



**STANDARD OPERATING PROCEDURES
FOR MEDICAL REFERRAL OF PERSONS OF CONCERN IN
ETHIOPIA**

UNHCR REPRESENTATION IN ETHIOPIA

(Updated March 2015)

Table of Contents

Acronyms	2
1. Purpose of the Standard Operating Procedure(SOPs)	3
2. Guiding principles	4
3. Target groups.....	5
4. Partners in healthcare provision	5
5. Access to healthcare services	7
6. Referral decision process.....	8
7. Joint transfer of medical cases by UNHCR and ARRA in the field.....	9
8. Referral pathways.....	10
9. Conditions of travel	12
10. Authorization for travel	13
11. Receipt of refugees upon arrival to referral site	13
12. Return to camp	13
13. Cost settlement	15
14. Non-referable medical conditions	15
15. Medical assessment for resettlement	16
16. Supervision, monitoring and evaluation.....	17
17. Privacy and confidentiality.....	17
18. Handling of fraud	18
19. Referral sites.....	19
20. Specialized public Hospitals in Addis Ababa.....	20
21. Referral decision.....	22
Patient Referral Paper.....	23
Pass Permit	24
PATIENT AGREEMENT FORM	25
CAREGIVER AGREEMENT FORM	26
Urban Status Notice	27
Standardised Specific Needs Codes	28
MEDICAL ASSESSMENT FORM	32

Acronyms

ARRA	Administration for Refugee and Returnee Affairs
DICAC	Development and Inter Church Aid Commission
DSA	Daily Subsistence Allowance
IOM	International Organization for Migration
IP	Implementing Partner
MOH	Ministry of Health
MRC	Medical Referral Committee
MSF	Médecins Sans Frontières
OCP	Out of camp Policy
PHC	Primary Health Care
PoC	Persons of Concern to UNHCR
PwD	Persons with Disabilities
RaDO	Rehabilitation and Development Organization
SGBV	Sexual and Gender Based Violence
SHC	Secondary Health Care
SOP	Standard Operating Procedures
STHC	Secondary and Tertiary Health Care
THC	Tertiary Health Care
UNHCR	United Nations High Commissioner for Refugees
UNICEF	The United Nations Children's Fund
WHO	World Health Organisation

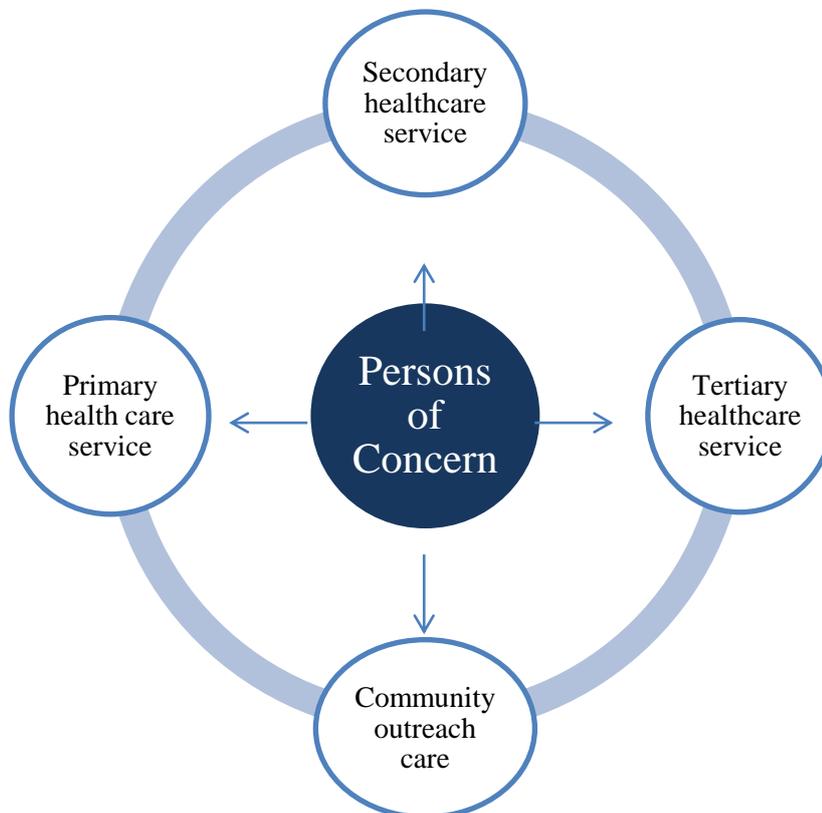
1. Purpose of the Standard Operating Procedure(SOPs)

The main purpose of this SOP is to guide medical referral of refugees and other Persons of Concern (PoC)¹ to Secondary and Tertiary Health Care (STHC) facilities in Ethiopia.

Referral is any process in which the healthcare provider at a health facility seeks the assistance of providers who have better expertise and facilities to guide in managing or to taking over a responsibility for a particular clinical condition in a patient.

Referral should be an important tool to ensure a continuum of care in a client by ensuring access to relevant services for physical, psychological and social needs. The concept of a continuum of care encompasses the need for care through all the stages of referral process.

Continuum of care



The functions of referral hospitals may broadly be categorized into (a) the direct clinical services provided to individual patients within the hospital and the community and (b) a set of broader functions indirectly related to patient care.

¹ PoC: These commonly include: asylum-seekers, refugees, internally displaced persons (IDPs), returning refugees, IDPs who return to their places of origin, and stateless persons. In the document, they have been referred as refugees for the sake of convenience.

Levels of Hospital

Hospital types	Services available	Alternative names
Primary hospitals	few specialties—mainly internal medicine, obstetrics and gynaecology, paediatrics, and general surgery, or just general practice; limited laboratory services available for general but not specialized pathological analysis	District hospital Rural hospital Community hospital General hospital
Secondary hospitals	highly differentiated by function with 5 to 10 clinical specialties; size ranges from 200 to 800 beds; often referred to as a regional hospital	Regional hospital Provincial hospital (or equivalent administrative area such as county) General hospital
Tertiary hospitals	highly specialized staff and technical equipment— for example, cardiology, intensive care unit, and specialized imaging units; clinical services highly differentiated by function; could have teaching activities; size ranges from 300 to 1,500 beds	National hospital Central specialized hospital Academic or teaching or university hospital

Public health facilities in this SOP refer to government hospitals that provide subsidized care to public patients, including the refugees. *Private health facilities* refer to for-profit hospitals that are generally funded by paying patients and are not subsidized. It should be noted that most private health sectors do not clearly delineate district, secondary, or tertiary hospitals.

2. Guiding principles

1. Clear target groups
2. Clear responsibility of partners
3. Clear referral decision process by the authorized medical personnel or Medical Referral Committee (MRC).

4. Cost-effective access to range of healthcare services.
5. Joint decision for transfer in to urban programme
6. Clear communication at all levels of care
7. Cost effective and efficient means of transportation
8. Transparency, clear communication and dissemination
9. Reliable assessment for medical resettlement
10. Supervision, monitoring and evaluation

3. Target groups

The groups of PoCs shall benefit from all ranges of care the referral system:

- Camp-based refugees;
- Out of camp refugees;
- Urban refugees;
- Camp-based refugees benefiting from scholarship programme ;
- Camp-based refugees temporarily out of camp for various reasons like interviews for resettlement.
- Asylum-seekers.

The referral system shall not include the following

- Nationals.
- National spouses of the refugees.

However, those excluded from the referral can benefit from the primary health care services, services for immediately life threatening conditions and ambulance service to the nearest referral sites for emergency medical conditions.

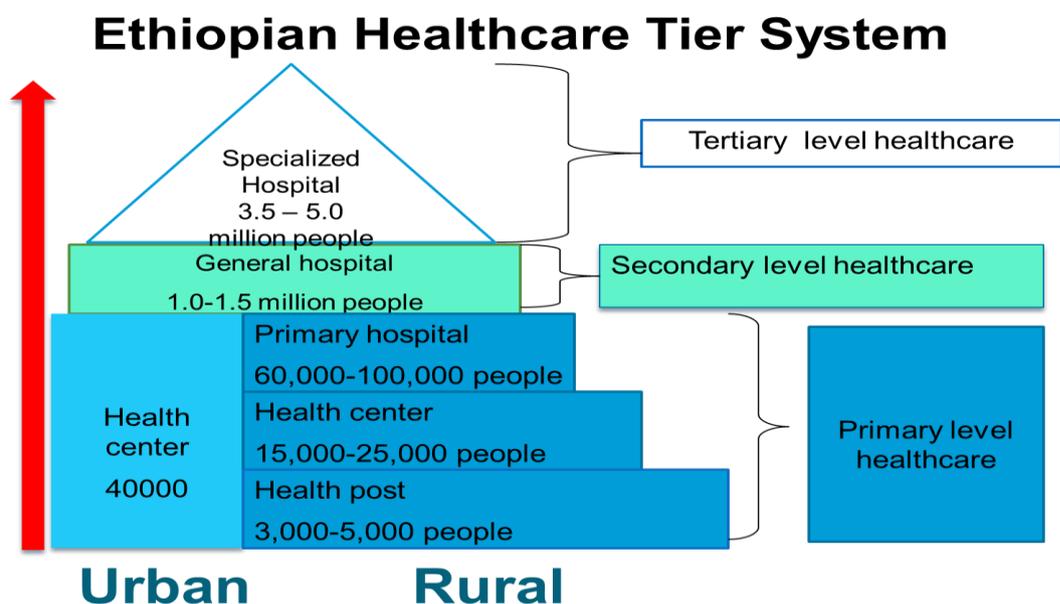
4. Partners in healthcare provision

4.1 UNHCR shall lead the coordination of healthcare assistance for refugees and other PoC and supports health assistance with/through the following Implementing Partners (IPs):

Table 1. Roles of partners

Partners	Role	
ARRA	<ul style="list-style-type: none"> • Primary healthcare service at camps. • Referral of camp based refugees. • Healthcare service for refugees in camps, transit and reception sites. • Refugees under out of camp policy • Facilitating referral of camp-based refugees who are in urban locations for reasons like scholarships, resettlement interviews, out of camp policy. • Joint UNHCR/ARRA urban transfer • Transportation of patients referred or transferred • Camp based specialized services. • Issuing pass-permit 	<ul style="list-style-type: none"> • All camps
RaDO	<ul style="list-style-type: none"> • Physical and social rehabilitation services to PwDs disabilities (PwDs). • Referral service for PwDs. • Camp based specialized services for PwDs 	<ul style="list-style-type: none"> • All camps
IOM	<ul style="list-style-type: none"> • Completion of the UNHCR Medical Assessment Form for resettlement. • Transportation of cases of resettlement. 	<ul style="list-style-type: none"> • Addis and field mission
DICAC	<ul style="list-style-type: none"> • Primary and referral service in urban assistance programme. 	<ul style="list-style-type: none"> • Addis Ababa
MSF	<ul style="list-style-type: none"> • Primary healthcare service and referral of emergency cases during initial phase of emergency 	<ul style="list-style-type: none"> •

5. Access to healthcare services



FMOH-MSD

- 5.2 UNHCR, in collaboration with partners, shall ensure that all refugees shall have access to effective primary healthcare services with strong clinical, preventive and promotional components. Those services shall be provided at facility and/or community levels. In addition, UNHCR along with ARRA shall advocate for refugees to have access to all national health initiatives and health programmes.
- 5.3 Refugees shall have access to a range of services of reasonable quality and cost. To ensure the efficient utilization of resources, alternative form of treatments or substitutions could be discussed and applied, like for example, substitution with equally effective generic medicines or procedures.
- 5.4 Partners referring patients shall assess, document and apply any cost-effective means for ensuring access to services, like for example, arranging transportation for a group of patients, sending specimens rather than physically sending the patients, telephone or email consultations.
- 5.5 Camp level specialized services by different specialities outsourced from health facilities in the regions or in Addis Ababa coordinated with training and skill transfer by visiting experts can also be option for ensuring access to specialized care in a cost effective manner.
- 5.6 Refugees shall have access to secondary and tertiary healthcare services which are mainly provided outside the camps, either in public or private health facilities.
- 5.7 Selection for service from either the public or private care facilities should depend on the health and cost benefits. For example, taking in to account the long lists of patients waiting for receiving services in public facilities, the referring agency might prefer to take the advantages

of immediate availability of the required service and cost reduction obtained from shortening the length of stay of the patients and their care-givers.

- 5.8 Refugees shall also have access to rehabilitative healthcare for mental and physical disabilities within or outside the camps.
- 5.9 Potentially communicable disease should be managed at camp level and could be referred only under proper care and when referral outside the camp is found to be absolutely necessary.
- 5.10 Periodic specialized outreach services, like for example, dental, psychiatric, ophthalmic, GYN/OBS, minor surgery, ENT and physical rehabilitation can be organized at camp-level by UNHCR or ARRA or other partners as cost-effective means of providing camp level access to specialized care.
- 5.11 Basic primary eye, dental and ENT care can be provided. However, dental prosthesis, fillings, cleaning, scaling and correction of refractive errors are not priority.
- 5.12 Access to costly treatments like dialyses and sophisticated investigations like computed tomography scanning and magnetic resonance imaging are not priorities. When these are prescribed, analyses of the long-term health benefits and the costs should be made and justified. For example, the likelihood of immediate access to a definitive form of treatment and expertise skill.
- 5.13 Given the high cost involved in undertaking compatibility testing, refugees with renal failure shall be permitted to have a short-term dialyse and one-time compatibility test *only* when immediate access to an organ transplant can be justified.
- 5.14 Compatibility testing for more than one occasion should be justified and approved by UNHCR protection/resettlement unit in consultation with health unit
- 5.15 In order to avoid the chance of incompatibility, prevent fraud and criminal activities such as organ sell, compatibility testing should be done among immediate family members.
- 5.16 When all chances for renal transplant have failed, the patient and the family should be counselled and further procedure should be withheld while continuing other forms of physical and psychosocial care and support.

6 Referral decision process

- 6.1 Taking in to account the health of refugees as a core point of concern and given the limited resources available, the medical practitioner should make a responsible decision in a cost-effective manner that can benefit the larger portion of the refugees.
- 6.2 Referral should be done at the right time before the health condition of the person deteriorates significantly and makes the survival unlikely and the referral cost expensive. .
- 6.3 Decision for referring should be only made by a certified and practicing medical professional on the bases of scenarios explained below.

Emergency: Referral of an immediately life-threatening or an immediately-detrimental to the function of vital organs. Referral of such cases should be done without delay.

Elective: Conditions benefiting from treatment available within the country, however, not immediately life threatening or immediately affecting the vital organs or their functions. Cases should be prioritized taking in to account the treatment outcome, the budget available and the cost.

6.4 Conditions which do not fit in to those categories should be treated in the most appropriate way with alternative forms of treatment like palliative and supportive care. These may include

- Conditions with no known form of treatment
- Conditions with poor likelihood of improvement.
- Conditions which are adequately treated with no favourable outcome
- Inactive conditions resulting from past illnesses or injuries like for example deformities, scars, etc. for which the outcome of treatment does not help the patient
- Terminal illness requiring expensive and sophisticated procedures with little benefit to the survival of the patient.

7 Joint decision to transfer of medical cases by UNHCR and ARRA in the field

7.1 For elective cases, UNHCR or ARRA can initiate joint requests for transfer of refugees to DICAC urban programme in Addis Ababa on medical grounds by justifying the long term health benefits.

7.2 For patients intended to be transferred from health programmes under the jurisdiction of ARRA to health programme under DICAC, ARRA should first settle all medical costs.

7.3 In order to ensure smoother transfer, it is advised that ARRA and DICAC jointly agree on contracting similar health facilities.

7.4 During the joint process, it is mandatory that the medical doctor or the most senior healthcare personnel is involved in the process of joint recommendation.

7.5 The intention to transfer into urban programme along with the justification should be communicated to ARRA and UNHCR health units in Addis Ababa and should first receive go ahead.

7.6 The recommendation letter signed by both UNHCR and ARRA in the field and should be sent to ARRA and UNHCR Addis Ababa along with all supportive medical documents.

7.7 ARRA and UNHCR health units shall write a joint recommendation letter which shall be addressed to ARRA programme unit.

- 7.8 Upon receipt of the letter of recommendation from the health units of UNHCR and ARRA, the programme unit of ARRA shall inform the protection unit of ARRA to write to Protection unit of UNHCR.
- 7.9 The protection unit of UNHCR shall again write to DICAC for inclusion of the refugees in the urban assistance.
- 7.10 To avoid inconveniences to the refugee on arrival due to lack of assistance, the process of transfer from the camps shall only be initiated after the UNHCR Protection unit has written a letter to DICAC and has notified the field on the decision made on the transfer.
- 7.11 After arrival of the refugee in Addis Ababa, assistance shall immediately be initiated by the urban programme implementer, in this case DICAC.
- 7.12 Similarly, UNHCR and ARRA health units in Addis Ababa can directly recommend urban transfer to refugees who have been referred from the camps and following up treatment in Addis Ababa.
- 7.13 Before transferring the refugees in to urban programme in DICAC, ARRA shall ensure that all the prior medical costs are settled and medical evidences of the patient are made available.
- 7.14 As ARRA and DICAC are not always contracting the same hospitals for providing service to the refugees, It is important that. ARRA provide information to DICAC about the facility the patient was being provided treatment the last time before the transfer from ARRA to DICAC.

8. Referral pathways

- 8.1 The referral of refugees from camp health facilities follows the national healthcare tire system.
- 8.2 PHC facilities are the first level of care where the need for referral is assessed and decided by the designated healthcare professional.
- 8.3 From primary healthcare facilities, refugees are referred to primary or general hospital and then to specialized primary health care facilities.
- 8.4 Except in emergency, cases referred by the primary or regional hospitals to a specialized care might, if the need be, go through the process of reprioritization.
- 8.5 It is important to ensure to ensure continuity of care by providing feedback to the referring facility.

Referral pathway for refugees

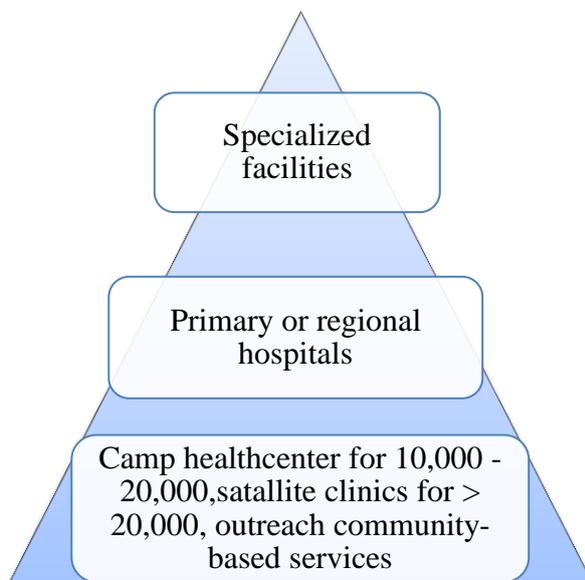
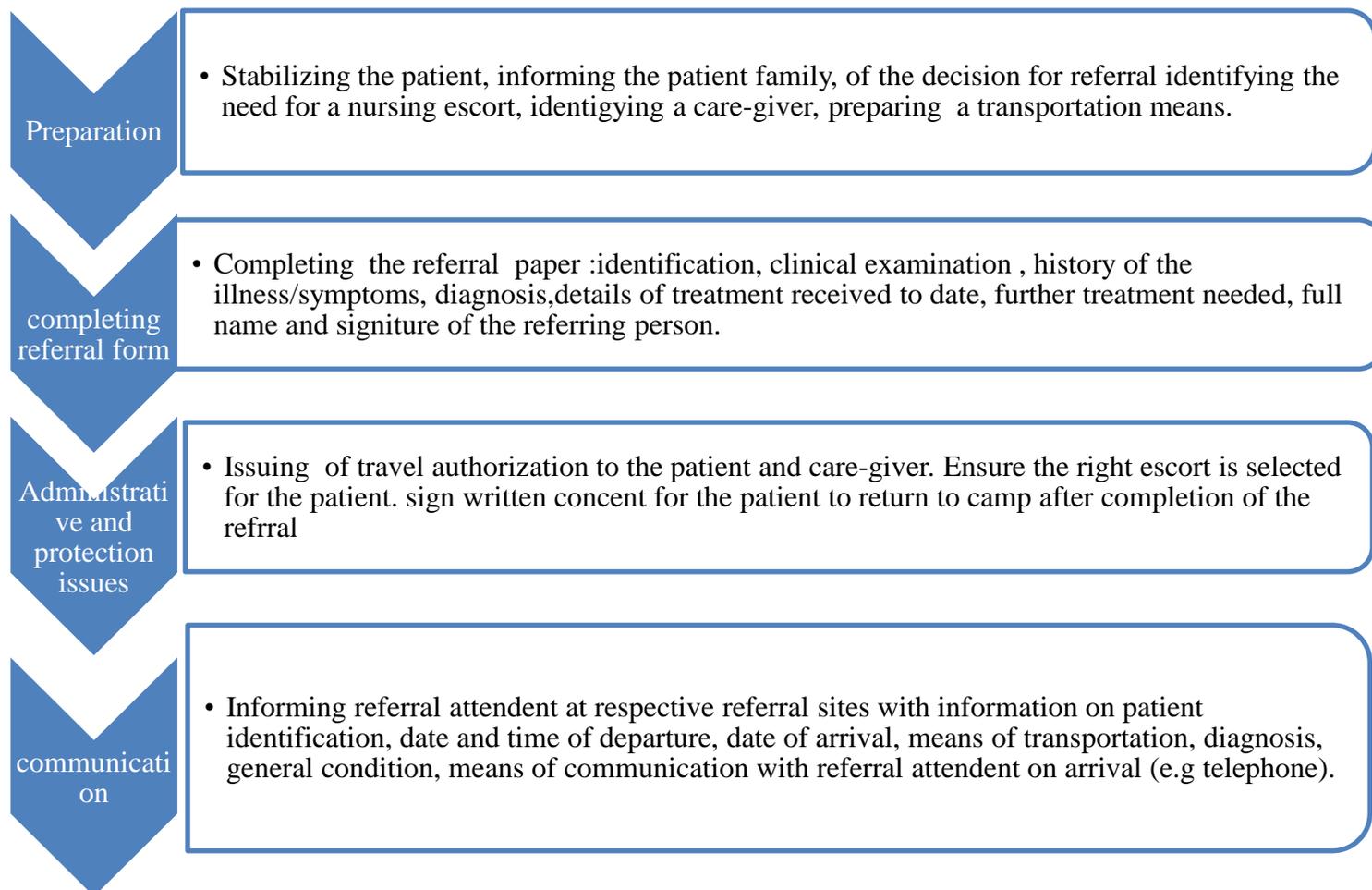


Figure Steps for referring patients after decision for referral



9 Conditions of travel

Assigning care-givers

- 9.1 In order to minimize the subsistence cost involved, a care-giver should be assigned only when it is required.
- 9.1 For capable patients, the assistance to the care-giver could be discontinued after careful analyses of the condition of the patient.
- 9.1 Similarly, with conditions like deterioration of the condition of the patient or when additional care is required like, for example, in case of general surgery, a care-giver could be assigned for a limited period of time until the condition of the patient improves.
- 9.1 A decision who should be the care-giver shall be made by the patient himself or when the condition of the patient does not allow to make a proper decision, the family member or the relatives shall suggest who should be the care-giver.
- 9.1 The patient could request for a change of a care-giver for a valid reason.
- 9.1 The care-giver should be healthy and above the age of 18.
- 9.1 A sick child below the age of 18 should always be accompanied by one of the parents as a care-giver.
- 9.1 The parents shall decide who should accompany the child. However, for children below the age of five years, it is encouraged that the mother accompanies the child unless in case of any justifiable reason (medical, social) that cannot allow the mother to travel.
- 9.1 If none of the parents is not available or not capable of being a care-giver, the most appropriate care-giver should be selected from among other refugees living in the camp, more a preferably other family member or closer relative.
- 9.1 In exceptional circumstances, a second caregiver could be assigned with justifications that benefit the patient.

10 Authorization for travel

- 10.1 Refugees shall receive travel authorization (Pass-permit) for referral or transfer out of the refugee camps, transits or reception sites and should not be allowed to travel without it.
- 10.2 The referring agency shall not be responsible for any inconvenience that occurs in accessing healthcare care service for refugees travelling without pass-permit.
- 10.3 Patients and care-givers should agree in writing to return to the camp after completion of referral.
- 10.4 Transportation could be arranged by any cost-effective means, either by an ambulance or public transportation, based on the condition of the patient and urgency of care.
- 10.5 Patients with potentially communicable diseases should be transported by with appropriate care and only by an ambulance in order to avoid any spread of disease.
- 10.6 Nursing escort shall be assigned when found necessary, like for example, emergency cases, potentially communicable disease, patients requiring a course of treatment during transportations.
- 10.7 Patients should have the prescribed course of medicines for the duration of stay until the next consultation at referral point.
- 10.8 Patients should always be well-stabilized before being transported and transportation should be free from risk of any deterioration.
- 10.9 All children should be checked that they have received the appropriate vaccination for their ages before they travel after ruling out any contraindication.

11 Receipt of refugees upon arrival to referral site

- 11.1 The Medical attendant shall ensure referral / appointment paper, pass-permit and other relevant documents are available and duly completed.
- 11.2 The medical attendant prepares authorization for services at an appropriate health facility.
- 11.3 The Medical attendant shall arrange transportation or escort, if necessary, to the referral site and ensures that the refugee has accessed proper and timely care.
- 11.4 The medical attendant shall ensure that the refugees have received the proper accommodation during their care process.

12 Return to camp

- 12.1 Return shall be decided when the referring agency finds that the patient could make subsequent follow ups at a camp level. Given their widespread misuse, medical certificates cannot justify further stay for the patients that could benefit from the same treatment in the camp unless the request is well-elaborated to mention the risks of sending back to the camp and the benefits of keeping the patient closer to the referral site.

- 12.2 Return should be arranged by any cost effective means, either ambulance or public transport, depending on the condition of the patient.
- 12.3 The referring agency shall cover DSA and transportation costs of the returning refugees. Further payment shall not be made should the patients and care-givers fail to return to camp.
- 12.4 The referring agency shall cover the burial cost of the deceased person, however will not be responsible for return of the dead body to the camp.
- 12.5 Upon completion of treatment, the patient and the care-giver should return to camp with proper documents like feedbacks on the diagnosis made, treatment given and medical advice for follow-up and date of next appointment.
- 12.6 The medical attendant in the respective referral sites shall communicate the details of arriving patients and care-giver, and upon arrival, the refugee should submit the feedback to the treating healthcare personnel in the camp.
- 12.7 Refugees shall comply with their obligations and exercise their right without fraud or misuse of any assistance provided to them.

13 Cost settlement

- 13.1 All referral services shall be provided free of charge and related authorized costs should be covered by the referring agency.
- 13.2 Referral cost should be minimized to the extent possible by avoiding delays, establishing a convenient system for transportation and effective communication.
- 13.3 Authorization should be obtained from the referring agency in writing for any prescribed services like medical procedures, laboratory services and prescribed medicines provided outside the referral hospital.
- 13.4 When written authorization is not possible, verbal or telephone authorization can be done which later on can be verified in writing.
- 13.5 Costs of services obtained outside the country shall not be covered.
- 13.6 Costs for completion of Medical Assessment for resettlement purposes shall be covered by UNHCR.

14 Non-referable medical conditions

In cases where treatment is particularly costly and/or in cases of uncertain prognosis, referral should not be considered. Some examples of such cases include:

- degenerative diseases and for which there is no known or doubtful likelihood of cure;
- chronic diseases which do not benefit from referral within the Ethiopian health system;
- healed and inactive lesions resulting from past illnesses or injuries such as an asymptomatic bullet in the body;
- terminal diseases, including terminal cancers, chronic liver diseases and end-stage renal failure;
- irreversible disabilities for which rehabilitative service is locally available or which cannot further benefit from any form of treatment;
- irreversible neurological damage for which rehabilitative service is locally available or which cannot not further benefit from any form of treatment;
- other health conditions requiring sophisticated surgery and medical care exceeding what is normally available to Ethiopian nationals, e.g. brain surgery, kidney, liver or heart transplant, and major skeletal reconstruction (in such cases, other options such as resettlement on medical grounds should be considered);

Chronic cases should be followed at camp level by a senior healthcare staff. Referral is needed only for valid reasons such as complication, failure to control the illness despite adequate medication or further laboratory examination which are not available in the camps.

Some of such examples included

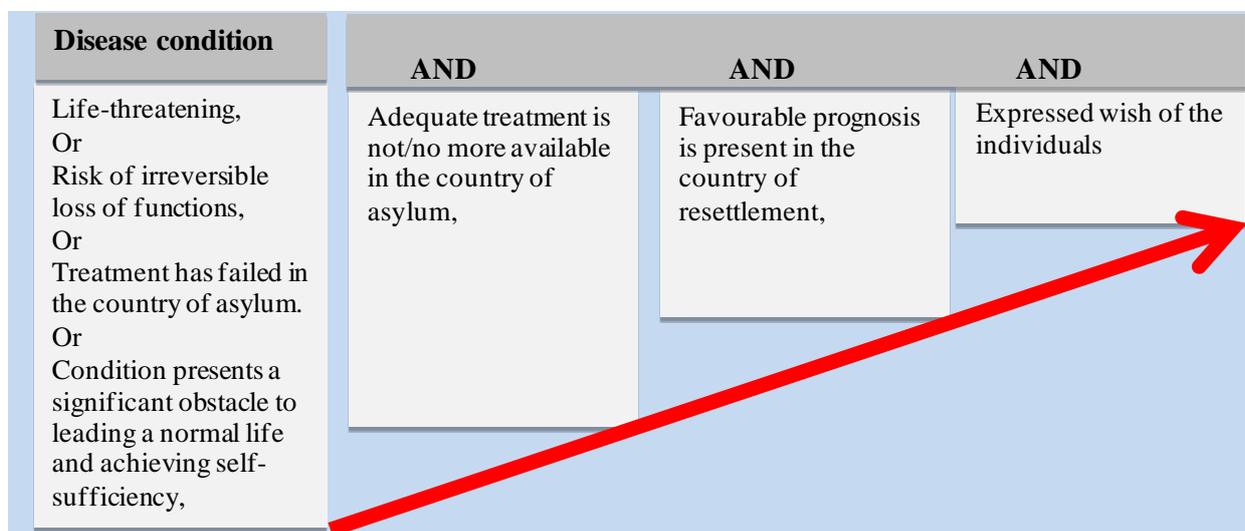
- Tuberculosis which, for the most part, can be both diagnosed and treated at camp level.
- HIV should not be referred unless specific treatment for complication is needed.
- Controlled diabetes mellitus, hypertension, seizure disorders.
- loss of limb, where the patient is now healed and adjusted to the disability; should have access to camp-based physical rehabilitation

Specific conditions related to reproductive health (Family planning, including tubal ligation and treatment for sterility/infertility will need to be decided upon on a case-by-case basis. Where infertility negatively affects a woman or family, due to the inability to fulfil cultural norms, consultation with UNHCR Protection/Community Services staff is advised.).

15 Medical assessment for resettlement

- 15.1 Request on Medical assessment shall be initiated by UNHCR when the existing medical documents (medical summary, laboratory results, radiological investigations, pathology results) are adequate available and updated during the last three months.
- 15.2 IOM shall complete the Medical Assessment Form (MAF) based on the available documents, physical assessment and additional investigated if need arises which shall be returned to the UNHCR Resettlement Officer.
- 15.3 To determine a resettlement on medical grounds as appropriate solution for the refugee, the following conditions must be met (See the figure below).

Figure: Decision for resettlement on medical grounds



16 Supervision, monitoring and evaluation

- 16.1 UNHCR has an overall responsibility for coordinating supervision, monitoring and evaluation of the proper functioning of referral system.
- 16.2 UNHCR, in collaboration with partners, will monitor the performance and the quality of service of health facilities used by refugees bi-annually to ensure that healthcare services are provided in a cost-effective, ethical, non-discriminatory and culturally sensitive manner.
- 16.3 UNHCR will coordinate review of refugees who have been granted urban status on medical grounds on quarterly bases.
- 16.4 A central registrar should be prepared for capturing all referred cases and all refugees who have been given referral are reflect in HIS.
- 16.5 UNHCR shall introduce tool like for example, urban HIS, which would help to monitor the healthcare provision of urban refugees who have been transferred to Addis Ababa on different grounds.
- 16.6 These SOPs will be revised every two years by UNHCR and all partners. The next revision will take place in January 2015.

17 Privacy and confidentiality

- 17.1 Privacy and confidentiality should be respected at all times throughout the referral process.
- 17.2 The principle of purpose-specification should be applied for sharing information about the patient. The principle of purpose-specification consists of 1) the author of the request must be

recognizable and authentic; 2) the request must state its purpose; and 3) the request must be in writing; and 4) consent of the individual concerned should be obtained when needed.

18 Handling of fraud

- 18.1 Refugees should keep away from any form of fraud as any suspicion might result in withholding of medical assistance which is detrimental to their health.
- 18.2 UNHCR has the right to counter-check any suspicious documents through any means available like for example telephone, email, formal letters, interviews and physical visits.

19 Documentation

- 19.1 All the referrals should be well documented on the individual patient card and should be easy to retrieve.
- 19.2 All referrals should be documented in the referral registration book in the refugee camp health facilities and the copy of each referral from the camp is filed separately in a referral file prepared for this purpose only
- 19.3 All the referral from the camp should be entered in to the referral tracking database installed at ARRA Zonal level.
- 19.4 All referrals to national hospitals to Addis Ababa should be entered into the referral tracking database

Distribution of hospitals by region

Region	Number of hospitals
Tigray	18
Afar	3
Amhara	23
Oromiya	31
Somali	8
Benishangul	4
SNNP	45
Gambella	1
Harari	6
Addis Ababa	41
Diredawa	5
Central	10
TOTAL	195

20 Referral sites

		Hospital	Referral focal person	Tel
Sudanse refugee in Fugnido				
		Gambella hospital		
		Aman hospital		
		Bonga hospital		
		Jimma hospital		
		Metu hospital		
		Gore hospital		
Eritrean refugees in Shirie				
		Shirie hospital		
		Axum hospital		
		Adwa hospital		
		Mekele hospital		
		Ayder hospital		
		Kuha Hospital		
Sudanse refugees in Assossa				
		Assossa hospital		
		Begi hospital		
		Nekemt hospital		
		Gimbi hospital		
Somalia refugees in jijiga				
		Jijiga, Kara Mara hospital		
		Diredawa Dill chora hospital		

		Harer hospital		
		Bisidimo hospital		
Somalia refugees in Dollo Ado				
		Dollo Ado		
		Filtu hospital		
		Negele Borena hospital		
		Hawasa hospita		

21 Specialized public Hospitals in Addis Ababa

Gynecology and obstetrics	Gandhi Memorial hospital
Pediatrics and child health	Ethio Swedish pediatric hospital under AAUMF
Fistula	Hamlin Addis Ababa Fistula hospital
Tuberculosis	St Peter Tb specialized hospital
Mental health	Amanuel specialized mental hospital
	Many Private hospitals providing -MCH, Cardiac, etc services

22 Referral decision

ADMINISTRATION FOR REFUGEE/RETURNEE AFFAIRS

Patient Referral Paper

Name of Patient: _____ ProGres Registration No.: _____ Age: _____

Sex: _____ Place of registration: _____ Date: _____

Referral To: _____ From: _____

History: _____

Clinical findings: _____

Laboratory _____

Diagnosis: _____

Treatment: _____

Reason for referral:

Referring Doctor: _____ Signature: _____

Feed back

Name of the patient _____ age _____ Sex _____

Laboratory tests _____

Diagnosis _____

Rx given _____

Recomendation _____

Pass Permit



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National Intelligence and Security Service
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Administration for Refugee Returnee Affairs



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Fax 011 1 55 20 08

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Ref. no.

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Date

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ፍቃድ የሚያበቃበት ቀን _____

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አብረውት ያሉ ቤተሰብ :-

ስም _____

የካርድ ቁጥር _____

ገንኙነት _____

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«ከሠላም ቤት»

PATIENT AGREEMENT FORM

Name of Patient _____ Age _____ Sex _____

ProGres Registration Number _____ Camp _____

I, (name of the patient): _____, hereby agree to return to the above mentioned camp upon the completion of my treatment and investigation at a higher health facility outside the camp.

Signature: _____

Date: _____

CAREGIVER AGREEMENT FORM

Name of Caregiver _____ Age _____ Sex _____

ProGres Registration Number _____ Camp _____

I _____, (name of the caregiver), have been assigned as a caregiver to _____ (name of the patient) and agree to return to the above mentioned camp upon the completion of the patient's treatment and investigation at a higher health facility outside the camp.

Signature: _____

Date: _____

Urban Status Notice

Name _____ **Age** _____ **Sex** _____

Case number _____ ProGres Registration Number _____

This is to inform (name of the refugee) _____ that you have been included in the Urban Assistance Programme and will remain so for the duration of your medical treatment.

This Urban Status entitles you to receive allowances and, if required, accommodation through DICAC. You are also entitled to continue your treatment in (name of the treatment location) _____.

Further decisions will be made after review of your case at the end of the treatment period.

Signed by _____ Date _____

Standardised Specific Needs Codes

SM	Serious medical condition	Serious medical condition that requires assistance, in terms of treatment or provision of nutritional and non-food items, in the country of asylum. Note: Exercise discretion and respect for confidentiality. Note: Assessment of the patient to define whether the condition is moderate or severe would require a specialist/ qualified personnel.
SM-MI	Mental illness	Person who has a mental or psychological condition which impacts on daily functioning. This includes both persons formally diagnosed and persons suspected of having a mental illness. Characteristics of this category include obviously confused thinking; disorientation in time, place or person; marked inattention; obvious loss of contact with reality; clearly peculiar behaviour and severe withdrawal, anxiety, or depression such that daily functioning is affected. Mental illness also includes risk of harm to self or others. Note: A mental impairment is defined as “disability”, when it is long-term and may hinder full and effective participation in society on an equal basis with others. When this is the case, the relevant disability codes (DS-MM and DS-MS) may also apply.
SM-MN	Malnutrition	Person who is either moderately or severely suffering from acute malnutrition as measured by "weight-for-height criteria", "mid-upper-arm circumference" (MUAC) or other recognised anthropometric (=body mass) measurements, and would benefit from a supplementary (or therapeutic) feeding and nutrition programme.

SM-DP (former PG-HR)	Difficult pregnancy	Woman or girl who is diagnosed with a difficult pregnancy, which requires increased medical attention and additional assistance (such as supplementary feeding and nutrition programmes or special travel arrangements). This includes women pregnant as a result of rape, pregnant women without a partner or a support network, pregnant women with HIV, and malnourished pregnant women.
SM-CI	Chronic illness	Person who has a medical condition which requires long-term treatment and medication under the supervision of a physician. Such conditions include diabetes, respiratory illness, cancer, tuberculosis, HIV/AIDS and heart disease. Note: The specific condition or illness should not be recorded. In particular, note that a person living with HIV should be assigned this code, but it should NOT be recorded that he/she has HIV or AIDS.
SM-CC	Critical medical condition	Person who has a life-threatening medical condition which requires immediate, life-saving intervention or treatment.
SM-OT	Other medical condition	Person who has a medical condition not otherwise mentioned, which has a serious impact on the ability to function independently. The condition requires caregiver support, but may not require hospitalisation or continuous medical care.
SM-AD	Addiction	Person who has an alcohol, drug or any other substance addiction that hinders, restricts or impacts his/her daily functioning. This may result in violent behaviour towards family members and/or inability to support family.

DS Disability Physical, mental, intellectual or sensory impairments from birth, or resulting from illness, infection, injury, trauma or old age. These may hinder full and effective participation in society on an equal basis with others.

Note: Assessment of the patient to define whether the condition is moderate or severe would require a specialist/ qualified personnel.

DS-BD Visual impairment (including blindness) Person who has a visual limitation from birth or resulting from illness, infection, injury or old age, which impacts daily life, may restrict independent movement, or require on-going treatment, special education or regular monitoring.

DS-DF Hearing impairment (including deafness) Person who has a hearing limitation from birth or resulting from illness, infection, injury or old age, which impacts daily life, and may require regular treatment, special education, monitoring or maintenance of artificial hearing device. The person may be able to communicate through sign language.

DS-PM Physical disability – moderate Person who has a physical impairment from birth or resulting from illness, injury, trauma or old age, which does not significantly limit the ability to function independently. This category may include mine victims and persons who lost fingers or limbs, which may be corrected with a prosthetic device.

Note: See also the SM-MI code.

DS-PS	Physical disability – severe	Person who has a physical impairment from birth or resulting from illness, injury, trauma or old age, which severely restricts movement, significantly limits the ability to function independently or pursue an occupation, and/or requires assistance from a caregiver.
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Note: See also the SM-MI code.

DS-MM	Mental disability – moderate	Person who has a mental or intellectual impairment from birth or resulting from illness, injury, trauma or old age, which does not significantly limit the ability to function independently and interact, but may require special education, some monitoring and modest medication.
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Note: See also code SM-MI.

DS-MS	Mental disability – severe	Person who has a mental or intellectual impairment from birth or resulting from illness, injury, trauma or old age, which significantly limits the ability to function independently or to pursue an occupation. It requires assistance from a caregiver, and may require medication and/or medical treatment.
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DS-SD	Speech impairment/disability	Person who is unable to speak clearly from birth or resulting from illness, injury, trauma or old age, which restricts or limits the ability to function independently, and may require speech therapy or medical intervention. The person may be able to communicate through sign language.
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UNHCR

MEDICAL ASSESSMENT FORM

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Definitions

Designated Health Professional: in the framework of the referral system, the Designated Health Professional is the person in any given treatment location who is authorised to and responsible for recommending and authorising medical referrals. It is generally the most senior staff (medical doctor, clinical nurse, clinical officer). In most set-ups the midwife on duty will be the Designated Health Professional for emergency obstetric referrals. Designation of an alternative is required for the case of the absence from duty of the Designated Health Professional.

Elective cases: an elective case is a case that would benefit from a procedure (complementary investigation, specialised treatment or surgery) that is advantageous to the patient but is not urgent and not always essential.

Emergency cases: an emergency case is a case of a patient whose life, long-term health or bodily integrity will be at risk because of an illness or an injury, if medical, surgical or obstetrical intervention is not performed rapidly.

Good Prognosis: the prognosis predicts the outcome of the treatment of a disease and therefore the future for the patient. The prognosis is good when it is expected that the patient will either recover fully or that at least his/her health or quality of life will improve significantly.

Primary Health Care (PHC):

Refugee Central Committee: in each camp and in Addis Ababa a committee of elected refugee representatives has been established to ensure adequate representation of refugees' priority needs and views and to identify potential solutions to refugees' problems in their respective locations. 50% female representation is ensured in all committees as well as diverse representation according to age, nationality and ethnicity.

Refugee Women's Association: A committee of refugee women has been established in all camps as well as in Addis Ababa. The WA organises awareness-raising events on issues of gender-equality and sexual and gender-based violence. It also identifies and refers to UNHCR cases of women with specific protection needs.

Secondary Health Care (SHC):

Tertiary Health Care (THC):