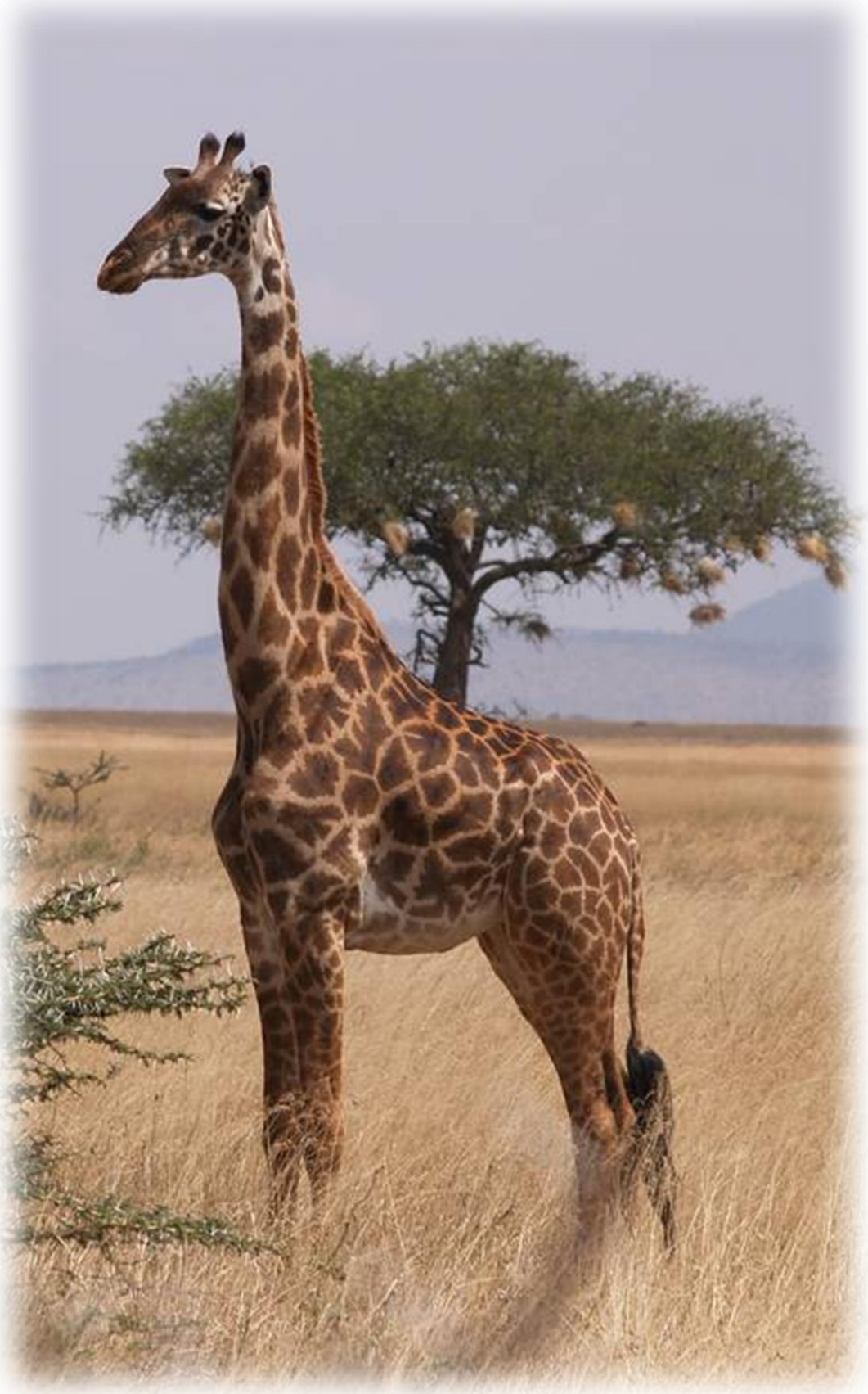
THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

Receiving Facility Name		Tel No.	Fax No. Email:		
Reply from (person completing form)	Name:		Date: Time		
	Position:	Department:			
Initiating Facility: (enter name and address)	Name:..... Address:.....				
Client Name					
Referral Number		Age	Sex	M	F
Receiving facility Patient registration number					
Client address					
Condition of the patient on arrival	Vital signs: Any supportive appliances (IV- line, O2, orthotics): YES or NO				
Diagnosis on arrival					
On transit complications					
Accompanying documents and Investigations					
Escorting medical personnel (Name and Signature	Name: ……	Signature: ……..			
Receiving Medical personnel	Name: ……	Signature: ……..			
Ambulance Driver	Name: ……	Signature: ……..			

NOTE PAD

NOTE PAD



Serengeti Giraffe, Northern Tanzania

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