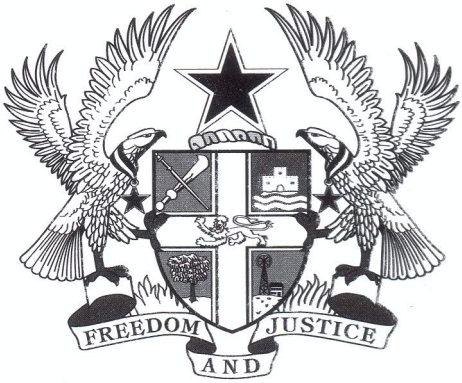
MINISTRY OF HEALTH

REFERRAL POLICY

&

GUIDELINES



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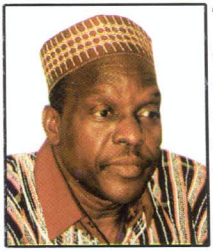
FOREWORD



The policy of referring patients from primary care levels to the appropriate level for continuous provision of health care in the country has been identified as an integral component of the health delivery system. There is the need, therefore, to ensure a well structured and efficient referral system that will not only stand the test of time but also be attractive to patients in particular and the public in general. The Ministry of Health is, no doubt, concerned with the current practice of patients' referrals which most of the times cause delays in accessing critical or emergency care and eventually leading to preventable deaths.

This can be attributed to lack of harmonization of the referral system and standard procedures that define roles and responsibilities of the referring and receiving health facilities. This affects the continuous and seamless delivery of health care to the patient.

These challenges facing the referral system in the health sector have made it imperative to develop this policy and guidelines to ensure their reduction or elimination and to bring about increase access to health care by all people living in Ghana.

The Ministry of health in its quest to ensure the attainment of its vision of creating a healthy population for national development, is committed to operating a referral system that will ensure safe and efficient transfer and care of patients within its health facilities. It is important to acknowledge that a good and reliable referral system is a key component of quality health service delivery. It is equally important to acknowledge that harmonization of the referral system will allow for better collaboration and communication between health facilities. This will contribute to the reduction or elimination of the challenges that affect smooth and responsive patient referrals. It is our hope that this document would help to build and improve patients' confidence in the referral system in the country and ensure efficient health care delivery. All public and accredited private health facilities shall adhere to this policy and guidelines and shall develop operational policies to facilitate its implementation. To ensure the continuous relevance of this policy and guidelines to prevailing situations, it shall be revised as and when necessary.

Hon. Alban Sumana Kingsford Bagbin (MP)
Minister of Health
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TABLE OF CONTENTS

PART ONE: MINISTRY OF HEALTH REFERRAL POLICY AND GUIDELINES

1.0 INTRODUCTION

The Ministry of Health is committed to providing quality health care to all people living in Ghana. All health care providers shall refer patients appropriately to ensure continuous provision between all levels of health care in the country.

2.0 THE CURRENT SITUATION

The referral system requires patients to first access primary care and be referred to the appropriate level when the need arises. However, patients/clients bypass the first level of care mainly due to ignorance, inadequate primary health care facilities and lack of confidence in the first level facilities.

Other factors making the system inefficient include lack of standard procedures for referrals, delays in referrals, non-use of referral forms, poor perception of the system by referred patients and lack of feedback. If the inefficiencies of the referral system are not addressed, the gatekeeper mechanism being advocated under the National Health Insurance Scheme will not work and it may result in high health care costs to mutual health schemes and their eventual collapse.

Therefore, for the NHIS to be successful, the system must be strengthened (refer guideline for Gatekeeper System and Free Maternal Policy Documents Appendix A).

3.0 DEFINITION AND CONCEPTS OF REFERRALS

Referrals 'involve the transfer of some or all the responsibility for the patient' Care temporarily or permanently and for a particular purpose, such as investigation, consultation, care or treatment of the patient'.

It ensures that patients can access care at the primary (lower) levels and be referred promptly for secondary or tertiary care if required. Likewise,

referral back to the lower facility is recommended when the reason for the referral has been addressed.

Referral involves cooperation, coordination and information transfer between the various service delivery levels.

3.1 Types of Referrals

- External
- Internal
- International

3.2 External Referral System

3.2.1 Pre-hospital Emergency Referrals

These include referrals from

- National Ambulance Service
- Other Ambulance Services
- Others e.g. Community Volunteers etc.

3.2.2 Facility to Facility (inter-facility) Referrals

Referrals may be received from any of the following institutions

- Teaching Hospitals
- Ghana Health Service (GHS) Institutions
- Private Practitioners including Midwives
- CHAG and other Mission Hospitals
- Quasi Government Hospital
- National Ambulance Service
- Others

3.3 Internal Referral System

This is referral within the health facility

- One department to another department
- Within a department
- One unit to another unit or a department.

3.4 Reasons for such referral

3.4.1 To obtain the opinion or advice of another provider
3.4 2 Co- management of a case
3.4 3 Further management/specialist care

4.0 GENERAL PRINCIPLES FOR REFERRALS

4.1 Organizing for Referral

4.1.1 The National Referral Policy and Guidelines as well as the Gatekeeper System and Free Maternal Care Policy shall be available in all the Units/Departments of all Health Facilities
4.1.2 A two-way referral system shall be implemented in all facilities. In this regard, referrals can be from a lower health facility to a higher or specialist facility and vice versa.
4.1.3 The Ministry of Health shall prepare and make available in all health facilities, a directory of facilities and services provided. This should be annually updated.
4.1.4 Patients shall be referred to facilities capable of handling the cases using the directory of health providers and services.
4.1.5 Registers shall be maintained for monitoring and evaluation of internal and external referrals in all health facilities

4.2. Referral Process

4.2.1 A completed standard referral form shall accompany any patient being referred.
4.2.2 The standard referral form shall be filled and a copy kept in the referring facility
4.2.3 The standard referral form shall contain:
A) Vital data or information about the patient.
I. Name
ii. Age/Date of birth
iii. Sex
iv. Health Insurance status
v. Address
vi. Clinical history and examination findings
vii. Results of relevant investigations

viii. Diagnosis and treatment given
B) The name, address and telephone number of the referring facility and the facility being referred to.
C) The date and time of referral must be indicated at all times
4.2.4 The referral form shall be completed legibly and comprehensively.
4.2.5 The referring practitioner/clinician must complete the referral form, write his/her name, signature and stamp if possible
4.2.6 The referral form must indicate the urgency of the referral
4.2.7 The reason for the referral
4.2.8 For all NHIS patients, all referrals should adhere to the Gatekeeper System and Free Maternal Policy Document
4.2.9 All referrals from all health institutions including private health facilities must conform to the Ministry of Health Referral Policy Guidelines Document.

4.3 COMMUNICATION OF PATIENT CARE AND TRANSPORTATION

4.3.1 Where possible, referrals must have prior communication (i.e. telephone, radiophone, email, fax etc.) to the receiving facility providing the following patient details:
a. Name, age, sex.
b. Presenting complaints
c. Examination and findings
d. Investigations carried out
e. Diagnosis and treatment given
f. Date and time of referral

4.3.2 Patients may be conveyed to and from the health facilities using a. suitably equipped ambulance or whatever other appropriate means of transportation available.
4.3.3 Where an ambulance is used to transfer a patient, the referring facility should make adequate arrangement for the return of the nurse/practitioner to the facility.

4.4 FEEDBACK

4.4.1 Feedback shall be sent to the referring facility.

4.4.2 The attending Practitioner/Clinician at the receiving (referred) facility shall, where possible refer patients back to the referring facility for continuation of management.

4.4.3 The attending Practitioner/Clinician at the receiving (referred) facility must clearly specify on the feedback form, details of ongoing management or further therapy required.

5.0 GUIDELINES ON PRE-HOSPITAL EMERGENCY REFERRAL

5.1. All health facilities/ emergency units must accept all emergency cases that can be handled in those facilities.

5.2. Adequate care must be provided to these cases

5.3. Where referral to another institution is required, initial care must be provided to the patient

5.4. In the case of referral to another facility, continuous medical care should be ensured.

5.5. Emergency in any form should not be turned away or refused without initial first aid being given.

5.6 Pre-hospital medical emergency forms shall be completed by the Ambulance Service crew and signed by the practitioner (Medical Assistant, Nurse or Doctor) at the receiving facility. The form should include:

5.6.1 Name, age, sex.

5.6.2 Time of arrival at the scene

5.6.3 Time of departure

5.6.4 Time of arrival at the health facility

5.6.5 Time of handing over the patient

5.6.6 Presenting complaints

5.6.7 Examination and initial findings

5.6.8 Monitored vital signs that include time, Blood Pressure, Temperature, Heart Rate and Respiratory Rate among others

5.6.9 Impression and initial management

6.0 EMERGENCY REFERRALS

6.1 Emergency Services shall be provided at all times, including

weekends and holidays.

6.2 There shall be a separation of outpatient and emergency services within the facility.

6.3 The emergency team on duty must officially and immediately receive emergency Referrals/ cases to the facility to be urgently evaluated by the practitioner/ clinicians.

6.4 Emergency medicines and supplies shall be available at any given time in the Emergency Unit/Department at all the levels of health facilities.

6.5 If it becomes necessary for an emergency unit to close down, prior and adequate arrangement shall be made for patients to receive emergency care.

7.0 INTERNAL REFERRALS

7.1 All internal referrals shall be accompanied by patients' notes indicating full detailed history, examinations, investigation, findings, treatment given and reasons for referral.

7.2 The referring Practitioner shall write his/her name, date, time and sign the referral letter in the patient's notes.

7.3 The practitioner to whom the patient is being referred must be given prior information (i.e. verbal) about the patient, as much as possible by the referring practitioner.

7.4 Patients with critical or life threatening conditions shall be attended to immediately.

7.5 A non critical patient should be responded to as soon as possible. However, it should be within twenty-four hours.

7.6 Policy on international referral and the gatekeeper and free maternal policy document shall be adhered to.

8.0 MEDICAL EVACUATION / INTERNATIONAL REFERRALS OUT OF THE COUNTRY

Medical Evacuation is provided for civil and public servants from Ministries, Departments and Agencies (MDAs) who by virtue of their condition of employment are entitled to such package.

As a policy, Medical Evacuation is primarily reserved for certain medical

conditions or diseases that cannot be managed locally for want of requisite equipment or professional expertise.

Apart from extreme emergency situations, MDAs are required to submit request for Medical Evacuation / International Referrals to the Director-General of the Ghana Health Service.
In both instances, a medical board should be constituted to verify and (or) evaluate the merits of the case.

8.1 International Referrals into the Country

International referrals should be directed to the appropriate health institutions and these referrals must follow the institution's administrative guidelines for such referrals. in conformity with International Health Regulation 2010

9.0 INTERFACES BETWEEN THE AMBULANCE SERVICE AND THE HEALTH FACILITIES

9.1 Complementarities between Pre-hospital and Hospital activities:

As much as possible, there should be coordination mechanisms between all actors involved in the management of the patients requiring emergency medical attention in the pre-hospital setting and who will need to be transported to a health facility.

9.2 Necessity to promote Emergency Medicine Units / Departments in hospital settings

Every hospital should develop its capacity and capability to manage emergency patients at the time of arrival to the facility without delay or interruption in the continuity of care delivery.

9.3 Appropriate management of Emergency patients at the site:

Basic Life Support skills can save many lives and therefore this should be considered as a priority in training staff of all agencies involved in the management of situations where emergency patients can potentially be met

9.4 Appropriate management of patients during transport;
All ambulance crew (both public & private) should receive proper training in managing emergency patients, basic technician level as a starting point and progress to advanced life support level depending on their specific role in the ambulance team.

9.5 Partnership in a network of all Agencies;
The coordination of the activities of the various agencies dealing with Medical Emergency patients should be organized and coordinated within the Ministry of Health.

10.0 MEDICO-LEGAL ISSUES

10.1 All requests for medico-legal examinations (i.e. rape, assault etc.) must be accompanied by an official request from the Police and other relevant authorities.

10.2 Medico-legal requests not within the capability of the health facility concerned should immediately be referred to the appropriate level.

10.3 All Medico-Legal records must contain complete data such as date and time of incident, findings and management.

10.4 The attending practitioner must write his/her name, sign and stamp all medico-legal documents.

10.5. A copy of the Medico-Legal report shall be kept in a file at the administration in the facility.

11.0 MONITORING AND EVALUATION:

The assessment of the needs and priorities over time as well as the assessment of the capacity of the partners should be conducted on a regular basis by the Monitoring Units of the various institutions as well as the Monitoring Units of the Ministry of Health. Monitoring of activities should be implemented to ensure that the process remains relevant, efficient and on track.

Improving implementation in the context of the NHIS

I. SECONDARY HOPITALS, TERTIARY HOSPITALS AND SPECIALIZED FACILITIES

SCENARIO NO.	SCENARIO DESCRIPTION	GUIDELINES	CLAIMS SUBMISSION AND PAYMENT	REMARK
A.	Emergency (Emergency includes any acute life threatening health condition)	1. Emergencies can be seen at any level with or without referral. 2. If maintenance care is required after the patient is discharged from the acute episode, see Scenario D	1. Full tariff applicable to the facility type for emergency care including follow ups for the initial episode. 2. Link original diagnosis to the review by quoting the diagnosis and the ICD-10.	1. Facilities must have emergency units/rooms. 2. Until the uniform MOH prescription form is introduced, there is no need for a facility to attach prescription form or investigation request form to any claim, emergency or otherwise, EXCEPT for unbundled claims such as claims from a standalone pharmacy or a standalone diagnostic centre. The uniform MOH prescription form will make provision for a copy to be attached to a claim. 3. Healthcare Facilities from district level upwards must have an equipped emergency room or unit.
SCENARIO NO.	**SCENARIO DESCRIPTION**	**GUIDELINES**	**CLAIMS SUBMISSION AND PAYMENT**	**REMARK**
B.	Acute and chronic non-emergency cases not referred but appearing at 2° or 3 ° hospitals and found to be a non-emergency.	1. The 2° or 3 ° hospitals should treat. 2. If maintenance care is required after discharge from the acute episode, see Scenario D below. 3. ENT, Dental, Eye cases do not	1. If referred, 2° or 3 ° tariffs apply respectively 2. If not referred, 1° tariffs apply. 3. For ENT, Dental	1. Caution: 2° or 3 ° hospitals must not turn patients away without triaging. Intensive education of staff and patients to be done by schemes and providers 2. Referral to the lower level should be

		need referral letters.	and Eye cases tariffs appropriate for the level applies	fully documented in the patient's folder 3. Database of chronic follow-up should be made available to NHIS and updated regularly. NHIS should develop codes for patients on chronic maintenance care. 4. If referral to a lower facility is required it should be to the appropriate level, e.g 3 ° to 2°, 3 ° to 1° or 2° to1°

SCENARIO NO.	SCENARIO DESCRIPTION	GUIDELINES	CLAIMS SUBMISSION AND PAYMENT	REMARK
C.	Emergency or acute or chronic referred to the 2° or 3 ° hospital	1. Treat and stabilize at the 2° or 3 ° hospitals. 2. If maintenance care is required after discharge from the initial episode, see Scenario D below.	1. Full tariff (secondary and tertiary respectively) 2. Attach referral to claim, with referral code.	1. Monitor referral claims from particular facilities. 2. Monitor for late referrals, unnecessary referrals and quality of referrals (both referrals up and referrals down). 3. Monitor for quality of feedback. 4. Referral up or down must have full documentation – see GHS referral forms. 5. Keep referral register at the facility.
D.	Maintenance care of chronic condition	1. For patients treated at a 2° or 3 ° hospitals, whenever maintenance care is required, the patient should be stabilized and referred to an appropriate lower facility on discharge from the initial episode. 2. However, if the condition requires continued specialist attention at the secondary or tertiary hospital, management should be continued at that level. Adequate justification	1. Full tariff applicable to the facility type for stabilization including follow ups on the initial visit 2. Full tariff for justifiable continued care at the 2° or 3 ° hospitals. 3. Primary hospital tariff for unjustifiable continued care at 2°	1. Monitor for unjustifiable continued specialist care at 2° or 3 ° hospitals. 2. Monitor for covert co-payments on the pretext of patient's insistence. 3. Facilities should maintain registers for chronic non-communicable conditions. 4. The referral code/number is the number/code on the chronic follow up list. 5. Facilities should institute appointment system with appointment cards,

		should be given for continued care at secondary or tertiary hospital, e.g. one justification for continued maintenance care at the 2° or 3 ° hospitals is where the medicine the patient is taking cannot be prescribed at the primary level. 3. If the specialist determines that continued specialist care is not required but the patient insists on continued specialist care at the 2° or 3 ° hospital, the patient should bear the full cost of that care.	or 3 ° hospital. 4. Patient pays full fee for own insistence on continued specialist care at 2° or 3 ° hospital. Provide adequate documentation of the patient's decision for the patient to sign and/or thumb print an undertaken or disclaimer form. 5. Attach referral to first claim and quote referral number/code on claim form. Subsequent claims quote referral number only.	6. Medication for chronic condition should not be prescribed for more than two months at a time. 7. Massive education of members and the general public about benefits and exclusions. 8. NHIA should monitor for co-payment 9. Proper documentation of patients records at both the provider and NHIA sites. 10. Disclaimer /undertaken form should be designed.

SCENARIO NO.	SCENARIO DESCRIPTION	GUIDELINES	CLAIMS UBMISSION AND PAYMENT	REMARK
E.	Chronic condition on maintenance care, who develops an acute or acute on chronic complication	1. If maintenance care has been by a primary facility or if rushed to a primary facility, the primary facility should treat or stabilize and refer to 2° or 3 ° hospital. 2. If the patient was referred to the 2° or 3 ° hospital, the 2° or 3 ° hospital should stabilize and refer back to the primary facility to resume maintenance care or continue specialist care in the 2° or 3 ° hospital based on justifiability. 3. If the patient shows up at the 2° or 3 ° hospital and turns out to have a chronic complication, the hospital should treat and retain on maintenance care in the 2° or 3 ° hospital. 4. If the patient had been on maintenance care in a primary facility, then the 2° or 3 ° hospital should treat and refer the patient back to the primary facility. However, the patient can be retained on maintenance care in the 2° or 3 ° hospital but adequate justification shall be provided by the facility.	1. Full tariff. 2. No referral required if patient has been on maintenance care at the 2° or 3 ° hospitals. 3. Attach referral if referred from a primary facility.	1. Monitor for facilities treating only what they are able to handle. 2. Monitor for undue delay in referring or (inappropriate referrals) unnecessary dumping of patients from primary facilities. 3. Complications of the chronic conditions should be regarded as emergencies. 4. During monitoring, check for the first diagnosis on the claim to ensure it is not the same as the one diagnosed in earlier visits (up to 2 weeks prior to the present visit).

SCENARIO NO.	SCENARIO DESCRIPTION	GUIDELINES	CLAIMS SUBMISSION AND PAYMENT	REMARK
F.	Chronic condition on maintenance care at 2° or 3 ° hospital who develops a 'simple' condition not due to the chronic condition, e.g. malaria	1. Treat at whichever level the patient shows up (1°, 2° or 3 ° hospital.	1. If treated at the 2° or 3 ° hospital, primary tariff applies.	1. Educate patients that they do not have to go to the 2° or 3 ° hospitals with all illnesses; else they will be turned to a lower facility. 2. Monitor for abuse of the gatekeeper system by patients.
G.	Internal referrals	1. Treat internal referrals of the first instance as in C above, with the only difference being that the referral comes from within. 2. An internal referral to a specialist should preferably be done by a medical doctor. 3. Treat maintenance care as in D above.	1. Higher tariff applies, i.e. 2° or 3 ° hospital tariff. 2. All diagnoses should be captured on claims form. 3. Attach referral form to the claim.	1. Monitor for adherence (abuse). 2. Prior to the development of a standardized internal referral form, providers shall use the GHS referral form.
SCENARIO NO.	**SCENARIO DESCRIPTION**	**GUIDELINES**	**CLAIMS SUBMISSION AND PAYMENT**	**REMARK**
I.	Specialized Facilities /Specialized Services in	1. Specialized facilities include Eye Clinics, Dental Clinics, ENT	1. For specialised (stand alone)	

	/Specialized Services in secondary or tertiary facilities	Clinics, Dental Clinics, ENT Clinics and Trauma/Orthopaedic Clinics in a secondary or tertiary hospital. 2. Patients may attend with or without referral.	(stand alone) facilities, primary tariffs apply. 2. For specialised service in 2° or 3 ° hospitals, the appropriate tariffs apply.	
J.	Chronic cutaneous ulcers	1. Should not be managed for more than 3 months at primary level but should be referred.	1. For non-referrals primary tariffs apply. 2. Referrals, full tariff applies.	
K.	Already in secondary or tertiary as maintenance before these guidelines	1. Those who can be managed at primary level, refer accordingly. 2. Those who need to continue on maintenance care at secondary or tertiary hospital document in chronic NCD and justified for the continued care at secondary or tertiary by March 31, 2012. 3. Secondary and tertiary institutions should provide list of chronic follow-up patients prior to NHIS inception and a justification for the continued follow-up. 4. Patients who do not need	1. Full tariff, except for those who insist on secondary or tertiary care.	1. Intensify education by providers and schemes.

		continued care at the secondary or tertiary hospital but who insists on continued care at the secondary or tertiary should bear full cost of the care.		
L.	Admission of walk-in patient at secondary or tertiary hospital	1. For patients visiting a secondary or tertiary hospital without referral (walk in), if treated at the OPD, the facility shall claim for primary hospital OPD tariff. 2. For a walk in patient who is admitted in a secondary or tertiary hospital on the same day, secondary or tertiary tariffs respectively shall be claimed by the facility, but OPD tariff shall not be claimed for the same day..		

II. FREE MATERNAL CARE

[SCENARIO NO.]	SCENARIO DESCRIPTION	GUIDELINES	CLAIMS SUBMISSION AND PAYMENT	REMARK
[H.]	**Free Maternal Care**	1. Pregnant women should be encouraged to elect to attend 1° facilities for antenatal, delivery and postnatal care. 2. Pregnant women may deliver at primary, 2° or 3° hospitals with or without referral. 3. For first visit the pregnant woman should be seen even if they have not registered with the scheme. 4. The woman should go to the scheme to register and obtain NHIS card (temporary or permanent) before the second visit. 5. Following the first visit registration can be facilitated through any of the following: a. Provider fills the name of the client on an NHIS Membership Registration Form and let her send to the	1. For non-referral antenatal and postnatal care primary tariffs apply at all levels 2. For deliveries, whether referred or not, the appropriate tariff for the facility type applies. 3. For referred cases 2° or 3 ° hospital tariffs respectively apply. 4. For referred cases, referral should be attached to the first claim. 5. Claims code /number should be quoted for referral claims.	1. Promote 100% focused ante natal and post natal care at all levels of care. 2. To enable 2° or 3 ° hospitals focus on referrals, pregnant women shall be encouraged to use primary facilities but shall not be restricted. 3. Pregnancy may be confirmed by examination, pregnancy test or ultrasound scan. 4. A pregnant woman who refuses to register with the scheme in spite of adequate education shall be deemed not to be willing to take advantage of the Maternal Care policy and shall not be compelled to do so.

		nearest scheme office for registration b. Where there is a scheme officer within the facility (say in the case of larger facilities), the provider should refer the client for registration c. In facilities where there are fixed antenatal days, schemes should go to the facilities to register the women on the antenatal days. 6. If the woman's membership has expired she should renewed (without paying premium or processing fee) before the second visit. 7. If the woman's card has not expired at the time she gets pregnant, she goes ahead and accesses antenatal, delivery and/or postnatal care. 8. The woman's card covers the baby for the first three months		