



EQUITABLE ACCESS TO HEALTH SERVICES: LESSONS FOR INTEGRATING DISPLACED POPULATIONS INTO NATIONAL HEALTH SYSTEMS

Lessons Learned & Innovative Approaches from the Humanitarian Health Response in Jordan, Bangladesh and Chad



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EXECUTIVE SUMMARY

There are more displaced people today than at any other point in history with displacement lasting 20 years on average for refugees and more than ten years for the majority of internally displaced persons (IDP).¹ For these vulnerable populations, access to essential, life-saving services including basic healthcare, remains a constant challenge. This indicates the need for long-term, sustainable solutions, rather than short-term fixes.

With health programs in more than 30 countries, the International Rescue Committee (IRC) strives to ensure that those who are experiencing or recovering from conflict and disaster – including refugees, IDPs, and people living in refugee host communities — have access to high-quality, affordable health services.

A study, including key informant interviews and a literature review, was conducted in early 2021, looking into ongoing health operations in three challenging contexts – Jordan, Bangladesh and Chad – with the aim of identifying best practices and lessons learned at the policy, financial, and practical levels.

¹ <https://bit.ly/2ZNOLju> (ECHO fact sheet 2020)

EXECUTIVE SUMMARY

In Jordan,² dwindling donor funds and limited resources have hindered access to affordable health services for vulnerable refugee and host populations. Health systems strengthening activities coupled with effective community health approaches aimed at improving non-communicable disease (NCD) patient adherence to medication and continuous care, have demonstrated that effective and timely cooperation between government, humanitarian agencies, and donors can yield positive results which more easily transition into long-term solutions.

In Bangladesh,³ the structural, technical and financial limitations of the national health system – as well as the absence of explicit health policies linked to refugee populations — have resulted in a challenging landscape for both refugee and vulnerable host populations. Capacity building activities led by the IRC and partners to enhance access to Sexual and Reproductive Health (SRH) services have helped young midwifery graduates gain experience in Rohingya refugee camps and go on to join Ministry of Health (MoH) facilities thus strengthening national health systems and improving the quality of care.

In Chad,⁴ the government has committed to integrating displaced populations in the national health system but implementation of the policy has been slow — this is also the case with implementation of the Reproductive Health Law. Coupled with human resource shortages, financial barriers and significant challenges linked to climate change, health services remain inaccessible to many, particularly people living in rural areas. The IRC and partners have strived to address these obstacles by working with the government to build health worker capacity, improve infrastructure and equipment, and advocate for implementation of existing policies that expand access to care for all.

The Jordan, Bangladesh and Chad contexts underscore the need to advance evidence-based, inclusive health policies that address the unique needs of vulnerable populations both in the immediate response as well as in long-term planning and financing. This is critical not only for ensuring equitable access to health for all, regardless of documentation status, but also for global and national health security – a principal clearly seen through the COVID-19 pandemic.

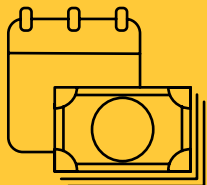
² <https://www.rescue.org/country/jordan> (IRC in Jordan, 2021)

³ <https://www.rescue.org/country/bangladesh> (IRC in Bangladesh, 2021)

⁴ <https://www.rescue.org/country/chad> (IRC in Chad, 2021)

EXECUTIVE SUMMARY

Donors, national governments, and implementing organizations should take forward these four overarching recommendations to enhance the health response in any acute or protracted crisis:



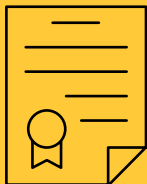
FINANCIAL

Donors must allocate long-term, flexible financing to ensure the sustainable provision of quality, affordable and accessible health services throughout the arc of a crisis – from immediate response to long-term recovery and resilience.



STRUCTURAL & LEGAL

Governments and donors must prioritize strengthening national health systems from the onset of any humanitarian health intervention through capacity building of health staff, enhancing health structures and medical resources, and investing in key technologies linked to data, surveillance, and information gathering.



POLITICAL

Governments must develop inclusive national policies that promote equitable access to health services, regardless of legal status. We must also see political will translated into concrete action with the funding needed to implement those policies. For example, refugees and displaced populations must be included in COVID-19 vaccine deployment and distribution plans.



COMMUNAL

Governments and implementing organizations should leverage decentralized community health approaches that empower vulnerable refugee, IDP and host population groups to help effectively address and prevent serious health conditions while also strengthening linkages with the formal health system.

ACRONYMS AND ABBREVIATIONS

ANC	Antenatal care	MHPSS	Mental health and psychosocial support
BemONC	Basic emergency obstetric and newborn care	MNH	Maternal and newborn health
CDC	Center for Disease Control	MoDMR	Ministry of Disaster Management and Relief
CHC	Comprehensive Healthcare Center	MoFA	Ministry of Foreign Affairs
CHW/V	Community Health Worker or Volunteer	MoH	Ministry of Health
CRRF	Comprehensive Refugee Response Framework	MOHFW	Ministry of Health and Family Welfare
CSO	Civil society organization	MoU	Memorandum of Understanding
cVDPV	Vaccine derived Poliovirus	MSF	Médecins sans Frontières/Doctors without Borders
DoH	Department of Health	NCDs	Non-Communicable Diseases
DRC	Democratic Republic of Congo	NGO	Non-governmental Organizations
EEC	Exceptional Care Committee (UNHCR)	PHC	Primary Healthcare Center
EU	European Union	PNC	Post-natal care
FP	Family Planning	PPE	Personal Protective Equipment
GDP	Gross Domestic Product	RH	Reproductive Health
HR	Human Resources	SARI ITC	Severe Acute Respiratory Infection Isolation and Treatment
HSS	Health Systems Strengthening	SBA	Skilled Birth Attendant
ICU	Intensive Care Unit	SDGs	Sustainable Development Goals
IDP	Internally Displaced Person	SRH	Sexual and Reproductive Health
IHR	International Health Regulations	STI	Sexually Transmitted Infection
INGO	International Non-Governmental Organization	TRC	Turkish Red Crescent
IOM	International Organization for Migration	UHC	Universal Health Care
IPC	Infection Prevention and Control	UN	United Nations
IPV	Intimate Partner Violence	UN OCHA	United Nations Office for the Coordination of Humanitarian Affairs
IRC	International Rescue Committee	UNFPA	United Nations Population Fund
ITCs	Isolation and Treatment Centers	UNHCR	United Nations High Commissioner for Refugees
IWC	Integrated Women Centers	US	United States
JoD	Jordanian Dinar	USD	United States Dollar
JRP	Jordan Response Plan	WB	World Bank
MH	Mental Health	WFS	Women Friendly Spaces
		WHO	World Health Organization

INTRODUCTION

There are more displaced people today than at any other point in history with displacement lasting 20 years on average for refugees and more than ten years for the majority of internally displaced people (IDP).⁵ For these vulnerable populations, access to essential, life-saving services including basic healthcare, remains a constant challenge. This indicates the need for long-term, sustainable solutions, rather than short-term fixes.

With health programs in more than 30 countries, the International Rescue Committee (IRC) strives to ensure that those who are experiencing or recovering from conflict and disaster – including refugees, IDPs, and people living in refugee host communities — have access to high-quality, affordable health services.

An essential aspect of this work includes advocating for the inclusion of refugees into national health systems — a strategy in line with the Global Compact on Refugees and the 2030 Agenda for Sustainable Development.

A closer look at the humanitarian health responses in Jordan, Chad and Bangladesh⁶ demonstrated varying degrees of success integrating vulnerable populations into national health systems and offers a range of key lessons as others seek to expand refugee access to health services.

Each case study examines some of the greatest barriers to access including the lack of long-term strategies and the creation of parallel health systems which make it difficult for the national government to absorb. Nevertheless, promising innovative approaches continue to be developed in all three contexts as the IRC – and other humanitarian health actors and partners – strives to strengthen national health systems while equipping local communities to tackle crucial health issues. Investing in both national and community-based health responses has proven critical to maintaining flexibility and ensuring continuity of care during emergencies such as the COVID-19 pandemic.⁷

More than 25 interviews were conducted with IRC health staff, international non-governmental organizations (INGOs), non-governmental organizations (NGOs) and civil society organizations (CSOs), as well as Ministry of Health (MoH) representatives in Jordan, Chad and Bangladesh to further understand the context and operational challenges in all three countries. Coupled with a literature review for each country, this study facilitated the identification of best practices, innovative approaches, and concrete recommendations to help shape how key stakeholders — including implementing organizations and policy makers — at global and national levels approach access to sustainable health services for displaced populations. This includes access to COVID-19 tools that are both life-saving and necessary for ending the pandemic.

⁵ <https://bit.ly/2ZNOLju> (ECHO fact sheet 2020)

⁶ Jordan case study also available in Arabic. Bangladesh and Chad case studies available in English.

⁷ <https://www.rescue.org/report/mitigating-covid-19-humanitarian-settings> (IRC Mitigating Covid-19 in Humanitarian Settings, April 2020)



JORDAN

ADAPTING TO A PROTRACTED CRISIS



THE CRISIS IN JORDAN

The Syrian refugee crisis remains the largest ever witnessed with more than 6.6 million⁸ men, women and children forced to flee their homes since the onset of the civil war in March 2011. Many have found refuge in neighboring Jordan – home to the largest Syrian refugee settlement in the world known as Zaatari Camp. In its 2020-2022 Jordan Response Plan (JRP), the government estimated the number of Syrian refugees within its territory to be close to 1.36 million – representing nearly 15% of its entire population.⁹ This has created economic strain on Jordan and particularly on its public health system. The Jordanian government has estimated that it would need nearly 178 million USD to cover the health needs of its refugee population in 2021.¹⁰ Worryingly, only 50.8% of the JRP's funding asks were covered in 2019, sinking even lower to 40.5% in 2020.¹¹

As of February 2021, the UN Refugee Agency (UNHCR) had registered 753,282 refugees in Jordan, most of them (664,414) originating from Syria.¹² The majority of these refugees (80%) currently reside in urban areas with the largest numbers located in the capital Amman, followed by Irbid, Mafraq and Zarqa governorates, respectively.¹³ Despite the significant presence, Jordan is not a signatory of the 1951 Convention relating to the Status of Refugees which outlines the rights of refugees, as well as the legal obligations of States to protect them.

Although the international community rushed to support Jordan in the early days of the response, a different landscape exists today. The presence of humanitarian

actors has gradually shrunk since the first ceasefire was ushered in for Southern Syria by the US and Russia in 2017, leading to the downscaling or phasing out of health programs following changes in operational strategies coupled with a lack of funds dedicated to the now protracted crisis. The repercussions are especially apparent in urban areas, where many refugee and vulnerable host populations have grown increasingly dependent on free health services provided by humanitarian actors.

The healthcare system in Jordan is quite developed with both private and public healthcare facilities including specialized hospitals concentrated in Amman, while Primary Healthcare Centers (PHCs) and Comprehensive Healthcare Centers (CHCs) are spread out primarily in the big cities across Jordan's 12 governorates. Many villages – particularly in the northern and southern regions – lack strong linkages with the public health system as clinics remain sparse in rural areas. The Jordanian health system is centralized, with strategic and financial decisions typically made at the central Ministry of Health (MoH) levels in Amman. These decisions are often slow to trickle down to health authorities in the different governorates, and key instructions sometimes fail to reach health centers in due time.¹⁴ The national health system remains over-stretched as it faces a continuous increase of patients and stagnating health budgets, making it difficult to retain qualified health professionals.¹⁵

⁸ <https://www.unrefugees.org/news/syria-refugee-crisis-explained/> (USA for UNHCR)

⁹ <https://reliefweb.int/sites/reliefweb.int/files/resources/77262.pdf> (JRP 2020-2022)

¹⁰ Ibid (JRP 2020-2022)

¹¹ <https://fts.unocha.org/countries/114/summary/2019> (FTS OCHA Jordan 2019-2020)

¹² <https://data2.unhcr.org/en/documents/details/85205> (UNHCR Jordan data as of 15 February 2021)

¹³ Ibid. (UNHCR Jordan data as of 15 February 2021)

¹⁴ A number of health actors, including IRC health staff, have reported that the continuous changes in government health policies in 2014, 2018 and 2019 did not always reach clinical staff in rural areas on time.

¹⁵ <https://reliefweb.int/report/jordan/improving-essential-public-service-delivery-jordan> (USAID Jordan, July 2020)

JORDAN

The Jordanian MoH has struggled to maintain a consistent provision of affordable, quality health services when having to absorb Syrian refugee patients into its national health structure. At the same time, uninsured Jordanians lack sufficient access to health services.¹⁶ Additional pressures were faced during the COVID-19 pandemic where more than 8,300 COVID-related deaths were reported in the

country as of mid-April 2021,¹⁷ pressing authorities to introduce strict lockdown measures which paralyzed the economic sector. Still, Jordan has been praised by the international community for persevering in its efforts to address the health needs of vulnerable populations on its territory,¹⁸ most recently through the inclusion of refugees in its COVID-19 response and vaccination plan.¹⁹

OPERATIONAL CHALLENGES TO DELIVERING HEALTHCARE

Funding Insecurities Hinder a Long-Term Vision

In the early years of the crisis, Syrian refugees benefited from free health services in both camp and urban settings. In November 2014, the government cancelled free health services for Syrian refugees in urban areas, requiring them to pay the same rate as uninsured Jordanians.²⁰ Following significant funding shortages for the health response, the Jordanian government introduced new regulations in February 2018 resulting in Syrian refugees no longer being able to access health services at the same rate as uninsured Jordanians, instead paying 80% of the foreigner rate.²¹ Both policy shifts greatly limited access to public health services for the majority of Syrian refugees and added further strain on international and local health actors.²²

After more than one year of advocacy led by UNHCR and health partners including IRC, a multi-donor trust fund was established to support Jordan's MoH with USD 22.5 million contributed by the United States, Denmark and Canada to expand health care coverage.²³ This led to the rollback of the latest policy in April 2019, allowing Syrian refugees to once again access MoH-run public hospitals and primary healthcare centres at uninsured Jordanian rates, while also being able to access maternal and child care services for free at these sites.²⁴ In response, the IRC conducted a routine monitoring exercise to better understand the policy's impact on refugee health seeking behaviors. Among the 887 beneficiaries interviewed, 76.6% reported having to seek out free health service providers prior to the policy reversal, while 15% reported selling food coupons and 8.4% reported borrowing money to afford health services no

¹⁶ In fact, almost one third of the Jordanian population is left without any type of health insurance <https://reliefweb.int/sites/reliefweb.int/files/resources/77262.pdf> (JRP 2020-2022)

¹⁷ <https://graphics.reuters.com/world-coronavirus-tracker-and-maps/countries-and-territories/jordan/> (Reuters Covid-19 graphics Jordan, March 2021)

¹⁸ Jordan has also signed the UHC2030 Global Compact in 2018. <https://www.uhc2030.org/blog-news-events/uhc2030-news/jordan-signs-the-uhc2030-global-compact-503573/> (UHC Jordan 2018)

¹⁹ <https://www.unhcr.org/news/press/2021/1/5ffffe614/refugees-receive-covid-19-vaccinations-jordan.html> (UNHCR Jordan Covid-19 Press Release, Jan 2021)

²⁰ <https://reliefweb.int/report/jordan/health-access-and-utilization-survey-access-healthcare-services-among-syrian-refugees> (UNHCR health access and utilization survey, Dec 2018)

²¹ This change presented a 2-to-5 fold increase in service rates for Syrian refugees in Jordan.

²² <https://www.msf.org/jordan-syrians%E2%80%99-access-medical-care-risk> (MSF PR Jordan, April 2018)

²³ <https://reliefweb.int/sites/reliefweb.int/files/resources/69371.pdf> (UNHCR Jordan Fact Sheet, April 2019)

²⁴ Ibid. (UNHCR, Fact Sheet, April 2019)

longer subsidized.²⁵ Furthermore, 70% of beneficiaries reported that the policy reversal had “no significant impact” on their daily lives as they could not afford to pay for any medical costs to begin with.²⁶

Interviews conducted with representatives from seven international and local organizations implementing health activities for refugee and host populations in Jordan confirmed a growing uncertainty around the long-term continuity of the health response. This is compounded by the economic impact of the COVID-19 pandemic on donor governments like the US, Germany and the EU Commission. As of February 2021, only 14% of UNHCR’s financial requirements for 2021 have been met according to public UN data.²⁷

Although it may be too early to predict how funding dynamics will evolve, the health sector will likely remain over-stretched unless a long-term vision for sustainable, accessible and quality health provision in Jordan is integrated at all levels of the response. This is in line with the concept of the Humanitarian-Development-Peace Nexus, which focuses on coherently addressing people’s vulnerabilities before, during and after a crisis, while challenging the “status quo” of the aid system which is often over-stretched and driven by short-term funding cycles.²⁸

Parallel Health Initiatives’ Slow Integration into the National Health System

Responding to urgent needs in a crisis can sometimes lead to the creation of parallel health systems – the one led by the government and another system managed by humanitarian aid organizations. The humanitarian response to Non-communicable Diseases (NCDs) in Jordan provides a good example of how creating a parallel system with vertical programming – those focused on addressing specific health issues – can ultimately inhibit efforts to strengthen the national health system. This is particularly problematic in countries that have a well-established public health system.

In Jordan, NCDs are a leading cause of death and morbidity placing a substantial burden on the country’s healthcare system.²⁹ Tobacco, overuse of dietary salt, low consumption of fruits and vegetables, physical inactivity and obesity are prevalent among both refugee and host-populations.³⁰ IRC data confirms the prevalence of NCDs with close to 41.5% of NCD patients being below 50 years of age. Between 2015 and 2016, the IRC established two primary health care facilities in northern Jordan (Ramtha and Mafraq) initially providing the full primary healthcare package including NCD³¹ and reproductive health (RH) services. Other organizations such as MSF and Caritas established similar clinics. With funding scaling back, organizations previously offering these dedicated services began closing their facilities, sometimes abruptly ending care or hoping the MoH or other humanitarian actors could take on their NCD cohorts.

²⁵ <https://reliefweb.int/sites/reliefweb.int/files/resources/72211.pdf> (IRC Monitoring Report Jordan, August-September 2019)

²⁶ Ibid. (IRC Monitoring Report Jordan, August-September 2019)

²⁷ <https://data2.unhcr.org/en/documents/details/85015> (UNHCR Jordan Operational Update, Jan 2021)

²⁸ <https://reliefweb.int/report/world/humanitarian-development-peace-nexus-what-does-it-mean-multi-mandated-organizations> (Oxfam, Humanitarian Development-Peace Nexus, June 2019)

²⁹ <https://www.moh.gov.jo/Echobusv3.0/SystemAssets/256a175e-9de8-43a2-87a0-fc121aff76d4.pdf> (Jordan STEPS survey for NCDs 2019)

³⁰ <https://www.moh.gov.jo/Echobusv3.0/SystemAssets/256a175e-9de8-43a2-87a0-fc121aff76d4.pdf> (Jordan STEPS survey for NCDs 2019)

³¹ <https://www.rescue.org/sites/default/files/document/4932/ncdbrief462020.pdf> (IRC NCD care 2020)

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While MoH facilities have been willing to absorb NCD patients previously supported by humanitarian health actors, they would still require Syrian refugees and uninsured Jordanians to pay for services at a subsidized rate.

The creation of this parallel NCD health system has been problematic in Jordan. A Department of Health (DoH) representative observed that many Syrian and Jordanian patients who sought NCD care from humanitarian organizations still visited MoH clinics and received extra NCD medications.

“When humanitarian actors established their health services in the host communities during the early days of the refugee crisis, it was a positive development as it relieved us from many of the added pressures. However, we noticed after some time that patients who were visiting the NCD clinics run by INGOs or NGOs were still coming to our MoH clinics for the same services... It ended up being double the work for everyone and some patients were even receiving their NCD medications twice which contributed to occasional shortages” the DoH representative said.



[Malak, pharmacist] at an IRC health center in Zaatari refugee camp where we provide comprehensive primary and reproductive health care to Syrian refugees.

From tracking supplies to monitoring patient care, the representative stressed on the need for more coordination to ensure overlap does not negatively impact the health systems. To support this approach and drive a smooth transition of NCD patients back to MoH facilities in 2021 and 2022, the IRC is now investing in ten MoH-run health centers through capacity building and training, medical supplies and equipment, as well as infrastructure rehabilitation and maintenance.³²

³² IRC's Approach to Health Systems Strengthening (HSS), Internal Memo, November 2019

LASTING BARRIERS TO ACCESS

Financial Constraints in the Host Community

Key humanitarian and MoH healthcare workers in Jordan confirm that both Syrian refugees and vulnerable Jordanians continue to face financial constraints, limiting their access to healthcare services. Interviews with IRC Jordan staff confirmed NCD patients have voiced concern about the financial costs they would have to cover for medications and for lab tests, which had previously been partially or fully covered by humanitarian actors. IRC Jordan program data confirms that financial costs and quality of care at MoH clinics are even concerning for vulnerable Jordanian patients who represent close to 17% of the organization's current NCD cohort in Mafraq and Ramtha. Even more, access to secondary and tertiary care is now only accessible for Syrian refugees and vulnerable host-populations – such as uninsured Jordanians – when considered “life-saving.”³³ This has made it near impossible for cancer or dialysis patients, for example, to access adequate treatment, especially if their disease has reached more advanced stages.



Many of our Syrian refugee patients need surgeries or consultations from specialists but they cannot afford to pay for it, even at the subsidized rates. It is very difficult for us to even make the decision to refer them for secondary or tertiary care because we know that it most likely won't be approved by the [UNHCR's Exceptional Care Committee] EEC. Therefore, we only refer the patient if it is absolutely necessary and we also go the extra mile to try and find a donor who can cover the fees” stated Dr. Sally al Shogran, a General Practitioner at the IRC's NCD clinic in Mafraq.

The COVID-19 pandemic has exacerbated this with economic growth stagnating under strict lockdown measures.³⁴ Towards the end of 2020, employment losses were estimated at over 20% while household income fell on average by one-fifth during lockdown periods.³⁵ Displaced Syrian's are among the hardest hit with close to 80% of Syrian refugee households in urban areas living below the poverty line.³⁶ Dr. Shogran, indicated that the economic downturn has been particularly difficult on Syrian refugees female-headed households, leading families to make difficult decisions on whether to spend limited money on food and other basic needs over health care costs.

³³ Syrian refugees' access to secondary healthcare services was consecutively impacted by the 2014 and 2018 Government of Jordan health policy shifts, and was not adequately addressed in the reversal of 2019 which focused primarily on primary health care. In 2020, UNHCR reported submitting over 8,000 referrals of emergency or life-threatening cases to hospitals across Jordan. <https://reliefweb.int/report/jordan/unhcr-jordan-2020-year-review-supporting-refugees-jordan-what-we-achieved-2020> (UNHCR 2020 milestones, Jordan)

³⁴ <https://bit.ly/3qSrmcA> (IFPRI on Jordan Economy, Nov 2020)

³⁵ Ibid. (IFPRI on Jordan Economy, Nov 2020)

³⁶ <https://reliefweb.int/report/jordan/echo-factsheet-jordan-03022020> (ECHO fact sheet Jordan 2020)

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IRC teams have been concerned about the record number of requests for financial assistance received through its hotline in Jordan.³⁷ From March to September 2020, the organization received triple the number of calls than it did throughout all of 2019 with 60% linked to requests for financial assistance to cover basic needs.³⁸ The IRC was able to support the most vulnerable with emergency cash assistance as well as start-up grants to enable home-based business ideas to thrive.³⁹

Limited Mobility: An Overlooked Barrier

Limited mobility among vulnerable populations was identified as a leading barrier to healthcare in urban areas. People living with NCDs for example, must travel long distances to reach the nearest clinic for monthly check-ups – a burden due to time, distance,

and transportation costs. IRC health staff working at the NCD clinic in Mafraq – a vast governorate with many rural areas not connected to main routes or lines of public transport – confirmed that patients sometimes needed to travel up to 100 km to reach care. These issues will weigh more heavily on vulnerable NCD patients once primary health clinics run by humanitarian actors begin phasing out activities in 2020-2021. This is most concerning for Syrian refugees earning as little as five Jordanian dinar (JOD) per day in the informal job market (equal to eight USD) making care largely inaccessible. IRC's appointment system at NCD clinics in Mafraq and Ramtha, allowed patients to organize transportation in advance. During the pandemic lockdown, the IRC transitioned towards remote care tailored for NCD patients with phone counselling and medication supply delivered directly to patients' homes.

BEST PRACTICES: SUCCESSFUL & INNOVATIVE APPROACHES

Investing in Community Health

In Jordan, decentralizing the national health structure with a strong community health system has been essential for increasing access to health services particularly in rural areas with few PHC facilities. This is also key for strengthening formal linkages with the national health system through referrals to secondary and tertiary care. In Mafraq and Ramtha, the IRC invested in strengthening the linkages between their clinical NCD approach and the community it serves through an active and well-informed mobile team of Community Health Workers (CHWs) made up of

more than 200 volunteers from the Syrian refugee and vulnerable host community populations. These volunteers follow up with NCD patients through home visits and phone calls to communicate information on healthy lifestyle, while also ensuring adherence to medications. Through this approach, the IRC aims to foster an enabling environment where the adoption of healthy behaviors can be established at the individual, family and community levels, to prevent disease and lower treatment costs.⁴⁰

³⁷ <https://www.rescue.org/press-release/covid-cases-surpass-120000-jordan-refugees-struggle-feed-their-families> (IRC PR Covid-19 impact, Nov 2020)

³⁸ Ibid. (IRC PR Covid-19 impact, Nov 2020)

³⁹ Ibid. (IRC PR Covid-19 impact, Nov 2020)

⁴⁰ <https://www.rescue.org/sites/default/files/document/4932/ncdbrief462020.pdf> (IRC: NCDs in Humanitarian and Fragile Settings, June 2020)



According to Afaf Abu Kaff, Nurse Supervisor of IRC's Community Health Team in Mafraq: "In the beginning of our intervention, we noticed that beneficiaries in the Syrian and Jordanian communities were lacking very basic information about NCDs. For example, those with hypertension or diabetes weren't aware that smoking would worsen their conditions, or which type of foods they should avoid, especially foods that are high in sugar or salt... Over time, our patients really benefited from the comprehensive awareness sessions provided at the community level. Volunteers also had the opportunity to interact with the patient's caregivers or relatives during home visits, where they could discuss the best ways to support the patient by cooking healthier meals for example. This encouraged the whole family to lead a healthier lifestyle together."

The community health approach on NCDs has the potential to help identify and monitor chronic diseases such as hypertension and diabetes, while strengthening the links between the community and the primary health care system.⁴¹ The approach is also cost-effective since CHWs do not necessarily require a health background, instead receiving an intensive two to three-week training plus continuous capacity building.⁴² The IRC's Community Health Team reports positive results with some patients reaching a healthier body weight while others quit smoking. The need for similar approaches has been confirmed by a recent study on the prevalence of hypertension and diabetes among Syrian refugees in northern Jordan which stressed that a persisting high prevalence of complications such as obesity among NCD patients in Jordan suggests that

programs should focus more heavily on reinforcing adherence and prevention.⁴³ This approach also strengthens the links between the community and the IRC clinics as feedback from the patients is brought back by CHWs to the medical staff and discussed each month to help improve the quality of care.



Saleem al Zoubi, Community Research Assistant at the IRC explained: "When patients come to the clinic, there isn't always enough time to discuss everything in great detail with health professionals who have to closely follow their appointment schedules. This is where CHWs play a key role where in addition to spreading awareness in the community, they can also act as intermediaries and bring pertinent feedback from the patients back to the clinic staff at the end of the day. Patients have also noticed that their feedback is taken seriously and acted upon, and this has ultimately consolidated the trust between the community, our CHWs and our clinic staff."

To strengthen the national health system, an effective community health approach would need to be gradually integrated into the MoH structure with non-medical profiles included in the MoH jobs database. This should allow the recruitment of representatives from vulnerable community groups such as refugees. Both IRC staff and DoH staff interviewed for this study confirmed that the MoH has expressed readiness to integrate a more developed community approach into its current health response.⁴⁴ This would require additional funding, human resources and capacity building to become a self-sustaining approach. Ideally, it should also be linked to more holistic and patient-centered approaches

⁴¹ <https://www.elrha.org/news/linking-research-impact-in-jordan-with-global-change-mapping-stakeholders-in-community-health/> (ELRHA/IRC ongoing research 2017-2021)

⁴² <https://www.elrha.org/project-blog/updates-from-our-research-ncds-among-syrian-refugees-in-jordan/> (ELRHA/IRC ongoing research 2017-2021)

⁴³ <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2771453> (Access to Care and Prevalence of Hypertension and Diabetes Among Syrian Refugees in Northern Jordan Study, October 2020)

at the clinical level where a comprehensive or complete PHC package is provided through each health facility linked to community outreach efforts.⁴⁵ The IRC in Jordan is now investing in ten MoH-run clinics across Northern Jordan, providing capacity building for clinic staff, supporting staff salaries, donating materials based on joint assessments with the MoH, and assisting in the development of clinical protocols rooted in high quality of care and patient-centered approaches. If adopted by the MoH, the community health approach would also help to decentralize the public health system as CHWs would be able to reach rural areas not directly linked to MoH-run health centers.

Transitioning Toward a Health Systems Strengthening Approach

While creating a parallel system may expand access to life-saving services during the acute stage of a crisis, evidence shows this is not an effective strategy in the long run.⁴⁶ Based on its experiences in Jordan, the IRC recognizes the benefits of gradually shifting from its current parallel PHC/NCD service delivery model toward integration within the national health system. This gradual shift allows ample time for the health system to achieve the necessary level of capacity to serve both Syrian refugee and vulnerable host populations. The IRC does not recommend an abrupt termination of service delivery as it would leave a critical gap and place too heavy a burden on the national system, too quickly.

As part of a longer-term, three phase transition strategy, the IRC is beginning to shift patient caseload to the MoH. In the first stage, IRC urban clinics in Mafraq and Ramtha cut down to only one clinic shift per day; in the second phase, IRC further scaled down to just NCDs and RH services, referring other cases to nearby MoH facilities; stage three will soon begin and the IRC will completely transition away from direct service delivery. In collaboration with the MoH and DoH representatives in the concerned governorates – and with financial support from The Pfizer Foundation – the IRC will provide tailored support including in kind assistance and medical equipment, training and support for managing patient flow, sensitive referrals and refugee protection. Investments that allow for a longer term, transitional strategy that prioritizes strengthening the existing health system will contribute to the country's resilience while continuing to meet the needs of vulnerable populations. Monitoring mechanisms will also be put in place to follow up with patients who have undergone the transition to tailor the approach accordingly.

⁴⁴ A DoH representative from northern Jordan confirmed that the MoH already runs a similar model where volunteers raise awareness about certain medical themes in MoH-run PHCs, schools, universities and other public institutions. Although these awareness efforts might not be as systematic or patient-centered as the activities led by INGOs/NGOs through their current outreach programs in Jordan, it can certainly be a stepping stone towards developing a more comprehensive MOH-led model at the community level which is not solely reliant on medical personnel. More info on CHWs: https://apps.who.int/iris/bitstream/handle/10665/249563/EMROPUB_2016_EN_1760.pdf?sequence=1

⁴⁵ The majority of health professionals interviewed for this research study – whether from the humanitarian or public health sectors – reiterated the need to provide a holistic and patient-centered approach to primary healthcare as opposed to funding or implementing activities linked to one particular health service. This is particularly relevant to NCD care which can be considered to be closely intertwined with MH or RH care. According to IRC health staff, cases of NCD patients suffering from psychiatric disorders can be quite challenging, or for example cases of pregnant women suffering from pregnancy-induced hypertension and gestational diabetes would also require a more holistic approach.

⁴⁶ <https://apps.who.int/iris/bitstream/handle/10665/332441/Policy-brief%2036-1997-8073-eng.pdf> (WHO HSS Policy Brief, 2020)



THE COVID-19 PANDEMIC IN JORDAN: MAINTAINING FLEXIBLE & COLLABORATIVE APPROACHES IN HEALTH EMERGENCIES

One year into the COVID-19 pandemic, cases continue to rise in Jordan with more than 692,000 total confirmed cases and more than 8,300 reported deaths as of mid-April 2021.⁴⁷ Despite the wide-ranging negative impacts of the pandemic on the country's economic and health sectors, Jordan's COVID-19 health response plan and subsequent vaccine roll-out have been largely inclusive of vulnerable population groups. The WHO worked closely with Jordan's MoH to support the development of the comprehensive National Preparedness and Response COVID-19 Plan which includes refugees from Syria and 55 other countries.⁴⁸

Meanwhile, the World Bank (WB) invested more than 20 million USD to help strengthen Jordan's health system through COVID-19 emergency response preparedness.⁴⁹ Other positive collaborations during the pandemic included the introduction of a new health policy by the Jordanian government which allowed non-Syrian refugees to access healthcare services at the same subsidized rate as Syrian refugees.⁵⁰ The Pfizer Foundation and other corporate and private foundations have also played an important role in supporting efforts to strengthen the national and community health systems before, and throughout, the pandemic. This is a testament to the need for

⁴⁷ <https://corona.moh.gov.jo/en> (Jordan Ministry of Health, Covid-19 statistical report, April 2021)

⁴⁸ <https://bit.ly/37UI3wq> (COVID-19: WHO's Action in Countries, including Jordan, July 2020)

⁴⁹ https://ewdata.rightsindevelopment.org/files/documents/72/WB-P173972_VW6HTeK.pdf (WB Jordan PID, June 2020)

⁵⁰ <https://reliefweb.int/report/jordan/inter-sector-working-group-jordan-refugee-response-coordination-coronavirus-update-0#:~:text=As%20per%20the%20decision%20of,issued%20Asylum%20Seeker%2FRefugee%20certificates> (Inter-Sector Working Group, Jordan, July 2020)

Although a significant change in the government's health policy was implemented last year, allowing non-Syrian refugees to access healthcare services at the same subsidized rate as Syrian refugees, this has yet to be applied to non-refugees or irregular migrants in the country, who have become increasingly vulnerable during the Covid-19 pandemic according to WHO representatives who were interviewed for the purpose of this study.

effective and enhanced collaboration between local governments and key international actors during emergencies.

Responding to the pandemic has demanded flexibility due to strict lockdown measures. The IRC quickly adapted to remote care through phone consultations and follow ups with NCD patients by clinical healthcare staff and CHWs, in addition to delivering two-three months supplies of NCD medication directly to patients' homes in Mafraq and Ramtha. This not only ensured constant support to patients, but also provided vulnerable patients – such as elderly or disabled persons – with additional protection measures against COVID-19 by reducing the need to travel to clinics for care.⁵¹ Referrals for secondary healthcare were also facilitated when the risks became too high for diabetic patients or those suffering from hypertension. This approach was shared with the health cluster working groups, encouraging other health actors to move towards remote care.

IRC health staff in Jordan continue providing services throughout the pandemic at clinics in Azraq Camp.



The success of the IRC's remote care approach for NCD patients during the spread of COVID-19 also highlights the key role CHWs can play as they are able to quickly adapt and maintain flexibility throughout an emergency response.

In January 2021, Jordan became the first country to kick off a COVID-19 national vaccination plan that would allow refugees and asylum seekers to receive the COVID-19 vaccine free of charge - similar to Jordanian citizens.⁵² Priority groups are the same for refugee and host populations, and include individuals above 60 years of age, particularly those suffering from chronic illnesses, as well as frontline healthcare workers. IRC's CHWs frequently discussed the vaccine roll-out plan with NCD patients to clarify key informational gaps and address their concerns, while stressing the urgent need for those suffering from chronic illnesses to protect themselves against the virus. CHWs reported more NCD patients expressing willingness to receive the vaccine and registered themselves through the online vaccination platform.

⁵¹ <https://conflictandhealth.biomedcentral.com/track/pdf/10.1186/s13031-020-00277-x.pdf> (Simple ideas to mitigate the impacts of the COVID-19 epidemic on refugees with chronic diseases, May 2020)

⁵² <https://www.unhcr.org/news/press/2021/1/5ffffe614/refugees-receive-covid-19-vaccinations-jordan.html> (UNHCR Jordan Covid-19 PR, Jan 2021)

RECOMMENDATIONS FOR JORDAN

FOR DONORS

POLICY RECOMMENDATIONS:

- 1** Invest in a long-term vision for the health responses in protracted crises settings – particularly in stable contexts such as Jordan – to ensure a consistent availability of resources. This can be done by expanding funding policies that promote resilience across the humanitarian-development nexus.
- 2** Strengthen national health systems from the onset of any intervention while continuing to advance policy efforts linked to Universal Health Coverage (UHC) for all residents, including displaced populations.

OPERATIONAL RECOMMENDATIONS:

- 1** Encourage decentralized approaches that can be implemented through community outreach tailored to the unique health needs of vulnerable populations.
- 2** Continue strengthening cooperation between the humanitarian sector and public health sector to increase efficiency and effectiveness of health response efforts that reach all people, including displaced populations.

FOR INTERNATIONAL & LOCAL HUMANITARIAN ACTORS

POLICY RECOMMENDATIONS:

- 1** Support the government of Jordan to develop inclusive health policies that reach refugee and vulnerable host populations – such as recent health policy changes which allowed Syrian and non-Syrian refugees to access primary health care services at the uninsured Jordanian rate.
- 2** Transition towards investments to strengthen the national health system at both strategic and operational levels and in close cooperation with the MoH to ensure continuity of services long after humanitarian health actors scale back support. This should include developing policies conducive to a more decentralized health system with strong operations in rural governorates.

OPERATIONAL RECOMMENDATIONS:

- 1** Emphasize cost effective preventive strategies through community health programs which encourage health seeking behaviors while also alleviating the burden on the public health system. Tailor these health interventions to local behavioral and cultural dynamics at the community level.
- 2** Pay close attention to vulnerable population groups such as female-headed households, disabled and home-bound patients, irregular migrants and asylum seekers who may fall through the cracks of the wider health response, particularly during emergencies like the COVID-19 pandemic.
- 3** Invest in innovative data solutions to help better coordinate efforts among humanitarian health actors and the public health system to avoid overlap and maintain a consistent quality of care. Such data systems can also help decentralize pharmaceutical orders and avoid medication shortages.

JORDAN

FOR THE GOVERNMENT OF JORDAN

POLICY RECOMMENDATIONS:

- 1** Include vulnerable refugee, non-refugee and migrant population groups in policies and plans to render healthcare services more affordable and accessible for all.
- 2** Ensure all UHC policies and programs are inclusive of vulnerable and displaced populations.

OPERATIONAL RECOMMENDATIONS:

- 1** Sensitize public health workers on the challenges faced by vulnerable population groups including host and refugee, non-refugee or migrant population groups, to enhance the quality of health services provided through a patient-centered approach.
- 2** Invest in CHWs while effectively linking them with the PHC/CHC networks to create a decentralized and self-sustained community health approach that enjoys the flexibility and capacity to respond quickly to future emergencies.

FOR ALL HEALTH ACTORS INVOLVED IN THE COVID-19 PANDEMIC RESPONSE:

- 1** Encourage the spread of consistent and factual information on social media, local TV channels and through community awareness initiatives to help combat misinformation and vaccine hesitancy.
- 2** Monitor the impact of the COVID-19 pandemic on the provision of other essential health services – such as routine vaccinations and NCD care – to avoid long-term negative impacts, particularly on vulnerable population groups.



BANGLADESH

**SEEKING A SUSTAINABLE SOLUTION FOR
THE ROHINGYA REFUGEE CRISIS**



THE CRISIS IN BANGLADESH

For more than 40 years, Rohingya men, women and children have fled persecution and statelessness in Myanmar seeking refuge in neighboring Bangladesh, with the most recent and largest wave of displacements triggered in August 2017, following a surge in violence in Myanmar's Rakhine state. Today, close to 860,000 Rohingya refugees reside in 34 overcrowded camps in the Ukhiya and Teknaf upazilas of Cox's Bazar, one of the country's poorest districts.⁵³ The arrival of the Rohingya refugees exacerbated existing challenges linked to food insecurity⁵⁴ and the limited availability of affordable health services. Bangladesh is not legally bound by international law to provide any services for refugees nor stateless persons as the country is not a signatory party to the 1951 Refugee Convention and its 1967 Protocol nor to the 1954 or 1961 Stateless Persons Conventions.⁵⁵ Bangladesh lacks any domestic legal framework for the administrative procedures linked to caring for refugees or asylum seekers and can therefore legally refuse to accommodate them.⁵⁶ The UNHCR is the government's primary partner tasked to ensure the protection of Rohingya refugees in camp settings in Bangladesh following a Memorandum of Understanding (MoU) signed in 1993.⁵⁷ The Ministry of Foreign Affairs (MoFA) and the Ministry of Disaster Management & Relief (MoDMR) have been responsible for overseeing the refugee response in Bangladesh

in coordination with UNHCR.⁵⁸ The Health Sector is led by the Civil Surgeon's office in Cox's Bazar – with technical support from WHO – and coordinates the humanitarian response to health emergencies including outbreaks.⁵⁹

Over the years, it has become clear there is no long-term strategy for the Rohingya refugee response in Bangladesh.⁶⁰ In December 2020, Bangladeshi authorities activated a controversial plan aimed at relocating more than 100,000 Rohingya refugees to the remote island of Bhasan Char, located in the Bay of Bengal.⁶¹ The UN stressed that Rohingya refugees must be able to make free and informed decisions regarding the island move, including the right to move freely from the island to the mainland, with consistent access to quality education, health care and livelihood opportunities.⁶² Humanitarian actors have raised concerns that for those who do relocate, access to healthcare services will be even more challenging as the closest hospital facility requires a three-hour boat ride and is most likely inaccessible during monsoon season.⁶³ In a recent breakthrough on March 17, 2021, the first UN team visited Bhasan Char to assess its facilities, and concerns continue to be raised by both local and international actors on serious limitations linked to refugees' access to health services

⁵³ <https://gho.unocha.org/rohingya> (UN OCHA Rohingya crisis overview 2021)

⁵⁴ *Ibid.* (UN OCHA Rohingya crisis overview 2021)

⁵⁵ http://www.jpss.mahidol.ac.th/PDF/JPSS-v25n2-Prodip_Rohingya%20refugee%20children.pdf (health status Rohingya children, April 2017)

⁵⁶ *Ibid.* (health status Rohingya children, April 2017)

⁵⁷ *Ibid.* (health status Rohingya children, April 2017)

⁵⁸ https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/20190512_final_report_jrp_2018.pdf (JRP Rohingya Bangladesh 2018, see diagram on p. 13)

⁵⁹ https://reliefweb.int/sites/reliefweb.int/files/resources/joint_humanitarian_press_release_in_english_-_one_year_on_bangladesh_has_so_far_successfully_limited_the_health_impact_of_covid-19_in_coxs_bazar-final.pdf (WHO Covid-19 PR, March 2021)

⁶⁰ <https://www.unhcr.org/news/briefing/2020/8/5f3e60124/unhcr-rohingya-crisis-needs-lasting-solutions.html> (UNHCR PR, Aug 2020)

⁶¹ <https://n.pr/3kXD4kb> (NPR PR, Dec 2020)

⁶² <https://bangladesh.un.org/en/103285-press-statement> (Bangladesh UN Statement, Dec 2021)

⁶³ <https://www.hrw.org/news/2020/12/03/bangladesh-halt-rohingya-relocations-remote-island> (HRW PR, Dec 2021)

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on the island.⁶⁴ To make matters worse, the recent military coup in Myanmar has rendered prospects of repatriation even bleaker. Although Commander-in-Chief Senior Gen. Min Aung Hlaing – who is now the leader of Myanmar – recently vowed the repatriation

process would continue,⁶⁵ Rohingya refugees are increasingly skeptical about returning to a country ruled by a military entity that repeatedly failed to uphold this ethnic minority's rights in the past.

OPERATIONAL CHALLENGES IN DELIVERING HEALTHCARE

The Absence of Long-Term Vision for Health Care Drives Structural and Financial Challenges

With the aim of gradually moving towards Universal Health Coverage (UHC), Bangladesh established an official Health Care Financing Strategy in 2012 aiming to reduce personal expenditure on healthcare services through client-centered, equity-focused and high quality health services by 2032.⁶⁶ While the country has made progress toward achieving its Sustainable Development Goals (SDGs) linked to health,⁶⁷ improvements are still needed across the health sector, particularly on governance structures, management capacities and regulatory frameworks at both the public and private levels.⁶⁸ Government allocations to the national health care sector have increased slightly since the start of the COVID-19 pandemic, but remain low at only 5.14 % of the total financial year budget, and represent less than 1% of the national GDP.⁶⁹ Low financial allocations designated for MoH and Family Welfare (MOHFW)

in Bangladesh has resulted in patients having to bear a significant portion of essential health costs.⁷⁰ This led to heavy investments by UN agencies, INGOs and major donors, with more than 53 million USD spent on the provision of health services at the peak of the crisis in 2018, representing 7% of the overall humanitarian response budget at the time.⁷¹ In 2020, the humanitarian aid budget designated for health increased to more than 61.5 million USD, representing almost 8% of the overall country response,⁷² and hinted at the lack of long term strategy for strengthening the national health system. Meanwhile, the same year, the COVID-19 health budget amounted to more than 13 million USD.⁷³ Since 2017, the largest donors for the Rohingya refugee response in Bangladesh have been the US, UK, the EU Commission, and Japan.⁷⁴

⁶⁴ <https://www.arabnews.com/node/1829456/world> (Arab News PR, March 2021)

⁶⁵ <https://www.npr.org/2021/02/11/966923582/what-myanmars-coup-means-for-the-rohingya> (NPR PR, Feb 2021)

⁶⁶ https://apps.who.int/iris/bitstream/handle/10665/136959/ccsbrief_bgd_en.pdf?sequence=1 (WHO Bangladesh Cooperation Strategy, 2017)

⁶⁷ https://www.bd.undp.org/content/bangladesh/en/home/library/democratic_governance/bangladesh-sustainable-development-goals--sdgs--progress-report-.html (Bangladesh SDGs progress report 2020)

⁶⁸ <https://www.who.int/workforcealliance/countries/bgd/en/> (WHO GHWFA Bangladesh Overview)

⁶⁹ <https://blogs.worldbank.org/endpovertyinsouthasia/case-building-stronger-health-care-system-bangladesh> (WB BLOG, July 2020)

⁷⁰ *Ibid.* (WB BLOG, July 2020)

⁷¹ <https://fts.unocha.org/countries/19/summary/2018> (UN OCHA FTS Bangladesh, 2018)

⁷² <https://fts.unocha.org/countries/19/summary/2020> (UN OCHA FTS Bangladesh, 2020)

⁷³ <https://fts.unocha.org/appeals/998/summary> (UN OCHA FTS Bangladesh Covid-19, 2020)

⁷⁴ <https://fts.unocha.org/countries/19/summary/2021> (UN OCHA FTS Bangladesh, 2017-2021)

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In April 2020, the World Bank launched a 100 million USD financing process designed to support Bangladesh's response to the COVID-19 pandemic while also committing to strengthen the country's national system and its capacity to respond to public health emergencies.⁷⁵ Considering that the spread of COVID-19 did not turn out to be as catastrophic as initially planned for – with fewer than 8,500 reported deaths countrywide among a population of more than 163 million⁷⁶ – this funding could potentially contribute to more sustained development of the health sector through larger budget allocation. Humanitarian

health actors have been advocating for a minimum allocation of 6% of the national GDP towards the MOHFW, with investments in health infrastructure and human resources in rural areas, to ensure the long term provision of quality health services for refugee and vulnerable host populations. This would need to be coupled with willingness by the Bangladeshi government and MOHFW to develop a multi-year plan addressing the needs of both vulnerable host and refugee populations, while also discussing more sustainable health solutions for the Rohingyas.

⁷⁵ <https://www.worldbank.org/en/news/press-release/2020/04/03/world-bank-fast-tracks-100-million-covid-19-coronavirus-support-for-bangladesh> (WB PR, April 2020)

⁷⁶ <https://covid19.who.int/region/searo/country/bd> (WHO Covid-19 data Bangladesh, 2021)



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Absence of Qualified Healthcare Workers

Significant shortages of graduated health professionals have hampered the quality of health services in Bangladesh – including at community clinics located in more rural areas. According to WHO, Bangladesh’s doctor-to-patient ratio is 5.26 per 10,000 people, the second-lowest in South Asia, with 70% of doctors stationed in urban areas despite the majority of the population (78%) residing in rural areas.⁷⁷ This situation has worsened with the arrival of Rohingya refugees in 2017, exacerbating existing social tensions between the refugee and vulnerable host communities and burdening an already overstretched health system.⁷⁸ Health sector budget restrictions make it difficult to properly remunerate and/or incentivize public health workers.⁷⁹ In rural areas, harsh living conditions and limited resources can be demotivating for health staff in MOHFW-run facilities. Some local humanitarian health staff have reported feeling unsafe working in refugee camps which sometimes experience outbursts of violence.⁸⁰

In addition to increasing budgets for financial incentives and capacity building, the WB also recommended greater collaboration between the private and public health sectors to help fill human resource gaps and address quality issues with the aim of achieving UHC.⁸¹ Some progress has already been made when the government introduced incentives for frontline health workers during the COVID-19 pandemic, including special insurance benefits.⁸² Meanwhile, collaboration with the private sector is advancing as private entities such as Bashundhara Group, Akij Group and China Railway Group contributed to the pandemic response through the provision of ICU beds and PPE.⁸³

Nevertheless, challenges persist, as interviews conducted with international and local humanitarian health providers confirmed that health staff in public facilities are not always sensitized towards the specific needs of vulnerable populations, particularly women experiencing gender based violence or in need for sexual and reproductive health services. This is particularly worrying as IRC data shows that domestic violence trends spiked during the pandemic, particularly among the Rohingya population that is prone to Intimate Partner Violence (IPV) in the congested camps of Cox’s Bazar.⁸⁴

⁷⁷ <https://www.bd.undp.org/content/bangladesh/en/home/stories/a-reality-check-for-bangladesh-s-healthcare-system.html> (UNDP PR, May 2020)

⁷⁸ <http://documents1.worldbank.org/curated/en/856271558671301506/pdf/Diagnostic-Study-of-Public-Financial-Management-To-Strengthen-Health-Financing-and-Service-Delivery-in-Bangladesh.pdf> (WB Report on Strengthening Health Finance and Service Delivery in Bangladesh, 2019)

⁷⁹ <http://documents1.worldbank.org/curated/en/856271558671301506/pdf/Diagnostic-Study-of-Public-Financial-Management-To-Strengthen-Health-Financing-and-Service-Delivery-in-Bangladesh.pdf> (WB Report on Strengthening Health Finance and Service Delivery in Bangladesh, 2019)

⁸⁰ https://www.researchgate.net/publication/340209120_Effective_maternal_newborn_and_child_health_programming_among_Rohingya_refugees_in_Cox's_Bazar_Bangladesh_Implementation_challenges_and_potential_solutions (Effective maternal, newborn and child health programming among Rohingya refugees in Cox’s Bazar, Bangladesh, March 2020)

⁸¹ <http://documents1.worldbank.org/curated/en/856271558671301506/pdf/Diagnostic-Study-of-Public-Financial-Management-To-Strengthen-Health-Financing-and-Service-Delivery-in-Bangladesh.pdf> (WB Report on Strengthening Health Finance and Service Delivery in Bangladesh, 2019)

⁸² <https://www.bd.undp.org/content/bangladesh/en/home/stories/a-reality-check-for-bangladesh-s-healthcare-system.html> (UNDP PR, May 2020)

⁸³ Ibid. (UNDP PR, May 2020)

⁸⁴ <https://www.rescue.org/press-release/new-irc-analysis-domestic-partners-perpetrate-94-gender-based-violence-against> (IRC analysis: Domestic partners perpetrate 94% of gender-based violence against Rohingya women in Cox’s Bazar, Jan 2021)

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Health actors like the IRC and UNFPA strive to fill human resource gaps linked to the reproductive health sector through capacity building for local midwives and Skilled Birth Attendants (SBAs). Similar approaches have been used in the mental health sector with nurses trained to serve as mental health and psychosocial support (MHPSS) focal points inside the camps where the needs are staggering.⁸⁵ Designing a clearer roadmap for strengthening Bangladesh's national health system – including investing in adequate human resources and capacity strengthening for the provision of quality health services at all levels, including the grassroots level – must become a priority for stakeholders.

Challenging Referral Pathways

There is a low ratio of hospital facilities in and around Cox's Bazar, compared to the wider availability of primary health clinics, making referrals for secondary health care challenging. Less than a handful of humanitarian health actors such as MSF, HOPE and the Turkish Red Crescent continue to run secondary health care facilities in or around the camps, while others scaled down or terminated services completely. The Malaysian Field Hospital (MFH) set up by the Malaysian government in 2017 in partnership with Saudi Arabia and the United Arab Emirates closed in October 2020, as Malaysian authorities abruptly decided to repatriate staff to combat the COVID-19 pandemic at home.⁸⁶ Meanwhile, humanitarian health actors who did run secondary health care facilities in Cox's Bazar admitted facing difficulties recruiting

qualified HR, including experienced surgeons who remain often prefer to work for the private sector. They also faced challenges pinpointing the number of surgical procedures that would be provided for free as the demands from both refugee and vulnerable host populations were high and diverse in scope.



According to IRC Health Coordinator Dr. Abu Syem Shahin: “We have some 39 functional PHCs in and around Cox's Bazar area and yet we only have a handful of secondary and tertiary care facilities run by humanitarian health actors and able to admit Rohingya refugees. When our patients require basic procedures such as blood transfusions or even C-sections, we need to refer them to secondary or tertiary health facilities outside the camps, which is often challenging for us... Often Government health facilities are unable to provide health services due to a low number of available health workers in their facilities, meanwhile other humanitarian health actors have already begun downscaling their services... This is particularly challenging when we face an emergency and the patient requires lifesaving care.”

IRC has integrated basic emergency obstetric and newborn care (BEmONC) facilities in its primary health care centers located in Camp 23 and 25 to reduce maternal and newborn mortality directly. The IRC also set up 12 referral hubs covering ten refugee camps where dedicated Community Health Volunteers

⁸⁵ <https://respect.international/wp-content/uploads/2021/02/The-Torture-in-My-Mind-The-Right-to-Mental-Health-for-Rohingya-Survivors-in-Myanmar-and-Bangladesh.pdf> (Rohingya MH Report, Feb 2021)

⁸⁶ https://malaysia.news.yahoo.com/coxs-bazar-field-hospital-closed-035000192.html?guccounter=1&guce_referrer=aHR0cHM6Ly93d3cuZ29vZ2xLmNvbS8&guce_referrer_sig=AQAAAFBO1D6yh4wN0bkU2Xiw0I0vnLz7brtNfBbwdpLzAPAgj5mVHVPEdXazO6go47rYfd_wFeZX2y4aFHdYTAnli1re-ttxFmfzHtpYo83IVi78ifG1RaFPntLV2TbCTIn1GHRmEBa9b7xaPtRZ2SoxG83h97V6HYgucDXhqToiXj62 (Malaysia News PR, Oct 2020)

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(CHVs) and Referral Hub Officers help with emergency referrals. Their efforts consist of supporting patients to secure funds from UN agencies such as UNFPA who cover referral transportation costs to secondary health care services, in addition to UNHCR and IOM who cover C-section procedures for example. Among the nearly 7000 referrals from IRC in 2020, more than 60% were linked to obstetric care.

“Our teams are truly saving lives through these emergency referrals which are positively contributing to the number of safe deliveries among the Rohingya communities in the camps where we work. When we first started our activities in 2018, merely 18% of deliveries were institutionalized, but today close to 52.5% of deliveries are taking place in adequate health facilities. This means that IRC health teams have played a key role in the establishment of a successful and far-reaching institutional delivery approach in Cox’s Bazar, while also contributing to the lowering of maternal mortality rates in the area,” said Dr Tanzila Zisa, IRC’s Reproductive Health Manager in Bangladesh.



LASTING BARRIERS TO ACCESS

Poor Health Seeking Behaviors Contribute to High Maternal Mortality Rates

More than half of the Rohingya population in Cox's Bazar's camps are adolescent girls and women who face risk of morbidity and mortality linked to pregnancy and childbirth, sexual exploitation, child marriage, violence and disease.⁹³ A study conducted by UNFPA and CDC in 2019 estimated that for every 100,000 live births, 179 mothers die from preventable causes – a rate more than twice the worldwide target for maternal mortality (set at 70 deaths per 100,000 live births).⁹⁴ The study also revealed that pregnancy-related deaths were primarily caused by obstetric hemorrhage followed by pregnancy-induced hypertension, and obstetric complications including complications from unsafe and incomplete abortion.⁹⁵ Even though the national menstrual regulation policy provides a favorable legal environment for the provision of comprehensive abortion care in Bangladesh, providing these services remains challenging due to low acceptance and stigma in the Rohingya community.

Ensuring satisfactory SRH coverage in Cox's Bazar's refugee camps has proven challenging as patients often feel reluctant to access the various family planning (FP), STI services, as well as maternal and childcare within the established health care structures. A baseline survey conducted in December 2017

indicated poor health literacy rates among refugees with the majority of births (90%) taking place at home with the help of informal midwives or caregivers.⁹⁶ The study also revealed that over 80% of Rohingyas relied on traditional “doctors” or “pharmacists” for their medical care while in Rakhine.⁹⁷ The Rohingya family and community structures are built on conservative patriarchal norms where the male figure – father, husband, brother, community or religious leader – is considered the primary decision maker including on issues related to women and girls' health.⁹⁸ Abortion remains a highly sensitive topic despite the prevalence of sexual violence and unintended pregnancies among young adolescent girls.⁹⁹ This makes it difficult to obtain accurate data on the number of informal or unsafe abortions conducted in the camps. A study conducted in January 2021 found that unfavorable abortion policies, lack of privacy and knowledge of abortion laws and policies, in addition to health care providers' personal beliefs and a lack of cultural safety, were all factors contributing to limited availability and accessibility of comprehensive abortion services in Cox's Bazar.¹⁰⁰

⁹³ <https://reliefweb.int/sites/reliefweb.int/files/resources/s13031-020-00329-2.pdf> (Challenges and strategies in conducting sexual and reproductive health research among Rohingya refugees in Cox's Bazar, Dec 2020)

⁹⁴ https://bangladesh.unfpa.org/sites/default/files/pub-pdf/Final%20RAMOS%20Summary%20Report%20for%20circulation_0.pdf (UNFPA & CDC Study on Maternal mortality, 2019)

⁹⁵ *Ibid.* (UNFPA & CDC Study on Maternal mortality, 2019)

⁹⁶ <https://pubmed.ncbi.nlm.nih.gov/32630181/> (Rapid Assessment of Rohingyas Health Literacy, Dec 2017)

⁹⁷ *Ibid.* (Rapid Assessment of Rohingyas Health Literacy, Dec 2017)

⁹⁸ <https://www.who.int/health-cluster/news-and-events/news/SRH-refugees-IDPs/en/> (WHO GHWFA Bangladesh Overview)

⁹⁹ <https://reliefweb.int/sites/reliefweb.int/files/resources/s13031-020-00329-2.pdf> (Challenges and strategies in conducting sexual and reproductive health research among Rohingya refugees in Cox's Bazar, Dec 2020)

¹⁰⁰ <https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-021-00338-9> A qualitative study on health care providers' experiences of providing comprehensive abortion care in Cox's Bazar, Bangladesh (Jan, 2021)

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Within the camps, the IRC established more than 24 Women Friendly Spaces (WFS) and five Integrated Women Centers (IWC) only accessible to women and girls. There, they can discreetly inquire about RH services – including access to abortion care – and report incidents of GBV.

“According to UNFPA: “the WFS is a safe space, locally known as ‘Shanti Khana’ where women and girls can socialize, re-build, and strengthen their social networks, and receive social support, information and services relating to women’s health and reproductive rights.”¹⁰¹

The IRC recruited female and male CHWs from both the Rohingya and Bangladeshi communities to raise awareness about SRH services available at IRC clinics and WFS. The male CHWs are also tasked with discussing and negotiating SRH access with senior male community, social, and religious leaders. IRC data in Bangladesh, shows that as of January 2021, more than 48,000 women and girls visited the WFS to seek SRH services since their inception in 2018. A new WFS recently opened in partnership with UNFPA to serve 6,500 women and girls from the host community of Ukhiya Upazila, Haldiapalong Union, Sikdarpara village in Cox’s Bazar.¹⁰²



Dr Abu Syem Shahin, IRC’s Health Coordinator in Bangladesh explained: “When we first started providing family planning services in the Women Friendly Spaces in 2018, we only received one or two beneficiaries per day and our midwives grew very anxious while waiting for patients.... But following the development of our Community Health Approach led by both female and male CHWs who sensitized the community about the financial, social and health benefits of backspacing pregnancies for example, even the husbands themselves started encouraging their wives to take up long term family planning methods in order to preserve their health. Rohingya men are gradually starting to realize that women and girls are an integral part of the family and today they are even encouraging women to take part in income generating activities inside the camps.”

Restricted Mobility Impacts Access to Services Outside of Refugee Camps

In 2019, Bangladesh’s Army Chief announced plans to install barbed wire fencing around Rohingya camps with the intention of replicating the process at Bangladesh’s border with Myanmar.¹⁰³ This followed previous recommendations by the national parliament to limit Rohingyas’ movement outside the camps¹⁰⁴ and has made it difficult for refugees to access secondary or tertiary services. It has also contributed to increased security risks within the camps as tensions have gradually risen.¹⁰⁵ At least one humanitarian health actor interviewed for this study admitted to receiving an increasing number of stabbing wounds at their clinics

¹⁰¹ <https://bangladesh.unfpa.org/en/news/unfpa-opens-new-women-friendly-space-host-community-ukhiya-coxs-bazar> (UNFPA WFS PR, Jan 2021)

¹⁰² Ibid. (UNFPA WFS PR, Jan 2021)

¹⁰³ <https://www.dhakatribune.com/bangladesh/nation/2019/11/24/army-chief-barbed-wire-fencing-of-rohingya-camps-is-in-process> (Dhaka Tribune PR, Dec 2019)

¹⁰⁴ <https://www.hrw.org/news/2019/09/30/bangladesh-halt-plans-fence-rohingya-refugees> (HRW PR, Sept 2019)

¹⁰⁵ <https://www.reuters.com/article/us-bangladesh-rohingya-idUSKBN26T1Z1> (Reuters PR, Oct 2020)

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in the past year which required emergency referrals for lifesaving secondary care services outside at hospital facilities of the camps. Some doctors also complained that it was sometimes challenging to refer Rohingya

patients for secondary health care services at MoH-run facilities in or around Cox's Bazar as the referral procedure is time consuming and requires a number of approvals.

BEST PRACTICES: SUCCESSFUL & INNOVATIVE APPROACHES

Strengthening Human Resource Capacity Through Midwifery Training Programs

While progress has been made in maternal health provision in Bangladesh since 2017, significant gaps remain with 38% of births still taking place in homes, with SBAs only present for 42% of the deliveries according to UNFPA.¹⁰⁶ Professional midwives remain scarce in Bangladesh, where nurses usually assist with normal birthing processes. According to UNFPA, midwives who are educated and regulated to international standards are capable of providing 87% of the essential care needed for women and newborns thus significantly reducing maternal mortality rates as well as high costs linked to avoidable or unnecessary C-section procedures.¹⁰⁷ Prior to the Rohingya crisis in 2017, UNFPA committed to train 3000 midwives across the country by capacitating nurses through advanced midwifery trainings, while also establishing a three-year diploma course to train new midwives.¹⁰⁸

According to Stenly Sajow, UNFPA's SRHR Team Leader in Cox's Bazar, three generations of midwives have already graduated from this program, and many have gone to practice midwifery at clinics located within the camps – including IRC clinics – while also being coached by international midwife mentors.

“Our three international midwife mentors accompany the new graduates at the camp clinics to coach them in their daily work and demonstrate protocols hand on... These midwife students become very resilient because they eventually get used to working under pressure in humanitarian settings with limited resources... They are providing services to both Bangladeshi and Rohingya populations while also learning the values of impartiality and neutrality in humanitarian work. Many of them go on to work in MOHFW facilities, or even in the private sector, and continue to contribute to lowering maternal mortality at the national level, even after their training days in the refugee camps” Sajow stated.

Some informal birth attendants from the Rohingya communities have transitioned to active CHWs to effectively contribute to SRH awareness. Others have been trained as SBA or midwife assistants and can work in the clinical setting but with limited responsibilities – lower education levels make it more difficult for Rohingya to serve as midwives. Nevertheless, Sajow is hopeful future generations of refugees will be able to access the program and eventually serve their community as official SBAs or midwives.

Additionally, UNFPA and the MoH utilized IRC produced materials on the Clinical Management of Rape (CMR) in training midwives – an important step for further integrating SRH and GBV services.

¹⁰⁶ <https://bangladesh.unfpa.org/en/topics/midwifery-0> (UNFPA Midwifery Bangladesh Overview)

¹⁰⁷ Ibid. (UNFPA Midwifery Bangladesh Overview)

¹⁰⁸ Ibid. (UNFPA Midwifery Bangladesh Overview)

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Investments Made During Health Emergencies May Promote Long-term Resilience

Strengthened Infection Prevention Control (IPC) systems and practices are fundamental to the capability of health systems to respond to emergencies, deliver safe routine healthcare and enhance capacity to manage future outbreaks. As part of the COVID-19 response, the IRC team in Bangladesh invested in improved IPC measures to help prevent the spread of the virus. Efforts included recruiting and training staff to help with screening and triage, ensuring water, sanitation and handwashing stations are available and functioning, strengthening processes around cleaning and disinfecting, and promoting proper behavior change like social distancing and use of PPE by patients and providers. Between August and December 2020, the IRC embarked on a large-scale assessment examining the state of IPC in 1,106 facilities across 22 countries including Bangladesh. The results indicate that these IPC investments in IRC managed facilities in Cox's Bazar are working with 89% of overall IPC standards met. This is essential not only for fighting the pandemic but for ensuring the safety and quality of care provided.

While the facilities assessed in Bangladesh were managed by IRC and based within the camp settings, they demonstrate how investments made during COVID-19 could help strengthen the national health system in the long run by training health workers, increasing coordination, and encouraging proper safety and hygiene protocols. We know from previous emergencies, however, that investments in IPC must be sustained. Hard fought gains during the Ebola outbreak in the DRC, for example, were quickly lost as funding and attention waned requiring facilities to once again invest in these same measures at the start of the

COVID-19 pandemic. Across the countries assessed including Bangladesh, IRC teams are now creating action plans to continue improving IPC in IRC and MoH health facilities and to ultimately see health systems become stronger and more resilient.

Ensuring Continuous Access to Essential SRH Services

COVID-19 related restrictions – in addition to stigma and misconceptions among the Rohingya community – have further limited women and girls' access to essential SRH services in Cox's Bazar's refugee camps. To mitigate this, UNFPA and IRC created several transit points in and around the camps with free shuttle services available for women and girls who needed to access SRH services at IRC clinics.

“The idea may sound simple, but with Covid-19 restrictions in place, having these dedicated transit points providing regular, free and safe shuttle services towards IRC clinics helped many women of reproductive age, from the Rohingya and host communities, to continue having access to essential SRH services during the pandemic” said Stenly Sajow, UNFPA's SRHR Team Leader in Cox's Bazar.

The IRC and UNFPA also created “safe maternity zones” consisting of dedicated, safe and isolated spaces within maternity wards, rooms or tents, to enable Covid-positive women and girls to deliver safely, and without putting other patients or health workers at risk. Both measures also contributed to decreasing the stigma around accessing SRH services at health facilities. At the same time, the IRC believes the integration of SRH and GBV to be critical for increasing access to, and uptake of, both services.

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THE IMPACT OF COVID-19

According to WHO, there have been 552,087 confirmed cases of COVID-19 including 8,489 deaths, reported in Bangladesh between early January 2020 and mid-March 2021.⁸⁷ Experts initially predicted the pandemic would have a devastating impact on the camps in Cox's Bazar but numbers were far lower than anticipated with WHO confirming 400 cases and 10 deaths out of the more than 860,000 Rohingya refugee population living in the various camps – these numbers may be severely underestimated given limited testing capacity⁸⁸ in addition to low testing uptake among Rohingyas due stigma and misconceptions.

The IRC prepared for the worst-case scenario setting up a 60 bed Severe

Acute Respiratory Infection Isolation and Treatment Centre (SARI ITC) hospital in Camp 23 where more than 96 patients were admitted, including 35 COVID-19 positive cases, while others were treated for COVID-19 like symptoms. The organization is also supporting four government-run Isolation and Treatment Centres (ITCs) in four sub-district hospitals (Chakaria, Ramu, Teknaf, and Ukhia). Although the infection rate has not been as serious as initially anticipated, IRC doctors interviewed for this study confirmed that applying COVID-19 protocols in the various health facilities in Cox's Bazar has resulted in positive impacts such as strengthening Infection Prevention and Control (IPC) protocols and health staff readiness for other emergencies.

⁸⁷ <https://covid19.who.int/region/searo/country/bd> (WHO Covid-19 Overview Bangladesh)

⁸⁸ <https://thediplomat.com/2021/03/rohingya-risk-being-forgotten-in-global-vaccination-drive/> (The Diplomat, March 2021)

Although movement restrictions introduced by the Bangladeshi authorities in April 2020 to minimize movements in and out of the camps contributed to lower infection rates, they also reduced Rohingya refugees' access to key services and limited humanitarian presence inside the camps.⁸⁹ Vaccination campaigns against measles and Rubella, for example, have largely been halted in the camps which are prone to outbreaks.⁹⁰ Humanitarian health actors interviewed for this study confirmed that the number of patients accessing primary health clinics within the camps significantly dropped during the last year due to these restrictions and stigma among the Rohingya population and host community related to the COVID-19 virus. These restrictions – which have impacted what authorities have dubbed “non-critical services” including some health services, nutrition, water and sanitation provisions, as well as waste management efforts⁹¹ – have yet to be eased. Despite these challenges, the IRC continued its health activities throughout the pandemic while capacitating staff to take necessary precautions.

Now, as COVID-19 vaccines are rolled out globally, the Bangladeshi government has partnered with the COVAX Facility led by WHO and committed to set aside 5% of its COVID-19 vaccines for refugees. It remains unclear when Rohingya camps will begin receiving doses – thus far, no refugees in Bangladesh have been inoculated against COVID-19.⁹²

An IRC staff member provides free medication at the pharmacy at the IRC's 24/7 health centre in Cox's Bazar, Bangladesh.



⁸⁹ <https://www.hrw.org/news/2020/04/28/bangladesh-covid-19-aid-limits-imperil-rohingya> (HRW PR Bangladesh, April 2020)

⁹⁰ Ibid. (HRW PR Bangladesh, April 2020)

⁹¹ Ibid. (HRW PR Bangladesh, April 2020)

⁹² Ibid. (The Diplomat, March 2021)

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RECOMMENDATIONS FOR BANGLADESH

FOR DONORS

FINANCIAL RECOMMENDATIONS

- 1** Increased and sustained investments must be made in the long-term humanitarian response with an emphasis on strengthening the health system's capacity to provide quality care – including at the secondary and tertiary levels – to the Rohingya refugees. Investments in training programs like the IRC's midwifery program not only bolster services in the short-term but also build a more qualified and resilient health workforce. Commit to multi-year funding plans for the health response in Bangladesh that will allow refugees access to high quality, comprehensive health care services inclusive of SRHR, secondary and tertiary care.
- 2** Invest in the strengthening of the national health system by supporting the government of Bangladesh to dedicate a larger budget to the MOHFW, as well as recruiting and training health staff. Encouraging further collaboration between the public and private health care systems could help fill longstanding gaps in the country's health response, particularly in refugee camps, and rural or isolated areas.

FOR INTERNATIONAL & LOCAL HUMANITARIAN ACTORS

POLICY RECOMMENDATIONS:

- 1** Continue providing life-saving services to Rohingya refugees and vulnerable host communities to meet their basic needs, while initiating roadmaps for durable solutions in partnership with local communities and authorities.
- 2** Address the needs of women and girls through a comprehensive SRH approach. While the national menstrual regulation policy provides a favorable legal environment for the provision of comprehensive abortion care, additional advocacy is needed to increase access to these services.
- 3** Work with MOHFW to ensure public health care providers have sufficient knowledge of and training in comprehensive SRH services, including safe abortion care and obstetric care.

OPERATIONAL RECOMMENDATIONS:

- 1** Invest in strengthening the national health system, particularly through building the capacity of health workers through training, supervision and mentorship.
- 2** Enhance coordination around health referral systems in and around the camps, while investing in quality secondary care provision, ideally through the strengthening existing MOHFW-run facilities, as opposed to creating parallel services. Strengthening national secondary care provision can help increase access to secondary care for Rohingya refugees.

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FOR THE GOVERNMENT OF BANGLADESH

POLICY RECOMMENDATIONS:

- 1** Contributions provided by international financial institutions such as the World Bank during the COVID-19 pandemic have provided the government of Bangladesh with a unique opportunity to expand its national health budget to ensure broader coverage and enhanced quality of health care in the country, including within refugee camps. This contribution should amount to at least 6% of the national GDP to inch closer towards reaching UHC and SDG health targets, while taking the specific needs of vulnerable host and refugee populations into account.
- 2** Ensure that the MOHFW can benefit from increased budgetary allocations in the coming year, particularly dedicated to:
 - Training, recruiting, regular capacity building, and incentivization of health care workers including midwives. This should include sensitizing health staff on specific needs of vulnerable populations.
 - Purchasing and maintaining medical equipment, supplies and medications.
 - Strengthening the development and/or administration of primary health care clinics in camps.
 - Developing secondary and tertiary care facilities as well as emergency transportation mechanisms/networks that provide care to displaced populations.
 - Strengthening available monitoring mechanisms and data systems to allow data-driven decision making that improves quality of health care.
- 3** Encourage further cooperation between the public and private health sectors to help cover outstanding health gaps, particularly those linked to standard vaccination campaigns for measles and rubella, or even secondary and tertiary healthcare provision. This collaboration should not negatively impact the costs of accessing health care, particularly for vulnerable populations.
- 4** Uphold and facilitate the freedom of movement of Rohingya refugees, particularly when it comes to accessing critical or lifesaving secondary health care services, education and economic opportunities.

OPERATIONAL RECOMMENDATIONS:

- 1** Restore Internet connectivity in and around the camps to allow vulnerable populations access to critical health information related to Covid-19, in addition to awareness on essential health services.
- 2** Address growing insecurity within the Rohingya camps – as well as ongoing tensions between refugee and host communities – to prevent implications on the provision of humanitarian and health services for both populations.

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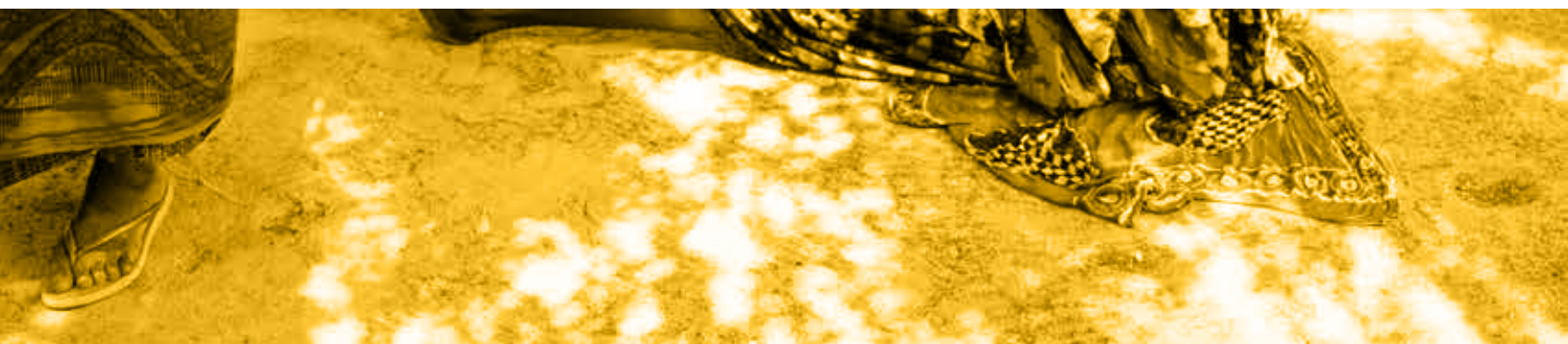
FOR ALL HEALTH ACTORS INVOLVED IN THE COVID-19 PANDEMIC RESPONSE:

- 1** The vaccination of Rohingya refugees must begin as soon as possible – per the proposed national plan – to ensure optimal immunization for all people in Bangladesh. This requires training for health care workers (which the government has already initiated), in addition to improved communication and engagement between authorities and Rohingya community leaders to address vaccine hesitancy.
- 2** MOHFW and humanitarian health actors must continue providing essential health services – including mental health services – to displaced populations throughout the pandemic and long-term recovery period to prevent devastating knock-on effects.



CHAD

**COMBATTING MULTIPLE
HUMANITARIAN CRISES**



THE CRISIS IN CHAD

Chad is among the five poorest nations in the world,¹⁰⁹ currently hosting more than 915,000 refugees, asylum seekers and IDPs¹¹⁰ originating primarily from Sudan, South Sudan, Nigeria and the Central African Republic (CAR). Most IDPs have been displaced from the Lake Chad region known as Lac Province, which suffers from rapid environmental degradation and growing instabilities.¹¹¹ The international community has applauded Chad for keeping its borders open to refugees and asylum seekers, despite half of its population living in extreme poverty.¹¹²

Over the past decade, donor funding has continued to fall short with 57% of the country's humanitarian response plan left unfunded in 2020.¹¹³ The US and the European Union Commission have been the largest donors,¹¹⁴ while the World Bank provided the national government with a 75 million USD grant in September 2020 aimed at improving refugee and vulnerable populations' access to education and health services.¹¹⁵

The provision of health services for the host population occurs through four main financing mechanisms:

- 1 direct payment,
- 2 free access to selected services,
- 3 health insurance, and
- 4 health mutual schemes.¹¹⁶

The first is the most common and represents ~50% of the total health expenditure while free services are financed by the state and include emergency surgery, obstetric and medical care per the social policy introduced in hospitals by the head of state in 2008.¹¹⁷ In August 2017, however, the government revised the free healthcare package to only include severe malaria, prenatal and neonatal consultations, C-section deliveries, child nutrition, and snake and scorpion bites.¹¹⁸ The absence of adequate financial mechanisms that enable free health services, has translated into significant implementation gaps and corruption in health facilities, particularly those located in rural areas.

¹⁰⁹ <https://www.usaid.gov/chad> (USAID Chad country profile)

¹¹⁰ <https://news.un.org/en/story/2020/12/1080862> (UN PR, Dec 2020)

¹¹¹ <https://www.msf.org/lake-chad-crisis-depth> (MSF Lake Chad Basin Crisis Overview)

¹¹² <https://www.usaid.gov/chad> (USAID, Chad Country Profile)

¹¹³ <https://fts.unocha.org/appeals/907/summary> (UN OCHA FTS CHAD 2011-2020)

¹¹⁴ Ibid. (UN OCHA FTS CHAD 2011-2020)

¹¹⁵ <https://www.worldbank.org/en/news/press-release/2020/09/08/chad-refugees-and-host-communities-support-project#:~:text=WASHINGTON%2C%20September%208%2C%202020%20%E2%80%93,basic%20social%20services%20and%20livelihoods> (WB PR CHAD, Sept 2020)

¹¹⁶ <https://peh-med.biomedcentral.com/articles/10.1186/s13010-015-0023-z#Abs1> (Health policy Chad, 2015)

¹¹⁷ Ibid. (Health policy Chad, 2015)

¹¹⁸ <https://reliefweb.int/report/chad/chad-situation-report-30-sep-2020> (Chad Situation Report, Sept 2020)

CHAD

In December 2020, Chad adopted its first Asylum Law, designed to enhance protection of its 480,000 refugees and provide key elements for their socio-economic inclusion within national structures.¹¹⁹ The Government of Chad also developed a framework to integrate refugees within the national health system, with the MoH already taking the lead on health clinics located in the established camps where refugees received free primary health care through UNHCR and partners like the IRC. Despite the introduction of these policies, Chad's health system remains fragile, under-resourced and lacking reach in rural areas. The MOH generally lacks funding with an average of 4% of the country's GDP allocated to the health sector.¹²⁰ Qualified health professionals are limited with less than

four doctors and two nurses per 100,000 people.¹²¹ Although some progress was made in 2020, with more than 400 new doctors assigned to hospitals and health centers, many young graduates are often unable to cope with the challenges of running these facilities, particularly in rural areas. The country continues to have among the highest maternal and child mortality rates in the world, with the majority of births not attended by skilled health care professionals.¹²² Complicating matters, the increasing burden of climate change – with seasonal droughts and flash floods impacting harvests – has impacted health outcomes by disrupting access to services and increasing the risks of malnutrition and diseases like cholera and measles.¹²³

¹¹⁹ <https://news.un.org/en/story/2020/12/1080862> (UN PR, Dec 2020)

¹²⁰ <https://www.who.int/countries/tcd/> (WHO Chad Profile)

¹²¹ <https://www.who.int/workforcealliance/countries/tcd/en/> (WFA Chad)

¹²² <https://www.rescue.org/country/chad#what-are-the-main-humanitarian-challenges-in-chad> (IRC Chad country profile).

¹²³ Ibid. (IRC Chad country profile).



OPERATIONAL CHALLENGES IN DELIVERING HEALTHCARE

Integrating Humanitarian Health Activities into the National System

In September 2018, the Government of Chad launched the Comprehensive Refugee Response Framework (CRRF) providing a formal roadmap to gradually integrate refugees into the country's national education and health structures.¹²⁴ An agreement between the MoH and UNHCR paved the way for the integration of health centers located in 19 refugee camps into the national health system.¹²⁵ Despite these agreements, it has remained challenging.

Aleksandra Roulet-Cimpri, IRC Deputy Director of Programs in Chad, explained that IRC plans to gradually hand over its health activities in refugee camps to the MoH but significant gaps remain as the state budget for health is not yet able to cover all host and refugee population needs.



“The number of patients still exceeds the number of qualified health care workers, particularly in rural areas. Some 400 doctors were trained and dispatched across the country by the MoH and partners last year, but the state remains unable to maintain adequate levels of salaries and capacity building” she said.

A survey among Chadian nurses in 2018 revealed difficult working conditions, particularly in hospitals with limited material and human resources, where a single nurse could sometimes end up covering all nursing duties for the entire facility during a 24 hour period.¹²⁶ Other factors affect staff motivation including workload, clinical capacities, poor recognition and support, and the desire for more supervision and training.¹²⁷ Weakness in core capacities to enforce International Health Regulations (IHR) and shortages of essential medical equipment and medications have further complicated handover.¹²⁸

The IRC supports the MoH with health staff incentives and advocates for INGO health staff to be integrated into the national health system for additional coverage and expertise. Even still, MoH absorption of new staff has remained slow and only occurs every few years, making it difficult to rapidly increase human and financial resources during public health emergencies. Nevertheless, the IRC's Action Plan for Chad continues to incorporate activities linked to capacity building, upgrades to management systems, information technology, and supply chain procedures for local health service providers to help ensure continuity for quality health services.¹²⁹ Long-term sustainability will largely be dependent on the government's willingness and ability to expand its national health budget and invest in recruiting and training qualified health staff.

¹²⁴ <https://globalcompactrefugees.org/article/chad> (Global Compact Chad Overview)

¹²⁵ Ibid. (Global Compact Chad Overview)

¹²⁶ <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2799-6> (Challenges and Opportunities for Health Care Workers in Rural Chad, 2018)

¹²⁷ Ibid. (Challenges and Opportunities for Health Care Workers in Rural Chad, 2018)

¹²⁸ <http://documents1.worldbank.org/curated/en/362921586510443703/pdf/Project-Information-Documents-Chad-COVID-19-Strategic-Preparedness-and-Response-Project-P173894.pdf> (WB Chad Document Covid-19 Preparedness)

¹²⁹ <https://www.rescue.org/sites/default/files/document/618/chadexternalsapfinal.pdf> (IRC Chad Strategy Action Plan 2020)

Slow Implementation of National Health Policies

Policies are only effective when disseminated, implemented, and accepted by key stakeholders. In addition to the challenges implementing the CRRF to integrate refugees into the national system, there have been similar issues with the comprehensive reproductive health law, introduced by the government to prohibit child marriage and female genital mutilation while promoting access to reproductive health services.¹³⁰ Despite becoming law in 2002, implementation has been slow with Article 14 – which defined access to “therapeutic abortion” – not going into effect until 2018.¹³¹ This created significant gaps between the adoption of the progressive law and its implementation across provinces, limiting reproductive health services and leaving health workers without proper guidance or protections.¹³²

Despite extensive advocacy efforts to liberalize the conditions under which a woman can access therapeutic abortion care under this RH law, the restrictive requirements for abortion care outlined in Article 14 render services effectively inaccessible to women and girls. The COVID-19 pandemic has also hampered community outreach activities which remain key to maintaining awareness and acceptance of SRH services. This is partially reflective of the COVID-19 restrictions, but also highlights the challenges faced by humanitarian health actors at the community and national policy level to provide a comprehensive reproductive health package.



Dr. Augustin Paluku, SRH Clinical Advisor at IRC said: “Everyone has the right to access universal health care services, women and young girls in particular. There is a need to provide a comprehensive SRH package in Chad as well as in others countries, without it, we cannot eradicate maternal.”

LASTING BARRIERS TO ACCESS

Persisting Financial Barriers

With more than half of Chad’s population living below the poverty line, most suffer significant financial barriers accessing quality health care. This is especially true for vulnerable host communities required to pay a fee for services and receiving medications at MoH-run primary health care clinics. Some clinics charge fees for services meant to be free according to the 2008 social policy due to lack of coordination between the different levels of the health system as well as absence of resources, particularly in rural areas.¹³³ Limitations imposed in 2017 on emergency care services covered

by the social policy worsened patients’ ability to pay the fees. To address this, the IRC and other health actors agreed with the MoH to open INGO clinic doors to vulnerable host populations so they too could benefit from free services. This has helped to reduce tensions between the refugee and host population, by creating more equitable access to care.

¹³⁰ <https://evaw-global-database.unwomen.org/en/countries/africa/chad/2002/law-no-6-pr-2002-on-the-promotion-of-reproductive-health> (Chad RH Law Overview)

¹³¹ <https://www.familyplanning2020.org/chad> (FP2020 Chad Overview)

¹³² <https://www.tandfonline.com/doi/full/10.1080/26410397.2019.1626185> (Catalyzing change for RH in Chad, June 2019)

¹³³ <https://peh-med.biomedcentral.com/articles/10.1186/s13010-015-0023-z> (Health Policy Chad, 2015)

CHAD

Gendered Barriers Contribute to High Maternal Mortality Rates

Chad's maternal mortality ratio is 856 deaths per 100,000 births – the highest in Sub-Saharan Africa and top three worldwide.¹³⁴ A study published in 2019 revealed that only 7% of 17,719 surveyed women reported utilizing all three recommended maternal health services (ANC, Delivery and PNC).¹³⁵ Factors impacting their utilization included mothers' education level, male partners' education and occupational status, marriage type (polygamous or monogamous), access to media information, use of contraceptives, household income level, and geographical location.¹³⁶ The majority (70%) of surveyed women were 20 to 34 years old, with two thirds (64%) reporting having no formal education compared to more than half (55%) of men and with the vast majority of respondents (80%) residing in rural areas.¹³⁷ Although half of the women were employed, access to information remained limited, with few (27%) having access to written, radio or televised news.¹³⁸ Although maternal mortality rates improved between 1990 and 2015, only 20% of women in Chad reportedly give birth at hospital facilities, indicating that the majority of births are not attended by skilled attendants.¹³⁹

Gender norms among host and displaced populations – including refugees – limited women's decision-making power for accessing health services which inevitably contributes to low health seeking and to the high rates of maternal mortality.¹⁴⁰



According to Yolande Flore Longang Tchounkeu, IRC's Women Protection and Empowerment Coordinator in Chad:

"Because of these cultural factors and norms, patients who are survivors of GBV are stigmatized and subject to prejudice, sometimes even by health providers themselves."

An evaluation published by IRC in October 2020 revealed that the COVID-19 pandemic added to these barriers as the safety of women and girls failed to be prioritized by both national and international health actors which has had a clear impact on the ability of displaced women and girls to access essential GBV and SRH services.¹⁴¹

A child receives treatment at an IRC health center in Mangalme', Guera region, Chad.



¹³⁴ <https://www.semanticscholar.org/paper/Exploring-factors-associated-with-maternal-health-Kim-Kim/89e707ba4703db14283ac40094e4aa95c9f7393b> (MHC study Chad, 2019)

¹³⁵ Ibid. (MHC study Chad, 2019)

¹³⁶ Ibid. (MHC study Chad, 2019)

¹³⁷ Ibid. (MHC study Chad, 2019)

¹³⁸ Ibid. (MHC study Chad, 2019)

¹³⁹ https://www.researchgate.net/publication/341113914_The_State_of_Maternal_and_Infant_Health_and_Mortality_in_Chad (The state of maternal and infant mortality in Chad, 2020)

¹⁴⁰ Ibid. (MHC study Chad, 2019)

¹⁴¹ <https://www.rescue.org/sites/default/files/document/5281/ircwpecovidreportv7.pdf> (IRC GBV evaluation, Oct 2020)

BEST PRACTICES: SUCCESSFUL & INNOVATIVE APPROACHES

Advocating for the Adoption of National SRH Guidelines

After more than 16 years of coordinated advocacy between humanitarian health actors, including the IRC, the decree of application associated with the 2002 reproductive health law's Article 14 was finally approved by the Council of Ministers in July 2018.¹⁴² In 2020, the IRC supported the MoH in Chad to develop national post-abortion care guidelines, essential to the well-being of women and young girls of reproductive age in addition to providing further guidance and protection for health workers. This is also helping to establish a baseline for the eventual development of more comprehensive abortion care guidelines.



According to Dr Lucien Kikwayaba Issa, Senior Health Program Coordinator at IRC: **“The advent of these policies has also made Chadian women much more accepting of modern contraceptive methods. In fact, more than 13,800 women acquired them from IRC in 2020 compared to approximately 11,700 in 2019.”**

In 2020, the IRC trained more than 43 MoH health care providers in Chad on post-abortion care – another critical step to implement existing policies. Similarly, in 2018, the MoH worked with civil society to develop a National Sexual Health Strategy for Adolescents and Youth.¹⁴³ To support effective implementation and dissemination of this strategy, the IRC organized trainings targeting young people to change attitudes and values around abortion care, while highlighting the importance of access to SRH services. This

demonstrates the important role NGOs can play not only in advocating for new policies but for their implementation and roll out across the country – an essential step to strengthening the national health system and increasing equitable access to services, including for refugees and other vulnerable populations.

Addressing Geographical Barriers

Geography plays an important role in access to health services, given the limited number of primary care clinics in rural areas which requires patients to pay transportation costs. On average, patients travel more than 14 kilometers to access health care services with some going by foot.¹⁴⁴ Other vulnerable persons – from the host, IDP and/or refugee populations – may seek services from traditional healers who are more affordable and usually located closer to home, but without formal training. For these reasons, IRC established two health posts in Liwa health district focusing on Salia and Magui IDPs sites, which provide basic primary care and first aid services specifically tailored for rural areas lacking clinics. Such structures could resolve gaps in access while also alleviating pressure on existing health facilities. Despite this, the health post model has yet to be recognized by the country's MoH and the IRC is actively advocating for their integration into the national system.

¹⁴² <https://www.tandfonline.com/doi/full/10.1080/26410397.2019.1626185> (Catalyzing change for RH in Chad, June 2019)

¹⁴³ <https://www.familyplanning2020.org/chad> (FP2020 Chad Overview)

¹⁴⁴ <https://peh-med.biomedcentral.com/articles/10.1186/s13010-015-0023-z#Abs1> (Health Policy Chad, 2015)

Enhancing SRH through Community Awareness and Systems Strengthening

Delivering quality MNH services to refugees living in Chad is critical but resources are insufficient to meet the need. Recognizing this, implementing partners must adapt their approaches to deliver high quality care to more people at less cost. Between Jan-Dec 2019, the IRC implemented the Saving Mothers and Newborn Lives project in five refugee camps (Iridimi, Amnabak, Touloum, Kounougou and Mile). The project was funded by the Bill and Melinda Gates Foundation to support UNHCR to significantly contribute to the reduction of maternal and newborn mortality through proven MNH interventions. Specific strategies included investing in low-cost, high impact interventions like Kangaroo Mother Care to reduce the risk of death by hypothermia in premature newborns; investing in community-based care with the support of CHWs trained to recognize danger signs during pregnancy, providing post-natal care for newborn at home and appropriate referrals to health facilities; investing in quality of care from skilled health workers through continuous on-the-job training on assisted vaginal delivery, manual removal of retained placenta, parenteral treatment of pre-eclampsia and eclampsia, promotion of KMC; the provision of maternity equipment including newborn resuscitation materials; and postnatal care through CHWs – because of this approach and the trainings provided, the IRC saw health workers capacitated and work environments become more functional – both of which increased

provider motivation. Staff and supervisors said for the first time they understood how they could drive this project themselves and felt proud of their ability to continue delivering quality care to the refugee community.

The IRC has implemented similar strategies through other projects in Chad for example investing in community health programs to tackle women's SRH needs by sharing information on the importance of family planning and access to maternal health services. This has resulted in a growing uptake in family planning with 13,865 women receiving family planning in 2020 compared to 11,754 in 2019 according to IRC data. The IRC also aims to improve women's decision-making power, by empowering local organizations and government institutions to give women and girls a voice in their communities.¹⁴⁵ More than 4,015 women benefited from IRC's Protection and Empowerment services in 2020.

As part of its Health Systems Strengthening approach, the IRC helped rehabilitate the maternal surgical ward in Liwa district,¹⁴⁶ donated essential medical equipment and conducted capacity building trainings with more than 30 hospital staff to ensure the provision of quality maternal health services such as C-section surgeries. More than 150 health care professionals and 80 midwives located across five provinces also received training from the IRC on safe approaches to SRH, maternal health and post- abortion care in 2020.

¹⁴⁵ <https://www.rescue.org/sites/default/files/document/618/chadexternalsapfinal.pdf> (IRC Chad Strategy Action Plan 2020)

¹⁴⁶ <https://www.humanitarianresponse.info/es/op%C3%A9rations/chad/document/chad-situation-report-24-april-2020> (Chad situation report, April 2020)

CHAD

Tackling Climate Change & its Impact on Health Outcomes

Chad is extremely vulnerable to the impacts of climate change and is increasingly exposed to unpredictable weather patterns resulting in drought and flooding which can have a devastating impact on food security and health.¹⁴⁷ Chad saw major flooding in 20 of its 23 provinces in August 2020, impacting more than 388,000 people and displacing close to 120,000.¹⁴⁸ Seasonal flooding increases the risk of waterborne diseases such as cholera and malaria, while also damaging essential infrastructure linked to sanitation

and hygiene – necessary to prevent the spread of viruses including COVID-19.¹⁴⁹ The IRC sought to improve water and sanitation infrastructure in a large number of camps including Treguine, K-Moura, Farchana and Gaga. This not only helps to mitigate the impacts of climate change but also strengthens the national health system through improved WASH at facilities which is linked with quality of services and strong IPC measures.

¹⁴⁷ <https://www.rescue.org/sites/default/files/document/5668/chad-watchlist2021.pdf> (IRC Chad Watchlist 2021)

¹⁴⁸ Ibid. (IRC Chad Watchlist 2021)

¹⁴⁹ Ibid. (IRC Chad Watchlist 2021)





THE COVID-19 PANDEMIC IN CHAD

As of mid-March 2021, 4,288 COVID-19 cases and 153 deaths were recorded by WHO in Chad.¹⁵⁰ Actual cases are likely higher but difficult to confirm given insufficient testing. The spread of the virus and subsequent lockdown measures have worsened the economic situation, while also impacting access to food and water, disrupting social support mechanisms, and affecting health seeking behaviors.¹⁵¹ Pandemic-related restrictions required many humanitarian services to downscale or temporarily pause.¹⁵²

The secondary impacts of the pandemic continue to be far reaching including disrupting malaria programs and routine immunization campaigns like those targeting measles and circulating vaccine-derived poliovirus (cVDPV).¹⁵³ A cVDPV outbreak was detected in February 2020 and spread to 36 districts, paralyzing more than 80 children.¹⁵⁴ Unfortunately, due to COVID-19, the vaccine campaign was delayed until November 2020.¹⁵⁵

¹⁵⁰ <https://www.who.int/countries/tcd/> (WHO Covid data Chad, 14 March 2021)

¹⁵¹ https://reliefweb.int/sites/reliefweb.int/files/resources/Impact_of_COVID-19_on_Youth_in_the_Lake_Chad_region_June2020_Eng.pdf (Impact of Covid-19 on youth in Chad, 2020)

¹⁵² <https://www.eiu.com/n/africa-faces-major-obstacles-to-accessing-covid-vaccines/> (The Economist PR, Jan 2021)

¹⁵³ <https://www.afro.who.int/news/over-33-million-children-vaccinated-chad-large-scale-polio-campaign> (WHO vaccination Chad, Dec 2020)

¹⁵⁴ Ibid. (WHO vaccination Chad, Dec 2020)

¹⁵⁵ Ibid. (WHO vaccination Chad, Dec 2020)

Essential, and already limited funding was diverted from the day-to-day health response towards pandemic response activities. In 2020, more than 8 million USD of humanitarian funding was provided for the COVID-19 health response, while only 1.5 million USD was spent on the general health activities according to UN OCHA's Financial Tracking Service data.¹⁵⁶ A local organization confirmed suffering from this diversion when a grant expected for 2020 was redirected

towards other health actors responding to the pandemic. The local organization also confirmed that restrictions impacted outreach efforts with fewer CHWs mobilized and social distancing measures limiting the number of participants attending awareness sessions.

Overall, the impact of COVID-19 on essential health activities in Chad further demonstrates the need for greater funding flexibility to ensure emergencies can be efficiently and effectively addressed without disrupting ongoing health activities.

IRC and partners run emergency four day Meningitis vaccination campaign to combat epidemic in Bredjing refugee camp.



¹⁵⁶ <https://fts.unocha.org/appeals/907/summary> (UN OCHA FTS Chad 2020)

RECOMMENDATIONS FOR CHAD

FOR DONORS	
POLICY RECOMMENDATIONS:	OPERATIONAL RECOMMENDATIONS:
<ol style="list-style-type: none"> 1 Support the development and implementation of policies – including the CCRF – that would enable the MoH to successfully integrate refugees and IDPs into the national health system. 2 Advocate for increased budget allocations from the national government to the health sector to enhance quality of care, strengthen the supply chain and improve access to life-saving services. 3 Support the government of Chad to develop more comprehensive emergency preparedness policies and financing mechanisms that could effectively address both ongoing and emerging crises ranging from public health threats to climate change. 	<ol style="list-style-type: none"> 1 Ensure the government’s 2008 social policy (Law No 006/PR/2002) is effectively implemented by investing in monitoring and accountability mechanisms – this must include implementation of “therapeutic abortion care” under Article 14 and entail a free provision of essential emergency services – including those withdrawn by the government in 2017. 2 Encourage the government to invest in recruiting, training, and supervising health workers. This would ensure the provision of quality health care services by motivated and competent staff who would also be better equipped to address the health needs of vulnerable populations.
FOR INTERNATIONAL & LOCAL HUMANITARIAN ACTORS	
POLICY RECOMMENDATIONS:	OPERATIONAL RECOMMENDATIONS:
<ol style="list-style-type: none"> 1 Advocate for comprehensive SRH policies inclusive of access to safe abortion and post abortion care. 2 Invest in proactive strategies and policies that could potentially mitigate the negative impacts of climate change on the health of host, refugee and IDP populations. 	<ol style="list-style-type: none"> 1 Continue efforts to change perceptions and attitudes towards SRH care – including stigma around abortion – among key stakeholders including policy makers, community leaders, and health workers through capacity building and awareness raising. 2 Strengthen the national health system through capacity building and incentives for health staff, in addition to developing systems linked to data collection, monitoring, IT and supply chain management.

FOR THE GOVERNMENT OF CHAD

POLICY RECOMMENDATIONS:

- 1** Increase the MoH health budget to expand access to quality, affordable primary health care while also rendering them more accessible to all vulnerable population groups – including refugees – in accordance with the CRRF vision.
- 2** Ensure Law No 006/PR/2002 on reproductive health and its Article 14 on “therapeutic abortion care” are successfully implemented across the country.
- 3** Introduce socio-economic policies to address the root causes of maternal and child mortality in Chad – such as early or forced marriage – and provide women and young girls with further decision-making power.

OPERATIONAL RECOMMENDATIONS:

- 1** Invest in health care workers through capacity building and incentives, particularly aimed at health staff working in difficult rural contexts with limited resources.
- 2** Invest in decentralized community health approaches to enable the effective dissemination of health information.
- 3** Integrate the health post structure into the national health system to expand the reach of MoH services in rural areas, while also alleviating the burden on primary health clinics.

FOR ALL HEALTH ACTORS INVOLVED IN THE COVID-19 PANDEMIC RESPONSE:

- 1** Adapt programs to allow safe delivery of essential health services – including comprehensive SRH services – throughout the pandemic and other emergencies.
- 2** Ensure refugees and other displaced populations are included within national COVID-19 vaccine deployment and distribution plans.

CONCLUSION & RECOMMENDATIONS

Humanitarian crises continue to pose complex, costly and persistent problems and this is unlikely to change. With the prevalence of protracted crises resulting in decades of displacement, there is an urgent need to better understand the unique health needs facing vulnerable populations including the barriers that exist to meeting them. With different programs and approaches being implemented around the world, we must take the time to learn from successes and failures in order to inform both policy and practice across contexts.

The Jordan, Bangladesh and Chad contexts underscore the need to advance evidence-based, inclusive health policies that address the unique needs of vulnerable populations both in the immediate response as well as in long-term planning and financing. This is critical not only for ensuring equitable access to health for all, regardless of documentation status, but also for global and national health security – a principal clearly seen through the COVID-19 pandemic.

The case studies provided outline a range of strategies and approaches that can be adopted by humanitarian actors as well as national health care providers. While context-specific operational, financial and policy recommendations have already been listed for each of the three case studies, overarching recommendations can also be drawn and applied to other settings.

Donors, national governments, and implementing organizations should take forward these four overarching recommendations to enhance the health response in any crisis:

1 FINANCIAL

Donors must allocate long-term, flexible financing to ensure the sustainable provision of quality, affordable and accessible health services throughout the arc of a crisis – from immediate response to long-term recovery and resilience.

2 STRUCTURAL & LEGAL

Governments and donors must prioritize strengthening the national health system from the onset of any humanitarian health intervention through capacity building of health staff, enhancing health structures and medical resources, and investing in key technological pillars linked to data, surveillance, and information gathering.

3 POLITICAL

Governments must develop inclusive national policies that promote equitable access to health services, regardless of legal status. We must also see political will translated into concrete action with the funding needed to implement those policies. For example, refugees and displaced populations must be included in COVID-19 vaccine deployment and distribution plans.

4 COMMUNAL

Governments and implementing organizations should leverage decentralized community health approaches that empower vulnerable refugee, IDP and host population groups to help effectively address and prevent serious health conditions while also strengthening linkages with the formal health system.

These recommendations apply across contexts and we have seen the importance of each play out through the course of the COVID-19 pandemic. Political, financial and technical support from the international community and INGOs is still very much needed, however, a change of vision is crucial to decrease dependence on humanitarian aid and increase resilience in the long term.

