Adapting health systems to respond to refugees' health needs: new empirical evidence on the inclusion of refugees into national health systems in LMICs

Background

As the number of refugees increases and displacement becomes more protracted, providing equitable, accessible and quality healthcare in the longer term is challenging. While the Global Compact on Refugees calls for inclusion of refugees in national health systems, the evidence base is still thin on how to achieve it.

What we did

Between 2023 and 2025, we conducted a large, comparative mixed-methods research programme, focusing on six LMICs: Kenya, Kurdistan Region of Iraq, Mauritania, Pakistan, Peru and Zambia. We draw evidence from two literature reviews and the six case studies each entailing document review, key informant interviews and Group Model Building (GMB).

What we have learned

Contextual and policy drivers influencing the policy trajectory for health systems integration:

- **Scale and speed of refugee arrivals:** slower inflows make integration more feasible. **Composition, number and distribution** of refugees relative to population also matter
- **Socio-economic context** shapes integration: GDP, fiscal arrangements
- **Legal frameworks** can accelerate inclusion into national health system, especially right to documentation and work (on paper and in practice)
- **Cultural affinity** can smooth acceptance and solidarity
- **Political discourses** can shape responses, positively and negatively
- **Geopolitical factors and external support** – degree of support, alignment of aid, balance of humanitarian/ development funding all influences choices
- The **strength of the national health system** dictates how inclusive it can be and the trade-offs of health system integration, in relation to quality and coverage compared to parallel systems

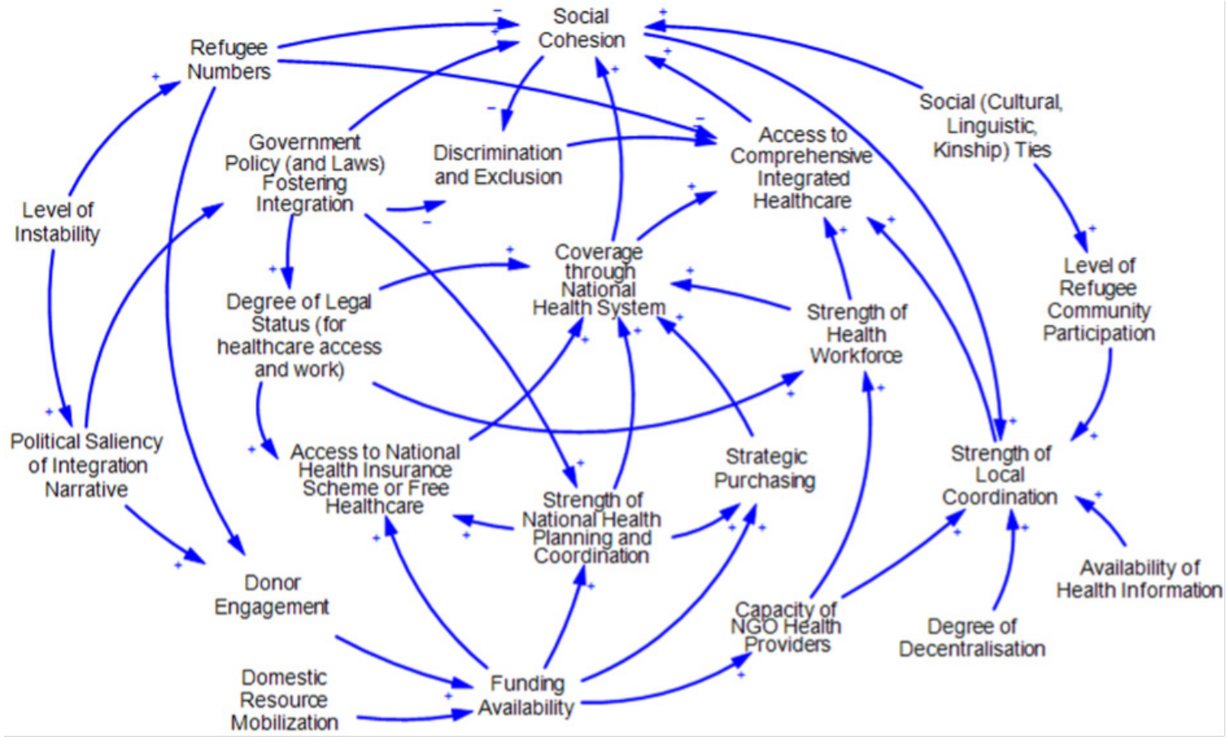
Conclusions

Inclusion of refugees into national health systems is complex and does not guarantee improved outcomes, especially when refugees previously benefited from a higher level of resources. However, committed leadership, coordinated external support, and investments in strengthening key components of the local health system can support adaptations in service delivery to respond to the shifting health needs of refugees and host communities alike.

Key enablers and barriers of integration across health system domains

	HEALTH SYSTEMS DOMAINS			
	Health governance	**Health financing**	**Service delivery & health workforce**	**Health information systems**
Enablers of integration What works to support refugee inclusion in this domain?	• Decentralisation of health system • Whole of society approaches that go beyond health governance • Transfer of facilities to public ownership is an effective starting point, if matched with sufficient resources • Inclusion of refugees in sectoral governance, e.g. managing committees	• Increased use of development funding to strengthen public systems used by both communities • Sufficient funding allocation to local health system to cover refugees • Universalist configuration of the health systems (e.g. free healthcare package, Social health insurance (SHI) accessible to refugees	• Alignment of service delivery and systems (procurement, training, etc.). • Support quality of care and trust, and strengthening of local health system • Engaging with committed community actors • Local training of refugee health workforce and creating pathways for them to join the national health workforce	• Support tools and approaches for harmonised but granular health data • Strengthen trust and ensure anonymity in data collection and surveys to increase refugee participation • Improve collection and analysis of standardised financial data
Barriers to integration What doesn't work for refugee inclusion in this domain	• Weak leadership and stewardship capacity of the local health system • Lack of inclusive policies and whole of society approach • Lack of international support	• Inadequacy of funding and differences in funding flows (e.g. camps and out of camps) • Poor functioning of some public risk pooling schemes like SHI • Barriers to access to SHI – documentation, right to work	• Differential in quality and coverage of care in the parallel systems • Barriers to care access related to documentation, right of movement, language, xenophobia • Non-recognition of qualification for refugee health workers	• Systems that are not interoperable • Limited disaggregation due to refugee fears and rigid systems

Figure: Dynamics influencing refugee inclusion in national health systems



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