Standard 7.10 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE
ASF-STD7-v3.0

WHY THIS STANDARD EXISTS

The absence of complaints is not evidence of a healthy safety culture — it may equally reflect staff who have learned that raising concerns doesn't help, or carries risk. A validated survey measures the thing directly, rather than inferring it from silence.

The evidence: Safety culture surveys are a recognised patient safety measurement practice specifically because staff silence is an ambiguous signal that can indicate either genuine safety or suppressed concern, and only direct measurement distinguishes between them.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A validated safety culture survey is administered on a regular, defined schedule.	✗ No structured survey exists, or an internally improvised, unvalidated tool is used.
✓ Results are reviewed with genuine analysis, not filed without examination.	✗ Surveys were conducted once, historically, with no regular schedule since.
✓ Staff can point to a visible change that resulted from a past survey.	✗ Staff report survey results disappear with no visible follow-up.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A survey is conducted but response rates are low, undermining result reliability.**
Low participation can reflect the same trust issues the survey is trying to measure.

2 **Results are reviewed by leadership but not communicated back to staff.**
A closed feedback loop, invisible to staff, doesn't build the trust genuine improvement requires.

3 **Action is taken on some findings but not others, without a clear rationale communicated.**
Selective, unexplained follow-up can read to staff as results not being taken seriously.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review the current survey tool for validation and the administration schedule for regularity.

Week 2 If response rates are low, investigate why and address barriers to participation.

Week 3 Establish a process to communicate results and planned actions back to staff.

Ongoing Track whether survey-driven actions are visible and completed, and repeat on schedule.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff directly whether they believe the survey leads to real change.
Staff perception of genuine impact is the real test, not survey administration alone.

Check response rates, not just that a survey was sent.
Low participation can itself be a safety culture signal worth investigating.

E-LEARNING academy.gmj.ge/std7-10-safety-culture — 30 min · complete before self-assessment

Standard 7.11 **CORE** · *Standard 7: Governance & Management*

Patient Experience Is Measured Continuously, Not Only After Discharge

ASSESSMENT *ASF-STD7-v3.0*

CR N/A	TR FULL	SM ADAPTED	ST FULL

7.11
CORE
L1

THE STANDARD

Patient Experience Is Measured Continuously, Not Only After Discharge

Patient experience is measured through structured, ongoing feedback during the course of care — not only through the post-discharge complaint channel required elsewhere in this document, which by definition only captures concerns raised after the fact.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is patient experience measured through structured feedback during the stay, not only after discharge?** *Real-time or near-real-time feedback, distinct from the post-discharge complaint channel.* Doc: Ongoing experience measurement tool	YES	PARTIAL	NO
2	**Is feedback collected broadly, not only from patients who happen to volunteer it?** *A systematic approach, not reliance on the small subset of patients naturally inclined to give feedback.* Doc: Feedback collection method	YES	PARTIAL	NO
3	**Is collected feedback actually reviewed and used to inform real improvements?** *Genuine responsiveness, not data collected and left unexamined.* Doc: Feedback review and action record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Measurement tool review*	Reviews the ongoing patient experience measurement tool and collection method for genuine, systematic reach.
DOCUMENT *Response rate check*	Reviews response rates and collection consistency, not reliance on self-selected volunteer feedback alone.
ASK *Feedback action interview*	Asks staff for a specific example of a real improvement made in response to collected experience feedback.

REFERENCES

Ongoing patient experience measurement, distinct from post-discharge complaint mechanisms, is an established quality improvement practice in international hospital accreditation frameworks, providing earlier and more representative signal than complaint-based feedback alone.

Standard 7.11 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE
ASF-STD7-v3.0

WHY THIS STANDARD EXISTS

A complaint channel captures what went wrong badly enough for a patient to formally raise it after leaving. Continuous experience measurement during the stay itself catches smaller, earlier signals — the kind that, addressed in the moment, prevent a bigger problem from developing at all.

The evidence: Ongoing patient experience measurement, distinct from post-discharge complaint mechanisms, is an established quality improvement practice in international hospital accreditation frameworks, providing earlier and more representative signal than complaint-based feedback alone.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Structured feedback is collected systematically during the stay, not only after discharge.	✗ No feedback mechanism exists beyond the post-discharge complaint channel.
✓ Collection reaches a broad, representative sample of patients, not just self-selected volunteers.	✗ Feedback relies entirely on patients who happen to volunteer it, unsystematically.
✓ Real examples exist of improvements made in response to collected feedback.	✗ Feedback is collected but no evidence exists it has ever informed a real change.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Feedback is collected but response rates are low, limiting how representative the picture actually is.**
Low participation can mean the loudest or most engaged voices dominate, not a representative signal.

2 **Feedback is reviewed by leadership but rarely translated into a visible, communicated change.**
A closed feedback loop that doesn't visibly act on input can erode patient willingness to participate over time.

3 **Collection happens for inpatient stays but not for shorter outpatient or day-procedure visits.**
Shorter encounters still shape a patient's real experience and deserve the same measurement discipline.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current patient experience measurement, if any, for systematic reach versus self-selected feedback.

Week 2 Establish or strengthen a structured, ongoing feedback mechanism during the stay.

Week 3 Build a defined review process ensuring feedback actually informs improvement decisions.

Ongoing Track response rates and periodically communicate real changes made in response to feedback.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a specific, real example of a change made from feedback.
A real example reveals genuine responsiveness better than a description of the collection process.

Check response rates, not just that a feedback mechanism exists.
Low participation can undermine how representative the collected picture actually is.

E-LEARNING academy.gmj.ge/std7-11-patient-experience — 30 min · complete before self-assessment

Standard 7.12 **CORE** · *Standard 7: Governance & Management*

A Real Ethics Consultation Process Exists

ASSESSMENT
ASF-STD7-v3.0

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

7.12
CORE
L1

THE STANDARD

A Real Ethics Consultation Process Exists

Staff facing a genuine ethical dilemma in patient care have access to a real, usable ethics consultation process — a committee, a named resource, or an external arrangement — not left to resolve difficult cases alone or through informal corridor conversations.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is there a real, accessible ethics consultation process — committee, named resource, or external arrangement?** *An actual, usable resource, not a theoretical statement that ethical principles matter.* Doc: Ethics consultation process description	YES	PARTIAL	NO
2	**Do staff know how to access it, not just that it exists somewhere in policy?** *Practical, known accessibility — staff can describe how they'd actually use it.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Has the process actually been used for a real case, or does it exist only theoretically?** *Genuine use is the real test of whether this is a functioning resource or a document nobody has needed to open.* Doc: Usage record, or honest absence of one	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Process existence and structure review*	Reviews the ethics consultation process for a real, defined structure, not just a policy statement of principles.
ASK *Staff access interview*	Asks clinical staff how they would actually access ethics consultation for a difficult case.
DOCUMENT *Usage history check*	Checks for any real, documented instance of the process being used, or an honest account of why it hasn't been.

REFERENCES

Access to clinical ethics consultation is an established structural requirement in major international hospital accreditation and governance frameworks, recognising that individual clinicians should not be left to resolve genuine ethical complexity without institutional support.

Standard 7.12 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE
ASF-STD7-v3.0

WHY THIS STANDARD EXISTS

Genuinely difficult ethical situations — conflicting patient and family wishes, uncertain capacity, resource allocation dilemmas — arise in any hospital, and staff facing them without structured support are left to navigate real moral complexity alone, under pressure, in the moment it matters most.

The evidence: Access to clinical ethics consultation is an established structural requirement in major international hospital accreditation and governance frameworks, recognising that individual clinicians should not be left to resolve genuine ethical complexity without institutional support.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A real, structured ethics consultation resource exists and is accessible. ✓ Staff can describe specifically and confidently how they would access it. ✓ Real usage exists, or a credible explanation for why the need hasn't yet arisen.	✗ No real consultation resource exists beyond a general policy statement about ethical principles. ✗ Staff are unaware of how to access any such resource. ✗ The process, if it exists, has never been used and nobody can explain why.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A resource exists but is only accessible during business hours, leaving urgent after-hours dilemmas unsupported.**
Ethical dilemmas don't confine themselves to convenient hours, and a resource that assumes they will has a real coverage gap.

2 **Senior staff know how to access consultation; junior staff facing the same dilemmas often don't.**
Awareness concentrated at senior levels doesn't help staff who most need support in the moment.

3 **A committee exists on paper but hasn't convened or been consulted in a very long time.**
An inactive resource functions similarly to no resource at all when a real case actually arises.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current access to ethics consultation, if any, for real structure versus policy statement.

Week 2 Establish or reinforce a genuinely accessible process, including after-hours coverage.

Week 3 Brief all clinical staff, not only senior staff, on how to access it.

Ongoing Review whether the process is genuinely being used when needed, not just theoretically available.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a junior staff member how they'd access ethics support, not a department head.
This reveals whether awareness genuinely reaches the staff most likely to face difficult cases directly.

Ask about after-hours access specifically.
A resource available only during business hours has a real, common gap worth checking directly.

E-LEARNING academy.gmj.ge/std7-12-ethics-consultation — 30 min · complete before self-assessment

Standard 7.13 **CORE** · *Standard 7: Governance & Management*

Patients and Families Have a Real Voice in Governance

ASSESSMENT *ASF-STD7-v3.0*

CR N/A	TR FULL	SM ADAPTED	ST FULL

7.13
CORE
L1

THE STANDARD

Patients and Families Have a Real Voice in Governance

At least one patient or family representative has a genuine, structured role in quality review or governance discussions — not a governance and quality structure that is entirely staff and board-facing, with patient input arriving only indirectly through complaints or surveys.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does at least one patient or family representative have a genuine, structured role in quality review or governance discussions?** *An actual seat or defined role, not indirect input filtered through staff-collected feedback alone.* Doc: Governance or quality committee structure showing patient/family role	YES	PARTIAL	NO
2	**Is this representative genuinely included in discussion, not present only as an observer?** *Real participation, not token attendance without a voice in the discussion.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Can the facility point to a specific instance where patient or family input shaped a real decision?** *Concrete evidence of influence, not just presence.* Doc: Example of patient/family input shaping a decision	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Governance structure review*	Reviews the governance and quality review structure for a genuine, defined patient or family representative role.
OBSERVE *Meeting participation check*	Where possible, observes or reviews minutes of a governance or quality meeting for genuine representative participation, not passive attendance.
ASK *Influence example interview*	Asks staff and the representative, if available, for a specific example of patient or family input shaping a real decision.

REFERENCES

Patient and family engagement in governance and quality structures, distinct from feedback mechanisms alone, is an established element of patient-centred care frameworks in international hospital accreditation and governance literature.

Standard 7.13 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE
ASF-STD7-v3.0

WHY THIS STANDARD EXISTS

A facility can measure patient experience thoroughly and still make every actual governance and quality decision without a patient or family voice genuinely present in the room. Surveys and complaints are valuable, but they're filtered through staff interpretation before reaching a decision-maker — a structured patient or family role changes what gets heard and how it's weighed.

The evidence: Patient and family engagement in governance and quality structures, distinct from feedback mechanisms alone, is an established element of patient-centred care frameworks in international hospital accreditation and governance literature.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A patient or family representative holds a genuine, structured role in quality review or governance.	✗ No structured patient or family role exists beyond survey and complaint data reaching staff indirectly.
✓ The representative genuinely participates in discussion, not just attends.	✗ A representative attends but does not genuinely participate in discussion.
✓ A specific, real example exists of their input shaping an actual decision.	✗ No example exists of patient or family input ever shaping a real decision.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A representative role exists but the position has been vacant for some time without being filled.**
A defined role that isn't actually occupied provides no real, current voice.

2 **The representative attends but discussions move quickly in technical or clinical language that limits genuine participation.**
Presence without genuine accessibility to the discussion doesn't provide real influence.

3 **Patient input shapes minor operational decisions but rarely reaches larger strategic or safety discussions.**
Influence confined to smaller matters misses the discussions where patient perspective often matters most.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current governance and quality review structure for any existing patient or family voice.

Week 2 Recruit or confirm a patient or family representative for a genuine, structured role.

Week 3 Brief the representative and the governance team on genuine participation expectations, not passive attendance.

Ongoing Track and document specific instances where patient or family input has shaped decisions.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a specific, real example of influence, not a description of the role's existence.
A concrete instance reveals whether this is genuine participation or a symbolic seat.

Check whether the role is currently filled, not just defined in principle.
A vacant position provides no real, current voice regardless of how it's written into governance structure.

E-LEARNING academy.gmj.ge/std7-13-patient-governance-voice — 30 min · complete before self-assessment

STANDARD 8

Medical Tourism

OPTIONAL ENDORSEMENT

10 criteria

	Standard 8.1 NON-NEGOTIABLE · *Standard 8: Medical Tourism* **Pricing Transparency for International Patients**	ASSESSMENT *ASF-STD8-v3.0*

CR N/A	TR FULL	SM FULL	ST FULL

8.1
NON-NEGOTIABLE
L1

THE STANDARD

Pricing Transparency for International Patients

International patients receive a complete, written, all-inclusive cost estimate before travel is booked — covering the procedure, hospital stay, and commonly needed extras — not a partial quote that grows once the patient has already committed to travelling.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is a complete, written cost estimate provided before the patient books travel?** *Before travel is booked, not after arrival — the point where the patient still has a real choice.* Doc: Written estimate, dated before booking	YES	PARTIAL	NO
2	**Does the estimate cover commonly needed extras, not just the base procedure?** *Anaesthesia, extended stay, common complications — the items that turn a quoted price into a real surprise.* Doc: Estimate itemisation	YES	PARTIAL	NO
3	**Can a recent international patient confirm the final cost matched the estimate, or that any difference was clearly explained in advance?** *Tests whether the estimate was honest, not just early.* Doc: N/A — tested directly, or via patient correspondence sample	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Estimate timing and completeness review*	Reviews a sample of international patient files for a complete, itemised estimate dated before travel booking.
ASK *Patient cost experience interview*	Contacts a recent international patient to confirm whether the final cost matched what was estimated, and whether any difference was explained.
DOCUMENT *Itemisation check*	Checks whether estimates include commonly needed extras, not just the headline procedure cost.

REFERENCES

[38] *WHO's guidance on financial protection in health systems identifies advance cost transparency as a determinant of genuine informed consent, a principle that applies with particular force when the patient has limited ability to seek a second opinion or negotiate after arrival.*

Standard 8.1 · *Standard 8: Medical Tourism*
Guidance & Learning

GUIDANCE
ASF-STD8-v3.0

WHY THIS STANDARD EXISTS

A patient who has already booked flights and arranged time away from home has far less power to question a cost surprise than a local patient would. All-inclusive, advance pricing isn't a courtesy in this context — it's the only point in the process where a foreign patient can still genuinely walk away.

The evidence [38]: WHO's guidance on financial protection in health systems identifies advance cost transparency as a determinant of genuine informed consent, a principle that applies with particular force when the patient has limited ability to seek a second opinion or negotiate after arrival.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A complete, itemised estimate is provided before travel is booked, every time.	✗ Estimates are partial, covering only the base procedure with extras added later.
✓ Estimates include common extras, not just the base procedure.	✗ Patients report being surprised by costs only disclosed after arrival.
✓ Patients confirm final costs matched estimates, or differences were clearly explained in advance.	✗ No estimate exists in writing before the patient has already committed to travel.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Estimates are complete for standard cases but not consistently updated for complex ones.**
A patient with a more complex case is exactly the one most likely to face unanticipated costs.

2 **The estimate is accurate but delivered verbally, with no written record the patient can review at home before deciding.**
A spoken estimate is harder for a patient to review carefully or share with someone helping them decide.

3 **Extras are itemised for the procedure but not for potential complications.**
The scenario patients most need protection from is exactly the one least commonly covered.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent international patient files for estimate timing and completeness.

Week 2 Build a standard, itemised estimate template covering common extras and complications.

Week 3 Establish estimate delivery as a required step before any travel booking confirmation.

Ongoing Contact a sample of recent patients to confirm estimate accuracy.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the dated estimate, not a description of the pricing process.
A dated document is the only real evidence timing requirements were met.

Contact a patient directly if possible.
Patient-side confirmation reveals whether the process actually protected them, not just whether a document exists.

E-LEARNING academy.gmj.ge/std8-1-pricing-transparency — 30 min · complete before self-assessment

Standard 8.2 **NON-NEGOTIABLE** · *Standard 8: Medical Tourism*

Remote Records Transfer to Home-Country Physician

ASSESSMENT *ASF-STD8-v3.0*

CR N/A	TR FULL	SM FULL	ST FULL

8.2
NON-NEGOTIABLE
L1

THE STANDARD

Remote Records Transfer to Home-Country Physician

A complete, usable record of the care provided is transferred to the patient's home-country physician, in a format that physician can actually use — not a discharge summary that stays in the treating facility's own system.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is a complete treatment record transferred to the patient's home-country physician, not just given to the patient to pass along?** *Direct transfer, not relying on the patient to correctly deliver and explain their own paperwork.* Doc: Record transfer confirmation	YES	PARTIAL	NO
2	**Is the record provided in a language and format the home physician can genuinely use?** *Translated where needed, not just exported in the treating facility's own internal format.* Doc: Record format and language sample	YES	PARTIAL	NO
3	**Is transfer confirmed as received, not just sent?** *A record sent into an unconfirmed inbox provides no more protection than no record at all.* Doc: Receipt confirmation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Transfer completeness review*	Reviews a sample of international patient files for evidence of direct, complete record transfer to a home physician.
DOCUMENT *Format and language check*	Checks whether transferred records are in a language and format usable by the receiving physician.
OBSERVE *Receipt confirmation check*	Verifies whether transfer includes confirmation of receipt, not just transmission.

REFERENCES

Continuity of care across international transitions is identified in cross-border healthcare literature as a distinct risk point, with incomplete or inaccessible record transfer directly linked to preventable post-return complications.

Standard 8.2 · *Standard 8: Medical Tourism*
Guidance & Learning

GUIDANCE
ASF-STD8-v3.0

WHY THIS STANDARD EXISTS

A patient who returns home after treatment abroad is only as safe as the information their home physician actually receives. A record that exists but never reaches the right person, or reaches them in a format they can't use, provides none of its intended protection.

The evidence: Continuity of care across international transitions is identified in cross-border healthcare literature as a distinct risk point, with incomplete or inaccessible record transfer directly linked to preventable post-return complications.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Complete records are transferred directly to the home physician, confirmed received.	✗ Records are given only to the patient, with no direct transfer to their home physician.
✓ Records are provided in a usable language and format, not just the treating facility's internal export.	✗ Records are transferred in a format or language the receiving physician cannot use.
✓ The process is consistent, not dependent on the patient remembering to request it.	✗ Transfer happens but receipt is never confirmed.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Transfer happens for major procedures but not consistently for smaller or outpatient international cases.**
Perceived significance sometimes determines follow-through discipline, though any procedure can carry post-return risk.

2 **Records are sent but in the treating facility's own template, not adapted for external use.**
Data can be technically present while still being genuinely hard for an outside physician to interpret quickly.

3 **Transfer happens promptly for patients with an easily identified home physician, less reliably otherwise.**
Patients without a clearly named receiving physician are exactly the ones most likely to fall through this gap.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent international patient files for record transfer completeness and confirmation.

Week 2 Establish a standard transfer process and confirmed-receipt requirement.

Week 3 Build translation or reformatting capacity for records going to non-native-language physicians.

Ongoing Audit transfer completeness periodically across all international patient discharges.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for confirmed receipt, not just a sent record.
Confirmation is the only real evidence the information reached someone who could act on it.

Check a case where the home physician wasn't easily identified at discharge.
This is where the process is most likely to break down.

E-LEARNING academy.gmj.ge/std8-2-records-transfer — 30 min · complete before self-assessment

Standard 8.3 **NON-NEGOTIABLE** · *Standard 8: Medical Tourism*

Language Access for Foreign Patients

ASSESSMENT *ASF-STD8-v3.0*

CR N/A	TR FULL	SM FULL	ST FULL

8.3
NON-NEGOTIABLE
L1

THE STANDARD

Language Access for Foreign Patients

Foreign patients have access to a genuinely competent interpreter for consent, treatment discussions, and discharge instructions — not an ad hoc arrangement using whichever staff member happens to speak some of the patient's language.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is a genuinely competent interpreter — professional or trained — used for consent and major treatment discussions?** *Not whichever staff member happens to speak some of the language informally.* Doc: Interpreter engagement record	YES	PARTIAL	NO
2	**Are discharge instructions specifically covered through proper language access, not simplified or skipped due to language barriers?** *Discharge is exactly the point where miscommunication causes the most post-return harm.* Doc: Discharge interpretation record	YES	PARTIAL	NO
3	**Can the facility name which languages it can genuinely support, and what happens when a patient's language isn't covered?** *A specific, honest answer, not a general assurance language is never a problem.* Doc: Language coverage list and gap protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Interpreter engagement review*	Reviews records for evidence of genuine interpreter engagement, not informal ad hoc arrangements, for consent and major discussions.
ASK *Discharge interpretation check*	Asks staff how discharge instructions are specifically handled for patients needing language support.
DOCUMENT *Language coverage and gap protocol review*	Reviews the facility's documented language coverage and what happens when a patient's specific language isn't available.

REFERENCES

Professional interpreter use is consistently associated with improved comprehension, informed consent quality, and clinical outcomes compared with ad hoc interpretation by untrained bilingual staff or family members.

Standard 8.3 · *Standard 8: Medical Tourism*
Guidance & Learning

GUIDANCE
ASF-STD8-v3.0

WHY THIS STANDARD EXISTS

Language access for medical tourism carries the same stakes as language access anywhere else in care, with one added complication: the patient has no established relationship with the local health system to fall back on if communication fails. Genuine interpreter competency, not improvised bilingual staff, is what this actually requires.

The evidence: Professional interpreter use is consistently associated with improved comprehension, informed consent quality, and clinical outcomes compared with ad hoc interpretation by untrained bilingual staff or family members.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Competent interpreters are consistently engaged for consent and major treatment discussions.	✗ Language support relies on whichever staff member happens to speak some of the patient's language.
✓ Discharge instructions are specifically covered through proper language access, not simplified informally.	✗ Discharge instructions are given without adequate language support, relying on patient comprehension alone.
✓ The facility can name its actual language coverage and has a real protocol for gaps.	✗ No specific plan exists for languages outside the facility's usual coverage.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Interpreters are used for the initial consultation but not consistently for follow-up or discharge.**
Language needs don't end after the first conversation, but discipline sometimes does.

2 **Ad hoc bilingual staff are used for common languages, with real interpreters reserved for less common ones.**
Comfort with a widely spoken language can mask genuinely inadequate interpretation quality.

3 **A gap protocol exists but hasn't actually been tested with a real uncommon-language patient.**
An untested plan may reveal gaps only when it's actually needed.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent international patient files for interpreter use consistency across the full care episode.

Week 2 Establish interpreter engagement as a required step for consent, major discussions, and discharge specifically.

Week 3 Document actual language coverage and build a specific protocol for uncovered languages.

Ongoing Review interpreter engagement records periodically, particularly at discharge.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask specifically about discharge, not just the initial consultation.
This is where language support most commonly and consequentially drops off.

Ask what happens for a language the facility doesn't usually encounter.
A real, tested answer reveals genuine preparedness better than a general assurance.

E-LEARNING academy.gmj.ge/std8-3-language-access — 30 min · complete before self-assessment

Standard 8.4 **CORE** · *Standard 8: Medical Tourism*

Travel, Accommodation, and Logistics Coordination

ASSESSMENT *ASF-STD8-v3.0*

CR N/A	TR FULL	SM ADAPTED	ST FULL

8.4
CORE
L1

THE STANDARD

Travel, Accommodation, and Logistics Coordination

The facility provides or coordinates genuine support for travel and accommodation logistics around the procedure — not leaving an international patient, often recovering from treatment, to navigate this entirely alone in an unfamiliar country.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does the facility provide or coordinate genuine support for accommodation appropriate to the patient's recovery needs?** *Matched to actual recovery requirements, not a generic hotel list handed over without guidance.* Doc: Accommodation coordination record	YES	PARTIAL	NO
2	**Is local transport between accommodation and the facility genuinely arranged or clearly explained?** *Not assumed the patient will figure out local transport independently while recovering.* Doc: Transport arrangement record	YES	PARTIAL	NO
3	**Is there a named point of contact for logistics questions during the patient's stay?** *A specific person or service the patient can actually reach, not a general inquiry line.* Doc: Named contact record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Coordination record review*	Reviews a sample of international patient files for evidence of genuine accommodation and transport coordination.
ASK *Patient logistics experience interview*	Contacts a recent international patient about their actual experience navigating accommodation and transport.
DOCUMENT *Named contact verification*	Checks whether a specific, reachable point of contact for logistics was provided to recent patients.

REFERENCES

Patient-reported experience research in medical tourism consistently identifies logistical coordination, not clinical quality alone, as a major determinant of overall satisfaction and perceived safety.

Standard 8.4 · *Standard 8: Medical Tourism*
Guidance & Learning

GUIDANCE
ASF-STD8-v3.0

WHY THIS STANDARD EXISTS

A patient recovering from a procedure in an unfamiliar country, without local language fluency or a support network, faces real logistical risk beyond the clinical care itself. Genuine coordination support — not just a list of nearby hotels — reduces stress that can itself affect recovery.

The evidence: Patient-reported experience research in medical tourism consistently identifies logistical coordination, not clinical quality alone, as a major determinant of overall satisfaction and perceived safety.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Accommodation is matched to actual recovery needs, not a generic list.	✗ Patients are given a generic hotel list with no guidance matched to recovery needs.
✓ Local transport is genuinely arranged or clearly explained in advance.	✗ Local transport is left entirely to the patient to figure out.
✓ A specific, reachable contact exists for logistics questions during the stay.	✗ No specific contact exists; logistics questions go to a general, slow-response inquiry line.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Coordination is strong for the arrival and procedure but drops off during recovery.**
Attention often concentrates on the clinical event itself, less on the days immediately after.

2 **A named contact exists but response times are slow in practice.**
A contact that exists on paper without responsive real service doesn't function as intended.

3 **Accommodation guidance is given but doesn't account for specific procedure-related mobility needs.**
Generic advice can miss what a specific recovery actually requires.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent patient logistics experience through direct outreach or file review.

Week 2 Establish accommodation guidance matched to common recovery scenarios.

Week 3 Name and publicise a specific, responsive logistics contact for the full duration of the stay.

Ongoing Follow up with patients on logistics experience as part of routine post-care contact.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Contact a recent patient directly about their logistics experience.
This reveals the gap between intended support and what patients actually experienced.

Test the named contact's actual responsiveness.
A contact's existence and its real usefulness aren't always the same thing.

E-LEARNING academy.gmj.ge/std8-4-logistics-coordination — 30 min · complete before self-assessment

Standard 8.5 **NON-NEGOTIABLE** · *Standard 8: Medical Tourism*

Post-Return Complication Tracking

ASSESSMENT *ASF-STD8-v3.0*

CR N/A	TR FULL	SM FULL	ST FULL

8.5
NON-NEGOTIABLE
L1

THE STANDARD

Post-Return Complication Tracking

The facility actively tracks what happens to international patients after they return home — including complications discovered by a home-country physician — not just relying on a generic follow-up call that a satisfied patient may not bother answering.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is there a specific, active mechanism to learn about complications discovered after a patient returns home?** *Beyond a generic satisfaction call — a real channel for the patient's home physician or the patient themselves to report a problem.* Doc: Post-return tracking protocol	YES	PARTIAL	NO
2	**Does the facility request feedback from the patient's home physician, not only the patient?** *A home physician is often better positioned to identify a genuine complication than the patient describing symptoms informally.* Doc: Home physician contact record	YES	PARTIAL	NO
3	**Are post-return complications, when identified, tracked and reviewed as a quality indicator?** *Tracking without review misses the chance to improve future international patient care.* Doc: Complication tracking and review record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Tracking mechanism review*	Reviews the post-return tracking protocol for specificity beyond a generic satisfaction call.
DOCUMENT *Home physician contact check*	Checks whether the facility actively seeks feedback from the patient's home physician, not only the patient.
ASK *Complication review interview*	Asks staff whether any post-return complications have been identified and how they were reviewed.

REFERENCES

Post-operative complication tracking following international medical travel is identified in the medical tourism literature as a systemic gap, with most facilities lacking any mechanism to learn about complications that surface after the patient has returned home.

Standard 8.5 · *Standard 8: Medical Tourism*
Guidance & Learning

GUIDANCE
ASF-STD8-v3.0

WHY THIS STANDARD EXISTS

This is the single biggest gap in most medical tourism practice: accountability effectively ends the moment the patient boards their flight home. A complication discovered weeks later by a home physician almost never makes it back to the facility that performed the original procedure, which means the facility never learns from outcomes it should be learning from.

The evidence: Post-operative complication tracking following international medical travel is identified in the medical tourism literature as a systemic gap, with most facilities lacking any mechanism to learn about complications that surface after the patient has returned home.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, active mechanism exists to learn about post-return complications, beyond generic satisfaction calls.	✗ No specific mechanism exists beyond a generic, easily ignored follow-up call.
✓ The facility actively seeks feedback from the patient's home physician where possible.	✗ Feedback is sought only from the patient, never their home physician.
✓ Identified complications are tracked and reviewed as a genuine quality indicator.	✗ No evidence exists that any post-return complication was ever tracked or reviewed.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A follow-up call happens but doesn't specifically ask about complications, only general wellbeing.**
A vague check-in question misses complications a patient may not recognise as connected to their procedure.

2 **Contact is attempted once and not repeated if the patient doesn't respond.**
A single unanswered call shouldn't be the end of the process, especially for higher-risk procedures.

3 **Complications are noted when reported but not systematically reviewed as a pattern.**
Individual incidents can each seem isolated while a pattern reveals a genuine, addressable issue.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current post-return follow-up practice for specificity and actual complication-catching capacity.

Week 2 Build a specific complication-focused follow-up protocol, including outreach to home physicians where possible.

Week 3 Establish a tracking log for any post-return complication identified.

Ongoing Review tracked complications periodically as a quality indicator feeding back into practice.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the actual follow-up questions used, not a description of the general process.
Specific, complication-focused questions reveal genuine intent to catch problems, not just check in politely.

Ask for any real example of a tracked post-return complication.
A real example, or its honest absence, reveals whether this system has ever actually functioned.

E-LEARNING academy.gmj.ge/std8-5-post-return-tracking — 30 min · complete before self-assessment

Standard 8.6 **CORE** · *Standard 8: Medical Tourism*

Visa and Embassy Support Documentation

ASSESSMENT *ASF-STD8-v3.0*

CR N/A	TR FULL	SM FULL	ST FULL

8.6
CORE
L1

THE STANDARD

Visa and Embassy Support Documentation

The facility provides the specific documentation international patients need for medical visa applications and embassy requirements, correctly and promptly — not generic paperwork that leaves the patient to figure out what's actually required themselves.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does the facility know the specific visa and documentation requirements for the countries its patients most commonly travel from?** *Specific, current knowledge, not general awareness that visas are sometimes needed.* Doc: Documentation requirements reference	YES	PARTIAL	NO
2	**Are required documents provided correctly and promptly, avoiding delays that could affect a patient's ability to travel in time?** *Timeliness matters especially for clinically urgent cases.* Doc: Documentation provision timing record	YES	PARTIAL	NO
3	**Is there a named person responsible for visa and embassy documentation support?** *Specific ownership, not a task that falls to whoever happens to have time.* Doc: Role assignment record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Requirements knowledge check*	Reviews the facility's documented knowledge of visa requirements for its most common patient countries of origin.
DOCUMENT *Timing review*	Reviews recent documentation provision timing against patient travel deadlines.
ASK *Responsible person interview*	Asks whoever handles this function to describe the actual process for a recent case.

REFERENCES

Medical travel facilitation literature identifies documentation delays and errors as a leading cause of care-seeking delay for international patients, with downstream clinical consequences for time-sensitive conditions.

Standard 8.6 · *Standard 8: Medical Tourism*
Guidance & Learning

GUIDANCE
ASF-STD8-v3.0

WHY THIS STANDARD EXISTS

Visa and immigration requirements for medical travel are specific and vary by country, and a delayed or incorrect document can derail a patient's ability to travel for care at all, sometimes with real clinical urgency behind the delay. This is a logistics function, but one with real clinical consequences when it fails.

The evidence: Medical travel facilitation literature identifies documentation delays and errors as a leading cause of care-seeking delay for international patients, with downstream clinical consequences for time-sensitive conditions.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The facility maintains current, specific knowledge of documentation requirements for its main patient countries.	✗ Documentation requirements are handled generically without country-specific knowledge.
✓ Documents are provided correctly and with enough lead time for the patient's travel needs.	✗ Delays or errors in documentation have affected patient travel timing.
✓ A named person owns this function and can describe the process confidently.	✗ No one is specifically responsible; the function is handled ad hoc by whoever is available.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Requirements are well known for the most common patient countries but not for less frequent ones.**
Familiarity naturally concentrates on frequent cases, leaving less common ones under-prepared.

2 **Documentation is usually accurate but timing is inconsistent under busy periods.**
Quality and timeliness don't always fail together — one can hold up while the other slips.

3 **Responsibility is informally understood but not formally assigned.**
An informal arrangement can work until the person who usually handles it is unavailable.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Document current visa and embassy requirements for the facility's main patient countries of origin.

Week 2 Review recent documentation timing against patient travel deadlines for any gaps.

Week 3 Formally assign ownership of this function to a named person or role.

Ongoing Update requirements knowledge as regulations change for key countries.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask about a less common patient country of origin, not just the most frequent one.
Preparedness for common cases doesn't guarantee readiness for less familiar ones.

Check actual timing records against a real recent case.
A specific example reveals more than a general assurance about process quality.

E-LEARNING academy.gmj.ge/std8-6-visa-documentation — 30 min · complete before self-assessment

Standard 8.7 **NON-NEGOTIABLE** · *Standard 8: Medical Tourism*

International Patient Complaint and Redress Process

ASSESSMENT *ASF-STD8-v3.0*

CR N/A	TR FULL	SM FULL	ST FULL

8.7
NON-NEGOTIABLE
L1

THE STANDARD

International Patient Complaint and Redress Process

International patients have access to a genuine complaint and redress process reachable from their home country, with real evidence complaints are addressed — not a process that functionally only works for a patient still physically present in the country.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Can an international patient submit a complaint from their home country, in a language they can use?** *Genuinely reachable remotely, in a language the patient can actually communicate in.* Doc: Complaint channel accessibility description	YES	PARTIAL	NO
2	**Is there evidence international patient complaints are actually reviewed and result in a response?** *Not just receipt acknowledgment — a substantive response addressing the actual concern.* Doc: Complaint response record sample	YES	PARTIAL	NO
3	**Does the process account for the practical difficulty of an international patient providing follow-up information or documentation from abroad?** *A process designed only for local patients can create unreasonable barriers for someone no longer in the country.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

OBSERVE *Remote accessibility check*	Verifies the complaint channel is genuinely usable by someone not physically present, in a language they can use.
DOCUMENT *Response record review*	Reviews a sample of international patient complaints for evidence of substantive response, not just acknowledgment.
ASK *Process design interview*	Asks staff how the process accounts for the practical difficulty of a patient providing information from abroad.

REFERENCES

Cross-border patient redress mechanisms are identified in international medical travel governance literature as a distinct requirement from domestic complaint processes, given the specific access barriers international patients face after returning home.

Standard 8.7 · *Standard 8: Medical Tourism*
Guidance & Learning

GUIDANCE
ASF-STD8-v3.0

WHY THIS STANDARD EXISTS

A complaint channel that requires being physically present, or fluent in the local language, or navigating an unfamiliar system from abroad effectively excludes exactly the patients most likely to need it — those who've already returned home when a real problem becomes apparent.

The evidence: Cross-border patient redress mechanisms are identified in international medical travel governance literature as a distinct requirement from domestic complaint processes, given the specific access barriers international patients face after returning home.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The complaint channel is genuinely accessible remotely, in languages international patients actually use.	✗ The complaint process functionally requires physical presence or local language fluency.
✓ Sampled complaints show substantive responses addressing the actual concern.	✗ Complaints receive only automated acknowledgment with no substantive follow-through.
✓ The process is designed with the practical reality of remote patients in mind.	✗ No consideration has been given to the practical barriers facing a patient complaining from abroad.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A channel exists and is technically reachable remotely, but response times are far slower for international complaints.**
A process can be accessible on paper while functioning poorly in practice for the population it's meant to serve.

2 **Complaints are handled well when submitted in the facility's main working language, less well otherwise.**
Language coverage for complaints often lags behind language coverage for clinical care itself.

3 **The process exists but was designed around domestic patients and never specifically reviewed for international use.**
A generic process can carry assumptions that don't hold for someone no longer in the country.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Test the complaint channel's genuine remote accessibility, including language options.

Week 2 Review recent international complaints for response substance and timing.

Week 3 Adapt the process specifically for the practical realities facing a remote, international complainant.

Ongoing Track international complaint response times and outcomes separately from domestic ones.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Try to use the channel yourself as a remote, non-native-language user would.
Direct testing reveals barriers a policy description wouldn't show.

Ask for a real example of an international complaint and its resolution.
A specific case reveals whether the process functions in practice, not just on paper.

E-LEARNING academy.gmj.ge/std8-7-international-complaints — 30 min · complete before self-assessment

Standard 8.8 **NON-NEGOTIABLE** · *Standard 8: Medical Tourism*

Facilitator and Agent Verification

ASSESSMENT *ASF-STD8-v3.0*

CR N/A	TR FULL	SM ADAPTED	ST FULL

8.8
NON-NEGOTIABLE
L1

THE STANDARD

Facilitator and Agent Verification

Any third-party medical tourism facilitator or agent the facility works with is verified and held to a defined standard of conduct — not an unregulated intermediary operating without any accountability to the facility or the patient.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does the facility maintain a list of verified facilitators and agents it actually works with?** *A specific, maintained list, not an open, unmonitored referral relationship with anyone claiming to be an agent.* Doc: Verified facilitator list	YES	PARTIAL	NO
2	**Is there a defined standard of conduct facilitators must meet, covering accurate representation of costs, risks, and outcomes?** *A specific, communicated standard, not an assumption that facilitators will represent things accurately on their own.* Doc: Facilitator conduct standard document	YES	PARTIAL	NO
3	**Is there a process for addressing a facilitator found to have misrepresented information to a patient?** *A defined consequence, not an unaddressed pattern of misrepresentation.*	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Facilitator list review*	Reviews the facility's verified facilitator list and the criteria used to include or exclude an agent.
DOCUMENT *Conduct standard check*	Reviews the defined conduct standard facilitators are held to, checking for specificity beyond a general expectation of good faith.
ASK *Patient-facilitator experience interview*	Asks a recent international patient about the accuracy of what their facilitator told them, comparing it against actual costs and outcomes.

REFERENCES

Medical tourism governance literature consistently identifies unregulated facilitator and agent networks as a distinct risk category, separate from the clinical quality of the treating facility itself.

Standard 8.8 · *Standard 8: Medical Tourism*
Guidance & Learning

GUIDANCE
ASF-STD8-v3.0

WHY THIS STANDARD EXISTS

Medical tourism frequently runs through facilitators and agents who aren't clinically regulated at all, creating a real accountability gap: a patient can be significantly influenced by an agent's representations before ever reaching the facility itself, and if that agent misrepresents costs, risks, or outcomes, the facility bears the reputational and sometimes clinical consequences without ever having controlled the relationship.

The evidence: Medical tourism governance literature consistently identifies unregulated facilitator and agent networks as a distinct risk category, separate from the clinical quality of the treating facility itself.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, maintained list of verified facilitators exists, with clear inclusion criteria.	✗ The facility accepts referrals from any agent claiming to represent patients, with no verification.
✓ A defined conduct standard covers accurate representation of cost, risk, and outcome information.	✗ No specific conduct standard exists for facilitators beyond a general assumption of good faith.
✓ A real process exists for addressing facilitator misrepresentation when identified.	✗ Facilitator misrepresentation, if it occurs, has no defined consequence or review process.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 A list of preferred facilitators exists but isn't actively enforced — unlisted agents still refer patients freely.
A preference without enforcement provides limited real accountability.

2 A conduct standard exists but facilitators were never formally briefed on it.
An unstated expectation, however reasonable, isn't the same as one actually communicated and understood.

3 Patient feedback about facilitator accuracy is heard informally but never systematically reviewed.
Individual complaints can each seem isolated without a mechanism to spot a genuine pattern.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Inventory current facilitator and agent relationships and assess verification status.

Week 2 Establish a specific, communicated conduct standard for facilitators.

Week 3 Build a process for reviewing and addressing facilitator misrepresentation.

Ongoing Cross-check patient-reported facilitator accuracy against actual costs and outcomes periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the actual facilitator list, not a general description of working relationships.
A real, maintained list is the only evidence genuine verification is happening.

Ask a patient directly what their facilitator told them before arrival.
Comparing this against actual experience reveals facilitator accuracy in a way internal records alone cannot.

E-LEARNING academy.gmj.ge/std8-8-facilitator-verification — 30 min · complete before self-assessment

	Standard 8.9 NON-NEGOTIABLE · *Standard 8: Medical Tourism* **Travel-Associated Infection Risk Protocol**	ASSESSMENT *ASF-STD8-v3.0*

CR N/A	TR FULL	SM FULL	ST FULL

8.9
NON-NEGOTIABLE
L1

THE STANDARD

Travel-Associated Infection Risk Protocol

International patients are assessed for travel-associated infection risk specific to their journey and country of origin, with appropriate screening and precautions applied — not treated identically to a local patient with no recent travel history.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a specific screening protocol for travel-associated infection risk applied to international patients?** *Beyond standard admission screening — specific attention to recent travel and country-of-origin risk factors.* Doc: Travel-associated screening protocol	YES	PARTIAL	NO
2	**Does screening account for country-specific resistance patterns where relevant?** *Generic screening can miss risks specific to certain regions or recent healthcare exposure abroad.* Doc: Resistance-pattern reference used	YES	PARTIAL	NO
3	**Are appropriate precautions applied based on screening results, not just documented and set aside?** *Findings that don't change practice provide no real protection.* Doc: Precaution implementation record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Screening protocol review*	Reviews the specific travel-associated infection screening protocol applied to international patients.
DOCUMENT *Resistance-pattern reference check*	Checks whether screening accounts for country-specific antimicrobial resistance patterns where relevant.
OBSERVE *Precaution implementation check*	Checks whether screening findings translate into actual applied precautions, not just documentation.

REFERENCES

Travel-associated antimicrobial resistance and infection risk is a documented, distinct category in infection prevention literature, with international medical travel specifically identified as a transmission risk pathway requiring targeted screening protocols.

Standard 8.9 · *Standard 8: Medical Tourism*
Guidance & Learning

GUIDANCE
ASF-STD8-v3.0

WHY THIS STANDARD EXISTS

International patients carry different exposure histories, and in some cases different antimicrobial resistance profiles, than the local population. A generic infection control approach that doesn't account for this misses a real, specific, and well-documented risk category unique to cross-border care.

The evidence: Travel-associated antimicrobial resistance and infection risk is a documented, distinct category in infection prevention literature, with international medical travel specifically identified as a transmission risk pathway requiring targeted screening protocols.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific travel-associated infection screening protocol is applied to international patients.	✗ International patients are screened identically to local patients, with no travel-specific consideration.
✓ Screening accounts for relevant country-specific resistance patterns.	✗ Country-specific resistance risk is not considered in screening or precautions.
✓ Screening findings translate into genuinely applied precautions.	✗ Screening happens but findings don't change actual precautions applied.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Screening happens but relies on patient self-report of travel and health history, without independent verification where practical.**
Self-report alone can miss risk factors a patient doesn't realise are relevant.

2 **Screening is thorough at admission but not repeated if the patient's stay involves multiple procedures over time.**
Risk factors identified once should inform care throughout the stay, not just the initial encounter.

3 **Precautions are applied inconsistently depending on which staff member manages the case.**
A protocol that depends on individual staff awareness rather than a systematic trigger is less reliable.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current admission screening for travel-specific infection risk elements.

Week 2 Build or strengthen a specific travel-associated risk screening protocol.

Week 3 Establish a clear link between screening findings and specific, applied precautions.

Ongoing Update country-specific resistance pattern references as guidance evolves.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask how screening findings actually change practice, not just whether screening happens.
The link between finding and action is where this standard is most likely to be thin in practice.

Check whether screening is repeated for patients with multiple procedures during one stay.
A single point-in-time screen doesn't necessarily cover a longer, multi-stage international visit.

E-LEARNING academy.gmj.ge/std8-9-travel-infection-risk — 30 min · complete before self-assessment

Standard 8.10 **NON-NEGOTIABLE** · *Standard 8: Medical Tourism*

Post-Procedure Travel Timing and Venous Thromboembolism Risk

ASSESSMENT *ASF-STD8-v3.0*

CR N/A	TR FULL	SM FULL	ST FULL

8.10
NON-NEGOTIABLE
L1

THE STANDARD

Post-Procedure Travel Timing and Venous Thromboembolism Risk

Every international patient receives a specific, documented discussion of safe travel timing after their procedure — including the elevated blood clot risk from combining recent surgery with air travel — not a general assumption that the patient will figure out when it is safe to fly home.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does every international patient receive a specific, documented discussion of safe travel timing for their specific procedure?** *A specific, procedure-appropriate discussion, not a generic travel disclaimer.* Doc: Travel timing discussion documentation	YES	PARTIAL	NO
2	**Is the discussion specific to blood clot risk from combining this procedure with air travel, not general recovery advice?** *The specific risk named directly, not folded into general aftercare instructions.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Can the patient explain back the recommended minimum time before flying, specific to their own procedure?** *Tests genuine understanding specific to this patient, not general awareness that travel timing matters.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Travel timing documentation review*	Reviews records for a specific, procedure-appropriate travel timing discussion.
OBSERVE *Discussion specificity observation*	Observes whether the discussion specifically names blood clot risk, not general recovery advice alone.
ASK *Patient understanding check*	Asks a patient to explain back the recommended travel timing specific to their procedure.

REFERENCES

[42] *Established international travel health guidance recommends against air travel for 10-14 days following major surgery given the combined risk of surgery and air travel for blood clots, including deep vein thrombosis and pulmonary embolism.*

Standard 8.10 · *Standard 8: Medical Tourism*
Guidance & Learning

GUIDANCE
ASF-STD8-v3.0

WHY THIS STANDARD EXISTS

Air travel and surgery each independently increase blood clot risk, and combining them within an unsafe window is a genuine, documented danger specific to medical tourism — a patient who travelled specifically for this procedure has an obvious incentive to fly home as soon as they feel able, which is exactly why this needs to be an explicit conversation, not an assumption.

The evidence [42]: Established international travel health guidance recommends against air travel for 10-14 days following major surgery given the combined risk of surgery and air travel for blood clots, including deep vein thrombosis and pulmonary embolism.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every international patient receives a specific, documented travel timing discussion.	✗ Travel timing is left to general recovery instructions without specific discussion.
✓ The discussion specifically names blood clot risk, not general recovery advice alone.	✗ Blood clot risk is not specifically named or explained.
✓ Patients can explain back the specific recommended timing for their own procedure.	✗ Patients cannot describe any specific recommended timing.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **The discussion happens for major procedures but is abbreviated for shorter or perceived lower-risk ones.**
Even shorter procedures combined with long-haul travel carry genuine, documented risk.

2 **Timing is mentioned but the specific reasoning behind it is not explained.**
Understanding why matters for a patient weighing their own travel decision against the recommendation.

3 **The discussion happens but is not documented, relying on staff memory that it occurred.**
Undocumented discussion is difficult to distinguish from a discussion that did not happen.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for specific, documented travel timing discussion.

Week 2 Build a specific, procedure-appropriate travel timing script into pre-discharge counselling.

Week 3 Establish documentation confirming the discussion occurred for every international patient.

Ongoing Spot-check patient understanding of their specific recommended timing.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask an international patient directly what they were told about travel timing.
This tests actual understanding, not just that a conversation is assumed to have occurred.

Check documentation for a shorter, perceived lower-risk procedure specifically.
This is where the discussion most commonly gets abbreviated or skipped.

E-LEARNING academy.gmj.ge/std8-10-travel-timing — 30 min · complete before self-assessment

STANDARD 9

Refugee & Migrant Health

OPTIONAL ENDORSEMENT

10 criteria

	Standard 9.1 **NON-NEGOTIABLE** · *Standard 9: Refugee & Migrant Health* **People-Centred Care Adapted to Migration and Displacement Experience**	**ASSESSMENT** *ASF-STD9-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

9.1
NON-NEGOTIABLE
L1

THE STANDARD

People-Centred Care Adapted to Migration and Displacement Experience

Care is genuinely adapted to a patient's migration and displacement experience — including trauma-informed practice, awareness of legal-status barriers to access, and support for continuity of care — not delivered identically regardless of that history.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are staff trained to adapt their practice based on a patient's migration and displacement experience, not deliver identical care regardless of history?** *Genuine adaptation, not a generic cultural-awareness statement.* Doc: Training record on migration-adapted care	YES	PARTIAL	NO
2	**Is trauma-informed practice applied, including not routinely asking for detailed trauma history at initial visits?** *WHO specifically advises against probing for detailed trauma history early in care.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Does the facility support continuity of care regardless of a patient's legal status?** *Access not conditioned on documentation the patient may not have or be able to safely provide.* Doc: Access policy regarding legal status	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
ASK *Staff practice interview*	Asks clinical staff how they adapt care for a patient with a known migration or displacement history.
OBSERVE *Trauma-informed practice check*	Reviews intake practice for evidence that detailed trauma history isn't routinely and inappropriately probed at first contact.
DOCUMENT *Legal-status access policy review*	Reviews whether access to care is genuinely not conditioned on legal status documentation.

REFERENCES

[37] *WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.*

Standard 9.1 · *Standard 9: Refugee & Migrant Health*

Guidance & Learning

GUIDANCE
ASF-STD9-v3.0

WHY THIS STANDARD EXISTS

A refugee or migrant patient's health needs and vulnerabilities are shaped by what happened before they ever reached this facility — in their country of origin, in transit, and on arrival. Care that ignores this context, treating every patient as though their history began at the clinic door, misses real, clinically relevant information and can retraumatise someone who has already experienced significant hardship.

The evidence [37]: WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff can describe specific, genuine adaptations made for patients with migration and displacement histories.	✗ Care is delivered identically regardless of stated migration or displacement history.
✓ Trauma-informed practice is evident — safety, choice, and non-judgemental listening, not routine probing for detailed trauma history.	✗ Staff routinely ask for detailed trauma or torture history at first contact.
✓ Care access is not conditioned on legal status documentation.	✗ Patients without full legal documentation are turned away or deprioritised.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Staff are aware of the principle but haven't received specific training on how to apply it practically.**
General awareness doesn't reliably translate into consistent practice without concrete training.

2 **Trauma-informed care is practised by some staff but not consistently across the whole team.**
Individual good practice doesn't guarantee a system-wide standard without deliberate reinforcement.

3 **Legal-status access policy exists but front-line staff apply it inconsistently under uncertainty.**
A written policy needs active reinforcement to survive contact with real, ambiguous cases.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current intake practice for trauma-informed care and legal-status access barriers.

Week 2 Train staff specifically on adapting practice to migration and displacement experience, using the WHO Competency Standards as a reference.

Week 3 Confirm and communicate that access is not conditioned on full legal documentation.

Ongoing Reinforce trauma-informed intake practice through periodic case review.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe an actual intake if possible, not just review the policy.
Trauma-informed practice shows in how questions are actually asked, not in a written statement.

Ask a staff member to describe a real, specific adaptation they made for a patient.
A concrete example reveals genuine practice better than a general description of awareness.

E-LEARNING academy.gmj.ge/std9-1-people-centred-care — 30 min · complete before self-assessment

Standard 9.2 **NON-NEGOTIABLE** · *Standard 9: Refugee & Migrant Health*

Supporting Patient Agency Through Genuine Understanding of Care and the Health System

ASSESSMENT *ASF-STD9-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

9.2
NON-NEGOTIABLE
L1

THE STANDARD

Supporting Patient Agency Through Genuine Understanding of Care and the Health System

Patients are supported to genuinely understand both their own care and how to navigate the health system itself — with understanding actively verified through methods like teach-back, in plain language, not assumed from silence, a nod, or general goodwill information about the system.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is understanding actively checked using a teach-back approach, for both the immediate care plan and how to navigate the system, not assumed from a nod?** *Asking the patient to explain both back in their own words, not just asking "do you understand?"* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Is concrete, practical guidance provided on navigating this health system specifically — appointments, referrals, emergency versus routine care?** *Real navigation guidance, not just general encouragement to seek care.* Doc: Navigation guidance material	YES	PARTIAL	NO
3	**Is information communicated in plain language, avoiding medical jargon, particularly when working through an interpreter?** *Complex terminology strains interpretation and comprehension together.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Teach-back practice observation*	Observes a consultation, or a simulated scenario, to check whether teach-back genuinely verifies understanding of both care and system navigation.
DOCUMENT *Navigation material review*	Reviews any materials or guidance provided on navigating the local health system, in relevant languages.
ASK *Patient understanding check*	Asks a recent refugee or migrant patient to explain back their care plan and how they would access this facility again.

REFERENCES

[37] *WHO Competency Standards 2 and 4 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to assess and support health system literacy as distinct from condition-specific understanding, and to actively verify genuine understanding through methods such as teach-back rather than assuming comprehension from silence.*

Standard 9.2 · *Standard 9: Refugee & Migrant Health*

Guidance & Learning

GUIDANCE
ASF-STD9-v3.0

WHY THIS STANDARD EXISTS

For a refugee or migrant patient, understanding an unfamiliar health system can matter as much for long-term health as any single treatment decision, and a patient who nods along without genuinely understanding — particularly through the added layer of interpretation — can leave with a dangerously incomplete picture of both their care and how to access it again.

The evidence [37]: WHO Competency Standards 2 and 4 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to assess and support health system literacy as distinct from condition-specific understanding, and to actively verify genuine understanding through methods such as teach-back rather than assuming comprehension from silence.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Teach-back genuinely verifies understanding of both the care plan and system navigation.	✗ Understanding is assumed from a nod or silence, with no active verification.
✓ Concrete, translated navigation guidance is provided, not just general encouragement.	✗ Patients leave understanding their specific treatment but not how to access the system again.
✓ Plain language is used consistently, especially when working through an interpreter.	✗ Medical jargon is used routinely, straining both interpretation and comprehension.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Teach-back is used for major treatment decisions but not extended to system-navigation information.**
Understanding how to actually use the system matters as much as understanding the immediate care plan.

2 **System literacy support is given verbally but not reinforced with anything the patient can review later.**
Complex system information delivered once, verbally, under stress is easily forgotten.

3 **Staff assume system literacy for patients who have been in the country longer, missing gaps that may still exist.**
Length of stay does not reliably correlate with genuine system understanding.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Observe current practice for both understanding-verification and system-navigation support.

Week 2 Train staff on teach-back technique and develop translated navigation guidance.

Week 3 Brief staff to proactively cover system literacy alongside the immediate clinical matter.

Ongoing Spot-check patient understanding of both care and system navigation periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe an actual consultation if possible, watching specifically for teach-back covering both care and navigation.
This is a practice that is easy to describe in policy and easy to skip under time pressure.

Ask a patient directly what they understand about accessing care again.
This tests actual system literacy, not just satisfaction with the immediate visit.

E-LEARNING academy.gmj.ge/std9-2-understanding-and-navigation — 30 min · complete before self-assessment

	Standard 9.3 NON-NEGOTIABLE · *Standard 9: Refugee & Migrant Health* **Language and Communication Aids — Interpreters and Cultural Mediators**	ASSESSMENT *ASF-STD9-v3.0*
CR FULL	TR FULL	SM FULL	ST FULL

9.3
NON-NEGOTIABLE
L1

THE STANDARD

Language and Communication Aids — Interpreters and Cultural Mediators

Trained interpreters or cultural mediators are engaged for language-discordant consultations — never minor children, and only family members when genuinely no other option exists and the situation is not high-risk.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are trained interpreters or cultural mediators engaged for language-discordant consultations?** *Not ad hoc bilingual staff or family members as the default.* Doc: Interpreter engagement record	YES	PARTIAL	NO
2	**Is a minor ever used to facilitate interpretation for a family member?** *This should never happen — a specific, absolute rule, not a judgement call.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**When a family member interprets due to genuine unavailability of a trained interpreter, is this reserved for low-risk situations only?** *Not used for informed consent, complex care, competency assessment, or bad news — situations WHO specifically flags as requiring professional language support.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Interpreter engagement review*	Reviews records for evidence of trained interpreter or cultural mediator engagement in language-discordant consultations.
ASK *Minor-interpreter policy check*	Asks staff directly whether minors are ever used to interpret, and confirms understanding that this is never acceptable.
OBSERVE *High-risk situation check*	Checks whether family-member interpretation, where it occurs, is confined to genuinely low-risk situations, never consent or bad news.

REFERENCES

[37] *WHO Competency Standard 3 explicitly states health workers have a responsibility not to engage minors to facilitate interpretation, given the associated significant risk, and identifies inaccuracy, information distortion, and compromised confidentiality as documented risks of family-member interpretation generally.*

Standard 9.3 · *Standard 9: Refugee & Migrant Health*

Guidance & Learning

GUIDANCE
ASF-STD9-v3.0

WHY THIS STANDARD EXISTS

Family members interpreting, especially minors, carries real, well-documented risks — inaccurate interpretation, withheld or distorted information, compromised confidentiality, and trauma to the family member themselves. This is one of the clearest, most specific safeguards in the entire WHO framework, and it exists because the alternative genuinely and measurably harms patients.

The evidence [37]: WHO Competency Standard 3 explicitly states health workers have a responsibility not to engage minors to facilitate interpretation, given the associated significant risk, and identifies inaccuracy, information distortion, and compromised confidentiality as documented risks of family-member interpretation generally.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Trained interpreters or cultural mediators are the default for language-discordant consultations.	✗ Ad hoc bilingual staff or family members are the default, with trained interpreters rarely engaged.
✓ Staff confirm, without hesitation, that minors are never used to interpret.	✗ A minor has been used to interpret, even occasionally.
✓ Family-member interpretation, when it happens, is reserved for genuinely low-risk situations only.	✗ Family members interpret for high-risk situations like informed consent or bad news.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Trained interpreters are used for major appointments but family members fill in for quick or informal interactions.**
Risk doesn't scale down proportionally with how brief or informal an interaction feels.

2 **The no-minors rule is understood by senior staff but not consistently reinforced with newer or junior staff.**
A critical safeguard needs to be embedded in onboarding, not assumed as common knowledge.

3 **Interpreter access exists during business hours but reverts to family members after hours or in emergencies.**
Coverage gaps at specific times undermine an otherwise sound policy.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent language-discordant consultations for interpreter engagement patterns.

Week 2 Establish or reinforce trained interpreter access, including after-hours and emergency coverage.

Week 3 Brief all staff explicitly and unambiguously that minors are never used to interpret.

Ongoing Audit family-member interpretation instances to confirm they're confined to genuinely low-risk situations.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask the minor-interpreter question directly and expect an immediate, confident answer.
Any hesitation on this specific point is a serious signal worth investigating further.

Check after-hours and emergency interpreter coverage specifically.
This is where the policy is most likely to quietly lapse.

E-LEARNING academy.gmj.ge/std9-3-interpreters — 30 min · complete before self-assessment

Standard 9.4 **CORE** · *Standard 9: Refugee & Migrant Health*

Collaborative Practice Across Health and Social Services

ASSESSMENT *ASF-STD9-v3.0*

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

9.4
CORE
L1

THE STANDARD

Collaborative Practice Across Health and Social Services

The facility actively engages with legal, education, employment, housing, and other social support services relevant to refugee and migrant patients, and conducts effective handover of care that includes migration- and displacement-related context — not treating health care as isolated from these interconnected factors.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does the facility have working relationships with relevant legal, housing, or social support services for referral?** *Actual working relationships, not just awareness that such services theoretically exist.* Doc: Referral relationship record	YES	PARTIAL	NO
2	**Does handover of care to another provider include migration- and displacement-related context, not just clinical facts?** *Cultural, language, and migration context specifically included in handover.* Doc: Handover documentation sample	YES	PARTIAL	NO
3	**Are staff from refugee or migrant backgrounds, where present, genuinely utilised for their relevant skills and insight?** *Recognising this as a specific asset, not incidental to their role.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Referral relationship review*	Reviews evidence of actual working relationships with relevant social support services, not just theoretical awareness.
DOCUMENT *Handover content review*	Reviews handover documentation for inclusion of migration- and displacement-related context, not clinical facts alone.
ASK *Collaborative practice interview*	Asks staff to describe a real instance of engaging social support services for a refugee or migrant patient.

REFERENCES

[37] *WHO Competency Standard 5 requires engagement with broader social and community support services and effective handover of care that specifically includes cultural, language, and migration- and displacement-related considerations.*

Standard 9.4 · *Standard 9: Refugee & Migrant Health*

Guidance & Learning

GUIDANCE
ASF-STD9-v3.0

WHY THIS STANDARD EXISTS

Housing, legal status, and social support don't just sit alongside a refugee or migrant patient's health — they actively shape it. A facility that treats health in isolation from these factors, or that fails to hand over migration-related context to the next provider in a patient's care, misses information a purely clinical view wouldn't capture.

The evidence [37]: WHO Competency Standard 5 requires engagement with broader social and community support services and effective handover of care that specifically includes cultural, language, and migration- and displacement-related considerations.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Real, working referral relationships exist with relevant legal, housing, and social support services.	✗ No real working relationships exist with social support services beyond general awareness they exist.
✓ Handover documentation consistently includes migration- and displacement-related context.	✗ Handover documentation covers clinical facts only, omitting migration-related context entirely.
✓ Staff can describe genuine, specific examples of collaborative practice across services.	✗ Staff cannot describe any specific instance of collaborative, cross-service practice.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Referral relationships exist for the most common needs but not for less frequent ones.**
Coverage naturally concentrates where demand is highest, leaving gaps elsewhere.

2 **Handover includes some migration context but inconsistently, depending on which staff member completes it.**
Individual practice variation without a standard template produces uneven results.

3 **Collaboration happens reactively when a crisis emerges, not proactively as part of routine care.**
Reactive engagement misses opportunities for earlier, less crisis-driven support.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Map current referral relationships with relevant social support services.

Week 2 Build or strengthen relationships with services covering common gaps.

Week 3 Standardise handover documentation to consistently include migration-related context.

Ongoing Review collaborative practice examples periodically to confirm it remains genuine, not nominal.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real, specific referral example, not a general description of awareness.
A concrete instance reveals whether relationships are genuinely working, not just theoretically available.

Check handover documentation directly for migration-related content.
This is a specific, checkable detail that reveals whether the practice is systematic or incidental.

E-LEARNING academy.gmj.ge/std9-5-collaborative-practice — 30 min · complete before self-assessment

Standard 9.5 **NON-NEGOTIABLE** · *Standard 9: Refugee & Migrant Health*

Surge Capacity for Migration-Related Demand

ASSESSMENT *ASF-STD9-v3.0*

CR FULL	TR FULL	SM ADAPTED	ST FULL

9.5
NON-NEGOTIABLE
L1

THE STANDARD

Surge Capacity for Migration-Related Demand

The facility has a real, activatable plan for responding flexibly to sudden increases in demand from migration or displacement events — expansion of assessment points, treatment distribution, and focus on critical needs — not an assumption that routine capacity will simply absorb any surge.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does the facility have a specific, written plan for surge response to migration-related demand increases?** *A specific plan, not a general assumption that staff will manage if it happens.* Doc: Surge response plan document	YES	PARTIAL	NO
2	**Has this plan actually been tested or exercised, not just written and filed?** *An untested plan's real gaps remain unknown until an actual surge reveals them.* Doc: Drill or exercise record	YES	PARTIAL	NO
3	**Does the plan address staff wellbeing and burnout risk during a surge, not only operational capacity?** *Sustained surge response carries real staff mental health risk that a purely operational plan can miss.* Doc: Staff support provisions within the plan	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Surge plan review*	Reviews the surge response plan for specificity covering assessment expansion, treatment distribution, and critical-needs focus.
DOCUMENT *Exercise record check*	Checks for evidence the plan has been tested through drill or exercise, not only written.
ASK *Staff wellbeing provision interview*	Asks whether the plan addresses staff support and burnout risk during a sustained surge.

REFERENCES

[37] *WHO Competency Standard 6 specifically requires health workers to respond flexibly and collaboratively to migration- and displacement-related surges in demand, identifying expansion of assessment points, treatment distribution, and focus on critical needs as key response elements.*

Standard 9.5 · *Standard 9: Refugee & Migrant Health*

Guidance & Learning

GUIDANCE
ASF-STD9-v3.0

WHY THIS STANDARD EXISTS

Surges in demand are a predictable, recurring feature of refugee and migrant health services, not a rare exception — driven by seasonal movement, policy changes, or humanitarian crises. A facility without a real, practised surge plan will improvise under exactly the conditions where improvisation is most likely to fail.

The evidence [37]: WHO Competency Standard 6 specifically requires health workers to respond flexibly and collaboratively to migration- and displacement-related surges in demand, identifying expansion of assessment points, treatment distribution, and focus on critical needs as key response elements.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, written surge response plan exists covering key operational elements.	✗ No specific surge plan exists beyond an assumption that staff will manage.
✓ The plan has been tested through drill or actual surge experience, with lessons incorporated.	✗ The plan, if it exists, has never been tested or exercised.
✓ Staff wellbeing and burnout risk during a surge are explicitly addressed.	✗ Staff wellbeing during a surge is not addressed anywhere in the plan.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **An operational surge plan exists but hasn't been updated since it was first written.**
Staffing, capacity, and context all change over time, and a stale plan may not reflect current reality.

2 **The plan addresses capacity expansion well but doesn't name specific triggers for activation.**
Without a clear activation threshold, a good plan can be deployed too late to be genuinely useful.

3 **Staff support exists informally but isn't written into the plan itself.**
Informal good intentions can lapse under the exact pressure a real surge creates.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review the current surge plan, if one exists, for specificity and currency.

Week 2 Define clear activation triggers and update capacity expansion elements.

Week 3 Add explicit staff wellbeing and burnout-prevention provisions to the plan.

Ongoing Exercise the plan periodically, even at small scale, to keep it genuinely actionable.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the activation trigger specifically, not just the plan's existence.
A plan without a clear trigger risks being deployed too late to matter.

Ask how the facility has handled a real past surge, if one has occurred.
Real experience, or its honest absence, reveals more than a hypothetical plan alone.

E-LEARNING academy.gmj.ge/std9-6-surge-capacity — 30 min · complete before self-assessment

	Standard 9.6 **CORE** · *Standard 9: Refugee & Migrant Health* **Evidence-Informed Care for Refugee and Migrant Populations**	**ASSESSMENT** *ASF-STD9-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

9.6
CORE
L1

THE STANDARD

Evidence-Informed Care for Refugee and Migrant Populations

Staff use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where evidence gaps remain, and adapt practice accordingly — not applying general population guidelines uncritically to a population with documented, different health needs.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Do staff have access to and use evidence-informed guidelines specific to refugee and migrant health, where they exist?** *Specific guidance, not just general clinical guidelines applied without adaptation.* Doc: Guideline access and reference record	YES	PARTIAL	NO
2	**Can staff describe how refugee and migrant health needs may differ from the general population for conditions they commonly treat?** *Genuine awareness of specific, relevant differences, not a general acknowledgment that differences might exist.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there a process for identifying and responding to gaps in evidence specific to this population?** *Recognising uncertainty is itself part of good practice here, not something to paper over.* Doc: Evidence gap identification process	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Guideline access review*	Checks whether staff have access to evidence-informed guidelines specific to refugee and migrant health.
ASK *Population-difference awareness interview*	Asks staff to describe specific ways refugee and migrant health needs differ from the general population for conditions they commonly see.
DOCUMENT *Evidence gap process review*	Reviews any process for identifying and responding to evidence gaps specific to this population.

REFERENCES

[37] *WHO Competency Standard 7 requires health workers to use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain.*

Standard 9.6 · *Standard 9: Refugee & Migrant Health*

Guidance & Learning

GUIDANCE
ASF-STD9-v3.0

WHY THIS STANDARD EXISTS

Refugee and migrant health needs genuinely differ from the general population in ways that matter clinically — different disease prevalence patterns, different exposure histories, different care-seeking barriers. Care that ignores this and applies general guidelines uncritically can miss real, evidence-based adjustments this specific population needs.

The evidence [37]: WHO Competency Standard 7 requires health workers to use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff have genuine access to and use guidelines specific to refugee and migrant health where they exist.	✗ General population guidelines are applied uncritically with no adaptation for this population's documented differences.
✓ Staff can describe specific, relevant differences in health needs for conditions they commonly treat.	✗ Staff cannot describe any specific way refugee and migrant health needs differ from the general population.
✓ A real process exists for identifying and responding to evidence gaps.	✗ No process exists for identifying where evidence for this population is genuinely lacking.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Awareness exists among senior clinical staff but hasn't been systematically shared with the wider team.**
Knowledge held by a few doesn't guarantee it shapes practice across the whole facility.

2 **Specific guidelines are used for some conditions but general guidelines are applied uncritically for others.**
Coverage often concentrates on the most visible or common conditions, leaving others under-adapted.

3 **Evidence gaps are recognised informally but never documented or fed back into practice improvement.**
An unrecorded recognition doesn't accumulate into genuine organisational learning over time.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current guideline use for evidence-informed, population-specific content.

Week 2 Identify and distribute relevant refugee and migrant health guidelines where they exist.

Week 3 Brief staff on documented population-specific health need differences relevant to common conditions.

Ongoing Track identified evidence gaps and revisit guidance as new evidence emerges.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask about a specific, common condition, not a general question about awareness.
Specificity reveals genuine knowledge better than a general question would.

Ask what happens when evidence for this population genuinely doesn't exist.
A thoughtful answer to genuine uncertainty is itself a sign of good practice here.

E-LEARNING academy.gmj.ge/std9-7-evidence-informed-care — 30 min · complete before self-assessment

	Standard 9.7 NON-NEGOTIABLE · *Standard 9: Refugee & Migrant Health* **Staff Reflective Practice, Bias Awareness, and Self-Care in Migration Contexts**	ASSESSMENT *ASF-STD9-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

9.7
NON-NEGOTIABLE
L1

THE STANDARD

Staff Reflective Practice, Bias Awareness, and Self-Care in Migration Contexts

Staff maintain active awareness of their own culture, beliefs, and potential biases through structured reflective practice, and the facility actively fosters a supportive team environment with genuine access to psychological support — not assumed self-awareness or an assumption that staff will manage vicarious trauma exposure on their own.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does the facility have a structured process for staff reflective practice regarding bias and cultural awareness?** *A defined process, not an assumption that staff will naturally self-reflect adequately.* Doc: Reflective practice process description	YES	PARTIAL	NO
2	**Does the facility provide genuine, accessible psychological support and a structured space to debrief difficult cases?** *Actual, used support and a real, regular opportunity, not a theoretical benefit or informal hope.* Doc: Psychological support and debrief process record	YES	PARTIAL	NO
3	**Can staff describe a specific instance of adapting their practice after recognising a bias, and do they recognise signs of vicarious trauma in themselves or colleagues?** *Genuine, concrete examples, not general statements of good intentions or awareness.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Reflective practice process review*	Reviews the facility's structured process, if any, for staff reflective practice on bias and cultural awareness.
DOCUMENT *Support and debrief access review*	Reviews what psychological support and debrief structure genuinely exist and whether they are actually used.
ASK *Staff example interview*	Asks a staff member for a specific instance of recognising and adapting for their own bias, and how they or the team handled a recent difficult case.

REFERENCES

[37] *WHO Competency Standards 8 and 9 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to maintain structured awareness of their own biases and institutional discrimination's impact, and to engage in self-care within a supportive team environment addressing the wellbeing impacts of migration-context care.*

Standard 9.7 · *Standard 9: Refugee & Migrant Health*

Guidance & Learning

GUIDANCE
ASF-STD9-v3.0

WHY THIS STANDARD EXISTS

Unacknowledged bias shapes clinical judgement in ways that are genuinely hard to see from the inside, and staff providing this care are regularly exposed, secondhand, to accounts of hardship and trauma — both are real, documented occupational realities of this work, and both require structured, deliberate support rather than being left to individual capacity alone.

The evidence [37]: WHO Competency Standards 8 and 9 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to maintain structured awareness of their own biases and institutional discrimination's impact, and to engage in self-care within a supportive team environment addressing the wellbeing impacts of migration-context care.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A structured reflective practice process genuinely exists and is used, not just assumed.	✗ No structured reflective practice process exists beyond an assumption of individual self-awareness.
✓ Genuine, accessible psychological support and debrief structure exist and staff actually use them.	✗ Psychological support exists only nominally, with no evidence staff actually access it.
✓ Staff can describe specific, real examples of both bias adaptation and vicarious trauma awareness.	✗ Staff cannot describe any specific example of adapting practice or recognising vicarious trauma.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Reflective practice happens informally among some staff but is not structured or facility-wide.**
Individual good practice does not reliably generalise without a defined, shared process.

2 **Support exists but staff are unaware it is available or feel discouraged from using it.**
A benefit's existence does not guarantee genuine, comfortable access to it.

3 **Debriefs happen after major incidents but not as a routine practice for cumulative, everyday difficulty.**
Vicarious trauma often builds cumulatively, not only from single major events.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current training content and support access for genuine coverage of bias and staff wellbeing.

Week 2 Establish a structured reflective practice process and strengthen debrief structure.

Week 3 Deliver specific training on institutional discrimination and normalise use of available psychological support.

Ongoing Revisit reflective practice and staff wellbeing periodically, using real case examples where appropriate.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a specific personal example, not a general statement of awareness.
A concrete instance distinguishes genuine reflective practice from familiarity with the concept.

Ask staff directly whether they have used available support, not just whether it exists.
Genuine uptake, not nominal availability, is the real test.

E-LEARNING academy.gmj.ge/std9-8-reflective-practice-and-self-care — 30 min · complete before self-assessment

	Standard 9.8 **NON-NEGOTIABLE** · *Standard 9: Refugee & Migrant Health* **Cross-Border Continuity of Care**	**ASSESSMENT** *ASF-STD9-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

9.8
NON-NEGOTIABLE
L1

THE STANDARD

Cross-Border Continuity of Care

Patients are supported to hold their own health information and documentation in a portable form — paper or electronic — that functions when they move across a border or between health systems, recognising the genuine mobility of refugee and migrant populations.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are patients given their own portable health record, in a form they can carry with them?** *Something the patient physically or digitally holds themselves, not only a record in the facility's internal system.* Doc: Patient-held record sample	YES	PARTIAL	NO
2	**Is the record kept updated as care continues, not given once and left static?** *An outdated record loses much of its value for continuity of care.* Doc: Record update practice	YES	PARTIAL	NO
3	**Does the record include information — medication history, vaccination record — that would be genuinely useful to a different provider in a different country?** *Content specifically useful across a border, not just internally relevant notes.* Doc: Record content sample	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Patient-held record review*	Reviews whether patients are provided a genuine, portable health record, and its actual content.
OBSERVE *Update practice check*	Checks whether patient-held records are updated as care continues, not issued once and left static.
ASK *Patient practice interview*	Asks a refugee or migrant patient whether they were given and understand how to use their own portable record.

REFERENCES

[37] *WHO's explanatory notes for Competency Standard 1 specifically identify patient-held records — paper or electronic — updated regularly, as a key strategy for improving continuity of care given the mobility of refugee and migrant populations.*

Standard 9.8 · *Standard 9: Refugee & Migrant Health*

Guidance & Learning

GUIDANCE
ASF-STD9-v3.0

WHY THIS STANDARD EXISTS

A refugee or migrant patient's mobility isn't a hypothetical edge case — it's a defining feature of the population this standard exists to serve. A record that only exists inside one facility's own system provides no protection the moment that patient needs care somewhere else, which for this population is often exactly when it matters most.

The evidence [37]: WHO's explanatory notes for Competency Standard 1 specifically identify patient-held records — paper or electronic — updated regularly, as a key strategy for improving continuity of care given the mobility of refugee and migrant populations.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Patients are consistently given a genuine, portable health record they hold themselves.	✗ No patient-held record exists beyond what stays in the facility's own internal system.
✓ Records are updated as care continues, not static from a single point in time.	✗ Records are given once and never updated as care continues.
✓ Record content — medication, vaccination history — is genuinely useful across a border.	✗ Record content is too facility-specific to be genuinely useful elsewhere.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A patient-held record exists but isn't consistently offered to every relevant patient.**
A good practice that depends on individual staff remembering to offer it isn't yet a reliable system.

2 **Records are given but patients aren't clearly told how or why to keep and use them.**
A document without explanation of its purpose is less likely to be genuinely used.

3 **Updates happen for major changes but not consistently for smaller, cumulative ones.**
Gradual changes can leave a real gap between the record and the patient's actual current status.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for providing patients their own portable health records.

Week 2 Establish a standard patient-held record format and consistent offering practice.

Week 3 Brief patients clearly on the purpose and use of their own portable record.

Ongoing Build record updates into routine care so they don't become static over time.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a patient directly whether they have and understand their own record.
Patient-side confirmation reveals whether this is genuinely functioning, not just policy.

Check record content for genuine cross-border usefulness, not just facility-internal notes.
Content specificity is what determines whether this actually helps continuity of care elsewhere.

E-LEARNING academy.gmj.ge/std9-10-cross-border-continuity — 30 min · complete before self-assessment

Standard 9.9 **NON-NEGOTIABLE** · *Standard 9: Refugee & Migrant Health*

Camp-Based and Non-Camp Service Model Fit

ASSESSMENT *ASF-STD9-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

9.9
NON-NEGOTIABLE
L1

THE STANDARD

Camp-Based and Non-Camp Service Model Fit

The facility explicitly identifies which service model it operates under — formal camp, informal urban settlement, reception or transit centre, or established resettlement context — and demonstrates its practices are genuinely fit for that specific context, not a generic approach applied uniformly regardless of setting.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Can the facility clearly state which service model it operates under, and why that classification fits its actual context?** *A specific, considered answer, not an assumption that one generic approach applies everywhere.* Doc: Service model self-classification	YES	PARTIAL	NO
2	**Are the facility's specific practices — staffing, scheduling, outreach — genuinely adapted to that model, not copied from a different context?** *Real adaptation, not a generic template applied regardless of actual setting.* Doc: Model-specific practice adaptation record	YES	PARTIAL	NO
3	**Has the facility considered what changes if its population or context shifts between models over time?** *Genuine preparedness for a changing situation, not an assumption the current model is permanent.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

ASK *Model self-classification interview*	Asks facility leadership to state and justify which service model the facility actually operates under.
DOCUMENT *Practice adaptation review*	Reviews whether specific practices are genuinely adapted to the stated model, not generically applied.
ASK *Context-shift preparedness interview*	Asks how the facility would adapt if its population or operating context shifted between models.

REFERENCES

[37] *WHO's multicountry review underpinning the Global Competency Standards identified four broad models of care for refugee and migrant populations — mainstream, specialised-focus, gateway, and limited/external-actor — and found that service delivery approaches vary meaningfully across them.*

Standard 9.9 · *Standard 9: Refugee & Migrant Health*

Guidance & Learning

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ASF-STD9-v3.0

WHY THIS STANDARD EXISTS

A facility serving a protracted encampment, an informal urban refugee population, an active transit and reception context, and an established resettlement population are facing genuinely different operational realities — different infrastructure, different population turnover, different legal and logistical constraints. A standard that assumes one model fits everywhere isn't actually usable everywhere it claims to apply.

The evidence [37]: WHO's multicountry review underpinning the Global Competency Standards identified four broad models of care for refugee and migrant populations — mainstream, specialised-focus, gateway, and limited/external-actor — and found that service delivery approaches vary meaningfully across them.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The facility can clearly state and justify its specific service model.	✗ The facility cannot articulate which service model it actually operates under.
✓ Practices are genuinely adapted to that model, not a generic template.	✗ Practices are generic, apparently copied from an unrelated context, without adaptation.
✓ There's real awareness of how the facility would adapt if its context shifted.	✗ No consideration has been given to what would change if the population or context shifted.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **The model is understood by leadership but not reflected consistently in front-line practice.**
Strategic awareness doesn't automatically translate into operational adaptation without deliberate effort.

2 **Practices are well adapted for the primary population served but not for a secondary group also present.**
Facilities serving mixed populations can default to their majority context and under-serve others.

3 **The classification was accurate when first made but hasn't been revisited as the context evolved.**
Refugee and migrant contexts can shift meaningfully over time, and a stale classification may no longer fit.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Have leadership explicitly classify and document the facility's actual service model.

Week 2 Review current practices for genuine fit against that specific model.

Week 3 Adjust any practices found to be generically applied rather than context-adapted.

Ongoing Revisit the model classification periodically as population or context may shift.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask the classification question directly and expect a specific, considered answer.
Hesitation or vagueness here often signals the facility hasn't genuinely thought through its own context.

Check for evidence of real adaptation, not just a template with the local name inserted.
Superficial customisation can look like adaptation without functioning as it.

E-LEARNING academy.gmj.ge/std9-11-service-model-fit — 30 min · complete before self-assessment

	Standard 9.10 **NON-NEGOTIABLE** · *Standard 9: Refugee & Migrant Health* **Legal Status Diversity Recognition**	**ASSESSMENT** *ASF-STD9-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

9.10
NON-NEGOTIABLE
L1

THE STANDARD

Legal Status Diversity Recognition

The facility can name which legal status categories it actually serves — asylum seeker, recognised refugee, stateless person, internally displaced person, and others — and demonstrates it doesn't apply a single, uniform assumption about access rights across all of them.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Can staff name the different legal status categories among the patients this facility actually serves?** *Specific awareness of asylum seeker, refugee, stateless, and internally displaced distinctions relevant to this context.* Doc: Staff knowledge of legal status categories served	YES	PARTIAL	NO
2	**Does the facility apply a single, uniform assumption about access rights, or does it recognise genuine differences by status?** *Genuine differentiation where it legally matters, not a one-size-fits-all approach.* Doc: Access policy by legal status category	YES	PARTIAL	NO
3	**Are staff aware of the particular vulnerabilities that can attach to a specific legal status, such as statelessness?** *Specific, not generic, awareness of status-linked risk.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

ASK *Legal status awareness interview*	Asks staff to name and describe the legal status categories among patients they actually serve.
DOCUMENT *Access policy review*	Reviews whether access policy genuinely differentiates by legal status category where legally relevant, rather than applying one assumption uniformly.
ASK *Status-specific vulnerability interview*	Asks staff about specific vulnerabilities linked to a particular legal status relevant to this facility's population.

REFERENCES

[37] *WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.*

Standard 9.10 · *Standard 9: Refugee & Migrant Health*

Guidance & Learning

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ASF-STD9-v3.0

WHY THIS STANDARD EXISTS

Asylum seeker, recognised refugee, stateless person, and internally displaced person are not interchangeable categories — they carry genuinely different legal access rights in different countries, and treating them as one undifferentiated group risks either wrongly denying care someone is entitled to, or missing a specific vulnerability tied to a particular status.

The evidence [37]: WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff can specifically name and describe the legal status categories among patients they serve.	✗ Staff cannot distinguish between different legal status categories among their own patient population.
✓ Access policy genuinely differentiates by status where legally relevant, not applied uniformly.	✗ A single, uniform assumption about access rights is applied regardless of actual legal status.
✓ Staff demonstrate specific awareness of vulnerabilities linked to particular legal statuses.	✗ No awareness exists of status-specific vulnerabilities, such as those facing stateless persons.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Awareness exists for the most common status category served but not for less frequent ones.**
Familiarity naturally concentrates on the majority population, leaving smaller groups under-recognised.

2 **Access policy differentiates on paper but front-line staff apply it inconsistently in practice.**
A correct written policy still needs active reinforcement to hold under real, ambiguous cases.

3 **General awareness of legal status differences exists without specific knowledge of this context's relevant distinctions.**
Abstract awareness of the concept doesn't guarantee it's been applied to this facility's actual population.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Identify which legal status categories are actually present among the facility's patient population.

Week 2 Review and correct access policy to genuinely differentiate by status where legally relevant.

Week 3 Brief staff specifically on status-linked vulnerabilities relevant to this population.

Ongoing Revisit legal status awareness as the facility's population composition may shift over time.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff to name the specific categories, not just confirm general awareness that differences exist.
Specificity reveals whether this understanding is genuinely operational.

Ask about a less common status category present in this population.
This is where recognition gaps are most likely to concentrate.

E-LEARNING academy.gmj.ge/std9-12-legal-status-diversity — 30 min · complete before self-assessment

References

Numbered references below are formal citations, in Vancouver style, each individually verified against the original source before inclusion. The [N] marker on each criterion's Reference line and "The evidence" line corresponds to its number here.

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Established Practice — Not Attributed to a Single Source

The statements below reflect genuine, widely recognised professional consensus — drawn from accreditation frameworks, quality improvement literature, and established clinical practice broadly — but are not attributed to one specific paper or document. They are listed here, honestly and separately from the numbered citations above, rather than assigned an invented formal reference.

- Access to clinical ethics consultation is an established structural requirement in major international hospital accreditation and governance frameworks, recognising that individual clinicians should not be left to resolve genuine ethical complexity without institutional support.
- Advance care planning and directive documentation is an established element of patient-centred care and end-of-life care quality frameworks internationally, with genuine accessibility and adherence identified as distinct requirements from the initial documentation step.
- Biomedical equipment maintenance frameworks consistently identify scheduled preventive maintenance, combined with clear removal-from-service protocols, as the primary control against equipment-related patient harm.
- Continuity of care across international transitions is identified in cross-border healthcare literature as a distinct risk point, with incomplete or inaccessible record transfer directly linked to preventable post-return complications.
- Correct patient identification and effective communication are named together among JCI's International Patient Safety Goals, with structured handoff communication specifically identified as a distinct requirement from general clinical documentation.
- Credential verification failures are a recurring, preventable category in patient safety literature — the checkable fact is whether verification happened directly with the issuing body, not whether a certificate was filed.
- Critical value reporting protocols with confirmed receipt are a widely adopted patient safety standard precisely because delayed recognition of urgent results is a well-documented, preventable harm pathway.
- Cross-border patient redress mechanisms are identified in international medical travel governance literature as a distinct requirement from domestic complaint processes, given the specific access barriers international patients face after returning home.
- Disaster preparedness frameworks consistently identify drill practice, not plan documentation alone, as the determining factor in real-world response effectiveness during mass casualty events.

• Discharge communication quality is consistently identified in patient safety literature as a determinant of post-discharge complications and readmission, distinct from the clinical quality of care received during admission.

• Environmental cleanliness in shared healthcare spaces is a recognised contributing factor to healthcare-associated infection transmission risk, distinct from direct clinical contact precautions.

• Environmental design research consistently identifies the full approach sequence, not only the building interior, as shaping patient perception of safety and care quality from first contact.

• Environmental sustainability and climate resilience programmes are an emerging but increasingly established requirement across international healthcare accreditation frameworks, reflecting both direct environmental impact and operational resilience considerations.

• Facility signage completeness, including evacuation route marking throughout the building, is a distinct requirement from initial wayfinding and evacuation drill practice in international healthcare facility safety frameworks, reflecting that a drill tests staff response while signage protects anyone in the building at any time.

• Fire safety and evacuation drill practice are established requirements in healthcare facility safety frameworks precisely because untested procedures reliably fail to translate into effective real-world response.

• Formal pain assessment and reassessment is an established element of patient-centred care standards in major hospital accreditation frameworks internationally, treated as its own distinct requirement rather than folded into general clinical assessment.

• Health information security frameworks consistently identify access control and incident response planning, rather than technology sophistication alone, as the primary determinants of practical data protection in resource-constrained settings.

• Health literacy and plain-language communication are established determinants of patient understanding and engagement in care decisions, consistently identified in patient safety literature as distinct from the simple provision of information.

• Health record retention requirements vary by jurisdiction and are legally defined precisely because both premature destruction and indefinite retention carry distinct, documented risks.

• Healthcare-associated infection surveillance and trending is a distinct, established requirement in international infection prevention frameworks, recognised as necessary alongside — not replaced by — individual prevention bundle compliance.

• Incident reporting culture, specifically the psychological safety staff feel around reporting without fear of punitive consequence, is consistently identified as the primary determinant of reporting volume, more so than system accessibility alone.

• Individualised, documented care planning is consistently associated with improved continuity of care across shift changes in health services literature, distinct from assessment quality alone.

• Induction and orientation quality is repeatedly identified in patient safety literature as a modifiable factor in early-tenure adverse events, distinct from formal qualification.

• Integrated environment-of-care risk management, tying individual facility safety domains into one reviewed register, is an established approach in international facility safety frameworks specifically because siloed tracking misses compounding and cross-cutting risks.

• Laboratory quality management frameworks, including CLSI and WHO laboratory quality standards, treat internal quality control as a non-negotiable precondition for result release, not an optional refinement.

• Look-alike, sound-alike medication confusion is a recognised, distinct medication safety category in WHO and international patient safety literature, requiring targeted controls separate from general prescribing safety measures.

• Medical record completeness auditing is a recognised quality assurance practice specifically because template existence alone does not guarantee consistent completion in real clinical practice.

• Medical tourism governance literature consistently identifies unregulated facilitator and agent networks as a distinct risk category, separate from the clinical quality of the treating facility itself.

• Medical travel facilitation literature identifies documentation delays and errors as a leading cause of care-seeking delay for international patients, with downstream clinical consequences for time-sensitive conditions.

• Non-discrimination and equitable treatment are foundational patient rights principles across international healthcare quality frameworks, consistently requiring verification through actual patient experience and observed practice, not policy existence alone.

• Nutritional screening and therapeutic diet management are recognised elements of clinical quality frameworks, reflecting evidence that nutritional status materially affects recovery, complication rates, and length of stay.

• Ongoing patient experience measurement, distinct from post-discharge complaint mechanisms, is an established quality improvement practice in international hospital accreditation frameworks, providing earlier and more representative signal than complaint-based feedback alone.

• Patient and family engagement in governance and quality structures, distinct from feedback mechanisms alone, is an established element of patient-centred care frameworks in international hospital accreditation and governance literature.

• Patient complaint systems with demonstrated action on findings are identified in patient safety literature as a distinct quality signal from complaint volume alone — the presence of a channel says little without evidence it functions.

• Patient confidentiality protection frameworks consistently identify physical environment design and staff behaviour, not policy documentation alone, as the practical determinants of actual privacy protection.

• Patient-reported experience research in medical tourism consistently identifies logistical coordination, not clinical quality alone, as a major determinant of overall satisfaction and perceived safety.

• Policy-practice gaps are consistently identified in healthcare quality literature as a distinct failure mode from policy absence — the existence of a written policy is not evidence of its implementation.

• Post-operative complication tracking following international medical travel is identified in the medical tourism literature as a systemic gap, with most facilities lacking any mechanism to learn about complications that surface after the patient has returned home.

• Professional interpreter use is consistently associated with improved comprehension, informed consent quality, and clinical outcomes compared with ad hoc interpretation by untrained bilingual staff or family members.

• Restraint and seclusion governance is an established patient rights and safety standard in international accreditation frameworks, reflecting recognised risk of physical and psychological harm from unmonitored or prolonged use.

• Resuscitation readiness protocols, including scheduled equipment checks and current life-support certification, are foundational elements of resuscitation system quality frameworks across international emergency care guidance.

• Root cause analysis methodology is a well-established patient safety practice specifically because surface-level incident review, without deeper systemic examination, is consistently associated with recurrence of preventable events.

• Safety culture surveys are a recognised patient safety measurement practice specifically because staff silence is an ambiguous signal that can indicate either genuine safety or suppressed concern, and only direct measurement distinguishes between them.

• Structured admission assessment is a foundational element of clinical governance frameworks across major health systems, directly linked to earlier detection of deterioration risk.

• Structured post-discharge follow-up contact is associated with earlier identification of complications and reduced avoidable readmission in health services literature, distinct from the quality of the discharge plan itself.

• Structured queue management and wait-time transparency are established elements of patient experience and flow-safety frameworks in ambulatory and emergency healthcare settings internationally, linked to both patient satisfaction and earlier identification of clinical deterioration during waiting periods.

• Travel-associated antimicrobial resistance and infection risk is a documented, distinct category in infection prevention literature, with international medical travel specifically identified as a transmission risk pathway requiring targeted screening protocols.

• Vulnerable patient protection frameworks, addressing populations with reduced capacity for self-advocacy, are established requirements across major international healthcare quality and safety standards, distinct from general patient rights provisions.

• WHO's Medication Without Harm Global Patient Safety Challenge (2017) identifies prescribing error as a leading, largely preventable contributor to medication-related harm worldwide, and does not specify which clinical role must perform the second check — only that one genuinely independent check occurs.

• WHO's Medication Without Harm initiative identifies transitions of care as a high-risk point specifically requiring structured reconciliation, distinct from routine prescribing safety measures — the requirement is the structured process, not a specific staffing model.

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