WORLD BANK CONSORTIUM

THE BIG QUESTIONS IN FORCED DISPLACEMENT AND HEALTH

FINAL REPORT | JUNE 2022

COLUMBIA | MAILMAN SCHOOL OF PUBLIC HEALTH

UKaid from the British people | UNHCR The UN Refugee Agency | WORLD BANK GROUP

Building the Evidence on Forced Displacement

Dedication

This report is dedicated to our World Bank colleague Aaka Pande. Her passion for giving voice to the voiceless was the driving force behind our work. Aaka unexpectedly passed away in July 2018. However, her commitment to ensuring the voiceless were afforded both dignity and access to justice lives on in these pages.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

This report was produced by a research consortium led by Columbia University. The consortium represents an innovative partnership between the Program on Forced Migration and Health at Columbia University; the Schneider Institutes for Health Policy at the Heller School for Social Policy and Management at Brandeis University; Georgetown University; the Global Health Institute at the American University of Beirut (AUB); and the School of Government at the Universidad de Los Andes. This work was part of the program "Building the Evidence on Protracted Forced Displacement: A Multi-Stakeholder Partnership." The program was funded by UK Aid and managed by the World Bank Group (WBG) in partnership with the United Nations High Commissioner for Refugees (UNHCR). The scope of the program was to expand the global knowledge on forced displacement by funding quality research and disseminating results for the use of practitioners and policymakers. This report does not necessarily reflect the views of UK Aid, the World Bank Group or UNHCR.

We thank the following consortium members for their invaluable leadership and contributions to each of the country studies.

	Team Lead	Health Systems Team Members	Health Financing Experts
Bangladesh	Dr. Claire Greene (Columbia University)	Tasdik Hasan Dip (Consultant)	Dr. Wu Zeng (Georgetown University)
Colombia	Dr. Arturo Harker Roa (Universidad de Los Andes)	Natalia Córdoba, MSc (Universidad de Los Andes) Adelaida Boada, MSc (Universidad de Los Andes)	Dr. Diana M. Bowser (Brandeis University) Dr. Donald S. Shepard (Brandeis University) Priya Agarwal-Harding (Brandeis University)
The Democratic Republic of the Congo	Dr. Les Roberts (Columbia University)	Gang Karume (Rebuild Hope for Africa) Roland Nyakasane (Rebuild Hope for Africa) Katherine McCann (Columbia University)	Dr. Diana M. Bowser (Brandeis University) Dr. Donald S. Shepard (Brandeis University) Priya Agarwal-Harding (Brandeis University)
Jordan	Dr. Fouad Fouad (American University of Beirut)	Dina Muhieddine (American University of Beirut) Theresa Farhat (American University of Beirut) Dana Nabulsi (American University of Beirut) Jasmin Lilian Diab (American University of Beirut) Dr. Yousef Khader Dr. Mohammad Al-Yahya Dr. Nihaya Al-Sheyab	Dr. Wu Zeng (Georgetown University) Dr. Yara Halasa-Rappel (Brandeis University) Dr. Eva Jarawan (Georgetown University)

Content Expertise and Guidance	Monette Zard (Columbia University) Dr. Patrick Kachur (Columbia University) Dr. Sara Casey (Columbia University) Dr. Rachel T. Moresky (Columbia University) Dr. Goleen Samari (Columbia University)	**Project Management and Coordination**	Dr. Ling San Lau (Columbia University) Dr. Nour Audi (Columbia University) Katherine McCann (Columbia University) Sarah Guyer (Columbia University) Christina Kay (Columbia University) Rocio Rodriguez Casquete (Columbia University) Sally Beiruti (Columbia University) Rachel Isaacs (Columbia University) Sabeen Rokerya (Columbia University) Serena Tohme (Columbia University)
Report Drafters	Jennifer Ostrowski (Columbia University) Katherine McCann (Columbia University) Monette Zard (Columbia University) Priya Agarwal-Harding (Brandeis University) Dr. Wu Zeng (Georgetown University)	**General Research Assistance**	Sarah Guyer (Columbia University) Christina Kay (Columbia University) Rocio Rodriguez Casquete (Columbia University) Sally Beiruti (Columbia University) Rachel Isaacs (Columbia University) Sabeen Rokerya (Columbia University) Serena Tohme (Columbia University)

LIST OF ACRONYMS

AAAQ	Availability, Accessibility, Acceptability, and Quality
AUB	American University of Beirut
BSC	Balanced score card
CHWs	Community health workers
COVID-19	Coronavirus Disease 2019
CSOs	Civil society organizations
DGHS	Directorates General of Health Services
DHIS2	District Health Information Software 2
DHS	Demographic and Health Survey
DRC	The Democratic Republic of the Congo
EmONC	Emergency obstetric and newborn care
EWARS	Early Warning, Alert, and Response System
FCV	Fragility, conflict, and violence
FDMNs	Forcibly Displaced Myanmar Nationals
FGDs	Focus group discussions
FTS	Financial Tracking Service
GIFMM	Grupo Interagencial sobre Flujos Migratorios Mixtos (Interagency Group of Mixed Migratory Flows)
GMH Lab	Global Mental Health Lab
GoB	Government of Bangladesh
HAUs	Health attention units
HCWs	Healthcare workers
HFAs	Health facility assessments
HIS	Health information system
ICUs	Intensive care units
IDIs	In-depth interviews
IDMC	Internal Displacement Monitoring Centre
IDPs	Internally displaced persons
INGOs	International non-governmental organizations
IOM	International Organization for Migration
IPS	Instituciones Prestadoras de Servicios de Salud (Institutional Health Service Providers)
IPT	Interpersonal psychotherapy
IRC	International Rescue Committee
ISCG	Inter-Sectoral Coordination Group
J-MNSA	Joint Multi-Sector Needs Assessment
JLMPS	Jordan Labor Market Panel Survey
JRP	Joint Response Plan
KIIs	Key informant interviews
LGBTQ	Lesbian, gay, bisexual, transgender, or queer

MCH	Maternal and child health
MDA	Multi-Donor Account
MHPSS	Mental health and psychosocial support
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health / Ministry of Health and Social Protection (Colombia)
MOHFW	Ministry of Health and Family Welfare
MSF	Médecins Sans Frontières/Doctors Without Borders
NCDs	Non-communicable diseases
NGO	Non-governmental organization
OCHA	United Nations Office for Coordination of Humanitarian Affairs
PBF	Performance-based financing
PEP	Permit of Permanence
PFMH	Program on Forced Migration and Health
PIC	Plan de Intervenciones Colectivas (Complementary Collective Interventions)
RAMOS	Reproductive Age Mortality Study
RAMV	Registro Administrativo de Migrantes Venezolanos (Administrative Registry of Venezuelan Migrants)
RHA	Rebuild Hope for Africa
RIPS	Registro Individual de Prestación de Servicios de Salud (Registry of Individual Provision of Services)
RRP6	Sixth Regional Response Plan
RRRC	Office of the Refugee Relief & Repatriation Commissioner
SDGs	Sustainable Development Goals
SGSSS	Sistema General de Seguridad Social en Salud (General Social Security Systems for Health)
SISPRO	Sistema Integrado de Información de la Protección Social (Social Protection Information System)
SIVIGILA	Sistema Nacional de Vigilancia en Salud Pública (National System of Public Health Surveillance)
SNIS	Système National d'Information Sanitaire (National Health Information System)
SPA	Bangladesh Health Facility Survey
SRH	Sexual and reproductive health
SWIHSS	SubREd Intergrada de Servicios de Salud Sur Occidente (South-West Integrated Health Service Sub-Network)
TB	Tuberculosis
TPS	Temporary Protection Status
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WBG	World Bank Group
WHO	World Health Organization
WISN	Workload Indicators of Staffing Needs

EXECUTIVE SUMMARY

The influx of large numbers of refugees and internally displaced persons (IDPs) can pose a significant challenge to health systems, even in the most developed settings. In contexts which are fragile or conflict-affected, the strain placed on health systems can be acute. In the emergency phase of a humanitarian response, global implementing partners often overcome this challenge by establishing parallel systems to deliver healthcare to displaced populations. However, in protracted crises, and where displaced persons settle within established host communities, the transition from an acute-phase humanitarian response to development support requires careful coordination with the national health system to avoid creating inefficiencies and service gaps or exacerbating inequity.

The Big Questions in Forced Displacement and Health project was commissioned against a backdrop where more than 78 percent of all refugees currently live in situations that are characterized as protracted, defined as displacement that lasts at least five consecutive years (UNHCR 2021b). The Global Compact on Refugees, endorsed by 181 states in 2018, calls for expanding and enhancing the quality of national health systems to facilitate access by refugees and host communities, including building and equipping health facilities and strengthening services (UN General Assembly 2018). The *Big Questions* project has been guided by the need to provide programming and policy guidance to those national and international actors who are involved in directing and funding health responses in situations of protracted displacement. Throughout the research, we have sought to identify optimal approaches that respond to the health needs of displaced populations while also strengthening health systems for host populations, supported by analysis of economic, demographic, and epidemiologic trends.

The project focused on various geographical, social and demographic contexts in fragility, conflict, and violence (FCV) affected countries facing protracted displacement conditions. The key questions considered by the project include:

- What are the common trends, similarities and differences in the health needs of forcibly displaced populations and host communities in different contexts beyond the initial emergency response?

- What empirical evidence and examples of good practice are available 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?
- What are the most cost-efficient mechanisms for financing health services for forcibly displaced populations and host communities?

Methodology

The *Big Questions* project has utilized a mixed methods approach anchored in research in four country sites - Bangladesh, Colombia, the DRC, and Jordan. These were chosen to reflect a diversity of contexts which may influence and shape health service financing and provision, including: system of delivery (camp, rural, and urban settings), provider type (non-governmental organization (NGO), local health system), host country context (active conflict, fragile, post-conflict), income level (low-income, lower-middle income, upper-middle income), and displacement type (refugees and IDPs). The selection also consciously reflects a diversity of geographic regions and differing national policies towards refugees and the displaced and incorporates considerations of data availability and feasibility. The research was undertaken by a consortium of universities led by Columbia University's Program on Forced Migration and Health and including the American University of Beirut, Brandeis University, Georgetown University, and Universidad de los Andes.

Each study comprised a desk-based literature review and analysis of epidemiologic and demographic datasets from secondary sources. Research teams in each country conducted focus group discussions (FGDs) or phone-based in-depth interviews (IDIs) with host and displaced community members, health facility assessments (HFAs) of purposively sampled health facilities, and semi-structured key informant interviews (KIIs). HFAs utilized a standard questionnaire, adapted according to local contexts, to collect data on indicators about health systems and costing. Health facilities were selected based on various factors, including delivery type (primary, secondary, or tertiary care); population served (host, displaced, or all); and setting (camp, rural, or urban) and logistical feasibility. The HFAs were not intended to be nationally representative nor comprehensive; instead, they were intended to provide a snapshot of the capacity and readiness of facilities across displaced and host population settings. Similarly, the rural/urban, camp/non-camp, and sex distribution of FGDs, IDIs, and HFAs varied by country and aimed to capture a snapshot of key features of the displacement situation in each context. Due to logistical constraints, HFAs were not conducted in Bangladesh.

Lastly, targeted KIIs aimed to capture a range of perspectives on health systems and financing from government officials, donors, international organizations, NGOs, civil society organizations (CSOs), health facility staff, and community leaders.

To situate the findings of the country studies and identify frameworks for interpreting results, integrative literature reviews, including academic and grey literature, were carried out. These reviews focused on the interplay between humanitarian and national health systems, the health workforce in humanitarian contexts, and sources of epidemiologic and demographic information in humanitarian contexts.

The impact of COVID-19

The emergence of the COVID-19 pandemic impacted both the timeline for the project and the feasibility of certain research approaches (for example, curtailing our ability to access some health facilities and necessitating phone-based IDIs in place of FGDs in Colombia). In consultation with the World Bank, we decided to retain a focus on the main research questions that the *Big Questions* project was tasked with (with some adaptations to our research tools), while, in parallel, generating a series of knowledge briefs that examined the pandemic-specific challenges to health systems and health financing in humanitarian settings. The knowledge briefs published include: the prevention and mitigation of indirect health impacts of COVID-19, family violence prevention in the context of COVID-19, addressing the human capital dimension of the COVID-19 response in forced displacement settings, and the impact of the pandemic in Colombia on utilization of medical services by displaced Venezuelans and Colombian citizens (Program on Forced Migration and Health n.d.; Roa et al. 2020; Lau et al. 2020; Audi et al. 2020; Shepard et al. 2021). These briefs are publicly available on the Program on Forced Migration and Health (PFMH) Action Hub on COVID-19 and Displacement and the World Bank webpage on Building Evidence on Forced Displacement.

Key Findings

It is important to note at the outset that a singular or uniform approach on the part of international and national actors can never hope to accommodate the diversity of political contexts and capacity constraints that exist in different hosting communities. However, several key and salient learnings emerged from across all four sites, and these are reflected below.

The importance of planning and integration

Humanitarian health practitioners, national governments and international donors are well advised to begin to plan early for the possibility that a displacement crisis might become protracted and require sustainable, long-term solutions – as unpalatable as that might be politically. Planning should start from the earliest phases of the crisis, once the immediate imperative to save lives has passed. An integrated approach to healthcare can provide potential benefits across the board in terms of planning and sustainability, cost effectiveness, and continuity of care for both displaced and host populations.

However, not every situation will lend itself to an integrated approach. In some political contexts – particularly where the government concerned is a party to conflict – the role of humanitarian NGOs remains critical. State fragility also complicates and may limit the prospects for integration, given weak state institutions, corruption, a lack of resources, and a lack of security, all of which serve to undermine trust and access to healthcare. This we saw most vividly in our work in the DRC. However, despite such challenges, health systems strengthening interventions have proven effective even in some fragile settings (Pal et al. 2019; Newbrander, Waldman, and Shepherd-Banigan 2011; Valadez et al. 2020; WHO 2021c)and have an important role to play in advancing healthcare for both host and displaced populations.

Our findings underscore the importance of a nuanced and contextualized analysis being undertaken, early in any crisis and on an ongoing basis, which assesses the prospects for an integrated approach going forward. Humanitarian leadership is critical, as an integrated approach requires close consultation, communication and coordination with national actors, including government, to calibrate and orientate the humanitarian sector's response.

Understanding health needs in both the host and displaced population:

An important consideration in planning any healthcare response is the availability of accurate and timely demographic and epidemiologic data to better understand who is in the displaced and host populations and anticipate and plan for their needs. It is well established that certain demographic groups (women, children, the elderly, lesbian, gay, bisexual, trans, or queer people (LGBTQ) and disabled people) experience added vulnerabilities during displacement (Klugman 2022;

World Bank Group n.d.)research and analysis of the gendered\n dimensions of displacement have been limited. The Gender\n Dimensions of Forced Displacement (GDFD. The *Big Questions* review found a paucity of demographic and epidemiologic data that was sufficiently comprehensive in scope and suitably disaggregated by migration status or a reasonable proxy (i.e. nationality, administrative area, etc., depending on context), and even less data that allowed for intersectional analyses for additionally vulnerable displaced and host community groups.

Colombia provided the most promising efforts in this area, with national data systems and registries facilitating a variety of comparisons among host and displaced populations. Although logistical limitations to registration remain that may lead to significant and important gaps in our understanding of health needs. In the DRC, population-wide data sources were incomplete and largely did not differentiate host and displaced populations, requiring instead geography to be used as a proxy for migration status. Jordan illustrates how international and national resources can be combined and leveraged as part of the response to displacement, with the national Department of Statistics effectively adapting standard tools, such as Demographic and Health Surveys (DHS), to collect data from host and displaced populations in a way that distinguishes camp and non-camp settings. Bangladesh presented a more classic, fragmented approach with fully separate data sources for host and displaced populations. This limits the visibility of Rohingya in national datasets, creating challenges for longitudinal comparisons and comparisons with the host population.

Ideally, a whole data approach would be taken, including coordination and collection of comprehensive demographic and epidemiologic data over time for displaced and host communities, to further inform population health needs and pathways for comprehensive health systems responses. However, at a minimum, from the onset of a humanitarian response it is important to anticipate the ways in which meaningful categories of disaggregation (age, sex, etc.) vary by context and can be woven into existing tools for longitudinal data collection, such as censuses and national surveys (for example, age can serve as a proxy for possible chronic disease burden). Longitudinal data on sex differences can provide further essential information on the gendered effects of protracted displacement. Even in areas where data is available at a national level, more work is needed to document the experiences of displaced and host populations over time, particularly those residing in insecure areas where data collection is often nonexistent.

Of note are the particular data gaps when it comes to IDPs, including the paucity of longitudinal data. IDPs are largely dependent on the

capacity and political will of the government to count and support them. Colombia and the DRC again offer up starkly different pictures of government efforts and capacity to register and account for their IDP populations.

Health gaps

While gaps were identified across all types of health needs, including in preventive and primary care, in all four countries studied, our research highlighted three major gaps – chronic disease management, specialized care, and mental health services – for which few large-scale, effective interventions have been implemented for host and displaced populations. While there are ongoing initiatives to begin to address these needs, further scaling of effective interventions is required, for which an integrated approach is both necessary and may offer up distinct benefits for both host and displaced populations (Fine et al. 2022)neurological, and substance use (MNS. It is important to note that there are gender differences with men and women experiencing different health needs and response systems for those needs (Klugman 2022)research and analysis of the gendered\n dimensions of displacement have been limited. The Gender\n Dimensions of Forced Displacement (GDFD.

Each of these health gaps raise different challenges for humanitarian actors, governments and donors. Strategies are required that address health gaps in a way that reinforces existing health systems and avoids diverting resources from funding and strengthening preventive and primary health services. The key challenge for specialized services is financing and sustaining their availability, including investment in strengthening referral pathways, as access to timely and affordable referral processes is particularly tenuous among displaced populations. Addressing care for chronic diseases requires both financing and improvements in referral networks to access different levels of care, as well as continued innovation in programmatic approaches that can reach populations in humanitarian settings. With respect to mental health services, there remains a need for more research to verify which interventions are effective and feasible at scale for both displaced and host populations. Particular attention should be paid to identifying programming that can reach vulnerable groups such as women, children, and the LGBTQ community. Emerging evidence and models for mental health service delivery in humanitarian settings must also be tailored to fit the cultural context.

Cost as a barrier for both displaced and host populations

In all four countries studied, cost – perhaps unsurprisingly – remained the defining issue determining healthcare access for many displaced and some host populations. Out-of-pocket medical and direct non-medical costs, such as transportation to seek care, emerged as the most significant barriers to accessing healthcare. Even in countries with facilities that provided free healthcare, lack of availability of care drove displaced and host populations to private facilities and the informal sector, where patients incur out-of-pocket spending. The DRC study in particular illustrates the link between lack of affordable care and low utilization of health services, to such an extent that barriers related to quality, availability, and acceptability were rarely mentioned by respondents in that context.

Yet, cost barriers are also nuanced. They are shaped by the preferences of users, who may be willing to pay more for services perceived as more acceptable or of higher quality. Such perceptions of quality of care were influential in driving many displaced populations to seek care from private and informal sources across the sites we studied. Cost is also intimately connected to other factors: the availability of services, such as distance to health facilities; social determinants, such as education and income; and legal status, such as official registration and the right to work. Efforts to reduce costs or make services free to users must consider these overlapping drivers and be integrated with comprehensive approaches that can help promote resilience and self-reliance through legal status and access to livelihoods. They must also include efforts directed towards improving quality of care—both real and perceived—across public, private, and informal sectors. Better long-term planning, supported by more sustained long-term donor funding, might also yield savings in terms of cost effectiveness. For example, in reducing contracting costs, enabling better training schemes and investments in human capital; and promoting cost-effective approaches, such as vaccines, preventive medicine and primary care.

Financing structures

Donor financing arrangements can play a crucial role in facilitating greater integration of health services for both host and displaced populations. This is a space where we have seen much innovation in recent years. In Jordan, refugee health has been an integral part of the country's joint response multisectoral action plan for the refugee crisis. Donors' contributions have been pooled to support the host country

response, and multilateral and some bilateral donors have focused their support on services provided within national healthcare systems, with part of the funds going to strengthen the overall healthcare system in Jordan. However, across all four countries studied, shifting donor priorities, short-term funding cycles, and a continual misalignment between host government needs and international funding create a difficult environment in which to realize the promise of an enhanced integrated approach. Invariably, host governments, often with local governments, shoulder a significant part of the cost associated with the health needs of the displaced populations. In the case of Colombia, this cost burden also falls on specific health facilities in areas with large numbers of displaced persons.

Innovations around demand-side arrangements (i.e. voucher programs) have also been implemented with varying results. Subsidies for displaced populations to use national health services can encourage integration and strengthen local economics, but such programs must be implemented with care to avoid overwhelming health service capacity. Promoting high-quality service provision through the use of incentives, such as performance-based financing (PBF) approaches, have also shown efficacy in some low- and middle-income and conflict-affected settings (Zeng et al. 2013), although here too, there are important caveats.

As noted above, our findings —both on the formidable barrier that costs continue to pose for displaced and host populations and the inherent unpredictability and insufficiency of donor funding — underscore the vital importance of financial arrangements that are embedded in policies supporting the longer-term resilience and self-reliance of refugees and displaced populations, including education and livelihoods strategies.

Social and environmental determinants of health and legal status

Health is intimately connected to a wide variety of other social and environmental factors that impact whether a person is able to live a healthy life – the social determinants of health — such as access to livelihoods, food security, education, and a clean environment. These social determinants are shaped by structural barriers around individual identities related to gender, sexuality, and age. For example, women have differential access to livelihoods, food security, and safety in protracted displacement which creates a unique set of vulnerabilities related to health. Investments in addressing these factors, with particular attention to the intersection of social determinants and gender, are also

foundational to preventive care and can lead to long-term, sustainable improvements in health that ultimately decrease the burden on health systems and health financing. In protracted displacement, it is critical that our responses incorporate these elements as an integral part of health care planning and financing.

Our research has also shown how vital a role legal status can play in ensuring both the ability and willingness to access health services. The stakes associated with documentation are amplified as national governments become more involved in the process of delivering healthcare. It is important to remain mindful of possible tensions between protection needs and healthcare needs, and to be cognizant of who is collecting data and for what purpose. Ensuring that appropriate firewalls are in place to protect sensitive demographic and health data from being used in immigration enforcement efforts is critical to ensuring full participation from displaced individuals and communities.

In short, whether someone is a refugee, IDP or member of the host population, it is important to take a "whole of person" approach to advancing their health and well-being.

Leveraging human capital

Finally, while the arrival of significant refugee and displaced populations can strain healthcare capacity in both rural and urban settings, effectively leveraging human capital can be critical to filling service gaps for both displaced and host populations. Opportunities for displaced populations vary significantly by gender and profession. In Bangladesh, a mental health and psychosocial support (MHPSS) program utilized a task shifting[1] approach to grow a diverse health workforce linking community- and facility-based care to provide outreach and service provision. As occurred in this example, effective task shifting requires access to appropriate formal or structured on-the-job training, as well as sustained supportive supervision. Engagement of the displaced health workforce can also serve to strengthen host health systems and address barriers to care around language differences and discrimination

1 Task shifting is defined by the WHO as "the rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health."

for displaced populations. However, permission to work, access to which can vary by gender, and formal recognition of foreign medical licensure remain barriers to leveraging this group (ILO, n.d.). There are often entrenched interests at the national level, including professional associations that oppose greater inclusion of foreign healthcare workers, that need to be factored into any future policy and advocacy efforts in this area.

In conclusion, with conflicts showing no signs of abating, and protracted displacement arguably here to stay, it is critical to think about the health and well-being of refugees and displaced populations in tandem with the host populations they live alongside. A singular or uniform approach on the part of international and national actors can never hope to accommodate the diversity of political contexts and capacity constraints that exist in different hosting communities. However, the *Big Questions* project underscores the varied and innovative ways in which the conversation about an integrated approach to health is advancing in different contexts and offers valuable lessons on how to better prepare for, and anticipate, the challenges and opportunities that can arise in contexts of displacement.

INTRODUCTION

Displaced persons and host populations in fragile settings affected by conflict and violence are often inadequately served by equally fragile and dysfunctional health systems. These systems are quickly overwhelmed by the influx of large numbers of refugees and IDPs. In the acute phase of a humanitarian response, global implementing partners often navigate this challenge by establishing parallel systems for preventive and curative health services. In protracted crises, and where displaced persons settle in the midst of established host communities, the transition from acute humanitarian response to development support requires careful coordination to avoid duplication of services, inefficiency, or increased inequity and service gaps. At each stage, host country health systems may be present alongside services offered by non-state actors and private sector providers. It can be especially difficult for decision-makers to anticipate and respond to health needs in such complex and pluralistic environments, and harder still for individuals and families to navigate and meet their health needs.

As the numbers of people displaced remains at historic levels worldwide, and as protracted crises become the norm, the global community is challenged as never before to find new solutions to dealing with this "humanitarian-development" nexus. And yet, this is also a moment of opportunity. The resounding endorsement by states of the Global Compact on Refugees and the global commitments to meeting the Sustainable Development Goals (SDGs) and realizing universal health coverage create an opening to test innovative approaches to addressing the health needs of displaced populations, alongside those of host populations. Ensuring that public sector health and development partners do not overlook the needs of displaced persons in pursuit of coverage targets, and that humanitarian actors do not destabilize already fragile government-run health systems, demands cooperation, collaboration and attention from actors working on both sides of the "humanitarian-development" equation.

A crucial element in effectively navigating this challenge lies in addressing the financing of the health response. There is currently a gap in systematic analysis of the evidence on how donors and multilateral agencies can best support countries to identify priorities, address the health needs of displaced populations and host communities, and optimize investments. Current financing services to meet the

health needs of displaced populations are unpredictable and not well integrated with the financing system in host countries. This results in a shortage or mismatch of service provision for these populations and decreases opportunities to improve health outcomes. There is a critical need for international donors to work together with host governments to develop a comprehensive framework for prioritizing interventions to strengthen the integration of health financing systems for the displaced populations with that of the host community. This report synthesizes the results from research across four case study countries to identify the health challenges in protracted displacement crises. It also discusses opportunities and highlights strategies for building and financing resilient health systems that can respond comprehensively and effectively to the needs of displaced populations alongside those of host communities.

The project focused on various geographical, social and demographic contexts in fragility, conflict, and violence (FCV) affected countries facing protracted displacement conditions. The key questions considered by the project include:

- What are the common trends, similarities and differences in the health needs of forcibly displaced populations and host communities in different contexts beyond the initial emergency response?
- What empirical evidence and examples of good practice are available 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?
- What are the most cost-efficient mechanisms for financing health services for forcibly displaced populations and host communities?

A note on terminology

From its inception, the *Big Questions* study prioritized incorporating and representing various types of displacement in the study, including refugees registered with UNHCR, unregistered internationally displaced individuals, displaced Venezuelans, and internally displaced persons (IDPs). Throughout this report, the authors have utilized “displaced populations” inclusively to refer to any of these communities. Additional clarification and differentiation regarding type of displacement is made when necessitated by the data or context.

Case study countries

Bangladesh, Colombia, the Democratic Republic of the Congo (DRC), and Jordan were chosen as case studies for this analysis in order to incorporate and assess a wide variety of contexts which may factor into health service financing and provision. The selection criteria included system of delivery (camp, rural, and urban settings), provider type (NGO, local health system), host country context (active conflict, fragile, post-conflict), income level (low-income, lower-middle income, upper-middle income), and displacement type (refugees and IDPs). Our selection also reflects a diversity of geographic regions and differing national policies towards refugees and the displaced and incorporates considerations of data availability and feasibility. For more information regarding the displacement context by country, see Table 1.

Table 1: Context of displacement and health systems in study countries

Bangladesh
Primary Displaced Population(s): Rohingya Refugees (925,380)
Source: UNHCR, April 2022

Access to Health Services for Displaced Population(s)	Cost to Users of Health Services for Displaced Population(s)	Financing of Health Services for Displaced Population(s)
Primary healthcare is available to refugee and host population at NGO and international non-governmental organizations (INGO)-sponsored facilities in the camp complex Emergency, secondary, and tertiary healthcare is available at government facilities. Refugees require formal referrals and legal permissions to leave camp Displaced and host populations also access care via private providers, including informal providers (see section 2.1.2)	Primary healthcare services at NGO and INGO-sponsored camp facilities are free to users Emergency and select secondary and tertiary care at government facilities outside camps is available at no cost to users if referred by primary facilities, but often incurs indirect costs (see section 2.2.1) Fees for informal and private providers are typically paid out-of-pocket, but may allow for more flexible payments (i.e. in-kind) (see section 6.4)	NGO and INGOs providing health services at camp facilities are typically funded by international donors UNHCR and International Organization for Migration (IOM) provide financial support for refugees to use referral services, including transportation and meals. Government facilities are supported by international donors (see Bangladesh country report, section 5.3.4) Private and informal providers are funded primarily through user fees

Colombia

Primary Displaced Population(s): Displaced Venezuelans (2,029,758) IDPs[2] (5,235,000)

Source: Migración Colombia, March 2022 Source: Internal Displacement Monitoring Centre (IDMC), December 2021

Access to Health Services for Displaced Population(s)	Cost to Users of Health Services for Displaced Population(s)	Financing of Health Services for Displaced Population(s)
Emergency health services are available at public facilities for all people, regardless of insurance or immigration status Preventive health services are available for all people through Plan de Intervenciones Colectivas (Complementary Collective Interventions) (PIC); the specific package of services is determined at the municipal level (see section 1.2.1) Access to primary, secondary, and tertiary health services is available at public facilities, but limited to those with insurance or the ability to pay; 93 percent of IDPs and 35 percent of Venezuelans in Colombia had health insurance in 2022 Displaced populations can access services through health attention units (HAUs) run by INGOs and NGOs along migration routes (see section 2.1.1) Displaced and host populations also access care via private providers (see section 2.1.2)	Emergency services can be accessed through insurance and are also provided free of change to people without insurance, per a mandate in the constitution Preventive health services through PIC are available to all people free of charge, regardless of insurance or immigration status Primary, secondary, and tertiary health services are available at public facilities through employment or government issued health insurance. Specific services are established in regulated health plans, sometimes including co-payments from the user (see Columbia country report, section 4.1) HAUs typically offer services at low or no cost to users Fees for private providers are typically paid out-of-pocket, but may be covered through insurance in cases of specialized referrals (see section 4.2.3)	Public facilities must initially cover the cost of emergency health services and apply for reimbursement from the state (see section 2.2.2) Preventive health services through PIC are funded through municipal and national budgets Health insurance is financed through direct tax on the labor contract (contributory regime), national and regional budget (subsidized regime) and independent funding mechanisms (special regimes) (see Columbia country report, Figure 9) HAUs are typically funded by national and international donors Private providers are funded through a combination of user fees and reimbursements from the national insurance system

2 This study has found that experiences in the health system (in terms of access, quality, and funding) are not significantly different across IDPs and the host populations but are significantly different for displaced Venezuelans. As such, the Colombia country study has a proportionally heavier emphasis on understanding health systems and financing challenges among displaced Venezuelans. IDIs were conducted with both groups (IDPs and Venezuelans).

The Democratic Republic of the Congo

Primary Displaced Population(s): IDPs (5,540,000) Registered and unregistered asylum seekers and refugees[3]

Source: IDMC, End of 2021 (Registered refugees: 518,836)
Source: UNHCR, April 2022

Access to Health Services for Displaced Population(s)	Cost to Users of Health Services for Displaced Population(s)	Financing of Health Services for Displaced Population(s)
Emergency, primary, secondary and tertiary health services are available at public facilities for displaced and host populations NGOs, INGOs, and religious organizations provide health services; the range of services available varies by organization. Generally, these services are not widely available, particularly outside of camp settings Displaced and host populations also access care via private providers, including informal providers (see section 2.1.2)	Health services at public facilities are intended to be free or low-cost for users, but in practice frequent payment delays and medication and supply stockouts lead to increased fees to users Health services from NGOs, INGOs, and religious organizations are typically free of charge, but may vary by organization and over time Fees for informal and private providers are typically paid out-of-pocket but may allow for more flexible payments (i.e. in-kind) (see section 6.4). In some cases, care is funded through health insurance, although there is an alarming disparity in coverage, with 12 percent of men and 15 percent of women in the richest quintile reported having health insurance, compared to 0.7 percent of men and 1 percent of women in the poorest quintile (see the DRC country report, Chapter 6)	Health services at public facilities are funded through the government budget. Some donors' funding is channeled through the government to fund public health facilities Health services from NGOs, INGOs, and religious organizations are typically funded by international donors and religious institutions Private and informal providers are funded primarily through user fees and, in some cases, insurance reimbursements

3 Given the large number of IDPs in the DRC, this group is the primary focus of in this report unless otherwise noted.

Jordan

Primary Displaced Population(s): Registered and unregistered refugees and asylum seekers,[4] primarily Syrians (registered: 674,458), Iraqis, and Palestinians.

Source: UNHCR, April 2022

Access to Health Services for Displaced Population(s)	Cost to Users of Health Services for Displaced Population(s)	Financing of Health Services for Displaced Population(s)
For Syrians living in Azraq and Zaatari refugee camps, UNHCR coordinates the provision of primary, secondary, and tertiary healthcare, including through referrals to specialized and high-level care outside the camps. Refugees require special permissions to leave the camps Syrians who reside in non-camp (primarily urban) settings can access primary, secondary, and tertiary healthcare at public primary healthcare centers and public hospitals, but access varies by registration status Syrians in non-camp settings can access services at NGOs/INGOs, though services vary by provider Syrians also access services through private providers, including at private pharmacies	UNHCR health services are free of charge to Syrian refugees living in the camps; UNHCR services are also free of charge to registered refugees living outside the camps, but coverage is limited (UNHCR 2018) At public providers, fees vary by registration status.[5] Refugees registered with UNHCR pay a share of service fees equivalent to uninsured Jordanians. Unregistered refugees pay a greater share of service fees, equivalent to foreigners. Select services (maternal and child health (MCH), vaccination, mental health) are provided free of charge at public facilities regardless of immigration or registration status (World Health Organization (WHO) and Jordan Ministry of Health 2020) NGO/INGO services are typically free or low cost Fees at private providers, including pharmacies, vary and are paid out-of-pocket, and sometimes via insurance. Health insurance coverage of any type (public, private, special arrangements) is limited, with 68 percent of Jordanians and 38 percent of non-Jordanians covered (Al Emam 2016; Department of Statistics 2016)	UNHCR health services in the Zaatari Camp, Azraq Camp, and in non-camp settings are funded through international donors Health services for refugees provided through the public health system are funded through a combination of the government budget and donor funds, including a multi-donor account to support the Ministry of Health, though funding policies have fluctuated in recent years (see section 2.3.1) NGO/INGO services are typically funded through international donors Private and informal providers are funded primarily through user fees and, in some cases, insurance reimbursements

4 Jordan has a robust history of welcoming internationally displaced individuals and continues to host refugees from many different countries. Given the comparative size and recency of migration, this report will primarily focus on the experiences of Syrian refugees in Jordan unless otherwise noted. FGDs were conducted With Syrian refugees, but *not* with non-Syrian refugees.

5 According to the 2015 national census, a total of 1,265,514 Syrian nationals were residing in Jordan. As of April 2022, a total of 674,458 Syrian refugees were registered with the UNHCR office in Jordan (ACAPS 2021).

Impact of COVID-19

The arrival and persistence of the COVID-19 pandemic created unique challenges and opportunities in this research. Upon recognizing that the initial approach to research, including a heavy reliance on international travel, would need to be addressed, the researchers – in coordination with the World Bank – determined how the project might incorporate the substantial impacts of the pandemic on displaced and host communities, while simultaneously retaining a central focus on the systemic challenges of health responses in protracted crises. In response, the primary data collection methodology was adapted to enable greater localization of collection and analysis, and the qualitative interview guides and quantitative surveys were rewritten to incorporate, and clearly differentiate, questions specific to the impact of the pandemic.

The research team also produced a series of knowledge briefs incorporating pandemic-specific challenges to health systems and health financing in humanitarian settings. These included the prevention and mitigation of indirect health impacts of COVID-19, family violence prevention in the context of COVID-19, addressing the human capital dimension of the COVID-19 response in forced displacement settings, and the impact of the pandemic in Colombia on utilization of medical services by displaced Venezuelans and Colombian citizens (Program on Forced Migration and Health n.d.; Roa et al. 2020; Lau et al. 2020; Audi et al. 2020; Shepard et al. 2021). These briefs are publicly available on Columbia University's PFMH Action Hub on COVID-19 and Displacement and the World Bank webpage on Building Evidence on Forced Displacement.

METHODOLOGY AND RESEARCH INSTRUMENTS

The information presented in this report is based on four country studies, carried out in Bangladesh, Colombia, the DRC, and Jordan from 2019 to 2022. Country studies began with a desk-based literature review of the forced displacement situation and health systems, followed by an analysis of demographic and epidemiologic datasets from secondary sources, including the Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS), and national databases (see Table 2). The most recent available data and data disaggregated by sex, age, and location were prioritized. For primary data collection, research teams in each country conducted focus group discussions (FGDs) with host and displaced community members (separate focus groups for men and women), health facility assessments (HFAs) of purposively sampled health facilities, and semi-structured key informant interviews (KIIs). In Colombia, due to COVID-19-related restrictions, phone-based in-depth interviews (IDIs) were conducted in place of FGDs. Both FGDs and IDIs were constructed to generate information about the experience of displaced and host populations when using the health system.

HFAs were conducted to collect data about health system readiness (including availability of basic amenities, equipment, essential medicines, and diagnostic capacity, as well as the presence of standard precautions in infection prevention), costing (including costs to households and actual economic costs), and other health system indicators, which country research teams adapted to local contexts from a baseline tool developed by the research consortium for this project. Health facilities were selected by country research teams based on various factors, including delivery type (primary, secondary, or tertiary care); population served (host, displaced, or all); and setting (camp, rural, or urban). Inclusion in the sample was also shaped by the ability of the research team to obtain facility consent to participate and whether the security situation enabled research staff to travel to the facilities for data collection. The HFAs are not intended to be nationally representative nor comprehensive; instead, they are intended to provide a snapshot of the capacity and readiness of facilities across displaced and host population settings. HFAs were not conducted in Bangladesh.

The rural/urban and camp/non-camp distribution of FGDs, IDIs, and HFAs varied by country and aimed to capture a snapshot of key features of the displacement situation in each context, including refugees living in the camp complex in Bangladesh, rural IDPs and refugees in the DRC, urban refugees in Jordan, and refugees and IDPs in Colombia. In all countries, FGDs were stratified by gender and host/displaced population to capture the different needs of these groups. FGDs with members of the host community were not conducted in Bangladesh for logistical reasons.

Lastly, key informant interviews (KIIs) aimed to capture a range of perspectives on health systems and financing from government officials, donors, international organizations, NGOs, civil society organizations (CSOs), health facility staff, and community leaders.

To situate the findings of the country studies and identify frameworks for interpreting results, integrative literature reviews, including academic and grey literature, were carried out focused on the interplay between humanitarian and national health systems, the health workforce in humanitarian contexts, and sources of health and demographic information in humanitarian contexts.

Table 2: Primary and secondary data sources by country

Country	Secondary Data Sources	Primary Data Sources			
		FGDs	IDIs	HFAs	KIIs
Bangladesh	- DHS (2017-18) - MICS (2019) - RAMOS[6] (2018)	8	N/A	N/A	19
Colombia	- SISPRO[7] (Multiple databases, multiple years) - DHS (2015)	N/A	35	20	13
DRC	- DHS (2013-14) - MICS (2017-18)	13	N/A	7	12
Jordan	- DHS (2017-18) - JLMPS[8] (2016)	12	N/A	22	18
Total	**DHS, MICS, national databases**	**33**	**35**	**49**	**62**

6 Reproductive Age Mortality Study

7 Sistema Integrado de Información de la Protección Social (Social Protection Information System)

8 Jordan Labor Market Panel Survey

CHAPTER 1: UNDERSTANDING DEMOGRAPHIC AND EPIDEMIOLOGIC PROFILES AMONG HOST AND DISPLACED POPULATIONS

Identifying demographic and epidemiologic profiles among host and displaced populations enables health systems to anticipate and respond appropriately to the health needs of each population. Needs may differ according to demographic profile, including gender, age, sexual orientation, and disability; living conditions; exposure to violence; and access to health services before, during, and after displacement. However, in the four countries studied, demographic and epidemiologic data was collected by separate sources, incomplete, and fragmented among displaced and host populations, complicating efforts to develop a full understanding of health needs. For displaced populations in particular, data systems do not adequately capture demographic and epidemiologic information, particularly from international migrants, and data collection, as well as survey and registry data, that allows for disaggregation by migration status is rare. **Taking a "whole data" approach that connects demographic and epidemiologic data among all communities in a country, which includes both displaced and host populations, has the potential to support policymakers and program planners in understanding the health needs and health system requirements for the whole population.** However, such an approach must be balanced with protection concerns (see Box 3: Protection Concerns around Data) and requires significant investment across demographic and epidemiologic systems for data collection and availability, from civil registration to disease surveillance. These systems currently exhibit major gaps and often function in isolation from one another.

1.1 Availability and utility of demographic and epidemiologic data

Epidemiologic and demographic data – such as mortality, age distributions, and fertility – are critical to understanding and planning for the health needs of host and displaced populations. To assess the availability and quality of data used by policymakers, donors, and others involved in planning for health systems responses to forced displacement, we reviewed nationally representative demographic datasets in Bangladesh, Colombia, the DRC, and Jordan. Data was reanalyzed and, where possible, disaggregated by migration status, often using nationality or geographic location as proxies (see Table 3). **We found that nationally representative datasets allowing for disaggregation of demographic characteristics by displacement status or reasonable proxy measures were most readily available in Colombia and Jordan. In Bangladesh, such data was only available from separate data sources for host and displaced populations, and in the DRC, it was essentially nonexistent.**

Specifically, our review of secondary data sources yielded four surveys that allow for the identification of forced migration status: (1) the 2015 DHS in Colombia (using Venezuelan nationality as a proxy), (2) the 2017 DHS in Jordan (using Syrian nationality as a proxy); (3) the 2018 Reproductive Age Mortality Study (RAMOS) from Cox's Bazar, Bangladesh; and (4) the 2016 Jordan Labor Market Panel Survey (JLMPS). Of these, only the DHS (Jordan and Colombia) and JLMPS (Jordan) were nationally representative to enable the calculation and comparison of displaced and host populations. In Bangladesh, no dataset included data for both host and displaced populations; RAMOS exclusively sampled Rohingya, while DHS and MICS exclusively sampled the host population. Comparisons between these various data sources must account for differences in survey design and timeframe. In the DRC, no nationally representative datasets that allowed for disaggregation by migration status were identified. While in some cases small-scale, cross-sectional surveys of IDP populations, conducted by humanitarian NGOs, were present, this data can play only a limited role in the larger demographic and epidemiological analysis due to its limited region and scope. In Colombia, national registries of displaced Venezuelans and IDPs, as well as data from Colombia's Social Protection Information System (SISPRO), facilitated a variety of comparisons among host and displaced populations, particularly related to health service utilization, that were not possible in the other countries studied. Although these statistics typically only reflect information from displaced persons who are registered, enrolled in the health insurance system, or access emergency health services.

While methods of using this data to estimate and compare key indicators among migrants and host populations can be tailored to context, significant limitations remain in our ability to understand differences among host and displaced populations (see Table 3). For example, in Bangladesh, the 2017-18 DHS and 2019 MICS surveys allowed for representative estimates of demographic and epidemiologic indicators among host populations living in Cox's Bazar district. However, because the camp complex was not included in the sampling frame, this data is not reflective of the demographic and epidemiologic profile of displaced Rohingya. Demographic and epidemiologic data about displaced Rohingya are available through separate datasets, such as RAMOS and the Joint Multi-Sector Needs Assessment (J-MSNA). In contrast, the DHS in Jordan was adapted to draw comparisons between the Jordanian and Syrian populations by designating refugee camps as separate sampling strata and collecting data on nationality, which can be used as a proxy for displacement status among people living in urban settings. In the DRC, where internally displaced persons are dispersed in host communities, geographic disaggregation of the DHS and MICS to administrative areas hosting high numbers of displaced persons, such as districts of North and South Kivu, may provide a sense of the combined demographic and health profile of displaced and host populations relative to neighboring regions or national averages. However, these surveys largely omit information from people living in insecure areas due to under sampling. The dearth of demographic and epidemiologic data in the DRC is further illustrated by the fact that no national census has been conducted since 1984 and IDPs only infrequently register with local authorities.

From the onset of a humanitarian response to forced displacement, it is important to anticipate the ways in which meaningful categories of disaggregation vary by context and can be woven into existing tools for longitudinal data collection, such as censuses and national surveys. For example, in Colombia and the DRC, assessments should account for both IDPs and people displaced across borders, meaning that data on nationality is an insufficient proxy for displacement. Additional levels of disaggregation to address complex and overlapping displacement settings, such as the impact of policy change on legal status over time, the prevalence of internally-displaced ethnic minorities, and specific technicalities of status (i.e. inheritability) may also require consideration (Oslender 2016). In Jordan, it is more useful to disaggregate the Syrian population by residence in camp- and non-camp settings, given the significant minority (17.3 percent) of Syrians residing in official camps (Krafft et al. 2018; UNHCR 2021c). It is important to note that disaggregation itself is not the objective but rather a method by which decision-makers can improve the strategic inclusion of relevant

groups in policy development and programmatic response (Lundkvist-Houndoumadi and Samarah 2022). For example, longitudinal data disaggregated by sex and displacement status can provide essential information on the gendered effects of protracted displacement. Across contexts, there is a dearth of longitudinal data about forcibly displaced populations, limiting researchers' and policymakers' abilities to assess and respond to how migrants' demographic and epidemiologic profiles and health needs change over time.

Relative to the other contexts examined in this study, the data rich environment in Colombia speaks to the importance of strengthening national statistics and civil registration systems, which can link data across sectors, provide a source of longitudinal data, and tailor categories of disaggregation to the national context (Lopez et al. 2007). The development of Colombia's national health information systems is discussed in more detail in Chapter 4 (Health Information Systems). Where national statistics and civil registration data are less robust or lack adequate indicators of migration status, international surveys like DHS and MICS can be adapted to draw useful comparisons between displaced and host populations (Checchi et al. 2017). This approach has been applied in Jordan, with respect to the DHS, as noted above. (Jordan Department of Statistics and DHS Program 2019). However, in contexts like the DRC, where not even national populations are adequately counted, the prospect of quantifying displaced populations and delineating their health needs remains remote, particularly for people living in insecure areas.

1.2 Examining epidemiologic profiles, health needs, and system gaps

Demographic and epidemiologic data can be paired with disease surveillance data and information on demand for, and coverage of, health services to assess health needs among all people in a country, including host and displaced communities. Demographic indicators like socioeconomic status (e.g., income and education) provide insight regarding determinants of health, such as living conditions, food security, stress, and the ability to meet the direct and indirect costs of accessing health services. Furthermore, sex differences in the prevalence and presentation of disease and health-seeking behavior further underscore the need of gender-sensitive approaches to data regarding health needs. Across the four countries analyzed, gaps in data collection and reporting and lack of alignment among epidemiologic

and demographic data made it difficult to carry out an assessment of health needs beyond the identification of broad trends. These trends are discussed below in relation to preventive health services, infectious disease management, trauma and emergency care (including emergency obstetric and newborn care, or EmONC), chronic disease management, access to specialized medical services, and mental health services.

1.2.1 Preventive health services

Persistent gaps in preventive health services were highlighted in all four countries, underscoring the importance of ensuring the sustained provision of affordable preventive services for displaced persons. Disparities in vaccination rates are an illustrative example: Syrian children in Jordan have 12 percent lower coverage with nationally recommended vaccinations compared to Jordanian children, whose rate of coverage averaged 88 percent, ranging from 64 percent (Ma'an) to 91 percent (Ajloun) (Jordan Department of Statistics and DHS Program 2019). In Bangladesh and the DRC, recent coordination and planning efforts have yielded gains in routine vaccination coverage, reaching 92 percent among Rohingya refugee children living in the camp complex in Bangladesh (measles, rubella) and 75 percent among all children in the DRC (Hepatitis B, polio, measles) (UNICEF 2022; 2020). However, disruptions to routine vaccination programs and decreases in health service utilization during the COVID-19 pandemic may slow or reverse such gains (ISCG 2020; 2021; Hategeka et al. 2021).

The countries in this study illustrate different means of improving access to preventive health services among displaced populations. For example, in Colombia, the nationally mandated Complementary Collective Interventions (PIC) provides vaccinations and other preventive medical services for free and regardless of migration or legal status, although implementation and prioritization of such programs is uneven across decentralized territorial entities. Meanwhile, within the Kutupalong camp complex, Bangladesh has utilized community health workers (CHWs) to enhance health education to promote the uptake of preventive services, particularly vaccination campaigns and COVID-19 safety measures (see Bangladesh country report, sections 2.1.2 & 5.1). These and other interventions that focus on primary prevention, rather than treatment, are often among the most cost-effective means of addressing the health needs of the population. However, especially when preventive interventions function outside of health facilities (i.e. vaccination campaigns, school-based interventions, etc.), special attention is needed to ensure they are inclusive of displaced populations at the levels of both policy and service delivery.

1.2.2 Infectious disease management

In countries where displaced populations reside in camp or camp-like settings, such as Bangladesh and Jordan, several informants in KIIs and FGDs described how early stages of the response appropriately focused on infectious diseases and other basic and initial care among the displaced population (see Bangladesh country report section 1.2.2, Jordan country report, chapter 3). Infectious diseases have been found to disproportionately impact migrant mortality ratios, in comparison to host populations, especially due to camp environments and associated determinants of health that amplify the likelihood of outbreaks, where shelters are not well-ventilated, conditions are unsanitary, and there are issues of overcrowding (Aldridge et al. 2018). Informants in Bangladesh cited key outbreaks and issues of diphtheria, cholera, measles, diarrhea, and skin diseases, and frequently referenced them in relation to overcrowded living conditions. Risks for infectious disease outbreaks were also found to be increasing in Jordan, where 17.3 percent of the Syrian displaced population resides in camps (Krafft et al. 2019; UNHCR 2021c), and were found to be a persistent threat in the DRC, where malaria and measles outbreaks, and Ebola outbreaks in areas with large displaced populations, have caused high rates of mortality in recent years (Emina, Doctor, and Yé 2021; MSF 2021; Severe Malaria Observatory n.d.).

Investments in disease surveillance and availability and diagnostic capacity of health services within and outside camps have been tied to improvements in infectious disease management and, at the same time, reinforced pathways for uptake of preventive medical services. For example, in Bangladesh, the COVID-19 pandemic prompted additional investments in a community-based surveillance system established by UNHCR (see Bangladesh country report, section 4.1). Resulting improvements in surveillance were tied to the ability to quickly identify a dengue outbreak in 2020 and respond with increased testing and community response. This included bolstering referrals by CHWs to health facilities and updating the policy to call for CHW visits every week (as opposed to every two weeks) for all households in the camp complex.

Infectious disease management provides an ideal lens with which to highlight the importance of a whole-of-person approach in health systems strengthening. For example, food security plays a key role in addressing susceptibility to infectious disease and improving health outcomes. Displaced populations frequently face high rates of both acute and chronic malnutrition in comparison to their host community counterparts (Owoaje et al. 2016). Reviews of the literature across the four country sites underscored this disparity. In Bangladesh, a 2017

study found nutritional status among Rohingya was poor, likely due to poor nutritional status in Rakhine State compounded by the multi-day journey to Cox's Bazar. While nutritional status has improved, limited dietary diversity as a result of reliance on food rations remains a challenge (Ministry of Health and Family Welfare (MOHFW) 2018). Focus groups in Bangladesh frequently referenced the lack of culturally appropriate food as a point of contention, in particular highlighting the impact of poor nutrition on maternal and child health outcomes. In Colombia, acute malnutrition among children under five was among the most prevalent health events recorded among Venezuelans in Colombia's national epidemiologic surveillance system (SIVIGILA), making up 2 percent, 4 percent and 8 percent of total events reported in 2017, 2018 and 2019, respectively (Migración Colombia 2019). In the DRC, focus groups consisting of both displaced and host population frequently referenced food security as a vital issue.

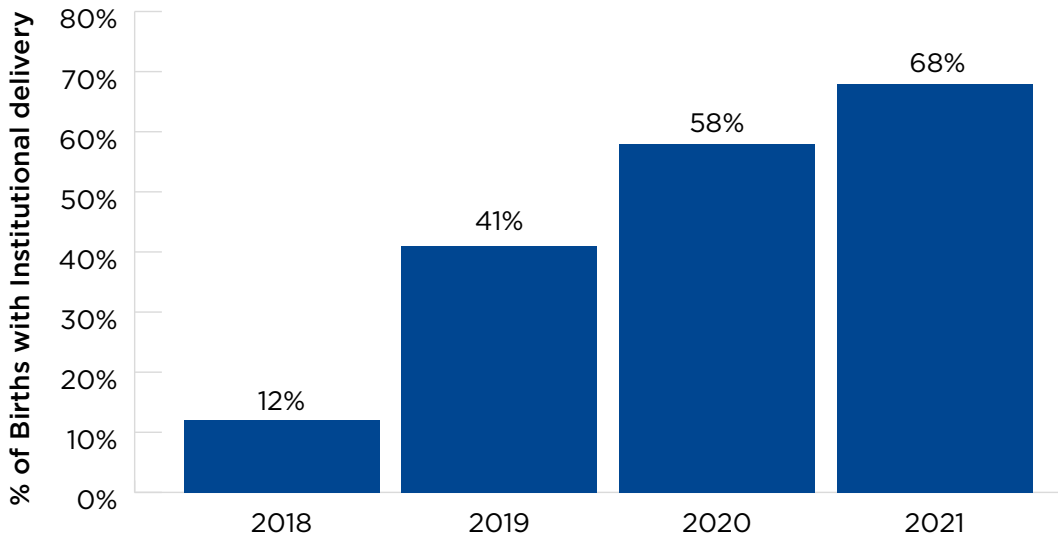
> ***"Pregnant women require some comfort in terms of living and need to eat healthy food, but they don't have access to these in the camp. As a result, they are being infected with many types of diseases, including skin diseases."***
> Female Focus Group Discussion, Camp 4 Extension, Bangladesh

1.2.3 Trauma and emergency care

Within the country studies, EmONC was used as a proxy for trauma and emergency care because it requires elements of care universal to trauma and emergency care, such as access to 24/7 services, necessary medications (oxygen, anesthesia), appropriate medical supplies, and robust, timely referral systems. The availability of high-quality EmONC services can also serve as an indicator of health system capacity to respond to sex-specific health needs and gender inequality. The DRC and Bangladesh exhibited the most significant gaps in EmONC services, despite recent improvements in these areas. In the DRC, maternal mortality has declined over the last two decades, but remains alarmingly high, at 473 per 100,000 live births. Areas with large populations of displaced persons (South Kivu) experience almost double that ratio due mainly to hemorrhage, anemia, heart disease, and malaria (The World Bank n.d.; Woolf, Célestin, and Justin N 2018). Two-thirds of maternal deaths occurred in rural regions, highlighting the importance of strong and timely referral systems (Woolf, Célestin, and Justin N

2018). In Bangladesh, midwives are a key point of contact in the health system for many Rohingya refugees living in the camp complex. United Nations Population Fund (UNFPA)-led efforts to increase facility deliveries have yielded promising results: as of 2021, 68 percent of deliveries were conducted in health facilities, compared to 12 percent in 2018 (see Figure 1). Similar gains were observed in antenatal care and immunization of children under one year of age (Health Sector Coordination Team 2021)(UNICEF 2015)(The World Bank n.d.; Woolf, Célestin, and Justin N 2018). However, there is significant variation by camp and, among FGD participants in Bangladesh, EmONC care was not viewed as accessible due to delays in referrals to emergency facilities outside the camps.

Figure 1: The utilization of institutional delivery amongst Rohingya in Bangladesh, 2018-2021



Source: Health Sector Coordination Team. Health sector bulletin #15. Geneva: WHO, 2021.

1.2.4 Probing health systems gaps

While gaps were identified across all types of health needs and effective responses varied by context, our research highlighted three major gaps across the four countries where few large-scale, effective interventions exist to meet the health needs of the host and displaced populations:

- (1) access to treatment of chronic diseases as a barrier for migrant populations;
- (2) access to specialized services, including secondary and tertiary care, especially for
- displaced populations; and
- (3) access to mental healthcare as a gap in services for both host and displaced populations.

Refugees and migrants face special risks in these areas due to the extreme stress of migration, reduced financial resources, and drastic and sudden life changes (WHO 2018). While there are ongoing initiatives to begin to address these needs, further scaling of effective interventions is required, for which an integrated approach is both necessary and may offer up distinct benefits for both host and displaced populations (Fine et al. 2022)neurological, and substance use (MNS. It is important to note that even here, there are gender differences with men and women experiencing different health needs and response systems for those needs (Klugman 2022)research and analysis of the gendered\n dimensions of displacement have been limited. The Gender\n Dimensions of Forced Displacement (GDFD.

1.2.5 Chronic disease management

The Colombia case provides a particularly salient example of the gap between displaced and host populations in accessing continuous care to manage chronic health conditions. This often requires long-term engagement with patients, supported by follow-up services, and frequently, sustained provision of medication. Despite the availability of free services through the public system, becoming and staying enrolled in government insurance schemes presents a major barrier to care for chronic conditions and specialized services among the displaced Venezuelan population, with displaced Venezuelans reporting being turned away from care as a result (see sections 2.2.2 and 2.3.1 for more detailed discussions of discrimination and enrollment in insurance, respectively). More than 80 percent of services provided to Venezuelans were found to be provided to individuals that are not enrolled in the public insurance system, and therefore only eligible for free emergency care (Shepard et al. 2021). In addition to being a critical barrier to timely and preventive care, this is an inefficient allocation of resources, as multiple studies have pointed to the fact that emergency care is much more costly than treatment for non-urgent conditions in primary care settings. This focus on emergency care represents a lost opportunity to invest in the long-term health of the population (Sven Engström, Mats Foldevi, Lars B 2001; Bozorgmehr and Razum 2015).

Similarly, in Jordan, while we found a high availability of services for treatment of non-communicable diseases (NCDs) in primary and NGO care facilities assessed (81 percent availability for hypertension services and 77 percent availability for diabetes management), national statistics point to a rise in NCDs among the Syrian population in Jordan since 2011, especially in urban areas (Jordan Department of Statistics and DHS Program 2019). This includes high rates of hypertension (14 percent) and diabetes (9.2 percent) among Syrians residing in Jordan

that add strain to the public system's ability to manage both host and displaced populations' chronic diseases (see Table 2, Jordan country report). National data for other types of NCDs, such as cardiovascular and respiratory conditions, is scarce (Rehr et al. 2018). Likewise, in Bangladesh, rising chronic diseases in the Rohingya population since migration were widely reported among Rohingya refugees living in the camp complex who participated in FGDs (see Bangladesh country report, section 1.3.2).

1.2.6 Specialized services

In the country studies, discussions of chronic disease frequently intersected with discussions of limited access to specialized care, including challenges in establishing and maintaining functional referral systems to link patients to secondary and tertiary care. Specialized care is more difficult to access for Syrian refugees than Jordanian nationals, as compared to primary care (The Higher Health Council 2014), and patients raised issues of diagnostic capacity and the lack of specialized doctors in public health facilities (see Jordan country report, Chapter 3 Results). In Bangladesh, camp based Rohingya refugees shared testimonials about the difficulties of obtaining and completing referrals for specialized services outside camps, the high costs of services outside the formal humanitarian health system (i.e. informal services and/or services outside the camps without a formal referral), and perceived discrimination when seeking care through the national system. These challenges can result in delays in specialized and/or emergency treatment (see Bangladesh country report, section 2.1.3). Additionally, issues were raised around availability of services for displaced populations who are elderly and/or have a disability; there is a rising need for these services in both Jordan and Colombia, although these issues are likely to be present in all countries studied.

1.2.7 Mental health services

There is also a large gap in the availability of mental health services. This is due to a lack of human resources and a qualified health workforce to treat these conditions (including specialized mental healthcare providers, e.g. psychiatrists and psychologists), stigma associated with seeking care and with working in the mental health profession, and minimal readiness to supply these services in most public primary health facilities (see Chapter 3 on Human Capital and Chapter 2 on Health Systems in this report). Even in Colombia, which has a more integrated public system for delivering care to both host and migrant populations, availability of mental health services was lacking. Our health facilities assessment in Colombia found that only 70 percent of facilities assessed provided any type of psychosocial support or mental health services

and, among those that did so, readiness to provide services, including availability of necessary drugs, was low (ranging from 18.2 percent to 63.6 percent readiness score). The implications of low service availability are particularly concerning among IDPs and displaced Venezuelans in Colombia, given evidence of a greater burden of mental health disorders compared to non-displaced individuals, including findings that lifetime prevalence of psychiatric disorders is 50 percent higher among displaced individuals (15.9 percent) compared to non-displaced individuals (10.1 percent) (León-Giraldo et al. 2021; Gómez-Restrepo et al. 2016). In both Bangladesh and Jordan, as with other chronic diseases, challenges with referral pathways for mental health services outside of camps and lack of services within camp settings present barriers to mental healthcare. In Jordan, there have been efforts in recent years to integrate mental healthcare in primary healthcare settings, as well as to provide mental health services to all residents (including refugees) at Ministry of Health (MoH) hospitals free of charge, but barriers persist, including cost, transportation, and stigma. Findings in the DRC point to almost no capacity at the rural level to provide such services, with only six mental health hospitals in the entire country, and most of these concentrated in Kinshasa.

These three service gaps – chronic diseases, specialized care, and mental health – raise different challenges for the humanitarian actors, governments and donors looking to devise effective strategies to address them. The key challenge for specialized services is financing and sustaining their availability, including investment in strengthening referral pathways as access to timely and affordable referral processes is particularly tenuous among displaced populations. Addressing care for chronic diseases requires both financing and improvements in referral networks to access different levels of care, as well as continued innovation in programmatic approaches that can reach populations in humanitarian settings to improve access to care and address social determinants of physical and mental health. With respect to mental health services, there remains a need for more research to verify which interventions are effective and feasible at scale for both displaced and host populations. Additionally, emerging evidence and models for mental health service delivery in humanitarian settings needs to be tailored to fit the cultural context. A whole data approach that includes coordination and collection of comprehensive demographic and epidemiologic data over time for displaced and host communities would further inform population health needs and pathways for comprehensive health systems responses, which are discussed in more depth in Chapters 2 and 3.

Table 3: Select demographic and epidemiologic indicators to illustrate method of disaggregation, by country

Country	**Colombia**			**Jordan**			**Bangladesh**			**The DRC**	
Method	National registries of displaced persons and national health service utilization data, disaggregated by nationality			National survey, disaggregated by nationality and camp/non-camp setting			National survey of host population only, disaggregated by geography			National survey with limited coverage of insecure areas, disaggregated by geography	
Indicator & Definition	**Colombian**	**IDP**	**Venezuelan**	**Jordanian**	**Syrian (camp)**	**Syrian (non-camp)**	**Bangladesh**	**Chittagong Division**	**Cox's Bazar District**	**The DRC**	**North Kivu**
Age distribution *% of population <18-20 years* *Age cutoff and gender vary by country*	Total Population <18 years: **30.7%** Year: 2019 Source: MoH	Total Population <18 years: **25.2%** Year: 2020 Source: Registro Único de Víctimas	Total Population <18 years: **24.2%** Year: 2020 Source: Migración Colombia	Female Population <20 years: **42.5%** Year: 2017-2018 Source: DHS	Female Population <20 years: **58.1%** Year: 2017-2018 Source: DHS	Female Population <20 years: **55.1%** Year: 2017-2018 Source: DHS	Female Population <20 years: **39.1%** Year:2019 Source: MICS	Female Population <20 years: **43.0%** Year: 2019 Source: MICS	*Not available*	Female Population <20 years: **58.2%** Year:2016 Source: MICS	Female Population <20 years: **58.2%** Year:2016 Source: MICS
Fertility *Age-specific fertility rates (annual number of births per 1,000 women in age group)* *Age ranges vary*	15-18: **42** 19-44: **59** Year: 2018 Source: RIPS	*Not available*	15-18: **63** 19-44: **42** Year: 2019 Source: RIPS[9]	15-19: **26** 25-29: **169** Year: 2017-2018 Source: DHS	15-19: **28** 25-29: **260** Year: 2017-2018 Source: DHS	15-19: **31** 25-29: **180** Year: 2017-2018 Source: DHS	15-19: **91** 25-29: **120** Year: 2014-2019 Source: MICS	15-19: **89** 25-29: **142** Year: 2014-2019 Source: MICS	15-19: **97** 25-29: **140** Year: 2014-2019 Source: MICS	15-19: **111** 25-29: **274** Year: 2012-2016 Source: MICS	15-19: **90** 25-29: **276** Year: 2012-2016 Source: MICS
Child mortality *Under-five mortality rate: Annual deaths per 1,000 live births*	**13.6** Year: 2018 Source: RIPS	*Not available*	**9.6** Year: 2018 Source: RIPS[10]	**18.0** Year: 2017-2018 Source: DHS	**17.2** Year: 2017-2018 Source: DHS	**31.2** Year: 2017-2018 Source: DHS	**40** Year: 2014-2019 Source: MICS	**40** Year: 2014-2019 Source: MICS	**46** Year: 2014-2019 Source: MICS	**70** Year: 2012-2016 Source: MICS	**26** Year: 2012-2016 Source: MICS[11]
Limitations of method	Registry of Individual Provision of Services (RIPS) data based on health service utilization, which differs by legal status; Data on IDPs in Registro Único de Víctimas relatively complete, but variables do not necessarily match those used in datasets for other displaced populations			Difficult to draw pre-conflict comparisons because Syrians in Jordan are not representative of Syria's national population			Largely represents the demographic profile of the host community, as clusters were based on the 2011 census and were not adjusted to include the 2017 influx of people into the camp complex			Insecure areas underrepresented; host and displaced populations cannot be distinguished	
Alternative and/or supplementary sources	Other national datasets, beyond RIPS, could be pulled from SISPRO databases; Data maintained by IOM and UNHCR through Interagency group of Mixed Migration (GIFMM); DHS (2015)			National census (does not disaggregate Syrian nationals by camp/non-camp); UNHCR refugee registration (misses those who are unregistered); Sixth Regional Response Plan (RRP6) inter-sectoral working groups for the health sector			Camp-based demographic surveys and registries, such as the J-MNSA (Inter-Sectoral Coordination Group (ISCG)), Family Counting Exercise (Office of the Refugee Relief and Repatriation Commissioner (RRRC)/UNHCR), Needs and Population Monitoring (IOM), RAMOS (Centers for Disease Control and Prevention); Camp-based disease surveillance (Early Warning, Alert, and Response System (EWARS), Health sector working groups)			Cross-sectional surveys, often as part of outbreak investigations; Program evaluations	

9 Given information constraints, the population denominators used to calculate the age specific fertility rates for the Venezuelan population are approximations. The new age groups were constructed based on the assumptions that the age groups reported by the Colombian Migration Agency (Migración Colombia) had a uniform distribution.

10 We believe that the indicators for the Venezuelan population are biased due to sub-reporting on number of deaths and births discriminated by nationality.

11 The lower rate of under-five mortality in North Kivu may reflect the presence of dedicated NGO efforts to reduce child mortality and/or inaccessibility of the entire population during the survey as a result of conflict (See Ngianga-Bakwin Kandala et al., 2014, doi: 10.1186/1471-2458-14-266)

CHAPTER 2: RESPONSE AND INTEGRATION OF HEALTH SYSTEMS AFFECTED BY DISPLACEMENT

2.1. Organization of the health response

Early in a humanitarian crisis, national health systems are frequently overwhelmed by a large influx of displaced persons. This acute phase of the humanitarian response often sees international actors addressing urgent needs through provision of services outside the national system – a "parallel" system of response. As crises extend, transitioning from the acute phase to the protracted phase of humanitarian response requires careful coordination with national actors to avoid duplication of services, inefficiency, increased inequity, and service gaps. The reality is that most countries experiencing protracted displacement sit somewhere along a continuum from a fully parallel health response to a fully integrated one. The four country sites that were the focus of this study each offer up a different blend of humanitarian and national health service delivery. This enabled a contextualized and nuanced analysis, guided by health systems strengthening frameworks, of the benefits and challenges of integration. The chapter begins with an exploration of two elements that shape any discussion of integration in healthcare: the role of policy and legal status, and the role of the private and informal health sectors.

2.1.1 The role of policies on legal status and encampment

National policies regarding the geographic and socioeconomic integration of displaced and host communities significantly impact health system response and adaptation to protracted crises. When displaced communities are physically distinct from host communities, such as in camps, parallel services set up during the initial response may be more likely to become long-term service delivery points for their needs. *De facto* separation of displaced populations into parallel systems may shape differences in health service access, quality of

care, and health outcomes relative to host populations, particularly in light of the impact that disparities in living conditions and other social and environmental determinants of health have on health needs. For example, governmental restrictions in movement outside the camps in Bangladesh lead Rohingya to rely primarily on NGO- and INGO-run healthcare facilities and/or informal healthcare sources within the camp complex, while access to advanced care at secondary or tertiary facilities is legally and logistically limited to those with referrals, approval, and resources to travel. This limitation is exacerbated by overcrowding in the camp, created by legal restrictions of movement, which can increase disease burden. Similarly in Jordan, Syrians living in refugee camps generally receive free healthcare within the camps and rely on referrals outside of camps for tertiary care, while Syrians in non-camp settings primarily pay out-of-pocket at the uninsured Jordanian rate to attend Jordanian health facilities or seek out NGOs and private clinics that may provide lower costs or shorter wait times. Notably in the DRC, most of those internally displaced were not registered with the government due to limited opportunities to register, fears regarding fees associated with registration, and lack of incentives for registration (see the DRC country report).

Legal status also plays a significant role in the ability of displaced populations to access the national health system. In Colombia, registered Venezuelans can enroll in the health insurance system and thereby access the national healthcare system, while unregistered Venezuelans maintain access only to emergency services. Despite substantial efforts from the government to register Venezuelans, bureaucratic hurdles and processing requirements – such as a valid identification document and proof of presence in the country on the date of the 2021 resolution expanding access to regularized status – remain barriers. Public hospitals have taken on the majority of migrant health needs, creating challenges related to patient congestion and health facility financing. However, due to long wait times and complexities within the national system, some Venezuelans prefer to utilize NGOs' HAUs, which do not require documentation and are seen as faster and more agile. HAUs are largely well-received by migrants and provide comprehensive care. They are particularly present in areas along the migratory route and near the border and have the capacity to provide for basic health needs.

> ***"For migrants the biggest barrier is if they did not enter the country legally. People who enter the country legally find it relatively easy to obtain their special permit. But there are many who***

entered illegally, so they do not have their passport stamped, some do not even have a passport, which is what happened with some patients, they do not have their identity document, so that is the biggest barrier for them to be enrolled".
KIRSO Bogotá

"When you go to the health service, you have to wait three, four to five hours for them to come out and they tell you: 'we can't attend you because you don't have a Permit of Permanence (PEP), you don't have a record'".
Venezuelan Migrant living in Maicao, Colombia

2.1.2 Informal and private health sectors

Informal and private health sectors also play a key role in ensuring health system access for both host and displaced communities. Interest in seeking out informal or private healthcare may be driven by factors such as inaccessibility, unaffordability, or unacceptability of the care provided by formal health systems, or they may be perceived by users as a more appropriate first step in addressing a given health need. The specific combination of factors shaping decisions to seek care in the informal and private sectors varied by context. In Bangladesh, the informal sector is the primary source of care for Bangladeshis in rural areas. Displaced Rohingya also often utilize the informal sector – via pharmacies or traditional healers – despite the additional cost. This is due to acceptability concerns, such as language, with respect to formal care provided at NGO- and INGO-run facilities. Avoiding long waiting times was an additional reason provided by Rohingya FGD participants, in common with urban Jordanian and Syrian FGD participants in Jordan who reported seeking private care despite the higher cost. In contrast, a 2019 needs assessment in Jordan found that Syrian refugees seek care at pharmacies due to high costs of seeking clinical consultations and anticipated stockouts of medications in the public sector (Al Rousan et al. 2018). Similarly, in the DRC, high costs of formal healthcare services are a motivating factor to seek out informal sectors, including informal pharmacies and traditional medicine. This is further nuanced by the ability in the DRC for patients to utilize more flexible forms of payment (i.e. payment schedules, in-kind payments) for informal services that would not be available from the formal health system.

2.2 Evaluation of health systems and challenges

As noted above, each country studied in the *Big Questions* project presents a different mix of parallel and integrated health service delivery. This section explores the strengths and weaknesses of the different approaches adopted, focusing on the provision and equitable reception of health services among both displaced and host populations.
Our analysis takes as its starting point the Availability, Accessibility, Acceptability, and Quality (AAAQ) rights-based framework (WHO 2021b; Homer et al. 2018), drawing on adaptations and extensions of the framework to address additional challenges, such as approachability and appropriateness (Levesque, Harris, and Russell 2013), as necessary. A summary of key health systems issues in each of the country studies is presented in Table 4.

Table 4: Summary of key health systems issues by country

Bangladesh Primary Displaced Population(s): • Rohingya Refugees (925,380) *Source: UNHCR, April 2022* Doctors, nurses and midwifery personnel per 10,000 population (WHO)[12]: 11.56	**Summary:** Displaced persons (Rohingya refugees) access primary health services provided by NGOs and INGOs within the camp complex; other services (emergency, secondary, tertiary) require a referral to government health facilities outside the camp. Officially, many health services are free to users, but often incur costs (i.e. missed work). Funding is provided mainly through international donors. **Key themes:** Camp management, referrals between camp- and non-camp services, quality of care, differences in language between host and displaced populations

12 Calculated using WHO Global Health Workforce statistics database (2018-2020) (sum of Medical Doctors per 10,000 and Nurses and Midwifery Personnel per 10,000) https://www.who.int/data/gho/data/themes/topics/health-workforce

Colombia Primary Displaced Population(s): • Displaced Venezuelans (2,029,758) *Source: Migración Colombia, March 2022* • IDPs[13] (5,235,000) *Source: IDMC, December 2021* Doctors, nurses and midwifery personnel per 10,000 population (WHO)[11]: 37.83	**Summary:** Most IDPs (93 percent), like other Colombians, are enrolled in the national health insurance system and can access the full range of health services (emergency, primary, secondary, tertiary) at public health care facilities. A 2021 presidential order allows Venezuelans to register for temporary residence/Temporary Protection Status (TPS), making them eligible to enroll in health insurance. As of 2022, 35 percent of Venezuelans in Colombia were enrolled in the national insurance system. The insurance system is funded through direct taxes on labor, national and regional budgets, and independent funding mechanisms. All people, regardless of insurance or immigration status, can access emergency health services at public facilities at preventive health services included in PIC (Complementary Collective Interventions). **Key themes:** Scale-up of social insurance system, comparing experiences of IDPs and displaced Venezuelans in the health system
The DRC Primary Displaced Population(s): • IDPs (5,540,000) *Source: IDMC, End of 2021* • Registered and unregistered asylum seekers and refugees[14] (Registered refugees: 518,836) *Source: UNHCR, April 2022* Doctors, nurses and midwifery personnel per 10,000 population (WHO)[11]: 14.85	**Summary:** Access to the national health system is the same for IDPs and the host population, with the greatest barrier among both groups being cost. The government attempts to cover costs, but frequent payment delays and stockouts lead to *de facto* user fees. In some areas, free services are available from NGOs, INGOs and religious organizations, which are funded primarily through donors. **Key themes:** Disconnect between government policies to cover costs and high patient fees, poor public finance management, fragility of public institutions and state infrastructure

13 This study has found that experiences in the health system (in terms of access, quality and funding) are not significantly different across IDPs and the host population but are significantly different for displaced Venezuelans. As such, the Colombia country study has a proportionally heavier emphasis on understanding health systems and financing challenges among displaced Venezuelans. IDIs were conducted with both groups (IDPs and Venezuelans).

14 Given the large number of IDPs in the DRC, this group is the primary focus of in this report unless otherwise noted. FGDs were *not* conducted with internationally displaced individuals (refugees).

Jordan

Primary Displaced Population(s):

- Registered and unregistered refugees and asylum seekers [15] primarily Syrians (registered: 674,458), Iraqis, and Palestinians
  Source: UNHCR, April 2022

Doctors, nurses and midwifery personnel per 10,000 population (WHO)[11]: 60.08

Summary: Among Syrian refugees, access to health services differs depending on registration with UNHCR and residence in camp or non-camp settings. Refugees residing in camps have access to free UNHCR-coordinated services in the camps and referrals to additional services outside the camps. Refugees residing outside the camps also have access to free UNHCR services, but coverage is more limited. Fees for Syrians seeking health services at public healthcare facilities vary by registration status, with registered refugees paying a lower rate, equivalent to that of uninsured Jordanians. Funding is provided to the MoH through a multi-donor account, though policies have fluctuated in recent years (see section 2.3.1).

Key themes: Urban refugees, comparing camp and non-camp settings, limited referral services, fragmentation of refugee service delivery, pooled funding mechanisms

2.2.1 Availability

Availability of health services describes the extent to which providers and facilities have the necessary resources – including adequate staff, physical space, and necessary medications and supplies – to provide services (IFHHRO n.d.).

Human resource limitations and frequent medication stockouts were found across all four sites. None of the countries met World Bank provider per population indicators (see Chapter 3). In Bangladesh, despite standard operating procedures specifying that non-communicable disease medications are provided in monthly courses, frequent medication stockouts at facilities in the camp complex contributed to the provision of medications in limited quantities, necessitating frequent, sometimes costly, repeat visits, especially among people with chronic disease. While in-camp health services were free, repeat visits incurred direct non-medical costs (transportation) and indirect costs (missed work and distributions of essential goods). Although the ambulance service for official referrals was free of charge, refugees were sometimes unaware of it and paid out-of-pocket for transportation to seek care in hospitals (see Bangladesh country report, section 5.2.4). In the DRC, stockouts were often associated with increased cost, even if services were free to users, as patients were required to provide their own medication and medical supplies. Furthermore, availability of care differed by time of day; in Bangladesh,

15 Jordan has a robust history of welcoming internationally displaced individuals and continues to host refugees from many different countries. Given the comparative size and recency of migration, this report will primarily focus on the experiences of Syrian refugees in Jordan unless otherwise noted. FGDs were conducted with Syrian refugees, but *not* with non-Syrian refugees.

health facilities in the camps close overnight, limiting access to emergency care to those who can obtain transportation and permission to seek treatment outside the camp.

At a macro level, there are limitations in specific types of care (i.e. chronic disease management) and levels of care (i.e. tertiary care), which will be revisited in more depth later in this chapter. In particular, sustainable treatment of chronic diseases remains a challenge across the four country sites. Provision of daily medication, particularly for non-communicable diseases, is limited by stockouts; the experience in Bangladesh is noted above (see Bangladesh country report, section 2.1.3). In Colombia, Venezuelans who are not yet affiliated with the insurance system cannot access non-emergency care to manage chronic conditions. Similarly, across all sites, mental health services are limited, particularly due to lack of appropriate staff (mental health specialists, e.g. psychiatrists and psychologists). Although efforts to engage in task shifting and peer support are present, they do not necessarily correspond to sufficient availability of services. In Jordan, for example, mental healthcare is theoretically available for UNHCR-registered refugees; however, the FGDs showed that availability of mental health services remains limited for both host and displaced populations.

2.2.2 Accessibility

Accessibility has four overlapping dimensions: nondiscrimination of access, physical accessibility, economic accessibility (affordability), and information accessibility, each explored in this secton (IFHHRO n.d.). Of these**, affordability served as the greatest and most frequent barrier to access for both host and displaced populations in the majority of our sites**, with displaced communities frequently facing especially steep cost barriers to care. As noted above, cost includes not just direct payments for health services, health insurance, medications, and medical supplies, but also direct non-medical costs, such as transportation and childcare costs, as well as indirect costs, such as missed work. The ability to meet these costs further links to social determinants of health, such as livelihood opportunities, gender dynamics around financial decision-making, and, in countries affected by international displacement, the legal right to work, which is discussed further in sections 3.2.1 and 6.5.

Affordability barriers were most prominent in the DRC, where inability to pay for services combined with fear of punishment for failing to pay created such a significant barrier that the system's other limitations – including limited human resources, limited medication, and lack of basic amenities such as clean water and electricity in facilities – were rarely raised in comparison. In Bangladesh, direct non-medical cost (transportation) and indirect costs (lost wages, missed distributions

of provisions) drove affordability barriers, as noted above. Direct and indirect costs were also reported as the main obstacle hindering Jordanians and Syrians from receiving healthcare, particularly for the 82.7 percent of Syrians living outside of refugee camps who must pay similar prices to uninsured Jordanians at public hospitals (see Jordan country report, Chapter 6). Finally, in Colombia, the government's approach is largely equitable on paper, given that the Temporary Protection Status (TPS) provided to Venezuelans by the 2021 presidential order includes access to the national health insurance system. However, logistical barriers, such as lack of proper paperwork, continue to hamper regularization through TPS and, by extension, affiliation with the health insurance system and access to care other than emergency care. TPS provides ten years of protection for recently displaced individuals and will cover those who arrive by legal channels over the next two years, as well. Uncertainty remains regarding what will occur if and when these benefits are allowed to expire (UNHCR 2021d; GIFMM 2021; Treisman 2021). Costing barriers and potential solutions are discussed further in Chapters 5 and 6.

Nondiscrimination of access focuses on the ability of vulnerable groups to equitably access the health system. (IFHHRO n.d.). Within the four case study countries, the impact of legal status on access, or lack thereof, was widespread. In Colombia, public health service providers must initially cover the cost to serve individuals without health insurance and apply for reimbursement from the state. This generates a notable, highly localized burden for facilities that attend to large numbers of uninsured Venezuelans and may lead to refusal to treat Venezuelans despite legal requirements to provide emergency care to all. The 2021 TPS decree, along with a mandate from the Ministry of Health and Social Protection (MoH) that emergency care be made accessible, and triage is not used as a method for blocking access, are helping to address these challenges. However, progress has been slowed by bottlenecks in administrative capacity, compounded by the fact that regularization is processed at the individual level rather than by family or household. In Bangladesh, as noted above, the government policy on encampment limits refugee access to specialized facilities outside the camps and creates delays in specialized and, in some cases, emergency treatment. In Jordan, the 82.7 percent of Syrian refugees who reside outside of camps are required to present their UNHCR card to be eligible for public health services at uninsured Jordanian rates, per the latest policy change in 2019. However, with approximately half of Syrians in Jordan remaining unregistered, this serves as a significant barrier to access (ACAPS 2021).

"When I was already here in Colombia, it was difficult for me to go to the doctor, to go to have some tests done, some exams, I couldn't do it because I didn't have IPS (Instituciones Prestadoras de Servicios de Salud – Institutional Health Service Providers) but nowadays I do, I really feel good because I go to my IPS and they take care of me in the best way possible, I have no complaints about that IPS... my concern is that my son doesn't have an IPS and my mother doesn't have insurance." – Displaced Venezuelan living in Cucuta, Colombia.

Physical access addresses maldistribution of services, poor integration of referral systems, and inability of patients to safely access facilities (Homer et al. 2018). In Bangladesh, focus groups reported facilities were often not wheelchair accessible, and rough terrain made accessing facilities challenging for elderly persons. While accessing healthcare via referrals often required additional processing by the government for legal permissions to leave the camp. In both Bangladesh and the DRC, long distances to health services, particularly higher-level facilities for referrals and emergencies, limited access; this was especially relevant for women and children who may face increased concerns for their safety while travelling to and from health facilities. Community-based services, such as CHWs in Bangladesh, and municipal programs to address the social determinants of health, including education and access to preventive medicine, in Colombia, provide examples of how to address challenges related to physical access through community outreach outside of health facilities.

2.2.3 Approachability

Approachability addresses an additional dimension of healthcare access: that of transparency, outreach, and health information (IFHHRO n.d.). In Colombia, accessing the host healthcare system requires securing legal status, followed by health insurance registration – a series of lengthy bureaucratic procedures – which were frequently cited by FGD participants as a barrier to accessing and affording care. Creating incentives for NGOs and public hospitals to link emergency aid services to enrollment in the health insurance system could help improve approachability and increase Venezuelans' enrollment in the national health insurance system (see Box 2). In Jordan, frequent policy changes

around payment and disjointed service provision have left many refugees unaware of the services and subsidies for which they are eligible (Shteiwi 2014; IRC 2019). Lack of awareness of the different services offered decreases the likelihood that refugees will seek care, a point directly raised in KIIs and FGDs (see Jordan Report, section 1.2.2).

2.2.4 Acceptability

Acceptability requires us to look at whether care is respectful and ethically and culturally appropriate, encompassing matters of language, cultural considerations, and social norms, as well as patient experience, such as waiting times and perceived discrimination (IFHHRO n.d.).

In the *Big Questions* country sites, host and displaced communities largely spoke a shared **language**, with the exception of Bangladesh. The Chittigonian dialect of Bangla and the Rohingya language are similar but distinct languages and, while some cross-communication is possible, Rohingya interviewees widely reported not being able to understand or express themselves properly when communicating with Bangladeshi healthcare workers (HCWs). Due to government regulation, most healthcare providers are Bangladeshi, and limitations to the legal right to work constrain the ability of facilities to hire Rohingya translators. Rohingya FGD participants in the camp complex also reported concerns regarding the lack of female healthcare providers at health posts, as well as the conditions women faced when waiting at health facilities, despite the presence of multiple midwifery training and outreach programs in the camps (UNFPA Bangladesh 2022).

> ***"And when we go to health posts, we can't explain our health issues adequately because we don't speak Bengali and the staff there don't understand our language."***
> Female Focus Group Discussion, Camp 4 Extension, Bangladesh

Displaced populations in need of health services also reported **discrimination** by health services staff, often due to assumptions about their ability to pay for services (Jordan, Colombia). In Jordan, access to medications for Syrians was seen to rely on the good favor of doctors, with focus group participants describing seeking out empathetic doctors or utilizing familial connections in order to obtain services.

Long waiting times were referenced in interviews in Bangladesh, Jordan, and Colombia. In Bangladesh, long waits were frequently described as problematic, particularly when accompanied by poor waiting conditions (no shade, nowhere to sit, crowding for women). In Jordan, long waits were a concern for both Syrians and Jordanians, leading patients to seek healthcare from costly private providers. In Colombia, long wait times and complex systems pushed some Venezuelans, even those who could access the full range of government health services, to utilize healthcare from NGOs. Attempts by Colombians and Venezuelans to circumvent long wait times may contribute to overuse of emergency services, overburdening emergency care providers, and further diminish access to health services among unregularized Venezuelans, who can only freely access the health system through emergency services. Despite evidence that long waiting times were also present in the DRC, the FGD and KII participants did not elaborate on this challenge, instead focusing on the barrier of cost as the predominant concern (Mulinganya et al. 2018).

> ***"For example, one needs an emergency operation within two days, they book him an appointment after six to seven months. There was a patient who has been assigned an appointment in two months... He died after a week of seeking care... There are many other similar cases."***
> Male Host Community Focus Group Discussion, Jordan

Finally, **expectations around care** may impact its perceived quality and acceptability. In Bangladesh, being given medications was seen by FGD participants, who were Rohingya refugees residing in the camp complex, as an indicator of quality care, regardless of the condition and the efficacy of medication to address it. Concerns raised by FGD participants in Bangladesh fell into five main categories: medication availability, appropriateness, perception of ineffective medications, equity of medication access, and cost of medications. Not receiving medications, or receiving paracetamol only, drove dissatisfaction with care at particular facilities and led patients to seek informal care or seek medication via private pharmacies, often at a higher cost. While some interviewees blamed the lack of medication on stigma or facility stockouts, others referenced the lack of clear communication between patients and HCWs. Increasing patient understanding through clear provider-patient communication (via translators, longer time spent with

patients, etc.), clearly posting clinical protocols and health education to address concerns and misconceptions related to healthcare may address this challenge.

2.2.5 Quality

High quality care involves scientifically and medically appropriate approaches to care, complete with the necessary staff training (discussed in Chapter 3), supplies, and space for care provision. While the methods for this study cannot assess the quality of care directly, it is possible to infer structural quality from the availability of essential supplies, medications, and equipment as to the capacity of facilities to meet the requirements for trained HCWs to provide care.

Lack of basic instruments and amenities – such as clean water, electricity, and waste disposal – were marked in lower-level facilities in Bangladesh and across interviewed facilities in the DRC. In Colombia, many health facilities lacked diagnostic and treatment capacity for malaria, measles, tuberculosis (TB), and diabetes. However, in this case, lack of diagnostic capacity was likely a reflection of the organization of the health system and HFA methodology, as the sampling approach utilized did not target facilities specializing in infectious disease diagnosis and management. Similarly in Jordan, most facilities had basic amenities but lacked basic equipment and supplies and diagnostic capacity, though some limitations were reflective of the tiered organization of the health system and the HFA methodology (i.e., centralization of TB testing and diagnosis).

Availability of essential medications also serves as an indicator of quality care. Bangladesh has a pharmaceutical sector that is well developed and self-sufficient, but challenges remain regarding the unreliable quality of medication and frequent stockouts in government-supported facilities, which may drive patient dissatisfaction with services at public facilities. In Jordan, the provision of essential medications varied widely across facilities. In the DRC, questions targeting essential medications were not included in the HFAs, but some KII participants referenced frequent medication stockouts.

2.3 Transitioning to integrated health systems

Some key learnings that emerged from our analysis of the experiences of the four countries in the *Big Questions* project are discussed below.

2.2.1 Linking decisions about integration to context

Efforts to integrate health services provided by humanitarian organizations with national health systems should account for political context, available funding, and the potential for improved health outcomes and equity among both host and displaced populations. Where it is feasible to implement, integrating humanitarian and national health systems from the beginning of a humanitarian response may support systems strengthening, sustainability, and accountability (Pal et al. 2019; International Rescue Committee 2021). When displacement crises become protracted, there is a particular need for long-term responses that reflect sustained collaboration among humanitarian, development and government actors to improve the well-being of host and refugee populations and avoid unintentionally weakening national health systems through repeated, short-term projects and funding cycles (P. B. Spiegel 2017). While attention should be paid to integration from the start of any crisis – as opposed to the creation and transition of parallel systems – it is important to acknowledge that in certain situations integration may not be advisable, for example if the government is party to the conflict or if government engagement otherwise threatens the well-being of displaced or host populations (Norwegian Refugee Council 2021).

The level and type of integration between governments and humanitarian organizations will vary according to political context and available funding. In settings where political decisions about legal status prevent displaced populations from accessing public services, humanitarian organizations may provide the only health services readily available to displaced persons. Access may vary by type of health service, as illustrated by the provision of emergency health services to unregistered displaced Venezuelans in Colombia, and over time, as illustrated by shifting co-payment requirements for Syrian refugees accessing MoH services in Jordan. The Jordan case study also illustrates how insufficient funding can undermine the integrated delivery of health services. The initial health systems response was relatively integrated, with registered Syrian refugees accessing public primary healthcare and hospitals free of charge in 2013-2014 (Karasapan 2022). However, the response became more fragmented as accumulating costs overwhelmed the national health system. From 2014 onward, national policies shifted repeatedly between requiring Syrians to pay the same rate as non-insured Jordanians (approximately 20 percent co-pay,

2014-2018, 2019-present) and the substantially higher foreigners' rate (approximately 80 percent co-pay, 2018-2019) (see Jordan country report, section 1.5). Concurrent with the shift in policy increasing co-pays from 20 percent to 80 percent, the percentage of refugees who reported seeking healthcare when needed dropped from 91 percent in 2016 to 45 percent in 2018 (see Jordan country report, Table 5). This figure then increased to 84 percent in 2021 after policy shifted back to 20 percent co-pay (the same co-pay as uninsured Jordanians), a change that was facilitated in part by the establishment of a multi-donor account to support the MoH in providing healthcare to refugees and vulnerable Jordanians in host communities.[16] Additionally, to help meet the costs of co-pays, UNHCR developed cash transfers for health, reimbursing patients for care received at the MoH facilities (UNHCR Jordan 2020). The need for greater integration and coordination of health systems financing and possible solutions are discussed in more detail in Chapter 6.

In addition to funding, state fragility has been proposed as a moderator of health systems integration, according to levels of security and government resources available to respond to displacement. These factors were perhaps most apparent in the DRC, where KII respondents described weak state infrastructure and corruption that led to delays in payments to HCWs and deliveries of supplies to health facilities. Ongoing insecurity constrained physical access to health facilities, was associated with attacks on health facilities and workers, and limited data collection and reporting. However, despite such challenges, health systems strengthening interventions have proven effective in fragile settings and can be implemented as part of the humanitarian response (Pal et al. 2019; Newbrander, Waldman, and Shepherd-Banigan 2011; Valadez et al. 2020; WHO 2021c). Donors and humanitarian organizations' roles in integrated responses might include sustained funding, preparedness and contingency planning, systems strengthening, technical assistance, protection monitoring, and advocacy, each tailored to the host country's existing capacity for health systems and public administration.

In settings where parallel systems of health service delivery exist, whether during the acute emergency response or later development phase, integration into national systems can be facilitated by (1) identifying and leveraging existing national strategies or policies; (2) planning for how the government should be involved (and at

16 In July 2020, the Government of Jordan expanded this benefit to refugees from other nationalities registered with UNHCR (UNHCR Jordan 2020).

what level); and (3) developing strategies to sustain cooperation or complete hand over (Patel et al. 2011). The lack of such planning is evident in an example from the DRC where an NGO project that funded free health services at a public facility closed, leaving the facility to assume responsibility for programming. While trained staff remained, services could no longer be offered for free to users, creating an affordability barrier that ultimately led to an 80 percent decrease in clinic attendance.

In Jordan, the scale-down of NGO programming for NCDs also illustrates how lack of integration can contribute to gaps in the health system response in protracted settings. As funding waned, NGOs closed clinical programs, sometimes abruptly ending care with the presumption that public facilities or other humanitarian actors could take on their NCD cohorts (International Rescue Committee 2021). To avoid this situation, the International Rescue Committee (IRC) incrementally closed clinics and transitioned clients to publicly run centers, where IRC provides support through capacity-building and training, medical supplies and equipment, and infrastructure rehabilitation and maintenance.

2.4 Coordination between humanitarian, government, and development actors

Humanitarian coordination frameworks can play a critical role in facilitating the integration of health services for refugees, displaced and host communities. Of the four countries studied, Bangladesh had the most active health sector that, as of 2022, involved 98 health sector partners, including local and international NGOs, governmental agencies, and U.N. agencies (Health Cluster 2022, 18). In Jordan, UNHCR co-leads the coordination and management in the Zaatari and Azraq refugee camps, in close coordination with the government. Neither the health cluster nor the health sector are formally active, but the inter-sectoral coordination group maintains open communication in monthly coordination meetings and sector and sub-sector working groups, including groups focused on health. The DRC and Colombia fell in the middle, with active cluster systems present but a less centralized approach than the health sector in Bangladesh.

While coordination between governments and international agencies has typically been overlooked by the cluster and sector systems, which focus on coordination among international agencies (Clarke and Campbell 2018), Bangladesh and Colombia present distinct models for national involvement. In Colombia, an interagency roundtable for the response to displaced Venezuelans is co-led by IOM and UNHCR, with

sectoral clusters engaging international humanitarian organizations. Personnel from international organizations are most involved in administrative and coordination tasks, while Colombian professionals are mainly dedicated to the provision of services. Local governments work with these organizations to facilitate access to services, and KII participants expressed an interest in including additional actors, such as insurance companies and registration offices. In Bangladesh, the level of coordination within the government was flipped; rather than linking with local governments to provide services, the health sector links with the national government, which takes an oversight and leadership role in the camps. In Colombia there is broad engagement of both central and local government in humanitarian coordination at all levels of the response, from planning to service provision. In contrast, Bangladesh's top-down model of government engagement in coordination signals the desire to keep the humanitarian infrastructure and funding intact, avoid committing to a long-term Rohingya refugee presence, and maintain repatriation of Rohingya refugees as the only acceptable outcome (see Bangladesh country report, section 1.1.2). The lack of political will to accept the long-term nature of displacement creates a barrier to greater integration that is not uncommon among host governments (P. B. Spiegel 2017; Norwegian Refugee Council 2021).

Much of the recent innovation in humanitarian coordination relates to funding, including coordination between humanitarian organizations, donors, and host governments to establish pooled and multi-donor funds. These financing innovations are discussed in detail in Chapter 6.

CHAPTER 3:
HUMAN RESOURCES FOR THE HEALTH RESPONSE

3.1. Deployment of health workforce: linking availability, acceptability, and quality

The healthcare workforce is one of the six WHO health system building blocks and serves as the backbone of the health system. Ensuring an adequately trained and supported workforce enables the provision of high quality, accessible and acceptable care for both host and displaced populations (WHO 2006). In low- and middle-income and fragile contexts, a trained health workforce is a particularly scarce resource, which invariably is placed under pressure by the arrival of displaced populations needing additional, and sometimes quite specific, care. At the same time, displaced populations often include health workers that can help to meet these needs, while the inflow of international resources can enable opportunities for training and resource provision that might not otherwise have existed. This chapter explores some of the opportunities and challenges with respect to managing the health workforce in situations of protracted displacement. Throughout this chapter, HCWs will be used inclusively to refer to "all people engaged in actions whose primary intent is to enhance health," including doctors and nurses, ancillary staff, and CHWs (WHO 2006). Our analysis below of the healthcare workforce challenges draws on the AAAQ framework described in Chapter 2.

3.1.1 Workforce availability and accessibility

Health workforce availability and accessibility spans challenges related to the supply of HCWs with a particular reference to matching skills and competencies to the health needs of both host and displaced populations based on population size, geographic distribution, and health needs (WHO 2021b). All four countries in the *Big Questions* study faced limited availability of adequately trained HCWs to meet the health needs of both host and displaced populations, and the large population influxes associated with displacement have compounded pre-existing health workforce inadequacies.

Key issues relating to HCW availability and accessibility included high staff turnover (Bangladesh, Jordan), lack of staff trained to work in a humanitarian context (Bangladesh), long waiting times to access the health system (Colombia, Bangladesh), high numbers of "ghost workers" (the DRC), and lack of clinicians, particularly mental healthcare providers (e.g. psychiatrists and psychologists), relative to population size.

Healthcare specialists are largely centered in urban areas which are far from, or inaccessible to, some displaced populations, thereby limiting access to care unless strong referral pathways are present. Specialists hired specifically for serving displaced communities may be recruited via short-term contracts, increasing the cost and instability of care. In the DRC, the healthcare workforce was disproportionately absent in rural and eastern regions, due to the government's non-systematic process for managing the health sector's human resources in combination with the lack of interest in rural care among HCWs (Michaels-Strasser et al. 2021; Nathe 2016)ICAP at Columbia University (ICAP. In Colombia and Bangladesh, displacement has driven substantial increases in population in rural areas, taxing local health systems and requiring the humanitarian response to relocate health workers. In particular, specialized HCWs providing emergency, secondary, and tertiary care are limited in these circumstances.

It is important to note that human resource challenges outside healthcare may also impact access to care. In Colombia, workforce availability issues were most acute among non-clinical administrative staff tasked with registering and enrolling Venezuelans in the national health insurance system following regularization of their legal status under TPS. Processing the registration of some two million displaced Venezuelans has placed a massive administrative burden on local and municipal staff (Migración Colombia 2021). Without timely access to registration in TPS and subsequent enrollment in the health insurance system, uninsured Venezuelans face continued denial of non-emergency care and discrimination at public health facilities.

3.1.2 Workforce acceptability and perceived quality of care

The WHO defines health workforce acceptability as the "characteristics and ability (e.g. sex, language, culture, age, etc.) to treat all patients with dignity, create trust and promote demand for services" (WHO 2021b). **In settings of protracted displacement, the provision of healthcare services to displaced communities by host communities can create tension and raise concerns about language and cultural barriers, stigma and discrimination, both real and perceived.**

In Bangladesh, government policies limiting the ability of Rohingya to work likely contribute to acceptability issues, particularly around language. Notably, Bangladesh served as the only case study with significant language barriers between host and displaced communities. While FGDs with displaced Rohingya suggested a willingness to provide their own translator when seeking healthcare, this was often not allowed due to COVID-19 restrictions on the number of individuals allowed in facilities. Similarly, despite the robust midwifery programs in Bangladesh, camp based Rohingya refugees participating in FGDs raised concerns regarding the lack of female healthcare providers in camp facilities, underscoring the importance of gender as a facet of healthcare workforce strengthening. In Colombia, acceptability challenges largely centered on discriminatory treatment of Venezuelans by health facility staff based on their perceived inability to pay for services. Furthermore, measuring health facility performance against key performance indicators based on outcomes may increase incentives for facilities to deny care to high-risk populations such as recently displaced Venezuelan communities due to the higher likelihood of poor health outcomes for those patients. Rather, recommended measures to improve quality in Colombia include strengthening communities of practice, supporting more robust health service quality information systems, strengthening regulatory frameworks and accreditation of healthcare providers, developing an improved core curriculum to train health professionals, and using telemedicine to improve healthcare in rural areas (World Bank and International Finance Corporation 2019).

> ***"Another problem is that some hospitals have only male doctors, and our daughters cannot discuss their problems with male doctors."***
> Male Focus Group Discussion, Camp 20

In Jordan and the DRC, the themes of stigma and acceptability were less pronounced. In the DRC, this was likely due in part to similarities in service provision expectations between host and internally displaced communities, compounded by cost barriers that prevented community members from accessing care at all. However, mistrust of the health system was a major concern for both communities and may have served to influence the high rate of attacks on healthcare workers seen in recent years, suggesting a challenge to acceptability that was not fully brought to light in the study (Insecurity Insight 2020; WHO 2021a). In Jordan, themes relating to discrimination by HCWs were not as prominent as other barriers, namely long waiting times and high

costs, but were still referenced as reasons for delays or denial of care. In contrast to the findings from the FGDs with Syrian refugees, key informants reported no discrimination in treatment between Syrian refugees and Jordanian nationals and tended to focus more on the role of socioeconomic status as a determinant of health among both Syrians and Jordanians. Workforce availability and acceptability issues intersected to shape users' perceptions of the quality of health services. As described in Chapter 2, user perceptions of quality of care are an important factor in care provision and reception that is distinct from quality of care itself.

In some cases, dissatisfaction with service quality, including lack of available staff and poor treatment by HCWs, led people to seek care outside the usual or default health system. In Colombia, displaced Venezuelans commented on the quality and comprehensiveness of health services provided by humanitarian organizations along migration routes, contrasting their experiences of denial of care and discrimination by HCWs in the national health system. In Bangladesh, lack of staffing for health services in the camps at night led people to seek care from informal providers. Concerns regarding acceptability and quality, particularly around provision of medications, led some to bypass the formal health system and seek out treatment from traditional healers or pharmacy staff. Conversely, care that was seen as acceptable was reportedly sought out despite barriers such as distance and, in some cases, cost. In Jordan, both Syrians and Jordanians reported choosing different health facilities due to shortages of medication and lack of organization at public facilities.

3.1.3 Increasing quality of care through healthcare workforce training and supervision

Training and supervision of the health workforce is a primary method for ensuring high quality care by establishing adequate skills, competencies, knowledge, and behavior of HCWs according to professional norms (WHO 2021b). Inputs informing quality include HCW pre-service training, in-service training, sustainable supportive supervision, quality task shifting, and the necessary funding to support these strategies. Effective HCW training and supervision involves continued opportunities for learning over time and ensure that HCWs have not just the knowledge but the competencies necessary to perform their work. Notably, HCW training must also address matters related to the reception of care, including respect and appropriate communication strategies.

In Bangladesh, for example, a variety of human resource challenges were named, including high staff turnover, lack of standardized training protocols across organizations, and lack of training to work with refugee populations in national medical training programs. These challenges often necessitated frequent on-the-job training to address the gaps. However, early in the response, training was brief and lacked the follow-up, supervision, adaptation, and evaluation needed to improve the quality of the health workforce. While the government, INGOs, and NGOs did attempt to predict future staffing needs and begin early recruitment, these efforts were insufficient to address the resulting gaps in workforce quality due to the high staff turnover created by limited funding amounts and short timeframes of support.

Key issues emerged across all four countries studied related to the structure and reliability of financing models which often undermined the ability to invest in health workforce training and development over the medium and longer term. Planning for training and staffing needs was a challenge across contexts, though barriers arose at different levels and through different processes. Notably, fragmented and short-term (single year) funding impacted the ability for programs to plan for and address identified structural training and supervision challenges. In Jordan, for example, despite having a formal WHO Human Resources for Health Strategy in place, most international organizations rely on annual funding disbursed on a quarterly basis, limiting the ability for long-term planning and investments in the healthcare workforce.

Unpredictable funding served not just as a challenge for planning but for staff supervision and retention as well. In the DRC, delay to the disbursement of government funds to pay healthcare workers is a widespread and persistent challenge, increasing reliance on user fees and leading some clinicians to provide care out of their homes where supervision is limited.

Across the four country sites, reliance on informal and traditional HCWs was prevalent due to expectations around healthcare norms, acceptability, and cost of accessing the formal system. In Bangladesh for example, cultural expectations and fears around cesarean sections led some women to avoid health facility deliveries in exchange for home birth attendants. **Given the important role of informal and traditional HCWs in enabling access to care, incorporating them into the healthcare system in a more structured way** and providing additional training may grant an opportunity to support access to acceptable care, while also addressing the variable quality and reliability associated with informal actors.

Box 1: Case study of MHPSS workforce strengthening in Bangladesh

One key informant representing a U.N. agency in Bangladesh described a comprehensive mental health and psychosocial support (MHPSS) program that highlighted several good practices. The program, developed and implemented by a U.N. agency, was designed to include both community- and facility-based services and involved the training, deployment, management, and supervision of staff and volunteers (IOM 2020; 2021b; 2021a). While the positionality of the informant – a U.N. staff member reporting on a U.N. program – is vulnerable to bias, the multi-layered design and implementation of the program illustrates the application of the principles of community participation and inclusion as part of the humanitarian response.

Community-based activities included cultural events, community support groups, sport and play for children. These community-based interventions were designed in close partnership with community members to strengthen informal sources of support and promote engagement and utilization of facility-based services. In health facilities, more focused MHPSS services were provided including assessment, counselling and training, among other activities. They coordinated services with other health activities and multisectoral programming to create a continuum of services. The coordinated care approach necessitated a diverse health workforce including CHWs and volunteers, training non-MHPSS providers and specialists in basic principles of MHPSS and engaging psychiatrists and other mental health specialists (e.g. psychologists) to manage more complex cases.

Staff, volunteers, and members of the refugee and host community were engaged in capacity- building activities from the beginning of the emergency response. The organization worked with partners, including the government and NGOs, to train their staff and sensitize them to planned activities to promote consistency and standardization in MHPSS. They aimed to avoid the model of brief training with limited follow-up and supervision that characterized many capacity-building activities happening in the camps. Mental health specialists provided consultations in health facilities so non-specialist healthcare providers could observe how cases were managed. Specialists also provided supportive supervision to reinforce the skills covered in this training. The program collaborated with the Department of Clinical Psychology at a local university to adapt educational curricula to prepare students to work on MHPSS in humanitarian emergencies.

Community engagement was seen as a core element of the MHPSS response. Particularly for community health and MHPSS, the inclusion of refugees in the MHPSS workforce promoted trust, community connectedness, and the appropriateness and sustainability of services. The program emphasized the inclusion of refugees as partners across all phases of a program. Investing in the training of refugee volunteers is essential for promoting sustainability. In developing this MHPSS program, the organizations involved aimed to advocate for more permanent roles for refugees within the MHPSS workforce.

3.2 Engagement of displaced health workers

Engagement of the displaced health workforce is one potential, sustainable solution to the challenges of availability, accessibility, and acceptability described above. Across the four case study countries, engagement of the displaced health workforce varied. While inclusion of displaced HCWs was generally regarded as positive – a means of improving the availability, acceptability, and quality of health services – it was not always possible due to national policies related to work authorization and the verification or transfer of training, certifications, and licenses. The DRC was a notable exception; the engagement of displaced health workers was not raised in FGDs or KIIs. This could in part relate to the fact that most of the displaced come from some of the most rural and poor areas of the country, while work authorization and credential verification issues would not be a barrier in relation to IDPs.

3.2.1 The right to work

In Jordan and Bangladesh, national policies restricting the right to work are a key limiting factor in the engagement of healthcare workers. In Jordan, while Syrian refugees are allowed to work in certain sectors, healthcare is not one of them. In Bangladesh, the establishment of a standardized Rohingya volunteer program with daily wages has allowed for the limited engagement of displaced healthcare workers. However, pay was generally considered too low for programming to be sustainable. In contrast, in Colombia, registered Venezuelan migrants are legally authorized to work in any sector. However, barriers to licensing and the verification of credentials, including resistance from Colombian professional organizations, has served to limit the engagement of Venezuelan healthcare workers.

3.2.2 Task shifting to support availability and acceptability

Task shifting[17] may offer up opportunities to enhance the engagement of communities, including refugee and displaced communities, in healthcare provision (WHO 2019). In Bangladesh, task shifting of health services and education to non-physician personnel, including through the Rohingya volunteer program described above, has been a key feature of efforts to engage the displaced population and expand the reach of health services. This model was generally reported by FGD and KII participants as a good practice that addressed barriers related to language, respect, and understanding, while better linking Rohingya community members to health information and care at health facilities. While it was rarely referenced by participants in the other country studies, task shifting approaches have been successfully used in contexts around the world to build local capacity and deliver health interventions in settings with resource constraints and have been advocated as "best buy" interventions for these contexts (WHO 2017b; Joshi et al. 2017; UNHCR 2021a). Additionally, the UNHCR Global Public Health Strategy (2021-2025) endorses task shifting as a means of engaging displaced communities (UNHCR n.d.).

Task shifting strategies could help to address three of the major gaps in health services coverage identified across the four country sites, including access to treatment of chronic diseases, specialized services, and mental health care (see Chapter 1.2). In addition to building on the existing quality workforce in these areas and improving health access, training and providing supportive supervision for non-physician health workers has been tied to improved screening and treatment, including dispensing medical prescriptions according to guidelines, for a range of the most common NCDs, including asthma, cardiovascular disease, hypertension, and diabetes, in low- and middle-income countries (Joshi et al. 2017)diabetes, and associated chronic kidney disease. Self-management of chronic disease care has also been increasingly recommended due to its ability to overcome barriers to accessing care through formal settings and its recognition of the essential role of patient-provider relationships in achieving successful disease prevention and management (Joshi et al. 2017; Bodenheimer 2002) diabetes, and associated chronic kidney disease. One example that

17 Task shifting is defined by the WHO as "the rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health."

integrates task shifting and self-management is the MoPoTsyo model of care in Cambodia, which uses locally-adapted networks of trained peer educators, who have themselves been diagnosed with diabetes, to facilitate services and education for people living with diabetes and hypertension (Joshi et al. 2017; MoPoTsyo 2010). Patients also have access to a MoPoTsyo revolving drug fund, which dispenses medications through community pharmacies at below market retail prices. All peer educators are supervised under a manager, appointed by MoPoTsyo and the local health authority in the operational district, and peer educator performance and quality assurance are closely monitored (Joshi et al. 2017; MoPoTsyo 2010)diabetes, and associated chronic kidney disease.

Task shifting and community-based approaches have also been shown to be effective for expanding coverage of mental health services (see Box 1) (van Ginneken et al. 2013). In displacement-affected areas of Bangladesh, Tanzania, and Peru, a partnership between the Global Mental Health Lab (GMH Lab) at Columbia University and UNHCR has introduced a simplified version of interpersonal psychotherapy (IPT), the WHO-recommended first line treatment for depression, that can be delivered by supervised facilitators who may not have had previous training in mental health (WHO 2020b). Preliminary results show that patients with depression report feeling better and see improvements in their overall functioning in social environments. While mental healthcare providers have found these approaches useful and well-suited to the cultural and social strengths of refugee populations and the mental health challenges they face (UNHCR 2021a; WHO 2016). The UNHCR has developed an overview of scalable psychological interventions (requiring minimum investments in training), including the UNHCR-Columbia University initiative discussed above, that have been effective in various contexts, including with displaced populations (see Annex 1). Incorporating these services into minimum benefit packages would help improve the availability and utilization of such services.

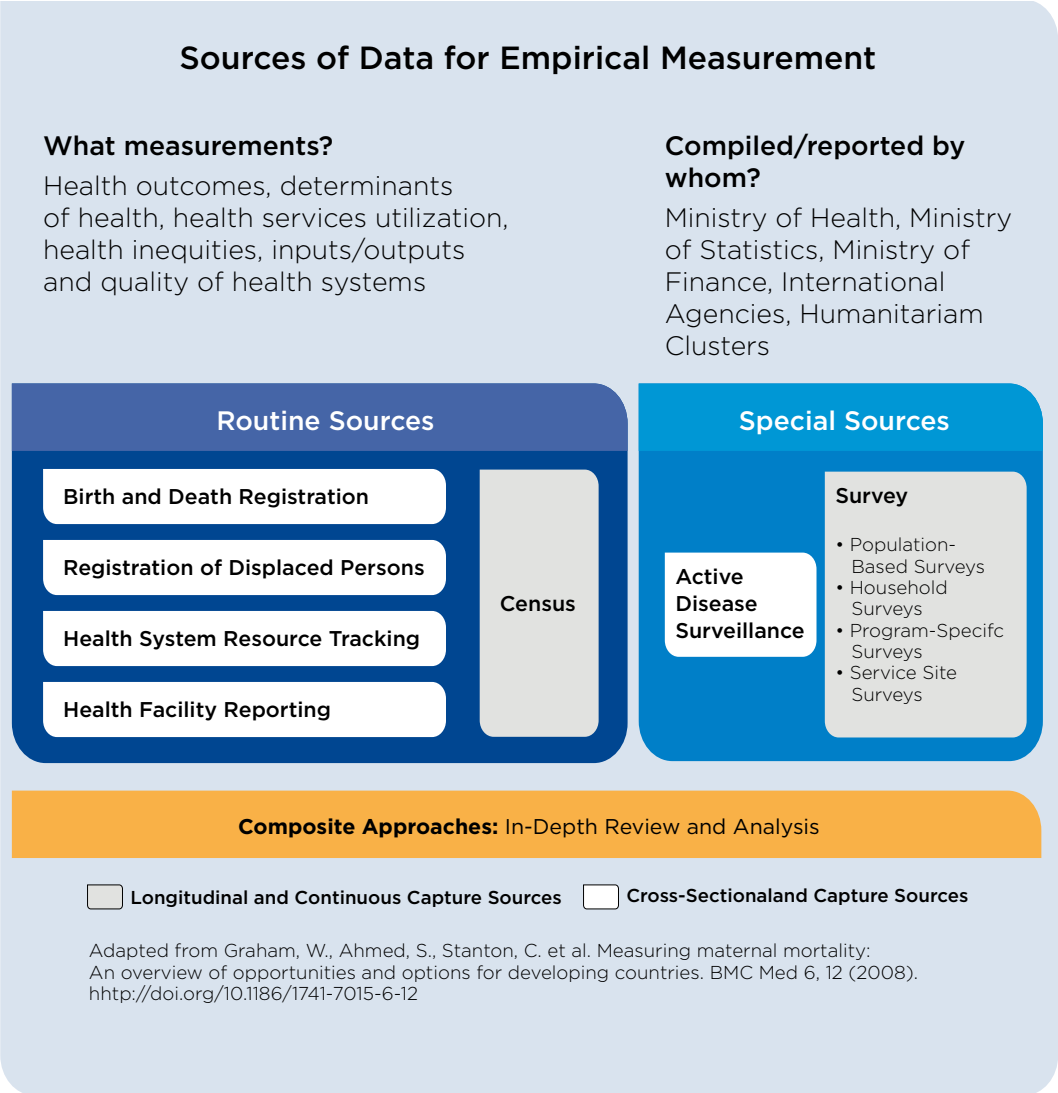
However, task shifting is not without drawbacks and must be implemented with care. Effective task shifting requires sustained supportive supervision, appropriate links to different levels of care, and government accreditation for HCWs engaged in the task shifting programs (UNHCR n.d.; Janneck et al. 2009; Abujaber et al., n.d.). Reliance on task shifting to enable displaced healthcare workers to join the workforce in a role below their level of training can provide the semblance of engagement while sustaining ingrained disparities. Further research should be undertaken to assess whether such interventions would be cost-effective in each of the countries studied and on a national scale, including whether and how they should be incorporated into minimum benefits packages.

CHAPTER 4:
HEALTH INFORMATION SYSTEMS FOR THE HEALTH RESPONSE

Health information systems (HIS) serve as one of the six WHO health system building blocks, spanning all elements of health systems to provide a foundation for decision-making through data generation, compilation, analysis and synthesis, and communication and use (WHO 2010). HIS collect data from both health and relevant non-health sectors; synthesize and analyze data to ensure overall quality, relevance, and timeliness; and share data in a manner enabling data-based decision-making in service provision, financing, and policy (WHO 2010).

This chapter analyzes and synthesizes learnings across the four country contexts by considering multiple sources of information (surveys, birth and death registration, registration of displaced persons, census, health system resource tracking, health facility reporting, disease surveillance), each generating different types of data (health outcomes, determinants of health, health service utilization, inputs and outputs of health systems, health inequities) and developed by multiple institutions (health facilities, MoH, international agencies, etc.) (see Figure 2). Notably, as introduced in Chapter 1, demographic data and vital statistics – often collected outside the health system through sources such as registration records, censuses, and nationally representative surveys – are considered as a distinct but invaluable facet of HIS. More systematic and substantial links between demographic data and HIS, particularly epidemiologic data, are needed to effectively identify and plan for the health needs of host and displaced populations (see Chapter 1).

Figure 2: Sources of data for health information systems



Adapted from Graham, W., Ahmed, S., Stanton, C. et al. Measuring maternal mortality: An overview of opportunities and options for developing countries. BMC Med 6, 12 (2008). hhtp://doi.org/10.1186/1741-7015-6-12

4.1 Analysis of HIS across country sites

In our four country studies, the level of integration of the HIS generally reflects the level of integration of the health system as a whole.

4.1.1 Bangladesh

In Bangladesh, the HIS in the camps is primarily a parallel system maintained by humanitarian organizations and camp leadership. Within the camps, the Health Sector, co-led by the Government of Bangladesh (GoB) and WHO, conducts service mappings and health facility assessments regularly to monitor accessibility, utilization, quality, and other key indicators in order to inform how resources (facilities, health workers,

etc.) are allocated across the camps. Additionally, UNHCR conducts annual balanced score card (BSC) assessments on the quality of care in UNHCR-supported facilities in the camps. EWARS is used for disease surveillance, with 75 percent of health facilities reporting as of November 2019. CHWs support community-based surveillance, including through regular household visits. The Health Sector disseminates data via its website, which links to 4W and EWARS dashboards and a public repository of reports (Health Sector Cox's Bazar n.d.). Key informants were familiar with the dashboards but reported using internal agency data to make organizational decisions, in part because this data was timelier.

Limited demographic data on Rohingya refugees living in the camps is collected through the J-MSNA (ISCG), Family Counting Exercise (UNHCR, RRRC), and Needs and Population Monitoring Site Assessments (IOM). Beginning in June 2018, UNHCR has worked with the government of Bangladesh to provide identification cards to all refugees older than 12 years (UNHCR 2019). While registration cards are often required for Rohingya to participate in activities and receive provisions, this was not referenced as a barrier to services among interviewees, likely due to the widespread reach of the identification program.

For the host population, health data is collected by the Government of Bangladesh through Health Facility Surveys (SPA), a facility registry, and a workforce summary, published to a Directorates General of Health Services (DGHS) portal. Demographic and epidemiologic data is collected through DHS, MICS and the Bangladesh Bureau of Statistics Sample Vital Registration System. The most recent iterations of MICS and DHS do not sample from displaced Rohingya living in the camp complex, though they theoretically include displaced persons living outside the camps in the sampling frame.

4.1.2 Jordan

In Jordan, UNHCR works closely with the Health Sector to coordinate HIS for care delivered in the camps. HIS coordination outside the camps is fragmented, particularly between public and private sector health facilities. Inside camps, health facilities are required to report via weekly, electronic reports to UNHCR's health information system. Outside the camp, a similar mechanism is run by the MoH Health Directorate. Passive disease surveillance systems are active both inside and outside camp settings, and EWARS was utilized particularly at the start of the Syrian crisis.

Under the UNHCR-led Sixth Regional Response plan (RRP6), six topical working groups (strategy, NCDs, community health, nutrition, sexual and reproductive health (SRH), MHPSS) gather and disseminate

information that addresses the health needs of the Syrian and Jordanian populations. Lack of electronic health information systems, especially in primary care settings, poses a challenge in Jordan.

Demographic and epidemiologic data on Syrians and Jordanians is available through the DHS/Jordan Population and Family Health Survey, which disaggregates by nationality and camp and non-camp settings. The national census also collects demographic information disaggregated by nationality. Notably, biometrics (primarily iris scans) are heavily relied upon for service provision, including cash assistance distribution, access to food and non-food assistance, renewal of legal documents, and updating of personal records (i.e., marital status, birth of child etc.).

4.1.3 The DRC

In the DRC, health facilities report information as required, but access and utilization of health services is extremely low, leading to an insensitive surveillance system overall.

Clinics are required to provide data on the number of patients seen each month. Certain illnesses (including measles and cholera) trigger an immediate report. Data is aggregated in the national health information system (SNIS).

KIIs with staff at the seven facilities assessed for this study indicate monthly reporting is timely, widespread, and linked to decision-making in facilities. However, surveillance remains insensitive due to low service utilization. Of the four clinics and three hospitals interviewed, two hospitals collected service provision data that differentiated host and displaced populations (regardless of nationality). Source of payment (healthcare voucher and NGO partnership) was the reason given for making the distinction, underscoring the heavy reliance on external funding provided, most frequently, by temporary programs.

Demographic and epidemiologic data is limited for both host and displaced populations, particularly IDPs. No national census has been conducted since 1984. Data is available from DHS (2013-2014) but does not disaggregate by displacement status and under samples insecure areas.

4.1.4 Colombia

By far the most developed HIS system exists in Colombia, where the HIS is integrated with national social protection information systems and has been adapted to better capture the health needs of displaced persons. However, these information systems remain completely separate from

the information systems of the IOM- and UNHCR-led Interagency Group of Mixed Migratory Flows (GIFMM).

In 2007, the Social Protection Information System (SISPRO) was legally constituted to manage information for the entire social protection sector, including health (see Colombia country report, section 4.2). Additional systems for health information were incorporated in 2011 to align with the mandate of the newly independent MoH (previously housed under the Ministry of Social Protection). SISPRO receives and processes data produced by all government agencies involved in the social protection system. Health information comes from 38 databases, 35 population studies, and 39 observatories. Service provision data is based on a legal mandate for providers to report care provided via the RIPS, a registry of services provided to individuals. In response to concerns that RIPS was not accurately capturing information on care provided to migrants, the MoH issued technical guidance in 2017 mandating providers and health secretariats to report an additional individual registry for foreign persons. This data has been used to monitor the demand for and utilization of health services by displaced Venezuelans throughout Colombia, including integration into the strategic health plans developed by all local governments for 2020-2023, and for the creation of electronic dashboards of basic frequency indicators of enrollment to health insurance, service utilization, and health needs, which can be disaggregated by nationality, year, age, gender, and administrative area (Minsalud n.d.).

Under SISPRO, the National Epidemiological Surveillance System (SIVIGILA) monitors health events by condition (malaria, domestic violence, low birth weight, etc.) and nationality of the affected person. SISPRO and its components remain separate from the data systems managed by the 75-member GIFMM, which is co-led by IOM and UNHCR and includes U.N. agencies, NGOs, and the Red Cross Movement and contains more detailed individual information including migrant status. Concern about protecting the identity of users is one reason for this.

Demographic data is available through the 2018 national census. Demographic data for IDPs is available in the official registry of victims; given the relatively robust and comprehensive support that IDPs are legally entitled to, the majority of IDPs appear to be registered (Zulver 2018). Demographic data for displaced Venezuelans is available through the Official Venezuelan Migrant Registry (RAMV); the number of Venezuelans registered remains limited however, as discussed below, but the figure is increasing in response to the availability of TPS.

4.2 Data quality

Data quality can be analyzed by assessing its completeness, consistency, timeliness, and accuracy (WHO 2017a). Across the four country sites, the most pervasive quality concerns relate to completeness (the capacity of the HIS to capture all cases, or a representative sample, and all variables, including variables related to displacement and migration). Key issues included reliance on health service provision and utilization data to assess health needs when utilization by displaced persons is low; under-registration of displaced persons in official registries; weak systems for gathering data on displaced persons living outside official camp boundaries; weak systems for gathering data on service provision from private or informal providers; and limited collection and reporting of variables that allow for disaggregation by migration status. These issues are closely related and have implications for linking health information to decision-making in systems planning and service provision (see Chapter 1).

4.2.1 Impacts of over-reliance on service provision and utilization data

Displaced persons are, in the aggregate, less likely to access services due to various barriers to care (see Chapter 2). **Heavy reliance on service provision and utilization data therefore is likely to underrepresent the health needs of displaced communities and can perpetuate inadequate and inequitable provision of care.** In the DRC, despite accounts of timely reporting from health facilities, surveillance remains insensitive due to low service utilization fueled in large part by cost barriers. For example, Médecins Sans Frontières (MSF) estimates 20 times more measles deaths in 2019 and 2020 than were reported by the MoH. Given that pharmaceuticals are provided to government health facilities in the DRC based on previous usage rates, consistent undercounts of health needs due to underutilization of services can perpetuate and potentially exacerbate health system deficiencies. In Colombia, health service utilization data is well integrated into the national statistics system, but the data is not representative of the needs of displaced Venezuelans, given lack of access to affordable, non-emergency services among this group.

Colombia has worked to address the limitations of service utilization data through the provision of additional, targeted studies to manage blind spots (i.e., among HIV+ migrants). By bolstering routine data collection with additional cross-sectional collection of specialized data – such as population-based surveys, active surveillance, censuses, etc. – health information systems can create a robust and more comprehensive illustration of the health needs of the population (Graham et al. 2008).

4.2.2 Impacts of under-registration of displaced communities on data collection and data-based decision-making

Under-registration of displaced persons in official registries creates discrepancies in data and can contribute to low health service utilization among displaced persons, as well as poor disaggregation of data, limiting the capacity for targeted data-based decision-making. The benefits of strong formal registration systems can extend beyond health services to include work permissions, access to education, and access to other social services programs, but must be balanced with protection concerns (see Box 2). The Colombian HIS illustrates how linking registration to meaningful health and protection benefits can increase registration, improving the completeness of both registration data and health service utilization data. As of 2018, only approximately 27,000 Venezuelans were affiliated with the national health insurance system through the Permit of Permanence (PEP). Under PEP, Venezuelans could stay, work, and enroll in the health insurance system in Colombia for up to two years, with no path to permanent residency. In February 2021, TPS was announced to "regularize" the status of Venezuelans by providing a path to residency and, by extension, enrollment in the health insurance system. Registration has increased since TPS was announced; as of August 2021, 19 percent of the two million Venezuelans residing in Colombia had regularized and 64 percent were in process of regularizing their status. The number of Venezuelans affiliated with the national health insurance system rose as a result, but with a considerable lag; by 2022, the number of Venezuelans affiliated to the Colombian health insurance system reached 653,126, corresponding to approximately 40 percent of Venezuelans with regularized legal status and approximately a third of all Venezuelans residing in the country (Ministerio de Salud y Protección Social n.d.). Thus, in addition to increasing demand for registration among the displaced, Colombia's experience also highlights the need to invest in human resources and administrative capacity to minimize bottlenecks when registering large numbers of people and linking them to health and other services. Comparatively, health insurance coverage among IDPs in Colombia is nearly universal (93 percent in 2018), largely due to special policy mechanisms that have granted IDPs priority access to the country's social protection network (see Colombia country report, Introduction).

Box 2: Case study of Health Insurance Registration Program in Colombia

The SubRed Integrada de Servicios de Salud Sur Occidente (South-West Integrated Health Service Sub-Network - SWIHSS), an integrated network of public hospitals in the southwestern region of Bogotá, has developed programming to connect patients with irregular migration status to social workers who assist in health insurance enrollment. The network, which has served more than 500,000 displaced Venezuelans in an irregular situation in recent years, has developed an internal protocol to identify Venezuelans who are entitled to permanent residence in Colombia and support them in the process of formalizing their migration status and enrolling in health insurance.

After the last wave of social and economic displacement from Venezuela, the SWIHSS implemented a pilot program aimed at improving the uptake of care among pregnant Venezuelan women in Colombia. As part of this initiative, the network provided pregnant Venezuelan women with prenatal check-ups and medicines, regardless of their legal status, and connected patients with social workers to guide them through the regularization of their migration situation.

The local government facilitates this program through health resource financing support via Bogotá's special Health-Financing Fund (Fondo Financiero Distrital de Salud) (Castiblanco 2022). In the case of emergency care and hospitalization services, the SWIHSS receives reimbursement of services provided to uninsured individuals directly from this fund. This enables the hospitals to continue to make their services accessible to unregistered Venezuelans and, through the implementation of regularization support services, ultimately increases registration rates.

Jordan's experience also exemplifies the challenges of incomplete registration. According to the 2015 national census, a total of 1,265,514 Syrian nationals were residing in Jordan. As of April 2022, a total of 674,458 refugees were registered with the UNHCR office in Jordan (UNHCR n.d.). Unregistered refugees are largely unidentified – and not included – in formal health system data. Civil registration also poses a problem in Jordan. A substantial minority of Syrian children (16 percent of children aged 0-5, compared to 2 percent of Jordanian children) lack birth certificates due to complicated registration procedures and their parents missing official documentation of nationality and marriage (UNICEF 2018; World Bank n.d.). Under-registration also has implications

for the amount of financing available for health and other programs because donors typically cannot finance activities and groups they cannot verify. In a context where identity documents are missing and/or difficult to verify, biometric IDs (iris scans) have been used to efficiently register people with unique IDs for the distribution of cash assistance, but the use of biometric data is not without its own unique challenges (See Box 3).

Box 3: Protection concerns around data

Protection concerns arise from the potential for individual data on refugees and displaced persons to be accessed by states and applied for initiatives – such as counterterrorism, security, and migration restriction measures – that may undermine the rights of displaced persons and compromise their access to protection. New technologies, such as mobile phones and biometric identifiers (such as the use of iris scans in Jordan), can facilitate efficient service delivery, in part addressing the need for unique identifiers in settings where many people lack identity documents (Molnar 2022). However, these same innovations are vulnerable to state surveillance. While methods for protecting data, such as limitations to sharing data across organizations, can limit the ability to validate and consolidate data (as we have seen in Colombia), that may be a limitation that is worth accepting in order to enhance trust in, and use of, these systems. Additionally, data on variables that facilitate disaggregation by migration status should be collected and disseminated with care, with robust security and privacy protections in place, to avoid perpetuating discrimination and stigma against migrants (Global Migration Group 2017).

Fears over data misuse and privacy breaches are not only theoretical. A 2021 Human Rights Watch report alleged personal and biometric information from Rohingya refugees in Bangladesh, collected by UNHCR, was shared with the government of Myanmar for repatriation purposes without the individuals' free and informed consent (Human Rights Watch 2021; Rahman 2021). UNHCR has stated that the data was collected and shared with informed consent; however, the collection of the data was a preliminary step in obtaining the Smart Cards used to access food, aid, and other essential services, creating a power dynamic and potential barrier to receiving truly informed – and optional – consent.

The COVID-19 pandemic has further illustrated the far-reaching implications of data protection concerns, particularly the barriers tenuous legal status creates for accessing health services. Migrants

in an irregular situation may be unable or unwilling to access healthcare or provide information on their health status when they fear or risk detention, deportation and penalties as a result of their immigration status (OHCHR 2020). Expanded regularization is a potential solution to ensure that migrants can safely seek medical assistance, including testing, treatment, and vaccination for COVID-19. In March 2020, the Portuguese government issued a forward-looking regulation by which irregular migrants who had previously started the regularization procedure were temporarily regularized and thus allowed full access to all social benefits, including healthcare (Raposo and Violante 2021). Establishing firewalls when collecting data to ensure clear separation between data collected for the provision of essential services and immigration enforcement activities (Crépeau and Hastie 2015) is vital to establish migrants' trust and improve access to health services, including critical COVID-19 response services, without fear that data will be shared and used for immigration enforcement.

4.2.3 Data representativeness and integration across settings and health sectors

Information systems divided between national and humanitarian systems may limit comparability across groups while simultaneously providing greater capacity for understanding the health needs of displaced populations. However, even within these more targeted systems, mechanisms for capturing information on people living outside of formal camps or accessing services in private or informal settings are often limited. Additionally, these reporting systems may not incorporate the private sector, further skewing data as the demographics of individuals utilizing the private sector, as well as the health services individuals prefer to seek from the private sector, may differ substantially from the national or humanitarian systems.

In Bangladesh, the parallel nature of the humanitarian and national health systems is reflected in the health information systems. UNHCR, the Office of Refugee and Repatriation Commission (RRRC), and IOM collect demographic and health data about Rohingya refugees through the J-MSNA, Family County Exercise, and Needs and Population Monitoring within the camps, separate from the data collection managed by the national health system. However, all of these sources use the block system for sampling, thus excluding refugees living outside the camp. While the camp-specific data allows for targeted review and intervention, health services provided outside the camp – for example, referrals to higher-level national facilities – are systemically missed, leading to a potential skewing of data that may underreport

severe or complicated health needs. Similarly, in Colombia, patients in certain regions of the country are often referred to the private sector for specific specialties, opening the door to data loss because information from private subcontractors is not necessarily reported to the public system.

In Jordan, UNHCR coordinates HIS for care delivered in the camps, but information systems outside the camp are more fragmented, in part due to the large number of displaced persons accessing services from private providers.

4.3 The use of health information systems for data-based decision-making

The use of the health information system for data-based decision-making varies within and between countries, but can be broken into two broad categories: data use at health facilities and data use by government officials and international agencies (Malaria Policy Advisory Committee 2020).

4.3.1 Data use at health facilities

At health facilities, staff motivation and capacity to engage in and apply data from the HIS can support planning and management of care. The health facilities sampled in the DRC provide an interesting example. Perhaps in part due to pharmacy restocking schemes reliant on usage data, staff described proficiency and motivation to collect and use health facility data. It is also notable that, due to logistical challenges, interviewed facilities did not include peripheral providers where one would expect most illness cases to be managed. Respondents reported frequent use of charts and registers to guide programming and the use of condition-specific registers to track antenatal care, communicable diseases of concern, CHWs' home visits, and medication management. While a direct link to INGO programming has not been identified between the high rates of reporting within these facilities, INGOs have provided health information systems strengthening programs in South Kivu in recent years.

The Colombia case study illustrates how limited links between data systems can complicate decisions about the provision of care. In this case, delayed linkages between the database of enrollees in the health insurance system and the payment system used by providers can result in the denial of services to newly registered users (see Colombia country report, section 5.2). As illustrated by the Bogotá hospital example described above, health facility staff can contribute to strengthening the

links between data systems and improving services available for patients by linking them to TPS registration at the point of care. However, the need to guide patients through the TPS registration process creates a burden on health facility staff that should be recognized and addressed.

4.3.2 Data use by government officials and international agencies

Government officials and international agency staff can use HIS data to guide national health strategies, budgets, and human resources planning. One promising practice is emerging in Jordan, where MoH and WHO are rolling out a program to make data-driven decisions about staffing needs using WHO's Workload Indicators of Staffing Needs (WISN) tool. This tool has the potential to better strengthen data about the capacity of the health workforce and to link demographic and health information to human resources planning.

Officials and high-level agency staff also have influence over decisions about when, whether, and how to integrate and/or allow data sharing or transfer among national or regional information systems. In Bangladesh, data sharing is practiced through health sector mechanisms such as EWARS, but limited data availability in the public domain, particularly for disaggregated and raw data, remains an impediment to coordination between INGOs/NGOs and robust secondary analyses (see Bangladesh country report, section 1.2). In Colombia, the separation of social protection information (in SISPRO) and immigration information (in GIFMM) and lack of interoperability between the systems, while important for protection considerations, does limit cross-checking of information, and may ultimately contribute to duplication of service provision. It also prevents the incorporation of individual-level information on services provided by GIFMM members into the design and targeting of health and social protection services for Venezuelans. There is no process for evaluation on the quality and biases of administrative data, particularly in regions of Colombia where service provision and overall institutions are weaker. Despite these limitations, RIPS data from SISPRO has been used to monitor demand for and utilization of health services by Venezuelan migrants, including the incorporation of this data into the 2020-2023 strategic health plans developed by all local governments.

The decision to roll out technological adaptations to data collection and processing systems across all four countries has created space for greater use of data in guiding strategy and planning, while reducing the burden on staff and improving reporting. District Health Information Software 2 (DHIS2) is active in both Bangladesh and the DRC, and it recently began a pilot in Jordan (DHIS2 n.d.); Colombia utilizes a robust national system with similar capabilities. Utilizing international

systems such as the DHIS2 enables HIS interoperability within and across countries. The use of technology for data collection and analysis decreases staff burden and enables timely, automated validation and presentation of data via dashboards. However, technology does not serve as a stand-in to training, and data analysis remains a skill that requires investment and training. Developing human resources can serve as a bridge between data and action.

Box 4: Impacts of COVID-19 on HIS

COVID-19 has played an important role in driving surveillance capacity. During lockdowns and at the height of the pandemic, healthcare utilization for non-COVID-19 needs was widely diminished. In Jordan, FGD participants described both Syrians and Jordanians facing barriers to accessing routine healthcare during the pandemic. In Colombia, COVID-19 restrictions created long delays for accessing care, particularly from humanitarian organizations. In the DRC, fear of COVID-19 quarantines and mandatory vaccination led to people self-medicating and seeking care outside the formal healthcare system. As patients moved to seek care from informal sources, health information systems reliant on service provision and utilization data to identify health needs became less complete.

At the same time, renewed awareness of and investment in surveillance did occur. In Bangladesh, the COVID-19 pandemic has reinforced improvements in disease surveillance. Prior to COVID-19, UNHCR established a new community-based surveillance system that utilized community health workers to identify and refer cases of disease within communities. This surveillance system was instrumental in the enhanced COVID-19 and other disease surveillance efforts (e.g., detecting dengue outbreaks). One key informant noted that the increase in funding for health surveillance that happened as a result of COVID-19-related funding has accelerated improvements in disease surveillance that are likely to yield benefits beyond the immediate imperative of tracking COVID-19 (see Bangladesh country report, section 4.1).

CHAPTER 5: HEALTHCARE UTILIZATION AND COSTS

This chapter aims to underscore key patterns and insights on health service utilization and costs that emerged from this study's analysis of Colombia, Jordan, Bangladesh, and the DRC. For the purpose of this chapter, healthcare costs will be defined as those expenses incurred by households to pay providers for health services rendered (Xu et al. 2003). Further examination of financing healthcare services from payers to healthcare providers is included in Chapter 6.

5.1 High costs of care and patterns of health service utilization

Across the four countries analyzed, similar trends emerged on demand and availability of health services, with low utilization of publicly operated health services among displaced populations due to lack of availability of services, high costs of care, and real and/or perceived issues around quality of care (see Chapter 2 of this report).

Out-of-pocket medical and direct non-medical (e.g. transportation) costs associated with seeking medical care, particularly for the most vulnerable populations due to income and/or legal status, were raised as the largest barriers to accessibility of care in all four countries. Even in countries with contracted facilities that provide free care, lack of availability of care in these facilities is a major driver to seek care in private facilities, where patients incur out-of-pocket costs. While these barriers were consistently brought up in interviews in all four country studies, decreasing health utilization for host and displaced populations alike, these trends did not impact inpatient services to the same degree as ambulatory services. In Jordan, while the majority of ambulatory services occur in the private sector (68 percent), followed by the public sector and NGO clinics, more specialized and costly inpatient services predominantly occur in the public sector (69 percent) (Francis 2015). Similar trends were observed in Colombia over the COVID-19 pandemic, where smaller gaps between host and Venezuelan migrant

population were observed in hospitalizations compared with ambulatory services, suggesting more severely ill patients still sought care through public hospitals (Shepard et al. 2021). In contrast to the experiences of displaced Venezuelans, national policies to ensure IDPs access to the country's social protection network, such as the Victims and Land Restitution Law (Law 1448 of 2011) have achieved almost universal health insurance coverage (93 percent) for all victims of the armed conflict, including IDPs (see Colombia country report, Introduction).

While patients often expressed preferences for seeking care through the private sector due to perceptions on quality of care, it is important to note that these sectors are often unregulated and may frequently prove to be more costly than the public sector. For example, in Bangladesh, without mechanisms for health insurance or other means of social protection, 93 percent of costs incurred in the private sector are covered through out-of-pocket payments, paid for directly by the patient (Joarder, Chaudhury, and Mannan 2019)economic, and demographic parameters. This study explores the existing health policy environment and current activities to further the progress towards Universal Health Coverage (UHC. This high burden on patients to cover the costs of care has impoverishing effects for many households. In Bangladesh, it was found that approximately 55 percent of Rohingya households reported taking on financial debt to cover the costs of healthcare (ISCG 2020). In Jordan, while public sector and NGO fees are covered for refugees residing within camps, interviewees cited that long delays in receiving care through the public sector led some families to take out loans to cover care sought through the private sector. In extreme cases, such as for dialysis treatment, the unavailability of care through public or NGO facilities, and the high costs of care through private facilities has even led some Syrian refugees to return to Syria to receive treatment, where these services are delivered free-of-charge through the public system (Jordan country report, chapter 2.3). In Colombia, while migrants have access to free services through the formal care system, if they are not enrolled in an insurance scheme, they risk having to pay out-of-pocket for care and medication at either public or private facilities.

Direct non-medical costs, in the form of travel expenses for the patient or the patient's family to accompany them to services, accommodation, food, and indirect costs tied to the time it takes to seek services, were also raised across the four countries. In the DRC, for instance, only approximately 30 percent of the total population is estimated to live within 5km of the nearest health facility, resulting in patients having to travel long distances and incur greater travel costs to seek care (United Nations Office for Coordination of Humanitarian Affairs (OCHA) 2021; Severe Malaria Observatory n.d.). In Bangladesh, where referral to

specialized services outside of camp settings is the norm for refugee populations, patients often cited a costly referral cycle, whereby patients and their caregivers moved from one referral to another in order to receive adequate treatment, tests, and medications (Bangladesh country report, section 5.2.5).

High costs of services, as well as real and/or perceived poor quality of care have also been tied to patients choosing to seek care through sub-optimal informal providers (discussed further in Chapter 2). This practice was the most common in the DRC, where financial fears and distrust in the formal medical system drive many ill people away from clinical care and towards utilizing pharmacies or traditional healers as the first line of treatment (see DRC country report, Chapter 5). This is evident from the fact that those in the poorest economic quintile are more likely to utilize informal providers, compared to wealthier quintiles (Laokri, Soelaeman, and Hotchkiss 2018). In Bangladesh, a large percentage of the refugee population—21 percent—were also found to seek care primarily through the informal sector (pharmacies or traditional healers) (ISCG 2020), as these providers are seen as trusted sources of information in communities, and due to the lack of formal care settings in camps (see Bangladesh country report, Chapter 3.2). While utilization of informal providers was not found to the same degree in data collection from Jordan, issues around perceived poor quality of care in the public sector and at INGO/NGO facilities were raised. This included perceived discrimination against Syrian refugees by healthcare workers and Jordanian people, manifesting in preferences for providing treatment to non-refugee populations, and lack of sensitivity to cultural stigmas, such as those surrounding sexual health issues (see Jordan country report, Chapter 2.3). Similarly, in Colombia, migrants without insurance affiliation also described attitudes of health workers as discriminatory (see Colombia country report, Chapter 4.4). Efforts to enhance the quality of care are therefore sorely needed. Accreditation, regulation and monitoring are key entry points for doing so. While user fees are sometimes floated as a strategy in this respect, it should be noted that the WHO has advocated abolishing user fees for primary healthcare services provided by aid agencies and there is no strong evidence that user fees directly increase quality of care. (IASC 2010; Lagarde and Palmer 2011; Steinhardt et al. 2013).

5.2 Impacts of COVID-19

While COVID-19 carried many negative impacts on populations and health systems in the four countries studied, as it did around the globe, some positive impacts were also found related to the increased availability of funds for health system strengthening and response.

Across the countries studied, COVID-19 reduced healthcare utilization, reporting of illness, and availability of care and medications. In both Colombia and the DRC, declines in health service visits were seen after the beginning of the pandemic, with an approximate 37 percent decrease in hospital rates per 100,000 for Colombians and 24 percent for Venezuelans between 2019 and 2020. Consultation rates also fell by 42 percent and 37 percent, respectively (Shepard et al. 2021). Similarly, in the DRC, outpatient visits decreased immediately after the start of the pandemic, reaching a peak disruption of approximately 20 percent in August 2021 (Hategeka, Arsenault, and Kruk 2020; "SUIVI DES SERVICES DE SANTE ESSENTIELS PENDANT LA PANDEMIE DE COVID-19" 2022). Likewise, in Bangladesh, a decline in utilization of care in INGO/NGO clinics was offset by an increase in use of sub-optimal informal care services in 2020 (Bangladesh country report, section 5.1). These decreases in formal care utilization have been attributed mainly to fears of contracting COVID-19 and/or increasing distrust in health systems due to fear of being labeled as having COVID-19, fear of forced vaccination, myths around the reality of COVID-19, or increased frustrations with systems due to higher costs of care and delays in treatment.

However, in some contexts, the influx of spending and donor support during COVID-19 also carried benefits to the health system and innovative solutions were developed to respond to pre-pandemic healthcare deficiencies that could be adopted in the future. For example, in the DRC, key informants reported that local faith-based NGOs had been hired to assist in the COVID-19 response, especially with delivering health information and encouraging vaccination take-up (see DRC country report, Annex 1) (Severe Malaria Observatory n.d.). These organizations have been identified as community-based providers of public health and health information that are trusted by local communities and could expand to play a more prominent role in general service delivery and social protection in the future. In Jordan, the continued operation of NGOs in camps despite the pandemic highlighted the importance of leveraging the strengths of three sectors (NGOs, private, and public sectors) to improve health services for refugees (Jordan country report, chapter 6, section 3.5). In Bangladesh, key informants, including U.N. staff and health services providers, reported a range of improvements to health infrastructure, health

information systems, and certain health outcomes after the start of the pandemic. These included increased inpatient capacity and intensive care units (ICUs) within camps, funding for disease surveillance and information systems, and improved coordination between donors and NGOs, and with governments. In some cases, increased health staff precautions while treating patients within ICUs and quarantine units within camps due to COVID-19 were perceived by patients to be inconveniences and poorer quality of care (e.g. more physical distance, perceptions that they had less time with the provider to explain their health condition, etc.). While increased spending on refugee populations residing in camps may have contributed to resentment by the host community toward the displaced population. However, such investments in sustainable health system infrastructure were seen by key informants as an overall positive investment in the health system for the future (Bangladesh country report, chapter 1.4).

5.3 Gaps and inequities in referrals, quality, and informal services

To minimize the burden of both medical and direct non-medical costs of care, and to bolster existing social protection mechanisms within countries for both host and displaced populations, governments and donors must work toward building and increasing awareness of structured referral systems between primary and higher levels of care. They must also establish and enforce norms and rules around proper and predictable charging for health services through government regulations and policies. To ensure the affordability of healthcare, it is critical to have a better understanding of the cost-sharing among stakeholders (e.g., donors, host governments, and patients), and take action to address the underlying reasons, if high out-of-pocket health expenses exist. Furthermore, efforts are needed to improve quality of care—both real and perceived—across public, private, and informal sectors, through formal accreditation standards; improved pre- and in-service training, including training on cultural sensitivity and issues of special relevance for treatment of displaced populations; and quality monitoring processes. Providing avenues to engage informal providers in formal service delivery within the health system could also help to improve access and acceptability of care, building trust in health systems, while also allowing formal quality monitoring and assessment of services. These mechanisms should seek to minimize the gaps between host and migrant or refugee populations when seeking services, due to differences in health seeking pathways, cost-covering schemes, and/or discrimination associated with legal or migratory status (see Chapter 2).

CHAPTER 6: HEALTHCARE FINANCING FOR THE DISPLACED POPULATION

This chapter summarizes the common themes on financing of health services for the displaced population from the four countries included in the study. To support host countries in reaching universal health coverage and the inclusion of refugees within their healthcare system, the World Health Organization introduced the Health Financing Progress Matrix to assess health financing systems and to measure the extent to which financial barriers affect population access to healthcare and the financial hardship faced in the process (WHO 2020a). In this chapter, we adopted the WHO health financing matrix, to better understand the financing of refugee health. Our analysis focused on (1) Source of finance, (2) Contract mechanisms with service providers, (3) Benefit package design, and (4) Payment to private and informal sectors. At the end of this chapter, we highlight promising practices to improve health financing for the displaced population in the four countries, drawing lessons from other countries. These practices aim not only to increase financial stability and volume of financial resources for health services but also to enhance the efficiency of using existing resources. We understand that improving financial commitments goes beyond the health sector, requiring multisectoral cooperation and strong commitments from both governments and development partners.

6.1 Sources of finance

The displaced population included in this report varied by country. In Bangladesh, Rohingya refugees are considered Forcibly Displaced Myanmar Nationals (FDMNs), which ensures access to basic humanitarian assistance, but denies their refugee status and many of the rights attached to that status (Banerjee 2019). In Colombia, Venezuelans are considered migrants rather than displaced peoples or refugees and the focus of the report is on those enrolled in the Sistema General de Seguridad Social en Salud (General Social Security Systems

for Health) (SGSSS) program. In the DRC, data is lacking regarding the size of refugee or host communities, and therefore, the report considers the *de facto* residents of the DRC. In Jordan, the focus is on Syrian refugees registered with the UNHCR, who reside in host communities. We obtained some insights from KIIs about the care provided for those who reside in camps, but little is known about Syrians who decided, for various reasons, not to register with UNHCR. Donors face challenges reaching refugees who are not registered in part because they are difficult to identify and verify, and donors typically cannot finance groups that they cannot verify.

Despite the heterogeneous displaced population considered in this study, external support from donors was the main source of finance for providing healthcare services for this population group in the majority of the countries (Bangladesh, the DRC, Jordan), with supplemental funding from out-of-pocket spending and, in some circumstances, from the host governments. For example, donor funding accounts for 87.3 percent of healthcare funding for Rohingya refugees in Bangladesh, and 53.5 percent for Syrian refugees in Jordan (Jordan country report, Table 14). The donor community established health facilities in camps in Bangladesh and Jordan and provides free care to refugees in the two countries. In the DRC, some humanitarian healthcare providers also provide free care to displaced communities. In Colombia, the international support for displaced Venezuelans was minimal, accounting for US$31 per refugee per year. Registered Venezuelans have the right to be insured through a health insurance scheme subsidized by the Colombian government, as noted earlier in the report.

The external funding comes from a wide range of donors, including multilateral development partners, such as the World Bank and United Nations agencies (e.g., UNHCR, UNICEF, and WHO), and bilateral donors, such as the U.S., Canada, Japan, United Kingdom, and Arab states' governments. These funds are voluntary contributions and fluctuate from one year to the next. Donors' commitment is limited in time and scope, causing unpredictability and instability in funds, thus hindering the implementing agencies' ability to plan for long-term projects and, in some cases, leading to the interruption of care. The unpredictability of external funding is one of the major challenges in financing health services for the displaced population. For example, in Bangladesh, the funding for health through the Joint Response Plan (JRP) ranged from US$40 million in 2019 to US$47 million in 2020, although it is important to note that JRP funding allocations reported by the Financial Tracking Service (FTS) do not capture unearmarked funding, including US$14.5 million and US$31 million spent by UNHCR on health in 2019 and 2020, respectively (FTS n.d. b; n.d. a). The variation is much larger in Jordan.

Donor priorities greatly affect their commitments to fund health services and impacts how funds for health are used. For example, it is likely that the recent Russia and Ukraine conflict, which has resulted in millions of Ukrainian refugees, may well divert donors' attention away from protracted refugee crises.

Across the four countries, there is a substantial shortage of funding for providing health services for the target population. The financial gap between the requested funds and those received is enormous. For example, in 2021, the government of Jordan requested US$412 million of budget support for the *Jordan Response Plan for the Syrian Crisis* but they received only 30.6 percent of the requested funds. In Bangladesh, the funding received in 2021 was only 31.1 percent of the requested amount. The health sector has to compete with other sectors, such as food security, education, and protection, often falling behind them in securing funding. The shortage of funding impedes healthcare providers from offering comprehensive care to the displaced population, although analysis of funding allocations from the FTS may not present a completely accurate picture of funding for health, in part because UNHCR assistance for refugees, including health assistance, may be categorized as multisectoral funding (FTS n.d. c). The scope of services provided by some donors through national and local NGOs created vertical systems for different types of patients with a focus on maternal and child health and adolescent health. This focus might lead to further fragmentation in the health system and duplication in programs, reducing the efficiency of donors' contributions.

The four countries studied in the *Big Questions* project have different levels of integration in financing and delivery of health services. Colombia is more advanced in integrating registered Venezuelans into its health financing and service delivery systems through the subsidized health insurance scheme. Once migrants join the health insurance scheme, this population group is entitled to receive comprehensive health service coverage, with minimal out-of-pocket spending. However, the share of registered Venezuelans is low (about 26 percent in either the subsidized or contributory insurance schemes), and those who are not registered only have access to emergency care and some public health services (e.g. vaccination). While national policy mandates basic health promotion and prevention services must be made available to all people regardless of insurance status, programming is often carried out according to the priorities of local authorities and is sometimes misaligned with population needs. In Jordan, refugee health was an integral part of the country's joint response multisectoral action plan for the refugee crisis, where donors' contributions were pooled to support the host countries to mitigate the refugees' impact on host

communities. Multilateral and some bilateral donors adopted the Global Compact on Refugees framework and focused their support on services provided within national healthcare systems, with part of the funds going to strengthen the overall healthcare system in the host countries. In Bangladesh, by contrast, there is little integration of financing and camp-based service delivery for Rohingya refugees into Bangladesh's national health system. Due to restrictions on travel outside the camp complex, Rohingya refugees are limited to camps with most services offered by INGO/NGO facilities. There is some discussion on having more government facilities in the camps to provide health services.

As a result, some host countries carry the financial burden associated with caring for the displaced population. In Colombia, 35 percent of Venezuelans were covered by the General Social Security Systems, of which 54 percent enrolled in the national health system as contributors, and 46 percent enrolled as subsidized members. In Jordan, the DRC, and Bangladesh, it is estimated that the host government finances 26.7 percent, 21.2 percent, and 12.7 percent of the displaced population's healthcare services, respectively.

Some innovative approaches were utilized to support the financing of healthcare needs for the displaced population. In Bangladesh, there are various working groups (e.g. epidemiology and case management, sexual and reproductive health, and community health) that were utilized to strategically enhance the healthcare for refugees as part of a multisectoral engagement approach. However, there was some redundancy in services provided to the refugee population due to the government regulatory process that donors had the obligation to meet and the fact that health facilities tend to concentrate in areas with better access to transportation (Ho et al. 2019). In December 2018, Jordan established the Multi-Donor Account (MDA) Directorate as a continuum of the Jordan Response Platform for the Syrian Crisis to streamline funding from donors to projects and programs needed by the MoH to meet the healthcare needs of refugees and host communities. The account enabled the MoH to play an active role and reach out to donors with specific requests to fund priorities set by the MoH in collaboration with the donor community and key stakeholders. The fund has supported infrastructure projects, the purchase of medical equipment, and invested in human resources by focusing on capacity-building programs, accelerating progress toward universal health coverage in Jordan and strengthening the health system to benefit both host and displaced populations (see Jordan country report, section 5.2.2.).

6.2 Contracting with service providers

Often there are many healthcare providers involved in delivering health services to displaced populations. Depending on the size of the displaced population, the number of service providers varies substantially. In Bangladesh, where about one million Rohingya refugees live in the camps, there were 31 international NGOs and 21 local NGOs working in the camps in 2021. Healthcare providers can be mixed, including government health facilities, international NGO facilities, and local NGO facilities, along with private facilities or traditional healers. Contracting with different healthcare providers is an important task to ensure that funding is used appropriately. Funders are committed to maximizing value for money and have formal procedures in place to identify healthcare providers and contract with them. Due to data limitations, we were unable to compare the cost and quality of health services provided by different types of health providers, which is a topic that needs further exploration.

Despite the strong commitment of funders and extensive experience in contracting with healthcare providers, one of the challenges identified is that funders are frequently limited by their organizational and funding structures that only allow short-term contracts with healthcare providers. Most of the time, healthcare providers receive a one-year contract – and even shorter in some circumstances – which makes it very difficult for healthcare providers to make a long-term plan, particularly in the first year of the project when initial capital investment (e.g., purchasing medical equipment) is needed. It generally takes a few months to set up a clinic and leaves little time to implement the project. Additionally, the short contract period makes health facilities financially unpredictable and, sometimes, leads to inefficiency in disbursing funding, contributing to the turnover of health personnel and the disruption of health service delivery. The disruption and unavailability of health services are one of the major reasons why the displaced population may prefer to seek care in private facilities rather than contracted facilities.

Another common challenge of contracting is a preference for international NGOs over financing local NGOs in some countries (Zee 2015). As previously mentioned, there is a clear process for selecting health facilities to contract with, including proposal solicitation, proposal review, and contracting. Local organizations are often at a disadvantage in competing with international organizations according to selection criteria, such as financial management, experience in clinical management, and reporting. However, local facilities may bring unique cultural advantages in delivering health services, which has

become increasingly important for displaced populations to determine where to seek care. The evaluation criteria to select an organization to contract should take this cultural aspect into consideration as well as the sustainability of future delivery of health services when displacement becomes protracted.

6.3 Benefit package design

Contracted health facilities provide a wide range of health services to displaced populations. All four countries included in the study had a clear benefits package that extended to displaced populations, with wide variations between them in terms of coverage. In Colombia, registered Venezuelan refugees have the most comprehensive coverage that encompasses almost all health services through a subsided health insurance scheme. However, the share of registered Venezuelan refugees is small; about 65 percent of Venezuelans are not affiliated with any insurance coverage (see Colombia country report, section 4.1). Services offered to the displaced population in the other three countries mostly focus on primary healthcare with limited referral services. Among Rohingya refugees, services offered by INGOs and NGOs were mostly primary healthcare services that are defined in the essential minimal healthcare package, with essential life-saving secondary health services. When needing secondary care or tertiary care, refugees may have to travel further away from their households. Along with other health system challenges (e.g., shortage of medicine), the limited benefits package drives patients away from seeking care in contracted health facilities.

Countries generally include referrals in the benefit package; however, the use of the referral system is often constrained by the maturity of national health systems and the health literacy of displaced populations. Sometimes, members of the displaced population do not realize that there is a funded referral program that covers their travel expenses. For example, in Bangladesh, UNHCR and IOM provide financial support to refugees for official referral services, including funds for transportation and meals for patients and caregivers, yet the cost of referrals remained a concern among FGD participants living in the camps (Bangladesh country report, Section 5.3.4). In Jordan and Bangladesh, to access services outside the camps, refugees living in camps need to be referred by primary healthcare providers within the camp. The health conditions for referral are limited to life-threatening conditions. As noted above, despite the presence of financial assistance in some cases, the distance of referral hospitals and the associated transportation and other direct non-medical costs often prevent refugees from seeking care.

The main gap in the benefit package design is the management of mental health and non-communicable diseases. COVID-19 has exacerbated mental health conditions for many and affected the delivery of services, particularly during the period of lockdown. The shortage of mental health specialists, such as psychiatrists and psychologists, is prevalent in all four humanitarian settings.

6.4 Payment to private and informal sectors

Fee for service payment dominates in private and informal sectors. Although most services in the NGO or public sectors are free, displaced populations also seek care in private facilities or through traditional healers. Fee for service is the most common approach to pay for such services. In-kind payment is also observed in some circumstances. The payment to private facilities and informal sectors is often unregulated. In the DRC, user fees may differ from area to area due to the presence of externally funded programs that directly finance a variety of local projects. Unpredictable and unregulated user fees at the health facility level exacerbate challenges to accessing care and provide a source of instability for health facilities. In the public sector and NGO sectors, healthcare providers are often funded through government or donor budgets, with occasional user fees, if services are not included in the contract. However, few programs have been implemented to incentivize healthcare providers to promote better financial and service performance.

6.5 Promising practices and persistent gaps for financing

Given the shortage and unpredictability of funding, new financing mechanisms should be explored to enhance the coverage of health costs for displaced and vulnerable host communities, such as investment bonds and demand-side financing programs (e.g. cash transfers, voucher programs) (P. Spiegel, Chanis, and Trujillo 2018). The approaches to generating financial resources could vary by country. As an example, in Colombia where the government provides major financial resources for displaced refugees, priority should be given to expanding the government's fiscal space to absorb health service costs incurred by Venezuelans if they register as a resident. However, in Jordan where health insurance is well established among Jordanians, donors and the government of Jordan should leverage the existing health insurance schemes in the country to support health services for Syrian refugees. It should be noted that existing health services are mostly donor-

supported from the supply side. Support could also be considered from the demand side, such as supporting premiums for health insurance or voucher schemes, although this may incur the upfront cost of structural investment. Such subsidies provided to the displaced population can facilitate their integration into national systems, although implementation of such programs must be managed with care in order to avoid overwhelming health service capacity or creating disincentives (i.e. due to untimely reimbursements) to treat the displaced community (Ahmed and Khan 2011). Thus, development partners could reduce their management of direct service provision. Instead, they could switch their focus to strengthening the national capacity to provide services for refugees and people in the host community. To achieve this, stronger advocacy among the donor community and with host governments is needed. More activities to spark stakeholders' interests and evidence to support the design and implementation of new financing mechanisms should be carried out, including engaging potential private foundations to finance health services for the displaced population.

Depending on the level of integration, the pooling of financial resources varies among the four countries. Colombia uses either the government budget or payroll tax to finance health services for Venezuelans affiliated with health insurance. The key question for Colombia is how to create additional fiscal space to finance health services if the coverage of health insurance is further expanded among Venezuelans. In Jordan, there is limited pooling of the resources to respond to refugees' health needs, mainly through the multi-donor account. Compared to the overall donors' budget for the refugees' health response, the amount included in the multiple donor account is small. There are early-stage discussions on integrating refugees into existing health insurance schemes. Strong government commitment and continued donor support are needed to move this agenda forward. In the DRC, some donors' funding is channeled through the government while some funding directly supports local and international health providers. In Bangladesh, no resource pooling mechanisms exist for Rohingya's health services. However, the Joint Response Plan plays an important role in coordinating financial resources to respond to Rohingya's health needs. Strengthened coordination is needed to avoid duplication of services and fill in service gaps.

There are some programs using incentives to promote good behaviors and link contract payments to the performance of healthcare providers. Performance-based financing (PBF) has been used widely, and often effectively, in many low- and middle-income and conflict affected countries (Zeng et al. 2013). However, similarly to subsidy programs, PBF requires careful implementation and evaluation to avoid challenges such

as data falsification, loss of confidentiality, and provision of unnecessary services (Turcotte-Tremblay et al. 2017; Turcotte-Tremblay, Gali Gali, and Ridde 2020; Kalk 2011)in contexts which are exceptionally fragile or experiencing widespread corruption, PBF may be less likely to be effective for public service provision. The DRC has implemented PBF programs with improved quality of care and coverage of select health services (Soeters et al. 2011). Development partners should continue to explore the applicability of this approach when contracting with healthcare providers. Adapting the concept of PBF and using simplified indicators specifically for displaced populations for contracting may help improve the effectiveness of PBF programs and the integration of displaced populations. An effective program would also in turn attract donors' support for investing in health for displaced populations.

Moreover, although a minimal package of health services is often established, the package should be monitored and adjusted based on the changing health needs of displaced populations. As we have seen, mental health and chronic disease have become increasingly prominent needs among displaced populations in protracted settings. Incorporating cost-effective interventions to address these health issues should be seriously considered and integrated into the essential benefit package. Additionally, to ensure the quality of care, which is one of the major concerns in the DRC and Bangladesh, development partners should also explore with host governments the possibility of initiating quality improvement activities, such as accreditation programs for contracting and ensuring that the quality of care offered is at a high level.

If possible, development partners, particularly those with multi-year funds, should also strategically prioritize some existing projects and provide long-term contracts with service providers that need large capital investments. They could work with credible health providers to develop a long-term plan to meet the needs of both host and displaced populations, as well as to improve the financial management system to avoid delays in funding disbursement.

Lastly, in places where there is protracted displacement, improving livelihoods and utilizing and building the capacity of the displaced population is critical for future financing for health. In the end, displaced populations need to be more economically independent and engaged in economic productivity to, at least partially, support their own health needs, with potential subsidies from donors and the host government. Programs hiring refugees as paid volunteers to support program activities to generate incomes are a good start. However, improved health financing should be accompanied by more active livelihood and income generation programs.

CONCLUSION AND RECOMMENDATIONS

The Global Compact on Refugees, endorsed by 181 states, in 2018 calls for expanding and enhancing the quality of national health systems to facilitate access by refugees and host communities, including building and equipping health facilitates and strengthening services (U.N. General Assembly 2018). With conflicts showing no signs of abating, and protracted displacement arguably here to stay, it is critical to think about the health and well-being of refugees and displaced populations in tandem with the host populations they live alongside. A singular or uniform approach on the part of international and national actors can never hope to accommodate the diversity of political contexts and capacity constraints that exist in different hosting communities. However, the *Big Questions* project underscores the varied and innovative ways in which the conversation about an integrated approach to health is advancing in different contexts and presents valuable lessons on how to better prepare for and anticipate both the challenges and opportunities that can arise in contexts of displacement. Some of these recommendations are shared below:

1. **The importance of planning and integration**
   An integrated approach to healthcare can provide potential widespread benefits in terms of planning and sustainability, cost effectiveness, and continuity of care for both displaced and host populations. Humanitarian health practitioners, national governments and international donors are well advised to begin to plan early for the possibility that a displacement crisis might become protracted and require sustainable, long-term solutions. However, it is important to note that not every situation will lend itself to an integrated approach. In some political contexts – particularly where the government concerned is a party to conflict – the role of humanitarian NGOs remains critical. State fragility also complicates and may limit the prospects for integration, given weak state institutions, corruption, a lack of resources, and a lack of security, all of which serve to undermine trust and access to healthcare. Key factors for donors and humanitarian and national actors to consider include political context, available funding, and the potential for improved health outcomes and equity among both host and displaced populations.

2. **Addressing the affordability barrier**
   Cost remains the defining issue determining healthcare access for many displaced, and even some host, populations. Out-of-pocket medical and direct non-medical costs, such as transportation to seek care, emerged as the most significant barriers to accessing healthcare. Even in countries with facilities that provided free care, lack of availability of care in these facilities drove displaced and host populations to private facilities and the informal sector, where patients incur out-of-pocket spending. To minimize this burden for both host and displaced populations, governments and donors must work toward building and increasing awareness of structured referral systems between primary and higher levels of care. They must also establish and enforce norms and rules around proper and predictable charging for health services through government regulations and policies.

3. **Addressing health gaps**
   Gaps in care across different types of health needs varied by country context, with limitations to basic services, such as access to preventive care, present across all four countries but most severe in low-resource settings. However, our research highlighted three major near-universal gaps – chronic disease management, specialized care, and mental health services – for which few large-scale, effective interventions have been implemented for host and displaced populations and for which an integrated approach is both necessary and may offer up distinct benefits for both populations. While there are ongoing initiatives to begin to address these gaps, further scaling of effective interventions is required.

   Each of these health gaps raise different challenges for humanitarian actors, governments and donors. Strategies are required to address health gaps in a way that reinforces existing health systems and avoids diverting resources from funding and strengthening preventive and primary health services. The key challenge for specialized services is financing and sustaining their availability, including investment in strengthening referral pathways, as access to timely and affordable referral processes is particularly tenuous among displaced populations. Addressing care for chronic diseases requires both financing and improvements in referral networks to access different levels of care, as well as continued innovation in programmatic approaches that can reach populations in humanitarian settings. With respect to mental health services, there remains a need for more research to verify which interventions are effective and feasible at scale for both displaced and host populations. Emerging evidence and models for mental health service delivery in humanitarian settings must also be tailored to fit the cultural context.

4. **Tackling issues of quality**
   Efforts to improve quality of care—both real and perceived—are critical, across public, private, and informal sectors; this can include formal accreditation standards; improved pre- and in-service training, including training on cultural sensitivity and issues of special relevance for treatment of displaced populations; and quality monitoring processes. Providing avenues to engage informal providers in formal service delivery within the health system could also help to improve access and acceptability of care, thereby building trust in health systems while also allowing formal quality monitoring and assessment of services. These mechanisms should seek to minimize the gaps between host and displaced populations when seeking services, due to differences in health seeking pathways, cost-covering schemes, and/or discrimination associated with legal or migratory status.

5. **The role of financing**
   Donor financing arrangements can play a crucial role in facilitating greater integration of health services for both host and displaced populations. For example, in recent years we have seen innovative examples of pooled multilateral and bilateral funds being used to support national health system strengthening for the benefit of both host and displaced populations. However, across all four countries studied, financing arrangements can also militate against integration. Shifting donor priorities, short-term funding cycles, and a continual misalignment between host government needs and international funding can undermine efforts towards integration.

   Invariably, host governments, often with local governments, shoulder a significant part of the cost associated with the health needs of the displaced populations. In the case of Colombia, this cost burden also falls on specific health facilities in areas with large numbers of displaced persons.

   Innovations around demand-side arrangements (i.e., voucher programs) have also been implemented with varying results. Subsidies for displaced populations to use national health services can encourage integration and strengthen local economics, but such programs must be implemented with care to avoid overwhelming health service capacity or excluding vulnerable individuals when the programs cease.

   As noted below, it is vital that financing arrangements are embedded in policies that support the longer-term resilience and self-reliance of refugees, including education and livelihoods strategies. This would require better coordination between the health sector and other sectors to ensure refugees receive training in specific skills to contribute to the economy of the host country.

6. **A whole of person approach – the social and environmental determinants of health**
   Health is intimately connected to a wide variety of other social and environmental factors that influence whether a person is able to live a healthy life, such as access to clean water and sanitation, food, livelihoods and education. These social and environmental determinants are shaped by structural barriers around individual identities related to gender, sexuality, and age. For example, women have differential access to livelihoods, food security, and safety in protracted displacement which creates a unique set of vulnerabilities related to health. Investments in addressing these factors, with particular attention to the intersection of social determinants and gender, are foundational to preventive care, leading to long-term, sustainable improvements in health that ultimately decrease the burden on health systems and health financing. In protracted displacement, it is particularly critical that responses incorporate these elements, including education and livelihoods strategies, as an integral part of healthcare planning and financing.

7. **The role of legal status in healthcare access**
   Our research has also illustrated how vital a role legal status can play in ensuring both the ability and willingness to access health services. This extends to both the insecurity caused by a lack of formal documentation of status and onerous governmental restrictions, such as limitations on travel outside of camps, which can have far-reaching impacts on the accessibility and availability of care. The stakes associated with documentation are amplified as national governments become more involved in the process of delivering healthcare. It is important to remain mindful of possible tensions between protection needs and health care needs, and to be cognizant of who is collecting data and for what purpose. Ensuring that appropriate firewalls are in place to protect sensitive demographic and health data from being used in immigration enforcement efforts is critical to ensuring full participation from displaced individuals and communities.

8. **Building a strong foundation – addressing the demographic and epidemiological data gap**
   A whole data approach that includes coordination and collection of comprehensive demographic and epidemiologic data over time for displaced and host communities would further inform population health needs and pathways for comprehensive health systems responses. Existing sources of data are often incomplete and rarely facilitate the breakdown of information by displacement status or a reasonable proxy (i.e., nationality, administrative area, etc., depending on context),

limiting their utility for planning the humanitarian response and health systems development. In particular, there is a dearth of longitudinal data about forcibly displaced populations that constrains the ability of policymakers to assess and anticipate their needs. Irrespective of conflict or displacement crises, there is a long-term need for sustained investments in data collection processes that meaningfully and accurately capture the demographic and health profile of host populations and refugee and displaced populations over time.

9. **Enhancing disease surveillance**
   Camps and camp-like settings are particularly susceptible to communicable disease outbreaks. Sustained investments in disease surveillance, including EWARS, in the availability and diagnostic capacity of health services within and outside camps, and in improving health literacy, such as with the use of CHWs, have been shown to yield dividends in terms of identifying and responding to outbreaks quickly. Investments in COVID-19 capacity should be leveraged to deepen and broaden these investments in health surveillance capacities, with a particular view to ensuring that surveillance systems are designed to integrate and address the needs of displaced and mobile populations.

10. **Leveraging human capital**
    While the arrival of significant refugee and displaced populations can strain healthcare capacity in both rural and urban settings, effectively leveraging human capital can be critical to filling health service gaps for both displaced and host populations. A task shifting approach can be effectively employed to grow a diverse health workforce linking community- and facility-based care to provide outreach and service provision. This requires access to appropriate formal or structured on-the-job training, as well as sustained supportive supervision. Engagement of the displaced health workforce can also serve to strengthen host health systems and address barriers to care around language differences and discrimination for displaced populations. For example, the report highlights the use of task shifting to address gaps identified in the areas of mental health, chronic disease and specialized care. However, permission to work and formal recognition of foreign medical licensure remain a barrier to leveraging this group — an issue which can only be addressed through concerted national government policy and action. It should be noted that there are often entrenched interests at the national level, including professional associations that oppose greater inclusion of foreign healthcare workers that need to be factored into any future policy and advocacy efforts in this area.

REFERENCES

Abujaber, Nadeen, Frédérique Vallières, Kelly A McBride, Greg Sheaf, Pia Tingsted Blum, Nana Wiedemann, and Áine Travers. n.d. "Examining the Evidence for Best Practice Guidelines in Supportive Supervision of Lay Health Care Providers in Humanitarian Emergencies: A Systematic Scoping Review." *Journal of Global Health* 12: 04017. https://doi.org/10.7189/jogh.12.04017

ACAPS. 2021. "Jordan Syrian Refugees." December 21, 2021. https://www.acaps.org/country/jordan/crisis/syrian-refugees

Ahmed, Shakil, and M Mahmud Khan. 2011. "A Maternal Health Voucher Scheme: What Have We Learned from the Demand-Side Financing Scheme in Bangladesh?" *Health Policy and Planning* 26 (1): 25–32. https://doi.org/10.1093/heapol/czq015

Al Emam, Dana. 2016. "'55% of Population, 68% of Jordanians Covered by Health Insurance.'" Jordan Times. February 22, 2016. http://www.jordantimes.com/news/local/55-population-68-jordanians-covered-health-insurance%E2%80%99

Al Rousan, Tala, Zaker Schwabkey, Lara Jirmanus, and Brett D. Nelson. 2018. "Health Needs and Priorities of Syrian Refugees in Camps and Urban Settings in Jordan: Perspectives of Refugees and Health Care Providers." *Eastern Mediterranean Health Journal* 24 (03): 243–53. https://doi.org/10.26719/2018.24.3.243

Aldridge, Robert W, Laura B Nellums, Sean Bartlett, Anna Louise Barr, Parth Patel, Rachel Burns, Sally Hargreaves, et al. 2018. "Global Patterns of Mortality in International Migrants: A Systematic Review and Meta-Analysis." *The Lancet* 392 (10164): 2553–66. https://doi.org/10.1016/S0140-6736(18)32781-8

Audi, Mhd Nour, Katherine McCann, Sarah Guyer, M Claire Greene, Ling San Lau, Fouad M Fouad, Monette Zard, Patrick Kachur, and Rachel T Moresky. 2020. "Addressing the Human Capital Dimension of the COVID-19 Response in Forced Displacement Settings." Knowledge Brief. Program on Forced Migration and Health, Columbia University.

Banerjee, Sreeparna. 2019. "The Rohingya Crisis: A Health Situation Analysis of Refugee Camps in Bangladesh." ORF. July 15, 2019. https://www.orfonline.org/research/the-rohingya-crisis-a-health-situation-analysis-of-refugee-camps-in-bangladesh-53011/

Bodenheimer, Thomas. 2002. "Patient Self-Management of Chronic Disease in Primary Care." *JAMA* 288 (19): 2469. https://doi.org/10.1001/jama.288.19.2469

Bozorgmehr, Kayvan, and Oliver Razum. 2015. "Effect of Restricting Access to Health Care on Health Expenditures among Asylum-Seekers and Refugees: A Quasi-Experimental Study in Germany, 1994–2013." Edited by Joan A Caylà. *PLOS ONE* 10 (7): e0131483. https://doi.org/10.1371/journal.pone.0131483

Castiblanco, Cindy. 2022. "Conoce qué es y cómo funciona el Fondo Financiero Distrital de Salud." Alcaldía de Bogotá. April 8, 2022. https://bogota.gov.co/mi-ciudad/salud/que-es-el-fondo-financiero-distrital-de-salud-secretaria-de-salud

Checchi, Francesco, Abdihamid Warsame, Victoria Treacy-Wong, Jonathan Polonsky, Mark van Ommeren, and Claudine Prudhon. 2017. "Public Health Information in Crisis-Affected Populations: A Review of Methods and Their Use for Advocacy and Action." *The Lancet* 390 (10109): 2297–2313. https://doi.org/10.1016/S0140-6736(17)30702-X

Clarke, Paul Knox, and Leah Campbell. 2018. "Coordination in Theory, Coordination in Practice: The Case of the Clusters." *Disasters* 42 (4): 655–73. https://doi.org/10.1111/disa.12282

Crépeau, François, and Bethany Hastie. 2015. "The Case for 'Firewall' Protections for Irregular Migrants: Safeguarding Fundamental Rights." *European Journal of Migration and Law (EMIL)* 2 (3): 157–83. https://papers.ssrn.com/abstract=2780641

Department of Statistics. 2016. "Health Insurance in Jordan: Analytical Paper Prepared According to the Results of General Population and Housing Census 2015." http://www.dos.gov.jo/dos_home_e/main/population/census2015/Health%20Insurance%20in%20Jordan.pdf

DHIS2. n.d. "In Action." Accessed April 12, 2022. https://dhis2.org/in-action/

Emina, Jacques B. O., Henry V. Doctor, and Yazoumé Yé. 2021. "Profiling Malaria Infection among Under-Five Children in the Democratic Republic of Congo." Edited by Thomas A. Smith. *PLOS ONE* 16 (5): e0250550. https://doi.org/10.1371/journal.pone.0250550

Fine, Shoshanna L., Jeremy C. Kane, Paul B. Spiegel, Wietse A. Tol, and Peter Ventevogel. 2022. "Ten Years of Tracking Mental Health in Refugee Primary Health Care Settings: An Updated Analysis of Data from UNHCR's Health Information System (2009–2018)." *BMC Medicine* 20 (1): 183. https://doi.org/10.1186/s12916-022-02371-8

Francis, Alexandra. 2015. “Jordan’s Refugee Crisis.” Carnegie Endowment for International Peace. September 21, 2015. https://carnegieendowment.org/2015/09/21/jordan-s-refugee-crisis-pub-61338

FTS. n.d. a. “Bangladesh: 2019 Joint Response Plan for Rohingya Humanitarian Crisis (January-December) | Financial Tracking Service.” n.d. a. https://fts.unocha.org/appeals/719/summary

———. n.d. b. “Bangladesh: 2020 Joint Response Plan for Rohingya Humanitarian Crisis (January-December).” n.d. b. https://fts.unocha.org/appeals/906/summary

———. n.d. c. “Glossary | Financial Tracking Service.” n.d. c. https://fts.unocha.org/glossary

GIFMM, R4V. 2021. “Support Plan 2021, Colombia - GIFMM Support Plan for the Implementation of the Temporary Protection Status for Venezuelans.” June 2021. https://reliefweb.int/report/colombia/support-plan-2021-colombia-gifmm-support-plan-implementation-temporary-protection

Ginneken, Nadja van, Prathap Tharyan, Simon Lewin, Girish N Rao, Sm Meera, Jessica Pian, Sudha Chandrashekar, and Vikram Patel. 2013. “Non-Specialist Health Worker Interventions for the Care of Mental, Neurological and Substance-Abuse Disorders in Low- and Middle-Income Countries.” Edited by Cochrane Effective Practice and Organisation of Care Group. *Cochrane Database of Systematic Reviews*, November. https://doi.org/10.1002/14651858.CD009149.pub2

Global Migration Group. 2017. “Handbook for Improving the Production and Use of Migration Data for Development.” Washington, DC: Global Knowledge Partnership for Migration and Development (KNOMAD), World Bank. https://reliefweb.int/report/world/handbook-improving-production-and-use-migration-data-development

Gómez-Restrepo, Carlos, Nathalie Tamayo Martínez, Adriana Bohórquez, Martín Rondón, Mauricio Medina Rico, Hernet Rengifo, and Nubia Bautisa. 2016. “Trastornos depresivos y de ansiedad y factores asociados en la población adulta colombiana, Encuesta Nacional de Salud Mental 2015.” *Revista Colombiana de Psiquiatría* 45 (December): 58–67. https://doi.org/10.1016/j.rcp.2016.04.009

Graham, W. J., S. Ahmed, C. Stanton, C. L. Abou-Zahr, and O. M. R. Campbell. 2008. “Measuring Maternal Mortality: An Overview of Opportunities and Options for Developing Countries.” *BMC Medicine* 6 (1): 1–8. https://doi.org/10.1186/1741-7015-6-12

Hategeka, Celestin, Catherine Arsenault, and Margaret E. Kruk. 2020. "Temporal Trends in Coverage, Quality and Equity of Maternal and Child Health Services in Rwanda, 2000-2015." *BMJ Global Health* 5 (11): e002768. https://doi.org/10.1136/bmjgh-2020-002768

Hategeka, Celestin, Simone E Carter, Faustin Mukalenge Chenge, Eric Nyambu Katanga, Grégoire Lurton, Serge Ma-Nitu Mayaka, Dieudonné Kazadi Mwamba, Esther van Kleef, Veerle Vanlerberghe, and Karen Ann Grépin. 2021. "Impact of the COVID-19 Pandemic and Response on the Utilisation of Health Services in Public Facilities during the First Wave in Kinshasa, the Democratic Republic of the Congo." *BMJ Global Health* 6 (7): e005955. https://doi.org/10.1136/bmjgh-2021-005955

Health Cluster, WHO. 2022. "Rohingya Refugee Crisis in Cox's Bazar District, Bangladesh: Health Sector Bulletin No. 18." April 2022. https://reliefweb.int/report/bangladesh/rohingya-refugee-crisis-cox-s-bazar-district-bangladesh-health-sector-bulletin-3

Health Sector Coordination Team. 2021. "Health Sector Bulletin #15." Geneva, Switzerland: WHO. https://www.humanitarianresponse.info/en/operations/bangladesh/document/health-sector-bulletin-15

Health Sector Cox's Bazar. n.d. "Health Facility Quarterly Monitoring Assessment." Microsoft Power BI. Accessed June 3, 2022. https://app.powerbi.com/view?r=eyJrIjoiYWU4ZjI1Mjgt
Mzg3MS00NDJmLTg0MzAtYjM0ZjNjYWQ2ZTJ
hIiwidCI6ImY2MTBjMGI3LWJkMj
QtNGIzOS04MTBiLTNkYzI4MGFmYjU5MCIsImMiOjh9

Ho, Shirley, Dena Javadi, Sara Causevic, Etienne V Langlois, Peter Friberg, and Göran Tomson. 2019. "Intersectoral and Integrated Approaches in Achieving the Right to Health for Refugees on Resettlement: A Scoping Review." *BMJ Open* 9 (7): e029407. https://doi.org/10.1136/bmjopen-2019-029407

Homer, Caroline S. E., Sofia Castro Lopes, Andrea Nove, Michaela Michel-Schuldt, Frances McConville, Nester T. Moyo, Martha Bokosi, and Petra ten Hoope-Bender. 2018. "Barriers to and Strategies for Addressing the Availability, Accessibility, Acceptability and Quality of the Sexual, Reproductive, Maternal, Newborn and Adolescent Health Workforce: Addressing the Post-2015 Agenda." *BMC Pregnancy and Childbirth* 18 (February): 55. https://doi.org/10.1186/s12884-018-1686-4

Human Rights Watch. 2021. "UN Shared Rohingya Data Without Informed Consent." June 15, 2021. https://www.hrw.org/news/2021/06/15/un-shared-rohingya-data-without-informed-consent

IASC, Global Health Cluster. 2010. "Removing User Fees for Primary Health Care Services during Humanitarian Crises." https://www.who.int/docs/default-source/documents/publications/removing-user-fees-for-primary-health-care-services-during-humanitarian-crises.pdf?sfvrsn=19631353_1

IFHHRO. n.d. "AAAQ Framework – IFHHRO." Accessed April 5, 2022. https://www.ifhhro.org/topics/aaaq-framework/

ILO. n.d. "Jordan: Advancing Gender Equality and Supporting Job Creation among Refugees and Host Communities through Public Works." Employment Intensive Investment Programme. https://www.ilo.org/wcmsp5/groups/public/---ed_emp/documents/publication/wcms_675168.pdf

Insecurity Insight. 2020. "Attacks on Health Care During the 10th Ebola Response in the Democratic Republic of the Congo - Democratic Republic of the Congo." ReliefWeb. November 21, 2020. https://reliefweb.int/report/democratic-republic-congo/attacks-health-care-during-10th-ebola-response-democratic-republic

International Rescue Committee. 2021. "Equitable Access to Health Services: Lessons for Integrating Displaced Populations into National Health Systems." https://www.rescue.org/report/equitable-access-health-services-lessons-integrating-displaced-populations-national-health

IOM. 2020. "IOM Bangladesh: Rohingya Humanitarian Crisis Response: Mental Health and Psychosocial Support: 2020 Overivew."

———. 2021a. "Assessment of MHPSS Services Availability in Cox's Bazar."

———. 2021b. "Mental Health and Psychosocial Support Needs Assessment." June 2021. https://reliefweb.int/report/bangladesh/iom-needs-assessment-report-mental-health-and-psychological-support-june-2021

IRC. 2019. "Public Health Access and Health Seeking Behaviors of Syrian Refugees in Jordan (9th Monitoring Report, Aug and Sep 2019)." November 2019. https://reliefweb.int/report/jordan/public-health-access-and-health-seeking-behaviors-syrian-refugees-jordan-9th

ISCG. 2020. "2020 Joint Response Plan: Rohingya Humanitarian Crisis." Cox's Bazar, Bangladesh: ISCG. https://reliefweb.int/report/bangladesh/2020-joint-response-plan-rohingya-humanitarian-crisis-january-december-2020

———. 2021. “Joint Response Plan Implementation Update.” Cox’s Bazar, Bangladesh. https://reliefweb.int/report/bangladesh/rohingya-humanitarian-crisis-joint-response-plan-implementation-update-october

Janneck, Laura, Nicholas Cooper, Seble Frehywot, Hani Mowafi, and Karen Hein. 2009. “Human Resources in Humanitarian Health Working Group Report.” *Prehospital and Disaster Medicine* 24 Suppl 2 (August): s184-193. https://doi.org/10.1017/s1049023x00021567

Joarder, Taufique, Tahrim Z. Chaudhury, and Ishtiaq Mannan. 2019. “Universal Health Coverage in Bangladesh: Activities, Challenges, and Suggestions.” *Advances in Public Health* 2019 (March): 1–12. https://doi.org/10.1155/2019/4954095

Jordan Department of Statistics, and DHS Program. 2019. “Jordan Population and Family Health Survey 2017-18.” https://dhsprogram.com/pubs/pdf/FR346/FR346.pdf

Joshi, Rohina, Andre Pascal Kengne, Fred Hersch, Mary Beth Weber, Helen McGuire, and Anushka Patel. 2017. “Innovations in Community-Based Health Care for Cardiometabolic and Respiratory Diseases.” In *Cardiovascular, Respiratory, and Related Disorders*, edited by Dorairaj Prabhakaran, Shuchi Anand, Thomas A. Gaziano, Jean-Claude Mbanya, Yangfeng Wu, and Rachel Nugent, 3rd ed. Washington (DC): The International Bank for Reconstruction and Development / The World Bank. http://www.ncbi.nlm.nih.gov/books/NBK525155/

Kalk, Andreas. 2011. “The Costs of Performance-Based Financing.” *Bulletin of the World Health Organization* 89 (May): 319–319. https://doi.org/10.2471/BLT.11.087247

Karasapan, Omer. 2022. “Syrian Refugees in Jordan: A Decade and Counting.” *Brookings* (blog). January 27, 2022. https://www.brookings.edu/blog/future-development/2022/01/27/syrian-refugees-in-jordan-a-decade-and-counting/

Klugman, Jeni. 2022. “The Gender Dimensions of Forced Displacement: A Synthesis of New Research.” Text/HTML 168165. https://documents.worldbank.org/en/publication/documents-reports/documentdetail/895601643214591612/The-Gender-Dimensions-of-Forced-Displacement-A-Synthesis-of-New-Research

Krafft, Caroline, Maia Sieverding, Caitlyn Keo, and Colette Salemi. 2018. “Syrian Refugees in Jordan: Demographics, Livelihoods, Education, and Health.” 1184. *Working Papers*. Working Papers. Economic Research Forum. https://ideas.repec.org/p/erg/wpaper/1184.html

Krafft, Caroline, Maia Sieverding, Colette Salemi, and Caitlyn Keo. 2019. "Syrian Refugees in Jordan: Demographics, Livelihoods, Education, and Health." In *The Jordanian Labor Market*, by Caroline Krafft, Maia Sieverding, Colette Salemi, and Caitlyn Keo, 141–72. Oxford University Press. https://doi.org/10.1093/oso/9780198846079.003.0006

Lagarde, Mylene, and Natasha Palmer. 2011. "The Impact of User Fees on Access to Health Services in Low- and Middle-Income Countries." Edited by Cochrane Effective Practice and Organisation of Care Group. *Cochrane Database of Systematic Reviews*, April. https://doi.org/10.1002/14651858.CD009094

Laokri, Samia, Rieza Soelaeman, and David R. Hotchkiss. 2018. "Assessing Out-of-Pocket Expenditures for Primary Health Care: How Responsive Is the Democratic Republic of Congo Health System to Providing Financial Risk Protection?" *BMC Health Services Research* 18 (1): 451. https://doi.org/10.1186/s12913-018-3211-x

Lau, Ling San, Sarah Guyer, M Claire Greene, Rachel T Moresky, Leslie F. Roberts, Sara E Casey, S. Patrick Kachur, Fouad M Fouad, and Wu Zeng. 2020. "Preventing and Mitigating Indirect Health Impacts of COVID-19 on Displaced Populations in Humanitarian Settings." Knowledge Brief. Program on Forced Migration and Health, Columbia University. https://www.publichealth.columbia.edu/sites/default/files/knowledge_brief_1.pdf

León-Giraldo, Sebastián, Germán Casas, Juan Sebastian Cuervo-Sanchez, Catalina González-Uribe, Oscar Bernal, Rodrigo Moreno-Serra, and Marc Suhrcke. 2021. "Health in Conflict Zones: Analyzing Inequalities in Mental Health in Colombian Conflict-Affected Territories." *International Journal of Public Health* 66 (May): 595311. https://doi.org/10.3389/ijph.2021.595311

Levesque, Jean-Frederic, Mark F Harris, and Grant Russell. 2013. "Patient-Centred Access to Health Care: Conceptualising Access at the Interface of Health Systems and Populations." *International Journal for Equity in Health* 12 (March): 18. https://doi.org/10.1186/1475-9276-12-18

Lopez, Alan D, Carla AbouZahr, Kenji Shibuya, and Laragh Gollogly. 2007. "Keeping Count: Births, Deaths, and Causes of Death." *The Lancet* 370 (9601): 1744–46. https://doi.org/10.1016/S0140-6736(07)61419-6

Lundkvist-Houndoumadi, Margharita, and Ola Samarah. 2022. "Does Disaggregation Equal Inclusion? Reflections on Producing Disaggregated Analysis to Ensure Inclusive Durable Solutions." *JIPS*, May, 5.

Malaria Policy Advisory Committee. 2020. "Overview of the Malaria Surveillance Assessment Toolkit." WHO. https://www.who.int/docs/default-source/malaria/mpac-documentation/mpac-december2020-session1-surveillance-toolkit-update.pdf?sfvrsn=f3091836_9

Michaels-Strasser, Susan, Paul W. Thurman, Narcisse Mwinkeu Kasongo, Daniel Kapenda, John Ngulefac, Beatrice Lukeni, Serge Matumaini, Lauren Parmley, Rebekah Hughes, and Faustin Malele. 2021. "Increasing Nursing Student Interest in Rural Healthcare: Lessons from a Rural Rotation Program in Democratic Republic of the Congo." *Human Resources for Health* 19 (1): 53. https://doi.org/10.1186/s12960-021-00598-9

Migración Colombia. 2019. "Fenómeno Migratorio: Población Venezolana En Colombia." https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/ED/infografia-migrantes-25junio2019.pdf

———. 2021. "Distribución de Venezolanos en Colombia - Corte 31 de Agosto de 2021." https://www.migracioncolombia.gov.co/infografias/distribucion-de-venezolanos-en-colombia-corte-31-de-agosto-de-2021

Ministerio de Salud y Protección Social. n.d. "Observatorio Nacional de Migración y Salud (ONMS)." Portal SISPRO. Accessed June 7, 2022. https://www.sispro.gov.co/observatorios/onmigracionysalud/Paginas/Observatorio-Nacional-de-Migracion-y-Salud.aspx

Minsalud. n.d. "Planes Territoriales de Salud (PTS) 2020-2023." Accessed April 27, 2022. https://www.minsalud.gov.co/salud/publica/epidemiologia/Paginas/planes-territoriales-de-salud.aspx

MOHFW, GoB. 2018. "The Costs of the Bangladesh Essential Health Service Package: Fourth Health Population and Nutrition Sector Programme." https://cdn.who.int/media/docs/default-source/searo/bangladesh/pdf-reports/year-2016-2018/the-cost-of-the-bangladesh-essential-health-service-package.pdf?sfvrsn=3d47225f_2

Molnar, Petra. 2022. "Territorial and Digital Borders and Migrant Vulnerability Under a Pandemic Crisis." In *Migration and Pandemics: Spaces of Solidarity and Spaces of Exception*, edited by Anna Triandafyllidou, 45–64. Cham: Springer International Publishing. https://doi.org/10.1007/978-3-030-81210-2_3

MoPoTsyo. 2010. "Peer Educator Networks for People with Diabetes Mellitus or High Blood Pressure in Cambodia: 'Healing a Market for Health' 2005-2010." https://mopotsyo.org/wp-content/uploads/2018/09/5YearReportInclude2010.pdf

MSF. 2021. "In DRC, Measles Is Spreading and Killing Again in What Seems to Be a Never-Ending Fight - Democratic Republic of the Congo." ReliefWeb. April 1, 2021. https://reliefweb.int/report/democratic-republic-congo/drc-measles-spreading-and-killing-again-what-seems-be-never-ending

Mulinganya, Vicky, Florentin Asima, Patrick Mirindi, and Hermès Karemere. 2018. "Temps d'attente Prolongés Aux Services de Consultation Médicale: Enjeux et Perspectives Pour Des Hôpitaux de Bukavu En République Démocratique Du Congo." *Pan African Medical Journal* 29. https://doi.org/10.11604/pamj.2018.29.173.13651

Nathe, Margarite. 2016. "Where Are the DRC's Doctors and Nurses? IHRIS Data Give Us Hints." IntraHealth. September 27, 2016. https://www.intrahealth.org/vital/where-are-drc%E2%80%99s-doctors-and-nurses-ihris-data-give-us-hints

Newbrander, William, Ronald Waldman, and Megan Shepherd-Banigan. 2011. "Rebuilding and Strengthening Health Systems and Providing Basic Health Services in Fragile States." *Disasters* 35 (4): 639–60. https://doi.org/10.1111/j.1467-7717.2011.01235.x

Norwegian Refugee Council. 2021. "Development Actors and the Nexus; Lessons from Crises in Bangladesh, Cameroon and Somalia." https://www.nrc.no/resources/reports/development-actors-and-the-nexus-lessons-from-crises-in-bangladesh-cameroon-and-somalia/

OCHA. 2021. "APERÇU DES BESOINS HUMANITAIRES: RÉPUBLIQUE DÉMOCRATIQUE DU CONGO."

OHCHR. 2020. "COVID-19 and the Human Rights of Migrants: Guidance." https://www.ohchr.org/Documents/Issues/Migration/OHCHRGuidance_COVID19_Migrants.pdf

Oslender, Ulrich. 2016. "The Banality of Displacement: Discourse and Thoughtlessness in the Internal Refugee Crisis in Colombia." *Political Geography* 50 (January): 10–19. https://doi.org/10.1016/j.polgeo.2015.08.001

Owoaje, EmeT, ObiomaC Uchendu, TumininuO Ajayi, and EniolaO Cadmus. 2016. "A Review of the Health Problems of the Internally Displaced Persons in Africa." *Nigerian Postgraduate Medical Journal* 23 (4): 161. https://doi.org/10.4103/1117-1936.196242

Pal, Nicole E., Lisa Eckenwiler, Shelley-Rose Hyppolite, John Pringle, Ryoa Chung, and Matthew Hunt. 2019. "Ethical Considerations for Closing Humanitarian Projects: A Scoping Review." *Journal of International Humanitarian Action* 4 (1): 17. https://doi.org/10.1186/s41018-019-0064-9

Patel, P. P., J. Russell, K. Allden, T. S. Betancourt, P. Bolton, A. Galappatti, Z. Hijazi, et al. 2011. "Transitioning Mental Health & Psychosocial Support: From Short-Term Emergency to Sustainable Post-Disaster Development. Humanitarian Action Summit 2011." *Prehospital and Disaster Medicine* 26 (6): 470–81. https://doi.org/10.1017/S1049023X1200012X

Program on Forced Migration and Health. n.d. “Knowledge Briefs on COVID-19 and Displacement | Columbia Public Health.” Columbia University. Accessed April 27, 2022. https://www.publichealth.columbia.edu/research/program-forced-migration-and-health/knowledge-briefs-covid-19-and-displacement

Rahman, Zara. 2021. “The UN’s Refugee Data Shame.” The New Humanitarian. June 21, 2021. https://www.thenewhumanitarian.org/opinion/2021/6/21/rohingya-data-protection-and-UN-betrayal

Raposo, Vera Lúcia, and Teresa Violante. 2021. “Access to Health Care by Migrants with Precarious Status During a Health Crisis: Some Insights from Portugal.” *Human Rights Review* 22 (4): 459–82. https://doi.org/10.1007/s12142-021-00621-5

Rehr, Manuela, Muhammad Shoaib, Sara Ellithy, Suhib Okour, Cono Ariti, Idriss Ait-Bouziad, Paul van den Bosch, et al. 2018. “Prevalence of Non-Communicable Diseases and Access to Care among Non-Camp Syrian Refugees in Northern Jordan.” *Conflict and Health* 12 (1): 33. https://doi.org/10.1186/s13031-018-0168-7

Roa, Arturo Harker, Sara E Casey, Goleen Samari, and Dana Nabulsi. 2020. “Family Violence Prevention in the Context of COVID-19 and Forced Displacement.” Knowledge Brief. Family Violence Prevention in the Context of COVID-19 and Forced Displacement.

Severe Malaria Observatory. n.d. “Democratic Republic of Congo: Malaria Facts.” Accessed April 7, 2022a. https://www.severemalaria.org/countries/democratic-republic-of-congo

———. n.d. “DRC Health System.” Severe Malaria Observatory. Accessed April 7, 2022b. https://www.severemalaria.org/countries/democratic-republic-of-congo/drc-health-system

Shepard, Donald S., Adelaida Boada, Douglas Newball-Ramirez, Anna G. Sombrio, Carlos William Rincon Perez, Priya Agarwal-Harding, Jamie S. Jason, Arturo Harker Roa, and Diana M. Bowser. 2021. “Impact of the COVID-19 Pandemic in Colombia on Utilization of Medical Services by Venezuelan Migrants and Colombian Citizens.” Knowledge Brief. Program on Forced Migration and Health, Columbia University. https://www.publichealth.columbia.edu/sites/default/files/covid_colombia_brief_v60.pdf

Shteiwi, M. 2014. “Dealing with the Crisis: A Review of the Response to Syrian Refugees in Jordan (2014).” مركز الدراسات الإستراتيجية (blog). November 20, 2014. https://jcss.org/980/dealing-with-the-crisis-a-review-of-the-response-to-syrian-refugees-in-jordan-2014/

Soeters, Robert, Peter Bob Peerenboom, Pacifique Mushagalusa, and Célestin Kimanuka. 2011. "Performance-Based Financing Experiment Improved Health Care In The Democratic Republic Of Congo." *Health Affairs* 30 (8): 1518–27. https://doi.org/10.1377/hlthaff.2009.0019

Spiegel, Paul B. 2017. "The Humanitarian System Is Not Just Broke but Broken: Recommendations for Future Humanitarian Action." *Lancet (London, England)*, June, S0140-6736(17)31278-3. https://doi.org/10.1016/S0140-6736(17)31278-3

Spiegel, Paul, Rebecca Chanis, and Antonio Trujillo. 2018. "Innovative Health Financing for Refugees." *BMC Medicine* 16 (1): 90. https://doi.org/10.1186/s12916-018-1068-9

Steinhardt, Laura C., Krishna D. Rao, Peter M. Hansen, Sahibullah Alam, and David H. Peters. 2013. "The Effects of User Fees on Quality and Utilization of Primary Health-Care Services in Afghanistan: A Quasi-Experimental Health Financing Pilot Study in a Post-Conflict Setting: PRIMARY HEALTH-CARE SERVICES IN AFGHANISTAN." *The International Journal of Health Planning and Management* 28 (4): e280–97. https://doi.org/10.1002/hpm.2178

"SUIVI DES SERVICES DE SANTE ESSENTIELS PENDANT LA PANDEMIE DE COVID-19." 2022. Global Financing Facility.

Sven Engström, Mats Foldevi, Lars B. 2001. "Is General Practice Effective? *A Systematic Literature Review*." *Scandinavian Journal of Primary Health Care* 19 (2): 131–44. https://doi.org/10.1080/028134301750235394

The Higher Health Council. 2014. "The National Strategy for Health Sector in Jordan 2015-2019." https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/jordan/jordan_national_health_sector_strategy_2015-2019_.pdf

The World Bank. n.d. "Maternal Mortality Ratio (Modeled Estimate, per 100,000 Live Births) - Congo, Dem. Rep. | Data." Accessed April 1, 2022. https://data.worldbank.org/indicator/SH.STA.MMRT?locations=CD

Treisman, Rachel. 2021. "Colombia Offers Temporary Legal Status To Nearly 1 Million Venezuelan Migrants." *NPR*, February 9, 2021, sec. Latin America. https://www.npr.org/2021/02/09/965853031/colombia-offers-temporary-legal-status-to-nearly-1-million-venezuelan-migrants

Tuepker, Anais, and Chunhuei Chi. 2009. "Evaluating Integrated Healthcare for Refugees and Hosts in an African Context." *Health Economics, Policy and Law* 4 (2): 159–78. https://doi.org/10.1017/S1744133109004824

Turcotte-Tremblay, Anne-Marie, Idriss Ali Gali Gali, and Valéry Ridde. 2020. "An Exploration of the Unintended Consequences of Performance-Based Financing in 6 Primary Healthcare Facilities in Burkina Faso." *International Journal of Health Policy and Management*, June, 1. https://doi.org/10.34172/ijhpm.2020.83

Turcotte-Tremblay, Anne-Marie, Idriss Ali Gali-Gali, Manuela De Allegri, and Valéry Ridde. 2017. "The Unintended Consequences of Community Verifications for Performance-Based Financing in Burkina Faso." *Social Science & Medicine* 191 (October): 226–36. https://doi.org/10.1016/j.socscimed.2017.09.007

UN General Assembly. 2018. "General Assembly Endorses Landmark Global Compact on Refugees, Adopting 53 Third Committee Resolutions, 6 Decisions Covering Range of Human Rights." UN Meetings Coverage and Press Releases. December 17, 2018. https://www.un.org/press/en/2018/ga12107.doc.htm

UNFPA Bangladesh. 2022. "UNFPA's Midwives Mark International Day of the Midwife in Cox's Bazar." May 5, 2022. https://bangladesh.unfpa.org/en/news/unfpas-midwives-mark-international-day-midwife-coxs-bazar

UNHCR. 2018. "UNHCR Service Guide." https://www.unhcr.org/jo/wp-content/uploads/sites/60/2018/08/WEB-FINAL_Service-Guide-August2018_ENG-HighRes.pdf

———. 2019. "Registration Gives Many Rohingya Refugees Identification for the First Time." UNHCR. May 17, 2019. https://www.unhcr.org/news/latest/2019/5/5cde66b84/registration-gives-rohingya-refugees-identification-first-time.html

———. 2021a. "2020 Annual Public Health Global Review." https://www.unhcr.org/publications/brochures/60dc89e24/2020-annual-public-health-global-review.html

———. 2021b. "Global Trends: Forced Displacement in 2020." UNHCR. https://www.unhcr.org/60b638e37.pdf

———. 2021c. "Registered Persons of Concern Refugees and Asylum Seekers in Jordan (30 November 2021)." December 2021. https://reliefweb.int/report/jordan/registered-persons-concern-refugees-and-asylum-seekers-jordan-30-november-2021

———. 2021d. "Temporary Protection Status in Colombia (November 2021)." December 2021. https://reliefweb.int/report/colombia/temporary-protection-status-colombia-november-2021-0

———. n.d. “Operational Data Portal: Syria Regional Refugee Response.” Operational Data Portal for Refugee Situations. Accessed June 6, 2022a. https://data.unhcr.org/en/situations/syria/location/36

———. n.d. “UNHCR Global Public Health Strategy 2021-2025.” UNHCR. Accessed April 4, 2022b. https://www.unhcr.org/publications/brochures/612643544/unhcr-global-public-health-strategy-2021-2025.html

UNHCR Jordan. 2020. “Supporting Refugees in Jordan: What We Achieved in 2020.” https://reporting.unhcr.org/sites/default/files/UNHCR%20Jordan%20-%202020%20Year%20in%20Review.pdf

UNICEF. 2015. “Maternal and Newborn Health Disparities: Democratic Republic of the Congo (DRC) - Democratic Republic of the Congo.” ReliefWeb. 2015. https://reliefweb.int/report/democratic-republic-congo/maternal-and-newborn-health-disparities-democratic-republic-congo

———. 2018. “85 per cent of Syrian Children in Host Communities in Jordan Live in Poverty - UNICEF.” UNICEF. February 26, 2018. https://www.unicef.org/press-releases/syrian-children-jordan-poverty-unicef

———. 2020. “DRC: Vaccination Sessions Increase by 50% in Vulnerable Provinces since 2018.” Press release. Kinshasa, DRC: UNICEF. https://www.unicef.org/drcongo/en/press-releases/vaccination-sessions-increase-vulnerable-provinces

———. 2022. “UNICEF Bangladesh Country Office Annual Report 2021.” 2022. https://www.unicef.org/reports/country-regional-divisional-annual-reports-2021/Bangladesh

Valadez, Joseph James, Sima Berendes, Jackline Odhiambo, William Vargas, Baburam Devkota, Richard Lako, and Caroline Jeffery. 2020. “Is Development Aid to Strengthen Health Systems during Protracted Conflict a Useful Investment? The Case of South Sudan, 2011–2015.” *BMJ Global Health* 5 (4): e002093. https://doi.org/10.1136/bmjgh-2019-002093

WHO. 2006. “Health Workers: A Global Profile.” 2006. http://whqlibdoc.who.int/publications/2006/9241563176_eng.pdf

———. 2010. *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies*. Geneva: World Health Organization. https://apps.who.int/iris/handle/10665/258734

———. 2017a. *Data Quality Review: Module 1: Framework and Metrics*. Geneva: World Health Organization. https://apps.who.int/iris/handle/10665/259224

———. 2017b. "Vaccination in Humanitarian Emergencies: Implementation Guide." https://www.who.int/publications-detail-redirect/WHO-IVB-17.13

———. 2018. "Health of Refugees and Migrants: Regional Situation Analysis, Practices, Experiences, Lessons Learned and Ways Forward - WHO European Region (2018)." https://www.who.int/publications-detail-redirect/health-of-refugees-and-migrants---who-european-region-(2018)

———. 2019. "Task Shifting: Global Recommendations and Guidelines." Geneva: World Health Organization. https://apps.who.int/iris/handle/10665/325480

———. 2020a. "Country Assessment Guide: The Health Financing Progress Matrix." Geneva, Switzerland. https://www.who.int/publications-detail-redirect/9789240017801

———. 2020b. "Group Interpersonal Therapy (IPT) for Depression." https://www.who.int/publications-detail-redirect/WHO-MSD-MER-16.4

———. 2021a. "Attacks on Health Care: Three-Year Analysis of SSA Data (2018-2020)." https://reliefweb.int/sites/reliefweb.int/files/resources/Attacks%20on%20Health%20Care_%20Three-year%20analysis%20of%20SSA%20data%20%282018-2020%29.pdf

———. 2021b. "What Do We Mean by Availability, Accessibility, Acceptability and Quality (AAAQ) of the Health Workforce?" World Health Organization. 2021. https://www.who.int/news-room/questions-and-answers/item/q-a-on-the-health-workforce-crisis

———. 2021c. "Scoping Review of Interventions to Maintain Essential Services for Maternal, Newborn, Child and Adolescent Health and Older People during Disruptive Events." ISBN: 9789240038318. https://www.who.int/publications-detail-redirect/9789240038318

WHO, Columbia University. 2016. "Group Interpersonal Therapy (IPT) for Depression." https://apps.who.int/iris/bitstream/handle/10665/250219/WHO-MSD-MER-16.4-eng.pdf;jsessionid=B307A05C987FD9CC3A032777B88C4379?sequence=1

WHO, and Jordan Ministry of Health. 2020. "Jordan: WHO Special Initiative for Mental Health: Situational Assessment." https://cdn.who.int/media/docs/default-source/mental-health/special-initiative/who-special-initiative-country-report---jordan---2020_414542ae-ce5d-4f1d-bf40-fe1b1cbf8003.pdf?sfvrsn=e813985_4

Woolf, Kapiteni, Mamba Célestin, and Kadima Justin N. 2018. "Insight into Audit Reports on the Causes of Maternal Deaths in Poor Health Settings: The Case of North Kivu Province in Democratic Republic of Congo." *International Journal of Women's Health and Wellness* 4 (2). https://doi.org/10.23937/2474-1353/1510079

World Bank. n.d. "Completeness of Birth Registration (%) - Jordan | Data." Accessed June 3, 2022. https://data.worldbank.org/indicator/SP.REG.BRTH.ZS?locations=JO

World Bank Group. n.d. "Gender Dimensions of Forced Displacement (GDFD) Research Program." Text/HTML. World Bank: Building the Evidence on Forced Displacement. Accessed June 17, 2022. https://www.worldbank.org/en/topic/gender/brief/gender-dimensions-of-forced-displacement-gdfd-research-program

World Bank, and International Finance Corporation. 2019. "External Assessment of Quality of Care in the Health Sector in Colombia." *World Bank*, July. https://www.worldbank.org/en/topic/health/publication/external-assessment-of-quality-of-care-in-the-health-sector-in-colombia

Xu, Ke, David B Evans, Kei Kawabata, Riadh Zeramdini, Jan Klavus, and Christopher JL Murray. 2003. "Household Catastrophic Health Expenditure: A Multicountry Analysis." *The Lancet* 362 (9378): 111–17. https://doi.org/10.1016/S0140-6736(03)13861-5

Zee, Bibi van der. 2015. "Less than 2% of Humanitarian Funds 'Go Directly to Local NGOs.'" *The Guardian*, October 16, 2015, sec. Working in development. https://www.theguardian.com/global-development-professionals-network/2015/oct/16/less-than-2-of-humanitarian-funds-go-directly-to-local-ngos

Zeng, Wu, Marion Cros, Katherine D Wright, and Donald S Shepard. 2013. "Impact of Performance-Based Financing on Primary Health Care Services in Haiti." *Health Policy and Planning* 28 (6): 596–605. https://doi.org/10.1093/heapol/czs099

Zulver, Julia. 2018. "Feasible Justice: Has Colombia Over-Promised and Under-Delivered Reparations for Its 8.6 Million Victims?" *JusticeInfo.Net* (blog). June 12, 2018. https://www.justiceinfo.net/en/37686-feasible-justice-has-colombia-over-promised-and-under-delivered-reparations-for-its-8-6-million-vic.html

COLUMBIA | MAILMAN SCHOOL OF PUBLIC HEALTH

UKaid from the British people | UNHCR The UN Refugee Agency | WORLD BANK GROUP

Building the Evidence on Forced Displacement

Brandeis UNIVERSITY

COLUMBIA | MAILMAN SCHOOL OF PUBLIC HEALTH
FORCED MIGRATION & HEALTH

AUB American University of Beirut | GLOBAL HEALTH INSTITUTE AUB

Universidad de los Andes Colombia | Escuela de Gobierno Alberto Lleras Camargo

COLUMBIA | MAILMAN SCHOOL OF PUBLIC HEALTH
HEILBRUNN DEPARTMENT OF POPULATION & FAMILY HEALTH

GEORGETOWN UNIVERSITY