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HEALTH CLUSTER
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Sexual and Reproductive Health Working Group Gaza

REFERRAL PATHWAY FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

GUIDANCE NOTE

April 2025

I. Background and Introduction

In the current context of the Gaza emergency, challenges related to shortage of supplies and equipment, qualified and specialized human resources, high cost and low availability of transport, fragmentation and multiplication of service providers have negatively impacted on the health system, including on referral pathways. At the same time, the number of service delivery points able to offer adequate service packages has dramatically decreased, hence increasing the need for effective referrals. Such challenges are likely to remain in the upcoming transition phase, at the early hour of the ceasefire, and during early recovery phases.

Effective referral pathways for Sexual and Reproductive Health and Rights (SRHR) services are crucial to reducing maternal and neonatal morbidity and mortality, and to improve timely and dignified access to care. Ensuring seamless coordination and communication among healthcare providers and with other sectors is essential to deliver timely, quality and holistic care without generating - or by minimizing as much as possible - out of pocket costs and additional burdens to people in need of services.

Since 2005, acknowledging the importance of specific referral mechanisms for SRHR, UNFPA and other international and national agencies, supported the Ministry of Health (Women's Health and Development Directorates) in drafting a Unified Reproductive Health Referral System - Policies, Protocols and Procedures Manual. Since then, with support and contribution by several agencies, criteria have been revised and updated.

This guidance-note outlines principles and suggests practical modalities to ensure smooth referral pathways for individuals seeking SRHR services and connected needs, it is adapted to the current context and based on the lessons learned by partners in the recent crisis. It is intended to be used as a short and immediate working tool, while referring to clinical policies and protocols for specific guidance. Moreover, while strongly encouraging service providers to align to the principles and standards listed below, each organization will have to adapt their referral pathways according to location, level of services, etc. The SRHR coordination team is available to provide more information and ad hoc support.

II. Definition and characteristics of referral pathways

A **referral pathway**[1] is a crucial component of the health care systems: it is **a flexible mechanism that safely links individuals** in need of care to supportive and competent services.

The need to refer from a facility or service provider to another can be due to **shortage of knowledge, skills, equipment and supplies or clear protocols** and to lack of clarity about roles and responsibilities. Conducting a referral is a powerful way to improve care, but it also comes with risks, while transferring clinical responsibility is passed from one provider to another. High-value referrals[2] are referrals conducted in a way to minimize wasteful activities and to ensure a rational use of limited resources. In a context like Gaza, this is critical.Both under-referral (not referring to specialized care when needed) and over-referral (not managing cases at the facility, even if the level of care would allow so) can have consequences on patients and health services (low quality of care, overburdening of hospitals or polyclinics, etc.), this is why appropriate strategies are needed.

Key concepts to consider for referrals include (The Unified Reproductive Health Referral System Policies, Protocols and Procedures A Guide for Health Providers at Primary, Secondary and Tertiary Health Care, MOH Palestine, UNFPA, December 2005) :

a) Danger signs and referral criteria

Danger signs could be recognized by the client, family member, friends as well as any category of health providers. It is also very important to discuss danger signs with women, girls and communities for self-referral.

Referral Criteria are guiding criteria, doctors, midwives and nurses working at SRMNH services evaluate the cases who need referral based on their clinical judgment and the capacities of their facilities, according to clinical guidelines. If there is any doubt about the decision, a line of communication should be established to discuss the case with consultants from the receiving facility to get advice regarding initial management steps, stabilization, and referral.
Referral criteria are listed in guidance documents, such as Guidelines and protocols on Obstetric Care Ante and Post natal care, Sexually Transmitted Infections, Family Planning and caring for survivors of violence, breast cancer, etc. Most of these guidelines can be found at the SRHWG repository.

Ensuring respectful referral:

- Inform and provide health education
- Discuss with the woman causes behind referral
- Discuss with the woman and her family the referral site
- Complete the upper section of the referral form
- Follow up with the referral site
- Make sure to provide feedback
- Make sure to have the completed referral form

1 Referral System
2 High-value referrals

b) The grade of urgency and the level of importance of the reason for referral

Is this a life-threatening, emergency situation, either for the woman, the fetus, or the newborn, or can it be deferred?

Is it urgent but does not require immediate action?

Is it important, for a positive health outcome, to have the person referred (and referred back), but not urgent?

- **Emergency referrals** include life-threatening conditions, immediate need for secondary care, etc. Some examples for SRMNH include: Unexplained vaginal bleeding, active labor, Neonatal hypothermia, eclamptic fits, sepsis, etc. **Should be done immediately.**
- **Urgent referrals** include time sensitive (but not emergency) conditions that require prompt transfer to higher levels of care. Some examples for SRMNH include : Anemic pregnancy, worsening/not stabilized, uncontrolled blood pressure, congenital, uncontrolled gestational diabetes, etc. **Should be done within the day or following day at latest.**
- **Important but not emergency/urgent referrals** include conditions that require specialized care or diagnostics but do not pose immediate threat to life or health, and are linked to ensuring positive health outcomes. Some examples for SRMNH include: Specialized test, consultation or treatment for high risk pregnancy follow up, or for STIs, access to preferred family planning method (If the most preferred family planning method is not available at the facility, individuals should be offered counselling and barrier/short term methods available, while arranging referral. **It should be arranged within a few days.**

**please see annex number 7 for detailed guidance on referral for high risks pregnancies*

c) Considerations on other needs and aspects of the person in need of referral

This can be around specific, sensitive issues that are linked for instance to nutrition, protection (e.g. GBV), MHPSS, financial assistance, shelter, etc. Based on such considerations, referring agents should act within a specific framework, ensure that necessary enablers and key actors are activated and conduct proper follow up.

d) Management plan for the patient being referred

This must include history, information, documentation on the reason for referral and next steps for follow-up. It is essential that patients understand the reason and the steps of the referral and grant informed consent. If a patient refuses referral, alternative options should be explored and explained. Confidentiality and privacy should also be respected at all times, while ensuring proper documentation. If they consider it is safe for them to keep it, referred patients should be given a copy of their medical records (including the referral form).

e) Levels of referrals

Referrals can occur from community to primary or secondary health care, and between different levels of care. They can also go both ways (referral to specialized/emergency care and counter-referral for follow up). It is important to understand how these different levels interact with each other, for the best care. Here below are some examples for SRMNH/SRHR.

At the community level: self-referral, based on the women's needs and assessment based on danger signs, or referral by community health workers.

At the primary health care level. In Gaza, PHC was composed of 4 levels (from midwife or general practitioner, up to to level 4 with specialized care, in addition to

laboratory, X-Ray, pharmacy and gynecologist/obstetrician). In the last revision (November 2024) of the essential package of service,[3] level 1 and 2 have been aggregated. Nonetheless, referrals can occur across different levels of PHC, not to congest hospitals while providing the needed quality of care. For instance, low risk pregnancies can be followed up at level 2, while for high risk, level 3 and 4 might be sufficient (severe cases still to be managed at hospitals). It is therefore important to know the level of your facility as well as of the ones around you. The SRHWG is working on a mapping of high-risk pregnancies clinics, which will be integrated in the SRHR service mapping (see annex). HRP can also be referred back to PHC 2, if the issues are resolved, for a follow up closer to their community. Therefore, it is important to know when to refer back safely. This is linked to danger signs and referral criteria, as mentioned above.

At the secondary and tertiary facilities. Referrals at secondary and tertiary level facilities can be received from any other level (community, primary, secondary, etc.). It is important that secondary and tertiary level facilities have clear admission and exclusion criteria, so that no precious time is wasted in referral. For SRMNH, this is particularly the case for CEMONC and NICU services. The SRHWG mapping lists the main admission and exclusion criteria per facility. Partners are strongly encouraged to inform the coordination team on any changes, to ensure this is updated.

f) Components and enablers for an effective referral system.

For a referral system to be effective, it needs to be organized in well-defined components, with adequate geographical coverage, and supported by a number of enablers.

Within the components, the key agents of the referral system are:


The referring facility or agent (mobile team, health center, hospital, patient itself)


The receiving facility (across levels of care)


The means of transport/referral (ambulances, etc.)


The means of communication


The points of contact (focal point) at referring and receiving facilities

Key stakeholders for effective referral: system: Ministry of Health, UN agencies, and NGOs, PRCS, EMTs, SRHWG, Health Cluster

Four key movements can occur:

1. Of the **actual patient** towards an appropriate level of care. Example: a woman with preference of a LARC FP method, being referred to a PHC level 3 that can insert IUD.

2. Of the **expert/specialist**. Example: a gynecologist rotating 2 or 3 days per week to a PHC to see patients internally referred for HRP or other gynecological needs that require specialized consultation.

3. Of **samples/specimens of patients** for tests. Example: an individual in need of specific follow up test for STIs, whose sample is sent to the nearest laboratory, from the clinic.

4. Of **information and clinical data** of the patient (parameters, etc.) for remote consultations. Example: telemedicine consultations for low-risk pregnancy follow up, counselling, or in case of security/access issues. Help lines.

Do not separate mother and baby unless absolutely necessary: *the best ambulance to transfer a baby is the mother, and the best "incubator" for the baby is the uterus.*

3 Essential package of service, Nov 2024

Key enablers of a referral system are:

- **Guidelines and protocols,** including clear roles and responsibilities
- **Communication systems**, including telecommunications and contact information. This can also include dedicated, real time platforms to facilitate the interaction between physicians and/or between patients and physicians (what s app groups, etc.), as long as confidentiality can be ensured.
- **Documentation tools and procedures**, including referral and counter referral (discharge) forms, with clear summaries of referred cases. Unified referral note (see annex)
- **Coordination platforms**, including service mapping
- **Monitoring and evaluation processes**, including feedback mechanisms. Regularly evaluating referral outcomes, including maternal and neonatal health indicators, documenting and addressing "drop-out" cases where patients fail to reach referred facilities, registering lessons learned is key to constantly improving referral for SRMNH. Referrals are part of the minimum indicators of the SRHWG. From a qualitative perspective, the referral network and system should also be assessed in terms of existence, availability, appropriateness and use of referral protocols and guidelines, existence and update of mapping/directory of services, existing agreements between referring and receiving institutions and how providers exchange information. These later aspects will be increasingly looked at by the SRHWG quality of care task force. Partners are encouraged to share any challenge and observation during the coordination meetings.

Referral is a key component of service provision, and should be included in the minimum requirements before starting a service.

Communication & Coordination is key for effective referral

Identify and maintain updated contact information for all facilities focal persons involved in SRH services and regularly updated in the Sexual and Reproductive Health mapping dashboard.

Cases should be referred to the closest health facility at the required care level.

Specific ambulance numbers are also available for providers (not for public), according to the district of intervention.

Please contact the coordination team if in need of support.

Implementation Tips for effective referrals

1. Know your neighbors! Scan the nearby facilities to establish referral pathways from YOUR facility according to mapping of services, including focal points contacts according to service needed. Visit each other!

2. Establish and strengthen communication. Utilize technology to improve coordination, such as WhatsApp groups for real-time updates. Assign focal people for each facility to streamline communication and share their contact information.
Identify responsible persons at facility (someone should always be on shift)

3. Identify clear protocols (when, where to refer for what) for admitting and for referring out and share with surrounding facilities. Maternity hospitals/outpatient SRHR facilities (MoH, field, NGOs) must add clear admission and exclusion criteria for women and newborn, and update them regularly on the SRHR mapping dashboard to enable a smooth referral process and avoid any miss-referral with its negative burden on both women and healthcare providers.

4. Identify means of transport, including emergency referrals. Ambulance Services. Maintain an updated ambulance service map and contact list for rapid response in each area.
NB: Women in active labor are considered an emergency and have the right to be transported by ambulance. All maternity hospitals and other health care facilities that treat obstetric and newborn cases should have procedures in place for the coordination of emergency inter-hospital transfer of patients.

5. Ensure proper documentation. This should include as a minimum:

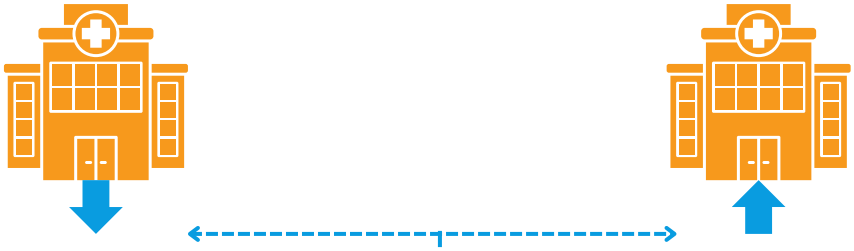
- Maternal and Child Health (MCH) Handbook: Ensure all cases are properly recorded during antenatal care & postnatal care visits
- Unified referral form (attached) and management plan
- Patient identification card (ID)
- Distribute information material on available services through community awareness and education

7. Ensure orientation/training for all staff on referral pathways and protocols. Continuous training for healthcare providers to recognize referral indications and manage emergencies. Standardize understanding of referral flexibility based on clinical needs. This should include community health workers and outreach teams linked to the fixed facility. Ensure that print out of contact directories, job aid, and protocols are available at the clinic for the staff.

8. Follow up with receiving facility for counter-referral, feedback and referral outcomes and necessary actions as per management plan.

9. Promote and participate in case discussions, indicators review, lessons learned reflections, both at your facility and during coordination meetings.

IT IS TIME TO REFER!



REFERRING FACILITY

1. Take timely decision based on danger signs and referral criteria and protocols

2. Agree with receiving facility, confirm beds/service availability through phone or other means of communication

3. Activate transport

4. Document

5. Get feedback

RECEIVING FACILITY

1. Ensure focal points are available and reactive

2. Receive patient

3. Examine documentation

4. Treat

5. Document and provide counter-referral / discharge form

ANNEX 1 - JOB AID FOR REFERRAL PATHWAYS

JOB AID: "know your neighbors"

Template for partners to use for identification of nearby facilities for referral

You can use this tool when compiling information health service delivery points near your facility, as an aid to set up your referral pathways

YOUR FACILITY	
Name of Facility	
Address	
Focal Point for Referrals	

FACILITIES TO REFER TO					
Referral Need	**Internal Referral:** indicate name of specialist, contact and working hours	**Name of Facility**	**Address/ Coordinates**	**Focal Point Number**	**Comments**
Emergency Referrals					
Urgent Referrals					
Family Planning					
High-Risk Pregnancy					
High Risk Postnatal Care					
STIS/UTIS					
Miscarriage Care					
Lab Services					
Safe Deliveries/Childbirth					
Post Natal Complications (Secondary)					
Neonatal Health					
Infant Warmers					
Breastfeeding / Re-lactation Support					
Mental Health					
Nutrition Services (Preventative/Curative)					
Other (Specify)					

ANNEX 2 - MOH Unified Referral Form

ANNEX 3 - SRHR Gaza Service Mapping (only for SRHWG members), including ambulance contacts. Available on Demand.

ANNEX 4 - ANC Guidelines for Standard Antenatal Care – Palestine – 2022

ANNEX 5 - Guidelines for Standard Postpartum Care

ANNEX 6 - High Risk Pregnancies Referral Criteria

High-Risk Condition	Referral and Management	Level of Care	Professional Health Workers
Gestational Hypertension (GHT)	**Follow up at Normal Pregnancy and follow up if any high risk appears**	**Normal pregnancy**	**Obstetrician, Midwife**
Puerperal Sepsis	**Follow up at Normal Pregnancy and follow up if any high risk appears**	**Normal pregnancy**	**Obstetrician, Midwife**
Gestational Diabetes Mellitus (GDM)	**Follow up at Normal Pregnancy and follow up if any high risk appears**	**Normal pregnancy**	**Obstetrician, Midwife**
Preeclampsia / Eclampsia	**Follow up at Normal Pregnancy and follow up if any high risk appears**	**Normal pregnancy**	**Obstetrician, Midwife**
Multiparity (≥ 6 children)	Referral to high-risk clinic for monitoring of risks associated with multiple pregnancies	High-risk clinic	Obstetrician, Midwife
Perinatal Deaths (≥1)	Referral to high-risk clinic for evaluation of underlying causes and future management	High-risk clinic	Obstetrician
Antepartum Hemorrhage (AP)	Referral to high-risk clinic for evaluation of bleeding source and appropriate management	High-risk clinic	Obstetrician
Postpartum Hemorrhage (PPH)	Referral to high-risk clinic for ongoing management of potential hemorrhagic complications	High-risk clinic	Obstetrician, Midwife
Deep Vein Thrombosis (DVT)	Referral to vascular clinic and high-risk clinic for anticoagulation therapy	High-risk clinic, Specialist	Vascular Surgeon, Obstetrician
Consecutive Abortions (<24 weeks, ≥2)	Referral to high-risk clinic for evaluation of causes and further management	High-risk clinic	Obstetrician, Gynecologist
Uterine Surgery	Referral to high-risk clinic for post-surgical monitoring and care (e.g., C-section, fibroid surgery)	High-risk clinic	Obstetrician, Gynecologist
Preterm Birth (24-<37 weeks, ≥2)	Referral to high-risk clinic and neonatology for monitoring and care during pregnancy	High-risk clinic, Specialist	Neonatologist, Obstetrician
Complicated Caesarean Section (CS)	Referral to high-risk clinic for careful monitoring during subsequent pregnancies, especially after complex C-sections	High-risk clinic	Obstetrician, Midwife
Recurrent Threatened Miscarriage	Referral to high-risk clinic and possible genetic counseling and specialist monitoring	High-risk clinic	Obstetrician, Genetic Counselor

High-Risk Condition	Referral and Management	Level of Care	Professional Health Workers
Age < 16 or > 40 years	Referral to high-risk clinic or obstetrician for monitoring and management of age-related risks	High-risk clinic	Obstetrician, Specialist
BMI ≥ 35	Referral to high-risk clinic, and monitoring for possible gestational diabetes, hypertension, etc.	High-risk clinic	Nutritionist, Obstetrician
Diabetes Mellitus (Type 1 or Type 2)	Referral to diabetes clinic or endocrinologist for specialized care	High-risk clinic, Specialist	Endocrinologist, Obstetrician
Chronic Hypertension	Referral to high-risk clinic for blood pressure management and monitoring for preeclampsia	High-risk clinic	Cardiologist, Obstetrician
Epilepsy	Referral to a neurologist and obstetrician for medication management and pregnancy monitoring	High-risk clinic, Specialist	Neurologist, Obstetrician
Renal Disease	Referral to nephrologist and high-risk clinic for close monitoring	High-risk clinic, Specialist	Nephrologist, Obstetrician
Hypothyroidism / Thyroid Disease	Referral to endocrinologist for thyroid management and monitoring	High-risk clinic, Specialist	Endocrinologist, Obstetrician
Bronchial Asthma	Referral to pulmonologist and high-risk clinic for management of asthma during pregnancy	High-risk clinic, Specialist	Pulmonologist, Obstetrician
Blood Disorders (e.g., anemia, sickle cell)	Referral to hematologist for management and monitoring of blood disorders	High-risk clinic, Specialist	Hematologist, Obstetrician
Cardiac Disease	Referral to cardiologist and high-risk clinic for management of pregnancy with cardiac conditions	High-risk clinic, Specialist	Cardiologist, Obstetrician
Mental Disturbance (e.g., depression, anxiety)	Referral to psychiatrist and high-risk clinic for mental health monitoring and support	High-risk clinic, Specialist	Psychiatrist, Obstetrician
Deep Vein Thrombosis (DVT) / Venous Thromboembolism (VTE)	Referral to vascular surgeon or specialist for anticoagulation therapy and pregnancy management	High-risk clinic, Specialist	Vascular Surgeon, Obstetrician
Others	e.g. Malnutriyion: BMI<18 or MUAC <21	High-risk clinic, Specialist	Nutritionist, Obstetrician

High-Risk Condition	Level of Care	Professional Health Workers
Gestational Diabetes Mellitus	High-risk clinic, Specialist Clinic	Obstetrician, Endocrinologist, Nutritionis
Signs of Pre-eclampsia	High-risk clinic, Hospital	Obstetrician, Specialist
Signs of Pre-eclampsia with severe features/Eclampsia	Hoapital	Obstetrician
Vaginal Bleeding	Hospital>High-risk clinic	Obstetrician
Discrepancy of Fundal Height (+/- 2cm)	Hospital>High-risk clinic	Obstetrician
Moderate Anemia (10-7 mg/dL)	High-risk clinic	Obstetrician, Hematologist
Severe Anemia (<7mg/dl)	Hospital	Obstetrician, Hematologist
Oligohydramnios (AFI <5cm/Deep Pocket <2cm)	Hospital	Obstetrician
Polyhydramnios (AFI >25cm/Deep Pocket >8cm)	Hospital	Obstetrician
Fetal Movement Decreased (≥20 Weeks)	Hospital	Obstetrician
Malpresentation (≥36 Weeks)	High-risk clinic> Hospital	Obstetrician
Rh Negative with Positive Indirect Coombs Test	High-risk clinic>Hospital	Obstetrician
Multiple Pregnancy	High-risk clinic>Hospital	Obstetrician
Preterm Premature Rupture of Membrane (pPROM), PROM	Hospital	Obstetrician
Pregnancy with Pelvic Mass	Hospital	Obstetrician
IVF Pregnancy	High-risk clinic>Hospital	Obstetrician
History of Infertility (1 Year)	High-risk clinic>Hospital	Obstetrician
Negative Fetal Heart Sounds (≥12 Weeks)	Hospital	Obstetrician
Other	as needed	as needed

NB: pregnancies under 18 are also considered at risk