

Ambulatory Clinic Standards — Full Guidance

Complete criterion-by-criterion guidance: worked examples, first steps, common mistakes, implementation plans, and Monitor verification methods for all 127 criteria.

26 standards · 127 criteria · Version 4.0

ASF STANDARDS · AMBULATORY CLINIC · STANDARD 25

Standard 25 — Refugee & Migrant Health

10 criteria · 5 non-negotiable · 5 core · Version 3.0

CRITERIA IN THIS STANDARD

25.1 — Language and Communication Aids — Interpreters and Cultural Mediators

25.2 — People-Centred Care Adapted to Migration and Displacement Experience

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

25.4 — Collaborative Practice Across Health and Social Services

25.5 — Evidence-Informed Care for Refugee and Migrant Populations

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

25.7 — Legal Status Diversity Recognition

25.8 — Care Is Documented and Provided Regardless of Immigration or Legal Status

25.9 — Cross-Border Continuity of Care

25.10 — Follow-Up Systems Account for Housing and Contact Instability

25.1

Language and Communication Aids —
Interpreters and Cultural Mediators

NON-NEGOTIABLE

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.

In plain terms: Trained interpreters or cultural mediators are used for language-discordant consultations — never children, and family members only when there is truly no alternative.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

This is the refugee-specific counterpart of 8.3, and the stakes are higher. Refugee patients may be discussing torture, sexual violence, or mental illness — topics a family member cannot interpret and should not hear. A cultural mediator adds what an interpreter cannot: understanding of why a patient from a particular background may refuse a male examiner, may not disclose a symptom, or may interpret a question as a threat. Children must never interpret for parents: it exposes them to adult content, it distorts the information, and it places the child in an impossible position. Where the clinic serves a refugee population, interpreter and mediator access is a core service, not an extra.

WHAT GOOD LOOKS LIKE

- Trained interpreters or cultural mediators are the default for language-discordant consultations.
- Staff confirm, without hesitation, that minors are never used to interpret.

COMMON FAILURE MODES

- Ad hoc bilingual staff or family members are the default, with trained interpreters rarely engaged.
- 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.

WORKED EXAMPLE

IN PRACTICE

A 16-room clinic serving a refugee settlement of 30,000 people.

BEFORE

Interpretation was by family members or other patients from the same language group. A ten-year-old was observed interpreting her mother's gynaecological consultation. A man was asked to interpret for a woman describing sexual violence. There was no interpreter budget and no mediator role.

ACTION

With NGO support, four cultural mediators from the main refugee language groups were recruited and trained. A phone interpretation service covered other languages. A written rule prohibited children interpreting and required same-gender interpreters for sensitive consultations. Interpreter and mediator use was documented. Staff were briefed on why family interpretation is unsafe.

AFTER

The Monitor reviewed 20 refugee patient records: interpreter or mediator documented in all language-discordant consultations. Observed a mediator-supported consultation. Interviewed a mediator who described the same-gender rule in practice. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask how the last ten refugee consultations were interpreted. Count how many used a child or a family member.
2. Write the rule today: no children; family only as a last resort and never for sensitive topics.
3. Recruit mediators from the main language groups — NGOs can help.

4. Contract a phone service for other languages.

The most common mistake: Using the patient's child to interpret because they speak the language best — the child is harmed and the information is distorted.

SELF-ASSESSMENT QUESTIONS

1. Are trained interpreters or cultural mediators engaged for language-discordant consultations? — *Not ad hoc bilingual staff or family members as the default.*

Evidence: Interpreter engagement record

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.*

Evidence: N/A — tested directly

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, or bad news — situations WHO specifically flags as requiring professional language support.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **The no-minors rule is understood by senior staff but not consistently reinforced with newer or part-time staff.** — A critical safeguard needs to be embedded in onboarding, not assumed as common knowledge.
- **Interpreter access exists during clinic hours but reverts to family members for same-day or urgent visits.**

IMPLEMENTATION PLAN

When	What
Week 1	Review recent language-discordant consultations for interpreter engagement patterns.
Week 2	Establish or reinforce trained interpreter access, including for same-day and urgent visits.

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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 interpreter coverage specifically for same-day or urgent appointments.** — This is where the policy is most likely to quietly lapse.

EVIDENCE BASE

[111] World Health Organization. Refugee and Migrant Health: Global Competency Standards for Health Workers. Geneva: WHO; 2021 — Competency Standard 3 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.

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25.2 People-Centred Care Adapted to Migration and Displacement Experience

NON-NEGOTIABLE

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.

In plain terms: Care is genuinely adapted for refugee and migrant patients — recognising trauma, legal-status fears, and the barriers they face — not just delivered the same way as for everyone else.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A refugee who has crossed a border on foot, lost family, and now fears deportation does not arrive at the clinic as an ordinary patient. They may not disclose symptoms that could mark them as a burden. They may not return for follow-up because they moved or because the last clinic reported them. They may react to a physical examination with terror rooted in what was done to them before. Trauma-informed care means staff understand this, explain before touching, ask permission, avoid triggering procedures where possible, and never threaten legal consequences. It means the clinic has decided that a person's migration status does not change their right to care — and staff know it.

WHAT GOOD LOOKS LIKE

- Care is genuinely, visibly adapted to migration and displacement history.

COMMON FAILURE MODES

- Care is delivered identically regardless of migration history.

- Trauma-informed practice is actually applied, not just referenced.
- Staff demonstrate specific awareness of legal-status access barriers.

- Trauma-informed practice exists only as a stated principle, not applied practice.
- Staff show no specific awareness of legal-status barriers.

WORKED EXAMPLE

IN PRACTICE

A 15-room clinic in a city with a large refugee population.

BEFORE

Refugee patients were treated identically to others. Staff had no training on trauma or migration. The Coordinator observed a nurse insisting a woman remove her headscarf for a routine examination, and a receptionist asking for immigration documents at registration. Refugee patients reported avoiding the clinic because 'they ask questions.'

ACTION

A half-day trauma-informed care module was delivered to all patient-facing staff, developed with a refugee support NGO. A written policy stated that immigration status is not asked and does not affect care. Registration was simplified to name, date of birth, and contact. Examination consent scripts were adapted. A refugee liaison worker was engaged part-time through the NGO.

AFTER

The Monitor reviewed the policy, training records (94% of staff), and interviewed the liaison worker and two refugee patients who described feeling safe. Observed a consultation where the clinician explained each step before touching. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask refugee-serving organisations in your area what their clients say about your clinic.
2. Write one sentence: 'We do not ask immigration status and it does not affect care.' Post it.

3. Arrange trauma-informed care training with an NGO that knows the population.
4. Remove immigration document requests from registration.

The most common mistake: Believing that treating everyone 'the same' is equity — for a traumatised patient, the same treatment is a different experience.

SELF-ASSESSMENT QUESTIONS

1. Is care genuinely adapted to a patient's migration and displacement experience, not delivered identically regardless of history? — *Genuine adaptation, not a generic cultural-awareness statement.*

Evidence: Training record on migration-adapted care

2. Is trauma-informed practice genuinely applied, not just referenced as a principle? — *Actual practice adaptation, not an assumption of general sensitivity.*

Evidence: N/A — tested directly

3. Are staff aware of legal-status barriers to access that may affect this specific patient? — *Specific awareness, not a general sense that barriers can exist.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Adaptation happens for patients who disclose their history but isn't proactively considered otherwise.** — Not every patient will volunteer this history unprompted, even when it is clinically relevant.
- **Staff are aware of the principle but haven't received specific training on applying it.** — General awareness doesn't reliably translate into genuine practice adaptation without specific training.
- **Continuity of care support exists for patients with stable documentation but not those without it.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for genuine adaptation to migration and displacement history.
Week 2	Train staff specifically on trauma-informed, migration-adapted practice.

When	What
Week 3	Build awareness of legal-status access barriers into standard practice.
Ongoing	Review practice adaptation periodically using real case examples.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Migration-adapted care interview	Asks staff how they adapt practice specifically for a patient's migration and displacement history.
OBSERVE	Trauma-informed practice observation	Observes a consultation for genuine trauma-informed practice, not generic sensitivity.
DOCUMENT	Training content review	Reviews training materials for specific coverage of migration-adapted, trauma-informed care.

SUPERVISOR TIPS

- **Ask staff to describe a specific example of adapting care for a patient's migration history.** — A real, specific example reveals genuine practice, not familiarity with the principle.
- **Ask about continuity of care support specifically for patients without stable documentation.** — This is where genuine adaptation is most tested.

EVIDENCE BASE

[112] 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.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

25.3

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

NON-NEGOTIABLE

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.

In plain terms: Refugee and migrant patients are helped to understand not just their own care but how the health system works — and you check that they actually understood.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A patient who does not know that the clinic has an outpatient department, that a referral means an appointment somewhere else, that a prescription must be filled at a pharmacy, or that emergency care is free regardless of status — that patient cannot navigate the system. Migrants often come from health systems with entirely different structures and assumptions. Explaining the system is as important as explaining the diagnosis. And explanation is not enough: teach-back, in the patient's language, is the only way to know it landed. The consequence of failure is missed follow-up, untreated conditions, and emergency presentations that could have been prevented.

WHAT GOOD LOOKS LIKE

- Teach-back genuinely verifies understanding of both the care plan and clinic navigation.
- Concrete, translated navigation guidance is

COMMON FAILURE MODES

- Understanding is assumed from a nod or silence, with no active verification.
- Patients leave understanding their

provided, not just general encouragement.

- Plain language is used consistently, especially when working through an interpreter.

specific treatment but not how to book again.

- Medical jargon is used routinely, straining both interpretation and comprehension.

WORKED EXAMPLE

IN PRACTICE

A 10-room clinic serving newly arrived migrants from several countries.

BEFORE

Migrant patients were given standard discharge information. A high proportion did not attend follow-up. When interviewed by a liaison worker, patients said they did not understand what a 'referral' was, did not know where the outpatient clinic was, and assumed all care cost money they could not pay. Some had returned to the emergency department for routine issues.

ACTION

A one-page 'How this clinic works' guide was produced in the six most common languages: what each department does, how referrals work, what is free, who to ask. It is given at registration and explained by the liaison worker or interpreter. Discharge includes a teach-back on the next step: 'Where will you go for your follow-up, and when?' Answers are recorded.

AFTER

The Monitor reviewed 15 migrant patient records with documented teach-back; follow-up attendance had risen from 40% to 72%. Interviewed two patients who described the system correctly. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five migrant patients what a 'referral' means and where the outpatient clinic is.
2. Write a one-page system guide in your most common languages.

3. Give it at registration and explain it.
4. Add teach-back on the next step at discharge.

The most common mistake: Explaining the diagnosis carefully and assuming the patient knows how to get the follow-up you have arranged.

SELF-ASSESSMENT QUESTIONS

1. Is understanding actively checked using a teach-back approach, for both the care plan and how to navigate the clinic, not assumed from a nod? — *Asking the patient to explain both back in their own words, not just asking "do you understand?"*

Evidence: N/A — tested directly

2. Is concrete, practical guidance provided on navigating this clinic specifically — how to book again, what to do for urgent concerns? — *Real navigation guidance, not just general encouragement to seek care.*

Evidence: Navigation guidance material

3. Is information communicated in plain language, avoiding medical jargon, particularly when working through an interpreter? — *Complex terminology strains interpretation and comprehension together.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Teach-back is used for major treatment decisions but not extended to booking or navigation information.** — Understanding how to actually use the clinic matters as much as understanding the immediate care plan.
- **Navigation support is given verbally but not reinforced with anything the patient can review later.** — Complex information delivered once, verbally, under stress is easily forgotten.
- **Staff assume system literacy for patients who have visited before, missing gaps that may still exist.**

IMPLEMENTATION PLAN

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

When	What
Week 2	Train staff on teach-back technique and develop translated navigation guidance.
Week 3	Brief staff to proactively cover navigation alongside the immediate clinical matter.
Ongoing	Spot-check patient understanding of both care and navigation periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Teach-back practice observation	Observes a consultation, or a simulated scenario, to check whether teach-back genuinely verifies understanding of both care and navigation.
DOCUMENT	Navigation material review	Reviews any materials or guidance provided on navigating this clinic, in relevant languages.
ASK	Patient understanding check	Asks a recent refugee or migrant patient to explain back their care plan and how they would book again.

SUPERVISOR TIPS

- **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 booking again or reaching the clinic urgently.** — This tests actual system literacy, not just satisfaction with the immediate visit.

EVIDENCE BASE

[113] 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.

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25.4

Collaborative Practice Across Health and Social Services

CORE

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.

In plain terms: The clinic works with legal, housing, education, and social services relevant to refugee patients — because their health depends on more than what happens in the clinic.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

A refugee child with malnutrition needs food, not just a prescription. A woman with chronic pain and a pending asylum claim needs legal support to reduce the stress that worsens the pain. A man with TB living in an overcrowded shelter needs housing to complete treatment. The clinic cannot solve these problems, but it can connect patients to those who can — if it knows who they are. Collaborative practice means a directory of local services, referral pathways that actually work, and periodic contact between the clinic and those services. It is the difference between treating symptoms and addressing causes.

WHAT GOOD LOOKS LIKE

- The facility actively, genuinely engages with relevant social support services.
- Handover to other providers specifically

COMMON FAILURE MODES

- Health care is treated in isolation from social support factors.
- Handover is generic, omitting migration-related context.

includes migration-related context.

- Staff can name specific, current local services relevant to this population.

- Staff have no specific knowledge of relevant local services.

WORKED EXAMPLE

IN PRACTICE

A 14-room clinic in a region hosting refugees with no established links to social services.

BEFORE

Clinicians saw refugee patients with problems rooted in housing, legal status, and food insecurity, and had no one to refer to. A child with recurrent chest infections lived in a damp shelter; the paediatrician prescribed antibiotics repeatedly. No directory of services existed; no one had met the local refugee legal aid organisation.

ACTION

The Coordinator and the refugee liaison worker mapped local services: legal aid, housing support, food assistance, education, mental health. A one-page directory was created for clinicians. A quarterly meeting with the three main NGOs was established. Referral forms were created and tracked. The child's family was referred to housing support and rehoused.

AFTER

The Monitor reviewed the directory, meeting minutes from three quarters, and 25 tracked referrals with outcomes. Interviewed an NGO partner who described the working relationship. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List the non-medical problems you see in refugee patients: housing, legal, food, education.
2. Find the organisations in your area that address each. Meet them.
3. Create a one-page directory for clinicians.

4. Track referrals and meet the organisations quarterly.

The most common mistake: Treating the medical consequence of a social problem repeatedly because no one has connected the patient to the service that could fix the cause.

SELF-ASSESSMENT QUESTIONS

1. Does the facility actively engage with relevant social support services, not treat health care in isolation? — *Genuine, active engagement, not a general awareness that such services exist.*

Evidence: Social services engagement record

2. Does handover to another provider specifically include migration- and displacement-related context? — *Specific inclusion of this context, not a generic clinical handover.*

Evidence: N/A — tested directly

3. Are staff aware of specific local services relevant to this population, not just services generally? — *Specific, current knowledge, not a vague sense that support services exist somewhere.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Engagement happens with legal services but not consistently with housing or employment support.** — Each of these factors can independently and significantly affect a patient's health.
- **Handover includes clinical information but omits migration-related context that shaped the care given.** — The next provider benefits from the same contextual understanding this facility relied on.
- **Staff know general categories of support exist but not specific, current local contacts.**

IMPLEMENTATION PLAN

When	What
Week 1	Map current engagement with relevant social support services.
Week 2	Establish or strengthen specific, current local service contacts.
Week 3	Build migration-related context into standard handover documentation.

When	What
Ongoing	Refresh knowledge of local services periodically as availability changes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Social services engagement review	Reviews evidence of active engagement with relevant social support services.
DOCUMENT	Handover content review	Reviews handover documentation for specific inclusion of migration-related context.
ASK	Local services knowledge interview	Asks staff to name specific local services relevant to refugee and migrant patients.

SUPERVISOR TIPS

- **Ask staff to name a specific local service they would refer a patient to, not a general category.** — Specificity reveals genuine, current knowledge rather than assumed awareness.
- **Review a real handover document for migration-related context inclusion.** — A real example reveals whether this happens in practice, not just in policy.

EVIDENCE BASE

[114] 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.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

25.5 Evidence-Informed Care for Refugee and Migrant Populations CORE

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.

In plain terms: Staff use clinical guidelines specific to refugee and migrant health where they exist, know where evidence is thin, and adapt sensibly.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Refugee health has specific evidence: screening for TB, hepatitis B, and parasites by region of origin; vaccination catch-up schedules; recognition of conditions rare in the host country; management of trauma-related mental illness. Applying host-country guidelines without adaptation means missing conditions the host population does not have and over-testing for ones the refugee population does not. Where evidence exists — WHO, UNHCR, national refugee health guidelines — staff should use it. Where it does not, they should know that, and adapt with judgment rather than guess.

WHAT GOOD LOOKS LIKE

- Staff are aware of and use population-specific evidence-informed guidelines where they exist.
- Staff can describe specific, genuine differences in this population's health needs.
- Practice is genuinely adapted where population-specific evidence indicates it should be.

COMMON FAILURE MODES

- General population guidelines are applied uncritically with no population-specific awareness.
- Staff cannot describe any specific way this population's needs differ.
- Awareness exists but doesn't translate into any actual practice adaptation.

WORKED EXAMPLE

IN PRACTICE

A 10-room clinic that had started receiving refugees from a region with high hepatitis B and TB prevalence.

BEFORE	Refugee patients were assessed using standard domestic protocols. Hepatitis B screening was not routine. Two cases of active TB were diagnosed late after multiple presentations. Clinicians were unaware of the WHO and national refugee health screening recommendations.
ACTION	The Coordinator obtained the national refugee health guideline and the WHO recommendations for the relevant region. A refugee health screening protocol was written: TB screening, hepatitis B and C, HIV with consent, parasitic infection screening, vaccination status, mental health screen. Clinicians received a one-hour briefing. The guideline was reviewed annually with an infectious diseases specialist.
AFTER	The Monitor reviewed the protocol with its sources, training records, and 20 refugee patient records showing protocol-based screening. Two hepatitis B cases identified and treated. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Find your national refugee health guideline, or the WHO/UNHCR one for your region.
2. Compare it to what you currently do for refugee patients.
3. Write a screening protocol based on the guideline.
4. Brief clinicians and review annually.

The most common mistake: Applying the domestic screening protocol to refugee patients from regions with a completely different disease burden.

SELF-ASSESSMENT QUESTIONS

1. Are staff aware of evidence-informed guidelines specific to refugee and migrant health where they exist? — *Specific, current*

awareness, not general clinical knowledge assumed to be sufficient.

Evidence: Guideline awareness record

2. Do staff recognise where this population's health needs genuinely differ from the general population? — *Genuine, specific recognition, not an assumption that general guidelines always apply equally.*

Evidence: N/A — tested directly

3. Is practice adapted where population-specific evidence indicates a different approach is warranted? — *Actual practice adaptation, not awareness without application.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Awareness exists for well-known differences but not for more specific or recent evidence.** — Evidence in this area continues to develop, and awareness needs to stay genuinely current.
- **Guidelines are known but not consistently applied under time pressure.** — Consistent application under real conditions is what gives awareness genuine protective value.
- **Evidence gaps are acknowledged but staff default to general population assumptions rather than flagging genuine uncertainty.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current awareness of population-specific evidence-informed guidelines.
Week 2	Establish access to current, relevant guidelines for staff.
Week 3	Train staff on specific, genuine population differences relevant to practice.
Ongoing	Refresh awareness as evidence in this area develops.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Guideline awareness review	Reviews whether staff have access to and awareness of population-specific evidence-informed guidelines.

Method	What	Detail
ASK	Population-difference interview	Asks staff to describe a specific way this population's health needs differ from the general population.
OBSERVE	Practice adaptation check	Checks whether practice genuinely reflects population-specific evidence where it exists.

SUPERVISOR TIPS

- **Ask staff for a specific example of a practice adaptation based on population-specific evidence.** — A real example reveals genuine application, not just familiarity with the concept.
- **Ask how staff would handle a genuine evidence gap for this population.** — A thoughtful, honest answer reveals genuine engagement rather than a default assumption.

EVIDENCE BASE

[115] 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.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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

NON-NEGOTIABLE

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

In plain terms: Staff actively reflect on their own biases and culture, the clinic supports this through structured practice, and staff working with traumatised patients are looked after.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Every clinician has assumptions about people from other cultures, and most are unaware of them. The nurse who assumes a refugee is exaggerating pain, the doctor who is impatient with a patient who will not make eye contact, the receptionist who is curt with someone who does not understand the form — each is acting on bias, and each affects care. Reflective practice — structured time to examine one's reactions — reduces this. The second element is staff wellbeing: hearing accounts of torture and loss every day takes a toll, and staff who are burned out become staff who withdraw. Supervision, peer support, and access to counselling are not luxuries in a clinic serving refugees.

WHAT GOOD LOOKS LIKE

- A structured reflective practice process genuinely exists and is used, not just assumed.
- Genuine, accessible psychological support exists and staff actually use it.
- Staff can describe specific, real examples of both bias adaptation and vicarious trauma awareness.

COMMON FAILURE MODES

- No structured reflective practice process exists beyond an assumption of individual self-awareness.
- Psychological support exists only nominally, with no evidence staff actually access it.
- Staff cannot describe any specific example of adapting practice or recognising vicarious trauma.

WORKED EXAMPLE

IN PRACTICE

A 14-room clinic where a third of patients are refugees.

BEFORE	No reflective practice existed. Staff complained about refugee patients in the break room; some described them as 'demanding.' A nurse who had heard multiple accounts of sexual violence had started avoiding female refugee patients. There was no supervision or support for staff exposed to trauma narratives.
ACTION	Monthly facilitated reflective practice sessions were introduced for clinical teams, led by a psychologist from a partner NGO, using real (anonymised) cases. An implicit bias workshop was run once for all staff. A peer support scheme was set up. Confidential counselling access was arranged through the NGO. Attendance was tracked.
AFTER	The Monitor reviewed session records (10 sessions, average 70% attendance), workshop records, and the counselling access agreement. Interviewed three staff who described the sessions as valuable and gave examples of changed practice. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Listen in the break room. What do staff say about refugee patients when they think no one is listening?
2. Arrange one implicit bias workshop with an NGO or university.
3. Start monthly reflective practice sessions with a facilitator.
4. Arrange confidential counselling access for staff.

The most common mistake: Training staff in cultural competence once and assuming bias is fixed — it is a practice, not a certificate.

SELF-ASSESSMENT QUESTIONS

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.*
Evidence: Reflective practice process description

2. Does the facility provide genuine, accessible psychological support and a real space to discuss difficult cases? — *Actual, used support and a real, regular opportunity, not a theoretical benefit or informal hope.*

Evidence: Psychological support and debrief process record

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Reflective practice happens informally among some staff but is not structured or clinic-wide.** — Individual good practice does not reliably generalise without a defined, shared process.
- **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.
- **Difficult cases are discussed informally but there's no routine, structured opportunity for it.**

IMPLEMENTATION PLAN

When	What
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 a real space to discuss difficult cases.
Week 3	Deliver specific training on institutional discrimination and normalise use of available support.
Ongoing	Revisit reflective practice and staff wellbeing periodically, using real case examples where appropriate.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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 handled a recent difficult case.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[116] 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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

25.7 Legal Status Diversity Recognition

CORE

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.

In plain terms: The clinic can name which legal status groups it serves — asylum seekers, recognised refugees, stateless people, internally displaced, undocumented — and knows what each group is entitled to.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

An asylum seeker in many countries is entitled to emergency care only. A recognised refugee has the same entitlements as citizens. A stateless person may have no entitlement at all under the letter of the law. An undocumented migrant may be entitled to nothing — or to everything, depending on the jurisdiction and the type of care. A clinic that does not know these distinctions either turns away people who are entitled to care or treats people it cannot be reimbursed for without knowing it. Knowing the categories, the entitlements, and — critically — the clinic's own policy on treating people regardless of entitlement is the foundation for consistent, fair, and legally defensible practice.

WHAT GOOD LOOKS LIKE

- Staff can name the specific legal status categories this facility actually serves.
- Policy genuinely differentiates access considerations across status categories.
- A specific, defined process exists for verifying unclear status.

COMMON FAILURE MODES

- Staff have only a general sense that "migrants" are served, without specific categories.
- A single, uniform assumption about access rights is applied regardless of status.
- No process exists for verifying status when it's genuinely unclear.

WORKED EXAMPLE

IN PRACTICE

A 14-room clinic in a country with five legal categories for displaced people and different entitlements for each.

BEFORE	Registration staff did not know the categories. Patients were sometimes turned away because 'refugees are not covered' when in fact they were. Others were treated and the clinic could not claim reimbursement because the correct category was not recorded. The clinic had no written position on treating people outside any entitlement.
ACTION	The Coordinator obtained the legal entitlements for each category from the Ministry and UNHCR. A one-page reference was created for registration staff. A clinic policy stated: emergency care for everyone regardless of status; other care per entitlement; and a defined charity fund for those with no entitlement. Registration records the category (with the patient's consent) for reimbursement purposes only — it does not affect clinical care.
AFTER	The Monitor reviewed the entitlement reference, the policy, and 20 registration records with category correctly recorded. Interviewed two registration staff who correctly described entitlements for three categories. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List the legal status categories that exist in your country for displaced people.
2. Find out what each is entitled to — ask the Ministry or UNHCR.
3. Write a one-page reference for registration staff.
4. Decide and write down what you will do for people with no entitlement.

The most common mistake: Treating all displaced people as one category — 'refugees' — when the law treats them differently and the clinic's obligations differ.

SELF-ASSESSMENT QUESTIONS

1. Can staff name the specific legal status categories this facility actually serves? — *Specific, named categories, not a general sense*

that "migrants" are served.

Evidence: N/A — tested directly

2. Does the facility avoid applying a single, uniform assumption about access rights across all statuses? — *Genuine differentiation, not treating all categories identically.*

Evidence: Status-specific access policy documentation

3. Is there a specific process for verifying which category applies when it's genuinely unclear? — *A real, defined process, not guesswork or assumption when status is ambiguous.*

Evidence: Status verification process

COMMON REASONS FOR A PARTIAL ANSWER

- **Staff can name the most common category served but not less frequent ones the facility still encounters.** — Even infrequent categories deserve genuine, specific awareness, not the risk of misapplied assumptions.
- **Differentiation exists in policy but isn't consistently applied by all staff in practice.** — A policy that exists on paper needs consistent application to provide real protection.
- **A verification process exists but staff are inconsistently confident applying it.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current staff awareness of the specific legal status categories actually served.
Week 2	Build specific, differentiated access guidance for each relevant status category.
Week 3	Establish a clear verification process for genuinely unclear status.
Ongoing	Refresh staff awareness periodically, particularly for less frequently encountered categories.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Status category awareness interview	Asks staff to name the specific legal status categories this facility actually serves.

Method	What	Detail
DOCUMENT	Status-specific policy review	Reviews documentation for genuine differentiation across status categories, not a uniform assumption.
DOCUMENT	Verification process review	Reviews the process for verifying status when it's genuinely unclear.

SUPERVISOR TIPS

- **Ask staff to name every specific legal status category the facility has served recently.** — Specificity reveals genuine, current awareness rather than a general assumption.
- **Ask what happens when a patient's specific status is genuinely unclear.** — A confident, specific answer reveals a genuine process, not improvisation.

EVIDENCE BASE

[117] 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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

25.8 Care Is Documented and Provided Regardless of Immigration or Legal Status

NON-NEGOTIABLE

Care is provided and fully documented for every patient regardless of immigration or legal status, with no differential standard of care, documentation practice, or record-keeping applied based on status — not a lesser or informal standard applied to patients without documented status.

In plain terms: Every patient receives the same care and the same documentation regardless of immigration or legal status — no lower standard, no incomplete record, no 'off the books.'

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

An undocumented patient treated 'quietly' with no record is a patient with no continuity of care, no evidence if something goes wrong, and no protection. A refugee given a lower standard because 'they won't complain' is discrimination. The standard is absolute: the same clinical care, the same consent, the same documentation, the same follow-up. Where legal status affects entitlement to funded care, that is an administrative matter handled separately from the clinical record and never a reason to withhold or dilute treatment. The clinic's own policy must say this plainly, and staff must know it.

WHAT GOOD LOOKS LIKE

- Care and documentation are genuinely consistent regardless of status.
- Staff are specifically trained on this principle, not assumed to understand it.
- Confidentiality protection is applied equally without exception.

COMMON FAILURE MODES

- Care or documentation practice differs based on a patient's known or assumed status.
- No specific training addresses this principle.
- Status-related information is handled less carefully than other confidential information.

WORKED EXAMPLE

IN PRACTICE

An ambulatory clinic in a city with many undocumented migrants.

BEFORE

Undocumented patients were sometimes treated without a record 'to protect them.' Some staff asked for documents at registration and turned patients away. A patient with a serious infection was given antibiotics informally, not documented, and was lost to follow-up; she was admitted to

	hospital a week later in sepsis with no record of prior treatment.
ACTION	A written policy stated: care and documentation are identical for all patients; immigration status is not asked; a record is created for every patient; funding is handled by the administrator after care, never as a barrier to it. Registration was simplified. Staff were briefed. A liaison with a migrant support organisation was established.
AFTER	The Monitor reviewed the policy, observed registration without status questions, and reviewed 20 records of migrant patients showing full documentation identical to other patients. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask your reception staff what they do when a patient has no documents.
2. Write a one-sentence policy: same care, same record, status not asked.
3. Remove document requests from registration.
4. Handle funding after care, never before.

The most common mistake: Treating undocumented patients informally 'to protect them' — an undocumented patient with no record is unprotected.

SELF-ASSESSMENT QUESTIONS

1. Is the same standard of care applied and documented the same way regardless of a patient's immigration or legal status? — *Genuinely equal treatment, not a lesser or informal standard for undocumented patients.*
Evidence: N/A — tested directly

2. Are staff specifically trained that immigration status is never a reason to withhold or alter care or documentation? — *Specific, documented training, not assumed understanding.*
Evidence: Staff training record

3. Is patient information protected with the same confidentiality standard regardless of status, with no informal sharing of status-related information? — *The same confidentiality protection extended to every patient, without exception.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The principle is understood by clinical staff but not consistently by administrative or front-desk staff.** — A patient's first interaction is often with administrative staff, where the same principle needs to hold.
- **Care is consistent but documentation habits vary informally based on individual staff assumptions.** — Consistency needs to extend to documentation practice specifically, not only the clinical care itself.
- **The principle is followed but has never been specifically, formally trained.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for any differential treatment based on status.
Week 2	Establish specific staff training on this principle, covering all staff, not only clinical roles.
Week 3	Confirm documentation practice is genuinely consistent regardless of status.
Ongoing	Reinforce training periodically, particularly for new staff.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Care standard observation	Observes whether care and documentation practice is genuinely consistent regardless of patient status.
DOCUMENT	Staff training review	Reviews training records confirming staff understand immigration status is never a basis for differential care.

Method	What	Detail
ASK	Confidentiality practice interview	Asks staff how patient status information, where known, is protected.

SUPERVISOR TIPS

- **Ask administrative and front-desk staff, not only clinicians, about this principle.** — This reveals whether the principle genuinely extends beyond clinical staff.
- **Ask how patient status information, where it becomes known, is protected.** — A specific, confident answer reveals genuine practice, not just a stated value.

EVIDENCE BASE

[118] Equal standard of care and documentation regardless of immigration or legal status, without differential record-keeping practice, is established practice in international guidance on healthcare access for migrant and refugee populations.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

25.9 Cross-Border Continuity of Care

CORE

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.

In plain terms: Refugee and migrant patients are given their own health record in a form they can carry — paper or digital — so it works wherever they go next.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A refugee may be in three countries in a year. Each clinic that treats them starts from zero: no history, no medication list, no vaccination record, no knowledge of the TB treatment started two countries ago. A portable record — a printed summary the patient keeps, a vaccination card, a QR code linking to a secure online summary — means the next clinician knows what was done. It must be in a form the patient can hold and use: a clinic number in a system the next country cannot access is not portable. The record is the patient's; the clinic's job is to give them a copy that works.

WHAT GOOD LOOKS LIKE

- Patients are genuinely supported to hold their own portable health record.
- The record is updated regularly, not provided once and left stale.
- The record format is genuinely usable across different health systems.

COMMON FAILURE MODES

- No patient-held record support exists beyond this facility's internal system.
- A record is provided once but never updated at subsequent visits.
- The record format only makes sense within this facility's own system.

WORKED EXAMPLE

IN PRACTICE

A 16-room clinic near a transit route used by refugees moving on treatment area.

BEFORE

Refugees received no record on departure. The clinic's electronic system was inaccessible from anywhere else. A patient started on TB treatment moved on after two weeks with no documentation; the next clinic restarted treatment from scratch, and resistance developed. Vaccinations given were not recorded anywhere the patient could show.

ACTION

A portable health summary was created: one page in English and the patient's language — diagnoses, medications with duration, vaccinations with dates, allergies, pending results, and the clinic's contact. It is printed for

every refugee patient at discharge and, where the patient has a phone, also sent as a PDF. A vaccination card is issued. The summary is explained by an interpreter.

AFTER The Monitor reviewed 15 refugee discharges, all with portable summaries and vaccination cards. Interviewed a patient who showed the summary on her phone and explained its contents. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask a refugee patient at discharge: 'What will you show the next doctor?' If the answer is nothing, that is the gap.
2. Create a one-page portable summary template in English and your main refugee languages.
3. Print it for every refugee patient and send as PDF where possible.
4. Issue a physical vaccination card.

The most common mistake: Keeping excellent records in a system the patient will never be able to access from the next country.

SELF-ASSESSMENT QUESTIONS

1. Are patients actively supported to hold their own portable health record, not relying solely on this facility's internal system? — *A genuine, patient-held record, not only an internal system the patient can't access elsewhere.*

Evidence: Patient-held record support documentation

2. Is the patient-held record updated regularly, not provided once and left stale? — *Genuine, ongoing updates, not a one-time document that quickly becomes outdated.*

Evidence: N/A — tested directly

3. Is the record provided in a form usable across different health systems, not tied to this facility's specific format alone? — *Genuinely portable format, not one that only makes sense within this facility's own system.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **A patient-held record is provided for major events but not updated for routine visits.** — Continuity depends on the record reflecting the patient's actual, current health picture.
- **The record exists in paper form but isn't offered in electronic form for patients who would prefer it.** — Different patients have different genuine needs for how they carry their own information.
- **Staff support the concept but aren't consistent about actually updating the record at each visit.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for patient-held record support and update consistency.
Week 2	Establish a standard, portable record format and offer both paper and electronic options.
Week 3	Brief staff to update the patient-held record consistently at every relevant visit.
Ongoing	Audit record currency for a sample of patients holding one.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Patient-held record review	Reviews whether patients are genuinely supported to hold a portable health record.
OBSERVE	Record update practice observation	Checks whether the patient-held record is genuinely updated regularly, not provided once.
ASK	Portability interview	Asks staff whether the record format would be usable by a different health system or facility.

SUPERVISOR TIPS

- **Ask to see an actual patient-held record and check how recently it was updated.** — A specific, dated record is the real evidence of genuine, ongoing support.
- **Ask whether the record format would make sense to a clinician at a different facility.** — This tests genuine portability, not just

internal usefulness.

EVIDENCE BASE

[119] 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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

25.10 Follow-Up Systems Account for Housing and Contact Instability CORE

Follow-up and recall systems have a genuine alternative pathway for patients without a stable address or phone number — community organization contact, in-person scheduling at the next visit, or another real mechanism — not a system that silently fails for any patient whose contact information changes or doesn't exist in the expected form.

In plain terms: Follow-up and recall systems have a working alternative for patients with no fixed address or phone — a community organisation contact, in-person scheduling, a trusted intermediary.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A recall letter to 'no fixed address' is a recall to nowhere. A phone call to a number that changed last month reaches no one. Patients in unstable housing, refugees in transit, and people without phones are the ones most likely to need follow-up and least likely to be reached by the standard system. The alternative must be defined and used: the next appointment scheduled before the patient leaves; a community organisation or shelter that will pass on a message; a walk-in slot the patient can use; a designated contact person. Without it, follow-up for these patients is a fiction.

WHAT GOOD LOOKS LIKE

- A genuine alternative follow-up pathway exists for unstable contact situations.
- The system actively identifies failed contact attempts, not silently losing track.
- Community organization relationships are real and genuinely functioning.

COMMON FAILURE MODES

- No alternative exists beyond the standard address-and-phone system.
- Failed contact attempts aren't identified or flagged, patients simply drop from tracking.
- Community organization relationships, if claimed, have never actually been used.

WORKED EXAMPLE

IN PRACTICE

An ambulatory clinic serving a refugee population with high housing instability.

BEFORE

Follow-up was by letter and phone. The Coordinator sampled 40 refugee patients due for follow-up: 22 could not be reached; 15 did not attend; none had an alternative contact route. A TB patient was lost to follow-up mid-treatment.

ACTION

An alternative follow-up protocol was written: for any patient without a stable address or phone, the next appointment is booked before they leave and written on a card; a secondary contact (community organisation, shelter, friend) is recorded with consent; the clinic keeps a walk-in slot each day for patients who lose their appointment; the refugee liaison worker follows up in person for high-priority cases (e.g. TB, pregnancy). Follow-up outcomes are tracked separately for this group.

AFTER

The Monitor reviewed 30 records of patients on the alternative protocol: 26 attended follow-up. Interviewed the liaison worker who described in-person follow-up for two TB patients. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Count how many follow-up letters came back or phone calls failed last month.
2. Book the next appointment before the patient leaves and give them a card.
3. Record a secondary contact with consent.
4. Keep a daily walk-in slot.

The most common mistake: Sending recall letters to patients you know have no address and counting them as 'contacted.'

SELF-ASSESSMENT QUESTIONS

1. Is there a genuine alternative follow-up pathway for patients without a stable address or phone number? — *A real, specific alternative, not an assumption the standard system will eventually work.*
Evidence: Alternative follow-up pathway document

2. Does the system actively identify when standard contact methods have failed, rather than silently losing the patient from tracking? — *Active identification of a failed contact attempt, not passive assumption contact succeeded.*
Evidence: Failed contact identification process

3. Are community organizations or other real intermediaries used as a genuine alternative contact channel where appropriate? — *A genuine, functioning relationship, not a theoretical option never actually used.*
Evidence: Community organization contact relationship

COMMON REASONS FOR A PARTIAL ANSWER

- **An alternative pathway exists but isn't consistently offered or explained to patients likely to need it.** — An unexplained option functions similarly to no option for patients who don't know to ask.
- **Failed contact is sometimes noticed informally but isn't systematically flagged.** — Systematic flagging catches gaps individual staff attention alone can miss.
- **A community organization relationship exists but hasn't been used recently, so its current functioning is unverified.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current follow-up system for how it handles unstable contact information.
Week 2	Establish a genuine alternative pathway, including community organization relationships where relevant.
Week 3	Build active failed-contact identification into the tracking system.
Ongoing	Confirm alternative pathways remain genuinely functional through periodic real use.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Alternative pathway review	Reviews the specific alternative follow-up pathway for patients without stable contact information.
OBSERVE	Failed contact identification check	Checks whether the system can identify and flag a failed standard contact attempt.
ASK	Community relationship interview	Asks staff about actual, functioning relationships with community organizations used for alternative contact.

SUPERVISOR TIPS

- **Ask for a real, recent example of the alternative pathway being used successfully.** — A real example reveals whether this is genuine practice, not a theoretical option.
- **Ask how the system would notice if a standard follow-up call simply failed to connect.** — A specific, confident answer reveals genuine active tracking, not passive assumption of success.

EVIDENCE BASE

[120] Follow-up systems accounting for housing and contact instability, distinct from standard address-and-phone-based recall systems, are established practice for maintaining continuity of care with transient and displaced patient populations.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Ambulatory Clinic
Standards — all standards**

**Self-assess against these
criteria →**

← **Standard 24 — Medical
Tourism**

**Standard 26 —
Rehabilitation →**

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Standard 26 — Rehabilitation

6 criteria · 2 non-negotiable · 3 core · 1 standard-level · Version 1.0

CRITERIA IN THIS STANDARD

- 26.1 — Individualized Rehabilitation Plan Based on Functional Assessment
- 26.2 — Coordination with Referring Physician and Other Providers
- 26.3 — Patient Goal-Setting and Home Exercise Education
- 26.4 — Progress Measured with Validated Functional Outcome Tools
- 26.5 — Equipment and Assistive Device Guidance Matches Need
- 26.6 — Course Completion and Continuity of Self-Management

26.1 Individualized Rehabilitation Plan Based on Functional Assessment

NON-NEGOTIABLE

Every patient referred for outpatient rehabilitation has an individualized plan built from a documented functional assessment, not a generic protocol applied regardless of the patient’s specific impairment and baseline function.

In plain terms: Each patient’s outpatient rehabilitation plan is genuinely built around their own actual function and impairment — not a standard protocol applied by

referral diagnosis alone.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A referral diagnosis alone doesn’t capture the real variation in functional starting point between patients — age, baseline fitness, occupational demands, and the specifics of the condition all shape what a genuinely appropriate plan looks like. In an outpatient setting with a fixed, often limited number of sessions, applying a generic protocol rather than one genuinely built around the individual’s own assessment risks wasting that limited time on goals that don’t match the patient’s actual need.

WHAT GOOD LOOKS LIKE

- A documented functional assessment is actually performed at the first visit.
- The plan is genuinely individualized, verifiable across several patient records.
- The plan is reassessed and adjusted as function changes across the course of visits.

COMMON FAILURE MODES

- A standard protocol is applied by referral diagnosis without a genuine individual assessment.
- Multiple patient plans read nearly identically, suggesting a template rather than individualization.
- The plan set at the first visit is never revisited as function evolves.

WORKED EXAMPLE

IN PRACTICE

Two patients referred for the same rotator cuff injury.

BEFORE

Both patients were started on an identical standard rotator cuff protocol, despite one being a desk worker with mild symptoms and the other a manual laborer with significant strength deficit and a physically demanding job to return to.

ACTION	The clinic required a documented functional assessment — strength testing, range of motion, occupational demands — completed at the first visit for every referred patient, with the plan explicitly built from that assessment rather than diagnosis alone.
AFTER	The Monitor compared the two patients' plans and found genuinely different pacing and strength-focused goals reflecting the manual laborer's occupational demands. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a standard functional assessment tool completed at every first visit.
2. Require the plan to explicitly reference the assessment findings, not just the referral diagnosis.
3. Compare several current patient plans to check for genuine individualization.

The most common mistake: Applying a standard rehabilitation protocol based on referral diagnosis alone, without a genuine functional assessment capturing the real differences in baseline function and occupational demands between patients referred with the same diagnosis.

SELF-ASSESSMENT QUESTIONS

1. Is a documented functional assessment actually performed at the first visit, not a generic protocol applied by referral diagnosis alone? — *Two patients referred with the same diagnosis can have very different functional starting points.*

Evidence: Functional assessment record

2. Is the plan genuinely individualized to that assessment, not a standard template with the patient's name filled in? — *Verified by comparing several patient plans for genuine difference, not just name changes.*

Evidence: Comparative plan review

3. Is the plan reassessed and adjusted as the patient’s function changes across the course of visits? — *A plan fixed at the first visit may no longer reflect the patient’s progress weeks later.*
Evidence: Plan revision history

COMMON REASONS FOR A PARTIAL ANSWER

- An assessment exists but plans still read as largely standardized by diagnosis.
- Plans are set at the first visit and rarely revisited.

IMPLEMENTATION PLAN

When	What
Week 1	Build or formalize a standard functional assessment tool.
Week 2	Require the tool’s completion at every first visit.
Week 3	Review several current plans for genuine individualization.
Ongoing	Build in a defined reassessment interval across the course of visits.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Comparative plan review	Compares plans across several patients with similar diagnoses for genuine individualization.

EVIDENCE BASE

World Health Organization. Rehabilitation in Health Systems. Geneva: WHO; 2017.

World Health Organization. Rehabilitation 2030: A Call for Action. Geneva: WHO; 2023.

26.2 Coordination with Referring Physician and Other Providers

NON-NEGOTIABLE

Rehabilitation care is coordinated with the referring physician and any other providers involved in the patient’s

care through genuine, two-way communication, not a one-time referral with no further contact until a final report.

In plain terms: The rehabilitation clinic genuinely stays in touch with the referring doctor during the actual course of care — not silence until a final report lands at the very end.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A referring physician who hears nothing until a final discharge summary has no real opportunity to adjust the broader medical care plan in response to what’s actually happening during rehabilitation — a complication, an unexpected plateau, or faster-than-expected progress that might change other treatment decisions. Genuinely responsive communication at meaningful clinical points, rather than a fixed mechanical interval, is what makes this coordination actually useful rather than a box-ticking exercise.

WHAT GOOD LOOKS LIKE

- Genuine two-way communication exists during the course of care, not just a final summary.
- Communication happens at meaningful clinical points, not a mechanical interval alone.
- Staff can describe a specific instance where this coordination changed the care course.

COMMON FAILURE MODES

- The referring physician hears nothing until a final discharge summary.
- Communication is a rote periodic update with no genuine clinical content.
- No example exists of coordination actually influencing a care decision.

WORKED EXAMPLE

IN PRACTICE

A patient referred for post-surgical knee rehabilitation.

BEFORE	The clinic sent only a final summary report to the referring surgeon at the conclusion of care, with no contact during the six-week course despite the patient experiencing an unexpected pain flare partway through that the surgeon was never informed of.
ACTION	The clinic built a policy requiring direct contact with the referring physician for any significant change — a plateau, an unexpected complication, or a notable improvement — not waiting for the final report.
AFTER	The Monitor reviewed a recent case where an unexpected pain flare triggered a direct call to the referring surgeon, who adjusted the patient's broader care plan in response. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether referring physicians currently hear anything before the final report.
2. Build a policy requiring contact at defined significant clinical points.
3. Ask staff to recall a specific instance where this coordination mattered.

The most common mistake: Sending only a final summary report to the referring physician at the conclusion of care, with no communication during the actual course of treatment even when something clinically significant occurs.

SELF-ASSESSMENT QUESTIONS

1. Is there genuine two-way communication with the referring physician during the course of care, not just a final discharge summary sent at the end? — *A referring physician kept entirely in the dark until a final report has no opportunity to adjust the broader care plan mid-course.*

Evidence: Communication record

2. Does communication happen at meaningful clinical points — a significant change, a plateau, a concern — not only at a fixed,

arbitrary interval? — *Genuinely responsive communication, not a mechanical check-the-box update.*

Evidence: Communication trigger policy

3. Can staff describe a specific instance where this coordination changed the course of care? — *Evidence the coordination process genuinely functions, not just exists as a policy.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Communication happens but only as a routine, content-light update.**
- **No clear trigger criteria exist for when to contact the referring physician.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current communication practice with referring physicians.
Week 2	Build a policy with defined clinical trigger points for contact.
Week 3	Brief staff on the policy and expected communication content.
Ongoing	Spot-check whether coordination genuinely influences care decisions.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Communication record review	Checks for genuine, clinically meaningful communication with referring physicians during active care.

EVIDENCE BASE

World Health Organization. Rehabilitation in Health Systems. Geneva: WHO; 2017.

26.3 **Patient Goal-Setting and Home Exercise Education** CORE

Rehabilitation goals are set collaboratively with the patient in understandable terms, with a genuine home exercise program taught and verified for correct technique, not goals and exercises handed over on a generic printed sheet.

In plain terms: The patient genuinely takes part in setting their own goals, and home exercises are actually taught and checked for correct form — not just a printed sheet handed over with no verification.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

In an outpatient setting, the home exercise program typically accounts for far more of the patient's total rehabilitation activity than the limited in-clinic session time, which makes correct technique at home genuinely central to the outcome. A generic printed sheet handed over without hands-on verification leaves no real assurance the patient can actually perform the exercises correctly, and incorrect technique can be ineffective or, in some cases, counterproductive.

WHAT GOOD LOOKS LIKE

- Goals are documented as genuinely collaborative, with visible patient input.
- Home exercise technique is actually verified in person, not just handed out.
- The patient can describe their own rehabilitation goals in their own words.

COMMON FAILURE MODES

- Goals are set by staff with no documented patient input.
- A generic printed exercise sheet is given without checking the patient's actual technique.
- The patient can't articulate their own goals when asked directly.

WORKED EXAMPLE

IN PRACTICE

A patient given a standard home exercise handout after a first visit.

BEFORE	Patients were handed a standard printed exercise sheet with illustrations, with a brief verbal “any questions?” but no hands-on check of whether the patient could actually perform the exercises with correct form.
ACTION	The clinic built a requirement to physically demonstrate and then watch the patient perform each home exercise at the first visit, correcting technique in person before the patient leaves, with a brief re-check at the following visit.
AFTER	The Monitor observed a first-visit session and confirmed the therapist watched the patient perform and corrected technique on two of the three prescribed exercises. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a requirement to watch the patient perform each exercise before they leave.
2. Add a brief technique re-check at the following visit.
3. Build a structured goal-setting conversation into the first visit.

The most common mistake: Handing the patient a generic printed home exercise sheet with a brief verbal explanation, without actually watching them perform the exercises to confirm correct technique before they leave.

SELF-ASSESSMENT QUESTIONS

1. Are goals documented as genuinely collaborative, with the patient's own input visible, not set unilaterally by staff? — *A goal-setting record showing only clinical input, with no patient voice, suggests a one-way process.*

Evidence: Goal-setting record

2. Is home exercise technique actually verified in person, not just a printed handout given without checking correct form? — *Incorrect technique at home can be ineffective or, in some cases, actively harmful.*
Evidence: Direct observation

3. Is the patient able to describe their own rehabilitation goals in their own words when asked? — *If the patient can't articulate the goals, the collaborative process likely wasn't genuine.*
Evidence: Patient interview

COMMON REASONS FOR A PARTIAL ANSWER

- Exercises are demonstrated but the patient's own technique isn't watched and corrected.
- Goal input is sought but not visibly reflected in the documented goals.

IMPLEMENTATION PLAN

When	What
Week 1	Build a structured goal-setting conversation template.
Week 2	Require hands-on exercise technique verification before the patient leaves.
Week 3	Add a technique re-check to the following visit.
Ongoing	Spot-check patient ability to describe their own goals.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	First-visit observation	Observes whether the therapist watches and corrects the patient's home exercise technique in person.

EVIDENCE BASE

World Health Organization. Rehabilitation 2030: A Call for Action. Geneva: WHO; 2023.

26.4 Progress Measured with Validated Functional Outcome Tools

CORE

Rehabilitation progress is tracked using a validated functional outcome measurement tool appropriate to the patient's condition, applied consistently at defined intervals across the course of visits, not relying on informal clinical impression alone.

In plain terms: Progress across the course of visits is tracked with a real, recognized measurement tool at consistent intervals — not just an informal sense of how the patient “seems to be doing.”

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

In a limited-session outpatient course, a validated outcome tool measured at consistent intervals is specifically what allows a genuine, objective decision about whether a plateau has been reached or whether the course should continue — informal impression alone is considerably less reliable for this specific decision. Outcome scores that are recorded but never actually used to inform whether to continue, adjust, or conclude the course of care provide no real clinical value beyond documentation for its own sake.

WHAT GOOD LOOKS LIKE

- A validated, recognized outcome tool is actually used, not an informal note.
- The tool is applied at defined, consistent intervals across the course.
- Outcome measurements genuinely inform

COMMON FAILURE MODES

- Progress notes are informal, without a validated, standardized tool.
- Measurement happens sporadically rather than on a fixed schedule.
- Scores are recorded but don't visibly influence course-continuation decisions.

treatment or course-
conclusion decisions.

WORKED EXAMPLE

IN PRACTICE

A patient on a twelve-session outpatient course.

BEFORE	Progress was tracked through informal session notes — “improving,” “tolerating well” — with no standardized tool. The decision to continue beyond the initial authorized sessions was based on clinical impression rather than any objective measure.
ACTION	The clinic adopted a validated functional outcome tool measured at a fixed interval — every third session — with the score explicitly reviewed before any decision to continue, adjust, or conclude the course.
AFTER	The Monitor reviewed a recent patient’s outcome scores and found a documented plateau at session nine that directly informed the decision to conclude the active course and transition to a self-management plan. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Select a validated outcome tool appropriate to your patient population.
2. Set a fixed, consistent measurement interval across the course.
3. Build a step connecting outcome scores directly into continuation decisions.

The most common mistake: Relying on informal session notes rather than a validated, standardized tool, which makes the specific decision of whether a plateau has been reached, and whether to continue the course, considerably less objective than a consistent measurement would allow.

SELF-ASSESSMENT QUESTIONS

1. Is a validated, recognized outcome tool actually used, not an informal, ad hoc progress note? — *A validated tool provides a consistent, comparable measure; informal notes don't.*

Evidence: Outcome tool documentation

2. Is the tool applied at defined, consistent intervals, not sporadically whenever convenient? — *Irregular measurement makes genuine progress tracking difficult.*

Evidence: Measurement schedule

3. Do outcome measurements actually inform changes to the treatment plan or a decision to conclude the course of care? — *Measurement that doesn't feed back into care decisions is documentation for its own sake.*

Evidence: Score-to-decision traceability

COMMON REASONS FOR A PARTIAL ANSWER

- **A tool is used but intervals are inconsistent.**
- **Scores are recorded but rarely visibly connected to continuation decisions.**

IMPLEMENTATION PLAN

When	What
Week 1	Select a validated outcome tool appropriate to the patient population.
Week 2	Set and communicate a fixed measurement interval.
Week 3	Build outcome review into the course-continuation decision process.
Ongoing	Spot-check whether scores visibly inform decisions.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Outcome-to-decision traceability review	Traces a specific outcome measurement to a resulting continuation or conclusion decision.

EVIDENCE BASE

World Health Organization. Rehabilitation 2030: A Call for Action. Geneva: WHO; 2023.

26.5

Equipment and Assistive Device Guidance

CORE

Matches Need

Where assistive devices or equipment — mobility aids, orthotics, adaptive equipment — are indicated, guidance is based on a genuine individual assessment, with the patient trained in correct use, not a generic recommendation handed out regardless of specific need.

In plain terms: Equipment advice is genuinely matched to what the patient needs, and they’re actually shown how to use it correctly — not a generic suggestion handed out regardless of their specific situation.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A generic equipment recommendation given regardless of the patient’s actual functional assessment risks suggesting the wrong level of support or an inappropriate device for their specific situation. Guidance given without hands-on training in correct use often results in equipment that’s used incorrectly or, in a meaningful number of cases, simply not used at all, which undermines the value of the recommendation.

WHAT GOOD LOOKS LIKE

- Equipment guidance is based on a documented individual assessment.
- The patient is actually trained in correct use, not just told what to get.

COMMON FAILURE MODES

- A generic recommendation is given regardless of the patient’s specific assessment.
- The patient is told what to purchase with no hands-on training in its use.

- A follow-up check at a subsequent visit confirms correct use.

- No follow-up check exists to confirm the equipment is being used correctly.

WORKED EXAMPLE

IN PRACTICE

A patient advised to obtain a knee brace after an outpatient assessment.

BEFORE	The patient was told to “get a knee brace from the pharmacy” with no specific guidance on type or fit, and no follow-up to check whether she’d obtained one or was using it correctly.
ACTION	The clinic built a requirement for a documented equipment assessment specifying the type and fit indicated, with hands-on fitting guidance where feasible, and a follow-up check at the next scheduled visit.
AFTER	The Monitor reviewed a recent patient record showing a specific brace type documented, fitting guidance given, and a follow-up note confirming correct use at the subsequent visit. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Require a documented individual equipment assessment, not a generic verbal suggestion.
2. Build hands-on fitting or use guidance into the visit.
3. Add a follow-up check at the next scheduled visit.

The most common mistake: Giving a generic verbal equipment suggestion with no specific assessment of the type or fit genuinely needed, and no follow-up to confirm the patient obtained and is using it correctly.

SELF-ASSESSMENT QUESTIONS

1. Is equipment guidance based on a documented individual assessment, not a default or convenience-driven recommendation?

— A generic recommendation given regardless of the patient's actual functional need is a specific, checkable gap.

Evidence: Equipment assessment record

2. Is the patient actually trained in correct use, not just told what to buy or where to get it? — Equipment without genuine training in its use risks being unsafe or unused.

Evidence: Training documentation

3. Is there a follow-up check at a subsequent visit on whether the equipment is being used correctly? — A recommendation made once with no follow-up often goes unverified.

Evidence: Follow-up note

COMMON REASONS FOR A PARTIAL ANSWER

- An assessment happens but hands-on training is inconsistent.
- No follow-up check confirms the equipment is actually being used correctly.

IMPLEMENTATION PLAN

When	What
Week 1	Require a documented individual equipment assessment process.
Week 2	Build hands-on fitting or use guidance into the relevant visit.
Week 3	Build a follow-up check into the subsequent visit.
Ongoing	Spot-check records for assessment and follow-up completeness.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Equipment record review	Checks patient records for documented individual assessment, training, and follow-up confirmation.

EVIDENCE BASE

World Health Organization. Assistive Technology. Geneva: WHO; 2024.

26.6

Course Completion and Continuity of Self-Management

STANDARD

As the course of rehabilitation concludes, the patient receives a genuine plan for continuing self-management — an ongoing exercise program, warning signs to watch for, and how to seek further care if needed — not simply told the sessions have ended.

In plain terms: When the sessions end, the patient leaves with a genuine plan for keeping up the progress on their own — not just told the course is finished with nothing further.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Functional gains made during an active course of rehabilitation can be lost without a genuine plan for continuing self-management, which means the final conversation at course conclusion carries real weight for whether the patient's progress actually holds. A patient who doesn't know what warning signs would warrant a return visit may either return unnecessarily for something minor or, more concerning, fail to seek care when something genuinely does need attention.

WHAT GOOD LOOKS LIKE

- Course conclusion includes a genuine, specific ongoing self-management plan.
- Specific warning signs and how to seek further care are communicated.
- A documented decision point marks the conclusion, not an indefinite drift.

COMMON FAILURE MODES

- The patient is simply told sessions have ended, with no ongoing plan.
- Warning signs and further-care guidance aren't specifically communicated.
- Care trails off with no clear, documented conclusion decision.

WORKED EXAMPLE

IN PRACTICE

A patient completing a course of lower-back rehabilitation.

BEFORE	At the final session, the patient was told “that’s your last visit, you’re all set,” with no documented ongoing exercise plan, no specific warning signs discussed, and no guidance on when or how to seek further care if symptoms recurred.
ACTION	The clinic built a structured course-conclusion conversation, documented in the chart, covering an ongoing maintenance exercise program, specific warning signs to watch for, and exactly how to seek further care if needed.
AFTER	The Monitor reviewed a recent course-conclusion record and found a documented maintenance plan, specific warning signs listed, and clear guidance on how to seek further care. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a structured course-conclusion conversation template.
2. Define specific warning signs relevant to your common patient conditions.
3. Document the conclusion as a clear decision point, not a drift.

The most common mistake: Treating course conclusion as a simple administrative notice that sessions have ended, without a genuine ongoing self-management plan or specific guidance on warning signs and further care.

SELF-ASSESSMENT QUESTIONS

1. Does course conclusion include a genuine, specific ongoing self-management plan, not just a notice that sessions have ended? — *A patient left without guidance on maintaining progress can lose the functional gains made during treatment.*

Evidence: Course-conclusion record

2. Are specific warning signs to watch for communicated, along with how to seek further care? — *The patient should know when a return visit or different care pathway is warranted.*

Evidence: Warning sign documentation

3. Is there a documented decision point, not an indefinite continuation with no clear endpoint or review? — *A defined course conclusion with a documented decision, not care that simply trails off.*

Evidence: Decision record

COMMON REASONS FOR A PARTIAL ANSWER

- A maintenance plan exists but warning signs aren't specifically discussed.
- Course conclusion lacks a clear documented decision point.

IMPLEMENTATION PLAN

When	What
Week 1	Build a structured course-conclusion conversation template.
Week 2	Define condition-specific warning signs for common patient groups.
Week 3	Brief staff on the structured conclusion conversation.
Ongoing	Spot-check course-conclusion records for completeness.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Course-conclusion record review	Checks records for a documented ongoing self-management plan, warning signs, and further-care guidance.

EVIDENCE BASE

World Health Organization. Rehabilitation in Health Systems. Geneva: WHO; 2017.

**Self-assess against these
criteria →**

**← Standard 25 — Refugee &
Migrant Health**

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