

2014 – 2018

Ethiopia Refugee Program Urban Health Sector Strategic Plan



Public Health, HIV and Reproductive
Health, Food Security and Nutrition
2014 – 2018



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ACRONYMS

ARRA	Administration for Refugee and Returnee Affairs
DICAC	Development and Inter-church Aid Commission
EWARNs	Early Warning Systems
HIS	Health Information Systems
IOM	International Organization of Migration
IYCF	Infant and Young Child Feeding
mhGAP	Mental Health Gap Action Programme
MOH	Ministry of Health
OCP	Out of Camp Policy
PHC	Primary Health Care
TB	Tuberculosis
HIV	Human Immunodeficiency virus
UAP	Urban Assistance Program
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

STRATEGIC PLAN PUBLIC HEALTH SECTOR 2014 – 2018

VISION

The United Nations High Commissioner for Refugees (UNHCR) working with Administration for Refugee and Returnee Affairs (ARRA) & their partners, aim to ensure that all refugees are able to fulfil their rights in accessing primary health care, and essential life-saving secondary and tertiary health services, to reduce mortality and morbidity

MISSION STATEMENT

UNHCR, in its effort to fulfil its mandate of leading and coordinating international protection of refugees and the resolution of refugee problems, works in partnership with governments, regional organizations; international and non-governmental organizations in order safeguard the rights and well-being of refugees. UNHCR coordinates and support access to standard and cost-effective public healthcare services in a comprehensive manner based on the principles of primary healthcare in timely manners during both emergency and stable situations.

It is committed to the principle of participation, believing that refugees and others who benefit from the organization's activities should be consulted over decisions which affect their lives.

OVERVIEW

This five-year strategy outlines the principles, impacts, objectives and strategic areas of focus for UNHCR Ethiopia's urban public health programme for the period 2014-2018. Administration for Refugee and Returnee Affairs (ARRA) is a key government counterpart and health partner in implementation of this strategy. ARRA is responsible for facilitating health care and referral of refugees who are in urban locations for reasons like scholarships, resettlement interviews, out of camp policy and joint UNHCR/ARRA urban transfer. DICAC is the main health partner for the urban assistance program and IOM primarily handles UNHCR medical assessment for consideration of resettlement and transportation of cases of resettlement.

The UNHCR global policy on refugee protection and solutions in urban areas elaborates a three pronged approach - advocacy, support, and monitoring & evaluation. UNHCR and ARRA will continue advocating on behalf of refugees and working closely with authorities to continue the current practice of making public services including health services available at similar costs to that of nationals or subsidized where necessary. UNHCR supports and facilitates integration into and strengthening of the national public health system. This may include direct funding or indirect support via partners. UNHCR, ARRA, FMOH and partners will assess, monitor, and evaluate the health, nutritional, educational and economic status of refugees, ensuring needs are met in line with accepted standards and that quality services are available and accessible.

In 2008, the Government of Ethiopia introduced the "Out of Camp Policy" (OCP) for Eritrean refugees who fulfilled certain criteria. The policy developed as a result of the long-standing and close historical, cultural, and linguistic ties between the Eritrean refugees and the Ethiopians hosting them. It was also a means by which Eritreans who were separated from family members as a result of the division of the two countries in 1993 could reunify.

Under the Out of Camp Policy, an Eritrean refugee who has resided in a refugee camp in Ethiopia for at least six months, has no criminal record and who has an immediate family member lawfully residing in Ethiopia who is willing and financially able to support him/her, can reside with that family member outside of the refugee camp. In doing so, however, OCP refugees forego financial assistance and material support from ARRA and UNHCR, except for emergency medical assistance. However, with time all OCPs have sort medical assistance from ARRA for both acute and chronic/ non-emergency conditions, due to various factors and this has overwhelmed ARRA's resource capacity in Addis Ababa. As with other refugees in Ethiopia, they are not authorized to work in the country.

Two other programmes that allow refugees to reside outside of the camps exist alongside the Out of Camp Policy. The first is the Urban Assistance Programme (UAP), whereby refugees are authorized to live in an urban area, generally Addis Ababa, for security, medical or family reunification reasons. UAP refugees receive support from UNHCR and are expected to return to the camps when/if the reason for their admission to the UAP has been resolved. The refugees receive monthly subsistence allowance from UNHCR, as refugees are not permitted to work in Ethiopia. There are currently some 2,700¹ refugees in the UAP.

The second programme allows refugees to reside outside of the camps to pursue university studies in Ethiopia. For many of these students, the Government of Ethiopia covers 75% of their tuition and other costs, with UNHCR covering the remaining 25%. Some students also benefit from DAFI or other scholarships. There are currently some 1,500² refugees, of various nationalities, residing outside of the camps to pursue university studies.

For this document public health refers to preventive and curative health and nutrition services. Limited reference in this document is made to food security, water, sanitation and hygiene promotion.

ETHIOPIA COUNTRY PROFILE

Ethiopia is Africa's oldest independent country. It is the tenth largest country in Africa, covering 1,104,300 square kilometres (with 1 million sq. km land area and 104,300 sq. km water) and is the major constituent of the landmass known as the Horn of Africa. It is bordered on the north and northeast by Eritrea, on the east by Djibouti and Somalia, on the south by Kenya, and on the west and southwest by Sudan.

Ethiopia is a country with great geographical diversity and its topography shows a variety of contrasts ranging from high peaks of 4,550m above sea level to a low depression of 110m below sea level³. More than half of the country lies above 1,500 meters. The predominant climate type is tropical monsoon, with temperate climate on the plateau and hot in the lowlands. There are topographic-induced climatic variations broadly categorized into three: the "Kolla", or hot lowlands, below approximately 1,500 meters, the "Wayna Degas" at 1,500-2,400 meters and the "Dega" or cool temperate highlands above 2,400 meters.

Ethiopia has a tiered government system consisting of a federal government overseeing ethnically based regional states, zones, districts (woredas) and neighbourhoods (kebele).

At present Ethiopia is administratively structured into nine regional states—Tigray, Afar, Amhara, Oromiya, Somali, Beneshangul-Gumuz, Southern Nations Nationalities and Peoples (SNNP), Gambella, and Harari—and two city administrations, that is, Addis Ababa and Dire Dawa Administration Councils⁴.

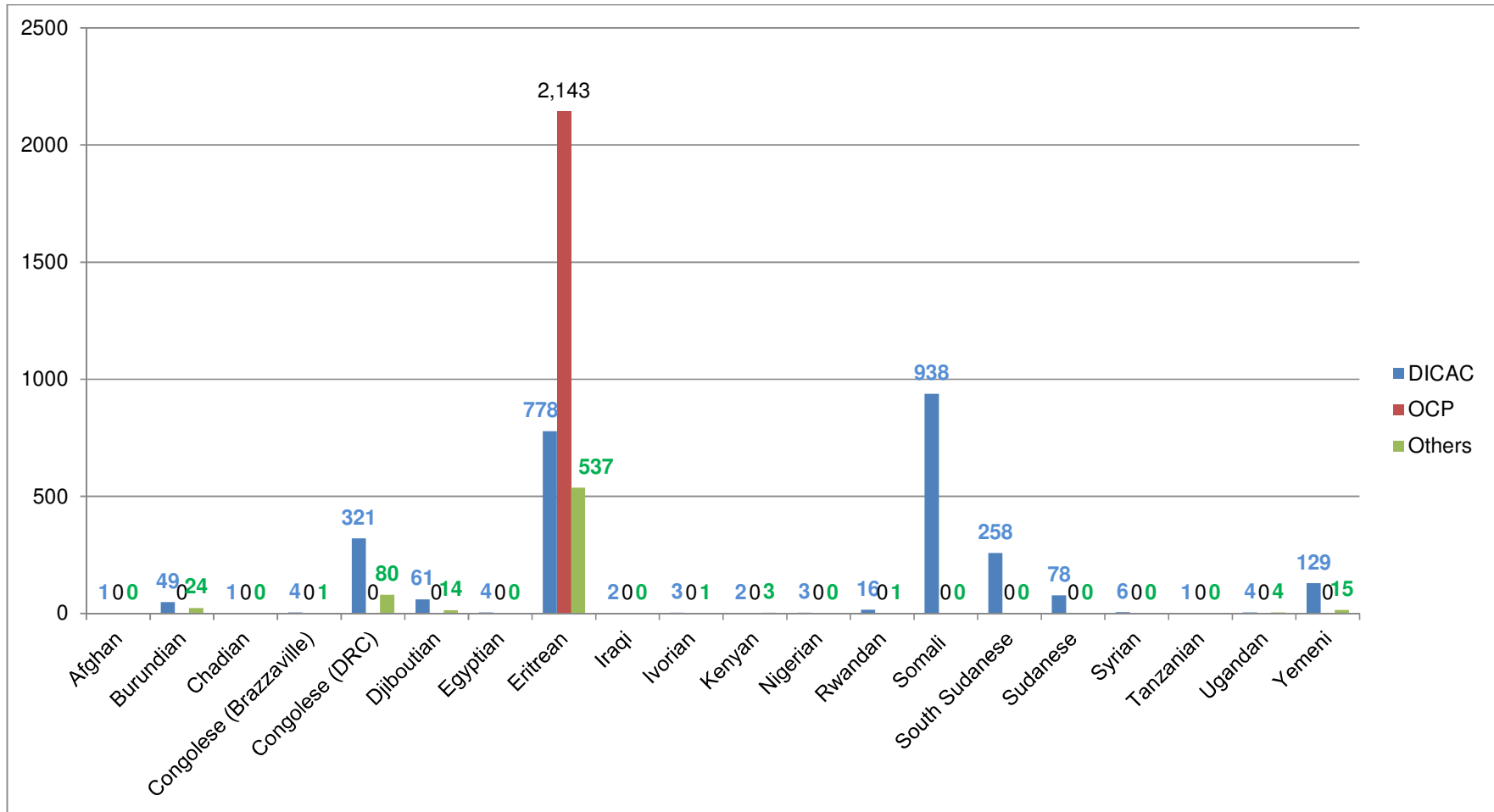
¹ UNHCR refugee population statistics, October 2014

² UNHCR refugee population statistics, October 2014

³ Central Statistical Agency (CSA) [Ethiopia]. 2009. Statistical Abstract of Ethiopia. Addis Ababa, Ethiopia: Central Statistical Agency.

⁴ Central Statistical Agency [Ethiopia] and ICF International. 2012. Ethiopia Demographic and Health Survey 2011. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ICF International

FIGURE 1: ETHIOPIA URBAN REFUGEE STATISTICAL GRAPH, OCTOBER 2014



URBAN HEALTH PROGRAM GUIDING PRINCIPLES

These principles are derived from UNHCR's policy on refugee protection and solutions in urban areas and from PHHIV Section's Guiding Principles and Strategic Plans and Principles and Guidance for Referral Health Care for Refugees that have been adapted to the urban context. The following principles will guide the response to urban refugees in Ethiopia;

1. Access and Equity

- UNHCR seeks to ensure that urban refugees have access to health services at similar or lower costs to that of nationals.
- Support mechanisms and safety nets for vulnerable refugees so that they can access services equitably.

2. Primary Health Care Principles

- Support for urban refugees in accessing health care is anchored in the principles of primary health care (PHC).
- Support primary health care programmes, to ensure that both prevention and curative care are provided
- Resource allocation based on public health approach with the aim of ensuring the greatest good for the greatest number of people.
- Support community level health programming as an essential component of PHC programmes.

3. Prioritization and Rationalization

- Access to primary health care and emergency care; will take precedence over long term costly secondary and tertiary care based on Ethiopia standard operating procedures/ policies.
- Promote cost-effective, evidence-based interventions, including the use of essential medicines and rational use of diagnostics.
- Support the rationalization of services by identifying and supporting a select number of quality service providers/ facilities for primary and essential referral care.
- Make clear agreements with appropriate health service facilities (including pharmacies and laboratories) and providers via signed memoranda of understanding or letters of agreements or contracts.
- Clearly state the roles and responsibilities of the partner agency, the service provider, the MoH and UNHCR.
- Include target indicators that help to monitor the impact of the services being provided to refugees (with potential benefit also to nationals).
- Negotiate reduced prices and include in agreements/memoranda of understanding with the hospitals

4. Integrated Approaches and Sustainability

- Ensure that public health services for refugees are embedded into the national public health system.
- The establishment of parallel health services will be supported only where necessary to cover short term needs, while working on mainstreaming refugees in the national public health system.
- Support health system strengthening while ensuring that immediate and short-term needs of refugees are addressed.

5. Monitoring and Evaluation

- Ensure evidence based decision-making, with regional and country analysis to improve and prioritize health interventions.

6. Partnerships

- Ensure strong partnerships with government, UN agencies and national and international NGOs and communities of refugees, utilising added advantage of partners while ensuring a refugee inclusive approach.

7. Communication.

- Establish effective communication mechanisms to improve access to priority primary health care (PHC) services and to improve health status of refugees.

8. Capacity Building

- Promote and strengthen the capacities of key stakeholders and partners to ensure a refugee inclusive approach based on international humanitarian public health principles.

OBJECTIVES

OBJECTIVE 1: SUPPORT ACCESS TO COMPREHENSIVE INTEGRATED PRIMARY HEALTH CARE

The focus of UNHCR's protection and assistance health programmes in Ethiopia will be a combination of curative and preventative health care that is supported by a community-based health approach. Primary health care centres should be the first contact with the formal health system and be available on a continuous basis.

1.1 Access to PHC Services and integration with government services

- 1.1.1 UNHCR together with its partners will support the Ethiopia Federal Ministry of Health (MoH) to ensure that refugees have access to curative and preventative health care services.
- 1.1.2 UNHCR through ARRA and DICAC will support MoH facilities and ensure geographical coverage, with a rational use of health services by identifying and supporting a select number of quality health service providers/facilities and partners with preference on use and support of government health facilities. ARRA and DICAC will ensure they have agreements with a common pool of government health facilities for primary health care. UNHCR and partners should regularly (annually or as needed) carry out a cost analysis of options for primary, secondary and tertiary (specialised) care.
- 1.1.3 Integration processes with government facilities should not detract from meeting the unique needs of refugees, and there may be need to support national public health services to be modified to be able to respond to diversity. This includes meeting the needs of people of different languages and different cultures that may not be so familiar with accessing an unfamiliar health system. For example, reproductive health services may need to be adapted, special mental health needs may require flexibility in service delivery, and protection for refugees from the particular vulnerabilities of physical and sexual violence may need to be specifically adapted and implemented by service providers.
- 1.1.4 UNHCR and ARRA advocate that fees for accessing health services should not be higher than the fees paid by nationals and should be in line with the relevant Ministry of Public Health fees.
- 1.1.5 Vulnerable refugees should be identified based on strict criteria and a suitable safety net provided for them to ensure access to preventative and curative health services. Refugees should have full access to immunisations, antenatal care and other maternal and child health services, tuberculosis (TB) and HIV prevention, care, support and treatment services (including access to antiretroviral therapy) and management of notifiable communicable diseases.
- 1.1.6 There may be several vertical programmes for nationals that have attracted external donor and/or UN agency support and refugees should be able to access these programmes for free. These may include the expanded programme of immunisation, the integrated management of childhood illnesses, communicable disease preparedness and response programmes, chronic disease programmes and programmes for HIV, TB and malaria.
- 1.1.7 Public health screening services such as those for breast, cervical and prostate cancer should be provided at a similar cost to those of nationals (preferably free of charge).
- 1.1.8 If UNHCR has sufficient funding, discuss and decide with government/MoH how UNHCR can provide funds or supplies for increasing staffing, provision of training, buying equipment, medicines or medical supplies, and/or improving infrastructure for primary health facilities (e.g. rehabilitating a health centre or adding a consultation room in areas where there are a high density of refugees). While encouraging integration, UNHCR recognises the increased burden this may create on public services, particularly when there are large concentrations of refugees in certain urban areas.

1.2 Ensure adequate information on access to services

- 1.2.1 UNHCR and partners will develop a service guide for the refugee community and agencies working with refugees, in appropriate languages and pictorials on the available health services in

refugee hosting areas. Details such as resettlement eligibility criteria, access to the referral care system and other relevant information will be clearly communicated.

- 1.2.2 Diverse communication modalities such as SMS messaging (targeted messaging only) and info lines on access to health care services will be explored. These one-way methods of communication, will be supported by personal communication modalities such as through the community based health work force.

1.3 Rational use of essential medicines and diagnostics

UNHCR will support the use of essential medicines in its programmes. UNHCR Ethiopia will support existing programs by MOH to improve clinical diagnostic skills in order to reduce the often expensive and unnecessary diagnostic procedures.

1.4 Enhancing emergency response

Although this document is primarily designed for non-emergency refugee urban settings, it may also be applicable in acute and immediate post-conflict or natural disaster settings where a large urban refugee influx occurs. For these scenarios, there are many emergency protocols that can be used but many have not been sufficiently adapted to the urban context. In these situations, UNHCR and its partners should advocate for free access to PHC and emergency services and inclusion of refugees into countries' emergency planning.

1.5 Support the development of Community based health care

UNHCR, DICAC and ARRA will further strengthen community level systems in order to link the refugee community to primary health care services by adopting from the national health extension programme. Ideally the community-based workforce will consist of 1 community based health worker for 250-500 persons (depending on geographical distribution and expected tasks). The community based health workers will need to address the main causes of morbidity and mortality, immunization in children, promotion of antenatal, post natal care, facility deliveries and early neonatal care and ensure correct information is communicated on eligibility criteria for resettlement and any other health program information as directed by service providers. The community based health worker is critical to strengthen the linkages between refugees and relevant services and partners.

1.6 Promote livelihood options and access to education

- 1.6.1 Provision of livelihood opportunities is a priority sustainable mechanism for reducing poverty and improving economic access to health services. It includes identifying livelihood opportunities for those with disabilities or for those who are mainly home-bound looking after themselves or sick relatives. UNHCR's operational guidance for urban livelihoods outlines these livelihood options.
- 1.6.2 Increasing educational opportunities also form part of a long term strategy to increase livelihoods and improve health status. In particular, UNHCR advocates that refugee children access school health and school feeding programmes that are available to national children. UNHCR's operational guidance for urban education outlines these livelihood options.

OBJECTIVE 2: DECREASE MORBIDITY FROM COMMUNICABLE DISEASES AND OUTBREAKS

UNHCR and ARRA recognize the PHC system as the cornerstone for identification and response to communicable diseases. UNHCR and urban health program partners will work with the MoH and WHO to ensure that the early warning systems (EWARNs) are functioning in areas where there are high concentrations of refugees living in out-of-camp situations. Selected indicators already developed for urban HIS will be used in the urban health program and the communicable diseases surveillance component will report to the national system to ensure integration.

OBJECTIVE 3: SUPPORT CHILDHOOD SURVIVAL AND EXPANDED PROGRAMME FOR IMMUNIZATION

- 3.1 UNHCR will support access for all urban refugee children to expanded immunization programmes and improved diagnosis and treatment of childhood illnesses. UNHCR and ARRA will support the MoH and UNICEF in strengthening national expanded immunization programmes (EPI) and ensure that urban refugees are included in these programmes;
- 3.2 Support the MoH to develop and strengthen the implementation of protocols for catch-up immunization in urban refugee children who may have interrupted their routine schedule.
- 3.3 Support PHC centres to actively follow up on vaccination status of all children under five. The aim is to ensure that all children who are unable to provide documented vaccination records will be given the opportunity to “catch-up” with their immunizations, regardless of age and based on Ethiopia-specific protocol.

OBJECTIVE 4: SUPPORT INTEGRATED PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES AND MENTAL HEALTH

- 4.1 UNHCR supports the management of non-communicable diseases at the PHC level through the establishment of standardized simplified management guidelines based on MOH protocols and the national essential medicines list.
- 4.2 In line with its operational guidance for mental health and psychosocial support, UNHCR will further strengthen its mental health programmes. UNHCR and partners will focus interventions at each of the four levels:
 - Level 4 (clinical services): implement integrated mental health into general health care services using the mhGAP Intervention Guide (2010) and the forthcoming WHO/UNHCR mhGAP Intervention Guide for humanitarian settings;
 - Level 3 (focused non-specialized support): explore task-shifting approaches with brief evidence based psychological treatments for mild -moderate mental disorders;
 - Level 2: Strengthening community and family support and improve links and referral between protection actors and health actors;
 - Level 1: Psychological first aid (PFA) training for registration and reception centre staff.

OBJECTIVE 5: SUPPORT ACCESS TO COMPREHENSIVE REPRODUCTIVE HEALTH & HIV SERVICES AND NUTRITION CARE

- 5.1 UNHCR and partners will strengthen access to comprehensive reproductive health care including neonatal care.
- 5.2 Poor attendance at antenatal services is a major problem, compromising maternal and neonatal health and contributing to high costs at the secondary care level. UNHCR and partners will actively support improving uptake and quality of antenatal and postnatal care and addressing the unmet need for family planning. To ensure that costs are maintained and service quality improves ANC services will be promoted with a package of four visits, syphilis screening, rubella screening, anaemia, glucose, blood pressure, and palpation and a rational justification of ultrasounds.
- 5.3 Furthermore, the delivery by skilled birth attendants in institutions with adequate facilities including emergency referral, access to safe blood transfusion and caesarean sections when indicated, post-natal care, including post-partum family planning counselling and early neonatal care. To reduce the high costs in neonatal care, UNHCR will work with partners to strengthen appropriate and low technology interventions when indicated, including early discharge from hospitals and Kangaroo mother care for low birth weight neonates, early initiation of exclusive breast-feeding, vitamin K and home visits of neonates and mothers.

- 5.4 UNHCR will continue to support the clinical management of sexual and gender-based violence in selected clinics, improved monitoring of services and appropriate confidential referral. Mandatory reporting continues to be an obstacle to the provision of confidential timely sexual violence services.
- 5.5 UNHCR and partners will continue to provide tuberculosis (TB) and HIV prevention, care, support and treatment services including access to antiretroviral therapy. UNHCR advocates for the removal of any discriminatory directives or practices that impede access to health. This includes the removal of any mandatory HIV testing and the avoidance of any compulsory measures to reveal an individual's HIV status outside of confidential medical settings.
- 5.6 In Ethiopia, cervical and breast cancer screening is provided at select public health facilities for free. It is very important to ensure before refugees are included in such programmes that costs of additional investigations and treatment access have been adequately considered. Screening should only be introduced if it is part of a well-established national programme with wide coverage and quality control measures in place.
- 5.7 UNHCR and partners will ensure eligible refugees receive nutrition screening, nutrition rehabilitation via in or out-patient therapeutic programmes, nutrition promotion, micronutrient supplementation programmes, and support to food security. These include including infant and young child feeding programmes and the promotion of exclusive breast feeding.

OBJECTIVE 6: SUPPORT ACCESS TO SECONDARY AND TERTIARY HEALTH CARE

- 6.1 While access to quality primary health care is the core of this strategy access to essential secondary and tertiary care based on Ethiopia specific standard operating procedures for medical referrals will be supported. The latter stipulate guiding principles, the referral process including roles of key actors and criteria for referral.
- 6.2 Monitoring of referral care, including the costs, is critical to strengthen analysis of the main burden of referral care, regional comparison and indicates where further development of case management criteria is needed. A new referral monitoring tool has been introduced for this purpose.
- 6.3 The relatively more sophisticated health services that may be available to refugees in cities brings many more costing and equity dilemmas that inevitably require that realistic limits be set, particularly for costly specialist services. UNHCR promotes the use of quality, cost effective, evidence-based public health services for all refugees.

OBJECTIVE 7: MAINTAIN AND EXPAND HEALTH INFORMATION SYSTEMS INCLUDING INFORMATION ON ACCESS, UPTAKE AND COVERAGE OF SERVICES

- 7.1 UNHCR promotes the use of population-based surveys in out-of-camp refugees where limited knowledge is available on the access and obstacles to health care for this population. UNHCR will expand the use of prospective surveillance to monitor key knowledge and access indicators in the out-of-camp populations.
- 7.2 A new referral tool has been introduced to monitor referral cases from camps in Addis Ababa. The reports will be collected on monthly basis and will form basis of analysing referral decisions.

OBJECTIVE 8: ADOPT & IMPLEMENT REFUGEE COMMUNICATION PLAN

- 8.1 UNHCR, DICAC and ARRA will establish a model community outreach programme by adopting from the national health extension programme. The outreach workers will be a key resource in information sharing, case finding and referral and health awareness and education through house to house visits and discussions at various locations that refugees assemble.
- 8.2 In addition a refugee communication plan will be developed where key health messages/ information will be displayed in posters, pamphlets etc. These will be translated in various languages spoken by the refugees and will be displayed/ distributed at strategic locations including UNHCR and partners' reception areas, and select health facilities that serve refugees.

- 8.3 Any communication with refugees by Protection case workers while referring to any agencies should not indicate/mention the name of any of the persons in that agency and the possible outcomes of the medical referral. This will avoid misinformation and contradicting medical advice provided to the refugee as well as possible victimization of staff.

OBJECTIVE 9: COORDINATION

- 9.1 UNHCR and ARRA will liaise closely and lead coordination efforts with the MoH and partner agencies so that services for refugees are integrated into those of nationals and encourage other partners to also advocate for the needs of refugees.
- 9.2 UNHCR will also be involved in wider coordination mechanisms to advocate that urban refugees are provided for within the government public health system and to promote improved services that tackle underlying determinants of health such as water and sanitation systems, food security and nutrition programmes, affordable housing and livelihood opportunities.
- 9.3 The MoH and other ministries in each country are ultimately responsible for providing quality health services for refugees in urban areas and any coordination mechanisms should promote their leadership in liaison with ARRA.
- 9.4 UNHCR and urban program partners should participate in meetings organised by, for example, the MoH or municipal authorities in which the needs of the urban poor including refugees are discussed.
- 9.5 UNHCR should also closely coordinate with other UN agencies so that any urban health initiatives for nationals benefit refugees in the same way.
- 9.6 UNHCR and ARRA public health staff will work closely and coordinate with UNHCR staff working in livelihoods, education, community services, protection and other sectors.

PROCEDURES FOR HANDLING DIFFERENT REFUGEE CATEGORIES

1. OCP, UNIVERSITY STUDENTS, SELF-REFERRAL/UNAUTHORIZED MOVEMENTS

- 1.1 There are many refugees who come to UNHCR and ARRA without following the proper referral pathways such as self-referrals, out of camp policy (OCP) beneficiaries and university students to request for medical services.
- 1.2 Any OCP beneficiary, unauthorized mover/self-referral or university student who presents him/herself to UNHCR reception area or elsewhere should be referred to ARRA without discussing medical details that may result in giving them expectations on the outcomes of such referrals.
- 1.3 In the case of medical emergencies related to any of the above category of refugees who present themselves at UNHCR reception or elsewhere, ARRA should be informed and they will then coordinate with DICAC to send an ambulance to refer the patient to the designated public health facility
- 1.4 If the above categories of persons of concern present themselves at UNHCR offices during late working hours and/or weekends, UNHCR should communicate with DICAC (through ARRA) to accommodate the patient until the next working day when DICAC will first call ARRA and agree if they should take the patient to ARRA office or keep them for a specified limited period at DICAC shelter. ARRA will receive and provide services for this category of patients/POC. This arrangement will continue until ARRA finalize the establishment of medical referral shelter in Addis Ababa.
- 1.5 Any OCP, university student, unauthorized movements/self-referral referred to ARRA should be communicated through e-mail, addressing to the health coordinator by explaining the referred case's situation and date that he/she was referred to ARRA and copy to UNHCR health unit.
- 1.6 ARRA will in turn provide the feedback of the person/s referred to them by indicating the assessment results and plan of action to the Protection case workers and UNHCR Health unit so as to ensure a common message is given to the refugee by all agencies involved.

- 1.7 OCPs continue to seek primary health care services and referral for secondary and tertiary care at ARRA offices in Addis Ababa. However, considering the capacity and resource challenges associated with the increasing number of OCPs in Addis Ababa seeking medical assistance at ARRA offices, the latter will sign agreements with various select public health facilities where refugees will receive primary health care services (similar model to UAP under DICAC). An alternative preferred arrangement will be to include the OCP as special category under DICAC's responsibility so that ARRA reverts to its main role as a coordinating and monitoring government agency. OCP beneficiaries who need secondary or tertiary referral care will be reviewed by ARRA/DICAC and UNHCR medical doctors for objective decision making based on availability of treatment, prognosis and cost. However, continued review and support to ARRA's/ DICAC's implementation capacity is needed while leveraging linkages/ opportunities with public health services under FMOH and other urban health partners.
- 1.8 ARRA and UNHCR will need to strictly apply the policy that self-referrals are not allowed in Addis Ababa/ other location unless the patient/ person has a self-sponsor and even then they should get exit permit from ARRA at respective camp level. ARRA and UNHCR should ensure that all refugees without an exit permit are returned back to their designated camp and communication on the same passed to ARRA and UNHCR at camp level for follow up and further support in medical management plan.

2. MEDICAL ASSESSMENT FOR CONSIDERATION OF RESETTLEMENT ON MEDICAL GROUNDS

- 2.1 Request for Medical Assessment for Resettlement (MAR) can be submitted to UNHCR by implementing partners responsible for healthcare services. In the case of Ethiopia, by ARRA for the refugees referred from the camps to Addis Ababa for tertiary level of care and by DICAC for those refugees in urban assistance program.
- 2.2 The health partner will send the request, summary of the clinical findings and copies of relevant laboratory and medical investigation results such as pathology, x-ray, ultrasound, CT-scan and MSI investigations signed by a qualified physician.
- 2.3 The request shall be addressed to UNHCR resettlement and health units. If **relevant information about the particular case is not complete and up-to-date**, UNHCR health/ resettlement unit shall send back the request to the respective partner to make it complete and up-to-date
- 2.4 UNHCR resettlement and health units in consultation with each other shall decide for medical assessment to be undertaken at IOM clinic. IOM shall be informed to carry out the MAR through UNHCR resettlement unit.
- 2.5 IOM clinic shall complete the Medical Assessment Form (MAF) **mainly** based on physical examination and existing laboratory and medical investigations done at ARRA and DICAC. However, IOM can request for additional investigations in consultation with UNHCR when it is found necessary.
- 2.6 After IOM has completed medical examination and relevant investigations, the treating physician will counsel the refugee appropriately on the diagnosis and management solutions.
- 2.7 If IOM proposes a local treatment option that may contradict with recommendation from DICAC or from Black Lion hospital (tertiary referral facility in Ethiopia) for treatment abroad or for that matter any other contradicting finding, IOM should contact DICAC doctor for further discussion and invite UNHCR health officer as necessary so as to review any new/ different considerations made and justifications for proposed treatment options and finally agree on a common recommendation. This recommendation and explanation on the same will then be reflected in the MAF and IOM physician will explain the same to the refugee.
- 2.8 IOM will then send a copy of the MAF report to UNHCR (copying DICAC focal person). After completion of the assessment, IOM will send the MAF back to UNHCR which will be again reviewed and endorsed by UNHCR resettlement unit in consultation with health unit.

- 2.9 UNHCR will then submit the report to the regional support hub (RSH) in Nairobi for further review and clearance before it is presented to third country (s) for consideration of resettlement.
- 2.10 It is important to note that no information on whether or not the refugee qualifies for resettlement should be provided to the refugee until feedback is received from the third country so as not to pre-empt the independent decision of the latter.
- 2.11 If IOM proposes a local treatment option that may contradict with recommendation from DICAC or from Black Lion hospital (tertiary referral facility in Ethiopia) for treatment abroad or for that matter any other contradicting finding, IOM should contact DICAC doctor for further discussion and invite UNHCR health officer as necessary so as to review any new/ different considerations made and justification for proposed treatment options and finally agree on a common recommendation. This recommendation and explanation on the same will then be reflected in the MAF and IOM physician will explain the same to the refugee.

3. URBAN ASSISTANCE PROGRAM

- 3.1 Referral of refugees to Addis urban program shall be in line with the SOPs on medical referral.
- 3.2 Refugees already in the urban assistance program (UAP) who present to UNHCR reception area or elsewhere and require assistance related to their medical condition should be referred back to DICAC, the designated health partner for the UAP. The Protection case worker should not get involved in the details of the medical condition or give any assurance of any type of management/ solution. This should be left for professional management by DICAC medical team. If the refugee expresses complaint on lack of appropriate assistance on their respective medical condition, then Protection unit should take note of the general information and write a mail to DICAC seeking clarification/ follow up on the case copying UNHCR health unit for follow up.
- 3.3 An already established urban assistance review committee meets on monthly basis to review both medical and protection cases for consideration of entry or exit from the UAP. UNHCR, ARRA and DICAC are members of this committee.
- 3.4 Medical doctors from UNHCR, ARRA and DICAC will have a separate special committee to review complicated cases with medical condition that may not have straightforward recommendation at the monthly urban assistance review meeting. Their recommendation will be based on objective review of the case files and ideally, none of the members should have contact with the refugee so as to ensure objectivity in judgement and decision making.

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