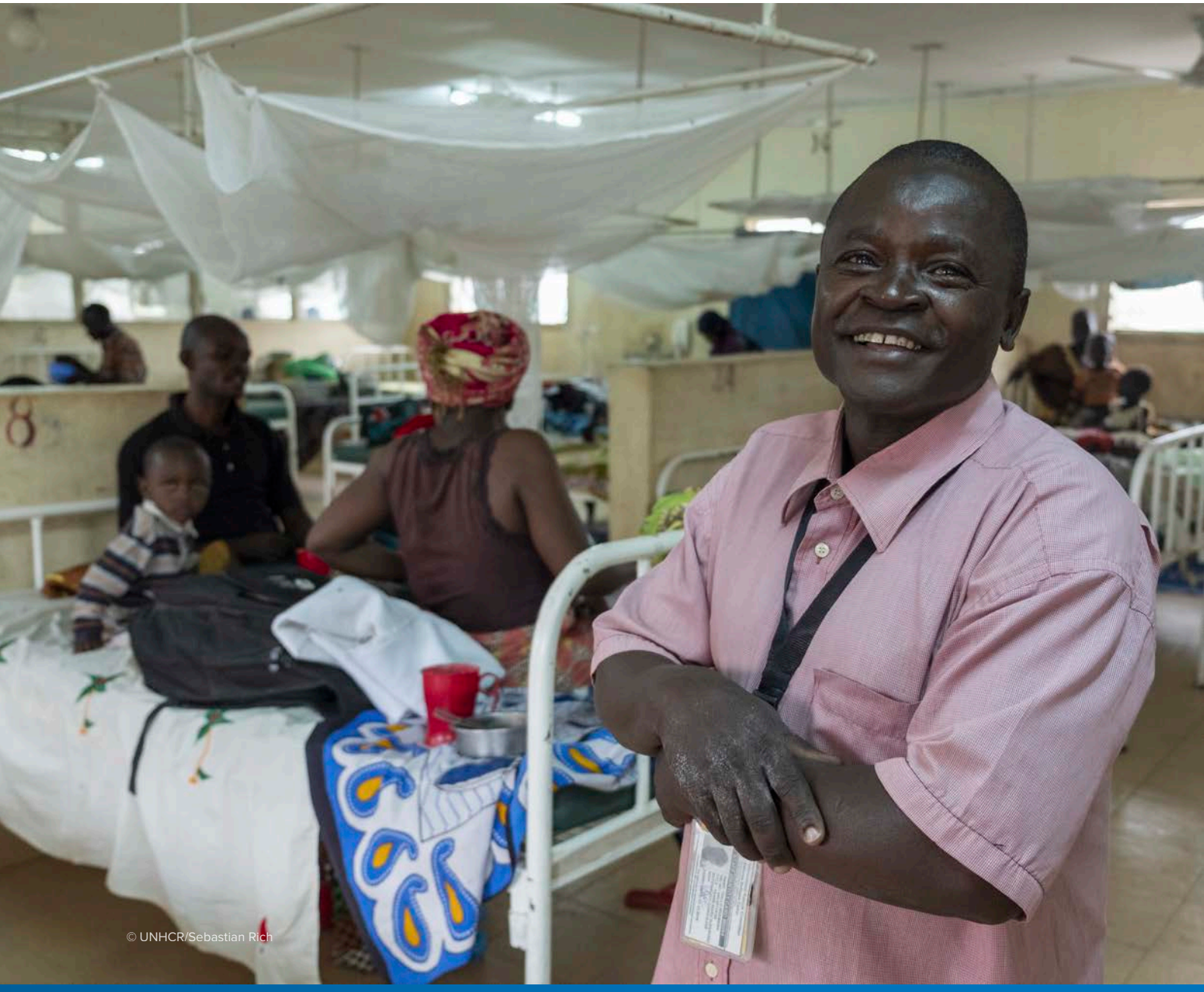
UNHCR
The UN Refugee Agency



Guidelines for
REFERRAL HEALTH CARE IN UNHCR COUNTRY OPERATIONS

October 2022

Public Health Section, Division of Resilience and Solutions

CONTENTS

List of Acronyms

CBI	*Cash Based Intervention*
ECC	*Exceptional Care Committee*
M&E	*Monitoring and Evaluation*
MRC	*Medical Referral Committee*
MRD	*Medical Referral Database*
NCD	*Noncommunicable Diseases*
NGO	*Non-Governmental Organization*
PHC	*Primary Health Care*
RCC	*Referral Care Committee*
SOP	*Standard Operating Procedure*
TPA	*Third Party Administrator*
UHC	*Universal Health Coverage*
UNHCR	*United Nations High Commissioner for Refugees*

1 INTRODUCTION

These guidelines provide United Nations High Commissioner for Refugees' personnel and partners with updated, specific, and practical principles and guidance on how to plan and implement a country level referral health care programme for refugees and other forcibly displaces persons.

These guidelines should be read in conjunction with the UNHCR Administrative Instruction on Public Health Programming.

UNHCR's public health programmes are based on the primary health care approach[1] and must be developed in line with universal health coverage (UHC) and other targets of Sustainable Development Goal 3.

Medical referrals to secondary or tertiary level facilities may be supported by UNHCR if other options are not available and accessible. The management of access to secondary and tertiary health care depends on the context, costs, and budgets available.

2 CHALLENGES AND LESSONS LEARNED

There may be several challenges in ensuring access to referral care.

These commonly include:

- Host Governments may grant refugees and asylum-seekers access to national systems for referral health care but this may not be on par with nationals and sometimes foreigners will be charged with higher user fees. In many countries, user fees are in place and cost will be a barrier to nationals as well as refugees. Refugees may be disproportionately affected where they do not have the right to work and / or access to the labour market is restricted.
- The Primary Health Care approach is prioritized in UNHCR's public health programming. Funds available to be allocated for referral care are usually lower than the need and prioritization is necessary.
- There is a range of health systems and services available across refugee hosting countries from very basic to very sophisticated and expensive systems. As health systems evolve, refugees are increasingly hosted in countries with availability of relatively sophisticated but costly medical services such as neonatal intensive care, renal dialysis and advanced cancer care.

1. A primary health care approach includes three components: meeting people's health needs throughout their lives; addressing the broader determinants of health through multisectoral policy and action; and empowering individuals, families and communities to take charge of their own health. See https://www.who.int/health-topics/primary-health-care#tab=tab_1.

- Changing disease patterns globally and ageing populations presents an increasing burden of Noncommunicable Diseases, cancer care among other referral health care needs.
- Geographical barriers exist where referral care may be in health facilities away from peripheral refugee settlements, thus posing logistic and additional financial constraints.
- Health facilities may need to adapt to language, cultural and specific vulnerabilities and protection needs of refugees.

Good practices and lessons learned

Through decades of implementing referral care programmes globally, a number of lessons have been learned and good practices implemented:

- The development of clear **country specific standard operating procedures (SOPs**) in large and/or complex referral care programmes will set out referral criteria and facilitate transparent decision making.
- **A Referral Care Committee (RCC)/Exceptional Care Committee (ECC)/Medical Referral Committee (MRC)** for large and/or complex referral care programmes is an effective mechanism to facilitate medical decision making for complex and expensive referrals balancing the prognosis with the cost and service availability.
- **Setting of financial ceilings** in SOPs can help in managing referral expenditures for costly cases. Requests to exceed the ceiling can be considered by the RCC/ECC.
- **Quality data collection** through a medical referral database to track referrals, trends and costs allows close monitoring and informed decision making on referral programmes.
- Use of regular **visiting specialists** for diagnosing, treatment and follow up of specific health conditions can reduce the need for referral. Also, the use of community-based support networks can also assist in supporting specific support and follow up including for NCDs, mental health and disability.
- **Establishing networks with other providers** e.g., NGO/philanthropic surgical teams repairing cleft lip/palate, orthopedic deformities can facilitate access. They should work within existing national regulatory frameworks and post- operative care and follow up when needed can be ensured.
- **Cash assistance** to enable refugees to access services has been used for predictable health needs such as to cover delivery care.
- In some large operations, use of a **Third Party Administrator (TPA)**[2] to manage referrals and reimbursement of facilities on behalf of UNHCR can be a more efficient approach than using multiple NGO partners. However, UNHCR still has an overall monitoring role and managing the contract and performance of the TPA itself.
- Successful i**nclusion of refugees in functioning national social health protection/ universal health coverage** on par with nationals may also cover access to essential referral care.
- If social health protection relies on contributory schemes, enrollment of refugees in a functional national **social health insurance** scheme may enable access to a package of referral health care services. The challenge with contributory schemes is sustainability and self-reliance of refugees to meet ongoing contributions. Refer to UNHCR-ILO Handbook on social health protection for refugees.

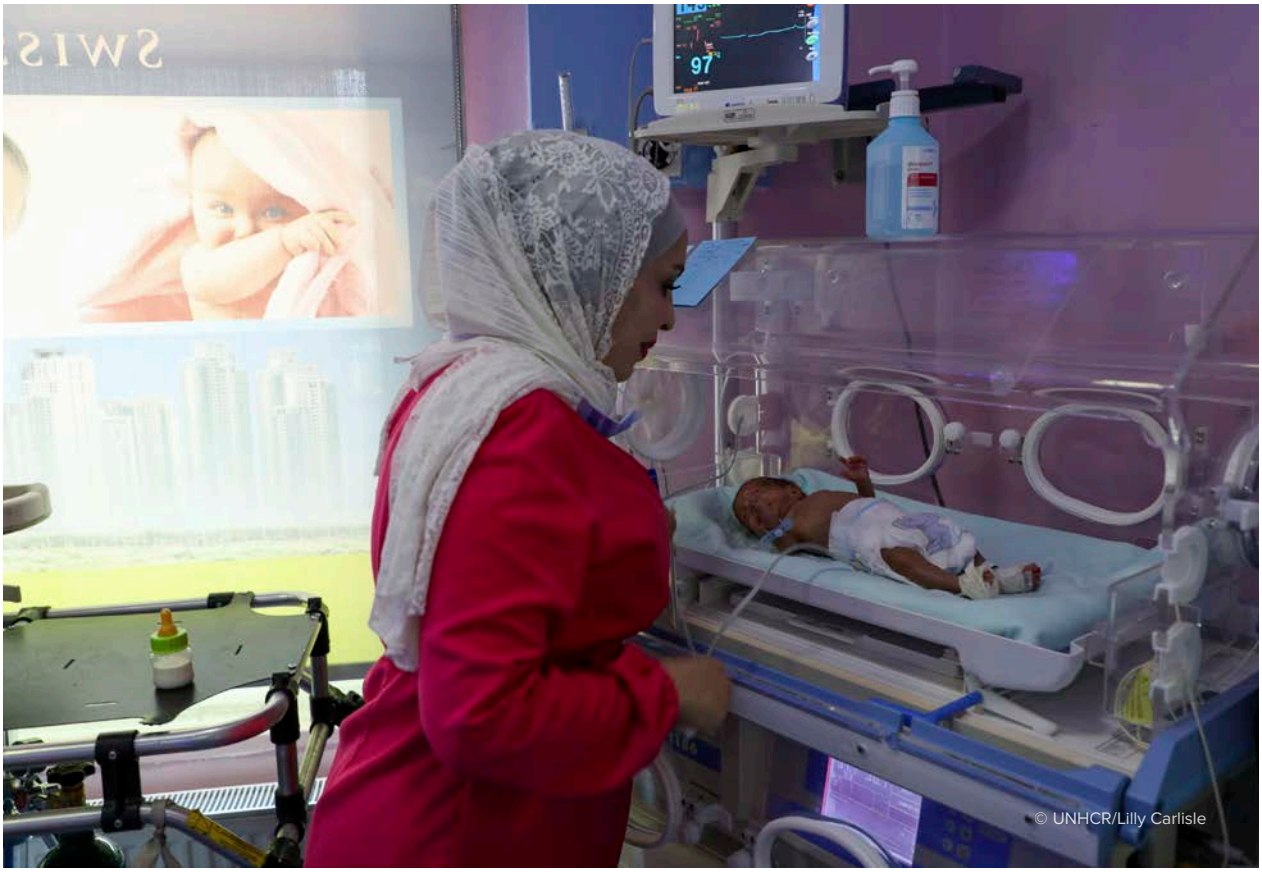
2. Third Party Administrator is a health care management entity, usually for profit, that can manage and monitor referrals on behalf of UNHCR , contract service providers and pay fees.

3 PRINCIPLES OF REFERRAL CARE

1. **A public health approach is required** providing the greatest amount of good for the greatest number of people for guiding the referral policy and procedures considering resources and budget are always limited.
2. **Primary Health Care (PHC) should be promoted as the entry point for all medical referrals** so that health care is delivered as close as possible to where people live. This includes mental health care, screening and early disease detection e.g for diabetes and hypertension and palliative care. Community health is an integral part of the PHC approach to improve disease control, treatment and reduce complications and referrals.
3. **The level of referral health care for refugees should be equitable to that of the host community.** If services are not free for refugees, referral costs may be supported by UNHCR according to country level standard operating procedures and taking into consideration how host nationals of similar socioeconomic status are supported to access referral care. Refugees should not be evacuated to a third country for treatment.
4. **Integrate with national services as much as possible.** Referral health care for refugees should be integrated in the systems of those for the host community as much as possible avoiding the use of parallel services. National/ governmental facilities should be used but in some contexts the use of private non-profit facilities may be considered due to lack of capacity to absorb refugees in national systems. The use of private facilities should remain exceptional.
5. **Referral is always a medical decision.** Referral care must be decided by a medical doctor, clinical officer or nurse according to SOPs.
6. **For all types of referrals, prognosis is the most important criteria followed by cost.** The prognosis determines the rationale to provide care. Prognosis must be assessed by a qualified medical doctor and comorbidities that affect prognosis need to be considered. Cost of treatment will also be considered as budgets are always limited. Long lasting and costly treatments (e.g., dialysis, some cancers) will require careful evaluation. Cases should not be referred for advanced care if survival or recovery is unlikely (e.g., cases of advanced renal failure, advanced cancers). Such cases should continue to receive medical treatment, including palliative care when appropriate and available locally. In operations where decisions on referral cases and their management become complex, costly or controversial, it is recommended to create a referral committee that will assess individual cases and make an objective decision about the referral based primarily on prognosis and cost.
7. **Ensure transparency of referral policies and procedures.** Partners and refugees should be clearly informed about the policy and procedures for health referrals including the limits of health assistance provided. A communication strategy that includes PoCs needs to be developed, implemented and disseminated in relevant languages.
8. **All referrals require informed consent and must remain confidential with data protection ensured.** Informed consent for referral should be sought from the patient or responsible caretaker. Medical records should be securely stored in a proper medical file or electronic medical record. A data sharing agreement may be needed with any third party provider such as TPA. The respect of confidentiality of patients' medical files should be closely monitored by UNHCR's Public Health Officer or another officer designated by UNHCR. Care must be taken with respect to emails containing medical information linked to identifying details so that only those who need to know and are involved in referral management are copied.

4 GUIDANCE TO DEVELOP COUNTRY LEVEL STANDARD OPERATING PROCEDURES (SOPS) AND IMPLEMENT A REFERRAL CARE PROGRAMME

Country level Standard Operating Procedures (SOPs) that clearly describes the health care referral procedures should be developed for eligible countries. SOPs are recommended for all operations but are mandatory for all operations with a referral care budget above USD 250,000 per annum.



The following items should be included in the SOP:

1. *Hospitals selected for referral care*
2. *Types of referral care covered*
3. *Non-referrable medical conditions*
4. *Decision-making processes for referral care*
5. *Mechanisms for engaging other actors in referral care*
6. *Cost settlement*
7. *Monitoring*

The following steps should be followed to inform the development of the SOP:

Step 1:

CONDUCT A SITUATIONAL ANALYSIS

UNHCR country teams should conduct a situational analysis including assessing the national policy on health care access for refugees, the system available and barriers to accessing care for refugees. Key considerations for a situational analysis include:

General	Health Policy and System
• Operational context • Number and location of refugees • Burden of disease • Health seeking behaviors and preferences • Specific vulnerabilities or at risk groups	• National health policy includes refugees? • Policy does not include refugees explicitly but de facto inclusion? • Assessment of availability and capacity of national referral facilities, including mapping and proximity to refugee locations. • Financing systems e.g., UHC/ subsidies/ fee for service; what fees are paid by nationals and foreigners in the country. • What social health safety nets exist for nationals? • Are there medical facilities managed by non-state entities e.g., faith based facilities, NGOs that can provide access. • What is the availability of visiting specialists or philanthropic medical teams? • What are the access barriers (financial, administrative, geographic, language, gender, social barriers to access services). • Which logistic requirements for referrals from primary health care level, availability of ambulance services are required?

Step 2:

EXPLORE ALL REFERRAL HEALTH CARE MODALITIES

Country teams are encouraged to explore all possibilities of referrals across the public health system and other local channels including faith based organizations and visiting national and international teams. UNHCR must advocate for access to referral care services on par with nationals. Networking is essential to create linkages with other assistance possibilities.

Outside of the national system, complementary means to support access to referral care may include:

- 'Visiting specialists' through national or international charitable organizations can provide treatment and follow up for NCDs, mental health, disability, and some elective surgical interventions (such as cataract surgery, cleft palates/lips, club foot, obstetric fistulas, dentistry).
- Charitable organizations that may provide specialized services such as cardiac surgery for children or cancer care.
- International NGOs and organizations, such as faith based organizations providing hospital services.

Step 3:

DEFINE CLEAR TARGET GROUPS

In all situations, those supported by referral health care programs must be clearly defined. Typically, this will be refugees and in some instances asylum seekers recognized by UNHCR and stateless persons. This should be properly communicated to all respective parties including government, non-governmental organizations and civil society.

Step 4:

DEFINE MEDICAL ELIGIBILITY AND INELIGIBILITY FOR ASSISTANCE

There are two types of eligible referrals:

Emergencies (obstetrical, medical, and surgical)

Elective cases for complementary investigations and/or treatment

For both types of referrals, **prognosis** is the most important criteria. The prognosis is based on medical experience and knowledge available, the likely course of a medical condition and the likelihood of cure. Prognosis must be assessed by a qualified medical doctor. Concomitant illnesses that affect prognosis need to be considered. For the most part, cases presented for medical referral should be those where the life or basic functions of the person are at stake. It is preferable to initiate medical referral at the early stages of illness when the prognosis is likely to better.

Cost of treatment will be an important factor as budgets are finite. Chronic care (e.g., dialysis, thalassemia, multiple sclerosis, some cancers) will require re-evaluation of the case on a regular basis. Particular attention must be given to the follow-up management of emergency case that will require longer term health treatment.

For emergency and elective cases, it is advised that each country follows the guidance below and develops an agreed list of conditions to be supported (and those that cannot be supported) and identifies and approves a list of health facilities able to manage them.

See annex 2 for a sample of conditions eligible for support and those that are ineligible.

i Eligible cases

It is impossible to have an exhaustive list of conditions for referral but there are some broad principles established by UNHCR for considering medical eligibility for referral:

- In case of emergencies that are life-threatening with consideration of prognosis
- Conditions that can potentially lead to permanent impairment or disability
- Limb, hearing or sight saving interventions
- Acute complications of chronic diseases taking into consideration prognosis
- For cost effective elective surgical procedures
- Palliative care

ii Elective surgery

To facilitate the decision making around specific elective surgery cases, the Disease Control Priorities (DCP3) Essential Surgery volume[3] identifies 44 surgical procedures as essential as they address substantial needs, are cost-effective, and can feasibly be implemented. Essential surgical conditions are those that have a significant health burden and can successfully be treated by a surgical procedure and other surgical care that is cost effective and feasible to promote globally. Refer to annex 4 for the DCP3 table of essential surgical procedures.

iii Palliative care

Palliative care should be accessible when needed for end-of-life care. Ideally palliative care should be home-based or available at primary care level but admission to hospital may be required for severe pain control, for example. A distinction should be made between palliative care and life-prolonging treatment for conditions with poor prognosis.

iv People living with disability, assistive devices, physiotherapy, occupational therapy

Country operations should ensure a coordinated response between the Protection and the Health to address needs for persons with disability or others in need of rehabilitative care and assistive technology. They should identify needs and the main actors providing assistance (e.g., the family itself, the national health and social safety net systems, NGO's, disability associations, or faith based or philanthropic associations). Refer to UNHCR need to know guidance on facilitating access to assistive technology, rehabilitation and related services (forthcoming 2023).

v Special consideration: resettlement to a third country on medical grounds

Whilst places for resettlement are very limited, in case a person's medical needs cannot be addressed within the country, the case should be flagged by UNHCR public health teams (or via the ECC/RCC/MRC) to the UNHCR Resettlement Unit. Given the limited number of places, it is important that cases are prioritized according to need.

3. https://dcp-3.org/.

To accurately assess the patient's diagnosis and prognosis, a specialist independent medical assessment is required to be filled out in a Medical Assessment Form (MAF). See UNHCR guidance on Medical Assessment Forms.

Mechanisms between protection, community services, and health units should be established to formalize the request for and processing of information. A separate UNHCR budget and procedures related to medical assessments for resettlement should be allocated under protection and should not come from the already limited referral care budgets. Commonly UNHCR protection units have an agreement with IOM for processing of MAFs.

To determine whether resettlement on medical grounds is the appropriate solution for the refugee, the following conditions must be met:

Diagnosis:
- The condition is life-threatening without proper treatment, OR
- There is a risk of irreversible loss of functions without proper treatment, OR
- The particular situation/environment in the country of asylum is the reason for or significantly worsens the health condition or is a protection risk.

Treatment:
- Adequate treatment is not available (e.g., lack of medical facilities or expertise) or is inaccessible (e.g., restrictions or lack of funds) in the country of asylum.

Prognosis:
- The health condition presents a significant obstacle to leading a normal life and achieving self-sufficiency, and puts the individual and/or dependent family member(s) at heightened risk in the country, OR
- In the case of a disability, the situation in the country prevents the individual from becoming well-adjusted and from functioning at a satisfactory level, OR
- The particular situation/environment in the country of asylum significantly worsens the health condition and/or disability; AND
- There is a favorable prognosis that treatment and/or residency in the country of resettlement would successfully address the health problem and, if possible, given the expected state of health after treatment/relocation, enable the individual to gain partial or total independence.

Informed consent:
- It is the expressed wish of the individual, after having been counselled, in particular with regard to prospects for treatment of the medical condition or disability as well as the social, cultural, and psychological adaptation required in a new community.

vi Ineligibility: cases not supported by UNHCR

As mentioned, cases should not be referred for treatment if the health of the patient has reached such an advanced stage of deterioration that survival or recovery is unlikely. Referral should not be supported for purely cosmetic reasons.

In case of non-eligibility, complete information must be given to the patient, family and caregiver and all alternative options must be discussed with them such as palliative care where needed.

Step 5:

SET UP THE REFERRAL CARE COMMITTEE/EXCEPTIONAL CARE COMMITTEE/MEDICAL REFERRAL COMMITTEE

For country operations with large and complex referral care programmes with an annual expenditure over USD 500,000, it is mandatory to establish a Referral Care Committee (RCC) or Exceptional Care Committee (ECC) or Medical Referral Committee (MRC) to facilitate decision making for complex, costly or controversial referral cases. These terms are used interchangeably in country operations. See Annex 1 for a sample Terms of Reference to be adapted according to context. A committee may be recommended for operations with lower expenditures as directed by the relevant regional bureau. The RCC/ECC/MRC adds value to objective decision-making through primarily assessing prognosis, availability of care and cost.

The composition of the committee depends upon the country context. Ideally two to three health professionals are recommended who know the health services in the country and who have knowledge of evidence-based practices. Ideally, health care professionals that have direct contact with refugees should not be part of the committee. It is recommended that the names of the members remain confidential to avoid any undue pressure or influence. UNHCR's participation (by health personnel) will ensure that the committee's decisions fit with referral health care principles, standard operating procedures and budget.

All data and decisions must be documented. The committee may also be able to identify cases that may be appropriate for consideration for medical resettlement to a third country.

The Regional Senior Public Health Officer can be consulted by the committee in exceptionally complex cases or for a second opinion or be part of a country/regional committee where countries may have no health staff and support is needed for decision making.

Step 6:

EXPLORE ALL FINANCING OPTIONS

Country teams must evaluate the financing options for referral care if these are not free of charge. Table 1 provides various financing options and one or a combination of different options may be applicable depending on the context.

Table 1: Financing options for referrals

Financing Options for Referrals	
1.	The preferred option is to refer to the public health system and ensure that refugees access on similar conditions as the host community. Ideally this may be free health care or subsidized but, a system of partial or total cost recovery may be in place that results in a high out of pocket expense burden on refugees.
2.	UNHCR may pay fee for service to providers through a partner managing referrals when costs cannot be met by refugees.
3.	In some contexts, UNHCR may pay fee for service to providers through contracting a third-party administrator (TPA) in which a specific set of referral centers and services have been pre-identified.
4.	Multi donor trust funds may be an option to explore depending on context where several donors contribute to a fund to support the government to enable access to referral care for refugees.
5.	If a national health insurance scheme (including community based health insurance) is in place for nationals that supports access to referral care, explore options for enrolment of refugees. Refer to Document - Handbook on social health protection for refugees: Approaches, lessons learned and practical tools to assess coverage options (unhcr.org).
6.	Cash-Based Interventions (CBI) may be a suitable option for a variety of interventions and may be most useful in urban refugee settings.[4,5]
7.	In some contexts, UNHCR support to health system strengthening (e.g., provision of hospital equipment) may be used to negotiate free care for refugees as part of a MoU and benefits host community.
8.	While some referral costs can be covered by partners, predictability and sustainability can be challenging.
9.	Reimbursement of refugees for cost incurred after hospitalization is not a recommended modality.
10.	Refugees who wish or decide to purchase health care outside the health services identified by UNHCR are free to do so but at their own expense.

Due to limitations in funding, further measures to manage costs are required in addition to prioritization of cases to be supported as defined in the SOP. Such additional measures may include:

1. **Setting of financial ceilings:** defining a maximum amount of money that UNHCR can support for a defined condition. This can be used for very high cost admissions such as neonatal intensive care and is also a disincentive for hospitals to attempt to prolong stays for financial gain. This can present ethical dilemmas when the ceiling is reached. Exceptions to exceed the ceiling can be considered by the ECC when the prognosis is good.
2. **Fixed fees for services:** supporting a defined fixed amount of money to support for a particular condition such as normal delivery irrespective of the facility.
3. **Cost sharing:** UNHCR contributes a proportion of the cost, and the refugee pays the remainder. Further targeting can be made according to the socioeconomic vulnerability of the person.

4. The Role of Cash Assistance in Financing Access to Health Care in Refugee Settings and for other People of Concern to UNHCR accessible on https://www.unhcr.org/5fc0b3fb4.pdf.
5. Good practices on cash based interventions and health, UNHCR 2022. https://www.unhcr.org/protection/operations/631856644/good-practices-cash-based-interventions-health.html.

Step 7:

DEVELOP APPROPRIATE AGREEMENTS WITH PARTNERS AND SERVICE PROVIDERS

i Referral partner

Commonly UNHCR will engage with a partner to manage the referrals from primary to higher level. Typically, this will be through an NGO partner who is providing primary care and part of the partnership agreement (PA) will include responsibility for referrals. In some cases, the partner implementing primary care and referrals may be the Ministry of Health. A single or limited number of referral partners present many advantages to UNHCR in terms of establishing agreements, securing protection and confidentiality, monitoring the quality of care, and adapting to the various cultural and language differences. It also helps to negotiate, rationalize, and monitor the costs.

ii Referral care services provider

Written agreements with hospital care service providers are necessary to clarify expectations, services that will be covered, ensure quality of care, and define types and guarantee of payments. It is an important document to monitor the roles and responsibilities of all stakeholders: partners, service providers and UNHCR. An agreement should describe all referral procedures such as documentation, forms, official signatories, transportation modalities, medical file management, reporting, and payments. It should also record the approved cost of hospitalization, cost of investigations and cost of treatment(s) based on official country level health sector documentation.

Memoranda of Understanding and contracts with hospitals are recommended. A Memorandum of Understanding is a simple agreement with a hospital, or with the Ministry of Health, that UNHCR and/or partners may support in terms of medical supplies, or equipment in exchange for hospital care provided. It is a less legally binding commitment compared with a contract. UNHCR may have broader MoUs with Ministries of Health in which referral care is included as one component. Contracts are more detailed and legally binding agreements that are requested when payment for hospital care is needed. **A contract needs to include at least the information listed below:**

Introduction:
- Background

Description of services required:
- Definition of beneficiaries
- Type of services required
- Cost of services required

Obligations of service provider (hospital):
- Reception of beneficiaries and provision of services required
- Quality of services provided
- Confidentiality/protection of beneficiaries' personal information (considering national law)
- Data and reporting

Obligations of UNHCR partner:

- Notification of arrival of patient
- Transport modalities
- Payment for services provided
- Monitoring

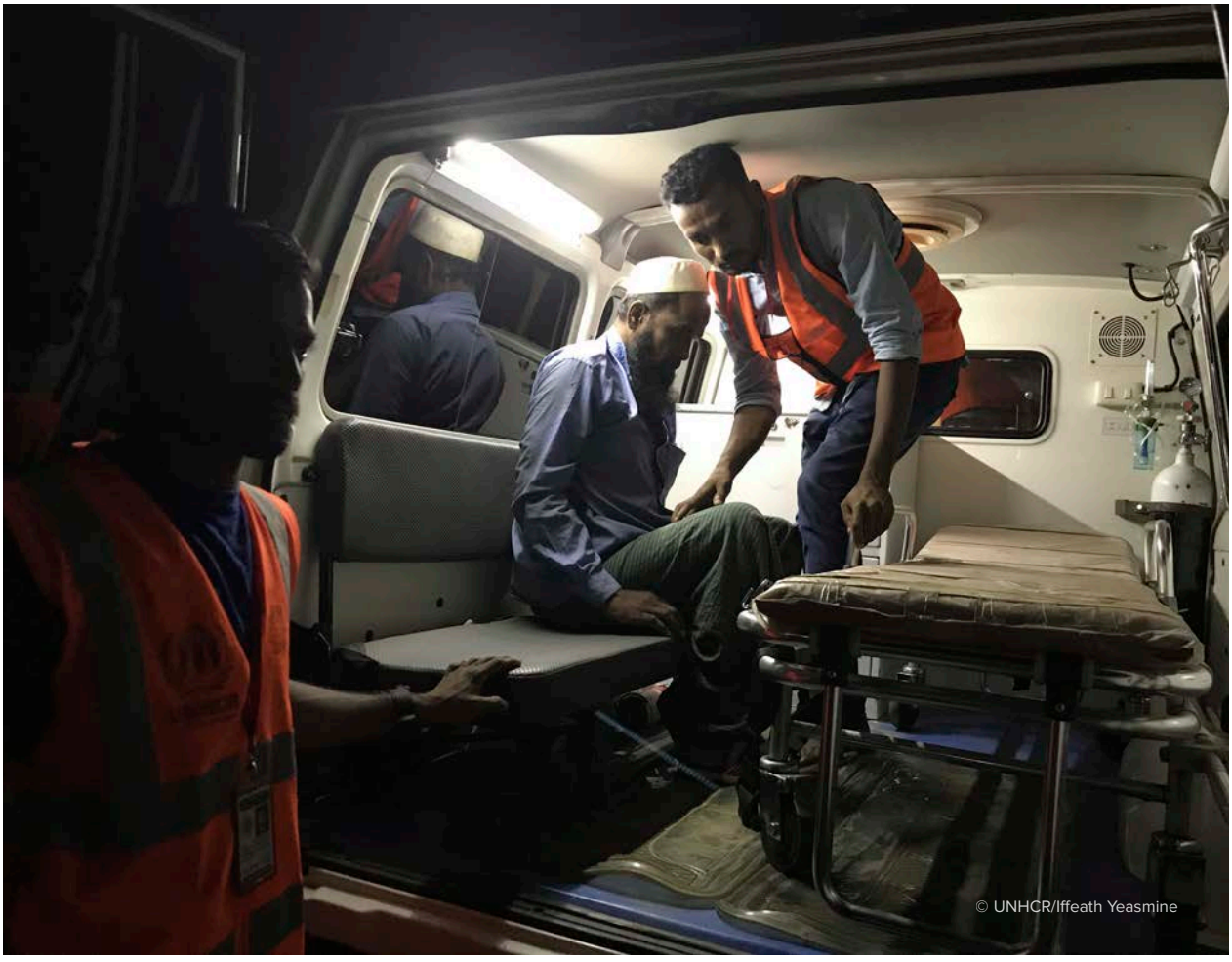
Penalties if obligations not respected:

Time of validity:

Signatures:

The agreement should be established between UNHCR's partner(s) and the referral facility. UNHCR may sign as a witness with possible quality and performance monitoring co-authority along with other involved government bodies.

Referrals will be preferably to public hospitals although private hospitals may be considered exceptionally according to context and cost effectiveness. In general, UNHCR and partners should negotiate with the hospital or Ministry of Health to provide the same rates as those given to the most vulnerable populations in the hospital's catchment area. All costs of services including ancillary costs should be negotiated for beneficial rates. Special higher fees for foreigners should not be accepted.



Step 8:

COMMUNICATING WITH REFUGEES

It is important that refugees are aware of support available for referral health care. Other key stakeholders must be informed such as Ministries of Health and NGO partners. In camps, dissemination of information is generally easy through existing channels but can be more difficult in urban areas. Regardless of this, it is important to provide information on rights regarding referral care and what to do in an emergency, where to seek care, what is supported and what is not, when to contact UNHCR and how to raise complaints. This information can be provided through contacts with refugees at registration and community centers and also using channels set up to communicate with refugees such as hotlines, UNHCR help.unhcr.org website, social media channels, communication trees and outreach volunteers. It is important to establish a complaints and feedback mechanism and a clear channel via which persons can make complaints that are assessed and responded to.

Step 9:

MONITORING

Monitoring of referrals is important to ensure proper follow-up of referred patients, monitor the quality of referral care and outcomes as well as the efficient management of resources.

The use of the online UNHCR Medical Referral Database (MRD) is mandatory in operations with an annual budget above USD 250,000 and recommended in operations where UNHCR is financially supporting referral care.

The UNHCR Medical Referral Database (MRD)

This tool supports the monitoring of the referral care programmes by partners. The system captures the reason for referral, the treatment provided, the outcome and costs. An online version of the database is available for countries to use and has the advantage of automated data analysis.

Table 2: Recommended minimum monitoring indicators

	Indicators	Data Source	Period
Financial	• Expenditure on referral care	Compass and the UNHCR medical referral database	Bi Annual/Annual
Health Coverage	• Number of referrals made disaggregated by AGD and referral facility • Top 10 reasons for referral (morbidity)	UNHCR medical referral database or equivalent	Monthly/Annual
Health Outcomes	• Referral outcome (cured, died, defaulted)	UNHCR medical referral database or equivalent	Monthly/Annual

Monitoring should also include feedback from refugees themselves. This can be done through several means such as exit interviews of people after treatment, participatory assessments and through feedback received through complaints and feedback mechanisms.

i Referral care programme review

Country offices should review the programme as part of its annual review and actively use the available monitoring data. Country SOPs (where applicable) should be reviewed every two years (or sooner if there are changes to the programme) and updated if required.

ANNEXES:

Annex 1 - Key definitions

Universal Health Coverage:
Universal health coverage (UHC) means that all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care (WHO, 2022).

Primary Health Care:
The World Health Organization (WHO) defines Primary Health Care (PHC) as a "*whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment*" (WHO, 2022).

Referral Health Care:
Referral is a dynamic process in which health care providers at one level of the health system, having insufficient resources (medicines, equipment, skills) to manage a given clinical condition, seek the assistance of a better resourced facility or provider to guide them in managing or to take over the management of a patient. Health care systems of most countries are designed in such a way to encourage people to first seek care at the primary level and then to approach a higher level of care according to the need.

Secondary Health Care:
Secondary health care is an intermediate level of health care that provides general medicine, general surgery, diagnostic radiology, basic anesthetics, general orthopedic surgery, obstetrics-gynecology, pediatrics, mental health, and rehabilitation having specialized personnel, equipment, laboratory facilities and inpatient bed facilities (Hensher, Price, & Adomakoh, 2006).

Tertiary Health Care:
Tertiary referral health care provides highly specialized staff and technical equipment—for example, surgical subspecialties, internal medicine, cardiology, neonatology, pediatric surgery, intensive care, ophthalmology, subspecialty orthopedics, and specialized imaging units; could be linked with a university and have teaching activities. (Hensher, Price, & Adomakoh, 2006).

Rehabilitative Care:
Rehabilitation is an essential health service and crucial for achieving universal health coverage. It is defined as a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment (WHO, 2022). The WHO recently launched the 'Rehabilitation 2030 Call for Action' to encourage steps towards the goal of strengthening rehabilitation within the health system and in particular within primary health care.

Palliative Care:
Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual (WHO).

Annex 2 - Sample terms of reference of the Referral Care Committee (RCC)/ Exceptional Care Committee (ECC)/Medical Referral Committee (MRC)

These terms of reference are to be adapted according to country context

Objective: To ensure fair, equal, and cost-effective treatment of patients requiring referral care.

Rules and Procedures: The Committee is guided by the country standard operating procedures for referral care.

Membership: The Committee should be comprised of a minimum of two to three health professionals. Members should understand the country health system and evidence-based practice:

- Chair (i.e., UNHCR Public Health Staff)
- Two members – ideally two independent external doctors
- One Secretary

Technical experts or other resource persons can be invited upon request to clarify and explain specific issues. The names of the committee members shall only be known to the Representative of UNHCR to avoid undue pressure. Camp level health partners involved in the case can be invited to the meetings to present the case but will not have a decision-making role.

Tenure of the Committee: The Committee shall be established for a period of 12 months and can be extended.

Frequency of Meetings: To be agreed by the committee based on the number of cases that require a decision.

The Core Roles of the Committee Include:

- Ensuring a fair process by reviewing exceptional cases (high cost or elective or other cases not clearly falling within SOPs) and informed decision making on support.
- Review progress of previously submitted cases and take appropriate action when required (e.g., continuation or discontinuation of the treatment).

Decision-making Criteria: The members and chair have decision making authority. The committee will review each case based on the following criteria:

- Necessity, adequacy, and duration of the suggested treatment
- Feasibility of the treatment plan
- Prognosis
- Cost
- Concomitant diseases/ comorbidities that may influence prognosis
- Experience with past cases in the suggested health care facilities

The Role of the Secretary under Guidance of the Chair:

- Receive new cases and all required supporting documentation, number sequentially.
- Notify members of the meetings and circulate all submissions to be discussed during upcoming meeting with supporting documentation no less than 3 days before scheduled meeting.
- Take minutes during meetings and decisions and provide final minutes 2 days after meeting.
- Maintain confidential file with all minutes of meetings and supporting documentation.

Information Required for RCC/ECC Review:

- Patient file must be completed and include all appropriate diagnostic results, proposed treatment as well as prognosis and any comorbidities.
- A cost estimate from the referral facility for the proposed treatment.

Annex 3 - Example of medical inclusion/exclusion criteria- to be adapted according to each specific context

Below is an example of an UNHCR inclusion/exclusion list and serves as a guidance to inform country SOPs. This list is neither exhaustive nor exclusive.

Inclusion	Exclusion
1. Reproductive health: the conditions may include but are not limited to: • Normal delivery if cannot be done at primary care level • Suspected ectopic pregnancies • Septic abortion • Preeclampsia / Eclampsia • APH or risk of APH • PPH or risk of PPH • Cases with potentially need emergency caesarean sections (e.g., prolonged labor, evidence of fetal distress, maternal conditions that warrants an emergency caesarean section) 2 Acute life-threatening conditions due to trauma. The following are examples: • Severe head injury • Compound fracture that needs orthopedic surgical interventions • Rupture of abdominal viscera • Pneumothorax 3. Acute life-threatening conditions due to communicable or non- communicable diseases The following are examples: • Acute severe infections • Evidence of evolving stroke • Acute myocardial infection • Diabetic ketoacidosis 4. Acute life-threatening surgical conditions such as: • Suspected acute abdomen • Incarcerated hernia • Acute cholecystitis • Septic arthritis	**In general, cases should not be referred if:** 1. The health of the patient has reached such an advanced stage of deterioration that survival and / or recovery is doubtful. For example: • Advanced renal failure • Advanced chronic liver diseases • Malignant cancers with metastases • Terminal diseases • Brain death • Advanced neuro degenerative disorders etc. 2. Health conditions requiring sophisticated and expensive surgery including organ transplantation, which is exceeding what is normally available to nationals in the government hospitals. 3. Conditions requiring aesthetic or cosmetic plastic surgery, for example major skeletal reconstruction surgery 4. The condition was treated correctly but was unsuccessful over an extended period such as corrected surgical cases with failed results. 5. Irreversible neurological damage and disabilities (i.e., hearing loss, incurable blindness) for which rehabilitative service is locally available or which cannot further benefit from any form of treatment. 6. Loss of limb, where the patient is now healed and adjusted to the disability, healed and inactive lesions resulting from past illnesses or injuries such as an asymptomatic bullet in the body. 7. Dental care: dental prostheses, filling other than cement, scaling.

Annex 4 - Essential surgical package: procedures and platforms (Essential Surgery | DCP3 (dcp-3.org))

Procedures in **red text** are for an emergency procedure whilst those in black text are elective.

Type of Procedure	Platform for Delivery of Procedure		
	Community facility and primary health center	First-level hospital	Second- and third-level hospitals
Dental Procedures	1. Extraction		
	2. Drainage of dental abscess		
	3. Treatment for cariesd		
Obstetric, Gynecologic, and Family Planning	4. Normal delivery	1. Cesarean birth	1. Repair obstetric fistula
		2. Vacuum extraction/forceps delivery	
		3. Ectopic pregnancy	
		4. Manual vacuum aspiration and dilation and curettage	
		5. Tubal ligation	
		6. Vasectomy	
		7. Hysterectomy for uterine rupture or intractable postpartum hemorrhage	
		8. Visual inspection with acetic acid and cryotherapy for precancerous cervical lesions	
General Surgical	5. Drainage of superficial abscess	9. Repair of perforations: for example, perforated peptic ulcer, typhoid ileal perforation	
	6. Male circumcision	10. Appendectomy	
		11. Bowel obstruction	
		12. Colostomy	
		13. Gallbladder disease, including emergency surgery	
		14. Hernia, including incarceration	
		15. Hydrocelectomy	
		16. Relief of urinary obstruction: catheterization or suprapubic cystostomy	
Injury	7. Resuscitation with basic life support measures	17. Resuscitation with advanced life support measures, including surgical airway	
	8. Suturing laceration	18. Tube thoracostomy (chest drain)	
	9. Management of non-displaced fractures	19. Trauma laparotomy	

Type of Procedure	Platform for Delivery of Procedure		
	Community facility and primary health center	First-level hospital	Second- and third-level hospitals
		20. Fracture reduction	
		21. Irrigation and debridement of open fractures	
		22. Placement of external fixator; use of traction	
		23. Escharotomy/fasciotomy (cutting of constricting tissue to relieve pressure from swelling)	
		24. Trauma-related amputations	
		25. Skin grafting	
		26. Burr hole	
Congenital			2. Repair of cleft lip and palate
			3. Repair of club foot
			4. Shunt for hydrocephalus
			5. Repair of anorectal malformations and Hirschsprung's Disease
Visual Impairment			6. Cataract extraction and insertion of intraocular lens
			7. Eyelid surgery for trachoma
Nontrauma Orthopedic		27. Drainage of septic arthritis	
		28. Debridement of osteomyelitis	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