# BUILDING THE EVIDENCE

## Health System Strengthening in Situations of Protracted Displacement

Lessons from Bangladesh, Colombia, the DRC, and Jordan

December 14, 2022

# Consortium Members

WORLD BANK GROUP

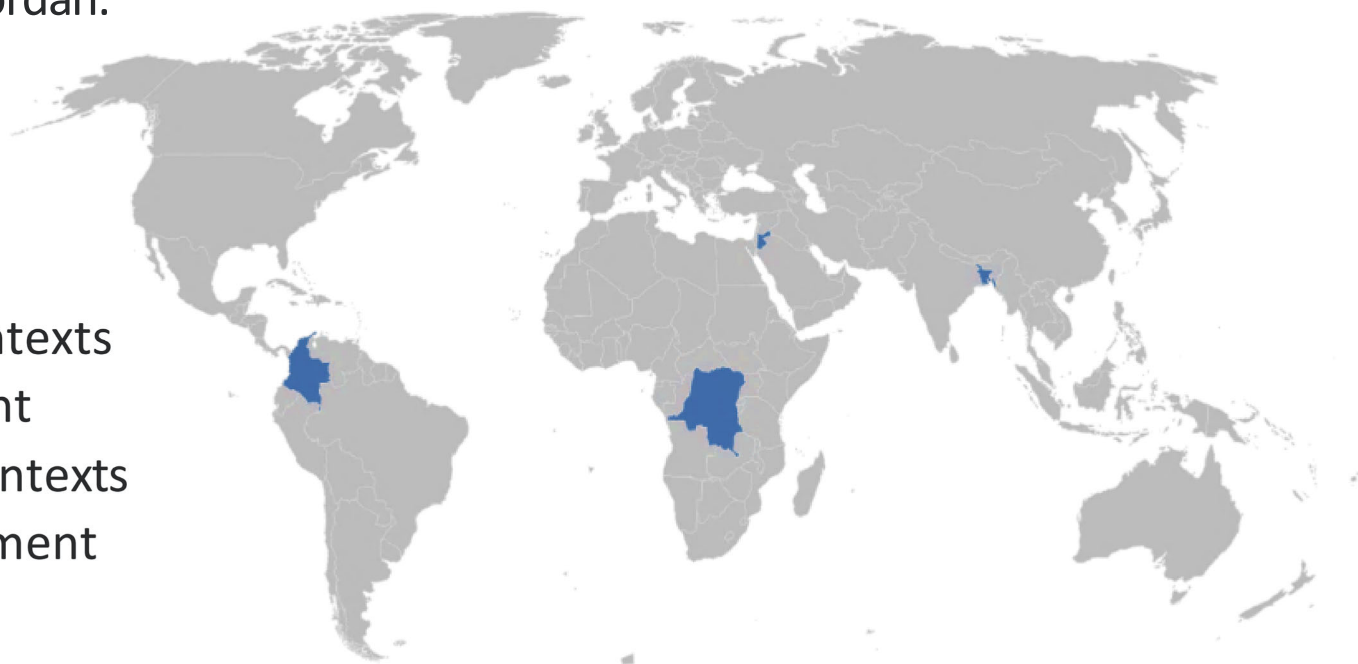
Building the Evidence on Forced Displacement

# Case Study Countries

This research is grounded in 4 study sites that present different contexts of displacement and humanitarian response – Bangladesh, Colombia, the Democratic Republic of the Congo, and Jordan.

These sites were selected to represent a spectrum of:

- Macro-economic contexts
- Types of displacement
- Legal and political contexts
- Duration of displacement



# Key Research Questions

**1**

What are the **common trends, similarities and differences** in the health needs of forcibly **displaced populations and host communities** in various geographical, social and demographic contexts of fragility, conflict, and violence (FCV) affected countries **facing protracted displacement** conditions beyond the initial emergency response?

**2**

What is the empirical evidence, lessons learned, and good practices, on **optimal ways** for host countries and development partners to be better prepared and to develop mechanisms **to systematically identify, prioritize, plan and deliver health services** at all levels of care for both host communities and displaced populations?

**3**

What are the most **cost-efficient mechanisms** for financing health services for forcibly displaced populations and host communities?

# Methods

**Desk-Based Research**

- Country-specific literature reviews
- Secondary analysis of demographic and epidemiologic data sources
- Literature reviews capturing key themes (e.g., integration)

**Field Research**

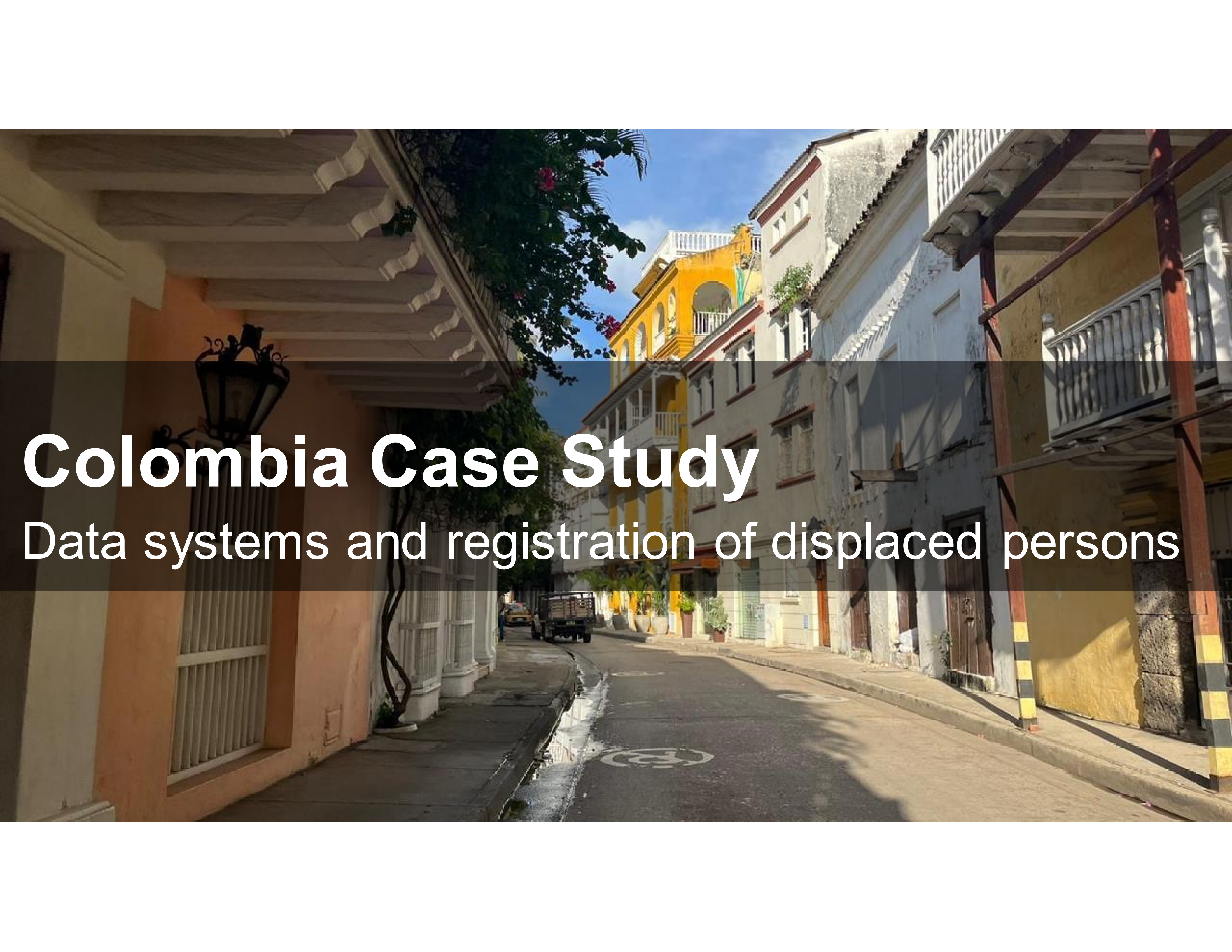
- Focus group discussions and/or in-depth interviews
- Key informant interviews
- Health facility assessments, health provider questionnaires, and a macro-costing tool

# Themes

1. Health data and surveillance
2. Organization of the health response
3. Health services access and utilization
4. Determinants of health and role of legal status
5. Financing

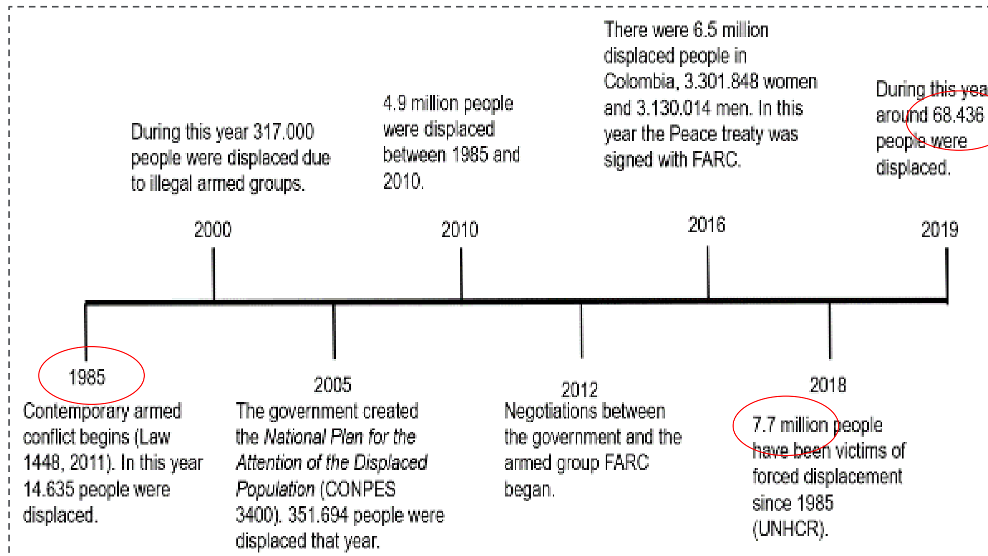
# Health Data and Surveillance

- **Paucity of demographic and health data** that were comprehensive and suitably disaggregated by migration status or a proxy
- **Weak and insufficient links** among demographic, financial, registration, and health data
- **Limited foundation** for decision making

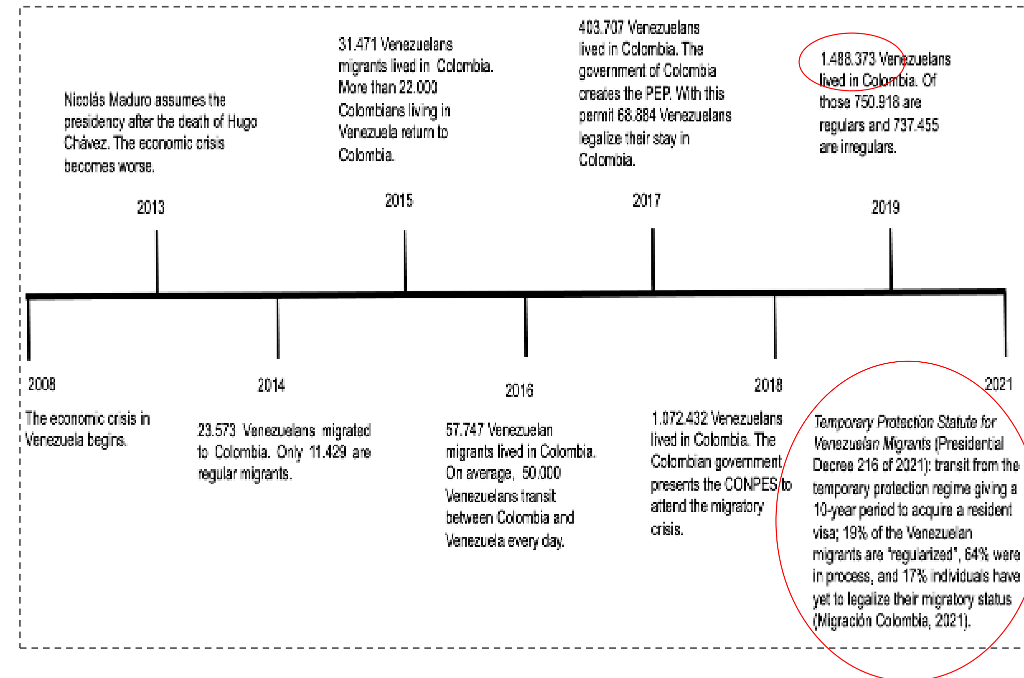

Colombia Case Study
Data systems and registration of displaced persons

# Colombia has a long history of dealing with displacement of various kinds:

1. Internally displaced population – IDP




2. Venezuelan migration – VM



# Colombia has very potent information systems

**Robust Health Information Data Systems in Colombia (SISPRO):**

Social and Health sector (SISPRO):

- Registro Individual de Prestación de Servicios (RIPS): Patient level data extracted from the healthcare administrative database in Colombia
- Base de Datos Unica de Afiliados (BDUA): Person data on health insurance enrollment
- Sistema de Vigilancia Epidemiológica (SIVIGILA): national epidemiological surveillance system
- … + 4 other

Migration:

- Registro Único de Víctimas (RUV): Official person level registry of armed conflict victims

**“Developing” donor agency data system**

*Grupo Interagencial sobre Flujos Migratorios Mixtos* (GIFMM):

- Data on the number and type of services provided, and aggregate resources invested
- Managed by the 75 members in the GIFMM
- Co-led by IOM and UNHCR, and includes UN agencies, international and local NGOs, the Red Cross Movement.

# Yet, there are still big challenges ahead:

1. Improving data quality:
   - Reporting biases in the RIPS.
   - Raising the bar on the GIFMM data system (which collects refugee and migrant crisis service provision data).
2. Integrating data systems
   - Integrating GIFMM system data to SISPRO.
   - Open access integrated datasets (e.g. health + demographic data) at more granular geographic levels
3. Developing data-to-action tools
   - Real-time person-level reports of services assistance received (diagnoses, interventions, hospitalization, ER services, prevention services, …)
   - Local, contextualized and data driven public health strategies.
   - Data driven demand inducing efforts for health insurance and health preventing activities.
   - Low-cost evaluation of public policy and system reforms.

# Organization of the Health Response

### Bangladesh

- 1.1 million Rohingya refugees
- Primary care in camps
- Referrals to national health system for specialized care

### Jordan

- 660,000 Syrian refugees
- UNHCR health services in camps
- National health system at uninsured Jordanian rate

### DRC

- 4.5 million IDPs and 550,000 refugees and asylum seekers
- IDPs and host population access services in national health system

### Colombia

- 2 million Venezuelans and 5.2 million IDPs
- IDPs and regularized Venezuelans can enroll in national health insurance
- Uninsured can access emergency services

# 3 Major Gaps in the Health Response

**1**

Access to **treatment of chronic diseases** as a barrier for displaced populations

**2**

Access to **specialized services**, including secondary and tertiary care, especially for displaced populations

**3**

Access to **mental health care** as a gap in services for both host and displaced populations

Bangladesh Case Study
Mental health gaps and promising practices

# Multi-layered mental health and psychosocial support program in Cox's Bazar, Bangladesh

Community & facility-based services

Community engagement

Task shifting

Workforce strengthening & multisectoral partnerships

# Health Services Access and Utilization

"**We do not have money to go to Cox's Bazar for treatment** and getting permission from *[Camp In-Charge]* is also a problem for us."

*– Male Rohingya refugee, Bangladesh*

"There are people who do **not have enough money to pay for the taxi** to get their treatment from the center."

*– KII participant, Jordan*

"Unless you have a serious accident or a high-risk illness, they attend to you here in the emergency unit, but otherwise, if you have a consultation or care [...] **you pay for it**."

*– Venezuelan migrant, Colombia*

# DRC Case Study

## Cost barriers and low health services utilization

# Cost was THE Barrier to HC access in DRC

- Visited 3 most IDP populated areas of South Kivu Province.
- 12 interviews with key informants, 13 rural Focus Groups, 3 Hospitals and 4 clinics were visited. All cited cost as the barrier!
- 1 clinics (Red Cross in a camp) was free.
- Staffing & attendance <25% WHO target accept in RC clinic.

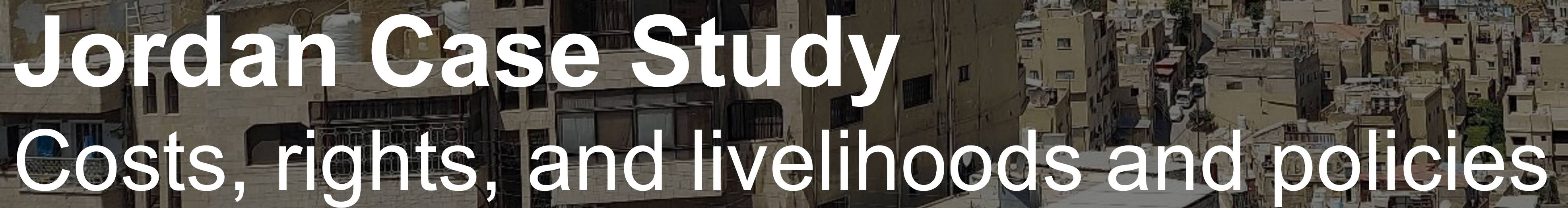
# Costs create interactions/synergies that undermine system

- Reading FG transcripts you would think 25% of patients are imprisoned until bill is paid.
- People rely on local traditional healers.
- <1 visit/pop/yr. prevents proper staffing, ½ the clinics have no water supply, many could not do transfusions or C-sections, no fuel for ambulances.
- 20% of clinic staff felt they were not properly paid on the month of our visit.
- Surveillance becomes very insensitive.
- When clinical care is free (as it was in one Red Cross), the language about service is completely positive.

# Determinants of Health and Role of Legal Status

- **Legal status** plays a key role in if, when, and how displaced communities access healthcare
- **Social and environmental determinants of health** are closely linked to legal status
- A **whole-of-person approach** is necessary for enabling accessible, affordable care

> *"When you go to the health service, you have to wait 3, 4 to 5 hours for them to come out and they tell you: '**we can't attend you** because you don't have a PEP, **you don't have a record**'."*
> *- Venezuelan Migrant living in Colombia*



# Jordan Case Study

## Costs, rights, and livelihoods and policies

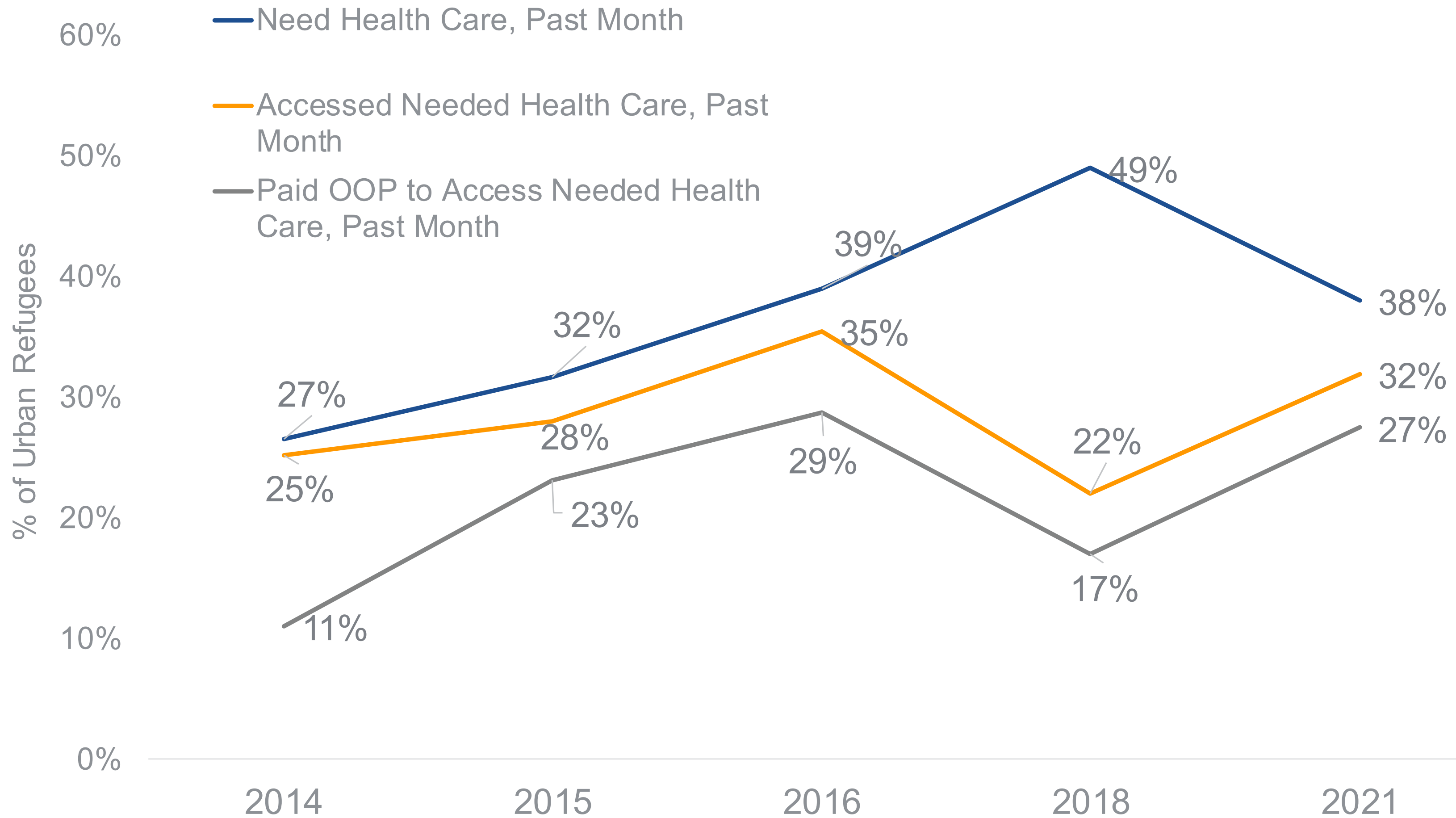
“**Sometimes they don’t provide** us with the treatment and if they do, **we will have to pay** half the value ourselves […] They **did not allow** my kids to get treatment for 5 months until I got them a **legal ID**.”

*- Syrian female FGD participant, Jordan*

# Trends in Health Needs and Spending among Urban Refugees in Jordan

2014-2021

*Source: UNHCR Healthcare Access and Utilization Surveys, 2014-2021*



# Financing

## Challenges

- Shortage
- Instability
- Short-term funding cycle
- Misalignment

## Efforts to Address Challenges

- Integration
- Pooled, multi-donor accounts
- Multi-sectoral funding arrangements
- Incentives in contractual arrangements

# Conclusion and Recommendations

1. The Importance of Planning and Integration
2. Addressing the Affordability Barrier
3. Addressing Health Gaps
4. Tackling Issues of Quality
5. The Role of Financing
6. A Whole of Person Approach
7. The Role of Legal Status in Health Care Access
8. Addressing the Demographic and Epidemiological Data Gap
9. Enhancing Disease Surveillance
10. Leveraging Human Capital

# Q&A

# Read the report

Now available at: bit.ly/DisplacementAndHealth