Learning from the Evidence on Forced Displacement:

Health Systems Strengthening in Situations of Protracted Displacement

October 18, 2023

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UNHCR The UN Refugee Agency
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Building the Evidence on Forced Displacement

Joint Data Center on Forced Displacement
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Building the Evidence

Health System Strengthening in Situations of Protracted Displacement

Lessons from Bangladesh, Colombia, the DRC, and Jordan

Training Outline

1. Introduction to the Health Project
2. Navigating Integrated and Parallel Health Systems
3. Health Financing in Contexts of Displacement
4. Discussion: Thematic Questions for Decision Makers
5. Conclusion: Key Takeaways for Policy and Practice

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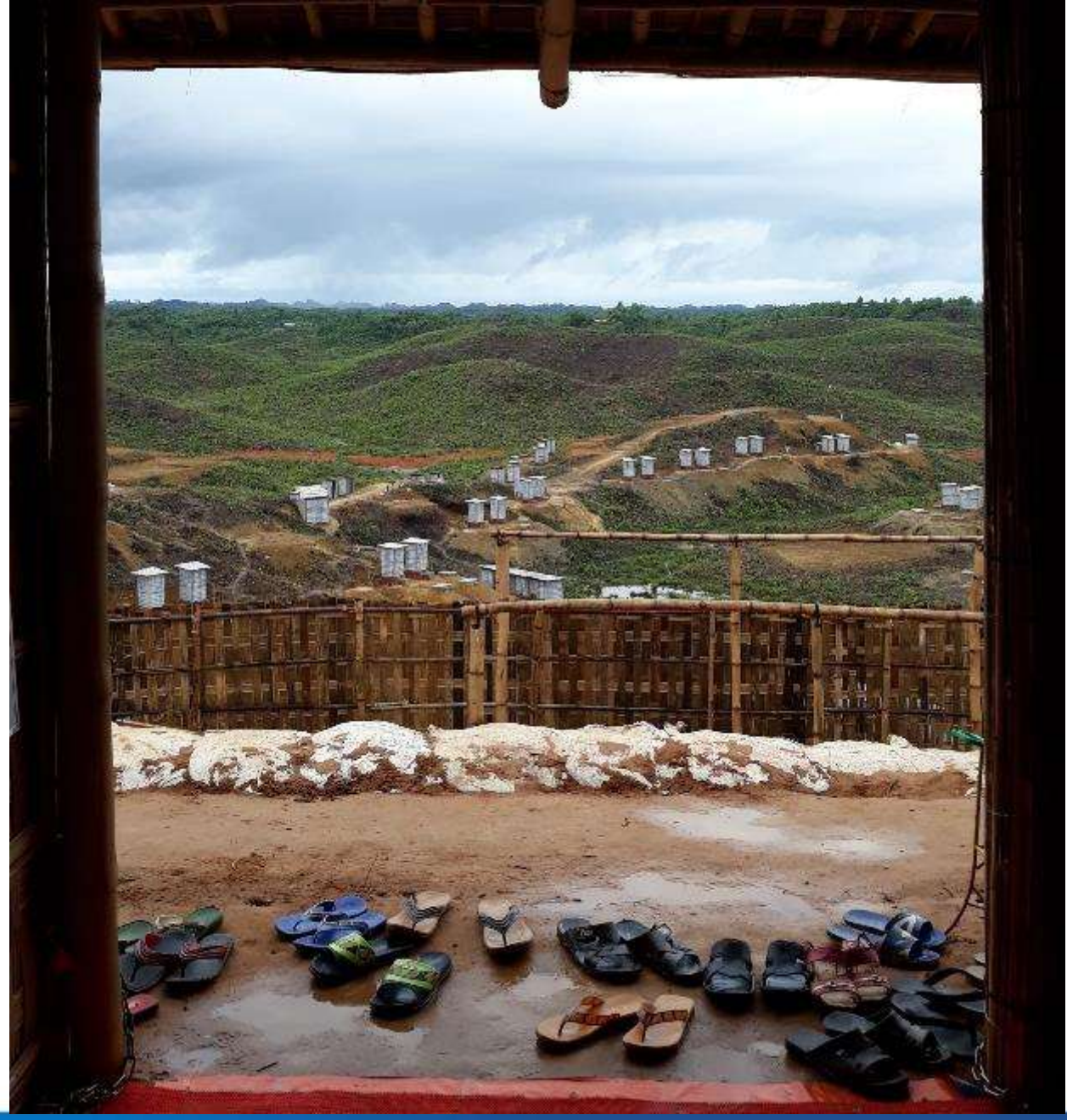
Global Context

- 67% of refugees in LMICs have been displaced for ≥5 years, per UNHCR (2022)
- Global Compact for Refugees (2018) calls for expanding and improving national health systems for refugees and host communities
- Need for program and policy guidance to organize and finance health response



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

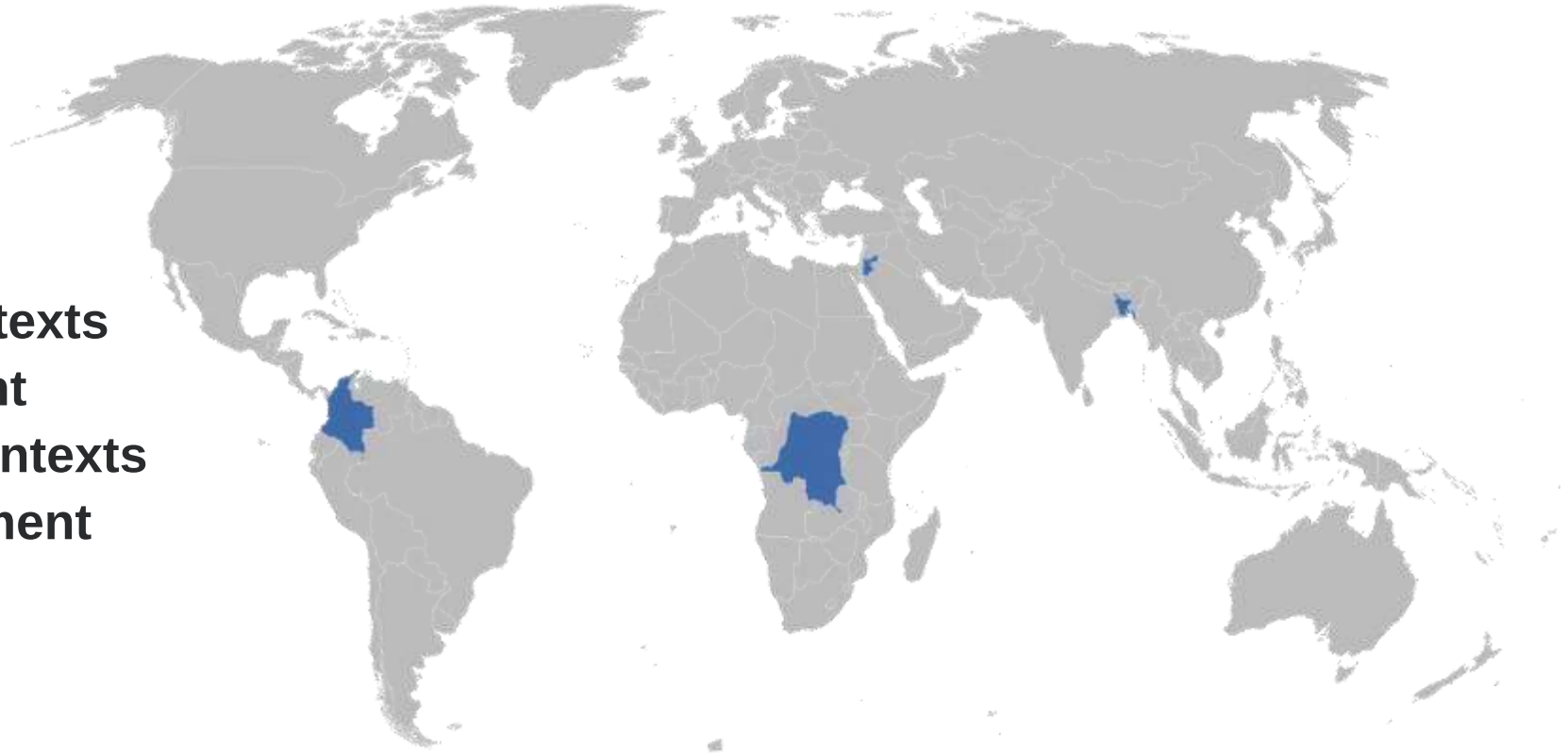
What are the empirical evidence, lessons learned, and good practices, on **optimal ways** for host countries and development partners to be better prepared and to develop mechanisms **to systematically identify, prioritize, plan and deliver health services** at all levels of care for both host and displaced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

3

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

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**

Methods

Desk 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

Parallel and Integrated Health Systems

Key considerations for forcibly displaced and host populations

Organization of the Health Response

Bangladesh

- 1.1 million Rohingya refugees *(UNHCR, April 2022)*
- Primary care in camps
- Referrals to national health system for specialized care

Note: 2021-2022 totals are used to reflect the numbers of forcibly displaced persons during the study period (2019-2022)

Jordan

- 674,000 Syrian refugees *(UNHCR, April 2022)*
- UNHCR health services in camps
- National health system at uninsured Jordanian rate

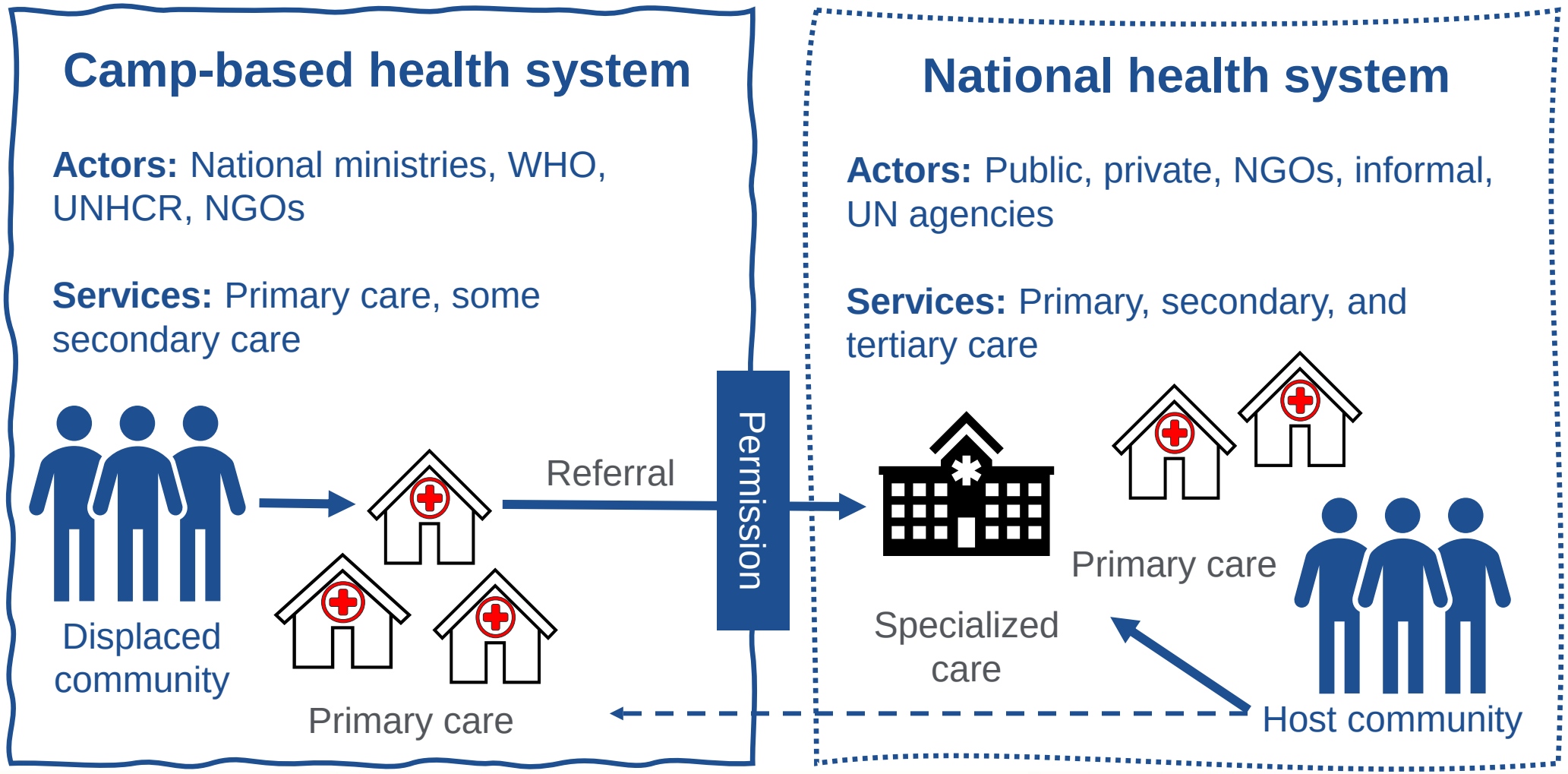
DRC

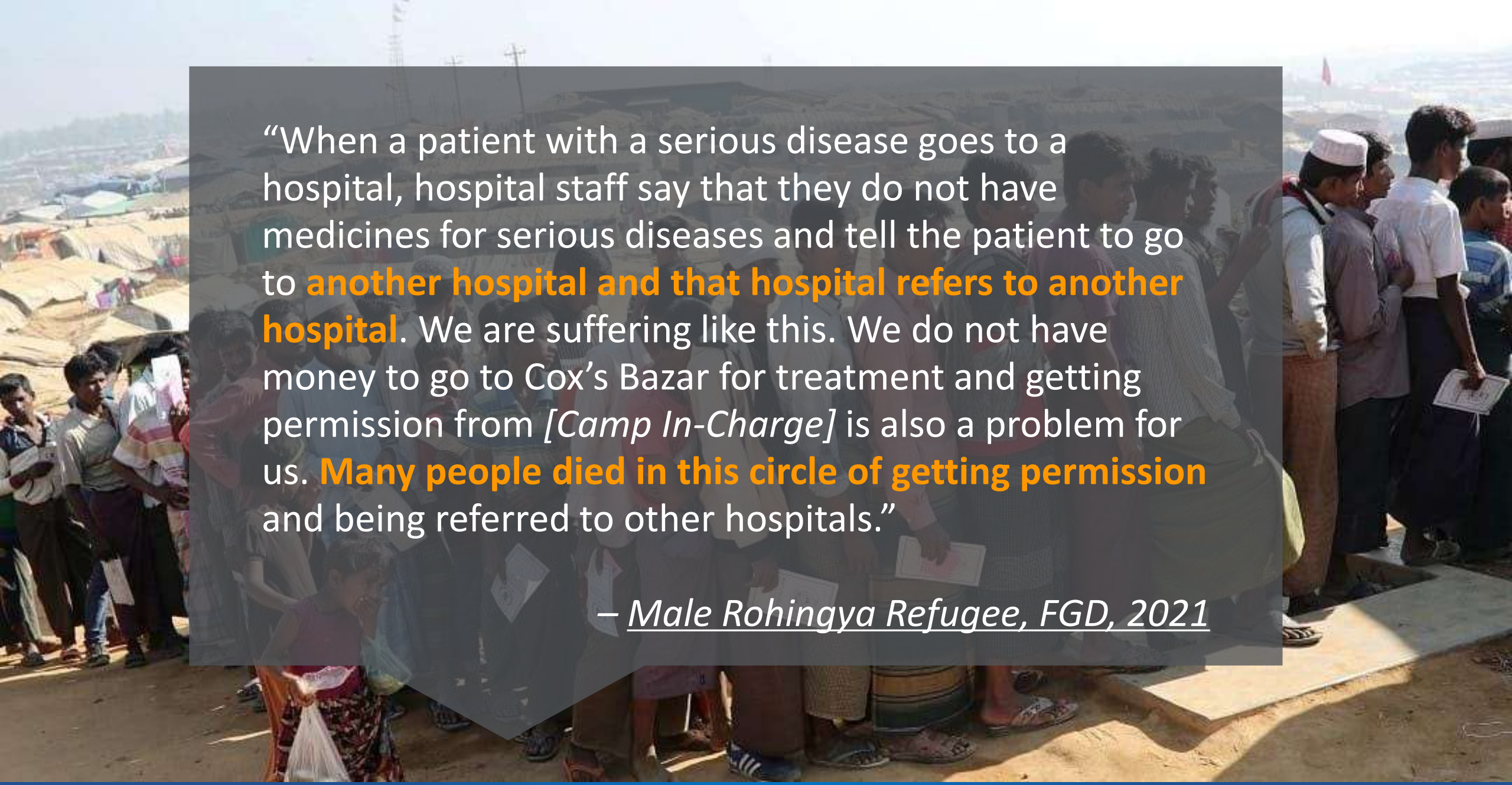
- 4.5 million IDPs *(IDMC, end of 2021)* and 550,000 refugees and asylum seekers *(UNHCR, April 2022)*
- IDPs and host population access services in national health system

Colombia

- 2 million Venezuelans *(Migración Colombia, March 2022)* and 5.2 million IDPs *(IDMC, December 2021)*
- IDPs and regularized Venezuelans can enroll in national health insurance
- Uninsured can access emergency services

Organization of Referrals in Bangladesh Camps





"When a patient with a serious disease goes to a hospital, hospital staff say that they do not have medicines for serious diseases and tell the patient to go to **another hospital and that hospital refers to another hospital**. We are suffering like this. 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. **Many people died in this circle of getting permission** and being referred to other hospitals."

– *Male Rohingya Refugee, FGD, 2021*

Organization of Referrals in Jordan Camps

- Camp-based services focus on primary and secondary services
- Tertiary care is facilitated through UNHCR referral system
- Referrals approved by Exceptional Medical Care Committee (Jordan report, p. 69)
  - 90% of referrals are due to life-saving and end of life conditions
  - 70% of referrals are to private hospitals → Issue of financing and capacity of government facilities

3 Major Gaps in the Health Response

1

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

2

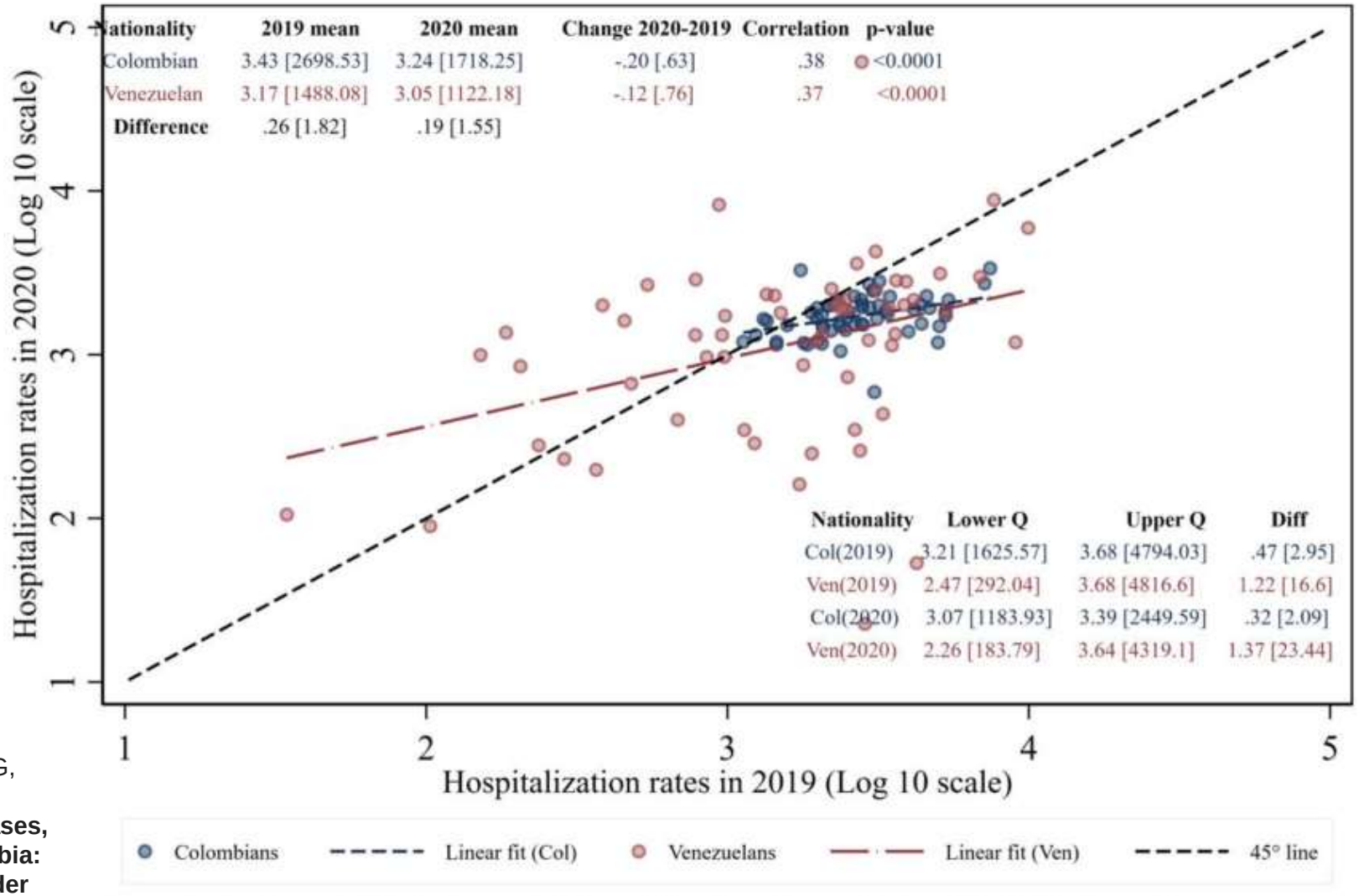
Access to **specialized services**, including secondary and tertiary care, especially for displaced populations

3

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

Narrow Disparities by Nationality and Hospitalization in Colombia

All-cause hospitalization rates, Colombians and Venezuelans, 2019 and 2020

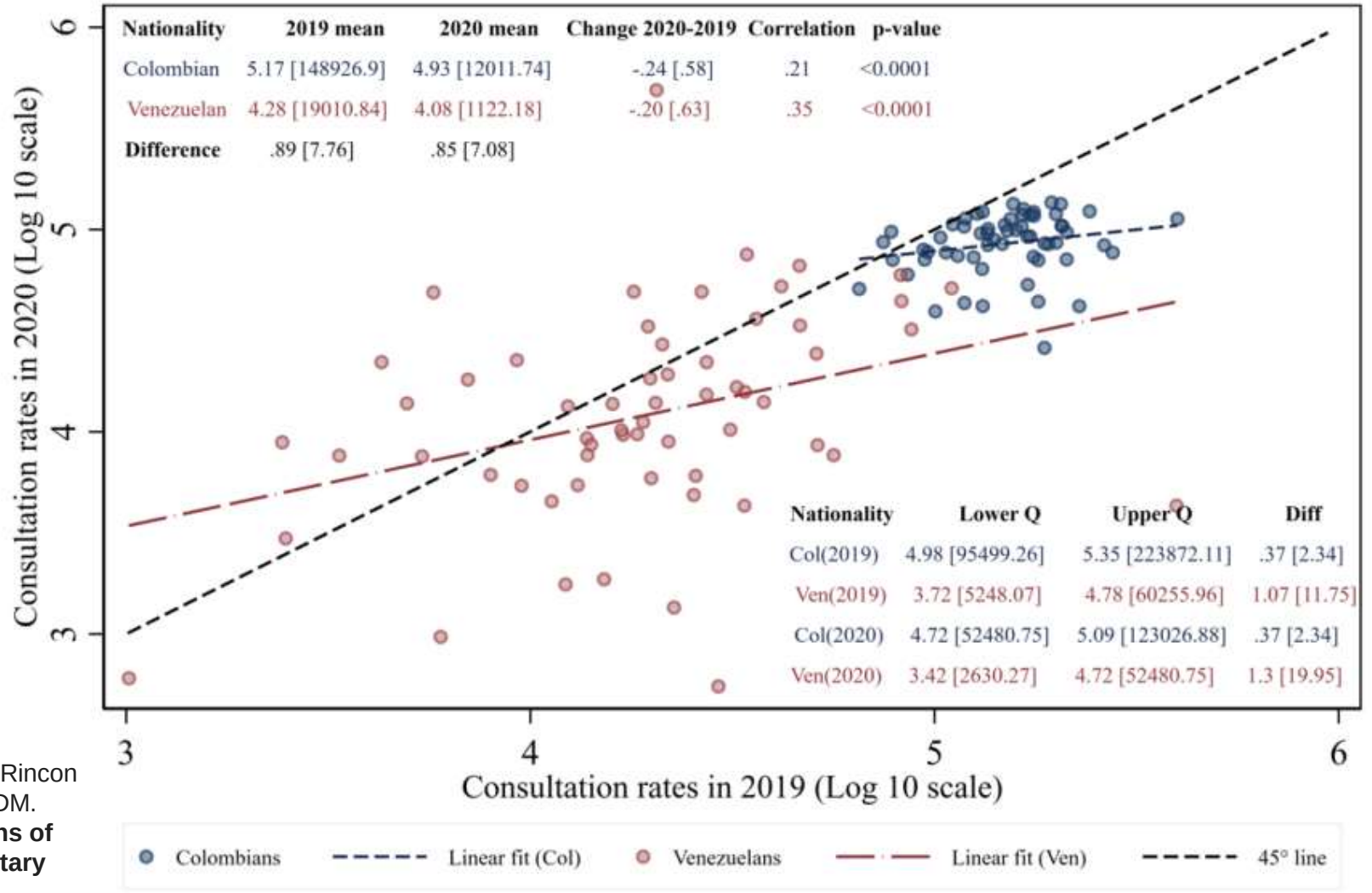


Data obtained from RIPS database for 60 municipalities. Rates calculated for 100,000 people. Rates are total hospitalizations from March 1 to July 31 for the years 2019 and 2020

Source: Shepard DS, Boada A, Newball-Ramirez D, Sombrio AG, Rincon Perez CW, Agarwal-Harding P, Jason JS, Harker Roa A, Bowser DM. **Impact of COVID-19 on healthcare utilization, cases, and deaths of citizens and displaced Venezuelans in Colombia: Complementary comprehensive and safety-net systems under Colombia's constitutional commitment**. PLoS One. 2023 Mar 28;18(3):e0282786. doi: 10.1371/journal.pone.0282786. PMID: 36976793; PMCID: PMC10047542.

Wide Disparities by Nationality and Consultation in Colombia

All-cause [ambulatory] consultation rates, Colombians and Venezuelans, 2019 and 2020



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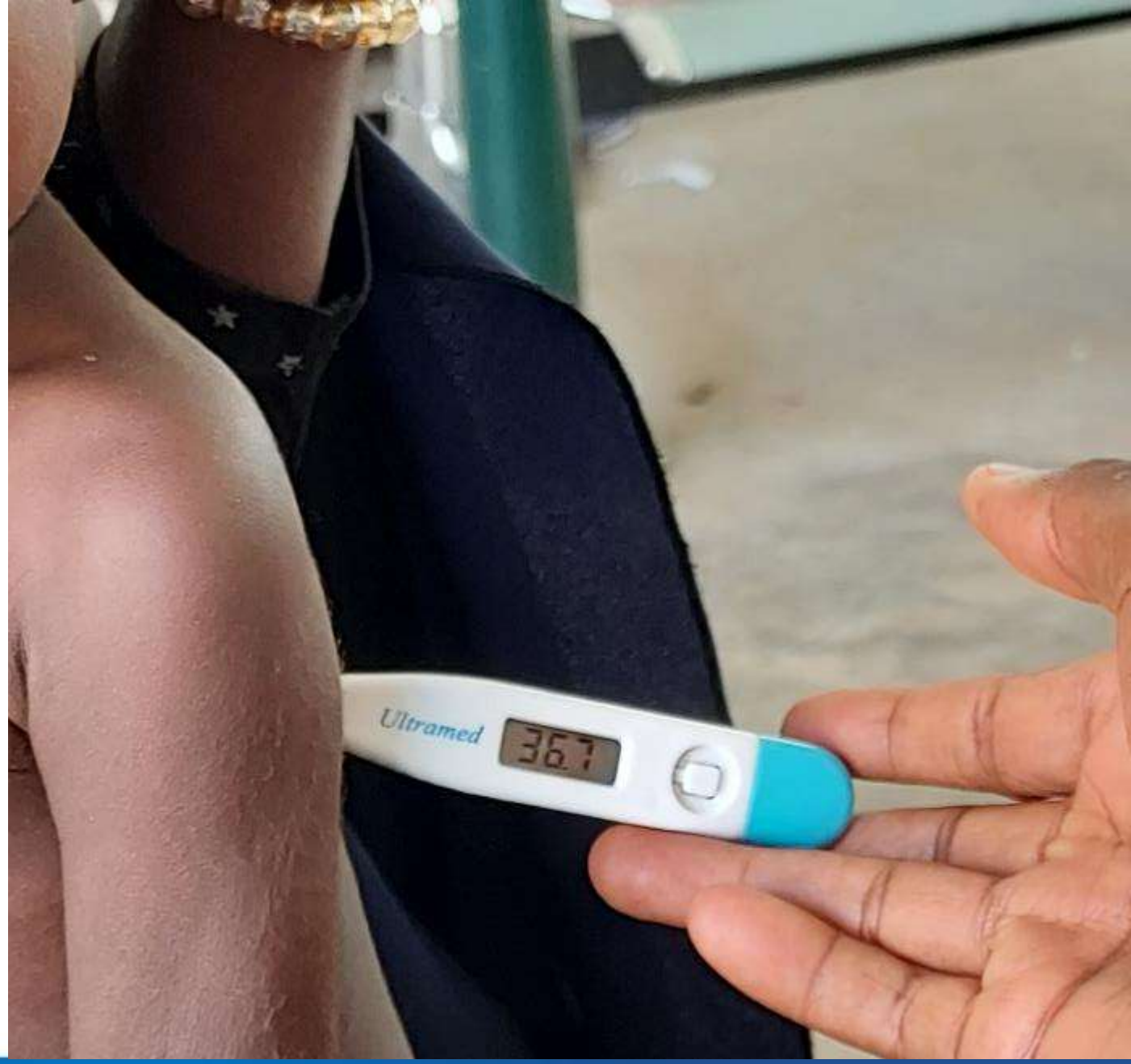
Data Availability

Paucity of demographic, epidemiologic, and health services utilization data that were:

- **(1) sufficiently comprehensive in scope (i.e., representative of the host and forcibly displaced populations);**
- **(2) suitably disaggregated by migration status or a reasonable proxy (i.e., nationality, administrative area, etc., depending on the context); and**
- **(3) able to capture changes over time (i.e., longitudinal, repeated cross sections, etc.).**



Leveraging the Displaced Health Workforce

Official permissions for work, movement, licensing, etc.

Support from professional bodies & training institutions

Task shifting strategies

Community engagement & multisectoral partnerships

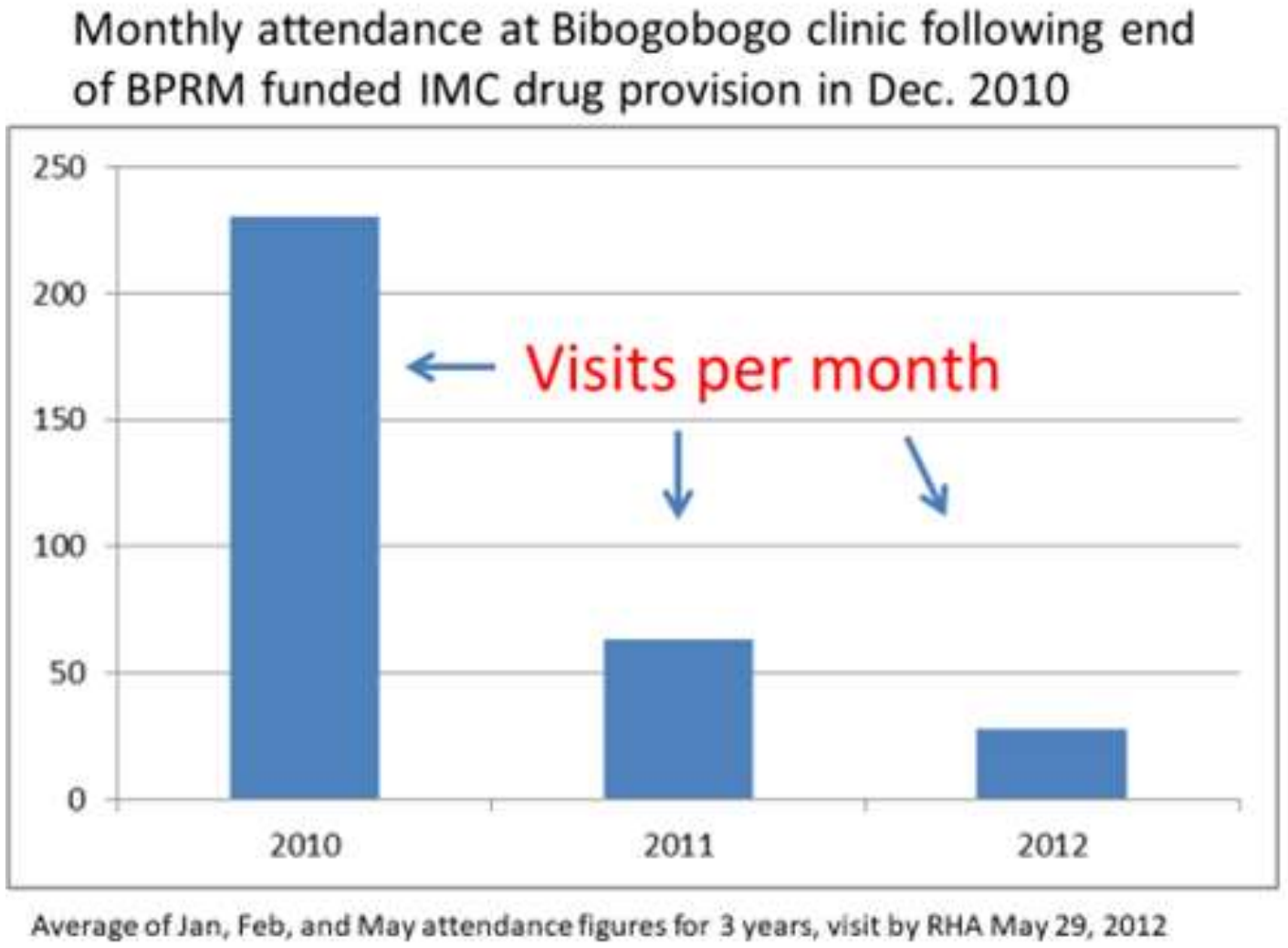
Key factors in transitions to greater integration of health systems

Cost as ”the” barrier to accessing care

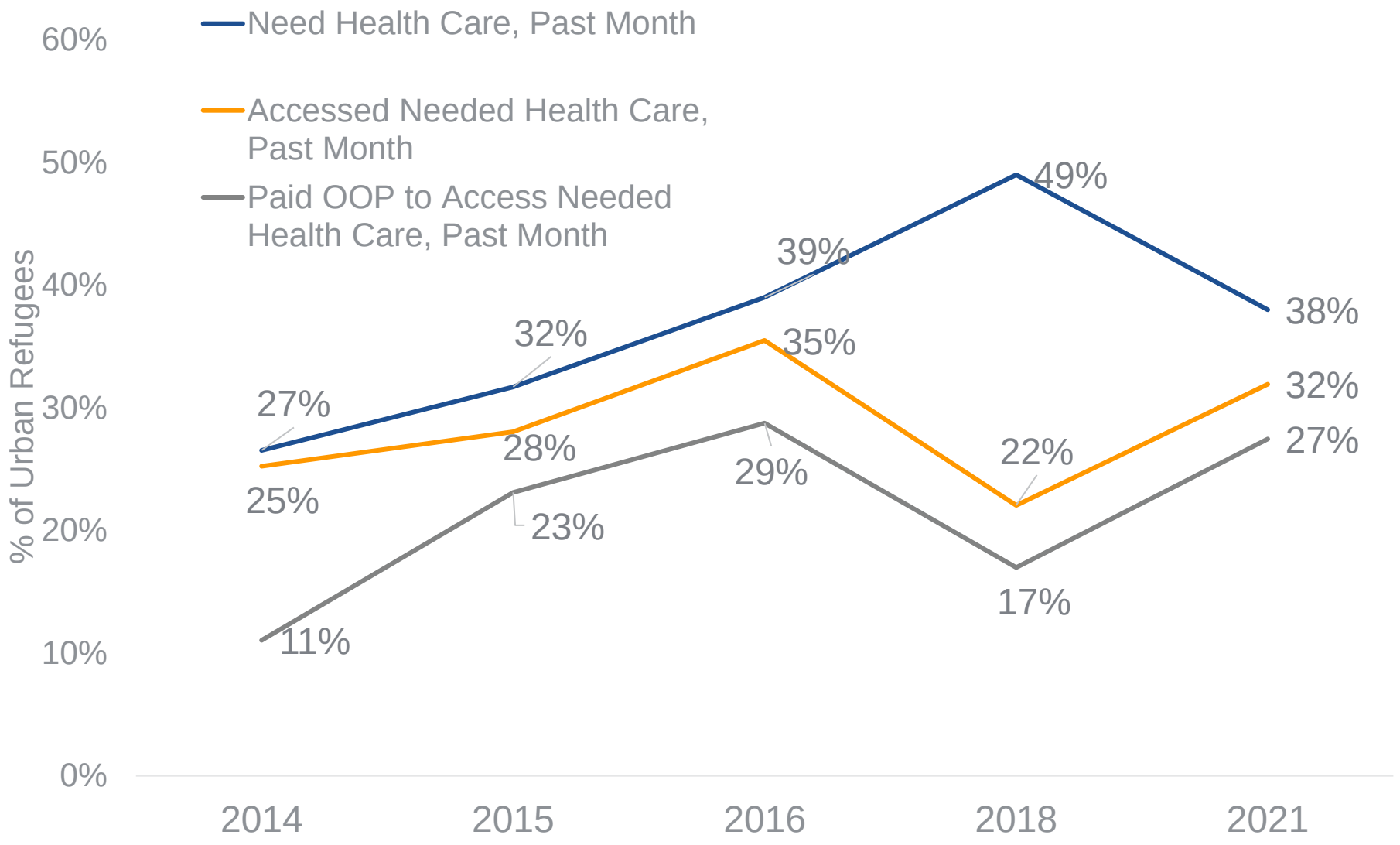
Source: DRC country report, p. 12. Figure 5: Example of impact of funding cessation.

BPRM: United States Bureau of Population, Refugees, and Migration

IMC: International Medical Corps



Trends in Health Needs and Spending among Urban Refugees in Jordan - 2014 to 2021



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

UNHCR Remarks

- **UNHCR experience of benefits and drawbacks of inclusion**
  - **Country examples**
  - **Lessons learned**

- **Navigating whether, when and how to transition**

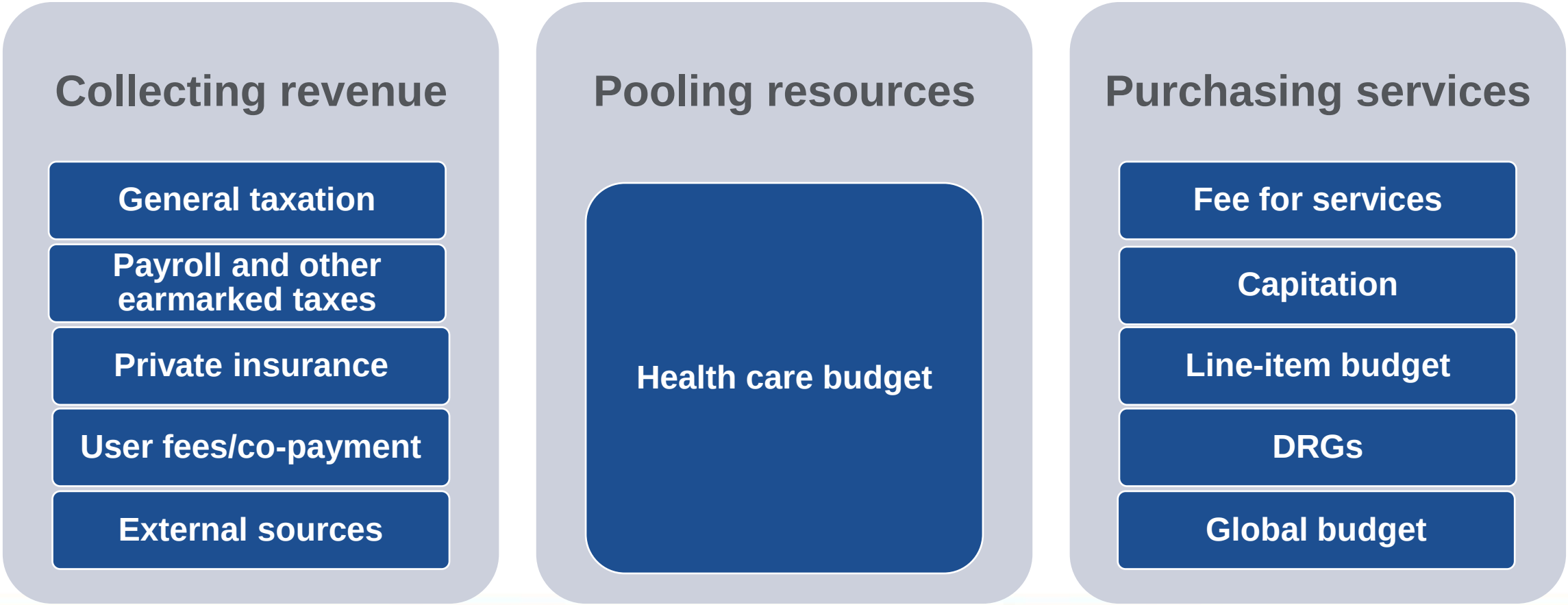
- **Reflections on key challenges and opportunities**

Financing Health Systems

Key considerations in settings of forced displacement

Financing for health systems

Adapted from the WHO Health Financing Progress Matrix (2020)



Financing for health systems for displaced persons

Collecting Revenue

- Donor governments and international organizations
- Host government (Government budget, bilateral and multilateral funds channelled through government)
- Out of pocket spending
- Other mechanisms (e.g. remittance)

Pooling resources

?

Purchasing Services from

- International NGOs
- Local NGOs
- Government facilities
- Private facilities

Collecting Revenue: The Role of Donors (Estimates)

Bangladesh

Funding for healthcare of displaced Rohingya:

- Donors & IOs: 87.3%
- Host government: 12.7%

IO: International organization

Jordan

Funding for healthcare of Syrian refugees:

- Donors & IOs: 53.5%
- Host government: 19.7%
- Refugee households: 26.7%

DRC

Funding for healthcare of IDPs:

- Donors & IOs: Insufficient data to quantify
- Host government: 21.2%

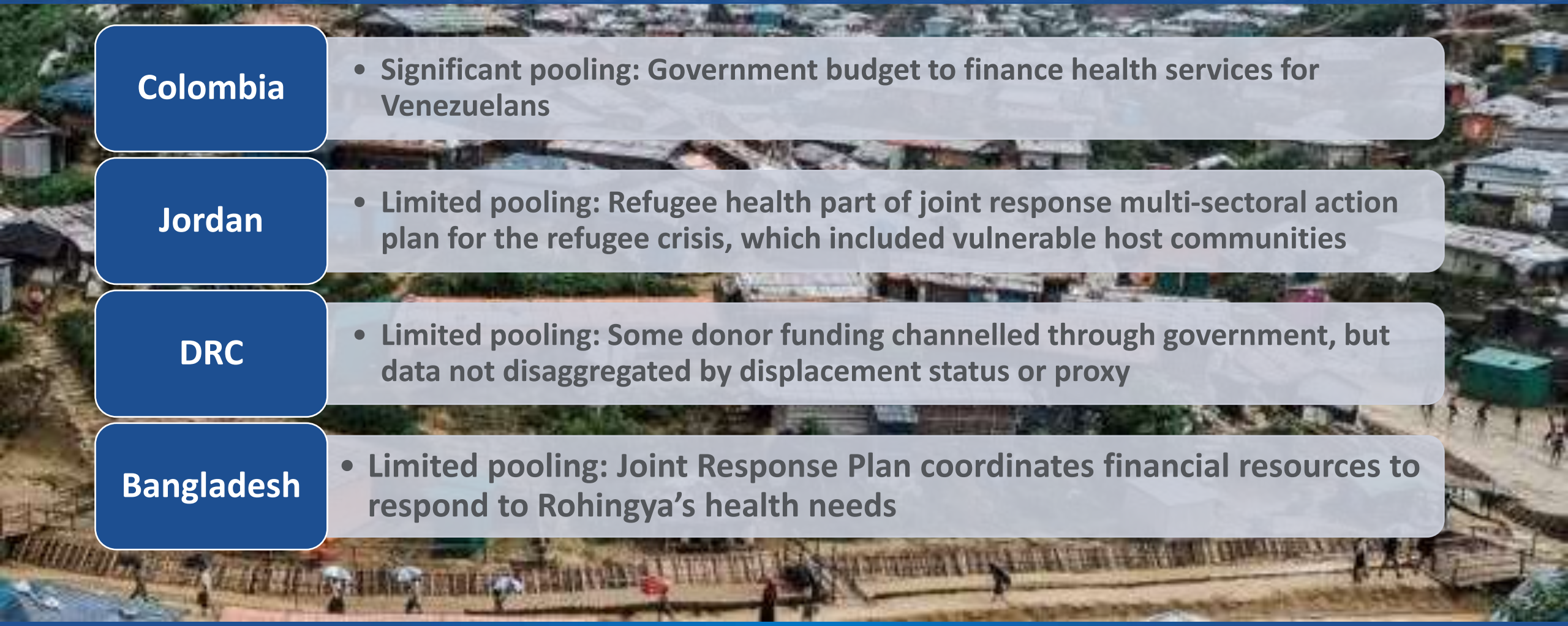
Colombia

Funding for healthcare of displaced Venezuelan:

- Donors & IOs: 31 USD/ person/ year
- Host government: 35% of Venezuelan migrants covered by insurance, plus access to emergency and preventive services

Pooling Resources

Global Report, p. 32



Colombia	• Significant pooling: Government budget to finance health services for Venezuelans
Jordan	• Limited pooling: Refugee health part of joint response multi-sectoral action plan for the refugee crisis, which included vulnerable host communities
DRC	• Limited pooling: Some donor funding channelled through government, but data not disaggregated by displacement status or proxy
Bangladesh	• Limited pooling: Joint Response Plan coordinates financial resources to respond to Rohingya's health needs

Purchasing Services: Key Challenges in Contracting

- **Health care providers are a complicated mix** of government health facilities, international NGOs, local NGOs, private facilities, and providers of traditional medicines.
- Funders' organization and structures allow for **short contracts (≤1 year), contributing to disruptions and unavailability** of services that lead displaced persons to seek care elsewhere (private and informal sectors)
- **National and local NGOs face particular challenges in contracting**, including the administrative burden of many contracts, limited capacity to absorb surges in funds, and donor and contractor concerns about corruption and quality of services.

"We're not insured in any private hospital. It used to be through the UNHCR but not anymore... They referred [my father] and gave him an appointment after a year and a half. If we wait for a year and a half, he will die for sure."

– *Male Syrian Refugee, FGD, 2021*

Benefit package design

- Limited benefits packages may drive patients away from seeking care in contracted health facilities
  - Low awareness among displaced persons of services included in benefits package contributes to the challenge
- Main gaps in benefit package design:
  - Management of mental health
  - Non-communicable diseases

Promising Practices

Demand side arrangements (premiums, vouchers)

Performance-based financing

Longer term, predictable financing, such as long-term contracts with service providers

Tools and processes for setting, monitoring, and adjusting the minimal package of health services

Improving livelihoods of displaced populations to reduce cost barriers

Key questions on health systems integration

1

- What have you observed in your own work – whether in health or related sectors – about how to strike a balance between the integrated and parallel systems of service delivery? What are the trade-offs in terms of quality, sustainability, cost, and timeliness?

2

- Drawing on your own experience, where and how can the humanitarian response support enhanced national capacities? Are there opportunities that have sometimes been missed to do so, or situations when it should not have been attempted? If so, what should have been done differently?

3

- What are the distinct and complementary roles of UN agencies, donors and implementing partners in advancing a more integrated approach to delivering health care? What effective strategies are there for engaging with host government policies that may pose a barrier to health integration?

Key questions on data for the health response

1. How we can improve representative data collection efforts among forcibly displaced populations in order to answer questions about demographic and disease profiles to compare the health needs, health services access, and health outcomes among displaced and host communities? Are there any good examples of longitudinal data collection efforts in this space?

2. How can decision makers use demographic, epidemiologic, and health system data to improve health systems service and delivery for displaced and host populations?

3. How do you strike a balance between comprehensive information systems and data protection needs?

Key takeaways for policymakers and practitioners

Conclusion and Recommendations

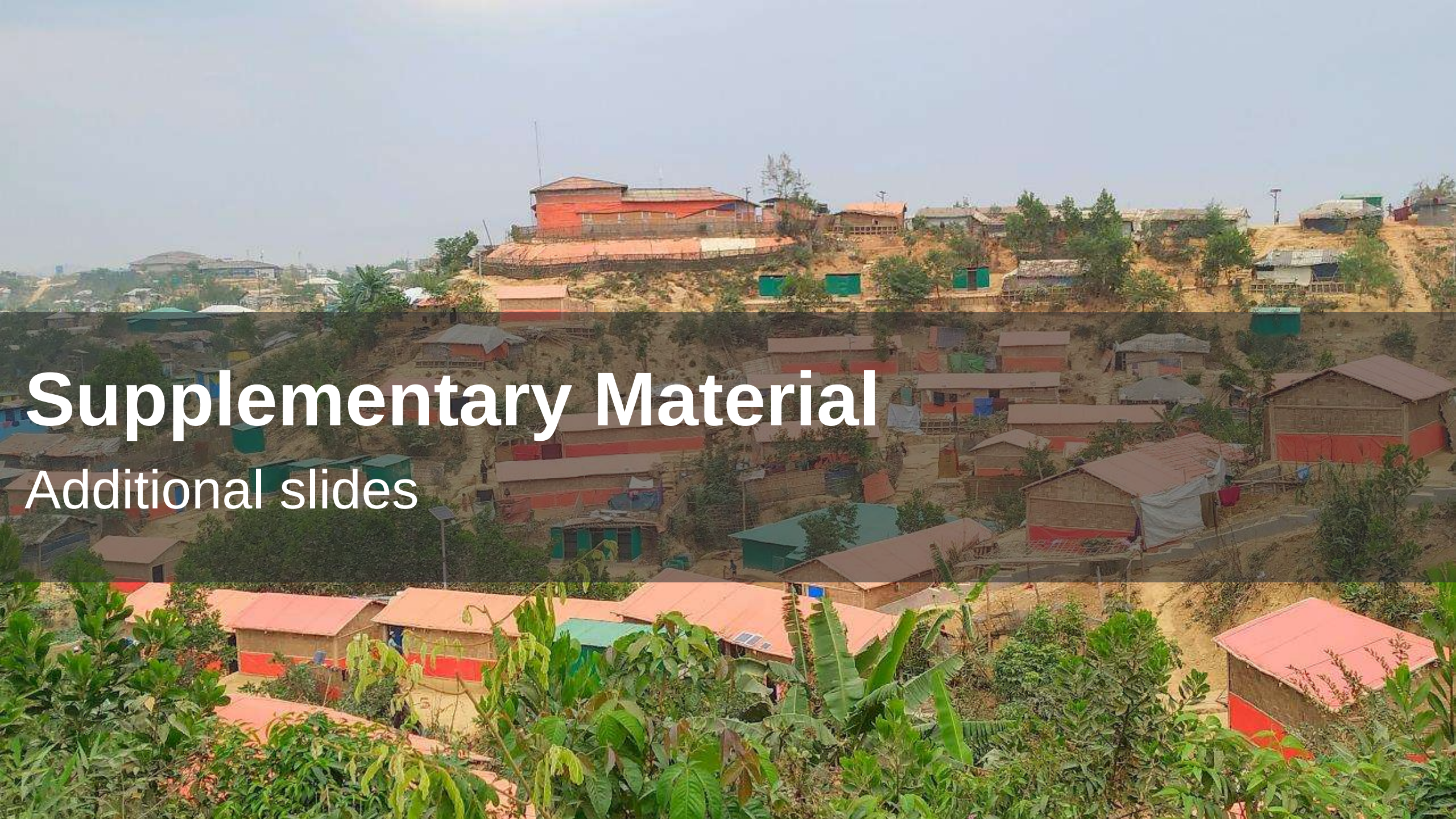
1. The Importance of Planning and Integration
2. Addressing the Affordability Barrier
3. Addressing Health Gaps
4. Tackling Issues of Quality
5. The Role of Financing
6. A Whole of Person Approach
7. The Role of Legal Status in Health Care Access
8. Addressing the Demographic and Epidemiological Data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

Tell us your feedback!

https://forms.office.com/r/d2GjNXaaaW

Resources from today's session:

https://www.worldbank.org/en/events/2023/10/18/strengthening-health-systems-in-situations-of-protracted-forced-displacement-module-4



Supplementary Material

Additional slides

Strengthening Human Capital

Improve and standardize models of training and supervision

Build capacity across national and humanitarian health systems

Prioritize quality of care

Include refugees in the health workforce

Engage community leaders and traditional healers

Methods of Estimating Indicators among Migrants

Data among migrant populations:

- May or may not be representative of migrants
- May or may not be nationally representative or offer a comparison group

Geographic methods:

- Disaggregation by administrative boundaries
- Distance to violence

Nationally representative datasets:

- Need to adequately capture rural vs. urban vs. camp differences
- Host community vs. displaced population BUT who is the appropriate comparison group?
- Cross sectional vs. comparisons over **time** (repeated cross sections, longitudinal, etc.)