



THE BIG QUESTIONS IN FORCED DISPLACEMENT AND HEALTH

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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 KIs 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.). 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). 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).

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 shifting¹ 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.

