Health Facility Rationalization Assessment Report: Ensuring Equitable and Efficient Distribution of Health Facilities in the Refugee Camps, Cox's Bazar Bangladesh- September 2022

1. Introduction

a. In 2017, a violent military crackdown in Rakhine State, Myanmar culminated in a sudden displacement of more than 742,000 people in August that year- triggering the ongoing humanitarian crisis in Cox's Bazar, Bangladesh where an estimated 913,660 Rohingya refugees (Female-51.5%, Male-48.5%) live under difficult conditions across 33 camps in Teknaf and Ukiya Upazilla in the Southern District of Cox's Bazar, Bangladesh[1] The crisis has impacted the health systems at many levels.

b. World Health Organization (WHO) is leading the coordination of the health sector response together with the Ministry of Health (MoH) as a Co-lead and in collaboration with the Office of the Refugee, Relief, Repatriation Commission (RRRC) and more than 70 health implementing organizations providing primary and secondary health care services through a network of about 130 health

c. The crisis has now reached a protracted level[2] and coupled with the impact of the COVID-19 pandemic, it is facing a significant funding shortfall renewing the efforts to find efficiency in the delivery of health assistance. To meet this new goal, in line with the local Health Sector Strategic Plan, the Health Sector undertook a review of the distribution and architecture of the local primary healthcare services to prepare for and adapt to these changing dynamics while ensuring equitable access to priority health services.

d. In the Health Sector, the number and geographic distribution of health facilities underpin the efficiency in the delivery of essential healthcare services. Without prioritization and alignment to evidence-based standards, an uncoordinated approach does amplify critical gaps in the response and promotes the waste of resources.

e. To inform the decision on the allocation and distribution of healthcare facilities, the Health Sector Strategic Advisory Group (SAG) endorsed the rationalization exercise described here.

f. The rationalization exercise aims to define an efficient and equitable distribution of all the affected people in a predictable, efficient, and timely manner so that the humanitarian community is more transparent and accountable[3].

g. In 2019, the health sector conducted a similar exercise that reformed the distribution of primary healthcare facilities from about 200 health facilities in the acute phase of the response to about 130 by 2020. However, despite strong oversight of the sector, the number of health facilities has gradually risen- rolling back some of the gains that were already made in achieving efficiency. This has happened due to illicit establishments perpetuated by other local administrative bottlenecks that are not within the scope of this document to explore.

h. The Health Sector, with the strategic oversight of SAG, led the exercise in collaboration with the Health Sector partners (United Nations, INGOs, NGOs). This

paper outlines the principles that governed the rationalization exercise in a systematic, accountable, and transparent manner.

1.1 Deliverables

a. A contextualized rationalization data collection tool based on tested health resources and services monitoring systems
b. Primary and Secondary data collected in and transparent process
c. Quantitative and qualitative data analysis with predetermined criteria for prioritization and rationalization
d. A consolidated report documenting the exercise from planning, data collection, analysis, results, and recommendations.

2. Methodology

a. Assessment Design: This assessment was conducted through a mixed method consisting of i) primary data collection through a cross-sectional survey using a standardized data collection tool, ii) secondary data collection using retrospective data from health sector service monitoring data, health service utilization data (4W), and iii) qualitative data collected through focused group discussions with SAG members
b. Designing data collection tools and techniques: The Health Sector Strategic Advisory Group (SAG) developed the health facility rationalization tool-adapting it from the WHO Health Resource and Service Availability Monitoring System (HeRAMS) to match the local context and extract reliable data to inform the health resource and service reprioritization exercise.
c. Scope: The health facility rationalization exercise targeted all Health posts, Primary Healthcare Centers, "Specialized Facilities", and Mental Health and Psychosocial Support (MHPSS) Centers. Women Friendly Spaces, Government-owned health facilities such as Community Clinics, Union Centers, Family Welfare Centers, Severe Acute Respiratory Infection Isolation and Treatment Centers/SARI ITCs, Field hospitals, and Upazilla Health Complexes were excluded from this exercise.
d. Data Collection: Data was collected by the SAG over a period of 2-3 weeks in July 2022. To minimize reporting bias, each SAG member was assigned to collect data from a specific group of health facilities without assessing a facility that they operate or fund. Data were entered into a Kobo database and stored by the Health Sector Information Management Unit.
e. Partner and stakeholder: A series of information-sharing meetings held with the health sector partners informing them about the exercise (design, objective, data collection, questionnaire, etc). Similarly, the health sector SAG (includes government representatives from the Office of RRRC, and Office of the Civil Surgeon) was duly informed and consulted. There was an active engagement effort to ensure buy-in, create trust, and participation of all stakeholders in the process, and guarantee ownership of the recommendation that emerged[4-7]

[a] *WHO,MOH, RRRC, United Nation Agency for Population Fund, HO, UNFPA, United Nations Children's Fund, United Nations High Commission for Refugees, International Organization for Migration, Save the Children, International Rescue Committee, International Federation for Red Crescent, Médecins Sans Frontières*

3. Data Analysis and Decision Framework

Information about each health facility was obtained through quantitative data using the standardized questionnaire, 4W utilization data, and past health facility monitoring. Qualitative information was obtained in the format of a focused discussion with SAG members. The analysis process triangulated information from the above sources and ranked the health facility based on the consolidated observations.

3.1 Data Analysis: Key principles/criteria for ranking health facilities.

3.1.1 Primary Criteria of Analysis

1. Population/ Health Service Catchment Criteria

First, the updated UNHCR population data were used to project the health service catchment for a specific geographic area/Camp, and based on this, the number of required health facilities was determined based on the technical standards from i) Sphere health systems standard 1.1: Health service delivery[8] that stipulates one healthcare facility (primary) per 10,000 people. This is similar to the Minimum Package for Essential Health Service Package for Primary Healthcare (MPEHS), Cox's Bazar, Bangladesh which stipulates[9]

- 1 Health Post for 10,000 people
- 1 Primary Healthcare Centre (PHC) for 25,000-30,000 people
- At least 10 Inpatient beds per PHC

Where PHC and HP co-exist in the same catchment area, the analysis factored in the observation that on average, PHCs absorb nearly 50% of HP coverage. Simply put, one PHC is approximately 1.5 HP.

2. Physical access/Geographic access.

The Sphere standard recommends the health facility be accessible within 1-hour walking distance for at least 80% of the population from dwellings. The Cox's Bazar MPEHS recommends a Health post to be accessible within 20 minutes walking distance from patients' homes a PHC within 30 minutes walking distance from patients' homes, physical barriers, topography, etc

3.1.2 Additional Analysis Criteria

3. Relevance and alignment to Health Sector Strategic Plan and MPEHS. Examined the extent to which the service is prioritized by the sector, existing legitimate gaps, etc. The health facility ranking also considered the scope of services as defined in the MPEHS, availability of essential medicines, inpatient hospitalization capacity for PHCs, coordination with the HS, reporting 4Ws/EWARS, basic amenities (toilets, water, electricity), waste management, referral system, triage, emergency care, EPI, NCDs, Communicable Disease, MHPSS, and SRH
4. Delivery approach: Here the analysis explores several aspects: integrated vs standalone service domains, availability of core service domains e.g., delivery for PHCs, inpatient for PHCs, lack of referral capacity, mobile vs static health service delivery

5. Co-location and proximity to other service providers: How close is the health facility to another facility providing similar or higher levels considering the stipulated population and walking distance standards? clustering, proximity to other healthcare providers within the same catchment population, and operational hours.
6. Host community coverage: How is the facility accessible for the host community in the spirit of peaceful co-existence and reducing pressure on the local healthcare system
7. State of infrastructure: Durability, resilience, and investments. Other basic amenities such as access to water, sanitation services, energy, space for expansion, state of infrastructure, etc.
8. Health Service Utilization: Based on reports on the Health Management Information System, the utilization of the facility-based services e.g., reported OPD, births, referrals, etc.
9. Buffer Capacity and flexible planning: A flexible range was considered in the final decision to cover acute disruptive events e.g., fires, monsoons, funding cuts, displacements, etc.
10. Localization Considerations: Ensure meaningful representations and space for UN, INGO, and National NGOs

3.3 Target/estimated requirement for primary healthcare facilities

Planning Scenario estimated catchment population: 900,000- 930,000 people

3.4 Health Facility Ranking

Based on considerations of all the above decision-making points, the facilities within each catchment area (camp) were collectively ranked on the following scale:

Rank	Category	Recommendations
1	Meets all expectations/standards	The facility and partners may continue operation where there is a gap/need. In some settings, the facility/partner may have met all the criteria for HP/PHCs however, there is a surplus or duplication. In such circumstances, the facility is still not prioritized through the rationalization recommendations however, the partner may realign its activity to support facilities in the same or different areas where there were gaps i.e., facilities in Category 2-4. recommended continuing operations
2	Meets most expectations/standards,	Category 2 facilities require minor improvements, but the course of action/recommendations is the same as for those in category 1.
3	Meets some expectations/standards,	Facilities in this category require moderate r for improvement. Depending on additional criteria e.g., access for the host community, physical access limitations, localization, government support, and availability of other providers, they may be

 		recommended to continue operation with an improvement plan (including integrating other partners), relocate to realign resources and support specific gaps in other facilities.
4	Does not meet expectations/standards,	Category 4 requires major recommendations, unless there is a critical gap or SAG acceptable justification along the set criteria, these facilities are not prioritized
5	Does not meet expectations, does not align with Health Sector priority and approach,	Based on all considerations, the facility/partners are not recommended to continue operation based on strategic considerations. For instance, SAG recommended all standalone MHPSS, SRH, and Dental centres be integrated into PHCs based on agreed approaches and standards. Physiotherapy, Rehabilitation Centres that were named as Health Post should be reclassified since they are not HPs/PHCs.

Recommendations: 77 Health facilities (42 Health Posts out of 93, and 35 PHCs out of 46) were unanimously prioritized with specific applicable recommendations for any improvement. About 10 facilities require additional verification and review at the time of the report and will be revisited as part of ongoing decision-making.

4. Proposed Implementation- principles:

The translation of the recommendations to a practical operation is crucial and will be navigated through a direct dialogue between partners and SAG. Key principles to consider include:

i. Feedback to Partners: Health SAG will provide feedback and specific clarification on rationalization recommendations at the partners' request. Where relevant, identify and consider any critical information to consider in the analysis and recommendation

ii. Transition plan: Discuss and agree with partners and donors on feasible transition (relocation, integration, closure) considering important variables such as funding commitments, opportunities for integration/merger, donor engagement, etc and agree on a phased approach, clear timelines, and monitoring. This plan will be incorporated into the results.

iii. Conclusion: Going forward, the preliminary SAG recommendations are the evidence base for the list of prioritized health facilities and should inform collective (Joint Response Plan) and individual agency/donor-based planning, and resource prioritization. It is noted that the Office of the RRRC is yet to evaluate and issue additional recommendations. So far, these results can be applied for planning purposes.

5. Important Annexures:

i. Health Facility Rationalization Assessment: [Primary data collection tool]
ii. Assignment of data collection (SAG members): [List]
iii. Health Facility Rationalization: [SAG Results and recommendations]
iv. Health maps: [Before and after rationalization]

6. References

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