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3MDG

IMPLEMENTING PARTNERS' WORKING GUIDELINES FOR SUPPORT TO EMERGENCY REFERRALS

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SECTION 1: INTRODUCTION AND OBJECTIVE

INTRODUCTION

"Emergency Referral" is the term used to define a patient who has a severe life threatening illness, or is suspected to have a life threatening illness, that needs both diagnosis and treatment by a skilled health professional. The Emergency Referral pathway is the method by which a patient is transferred from the community level to an appropriate point of secondary care that is capable of treating most life threatening emergencies, including obstetric emergencies. This is usually the Township (District) Hospital and may be a Station Hospital. The principle of this pathway is to ensure that all possible barriers are removed from the timely referral of a suspected medical emergency, with the goal of improving survival rates, as well as prevent potential complications.

An effective health programme should promote both awareness and knowledge of the importance of timely referrals within the community for such cases as complications in pregnancy, delivery and in postpartum mothers, severely ill children under 5 years of age and other life threatening illnesses including severe malaria. This active promotion means that the project teams supervising a community based health programme should work with a defined Behavioural Change communication (BCC) strategy with the use of appropriate Information, Education and Communication (IEC) materials.

Early diagnosis and prompt treatment not only saves lives but also reduces the catastrophic financial and health impact on vulnerable communities that serious illness can have. In the "three delays" model, Thaddeus & Maine conceptualize the barriers to achieving appropriate obstetric care as a series of delays, described below. While the model refers specifically to maternal health, the concept may be applied to child health and other emergency situations. The first delay pertains to recognition and willingness to seek help. There is a necessary amount of work to be done at community level to raise awareness about danger signs amongst pregnant women, mothers and fathers, and also raise awareness of support for referral of emergency cases. The second delay is the inability to access care because of a lack of transport, bad roads, poor community support and/or the cost of transport. Recognising that one of the the principle barriers to accessing health facilities in an emergency is the cost of transportation from the community to the point of referral, providing that transportation cost is critical to the success of a community based health programme. The third delay is incurred at the health facility, due to inadequate staffing, absent staff, staff attitude, poor health infrastructure, inadequate equipment and supplies, etc. The costs incurred at the point of referral are also a barrier to accessing emergency care and are grouped into the following categories, for ease: meals (including caretaker); treatment and drugs; laboratory and investigations; and finally administration fees.

Providing financial support for patients needing to access emergency care is essential in particular for the most vulnerable members of a community and communities that are defined as hard-to-reach.
Every Township should have a mapped referral pathway for the areas/villages in their area, addressing the following:

1. Names of the nearest secondary facility with Comprehensive Emergency Obstetric Care services to a particular village/area
2. The name and telephone of the BHS responsible for referral from that area
3. The name and number of the Village Health Committee (VHC) chairman
4. The nearest tertiary hospital from the secondary hospital

The communities or at least the BHS and the VHC chairperson should have:

1. The contact number and name of the referral hospital appropriate for that locality
2. A communication strategy to inform communities of emergency services' location and that maternal and child emergencies are free of charge
3. The contact number of any organization that supports referrals

Implementing partners (IPs) should try if possible to work with the Township Medical Officers (TMOs) to ensure the following:

1. That the costs charged in facilities for emergencies are standardized and displayed in all facilities. These include:
   - Radiology costs
   - Laboratory costs (costs have been standardized by MoH in 2009)
   - Ultrasound (a standard cost needs to be agreed)
   - All maternal and child emergencies should be free
2. That facilities display the essential drugs lists to be provided free in facilities

All data collected through an emergency referral pathway belongs to the Township and should be made freely available to all relevant actors especially counterparts at Township and State/Regional level.

OBJECTIVES OF THE GUIDELINE

- To reduce maternal and child morbidity and mortality by promoting timely referral to the closest point of secondary care (usually a public sector hospital)
- To be used as a tool to raise awareness and to generate trust within the communities, such that there is an increased demand to seek the appropriate health care services
- Increase utilization of health services in nearest health centres and hospital by avoiding the three delays as highlighted in the MOH Guidelines and the MCH Handbook
- By instituting and enabling a referral pathway to exist, the Township health system will meet one of the essential elements of a primary health care system and provide critical support to the continuum of care
- To strengthen the capacity of civil society groups and community level bodies to not only facilitate referrals but to do so with full and active participation
- Coordination with hospitals and THD to promote timely and appropriate handling of all referrals

SECTION 2: EMERGENCY REFERRAL PROCEDURE

<u>Who</u> should identify the emergency cases and be responsible for referral to the nearby hospital?

a. The Basic Health Staff of the health facilities
b. Volunteer Health Workers like Auxiliary Midwife (AMW), Community Health Worker (CHW)
c. Member of the Village Health Committee or Village Health Tract Committee, in the absence of the health worker
d. A senior person within the community and other appropriate informal service providers
e. Self referral (no forms available or no person available to support referral)

The last system is the exception rather than the rule; whilst not encouraging self referral, we must consider it as an option. Self-referrals will need approval on a case by case basis by Implementing Partner staff, who will need to seek and document an explanation as to why other referral approval was not available in that instance.

<u>Who</u> should refer from the secondary (Township and District) to the tertiary (State/Region) facility:

- The TMO
- Acting TMO
- Assistant Surgeon
- Non specialist clinicians - SMO, TMOs.
- Township Health Nurse or Senior Hospital Nurse in the absence of a medical officer

<u>How</u> should an emergency referral cases be referred?

The principle message at the start of the pathway has to be **IF IN DOUBT – REFER!**

While making a 'non' emergency referral may cost a health programme money, failing to make an emergency referral at time of need could cost that person his/her life. Furthermore, preventing a referral because it may not fit some criteria will have a major negative impact upon the community in terms of trust in the system. So communities, BHS and all relevant actors should ensure that the initial referral is made as easy as possible with the fewest obstacles.

Repayment of the transportation costs must have a paper trail and so the following forms and formats should accompany the patient in order for the transport cost to be paid:

1. **Referral Form (BHS)**
2. **Referral Form (CHW/AMW) can be used by a member of the VHC and a senior person within the community**

   If Referral form from VHWs or BHS is not available, approval will need to be sought from senior Agency staff and senior THD staff

The forms must also be signed by a village authority or member of the VHC or any government official living or working in the community, simply to identify that the patient has begun their referral from that specific community. They **DO NOT** have to be a resident as they may be a traveller or a relative visiting family, for example.

If possible, patients should carry with them relevant documentation such as MCH Handbook and/or child health card.

2.1 Referral Sites

Referral sites will be identified by the Township Medical Officer, Station Medical Officer and Basic Health Staff as required. The site must be able to offer **comprehensive emergency obstetric care and care for sick children** and is nearest to the area from which women and children will be referred. This also means that it is not necessary that the Township hospital that is responsible for that administrative area is the right place for referral; it must be the one that is closest to that area. Therefore patients can be referred to the hospital of another Township.

In addition, the referral site for tertiary care that is closest to the secondary facility will also be identified.

2.2 Referral Costs

Generally referral costs can be split into 5 broad cost categories, listed below, with the first 4, almost always eligible under donor regulations. It is important to note that since 2013 there has been a major push by the Ministry of Health for services, especially those for MNCH, which are free at the point of care.

1. Transportation Cost
2. Meal/Food Cost
3. Treatment Cost – (should be free at point of care)
4. Drugs and laboratory/radiological investigation (should be free or standardized at the point of care)
5. Administration costs (not usually eligible under donor regulations)

Transportation Cost

This should cover travel for the patient and the caretaker from home to health facility and back. Reimbursement will be made when a patient travels (with a caretaker) from their community to the hospital seeking emergency medical care. Ideally, all the necessary referral forms should be with the patient, signed by the right persons (listed in Section 2) to ensure that the transportation actually occurred. Sometimes this may not be the case and if the patient has had care and treatment at the Hospital the transportation costs should still be reimbursed with the necessary follow up with the point of referral. Where transport costs are unsure or a receipt is not available (e.g. lost) it is recommended that estimates are made in advance for the Township as a whole, based on all available information and that costs are reimbursed based on these estimates. If a receipt for transport cost (e.g. river taxi ticket) then the exact amount is repaid based on the receipt and not the estimated costs (higher or lower).

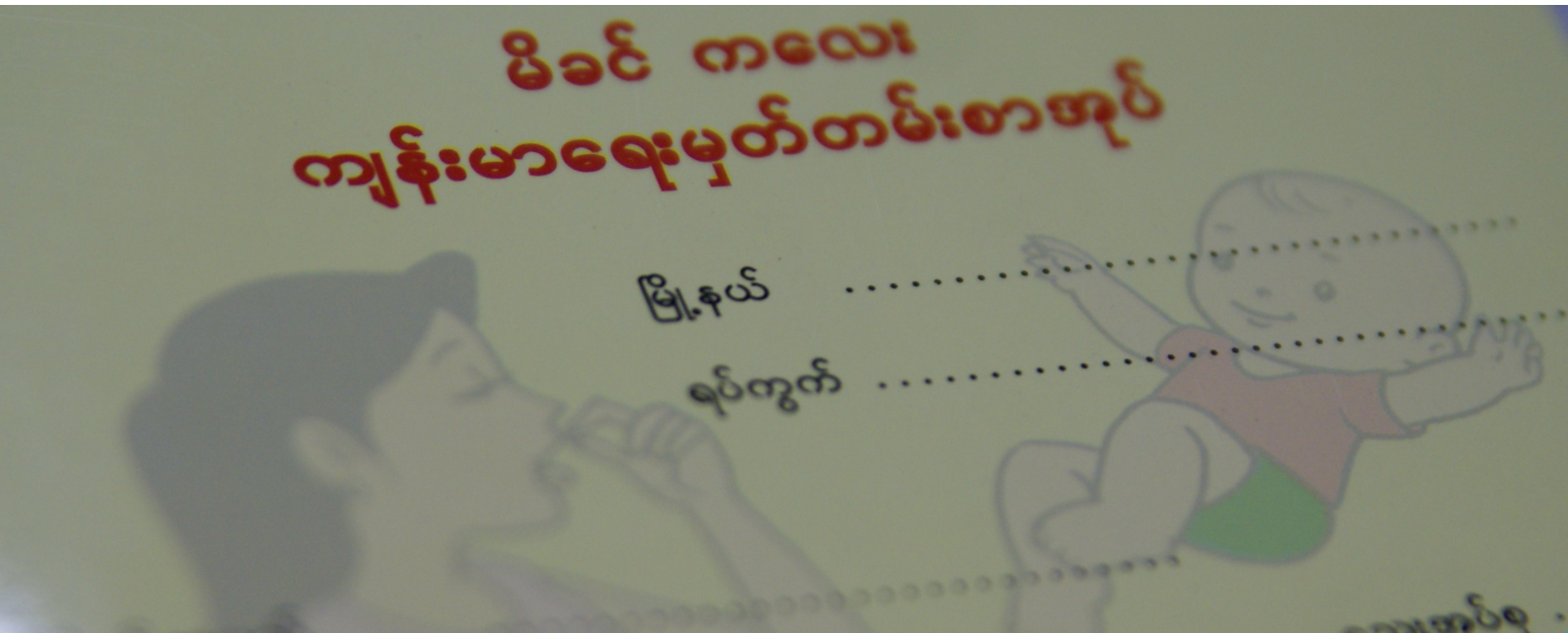
Meal Cost

Based on the number of days of hospitalization of the patients **PLUS** one care taker, which will be verified through the date of admission and discharge certificate/document. The number of days to support meal cost for both (patient and escort) will be for a maximum of up to ten days of hospital stay, although this can be extended with the authorisation of the most senior health person available at the implementing agency.

- Standard meal cost: 3000 MMK/day/person for 10 days, over 10 days has to be approved by the TMO

Treatment Cost

In line with the referral criteria (listed below), costs will be reimbursed immediately on discharge from hospital. However some discretion has to be applied by the most senior health person available at the implementing agency such that exceptions can be made. In particular this would be for costs incurred in a non life threatening emergency for highly vulnerable persons. The criteria can't be seen as definitive but as a guidance and repayment is ultimately governed by budget limitations. Maximum repayment costs do not have to be set but for budgeting purposes, it would make it easier if they were set. Example of documentation that would be useful for making these payments are: discharge forms, lab and investigation forms and prescription sheets for drugs.



Drugs and laboratory/radiological investigation
Drugs and laboratory/radiological investigation are reimbursed against the actual cost on production of a receipt or voucher provided by the hospital. The amount paid will be based against any ceiling set due to budget limitations.

Administration costs - Not covered
In the event of that the outcome is the death of the patient, the Township (through IP fund flow) will provide a fixed fee to support the recovery of the body to be returned to the family. This would include the transportation charge back to the home community (the return trip in effect). The fee needs to be identified within each Township and added to the CTHP and then made available to the wider community.

2.3 Steps for Referrals

1. Entry to the Referral pathway:
   a. A routine consultation of the patient by BHS, CHW/AMWs gives cause for an emergency referral

   b. An out-of-hours emergency consultation is sought by the patient (or family member) where the indication is that an emergency referral is required

   c. Danger signs and severe conditions have been diagnosed according to Treatment Algorithms and if possible, according to the criteria for emergency referral

   d. Any first treatment or supportive measures are carried out as per guidelines and according to algorithms before referrals are made by VHWs and BHS

   e. A member of the VHC, village elder or similar can confirm and sign the referral form stating that the patient is departing the identified community to seek further consultation at the secondary level of health care

2. Patient/Care taker should be counselled about the emergency condition and importance of getting to secondary care as soon as possible.

3. Patient/Care taker will be informed of referral support system, procedures provided at Implementing Partner (IP) or Township Health Department (THD) office and ways to reimburse the costs incurred on behalf of overall referral pathway completed by the patient/s.

4. Consent forms are available at the hospitals and can be signed by the Patient or the Care taker.

5. Referring to the agreed referral points (Station Hospital/ Township Hospital) which have been identified and agreed in Township coordination meetings.

6. Referral form is prepared by the relevant person BHS or CHW or AMW and signed.

7. Transportation cost is provided to patient/caretaker, from community emergency funds, where these are available as an advance.

8. Arranging for communication to the referral sites of the referral beind made with initial diagnosis if available.

9. To inform IP Township office of the referral and details of the caretaker.

10. Patient/ Care taker to make claims for reimbursement at a recognised point of collection; IP office, township Health Department office or similar, according to procedures in this document.

2.4 Recording, Reporting and Data Analysis

THD responsibilities: The senior medical staff at the referral site is responsible for receiving the referral case and providing care as per the agreed guidelines. They will need to sign the relevant documents on discharge so that patients and caretakers can make the claims for payment.

Both the THD and the supporting IP should be aware of, and IPs should review documentation for the threat of the 'fixers' who attempt to take a commission for referral and who also arrange for unnecessary referrals in order to obtain a commission. The THD should lead on any measures to be taken for such cases during the coordination meetings.

After completing the referral payments, the referral cases supported should be recorded in the database at township level by the database operator responsible for the task or a designated other member of staff as soon as possible. Referral data should be regularly monitored and analysed by a senior member of the Health Team; the analysis is to be shared with the TMO. These referrals and their outcomes are an important part of routine data reporting. Area Managers and their project staff should then ensure that cases falling inside their catchment area are followed up at the next available village level visit.

Photo: An Auxiliary Midwife providing antenatal care to a pregnant mother in Bogale Township, Ayeyarwaddy Region (Credit: 3MDG)

"VOICES"

When her daughter suffered from a bad bout of diarrhea, Htaung Zar Some (not her real name), a 24 year old widow living in Tonzang Township in Chin, tried all traditional treatment methods possible until her daughter was unable to drink or eat anything. Accompanied by her mother, Htaung Zar Some brought her child to a community health worker who immediately referred her to the hospital.

"He told me that my child was in dangerous condition and that I had to take her to hospital. He gave me a referral letter to refer my child to hospital and he explained that [emergency referral] will cover the transportation cost and meal cost in line with their referral system" she said.

Even though she had no money on her, with the guarantee of this financial support Htaung Zar Some was able to take her daughter to the hospital- renting a motorcycle from a villager whom she would pay later.

"Now, my child has recovered and we don't have to be in debt as the project has covered all expenses for transportation, medical expenses and even meal costs for us during hospital days. If this had not happened, I would be in paying back the debt for long time, maybe a year," she said.

SECTION 3: IMPLEMENTATIONAL PROCEDURE

3.1 Advocacy and information

Emergency referral flow charts and leaflets should be distributed and explained to all members of the communities by the volunteers, the VHCs and the BHS. They should also be shared with the Township Administration staff and other relevant local authorities and any relevant CSO, NGO, INGO partner. The pathway should be a regular topic for discussion at monthly health coordination meeting at RHCs and quarterly VHC meetings or any other events of this nature Township Health Committee meetings, VTHC meetings etc.).

Information should be disseminated to the community that Comprehensive Obstetric Care can be accessed unconditionally in State and Region Tertiary Hospitals and at the Township and Station hospitals.

3.2 Procedure for reimbursement

1. Patient or caretaker visits the IP office during office hours. They should have the following documentation, if possible:
    - Completed referral card
    - Medical record book from hospital
    - VHC recommendation letter
    - Emergency referral transport form
    - NRC card number and telephone number of the recipients
2. The assigned person for emergency referral support, reviews and completes the IP referral slip in the Expenditure record form to process reimbursement of eligible costs certified by medical officer, doctors at hospitals, or relevant THD officer of the referral hospital.
3. The assigned person should sign the IP Expenditure record form which is prepared by the Referral assistant (or assigned person), thus certifying that s/he has checked the claimed cost and that it is in line with the policy. S/he explains the procedure and payment to the patient/care taker receiving the reimbursement costs and ensures the person signs the document upon receipt of payment. Again, efforts should be made to protect the patient from the 'fixers' taking commission.
4. The budget holder or authorized person approves payment.
5. The finance team makes payment after checking the overall amount and verifying the receipts and signs.
6. The assigned person updates referral record book.
7. Payments can be made in a maximum of TWO instalments:
    - payment of one way transport costs and the cost of three meals in advance on arrival at referral point. This payment often needs to be prompt as some

Photo: An implementing partner aids the beneficiary through the emergency referral process (Credit: Relief International)

patients borrow money from the village which can have high daily interest rates.
    - payment of full eligible reimbursement following discharge
8. If the patient/caretaker is requesting only the first instalment payment, then the referral card should be copied and returned to the patient/caretaker.

9. The VHC will sign for receipt of repayment of the advance provided to the patient prior to referral from its fund and informs to IP of this event.

Any disputes regarding the reimbursements of costs should be handled by a senior member of the health team on duty and if required support should be sought from the Project Health Coordinator and Finance Manager. Unresolved disputes need to be addressed by the Project Coordinator or appropriate person in charge.

3.4 Monitoring and Reviewing of referral policy

The Referral guidelines and policy should be reviewed at project level (Township Health Department or Hospital site) and the policy should also be reviewed at the organizations National and HQ level for effectiveness and feasibility at least once a year, covering the issues of referral criteria, referral costs covered and appropriateness of procedures. At the Townships and State levels, relevant actors should be included: TMO/MS, Paediatricians, Obstetricians, State/Regional officers. The referral policy should be reviewed in light of the death audits regularly.

Outcomes of the referred patients should be monitored at the community level by Project Officer/Emergency referral focal person and the performance of CHWs and AMWs should be checked regularly with the use of supervisory checklists by Project officer teams as well as by Area Managers.

The referrals should be discussed with the relevant Township and Hospital authorities as a regular agenda item at meetings to analyse the outcomes and the costs. With the recent changes in Myanmar as much effort as possible should be made to ensure services that should be free at point of care are actually free. No payments should be made without a receipt.

Recommendations

1. It is critical for community buy-in of the guidelines and the pathway that the voices of the community are taken into account. Lessons learned through regular discussions with VHC, volunteers, and community leaders (teachers, administrators, elders etc...) regarding the referral process should be incorporated into annual reviews of this document. The emphasis has to be on ensuring access is as open and free from barriers as possible.

2. Where possible, relevant other documents should accompany a patient, e.g. MCH handbook or HBMR book growth cards, vaccination cards. A patient or their caretaker often forgets these when under the stress of an emergency. Advocacy around remembering these documents should be carried out with BHS, volunteers and members of the VHC.

Photo: A beneficiary of 3MDG's Emergency Obsteric Care in Bogale poses with her children (Credit: 3MDG)

SECTION 4: CRITERIAS FOR EMERGENCY REFERRALS

The following tables are for guidance purpose only when used by a trained skilled health worker when ascertaining what is the cause behind the referral. It is **NOT** a definitive set of criteria and there may be other reasons not listed for making an emergency referral.

SIGNS AND SYMPTOMS	POSSIBLE DIAGNOSIS AND ACTION
Emergency Obsterics	
Pre-natal	
Teen pregnancy Elderly primigravida Grand multiparity Bad obstetric history (previous Still Birth, preterm delivery, history of congenital anomalies Maternal height below 4'9", Maternal obesity Previous LSCS / uterine scar Pregnancy with Medical disease (heart disease, gestational Diabetes mellitus, HBV,HCV and HIV infection)	High risk pregnancies Birth plan and Mode of delivery during 3rd trimester should be made Vaginal birth short trial after LSCS in hospital Joint care with physician
Pregnant women with vaginal bleeding -Early pregnancy (less than 13 weeks) -Late pregnancy	Abortion, Hydatidiform mole and ectopic APH and to exclude Cervical Pathology
Pregnant women with severe pain in lower part of abdomen and/or bleeding per vagina with/without Shock (period of amenorrhoea)	Incomplete Abortion (Septic or induced) Ectopic Pregnancy
Symphysio-fundal Height is not in line with LMP and EDD	Twin Pregnancy Poly-hydramnios Intra-uterine growth retardation (IUGR) or wrong date
Early pregnancy with acute retention of urine	Impacted ovarian cyst
Pregnant women with severe difficult breathing/ breathlessness	Respiratory tract infection
Pregnant women with dyspnoea at rest or on exertion and unable to lie flat	Suspicious of Heart disease
Swelling, breathing difficulty, fatigue	Wet Beri Beri
Wasting and partial paralysis (Difficulty in walking, numbness in hands and feet, Loss of muscle functions, speech difficulties)	Dry Beri Beri/endemic neuritis
Pregnant women with palpitation, severe pallor, lethargy, restlessness and breathlessness	Severe Anaemia
Pregnant women with fits or unconsciousness	High Fever with infection Meningitis, encephalitis cerebral malaria ,Eclampsia
Pregnant women with high blood pressure (Systolic Blood Pressure – 140 mmHg or above; Diastolic Blood Pressure - 90 mmHg or above)	Hypertension/PIH Pre-eclampsia

Pregnant women with severe vomiting with headache and blurred vision and Hypertension (>160//100 with proteinuria)	Impending Eclampsia Severe Pre-eclampsia Inj. Magnesium Sulphate IM before referral
Pregnant women with swelling in the feet, legs and hands	Severe Pre-eclampsia Heart failure
Pregnant women with very less urination or no urination at all (oliguria/ anuria)	Eclampsia with renal problem
Passage of profuse watery discharge from birth canal before labour pain	Premature Rupture Of Membranes
Labour pain before 37 weeks	Preterm labour (refer for neonatal facility) Inj. Cortico steroid for mother only at hospital
Breech or Transverse position in Abdominal examination	Abnormal Foetal Lie
Reduced foetal movement(<10 times/12 hrs) or abnormal Foetal Heart Rate	Impaired foetal well being for further monitoring and management
No foetal movement/ No Foetal Heart Sound	Intra-Uterine Foetal Death
Vaginal discharge (foul smelling, purulent or blood stained Pregnant women with fever of more than three weeks	Infection during pregnancy/ Pyrexia of Unknown Origin
Pregnant women with severe pain in lower part of abdomen and without Shock (vital signs stable) With shock (vital signs not stable)	Acute Abdomen Urgent referral after resuscitation
Bleeding per vagina of small amount under observation	Threatened miscarriage, incomplete /complete miscarriage
Post-date pregnancy	For Induction of labour/ delivery
Intra-Natal	
Foetal Heart Rate: <120/min (or) >160/min	Foetal distress Foetal bradycardia/ Tachycardia for urgent delivery
Breathlessness, fever, tachycardia, vomiting	Maternal distress
Cord/Hand prolapsed during delivery	Cord/ Hand Prolapse
Face/Brow/Breech presentation during delivery	Abnormal Presentation
No Progress in Labour – more than 12 hours No descent of presenting part Presenting part > 3/5th above the brim	Prolonged Labour Obstructed Labour Cephalopelvic disproportion
Meconium stained amniotic fluid Foul smelling amniotic fluid Blood stained amniotic fluid	Foetal distress Chorioamnionitis Suspicious of abruption placenta
Pregnant women with impending shock (BP < than 90/60) With scar	Abruptio placentae Scar rupture
Vaginal bleeding with severe abdominal pain during delivery	Uterine Rupture
Breathlessness with cold and clammy extremities during delivery	Shock Amniotic fluid embolism
Fits or unconsciousness during delivery The same findings with fever	Intra partum Eclampsia Exclude others

Scar tenderness or SPA pain during labour Previous CS/Myomectomy scar	Impending scar rupture
No spontaneous delivery of placenta (more than 1 hour after delivery)	Retained placenta
Swelling in the vulva with pallor and hypotension	Haematoma (needs urgent exploration)
Post-natal	
Protrusion of Uterus out of birth canal after delivery	
Massive vaginal bleeding after delivery	
High fever in post-natal period (More than 38C) with foul smelling lochia/discharge and sub involution of uterus	Puerperal pyrexia Puerperial sepsis (Metritis, Pelvic abscess)
Abdominal distension, pain and tenderness with guarding	Peritonitis/ Intra abdominal abscess
Dribbling of urine from vagina	Vesico vaginal fistula
Newborn and Child Emergency (all life thretening emergencies beyond the skill of the VHW)	
Delivered before 37 gestational weeks	Premature baby
Birth weight – less than 2.5 kg or 5.5 lb	Low Birth Weight
Difficult Breathing (Fast Breathing: >60 per minute, Slow Breathing: <30 per minute)	Severe Pneumonia Respiratory distress Birth Asphyxia
Chest Indrawing	Very Severe Pneumonia
Fits or Convulsion, Unconsciousness, Cannot suck and breast feed	General danger sign
Fever	Hyperpyrexia
Cold & Clammy extremities (legs, feet and hands)	Shock/ Impending Shock
Loose motion (more than 3 times/day)with signs of lethargy and other danger signs	Diarrhoea with signs of dehydration
Umbilical cord bleeding or inflammation	Umbilical cord sepsis
Papules/ Macules/Pustules over the body and peripherals	Measles Bacterial skin infection
Yellow colouration of skin and sclera	Neonatal jaundice
Imperforated anus	Congenital Deformities
Breathlessness, loss of voice, cyanosis, vomiting with reduced suckling and reduced urination	Infantile Beri Beri
Neonate & Infant (7 days - 2 months)	
Fast breathing (more than 60 per minute) and/or Chest indrawing	Very/ Severe Pneumonia
Fits/ Unconsciousness, Cannot suck/ breastfeed	General Danger Sign
Body Temperature: > 38'C/ 100.4'F	Hyperthermia
Body Temperature: < 35.5'C/ 96'F	Hypothermia
Bulging of forehead (Anterior frontenellae)	Meningitis
Umbilical cord bleeding or inflammation	Umbilical cord sepsis
Breathlessness, loss of voice, cyanosis, vomiting with reduced suckling and reduced urination	Infantile Beri Beri
Infant & Children (2 months - 5 years)	
Cannot drink/ breastfeed, Vomiting all food and drinks, Fits, Unconsciousness	General Danger Sign

Chest indrawing and/or Stridor during inhalation Increased Respiratory rate by age group: ≤2 months: 60 breaths per minute or more 2 - 12 months: 50 breaths per minute or more 12 months - 5 years: 40 breaths per minute or more Children with stridor when calm may or may not have fast breathing or lower chest wall indrawing. Refer all children with stridor	Severe Pneumonia/Severe Asthma
Loose motion with severe dehydration	Severe Dehydration
Bloody Diarrhoea	Dysentery Other Surgical disease
Fever PLUS one or more of the following symptoms:	
Fever does not improve after 3 days after giving paracetamol	Prolonged Fever (PUO)
Neck stiffness	Meningitis
Cold and Clammy extremities (Legs, feet and hands)	Shock/Impending Shock
Bleeding – nasal, gums, etc	Dengue Haemorrhagic Fever
Black (Coffee ground) vomiting	Dengue Haemorrhagic Fever
Rash/red eyes/running nose	Measles
Bulging of forehead (Anterior frontenellae)	Meningitis
MUAC – Red or <11.5 cm (only 6 mth – 5 yrs)	Severe Malnutrition
Bilateral pitting oedema	Protein-Energy Malnutrition Renal Disease
Breathlessness, loss of voice, cyanosis, vomiting with reduced suckling and reduced urination	Infantile Beri Beri
Bleeding – nasal, gums, Black (Coffee ground) vomiting etc	Dengue Haemorrhagic Fever
Fits or unconsciousness	Epilepsy/Drowning/Poisoning/drug overdose, accident (etc)
Fever, paralysis	AFP
Pallor with/out bleeding or lymph node enlargement or hepato-splenomegaly	Haematological abnormalities (emergencies)
Psychiatric problems (Acute confusion)	Psychological illness
Injuries, bleeding with viginal tear	Rape case (PC case)
Dyspnoea or chest pain with murmur	Congenital or valvular heart disease
Fever, cough and failure to thrive	Childhood TB (hospitalized)
Dyspnoea with frequent cough	Childhood asthma
Bilateral pitting oedema/hypertension	Renal Disease, Protein-Energy Malnutrition
Dog bite, severe injuries etc	Dog bite, injury
Malaria Referral (All Ages)	
RDT positive for PF malaria ineligiblepatients who are too sick for the CHW to treat with following danger signs: Severe Vomiting/ unable to take medicine, High Fever > 40'C, Severe Headache, Neck stiffness, Lethargy, Severe pallor, Yellow colouration of skin and sclera, Difficult breathing, Restlessness, irritable, Convulsion/ Unconsciousness, Passing of black coloured urine, Passing of bloody stool	Severe Malaria

Other Emergency Cases of all ages	
Severe Traumatic Injury (Eg: Road Traffic Accident, Fall from height, etc)	Major Injuries/Trauma
Burns and Scald (Burn Area >15% of Body surface area in adult and >10% in children) **following rule of 9	Deep Burns & Scald
Severe injuries due to rabies suspected, dog bite and snake bite (poisonous sting)	Animal bite
Stridor	Foreign body inhalation/ Acute Asthma
Sudden onset of acute abdominal pain	Acute abdomen
Sudden onset of acute abdominal pain	Ischemic Heart Disease
Fever with fits or unconsciousness	Febrile fits Epilepsy
Loose motion with severe dehydration	Severe Dehydration
MDRTB and HIV with opportunistic infection, PMCT cases?	MDRTB, HIV with complications
Acute confusion	Psychiatric crisis/ Drug overdose

References

The above table is generated from the following guidelines

1. Treatment Algorithm (IP)
2. CHW Manual (MoH)
3. AMW Manual (MoH)
4. Comprehensive and Basic Emergency Obstetrics Care (A Manual for Doctors) (WHO/MoH/UNFPA)
5. WCHD project: Women and Child Health Care (WHO/MoH)
6. Analytical data of referral support cases bases on 3 MDG township delta experience
7. MOH led Workshop to Discuss Emergency Referral Guidelines held in Nay Pyi Taw in November 2014

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