Annex iii: Terms of Reference for the Camp Medical Referral Committee (MRC)

Objective: To ensure a fair, equitable, ethical, and cost-effective referral system for elective case treatment and for the review of cases referred for emergency treatment from the camps. The overall aim and mandate of the committee is to deny or obstruct a necessary referral and access to treatment where such treatment is available but to ensure there is a systematic and transparent approach to receiving such treatment in a prioritized and efficient manner locally.

Committee membership (Camp Level):

1. CIC (Chair)
2. Clinician referring the patient (Member)
3. One independent clinician not involved in the case/referring partner (Member)
4. Referral focal points (Member)
5. Camp Health Focal Point (Member Secretary)

Procedure for the meeting

- Medical record: On a weekly basis, CHFPs will coordinate with the partners and compile a summary of all elective deferrals. The referring partner will maintain control/access to the patient medical records in line with medical ethics principles
- Quorum: The meeting shall proceed when 4/6 of the members are present.
- In the absence of the CIC or designate, his/her leave substitute will lead the meeting
- Meeting frequency: The meeting will be conducted on a need basis and will do so within one week whenever there is a case to be reviewed. The meeting will take place at the Office of the CIC or a selected venue in the camp.
- Decision: The clinicians will provide a technical decision on the referral as General practitioners at the camp level. In some cases, the decision will be reviewed further by Specialized doctors at the referral facility before a final decision is issued. For patients to be referred through the UNHCR/RHU-supported referral systems, CICs will consult further with the Health Coordinator RHU /RRRC on resource availability and referral decision
- Patients to be referred by individual agency: If partners do have adequate resources and the referral is deemed technically necessary based on the Referral SOP, such referrals should be approved.
- Documentation: For each referral meeting, a meeting note should be documented summarising the case, the reason for referral, the agency involved, the decision, and the reason for the decision
- Unresolved case: Where there is a need for further review of the case both for technical and administrative reasons, the case shall be referred to the Cox's Bazar Medical Referral Committee
- The committee will meet weekly or periodically depending on the cases to be reviewed. If the committee cannot convene within a week's time, the clinician's discretion will prevail.

General Roles and Responsibilities of the Committee:

1. A minimum of three health professionals is recommended in the committee to ensure a fair and transparent process that understands both the reality of health services in the country and has knowledge of the best evidence-based practice
2. Health care professionals that have direct contact with the PoC will not be part of the committee decision-making body. They may present the case to the board, but the decision shall be made by the other physicians on the board.
3. The committee proceeding shall remain confidential to avoid any undue pressure or influence from beneficiaries that would prevent objective decision-making. Therefore, it is advisable to have the committee in a controlled environment.
4. Camp-level health partner physicians shall assess the case clinically and collect all investigation findings and present the case to the referral committee.
5. Partner health experts evaluate the case based on the prognosis and make the decision to refer or not. When the case carries a good prognosis from a technical point of view and feasible cost analysis, the decision of referral is made by the partner experts with consultation with concerned CIC/ACIC. Partners will submit a summary of the case in the standard Patient Evaluation sheet (annex 1) along with supporting documents.
6. FDMN/Refugees shall not be given any assurance of referral by the committee members before the committee makes the decision to refer. The camp health partners of the referral committee are to strictly adhere to this point
7. Ensure a transparent, efficient, ethical, and cost-effective decision-making process
8. Ensure that all cases referred satisfy the criteria outlined in the current Medical Referral SOP.
9. Meet regularly to review newly submitted cases and to decide on the referral of non-emergency patients from Refugee camps
10. Seek physician recommendation on treatment options taking note of its anticipated end date.
11. Review cases that are within one month of their original treatment end date, to informed to determine if treatment needs to be extended or can be terminated at the time originally recommended.
12. Review cases that require follow-up at referral facilities more than two times. Deciding on the extent/limitations of assistance, especially for cases with repeat / recurrent referrals.
13. The referring agency will provide feedback after each meeting to the concerned beneficiaries while the referring agency will provide feedback to relevant staff members of the referring agencies.
14. Document deliberations on sessions held via taking and sharing of meeting minutes.

Role of camp health partners:

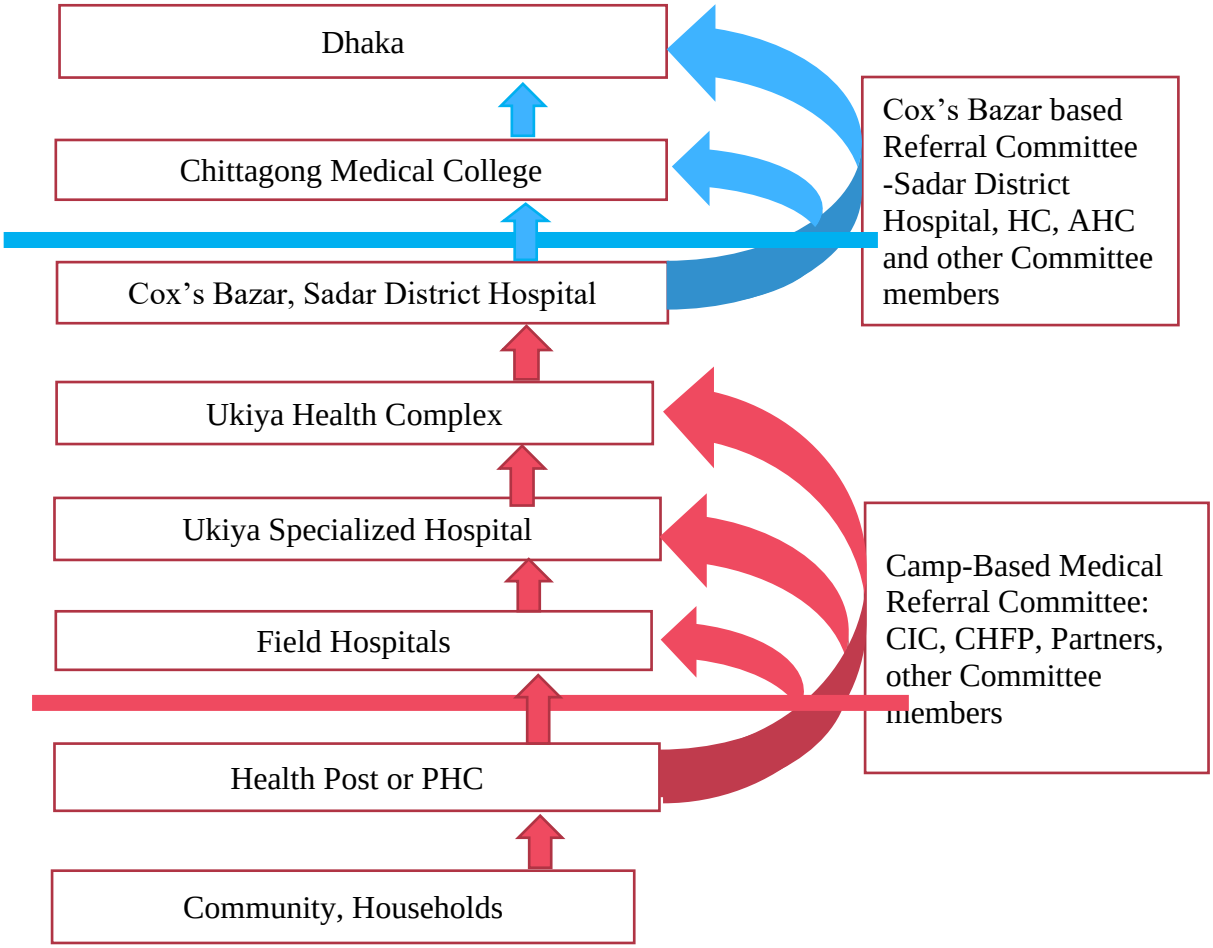
1. Identify the cases that could potentially benefit from Medical Referrals to higher centers
2. Assess the cases clinically and with necessary investigations
3. Formulate the case file for each case including the clinical condition, investigation, proposed treatments, and the tentative costs
4. Receive files of new cases, number sequentially and ensure that all parts of the Patient Evaluation Sheet are filled, supporting documentation is complete, including necessary identification documents
5. Present to the referral committee the case files and present the cases following the general clinical guidelines of medical history presentation with investigations, prognosis, and the proposed treatment
6. Arrange the necessary documents for the referral and take necessary camp exit permits
7. Refrain from assuring any refugee/FDMN patient in the camp for medical referrals until the medical referral committee take the decision on referral
8. Follow-up on the progress of agreed-upon actions or interventions during committee meetings:
    a. Send authorized referral cases (including stamped standard referral forms, referral letters, medical reports, diagnostic reports, and patient and caretaker photos ID/FCN) via email to RHU Health Referral Coordinator for referral appointments with a copy to CIC/ACIC
    b. Follow-up with RHU regarding schedules of date of departure, progress/status of the referral, and date of return to the camp referring agency must inform CIC/ACIC
9. Maintain a confidential file with all minutes of meetings and supporting documentation at the camp level with regards to patients referred from their respective facility
10. No patient personal information that has been provided for use by the committee shall be transmitted to other parties outside the committee unless expressly approved by the committee as relevant to the medical decision or care.
11. Sharing of feedback regarding the progress of referral cases to concerned beneficiaries and relatives.
12. Follow up with all patients who return from referral facilities in cooperation with RHU.
13. Carry out necessary counselling with patients who are not referred and provide them with alternate care available in the camps
14. Inform CIC on weekly progress/status updates of cases referred and dates of return to the camp with camp health agency coordinators/team leaders.
15. Ensure all cases are provided with necessary transportation and reasonable living allowances during transit to and from the camp.
16. Keep an updated database for all cases referred including costs incurred using the standard UNHCR referral database format.
17. Share the monthly referral statistics with Health Sector for verification, and share with CIC

The CIC is responsible for the following:

1. Ensure availability to discuss elective referrals on a weekly basis
2. Participate in the quarterly referral review workshop

3. Review referral performance at the camp level with the CHFPs
4. Support movement permits from Cox's Bazar onwards and referral appointments with referral facilities.

Role of CIC in Referral pathway for Elective Case



List of selected Emergency Referral Services.

Injury and Illness

- Hypothermia or frostbite
- Intestinal obstruction
- Pancreatitis
- Peritonitis
- Poisoning
- Food poisoning
- Venomous animal bite
- Ruptured spleen
- Septic arthritis
- Septicaemia blood infection
- Severe burn (including scalding and chemical burns)
- Spreading wound infection

Injury and Illness…

- Abdominal pain, severe
- Appendicitis (leading to peritonitis)
- Bone fracture, compound
- Chest pain, acute
- Cholecystitis
- Drug overdose or withdrawal
- Ear injury
- Electric shock
- Gangrene
- Head trauma
- Hyperthermia (heat stroke or sunstroke)
- Malignant hyperthermia

Metabolic

- Acute renal failure
- Addisonian crisis (seen in those with Addison's disease)
- Severe Dehydration
- Diabetic coma: Diabetic ketoacidosis, Hypoglycaemic coma
- Electrolyte disturbance, severe (along with dehydration, possible with severe diarrhoea or vomiting, chronic laxative abuse, and severe burns)
- Hepatic encephalopathy
- Lactic acidosis
- Malnutrition and starvation (as in extreme anorexia and bulimia)
- Thyroid storm

Respiratory

- Agonal breathing
- Asphyxia
- Angioedema
- Choking
- Drowning
- Smoke inhalation
- Asthma, acute/Acute exacerbation of COPD
- Epiglottitis or severe croup
- Pneumothorax
- Pulmonary embolism
- Respiratory failure

Ophthalmological

- Acute angle-closure glaucoma
- Orbital perforation or penetration
- Retinal detachment

Urological, andrological, gynecologic, and obstetric

- Eclampsia
- Pre-eclampsia
- Ectopic pregnancy
- Gynecologic hemorrhage
- Obstetrical hemorrhage
- Paraphimosis
- Priapism
- Sexual assault (rape)
- Testicular torsion

Shock

- Due to any cause

Cardiac and Circulatory

- Air embolism
- Aortic aneurysm (ruptured)
- Aortic dissection
- Bleeding: Haemorrhage, Hypovolemia, Internal bleeding
- Cardiac arrest
- Cardiac arrhythmia
- Cardiac tamponade
- Hypertensive Crisis
- Myocardial infarction (heart attack)
- Subarachnoid haemorrhage

Neurological and psychiatric

- Attempted suicide, non-fatal
- Cerebrovascular accident (stroke)
- Convulsion or seizure
- Meningitis
- Psychotic episode
- Suicidal ideation
- Syncope (fainting)

Diagnostic Indications

- Renal Function, Liver Function Test
- Imaging e.g., CT Scan, X-ray

Note, that the list of possible emergency conditions is not exclusive. Further, information must be discussed with the attending physician.