Crossing lines: Health systems and forced migration through a cross-border lens

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Key messages

- National health systems face legal, financial, and capacity barriers in meeting displaced populations' needs – restrictive laws, discretionary inclusion and underfunding often constrain access.
- Forced displacement is a long-term, overlapping crisis requiring sustained, multisystemic approaches.
- Refugees and internally displaced persons (IDPs) traverse both international and internal "power lines". Global policy should shift from state-centric models to apply a "cross-border lens", an approach that is sensitive to cross-border dynamics and areas of limited statehood, accounting for contested authority, with services spanning beyond one sovereign state.
- Health governance in displacement contexts is plural and fragmented. Non-state actors, diaspora networks and humanitarian agencies often act alongside or instead of governments.
- Community-led innovations show resilience but lack sustainable support. Refugee-run clinics, informal insurance schemes, and local provider networks fill gaps but remain precarious without funding or recognition.
- Flexible financing, workforce recognition, and regional data systems are central to building health system resilience for displaced populations.

Definitions

Borders: For this brief, the term 'borders' refers to both internationally recognised lines separating sovereign states, and internal power lines that divide a territory between different governing authorities, including non-state groups.

Refugees (UNHCR definition): People fleeing conflict or persecution across an international border who are granted protection under international law (e.g. the 1951 Refugee Convention).

Internally displaced persons (IDPs): People forced to flee their homes due to conflict, violence, disasters, or human rights violations, who remain within their country's internationally recognised territory (but they may or may not cross the internal power lines).

Limited statehood: Areas where the central government lacks the capacity to enforce rules or provide services, allowing non-state or hybrid authorities to assume governance roles.

Why it matters

Forced displacement today is neither temporary nor peripheral - it is a defining feature of our era of crisis, driven by intersecting conflicts, climate shocks, and political instability. In 2025, UNHCR estimated there were 122 million forcibly displaced people globally, 73% of whom were hosted in low- and middle-income countries (LMICs). 45.3 million of these were refugees or asylum seekers and 73.5 million IDPs – nearly double the number a decade earlier.

Displacement is usually protracted, with the average length of displacement between 10 and 20 years. More than three-quarters of refugees are hosted in LMICs, many of which are fragile or conflict-affected. Meanwhile, host and origin country health systems are severely strained, and global aid budgets are shrinking; by mid-2025, major donor cuts reduced humanitarian funding by about one-third from the previous year, risking essential support.

Forcibly displaced populations face profound health inequities, yet their access to care is dictated less by medical need than by their pattern of mobility and the borders they encounter. Whether crossing international frontiers or trapped behind internal conflict lines, displaced people's well-being is often determined by jurisdictional and political boundaries.

Borders play a significant role in defining who is entitled to care and how health systems respond. Crossing an international border can confer refugee status and access to UN or host-state assistance, whereas those displaced internally remain under national sovereignty with no special international protection – a legal distinction that creates stark gaps in services and protection.

Background

Health systems are increasingly challenged by the scale and complexity of forced displacement, with current responses falling far short of needs. Borders act as filters, determining who can access services, what level of care is available, and how resources flow. Meanwhile, fragmented governance and financing force humanitarian and development actors to navigate complex, overlapping systems. Separate funding streams and policies typically apply to refugees versus IDPs; parallel health services proliferate when parts of a country lie outside government control, resulting in duplication, gaps, and inefficiencies in coverage for displaced groups.

In LMICs, health systems are often under-resourced and overstretched even before displacement occurs. They are caught between global policy frameworks (e.g. refugee compacts, humanitarian principles) and local political realities (e.g. public resentment, security concerns).

In active conflict settings, internal power lines and areas of limited statehood further complicate efforts to provide equitable care. Millions of IDPs end up in territories controlled by non-state actors or divided by conflict lines, beyond the reach of the official health system. Governance in these areas is fragmented and contested, leaving populations doubly vulnerable – excluded from their government's services and lacking consistent international aid. They often rely on a patchwork of local charities, informal providers or intermittent humanitarian assistance under insecure conditions.

Policy discussions often treat "forced migrants" as a single category, but refugees, IDPs, and other displaced groups (e.g. stateless persons) experience health systems very differently. A refugee who crosses into a neighbouring country may access that country's clinics (or parallel refugee programmes), but an IDP in a conflict zone might rely on a humanitarian mobile clinic or an NGO hospital operating outside government oversight. Recognising these differences reveals structural barriers and opportunities in each context. Adopting a "cross-border lens" means classifying displacement contexts by the borders involved (international vs. internal) and the nature of governance across those borders (stable state vs. limited statehood). This lens illuminates how health system responses differ and informs tailored strategies to strengthen resilience beyond one-size-fits-all models.

Displacement contexts through a cross-border lens

Applying a "cross-border lens" yields three broad contexts:

1. Refugee integration within national health systems of host countries

Definition: Displaced populations cross an international border and are included in the host country's health system. Refugees in this context use public clinics and hospitals of the host state, sometimes supplemented by international funding or parallel programmes later integrated into national structures.

Opportunities: Integrating refugees into national systems can enhance sustainability and equity. Humanitarian funding can strengthen public health services for both refugees and host communities rather than creating duplicate systems. Over time, this builds more inclusive Universal Health Coverage (UHC). For example, Uganda's long-standing policy grants refugees access to government health and education services equal to those of citizens, with donor support for infrastructure, medicines, and staff improving care for all.

Challenges: Integration is often politically sensitive. Host governments and populations may worry that refugees will overburden already strained services or receive "preferential" aid. Legal barriers (e.g. refugees lacking health insurance or official documents), funding gaps and disputes over who pays for refugee care are common. Even well-intentioned policies can falter without sufficient resources. In Jordan and Lebanon, efforts to integrate Syrian refugees into health services wavered when external funding lagged or domestic politics shifted. Sustaining donor support and fair burden-sharing is crucial. The degree of integration varies significantly across different host countries, influenced by their policies, capacities, and political contexts. For example, Syrian refugees in the three neighbouring countries experience distinct levels of integration. Turkey exemplifies a model of partial integration through its Migrant Health Centres, which provide free and culturally tailored primary care within the public health system for those under temporary protection status. In contrast, Lebanon has adopted a largely parallel approach. In this case, health services for Syrians are primarily delivered by NGOs and international agencies, often operating outside the national system. This has resulted in fragmentation and inequities in

access to care. Jordan presents a mixed scenario: Syrian refugees can access public health services, particularly primary care; however, they often encounter out-of-pocket costs and a tiered access system. Additionally, the quality of services depends significantly on ongoing donor support.

2. IDP health needs addressed through central governments

Definition: Here internally displaced persons remain under their central government's authority having fled their homes and crossed internal power lines, relocated to state-controlled areas. The national government (often with international donor support) assumes primary responsibility for IDPs' health care. Displacement may strain certain regions, but the state acknowledges IDPs and can integrate their needs into national health strategies or special programmes.

Opportunities: A state-led response through national institutions can strengthen capacity and legitimacy. It avoids parallel systems: investments to help IDPs can also improve services for host communities, aligning with development goals.

Ideally, donor funds in this context bolster broader health systems – building clinics in areas hosting IDPs, training health workers, expanding surveillance – leaving a positive legacy even after IDPs return. A state-led approach allows nationwide coordination: IDPs can be included in national health insurance or disease control programmes, ensuring continuity of care as they move. Politically, visibly caring for IDPs can bolster social cohesion and public trust in the government by showing it protects all citizens. After 2017, Iraq faced one of the largest internal displacement crises in the region, with more than 6 million people displaced at the peak. Many IDPs relocated to government-controlled areas, where the Iraqi Ministry of Health, supported by WHO, the World Bank, and international non-governmental organisations (NGOs), coordinated the response. This included deploying mobile medical teams, restoring primary health centres in host and return areas (e.g. Anbar, Nineveh), and integrating IDPs into national immunisation and disease surveillance programmes.

Challenges: Governments may be reluctant to

Afghan refugees in camps in Pakistan © European Union, 2020. Photographer: Mallika Panorat via Flickr

fully acknowledge or plan for IDPs, as doing so can imply internal conflict or state weakness. Stigma and political sensitivities often impede recognition of IDPs' needs. Even when policies exist, implementation may be uneven – IDPs might face bureaucratic hurdles accessing care outside their home district, or they may be omitted from budgets. Despite a state-led approach, chronic underfunding persists. Governments dealing with conflict frequently rely on humanitarian agencies to fill gaps, resulting in a hybrid response. If donor support wanes or the crisis falls off the international radar, IDP health services can deteriorate quickly. In Ethiopia's recent conflicts, government responses to IDPs were inconsistent – at times providing centralised aid, at other times blocking access and leaving NGOs to fill gaps.

3. Cross-border mechanisms for displaced populations

Definition: When integration into national systems is unfeasible or blocked, displaced groups may have to rely on cross-border arrangements to maintain health access across international boundaries. This involves formal or informal cooperation enabling people to obtain care in a neighbouring country or through transnational programming. In territories beyond the effective control of the central government - such as areas held by insurgent groups, de facto authorities or contested administrations - the official state health system is unable or unwilling to operate fully. As a result, health services are typically delivered by a mix of humanitarian organisations, local community actors, the private sector and alternative governance structures.

Opportunities: Cross-border health mechanisms can ensure continuity of care for populations by leveraging resources on both sides of a border, e.g. referring war-wounded patients from a conflict zone to a hospital in a neighbouring country, or setting up humanitarian corridors, bilateral agreements, and regional initiatives such as synchronised vaccination campaigns in border regions. Such cooperation shares responsibility between countries and reaches populations otherwise cut off by conflict. The UN Security Council authorised cross-border operations in Northern Syria, which have been a lifeline for IDPs, delivering disease surveillance, vaccines and trauma care where the national system cannot operate. Local health directorates, local NGOs, and international charities formed a semi-coordinated network operating independently of Damascus, with funding and supplies channelled through Iraq and Turkey.

A similar approach has supported conflict-affected communities along the Thailand–Myanmar border, where ethnic health organisations deliver services inside Myanmar with cross-border aid coordinated from Thailand. Health facilities in Thailand offer care to refugees and migrants who cannot access services in Myanmar and can develop significant capacity, while in ethnic areas within Myanmar some of the hospitals and training programmes have been operational for decades.

Armed conflict in Ethiopia's Tigray region severely disrupted health governance and access. Large populations of IDPs found themselves in areas beyond effective federal control, where public services collapsed and humanitarian access was heavily restricted. Health care for displaced communities depended almost entirely on non-state actors and international NGOs operating under extreme constraints.

Parallel systems may become the backbone of care for those communities, achieving impressive coverage in challenging circumstances. Humanitarian agencies bring resources and expertise to prevent total collapse. These semi-formal networks represent a pragmatic response to health needs in zones of limited state control and can spur innovation: for instance, community health worker networks or telemedicine may emerge in areas with no formal clinics, supported by diaspora networks. They have community trust and tailor services to local needs, building resilience.

Challenges: Cross-border arrangements are fragile. They depend on political goodwill and can be undone by shifting geopolitics or a single government controlled by non-state vetoes. Syria's cross-border aid mechanism, for instance, requires periodic UN approval and has faced closure threats from changing international political agendas. There is a risk of institutionalising parallel systems: populations rely on external services across borders while local health system development stagnates and local governance is side-lined. Fragmentation and lack of sustainability are downsides. Services delivered by NGOs or rebel authorities might not meet national standards and often depend on short-term external funding. Reintegration of these services into a national system after conflict is challenging. Cross-border activities are also hampered by security concerns and restricted movement (e.g. border closures). Diplomatic and legal complexities (such as treating patients from one country in another's facilities) must be managed. Legitimacy is contested: governments may refuse to recognise or coordinate with providers in rebel areas (and vice versa),

undermining comprehensive planning. Populations in these zones face a double vulnerability; excluded from state services (sometimes deliberately denied aid as a war tactic) while dependent on insecure, volatile relief efforts. Health workers in these contexts may have unrecognised credentials (not acknowledged outside their area); supply lines are tenuous; and any gains can be undone by renewed fighting. There is also a moral hazard that the availability of humanitarian services allows the central government to abdicate responsibility for IDPs in opposition areas. Crucially, no one plans long-term for these populations – they occupy a grey area of governance.

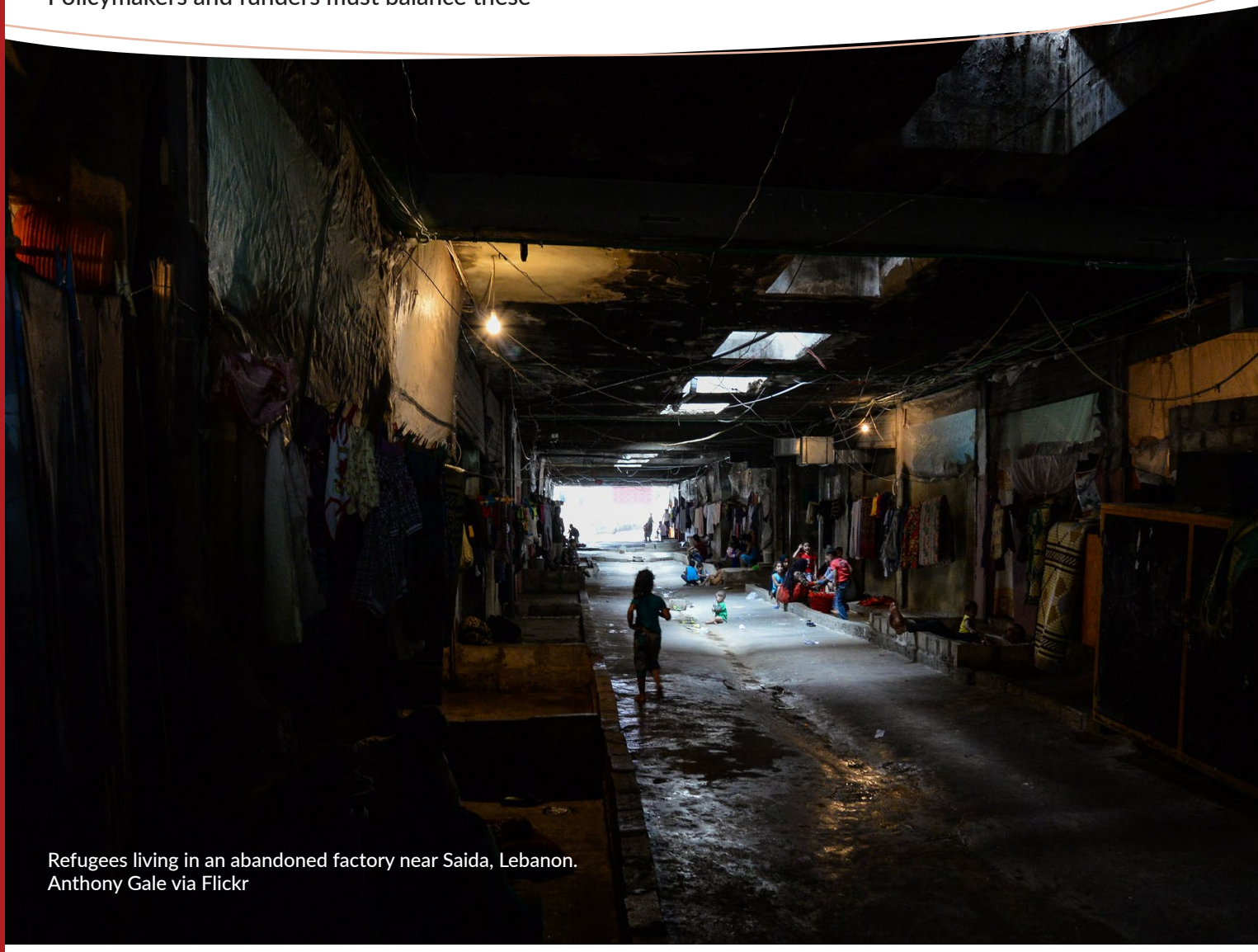
Reflections and implications

Key trade-offs in designing responses: These contexts highlight several key tensions: integration vs. parallel health services (parallel efforts should be short-term bridges to integration), state sovereignty vs. the humanitarian imperative to reach those in need, and short-term emergency aid vs. long-term health system resilience. Policymakers and funders must balance these trade-offs, from which emerge several lessons for building resilient health responses:

Policymakers should acknowledge how borders shape governance, service delivery and access and adopt a **"cross-border lens"**, tailoring strategies to specific contexts. Humanitarian action must be bridged with development efforts – aligning short-term relief with long-term system strengthening – and strategies should transition into national or local systems whenever possible.

Financing and cooperation need rebalancing: flexible multi-year funding (including regional pooled funds and support through government systems) is required to sustain health services for the displaced, and greater cross-border and international collaboration can address shared health challenges.

Throughout, **equity and inclusion** must be mainstreamed – refugees and IDPs should be integrated into health plans ("leave no one behind"), with efforts to combat discrimination and foster social cohesion so that support for displaced people also benefits host communities.



Refugees living in an abandoned factory near Saida, Lebanon. Anthony Gale via Flickr

Policy recommendations

Develop health strategies that reflect the specific border dynamics shaping displacement. Responses should distinguish between refugees crossing international borders and IDPs navigating internal power lines, such as limited statehood or government-held areas. Each context demands adapted governance, financing, and coordination models that reflect the specific barriers and actors involved.

Institutionalise cross-border coordination mechanisms. Where national systems cannot reach (e.g. in conflict zones or borderlands), governments, UN agencies, and donors should support formalised cross-border health delivery, surveillance, and referral systems that transcend geopolitical divides.

Support health governance in areas of limited statehood. Global and national actors should formally recognise non-state health providers (e.g. ethnic health organisations, local NGOs) as part of the health ecosystem in contested areas. Where appropriate, these actors should receive technical assistance, resources, and coordination support.

Integrate displaced populations into national health policies. Refugees and IDPs should be explicitly included in Universal Health Coverage commitments and health sector planning, regardless of their legal status or location relative to administrative boundaries.

Enable mobility of the health workforce. Support mutual recognition of health worker credentials across border regions and among informal systems. This promotes continuity of care and leverages displaced professionals already embedded in communities.

Invest in interoperable health information systems. Surveillance and patient records should function across regions and authorities, enabling continuity of care for displaced populations and better monitoring of border-related health gaps.

Adapt financing models to border-crossing realities. Displacement-aware financing should be flexible, pooled, and multi-year, enabling support to populations across jurisdictional divides and to non-state providers. Donor strategies should support long-term resilience, not just humanitarian containment.

UNHCR refugee registration centre near Tripoli, Lebanon.

Conclusion

Resilience in refugee and migrant health cannot be achieved through state-centric frameworks alone; the realities of 21st-century displacement – protracted crises, overlapping emergencies, and large populations in areas of limited statehood – demand a different approach. Health systems must be reconceived as border-traversing, networked, and inclusive of non-state and community actors. In other words, achieving health for all requires moving beyond the assumption of neatly bounded national systems serving sedentary populations.

Flexible systems are needed that take into consideration human mobility and the patchwork governance in which displaced people seek care. Applying a "cross-border lens" at every level of health policy and practice is essential. This means adopting flexible financing, embracing diverse governance structures, and building regional cooperation on the health workforce and data. These shifts move responses from fragmented emergencies to sustainable health systems resilient to displacement.

This vision aligns with a normative view established with the Global Compact that human mobility is a continuum best addressed through cooperative, pluralistic efforts even if this is under attack by isolationist national agendas.

Ultimately, rethinking health systems through a cross-border lens is about aligning displacement realities with the ideal of health equity. It shifts focus from abstract categories of refugees, IDPs or migrants to the concrete legal, geographic, and political barriers they face – and how to overcome them. By recognising and addressing these border-induced dynamics, health will no longer be determined by which side of a border a person is on. Only then will health resilience truly extend beyond borders, ensuring that all people – displaced or otherwise – receive the care they need, wherever they need it.

Context	Border Type	Defining Features	Opportunities	Challenges	Examples
1. Refugee integration within national health systems	International borders (refugees entering host states)	Displaced populations access host-country health systems, sometimes with donor support; mix of public, NGO, and refugee-run services	Promotes sustainability; strengthens national systems; equity between displaced and hosts	Political sensitivities; financing gaps; risk of overburdening fragile systems	Jordan (primary health care integration), Lebanon (hybrid public/NGO system), Uganda (refugees in national services)
2. IDP needs addressed through central governments	Internal power lines (within government-controlled areas)	IDPs remain under central government authority; responses shaped by politics and donor support	Strengthens state legitimacy; reduces fragmentation; donor investments may support wider health system	Political sensitivities; uneven recognition; securitisation of aid; underfunding	Iraq (post-ISIS IDP integration), Ethiopia (variable centralised vs. fragmented approaches)
3. Cross-border mechanisms for displaced populations	International borders (cross-border aid or cooperation) and internal power lines (contested governance, non-state authority)	Humanitarian corridors, bilateral agreements, or regional arrangements sustain services across frontiers. Services delivered by local or humanitarian actors. Parallel systems emerge	Continuity of care for displaced populations and when state cooperation fails; shared responsibility; Local innovation and community resilience.	Fragile arrangements; dependent on politics and donors; risk of parallelism. Fragmentation; contested legitimacy; exposure to insecurity.	NW and NE Syria (aid from neighbour states), Myanmar (Ethnic regions; Thailand border supply chains), Horn of Africa (regional vaccination campaigns); Gaza (contested governance, humanitarian dependence)

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