HEALTH SECTOR
COX'S BAZAR

Patient Referrals and Transfers to Secondary & Tertiary Level Healthcare Facilities

for the Refugee/Forcibly Displaced Myanmar Nationals

in Cox's Bazar, Bangladesh

Referral Standard Operating Procedure (SOP)	
Functional Area	Health
Ownership	Ministry of Health and Family Welfare Office of the Civil Surgeon, Cox's Bazar, Bangladesh Ministry of Disaster Management and Relief Office of the RRRC, Cox's Bazar, Bangladesh
Technical Lead	Health Sector
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Developers:

World Health Organization

IOM UN MIGRATION

UNHCR The UN Refugee Agency

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GLOSSARY OF TERMS

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Referral	A process in which a health worker at one level of the health system, having insufficient resources (drugs, 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.
Initiating facility	The facility that starts the referral process
Receiving facility	The facility that accepts the referred case
Back referral	A document prepared by the receiving facility detailing what has been done and sent to the initiating facility. This completes the referral loop between the 2 facilities
A referral loop	The complete cycle/link between the initiating and receiving facility
Medical Emergency	The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Obstetric Emergency is a medical emergency occurring to the mother or foetus.
Elective/Non-emergency	Cases with health conditions that may benefit from advanced care but not having any acute life-threatening condition or seriously debilitating condition. Although necessary to alleviate suffering, elective medical intervention does not meet the judgement for medical emergencies and is scheduled in advance considering availability of care. Locally, tertiary referral for elective medical interventions will be reviewed and pre-approved by a Medical Referral Committee.
Medical Referrals for acute life-threatening conditions (MRALC)	An emergency referral framework developed under the Health Sector Coordination, funded by UNHCR and IOM as a safety net for emergency referrals. The agencies support partners (without referral capacity) on a temporary basis to meet referral and treatment costs based on agreed criteria.

Critical Care Patient Transfer Team (CCPT/T)	A dedicated pre-positioned human and physical resources within the camps provided by health partners, that can support 24 hr 7 day a week on-call critical care patient transfers.
Medical Referral Committee	Comprised of technical members from Sadar Hospital/Upazila Health complex and representation from the referring agency in the respective Upazila, the MRC review the Elective/Non-emergency Referral requests twice a month and provide recommendations on further management based on agreed referral criteria while taking into account availability of services and capacity of provider.
Patient Attendant	Refers to any person accompanying a patient for the protection (i.e. safety and physiological well-being) of the patient during physical transportation and under care. This may be a patient's family member or any next of kin.
Referral Facilitation Agency	A health partner/agency that takes responsibility for facilitating the referral services including the transfer of the patient. They ensure that the patient receives the recommended treatment and all related expenditure at the receiving facility is covered including the return of the patient/attendant to the camp as agreed between the receiving facility and the health partner/agency.
Dispatch and Referral Unit (DRU)	A 24 hr 7-day-week ambulance dispatch and transfer support system, that health partners within the camps can access if there is no PHCS and/or field hospital capacity for an inter or intrapatient transfer request.

BACKGROUND

An effective referral system ensures a continuum of care is accessible at different levels of health care providers within the health systems ensuring timely access to lifesaving health care. When implemented well, in addition to ensuring a continuum of care, referral systems relieve pressures on receiving facilities, while ensuring intermediate health facilities are utilized efficiently and capacity built. It constitutes a core element of the health systems for service delivery. Without a proper referral system for more complex and life-threatening conditions to access care, the primary health care services may not be understood nor accepted by beneficiaries [1]. The Cox's Bazar Health Sector Strategic Plan (2019-2022) recognizes the importance of referral and set the '24/7 availability of referral capacity' as a minimum standard for all Primary Health Care Facilities in the camp[2]. However, the effective and responsible implementation of a referral system has been plagued by a variety of challenges.

Implementing a referral system in a humanitarian setting can be complicated by challenges emanating from several factors. Inadequate financing tends to be a recurrent issue affecting partners' capacity to meet the wide range of referral needs. In Cox's Bazar, insufficient funding to the health sector promotes short-term interventions; while during the COVID-19 response partners have had to reprioritize the available resources to meet the essential care demands. These resource limitations expose some practical challenges e.g., lack of funds to cover inpatient feeding, diagnostic and treatment costs at receiving facilities. Delay to receive care at the receiving facilities is not uncommon due to unavailability of skilled staff, lack of medical commodities, etc. Coordination in the camps seldomly suffers from slow approval processes to permit refugees out of the camps and accountability for refugees who didn't return to the camps for reasons that may be beyond the partners' control. A common, transparent decision-making tool such as SOP is therefore useful to guide an objective prioritization process to ensure universal coverage for referral health care for those most in need.

Under the leadership and coordination of the Health Sector in 2019, in addition to the Health Sector Referral SOP) at the time, an addendum for 'Medical Referrals for Acute Life-threatening Conditions' (MRALC) was developed and funded by UNHCR and IOM as the lead agency to bridge the referral gap and ensure a continuum of care. In 2020, UNHCR and IOM supported partners to refer a total of 8128 patients from the camps (UNHCR-63%, IOM-37%). Of these referrals, 35% were within Ukiya and Teknaf (Upazila Health Complexes, Field Hospitals, PHCs), 55% to Sadar District Hospital, and 9.2 % to Chittagong. The top three reasons for referrals included 1) trauma and other injuries-16.7% amongst UNHCR supported referrals, IOM-32%, 2) Surgical cases (13.2%), Obstetrics (13-15%)

[1] UNHCR's Principles and Guidance for Referral Health Care for Refugees and Other Persons of Concern. Available at: https://www.unhcr.org/protection/health/4b4c4fca9/unhcrs-principles-guidance-referral-health-care-refugees-other-persons.html

[2] Minimum Essential Health Care Service Package for Primary Healthcare Centres (PHCs) in the camps

The COVID-19 pandemic has amplified the health systems vulnerability including referral capacity. For instance, resources had to be invested to establish a temporary dedicated COVID-19 Dispatch and Referral (DRU) ambulance transfer system for the quarantine of new arrivals, the isolation and treatment of suspect and / or confirmed COVID-19 patients in Severe Acute Respiratory Infection Isolation and treatment Centres (SARI ITCs).

The support from IOM and UNHCR under the MRALC is planned to phase out by end 2021, allowing other health partners/agencies enough time to plan for this transition going into 2022. Whereas the implementation of the past referral framework led to some progress, the gains from a single agency support system are temporary and unstainable. A whole-of-sector approach is required, as exemplified during the COVID-19 pandemic, where actors plan and establish individual referral infrastructures aligned to the Minimum Essential Health Care Service Package (MESP) and governed within a harmonized referral SOP. This is the background to the revised referral SOP commenced in January – March 2021.

THE REFERRAL SYSTEM: PRINCIPLES AND PRACTICALITIES.

REFERRAL STAKEHOLDERS-ROLES & RESPONSIBILITIES

	Stakeholder	Role	Responsibilities
5.1	Gov. of Bangladesh	Leadership and Coordination	• Facilitate timely access by eliminating any barriers to patient transfers within agreed protocols/procedures. Both partners (government structures and partners) at all levels- district, camps- mutually recognize and adhere to the endorsed 'Patient Referrals and Transfer to Secondary & Tertiary Level Healthcare Facilities' policy and supporting SOPs • Work collaboratively with the Health Sector to Coordinate the referral system while supporting monitoring, accountability, capacity building, advocacy, etc • Buy-in from health authorities, service providers, and M&E officers to undertake routine data collection and use the data
5.2	Health Sector	Technical Lead	• Monitoring: collaborate with health partners and facilities to regularly analyse and disseminate referral statistics and to provide feedback as appropriate to all stakeholders. Coordinating

			referral monitoring, analysing data, and preparing periodic reports. ● Accountability: Provide technical support to the MoHFW local leadership to establish accountability mechanisms aimed at effective and responsible implementation of the referral system ● Continuous quality improvement: Lead on the periodic sector-wide review of the referrals SOPs and provide strategic guidance to health facilities in strengthening referral system ● Service Availability and Readiness: Map out and disseminate known referral entities: referral facilities, contact, the scope of services, etc Widely disseminate referral pathway information
5.3	Health Partners	Implementation: Initiating facility	● Ensure health worker attends to referred patients promptly based on local triage criteria, treats them with respect, privacy, and confidentiality, acknowledge their cultural beliefs, and identify their needs ● Ensure adequate assessment and documentation. In an emergency condition, maintain all vital functions and minimize any further damage. Hand over the patient to receiving facility clinical staff ● Making the decision to refer the client timely ● Inform the receiving facility of the referral and obtain information on service availability to the receiving facility.
		Implementation: Receiving facility	● Avail health workers with ready access to essential medical supplies and equipment to provide care, and train staff on relevant protocols. ● Complete medical referral register ● Ensure availability of 24/7 communication mechanism at the receiving facility through which initiating facilities can coordinate referrals.

			● The receiving facility to provide feedback and back referral to the original facility or where follow-up care can be accessed ● **The receiving facility should not decline the transfer unless an alternate disposition is preferable for the patient**.
		All	● Where possible, communicate with the receiving facility in advance of the arrangements for the referral, ● Ensure timely referral ● Ensure medical referral database is up to date and contribute health sector referral monitoring ● Collaborative engagement and coordination with the health sector and partners ● Adherence to the agreed Patient Referrals and Transfer to Secondary & Tertiary Level Healthcare Facilities' policy and supporting SOPs ● Adhere to the minimum Essential Health Care Service Package ● Patients and their family members (or other) should be adequately counselled and made aware by the referring facility staff of any possible negative outcome, so that an informed decision can be made.
5.4	Medical Referral Committee (MRC)- Detailed in ToR attached.	Implementation	● Review and make the final decision on elective referral requests primarily for tertiary referrals including referrals to Dhaka. ● Make recommendations on further management (as per agreed referral criteria and capacity) ● Support in the evaluation of the referral system
5.5	Dispatch & Referral Unit (DRU)	Implementation	● Lead in patient referrals and transfer

			• Provision of a 24 hr 7-day week ambulance dispatch and transfer support system that is accessible to all health partners • Coordination and dissemination of the rotational 'on-call' roster
5.6	Community	Community transportation: from Household to the health facility	• Transportation from household to the health facility is the community responsibility. Under the overall supervision of the CHWG, the CHWs attached to the PHCs/HPs will facilitate community mobilizations to identify community-based referral volunteers that can move the patients from the household to nearest ambulance pick up point or nearest health facility. The health facility partners to support community volunteers with basic materials for safe transportation e.g., stretchers, gloves.

PURPOSE OF THE REFERRAL SOP

Define local referral system: This Referral SOP draws lessons learned from past interventions and lays out a new *modus operandi* aimed to improve referral across the health sector for adequate access to lifesaving emergency and elective care.

Scope: This medical referral system is to facilitate the referral of patients from the camp health facilities to pre-identified secondary and tertiary health care institutions for advanced medical care. This Referral SOP shall cover all refugees/Forcefully Displaced Myanmar Nationals, and asylum seekers that are accommodated within designated camp settings of Cox's Bazar.

Inclusion/Exclusion Criteria: Key inclusion and exclusion for emergency and elective referral supported within this SOP to ensure consistency and appropriateness of any referral and transfer request is provided in Annex ii.

Referral decision: Referral is primarily a medical decision, based on prognosis, cost, and availability of specialist service. Based on resource availability, the eligibility criteria shall be collectively and regularly revised to prioritize those most in need. During medical emergencies, the clinician will hold unilateral discretional to make a sound evidence-based decision to referral. However, elective referrals will be coordinated through a designated referral committee at Cox's Bazar Sadar hospital or at the camp level.

Amendment: Amendments to the referral SOP and transfer criterion may be required in exceptional circumstances and as deemed necessary, documented, and endorsed by Strategic Advisory Committee of the Health Sector Coordination.

PATIENT TRANSFER FROM INITIATING FACILITY TO RECEIVING FACILITY.

24/7 Availability of functional Ambulance service: The initiating health facility shall have in place the recommended means to transfer patients from the camp level to the receiving facility and back to the camp upon discharge. Where such means of transfer is not available, the initiating facility will coordinate with other providers in the referral network for a timely transfer.

Patient Transfer outside of the camp: The health partner/agency is responsible for the patient transfer to the Secondary and Tertiary levels. This transfer can be an onward referral/ambulance transfer from a facility e.g., Upazila Health Complex, Cox's Bazar or a direct referral and an ambulance transfer request from the PHC or other specialist health facility. When necessary, the latter prevents delay and saves lives when carefully coordinated with the higher-level facility and is recommended.

Referral Cost Coverage: The referring health partner/agency has the primary responsibility to meet all costs/expenditures related to transfer to and from the receiving facility upon discharge. This includes all costs related to the referral services e.g., transportation, diagnostic services, feeding, medical supplies, other medical management costs, etc as agreed between the initiating and receiving facility.

Transfer of a Dead Body: The referring facility's health partner/agency is responsible for the safe and dignified transportation and return of the deceased to the refugee camp.

Managing the Transfer Process: Always, follow triage protocols and stabilise the patient appropriately including during transportation. By using triage tools, decision-making around referrals will be optimized and will help to save lives and reduce incidences of inappropriate referrals.

Number of patient attendants: Only one attendant (>18yrs) shall travel with the patient in the ambulance. Exceptional circumstances e.g., breastfeeding mothers, unconscious patients, and patients <5 years of age may justify two patient attendants and may be supported. This circumstance must be discussed and approved by the referral agency to ensure the protection of the patient. When required, consult with the Protection Sector for further guidance.

Informed Consent: Patients and attendants should be adequately counseled, and informed consent obtained prior to referral.

BLOOD DONATION

Note: BDRCS working together with relevant stakeholders to strengthen availability and distribution of blood transfusion services within the camps.

- The initiating facility shall make every effort to ensure that the patient has access to safe blood products for transfusion at the referral point.
- Where possible, the initiating facility shall always check in advance with the receiving facility for availability of blood products and decide timely on alternate nearest facility with blood transfusion services.
- Alerting the BDRCS responsible person of the blood transfusion and blood bank service may also be required.
- The referring facility should strengthen local capacity to conduct blood grouping and typing for the patient and potential blood donor
- Note: In acute life-threatening conditions, NEITHER the initiating facility NOR the receiving facility should DELAY/DENY the referral whilst trying to secure blood products.

DOCUMENTATION

All referrals must complete the following documentation:

- The approved common referral form issued by the medical officer &/or designated staff from the referring health facility (see annex iii.) Health Facility will collect the referral forms (with serial numbers) through the health sector
- At a minimum, verbal consent should be obtained by the medical officer & /or designated staff.
- Patients and attendants Identification Card (ID). In the event of an acute life-threatening emergency and the patient or attendants does not have their ID card on their persons, then the initiating health facility should consult and coordinate with the local authority (CIC) to obtain permission.
- Despite pre-approved CIC permission for emergency referrals; additionally, partners **should expeditiously inform CIC about emergency** referrals while preserving the ethical principle of primacy of life.
- Complete the facility-based medical referral register/database-Annex iv

UNHCR AND IOM'S MEDICAL REFERRALS FOR ACUTE LIFE-THREATENING CONDITIONS (MRALCS)

As stated above, the support from IOM and UNHCR under the MRALC is a temporary measure to address gaps in the referral system. It is not intended to replace the terms in this SOP nor substitute the health partners' responsibility to provide referral services as recommended in the MESP. Recognizing the gradual processes involved in establishing a referral system, the MRALC will remain accessible as a provider of last resort.

MEDICAL REFERRAL COMMITTEE (MRC)

The referral committee shall review and provide approvals for non-emergency (Elective) referrals, tertiary referrals and referrals to Chittagong & Dhaka. Please refer to the annexures for a non-exhaustive of the medical conditions that may constitute a medical emergency

MONITORING AND REPORTING

The monitoring framework will ensure the capacity of the health sector to monitor the functionality, costs, and effectiveness of the referral systems. To achieve this, the initiating and referring facilities will ensure that the following elements for monitoring the referral system are in place and used:

Mandatory documents

- Referral Registers: a common Health Sector approved register, available and used at the facility
- Staff members trained at the facility to understand how to document referrals and the importance of data quality. Provide detailed referral information of any refugee/FDMN case referred out of respective Upazila (Ukhia/Teknaf) to Cox's Bazar Sadar Hospital or Chattogram Medical College Hospital with the Civil Surgeon office. These include contact details name, details of referring officer- designation, email, telephone number, and reason for referral.

Recommended documents

- Database for entering and analyzing referral data and related costs.
- Periodic client satisfaction surveys.

Optional documents

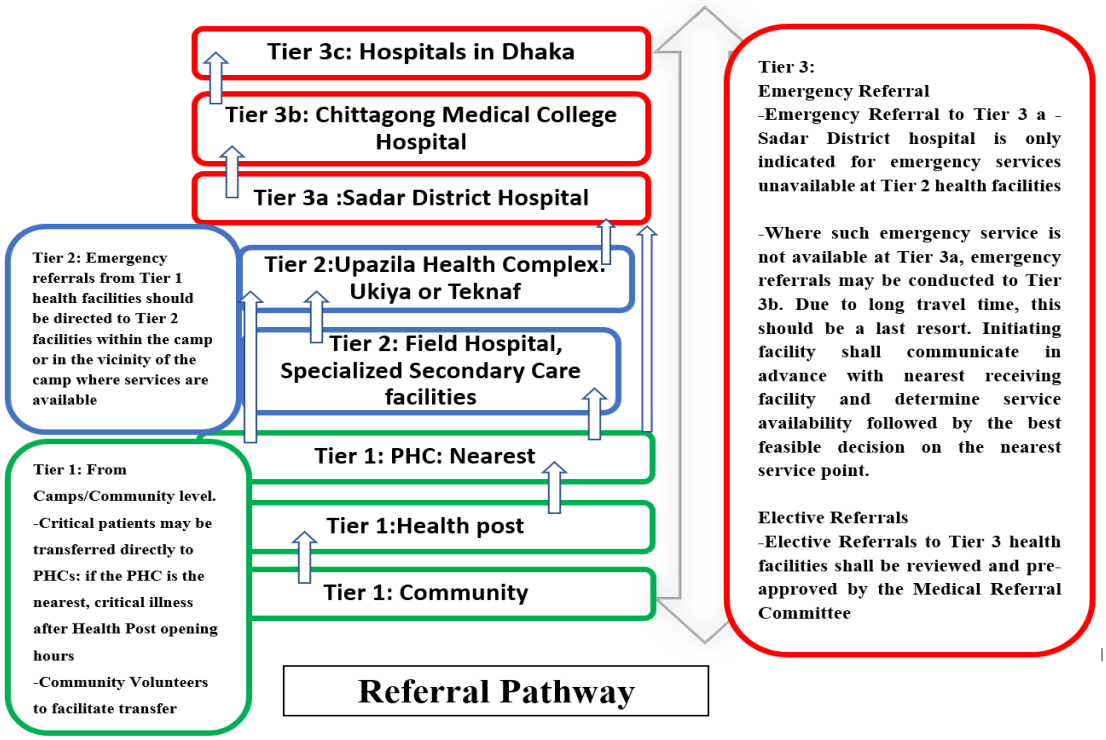
- Referral Reporting Forms, where referral data are summarized and aggregated for reporting purposes
- Indicator Reporting Forms to document the indicators that are calculated using the Referral Reporting Forms

Selected Monitoring Indicators: Reported monthly using data from the Referral Register

Indicator Name	**Description**	**Numerator/Denominator**	**Data Source**

1. Referral Initiation	Proportion of patients referred by initiating facility	Number of clients referred from initiating facility	Referral Form, Referral Registers
		Number of clients seen at initiating service	
2. Referral Completion	Proportion of referred patients that complete referral at receiving service	Number of referred patients seen at receiving facility	Referral Form, Referral Registers
		Number of patients referred from initiating facility	
		Number of referred patients seen at receiving facility	

REFERRAL PATHWAY ACROSS THE HEALTH SERVICE DELIVERY POINTS



COVID 19 DISPATCH AND REFERRAL UNIT (DRU):

Operated through a 24/7 call center, the COVID-DRU is exclusively intended to support COVID-19-related referrals. This includes

- transport and referral of Rohingya suspected or confirmed COVID-19 cases to a SARI Isolation and Treatment Centre (SARI ITC) or Isolation Unit (ISOU),
- transport of asymptomatic Rohingya COVID-19 contacts to facility quarantine,
- transport of suspected COVID-19 cases among NGO workers based near or within the Rohingya Refugee Camps, to the Isolation Unit for testing, transport of travelers/new arrivals to the transit center

For details on the COVID-19 DRU, refer to the Guidance Note in Annex vi

ANNEXURES

Other important documents to the patient referral process include:

i: Referral Form (to be produced by the Health Sector)

ii: Referral Register (Sample)

iii: Medical Referral Committee TOR

iv: COVID-19 DRU Guidance Note