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Policy Research Report

Inclusive Social Protection for Refugees and Asylum Seekers

Integrating Refugees and Asylum Seekers within the Universal Health Insurance Program: Promoting Long-Term Financial Sustainability

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ECONOMIC RESEARCH FORUM
منتدى البحوث الاقتصادية

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Acronyms

CAPMAS	Central Agency for Public Mobilization and Statistics
DAC	Development Assistance Committee
EGP	Egyptian Pound
ERC	Egyptian Red Crescent
ERF	Economic Research Forum
EU	European Union
GCR	Global Compact on Refugees
GNI	Gross National Income
GoE	Government of Egypt
GoJ	Government of Jordan
HIO	Health Insurance Organization
ILO	International Labour Organization
JD	Jordanian Dinars
JMoH	Jordanian Ministry of Health
KIIs	Key Informant Interviews
KSA	Kingdom of Saudi Arabia
MENA	Middle East and North Africa
MoHP	Ministry of Health and Population
MoU	Memorandum of Understanding
MTFF	Medium-Term Financial Framework
NCDs	Non-Communicable Diseases
NGOs	Non-Governmental Organizations
ODA	Official Development Assistance
OIC	Organization of Islamic Cooperation
OOP	Out-of-Pocket
PHC	Public Primary Healthcare
POCs	Persons of Concern
RAS	Refugees and Asylum Seekers
SA	Saudi Arabia
SGK	Social Security Institution
SHIP	School Health Insurance Programme
TPR	Temporary Protection Regulation
UAE	United Arab Emirates
UHC	Universal Health Coverage
UHIA	Universal Health Insurance Authority
UHIL	Universal Health Insurance Law
UHIS	Universal Health Insurance System
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency
WFP	World Food Programme

Summary

Background

In light of growing global displacement, host countries face increasing pressure to provide inclusive and sustainable access to social protection (SP) and health services for Refugees and Asylum Seekers (RAS). This is particularly pressing in Egypt and the wider MENA region, where national systems were not originally designed to serve non-nationals at scale. While humanitarian actors continue to fill critical gaps, there is a growing international consensus that long-term solutions must center on inclusive, nationally led systems. This study responds to that imperative by exploring how Egypt's evolving Universal Health Insurance Scheme (UHIS) could serve as an entry point for RAS inclusion, drawing on international norms and comparative country experiences.

Methods

The study employed a mixed-methods approach. It combined an extensive desk review of national legal and policy frameworks, programmatic documentation, and secondary data with 23 semi-structured key informant interviews (KIIs). These interviews were conducted with representatives from government ministries, UN agencies, NGOs, and development partners. The research also drew on comparative case studies from Jordan, Lebanon, Turkey, and Uganda—countries that have implemented various models of RAS inclusion in national social protection and health systems. The analysis focused on legal, institutional, and financing dimensions, with particular attention to the potential for RAS inclusion under Egypt's Universal Health Insurance Scheme (UHIS), introduced through Law No. 2 of 2018 .

Findings

The study identifies five major findings:

- Fragmented Systems: RAS in Egypt primarily access services through humanitarian channels—largely parallel to national systems—limiting sustainability and efficiency.
- Legal and Policy Gaps: Egypt's legal framework currently lacks explicit provisions for RAS inclusion in the UHIS, despite international commitments to non-discrimination and equal access.
- Underfunded Humanitarian Health Response: Between 2023 and 2025, the RAS population more than tripled, while health sector funding decreased in relative terms, creating a widening service gap.
- Promising International Practices: Turkey and Uganda provide relevant models for integrating RAS into national systems, leveraging donor support, legal reform, and institutional coordination.
- Egypt's Reform Potential: Egypt's UHIS offers a viable platform for gradual RAS inclusion. However, this will require legal amendments, sustainable **financing,** interagency coordination, and pilot implementation models.

Summary

Recommendations:

To support inclusive, rights-based social protection and health access, the report recommends:

1. Legal and Policy Reform: Amend relevant legislation to enable RAS enrollment in UHIS, in line with Egypt's international obligations.
2. Sustainable Financing: Develop co-financing arrangements involving government, development partners, and refugees themselves, where feasible.
3. Institutional Coordination: Strengthen collaboration among national ministries, UN agencies, and humanitarian actors to align planning, eligibility, and service delivery.
4. Pilot Integration Models: Initiate pilot programs in selected governorates to assess feasibility and generate lessons for national scale-up.
5. Knowledge Exchange: Facilitate structured learning from peer countries with established RAS-inclusive models.

This study highlights a critical moment for Egypt to align humanitarian and development responses, moving toward integrated systems that serve both host and refugee populations more equitably and efficiently.

1. Introduction

The latest figures released by the United Nations High Commissioner for Refugees (UNHCR) serve as a stark reminder of the global disorder the world is currently facing. With a staggering 114 million refugees and displaced people worldwide, this population is often overlooked despite its profound impact.[1] Analysis of data from 2022 reveals that among these individuals, 32.9 percent are refugees, 57.6 percent are internally displaced people, and nearly five percent consist of asylum seekers and individuals in need of international protection.[2]

Despite the escalating need for humanitarian assistance, the funding allocated to these interventions is faltering, with only 56 percent of the required funds being met.[3] This poses a significant challenge—especially for low- and middle-income countries, which bear the burden of hosting 78 percent of the global total of individuals in need of international protection (World Bank, 2023). Among the key host countries at the global level are Turkey (hosting 3.4 million), the Islamic Republic of Iran (3.4 million), Colombia (2.5 million), Germany (2.5 million), and Pakistan (2.1 million).[4] In the Middle East and North Africa (MENA) region, which generates and receives refugees and asylum seekers (RAS), the number of hosted refugees reached 2.4 million in 2022.[5] Political instability, economic shocks, and increased conflict have contributed to this figure. As we move toward the end of 2025, the Middle East and Africa continue to grapple with overlapping crises that are deepening humanitarian needs and driving displacement. The protracted war in Gaza, ongoing conflict and instability in Sudan, persistent insecurity in parts of the Sahel, and, more recently, the sharp escalation in tensions between Israel and Iran are fueling sustained population movements across the region. Should the situation deteriorate further, new waves of refugees could emerge from conflict-affected areas and move toward countries like Egypt.

Lebanon currently holds the highest number of RAS in the MENA region, with an estimated 1.5 million Syrian refugees and 11,778 refugees from other nationalities.[6] This makes Lebanon the country with the highest per-capita refugee population in the world. Jordan follows closely, hosting approximately 760,000 people,[7] while Egypt ranks as the region's third-largest host, with the UNHCR recognizing around half a million registered refugees in early 2024.[8]

However, the funding needed to support RAS in Egypt faces persistent shortfalls, a challenge commonly observed in most host countries. This challenge is further exacerbated by the allocation of donor funds toward parallel initiatives rather than supporting government-provided public services for RAS. This disjointed approach, together with administrative complexities, results in financial inefficiency and hampers the inclusion of RAS into existing national social and health protection systems, which is vital for upholding their fundamental human rights, facilitating their healthcare access, and enhancing social unity.

The Universal Health Insurance System (UHIS) in Egypt is a transformative initiative aimed at ensuring equitable access to healthcare services for all citizens. By encompassing compulsory coverage for the entire population and providing subsidies for the most vulnerable, the UHIS introduces comprehensive healthcare packages and significant structural reforms. However, as Egypt transitions to this system, RAS face considerable challenges. Existing agreements governing their healthcare access are nullified, thereby exacerbating limitations, while vague provisions in national law delay their inclusion in the UHIS. Financial constraints further hinder RAS participation, highlighting the need for comprehensive solutions. Despite these complexities, the phased implementation of the UHIS offers a gradual pathway for RAS inclusion, with the inclusion in the first governorates providing valuable insights for continuous integration efforts.

Therefore, there are three urgent motivations for this study. Firstly, the number of Refugees and Asylum Seekers (RAS) registered with UNHCR has surged dramatically—rising by 73.5 percent between January 2023 and

[1] https://www.unhcr.org/news/speeches-and-statements/high-commissioner-s-statement-united-nations-security-council.

[2] Calculated by the authors from the data available at https://www.unhcr.org/refugee-statistics/.

[3] https://europeanhumanitarianforum.eu/media/2i4iz5zh/fighting-humanitarian-funding-gap_20_03_2023.pdf.

[4] https://www.unhcr.org/refugee-statistics/#:~:text=The%20Islamic%20Republic%20of%20Iran%20and%20Türkiye%20each%20hosted%203.4,Pakistan%20hosted%202.1%20million%20refugees.

[5] https://www.unhcr.org/sites/default/files/2023-06/global-trends-report-2022.pdf.

[6] UNHCR (2023). Fact Sheet- Lebanon. April. https://reporting.unhcr.org/lebanon-factsheet.

[7] https://www.unhcr.org/countries/jordan.

[8] https://www.unhcr.org/eg/about-us/refugee-context-in-egypt#:~:text=Egypt%20hosts%20around%20410%2C000%20registered,%2C%20Yemen%2C%20Somalia%20and%20Iraq.

January 2024, followed by a further 100 percent increase through June 2025, reaching a total of 992,000 individuals.[9] This 3.3-fold overall increase presents serious humanitarian challenges for the country. Secondly, despite the growing need for funding, RAS in Egypt faces a substantial 63 percent shortfall, resulting in reductions in coverage and benefits. Thirdly, the distribution of donor funds through separate initiatives instead of bolstering government-provided public services not only leads to financial inefficiencies and undermines refugee integration into existing social systems but also deprives vulnerable Egyptians and non-Egyptians of potential benefits from strengthened public service systems. These challenges jeopardize the fundamental principles of our shared humanity, violating the basic rights and dignity of every individual.

1.1. Purpose and scope of the study

This report, which is a collaboration between the Economic Research Forum (ERF), the United Nations Children's Fund (UNICEF), the International Labour Organization (ILO), the UNHCR, and the World Food Programme (WFP), is part of the Partnership on "Inclusive Social Protection for Refugees and Asylum Seekers." It focuses on financing the integration of RAS into Egypt's UHIS on equal footing with Egyptians, advocating for their basic rights in alignment with international legal obligations. Rather than offering detailed solutions, the paper aims to spark informed discussions and develop actionable recommendations based on an exploration of feasible options, It also presents potential sustainable funding sources for RAS integration into Egypt's UHIS, initiating informed discussions on their feasibility and effectiveness in expanding available resources and improving their utilization efficiency.

Thus, the paper examines the present situation of RAS in Egypt, scrutinizes the coverage, benefits, and financing mechanisms of UHIS, and investigates the practices of significant host nations in MENA and Africa. Insights gleaned from these practices inform strategies for harmonizing refugees' requirements with fiscal constraints, securing sustainable funding, mobilizing resources, and ensuring fair access to healthcare services. Moreover, the study proposes potential funding streams from regional and global stakeholders to address the sustainability challenges of financing RAS human rights faced by Egypt, international humanitarian donors, and agencies.

As an integral component of a larger initiative, this report extends its analysis and findings from two related studies: 'The Voices of Refugees, Migrants, and Asylum Seekers: Social Protection Needs, Challenges, and the Way Forward' and 'Feasibility Study on the Enrollment of RAS in the Egyptian UHIS.' Both studies are conducted by the UNHCR and ILO and include technical implications and the feasibility of refugee inclusion. Furthermore, it complements the note on "Integrating Refugees and Asylum Seekers within Egypt's National Social Assistance: Promoting Long-Term Financial Sustainability."

To achieve its objective, the paper addresses four main questions:

- What is the current status of healthcare provision for refugees, including funding sources?
- Why and how should RAS be included in Egypt's UHIS, and what benefits and funding sources are involved?
- What lessons can be drawn from the international experience in similar host countries regarding the financing models, benefits, and strengths of including RAS in the health system?
- What potential sources of financing are available for extending UHIS to cover RAS, and what political economy dimensions in Egypt need consideration?

1.2. Methodology

To address the research questions, the paper uses the following methodology:

Desk Review: A comprehensive desk review is undertaken to collect baseline information on health services provided to RAS in Egypt; Egypt's UHIS coverage, benefits, and financing; and healthcare services schemes that include RAS in comparable countries.

This review draws upon various sources, including academic papers, reports from government and international organizations, handbooks, guidelines, blogs, newspaper articles, and other pertinent literature. Nonetheless, it faces several limitations regarding the availability of data on humanitarian assistance for RAS, particularly in relation to healthcare services. Key constraints include:

- Lack of continued time series of global estimates regarding the financial requirements for forced displacement crises and comprehensive data on humanitarian and development resources allocated to support RAS and host communities.
- Insufficient detailed data on the expenses associated with healthcare services for RAS in host communities, hindering assessments of progress toward burden-sharing commitments and the cost-effectiveness of interventions.

[9] UNHCR Egypt - Fact Sheet June 2025 | UNHCR Egypt

- Incomplete data on healthcare assistance, characterized by inconsistent definitions and methodologies.
- Absence of comparable data across donor and recipient countries, with data collection fragmented across multiple organizations and reliant on voluntary reporting.
- Limited data on domestic spending by host governments and communities on refugee-related healthcare initiatives.
- Challenges in tracking expenditures to ultimate beneficiaries, complicating assessments of the cost-effectiveness of healthcare services for RAS.

Primary Data and Information Collection: This is done through key informant interviews (KIIs) with stakeholders engaged in the provision, financing, and budgeting of UHIS and healthcare services to RAS. This includes 16 interviews with relevant stakeholders from the government, international organizations, and donor agencies (see Annex List for details). The objectives of these interviews are: (i) to gain insight into the current healthcare services schemes and their funding schemes and (ii) to explore opportunities for potential contributions to funding an inclusive UHIS for RAS.

1.3. Outline

This paper comprises six sections, beginning with this introduction. Section 2 delineates the distinctions between RAS and migrant populations in Egypt, examines the legal framework governing services for RAS, and analyzes their demographic characteristics, vulnerabilities, and challenges in the Egyptian context. Section 3 outlines the healthcare services available to RAS in Egypt and evaluates the UHIS, addressing its coverage, benefits, public spending, and operational capacity. Section 4 explores the experiences of four host countries with providing healthcare services to RAS, offering insights relevant to Egypt. Section 5 introduces innovative concepts related to responsibility-sharing, including managing health protection costs for RAS, identifying new funding sources, and equitably distributing responsibilities and funding among host countries, donors, and potentially RAS themselves, as well as engaging the wider regional and global community. Finally, section 6 summarizes the key findings and lists policy recommendations for ensuring the long-term financial and social sustainability of hosting policies.

2. The reality of RAS in Egypt: insight of current status and challenges

In Egypt, there appears to be a tendency to conflate migrants with refugees in the public discourse. Official statements suggest that Egypt hosts a sizable population of six[10] to nine million[11] migrants and refugees. The portrayal of the Government of Egypt (GoE) providing substantial support to refugees and migrants—particularly those considered vulnerable or people of concern (estimated at around 1,100,000 to 1,300,000 individuals)—[12] is a prevalent aspect of this discourse. The most cited examples of the government's inclusive approach include essential services such as public primary healthcare (PHC) and basic education offered to specific refugee and migrant nationalities, including Syrians, Yemenis, Sudanese, and South Sudanese, and the various presidential initiatives for health like the '100 Million Healthy Lives' and the national COVID-19 vaccination plan.[13] Additionally, approximately 65,000 Arabic-speaking children of migrants and refugees benefit from free pre-university education,[14] further highlighting the GoE's commitment to addressing the needs of these populations within the public narrative. The GoE has recently endeavored to calculate the expenses it incurs for the services extended to this substantial population of non-Egyptians, including associated investments and subsidies.[15]

However, this confusion between migrants and RAS (nine million)[16] may obscure the distinct characteristics of RAS (575,000)[17] who constitute only 6.4 percent of the estimated non-Egyptian population in Egypt and 0.5 percent of the

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10 https://www.sis.gov.eg/Story/152277/Statement-by-H.E.-President-Abdel-Fattah-El-Sisi-before-the-75th-Session-of-the-UN-General-Assembly?lang=en-us.

11 https://egypt.iom.int/sites/g/files/tmzbdl1021/files/documents/Migration%20Stock%20in%20Egypt%20July%202022%20EN*_Salma%20HASSAN.pdf

12 Ibid.

13 Daily Press Briefing by the Office of the Spokesperson for the UN Secretary-General, 27 January 2021. Available at: https://www.un.org/press/en/2021/db210127.doc.htmun.org. There is anecdotal evidence suggesting that RAS may not have access to all components of the '100 Million Healthy Lives' initiative.

14 GCM Regional Review, Voluntary National Report by the Arab Republic of Egypt, January 2021. https://migrationnetwork.un.org/sites/g/files/tmzbdl416/files/docs/egypt_report_-gcm_regional_review_final_6.pdf.

15 https://www.sis.gov.eg/Story/269800/The-government-begins-auditing-the-numbers-of-refugees..and-the-cost-of-the-services-to-care-for-the-state-bearing-of-the-state?lang=ar.

16 As indicated by official statements from the GoE in public speeches. For example, see: https://www.skynewsarabia.com/business/1683720-لحصر-التكاليف-مصر-تبدأ-تدقيق-أعداد-اللاجئين-أرضها; https://arabic.cnn.com/middle-east/article/2024/01/09/egypt-announces-an-audit-of-the-numbers-of-refugees.

17 https://www.unhcr.org/eg/wp-content/uploads/sites/36/2024/04/UNHCR-Egypt-Factsheet_APR-2024.pdf.

Egyptian population inside Egypt (106.3 million)[18] as of May 2024. This blurring of distinctions could potentially dilute the rights and protections to which RAS are entitled by international conventions and undermine their equal treatment alongside Egyptian nationals. Hence, it is important to provide a brief clarification early on regarding the disparities between migrants and RAS to foster a more nuanced understanding of their respective circumstances.

2.1. Defining 'refugees,' 'asylum seekers,' and 'migrants'

RAS and migrants have distinct characteristics, requiring different protection mechanisms. The 1951 Refugee Convention defines a refugee as a person who "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of [their] nationality and is unable or, owing to such fear, is unwilling to avail [themself] of the protection of that country." The 1951 Refugee Convention and its 1967 Protocol serve as crucial legal instruments for safeguarding refugees, offering a universal definition of refugee status and establishing minimum standards for their protection. Central to these documents is the principle of nonrefoulement (Article 33), which asserts the right of refugees to not be forcibly returned to situations where their life or freedom would be endangered. Signatory countries of the Convention are bound to adhere to these standards, ensuring the appropriate treatment of refugees. The UNHCR actively encourages nations to ratify the Convention and assists governments in aligning their domestic legislation with its provisions.[19]

An asylum seeker, also known as an 'international protection applicant,' is an individual who has submitted an application to be recognized as a refugee and is awaiting a decision on their status. They remain in the host country during this period until authorities determine whether they meet the criteria for refugee status.[20] Refugee status determination—i.e., the process of assessing an individual's circumstances to determine their eligibility for refugee status—is typically conducted by host countries or by the UNHCR when necessary. In situations where large numbers of people are forced to flee their country simultaneously, all individuals fleeing may be granted refugee status on a 'prima facie' basis, streamlining the process to avoid individual assessments.[21]

On the other hand, there is no universally accepted definition of "migrant" at the international level. However, for its operational purposes and without creating any new legal classification, the International Organization for Migration (IOM) defines "migrant" as a broad term encompassing individuals who have moved from their habitual place of residence, whether within a nation or across borders, temporarily or permanently, and for various reasons. This definition covers individuals regardless of their legal status, the voluntariness of their movement, the reasons for their relocation, or the duration of their stay.[22] The UNHCR further specifies that a migrant departs their country for reasons unrelated to immediate danger and retains the option to return without facing imminent threats to their safety.[23]

Considering the aforementioned distinctions in status, the UNHCR emphasizes the critical importance of avoiding the misclassification of individuals who may be potential asylum-seekers or refugees as migrants. Such misclassification could weaken the legal protections afforded to refugees under international law.[24] Therefore, governments typically make a clear distinction between migrants and refugees within their legal frameworks. While migrants are subject to immigration laws, refugees are protected in accordance with established principles in national and international law.[25]

2.2. Legal framework[26]

The legal framework surrounding RAS in Egypt is multifaceted, comprising international conventions and pro-

[18] CAPMAS Population Watch. https://www.capmas.gov.eg. Retrieved on 14 May 2024.

[19] https://www.unhcr.org/refugees#:~:text=A%20refugee%20is%20someone%20who,that%20refugees%20are%20entitled%20to.

[20] Difference between an asylum seeker and a refugee | Irish Refugee Council.

[21] https://www.unhcr.org/refugees#:~:text=A%20refugee%20is%20someone%20who,that%20refugees%20are%20entitled%20to.

[22] https://www.iom.int/about-migration and https://www.un.org/en/fight-racism/vulnerable-groups/migrants#:~:text=The%20UN%20Migration%20Agency%2C%20International,the%20person's%20legal%20status.

[23] https://www.unhcr.org/sites/default/files/legacy-pdf/617807424.pdf.

[24] https://www.unhcr.org/refugees#:~:text=A%20refugee%20is%20someone%20who,that%20refugees%20are%20entitled%20to.

[25] This paragraph on the distinction between migrants and refugees draws on UNHCR viewpoint: 'Refugee' or 'migrant' – Which is right? | UNHCR.

[26] For more details, see Barsoum and El Barrawi (2024).

tocols, constitutional provisions, and ongoing legislative developments.

Egypt has signed the 1951 Convention and the 1967 Protocol of RAS.[27] The country has also ratified the 1969 Organization of African Unity's Convention, which addresses refugee challenges in Africa, including internally displaced persons.[28] However, Egypt has made reservations to certain provisions, including personal status, rationing, access to education, public relief and assistance, and labor legislation. These reservations are reflected in the national provisions on social insurance, social assistance, health insurance, and education support (Barsoum and El Barrawi, 2024). Over time, some of these reservations have been modified.[29] Egypt also ratified the Convention on the Rights of the Child (CRC) in 1990 without reservations. The CRC mandates that children have access to social security, education, and healthcare while requiring states to guarantee their right to the highest attainable standard of health and an adequate standard of living.

Egypt's commitment to international laws is evident through its constitutional guarantees ensuring adherence to these treaties. While the Egyptian Constitution—amended in 2018—did not explicitly define refugees, it guarantees the right of political refugees to asylum and prohibits their refoulement. Additionally, it grants the force of law to all international treaties upon ratification, including those concerning human rights and obligations toward refugees (Barsoum and El Barrawi, 2024). While Egypt has made commitments to uphold international standards regarding RAS, the legal status and rights of RAS within the country are primarily determined by the government's interpretation of international legislation (Sadek, 2016). Notably, Egypt has yet to enact a comprehensive national asylum law despite ongoing drafting efforts since 2019 (UN, 2022). In this section, we will consider key legal considerations relevant to the objectives of this paper, particularly focusing on aspects such as personal status, access to healthcare services, and employment rights.

Regarding the RAS registration process, the UNHCR has been entrusted by the Egyptian government with this process since 1954, as established in the Memorandum of Understanding (MoU), which has evolved over time to now include biometric data. Registration enables them to obtain renewable residence permits, granting unrestricted movement within the country.[30] State authorities acknowledge UNHCR documentation for granting asylum-related residency permits, enabling individuals' access to essential services such as birth registration, legal representation, education, healthcare, and protection from forced return (Barsoum and El Barrawi, 2024), with temporary permits being possibly granted to those who entered Egypt illegally.[31]

While employment rights for RAS in Egypt are not explicitly reserved, obtaining work permits remains challenging. Without specific regulations governing their employment, RAS are subject to the same laws as all foreign workers, making it challenging for them to obtain work permits and access social insurance systems (Andrade et al., 2021). Consequently, most RAS are compelled to work in the informal economy, facing exploitation and abuse from employers (UN, 2022). Despite the extension of coverage under the social insurance Law No. 148/2019, to include inter alia the self-employed and informal workers, and the removal of reciprocity requirements from previous laws, refugees still encounter discrimination, often pushing them into informal sectors.[32] Therefore, refugees' access to contributory social insurance relies on securing work permits and formal employment, emphasizing the significance of legal employment in accessing social security benefits.

Moreover, healthcare rights for RAS are anchored in international human rights instruments, obligating Egypt to ensure equal access to healthcare services. The International Covenant on Economic, Social and Cultural Rights, ratified by Egypt in 1982, guarantees RAS the right to the highest attainable standard of health without discrimination. Similarly, the International Convention on the Elimination of All Forms of Racial Discrimination, ratified by Egypt in 1967, recognizes everyone's right to access public health and medical care without discrimination, including RAS. Additionally, the Convention on the Rights of the Child, ratified by Egypt in 1990, ensures that refugee children have access to healthcare services as stated in Article 24. Moreover, the Convention on the Rights of Persons with Disabilities, ratified by Egypt in 2008, grants disabled refugees the right to the highest attainable standard of health without discrimination, per Article 25. These conventions establish binding international obligations on state parties, guaranteeing that RAS have equal access to healthcare

[27] UNHCR-7-Decades-In-Egypt.pdf.

[28] https://au.int/sites/default/files/treaties/36400-treaty-36400-treaty-oau_convention_1963.pdf.

[29] UNHCR-7-Decades-In-Egypt.pdf.

[30] https://www.unhcr.org/eg/wp-content/uploads/sites/36/2023/06/UNHCR-Egypt-Factsheet-june-2023.pdf.

[31] https://help.unhcr.org/egypt/wp-content/uploads/sites/50/2022/06/Service-Brochure-May-2022-En.pdf.

[32] Regulation of Migration in Egypt | Middle East Institute (mei.edu).

services, irrespective of their status, thereby safeguarding their right to health (Barsoum and El Barrawi, 2024). With respect to healthcare, efforts have been made to integrate RAS into the Egyptian healthcare system; in fact, several ministerial decrees[33] have been enacted for this purpose. The Ministry of Health and Population (MoHP) and the UNHCR collaboratively signed two MoUs in 2014 and 2016 to provide refugees of all nationalities with the same access to primary, secondary, and emergency public healthcare as Egyptian citizens, aligning their rights with those of Egyptian citizens. However, these MoUs specifically apply to health facilities managed by the MoHP and do not extend to public health facilities operated by other entities, such as university hospitals. Additionally, MoHP facilities are planned to be taken over by the Egyptian Health Authority (EHA) under the UHIS, rendering these MoUs irrelevant.

Also, Law No. 2 of 2018, known as the Universal Health Insurance Law (UHIL), introduced a comprehensive framework for health insurance in Egypt to address coverage gaps, financial sustainability issues, and high out-of-pocket (OOP) payments. Registration is mandatory for citizens in Egypt, and foreign residents and visitors can access services through the Universal Health Insurance Authority (UHIA) if reciprocity conditions are met. Additionally, the law allows for the inclusion of RAS in the UHIS through agreements between the government and organizations like the UNHCR. RAS can access MoHP facilities under the same conditions as Egyptians, facilitated by UNHCR-issued cards. However, OOP payments may still apply, particularly for chronic diseases or advanced healthcare services. Despite some agreements providing rights to nationals of certain countries, strains on the public health system due to population size and limited budget hinder its capacity to provide comprehensive treatment (for more details, see Barsoum and EL Barraw (2024) and ILO and UNHCR (2023).

Although Egypt has made significant strides in aligning its legal framework with international obligations to protect the rights of RAS, challenges persist in ensuring their full access to essential services. Efforts to address these challenges through ongoing legislative developments and collaborative initiatives with international organizations are crucial for safeguarding the rights and well-being of RAS in Egypt.

[33] Including ministerial decrees No. 217, 337 and 601 of 2012, and 909 of 2018, which ensure that refugees from Sudan, South Sudan, Ethiopia, Yemen, Eritrea, and Syria—who represent over 88 percent of the registered refugee population in January 2024 (UNHCR- Egypt Fact Sheet-January 2024)—receive equal treatment to Egyptians within hospitals offering secondary and tertiary healthcare (UNHCR, 2022).

2.3. Exploring trends and challenges of RAS in Egypt

Egypt, with a rich history of providing safety to refugees, serves as both a transit and a destination country for thousands of individuals fleeing conflicts in Syria, East Africa, the Horn of Africa, Iraq, and Yemen.[34] The number of registered RAS in Egypt has seen a notable increase, reaching 288,173 in October 2022,[35] rising to 352,000 in September 2023,[36] and further escalating to around half million in early 2024, originating from 62 different countries. Between mid-April and September 2023, the Sudan crisis alone drove an estimated 287,230[37] to 338,374[38] individuals to seek refuge in Egypt. The ongoing crisis in Gaza is anticipated to lead to a substantial influx of new RAS, although an exact forecast remains uncertain at this time.

Since November 2023, individuals of Sudanese nationality have replaced Syrians as the top nationality among RAS in Egypt.[39] As of June 2025, Sudanese account for 73.2 percent of the total RAS, followed by Syrians at 13.3 percent.[40] This demographic shift is likely due to the relaxed entry procedures that were in place prior to the onset of the respective conflicts. The remaining RAS primarily originate from Sub-Saharan African countries such as South Sudan, Eritrea, and Ethiopia, as well as other Middle Eastern nations including Yemen and Iraq.[41] Demographically, registered RAS exhibit a balanced gender and age distribution, with 58 percent aged between 18 and 59, and 38 percent being children under 18 (UNHCR Newsletter, August

[34] https://mailchi.mp/adf1526197e6/unhcr-egypt-newsletter-july-2023-15283777.

[35] Egypt-Factsheet-October-2022.pdf.

[36] https://www.unhcr.org/eg/wp-content/uploads/sites/36/2023/09/UNHCR-Egypt-Factsheet_SEPT-2023.pdf.

[37] https://www.unhcr.org/eg/wp-content/uploads/sites/36/2023/09/UNHCR-Egypt-Factsheet_SEPT-2023.pdf.

[38] As per an official update from the GoE, since the outbreak of conflict in 2023, around 1.5 million Sudanese have sought refuge in Egypt, representing a tenfold increase from pre-crisis levels and placing considerable pressure on the country's already stretched resources (UNHCR-Egypt-Factsheet_JAN-2024.pdf | UNHCR Egypt).

[39] https://www.unhcr.org/eg/wp-content/uploads/sites/36/2023/11/UNHCR-Egypt-Factsheet_NOV-2023.pdf., and unhcr-egypt-factsheet-june-2025.pdf

[40] unhcr-egypt-factsheet-june-2025.pdf.

[41] https://www.unhcr.org/eg/wp-content/uploads/sites/36/2023/09/Monthly_Statistical-_Report_August_2023.pdf.

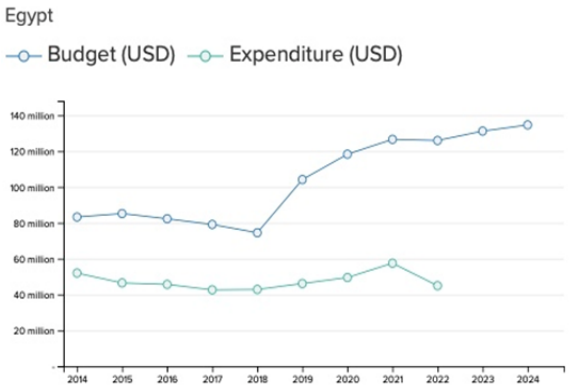
2023).[42] Notably, there has been a significant increase in the number of unaccompanied and separated children among recent arrivals.[43]

Despite the substantial number of refugees, Egypt has yet to establish clear national procedures to regulate RAS influx (ILO, 2022). Importantly, the GoE refrains from establishing refugee camps, championing the right to free movement for migrants and refugees.[44] Nearly all RAS reside in urban areas throughout the country, with 81 percent in Greater Cairo, eight percent in Alexandria, and four percent in Sharkeya.[45] RAS primarily live in informal urban settlements and heavily rely on the informal sector for their livelihoods (WFP, 2023), sharing socioeconomic conditions with lower-income host communities.

As revealed by a survey conducted in 2018, RAS encounter significant challenges, with 29 percent unemployed and 47 percent below the national poverty line (UNHCR, 2018). The impact of the COVID-19 pandemic has exacerbated these challenges, leaving many refugees unable to afford basic necessities such as food and housing, while also worsening the stigmatization and discrimination experienced by refugees, particularly those from Sub-Saharan regions (WFP, 2023). In 2021, refugee communities expressed foremost concerns about legal and physical protection, followed by challenges related to accessing sustainable livelihoods (UN, 2022). However, according to ILO socioeconomic profiling (2023), unemployment decreased to 11 percent, with mean monthly household income from wages, salaries, and charity reaching 4,829 Egyptian pounds (EGP) in late 2021. Additionally, a recent food security assessment revealed that 20.8 percent of refugees experienced poor access to food, indicating food insecurity, while 55 percent were vulnerable to food insecurity due to insufficient dietary intake or limited economic capacity (WFP, 2023).

Also, there is evidence that RAS experience a surge in mental health needs, reflected in increased rates of suicide attempts, violence, and substance abuse.[46] The March 2022 UNHCR Participatory Assessment highlighted safety, security, education, cash-based interventions, livelihoods, and health as RAS' significant concerns.[47] Moreover, the surge in inflation rates and the escalating cost of living since 2022 are expected to have worsened the socioeconomic circumstances of RAS, significantly affecting their health, welfare, and nutritional status.

Figure 1. UNHCR - Egypt: budget and expenditure trend



Source: https://reporting.unhcr.org/operational/operations/egypt.
Note: Budget reflects global needs, while expenditure is a function of the quantity and quality of funding received by the UNHCR.

Despite the involvement of 25 partners, including UN agencies and non-governmental organizations (NGOs), plans to support RAS in Egypt remain severely underfunded. In recent years, UNHCR's operations have faced a consistent decline in funding relative to actual financial needs. Between May 2024 and May 2025, requested funding increased by only 2.2%—from USD 134.7 million to USD 137.7 million—while the share of funding received improved slightly from 26% to 29%. This modest rise stands in stark contrast to the 47.6% increase in registered RAS during the same period, from 672,000 in June 2024 to 992,000 in June 2025. Of the USD 39.8 million secured as of June 2025, 75% (USD 29.95 million) is earmarked and restricted, primarily provided by the United States.[48]

The reduction in resources available to the UNHCR in Egypt, coupled with already worsening socioeconomic conditions and the continued dramatic increase in the number of Sudanese RAS, raises concerns about the potential exacerbation of challenges faced by RAS. If not addressed, the underfunding could force RAS to resort to

[42] https://mailchi.mp/a3698f7f31cc/unhcr-egypt-newsletter-august-2023-15287097.

[43] https://civil-protection-humanitarian-aid.ec.europa.eu/where/middle-east-and-northern-africa/egypt_en.

[44] Sisi: No refugee camps on Egyptian soil-SIS.

[45] https://www.unhcr.org/eg/wp-content/uploads/sites/36/2023/10/Monthly_Statistical-_Report_September_2023.pdf.

[46] https://reporting.unhcr.org/files/2023-06/MENA%20-%20Egypt.pdf.

[47] https://reporting.unhcr.org/egypt-funding-2023.

[48] Figures are based on data from UNHCR Egypt Fact Sheet, June 2024 and UNHCR Egypt Fact Sheet, June 2025, available at UNHCR Egypt - Fact Sheet June 2025 | UNHCR Egypt and UNHCR-Egypt-Factsheet_JUN-2024.pdf | UNHCR Egypt

harmful coping mechanisms to meet their basic needs.[49] This funding crisis, particularly with a significant reliance on earmarked and restricted funds, underscores the urgency of addressing the financial gaps to ensure the well-being and sustainable integration of the RAS population in Egypt.

3. Healthcare system in Egypt

3.1. Understanding Egypt's healthcare system

Egypt has a diverse and multifaceted healthcare system that encompasses various public and private providers and financing entities (MoHP et al., 2015). The country has thousands of healthcare institutions, with around 95 percent of Egyptians residing within five kilometers of a healthcare center (DHS program, 2018). In recent decades, Egypt has made remarkable progress in enhancing the health of its citizens, and the improvements are noticeable across various indicators. For instance, life expectancy has risen from 68.37 years in 2020 to 72.38 years in 2022.[50] Additionally, under-five mortality has decreased from 48.4[51] to 19.8[52] deaths per 1,000 live births between 2000 and 2020. Nonetheless, disparities persist based on gender, geography, and socioeconomic factors. Egypt's performance surpasses that of many lower-middle-income countries but still falls behind other regional comparators (World Bank, 2022).

The MoHP and university hospitals form the backbone of the government's healthcare sector.[53] The MoHP oversees the public sector, managing various healthcare facilities ranging from PHC centers to specialized hospitals. While approximately 80 percent of public healthcare services are subsidized, the remaining 20 percent require some form of fee payment (Rizk and Abou-Ali, 2016). Another essential public stakeholder in the healthcare sector is the Health Insurance Organization (HIO), an independent government organization operating under the MoF. Established in 1964, the HIO offers compulsory insurance primarily to formal sector employees, with the option for individuals to opt-out (Nakhimovsky et al., 2011). The absence of mandatory enrollment has led to a highly fragmented system with duplicated health insurance pools and inadequate financial coverage.

Approximately half of the population (49.8 percent) lacks insurance coverage, with most of the remaining half (around 47 percent) enrolled in governmental schemes like HIO or student insurance, while only three percent are covered by private health insurance (World Bank, 2022). This multitude of insurance schemes limits the system's ability to redistribute resources effectively and often results in insufficient coverage for health services and inadequate premium collection, leading to low efficiency and financial protection. Many individuals are eligible for coverage by multiple schemes, further complicating the landscape. These fragmented and overlapping risk pools lead to complex management processes, high administrative costs, and adverse selection in some schemes, such as widespread opt-outs in the HIO (World Bank, 2022). Furthermore, the scheme faces challenges in extending coverage to the entire population, particularly the informal sector and self-employed individuals, leading to significant OOP expenditures for vulnerable populations (Shawky, 2010; Devi, 2018).

The GoE also utilizes the Program of Treatment on the Expense of the State (PTES) to cover healthcare for the uninsured poor and the informal sector, excluding refugees. The PTES operates through a network of sub-medical councils, major hospitals, and local hospitals across all governorates, offering a comprehensive package covering inpatient and outpatient treatment for Non-Communicable Diseases (NCDs), surgical procedures, and oncology treatments (ILO and UNHCR, 2023).

Despite rapid nominal increases in government spending on health, Egypt continues to face a significant healthcare challenge due to historically low real spending on this sector. During the last decade, Egypt has allocated only between 1.3 percent and 1.7 percent of its GDP to healthcare, with the allocation standing at 1.3 percent in FY23.[54] This figure starkly contrasts with that of other peer countries; for instance, in 2020, Jordan allocated 7.5 percent of its GDP, Algeria and Tunisia allocated 6.3 percent, and India allocated 2.9 percent.[55] Insufficient budget allocation for

[49] https://reporting.unhcr.org/files/2023-06/MENA%20-%20Egypt.pdf.

[50] https://data.who.int/countries/818.

[51] https://www.ceicdata.com/en/egypt/health-statistics/eg-mortality-rate-under5-male-per-1000-live-births.

[52] https://www.google.com/url?sa=t&source=web&rct=-j&opi=89978449&url=https://censusinfo.capmas.gov.eg/Metadata-ar-v4.2/index.php/catalog/1823/download/6379%23:~:text%3DUnder%25205%2520Mortality%2520Rate%2520recorded,2.0%2520per%2520thousand%2520live%2520births.&ved=2ahUKEwiHsZSbuI2GAxXjQvEDHYRpDA0QFnoECA4QAw&usg=AOvVaw2pJYsn95zin4eMlg8My8m-.

[53] https://www.macrotrends.net/countries/EGY/egypt/life-expectancy#:~:text=Chart%20and%20table%20of%20Egypt,a%200.22%25%20increase%20from%202021.

[54] Calculated from various issues of the Financial Statement of the MoF.

[55] Retrieved from the WDI data website: https://databank.worldbank.org/source/world-development-indicators#.

healthcare in Egypt has hampered the development of healthcare infrastructure, the procurement of medical equipment and supplies, the recruitment and retention of skilled healthcare professionals, and the implementation of preventive and promotional health programs (World Bank, 2022). Therefore, the adequacy and quality of services provided are affected, and the accessibility of healthcare becomes a challenge for many Egyptians, particularly those in marginalized communities (ILO and UNHCR, 2023).

Consequently, Egypt's healthcare system has heavily relied on OOP expenditure, which is widely recognized as an inefficient and inequitable source of health financing (World Bank, 2022). Despite a gradual decrease in the proportion of OOP spending as a percentage of total current health expenditure from 2001 to 2020, with figures dropping to 63 percent in 2019 (ILO and UNHCR, 2023) and 59.3 percent in 2020,[56] Egypt still ranks among the highest globally in this regard (World Bank, 2022). This persistent reliance on OOP expenditure places a significant financial burden on the Egyptian population, with healthcare expenses emerging as the primary source of funding for healthcare (ILO and UNHCR, 2023) and the third most significant expenditure category for Egyptian households, following food and housing (World Bank, 2022). The repercussions are evident, as nearly seven percent of Egyptian households fell into poverty in 2017 due to high OOP spending on healthcare (World Bank, 2022).

The second source of financing for health is the MoF and other government ministries, contributing nearly one-third of total health spending in 2022 (ILO and UNHCR, 2023). The MoHP directly funds parastatal organizations such as the Curative Care Organization (CCO) and the Teaching Hospitals and Institutes Organization (THIO) for curative and hospital services. Patients in MoHP hospitals also contribute through co-payments and user fees. The MoF contributes about 37 percent of public health spending, supporting 93 percent of MoHP activities and 72 percent of the Ministry of Higher Education's healthcare initiatives (Fasseeh et al., 2022).

As for the HIO, the primary sources of funding are contributions paid by insured individuals and employers. Additionally, beneficiary co-payments for certain services contribute to approximately 25 percent of the overall service fees. The remaining funds are derived from national taxes, payroll taxes, earmarked taxes on tobacco, and government subsidies for specific population categories, such as school students, children under seven years old, and female-headed single-parent households (MoHP et al., 2015; ILO and UNHCR, 2023). While some poor Egyptians are included in this health insurance programs, they continue to experience inadequate financial security and utilize fewer services (World Bank, 2022).

While there is a growing private-for-profit sector, especially in tertiary care for specialized health services in large urban areas, its presence in PHC and rural areas is minimal, contributing to only around three percent of private health financing (ILO and UNHCR, 2023; Fasseeh et al., 2022; Rashad and Sharaf, 2015). NGOs, including religious clinics and charitable organizations, provide private not-for-profit services. While there is less data found on the activities of the private healthcare sector in Egypt, studies suggest that private clinics consume around 38 percent of all OOP spending, followed by pharmaceuticals at 33.1 percent, and hospitalization at private hospitals at 8.3 percent (Nakhimovsky et al., 2011).

Addressing the funding gap and increasing public investment in the healthcare sector are crucial to improve the adequacy, quality, and accessibility of healthcare services in Egypt while ensuring financial protection. This would enable the expansion of healthcare facilities, the enhancement of medical resources, and the implementation of comprehensive health programs that cater to the needs of the population.

3.2. Overview of Egypt's UHIS

Law No. 2 of 2018, known as the UHIL, reflects the Egyptian government's commitment to substantial healthcare system reform. It aims to face all the inherent challenges of the existing health insurance scheme, including inadequate financial protection, excessive OOP spending, fragmented and inefficient risk pools, adverse selection, high rates of opting out, absence of gatekeeping and referrals, restricted provider options, and limited financial sustainability of insurance programs (World Bank, 2022).

To ensure equal access to healthcare services for all citizens while addressing high OOP health expenditures and promoting equitable access to quality healthcare services, Egypt's UHIL aims to ensure compulsory coverage for all citizens nationwide, encompassing vulnerable populations (no more than the poorest 30 percent) who will receive full government subsidies.[57] Furthermore, the UHIL permits (i) optional coverage for Egyptian expatriates and (ii) coverage for all foreign residents, contingent upon reciprocal

[56] https://knoema.com/atlas/Egypt/topics/Health/Health-Expenditure/Out-of-pocket-expenditure-as-a-share-of-current-health-expenditure#:~:text=In%202020%2C%20out%20of%20pocket,ending%20at%2059.3%20%25%20in%202020.

[57] https://manshurat.org/content/thdyd-gyr-lqdryn-wdwbt-fyhm-mn-b-nzm-ltmyn-lshy-lshml-myyr-2023.

agreements with their respective countries (World Bank, 2022). It adopts a family-based approach, providing coverage for the entire family, and offers a comprehensive package of health services. Furthermore, preventive and promotive health services, such as vaccinations, family planning, emergency services (excluding hospital admissions), and pandemic-related healthcare, are financed by the MoHP and are provided free of charge to both Egyptians and refugees, as stipulated by the MoHP decree.[58] The UHIL categorizes population groups and their corresponding contribution rates into categories based on various Egyptian laws governing social insurance statuses. Table 1 provides a summary of these categories, including their contribution rates, as well as those of their legitimate dependents, and outlines the dependent beneficiaries and the benefit package. It is important to highlight that the UHIL set vulnerable groups to receive subsidies from the public treasury as outlined in Prime Minister Decree No. 4568/2023. These groups include individuals or families[59] meeting the following criteria:

- Eligible for Takaful and Karama programs, social security, and child pension, with a maximum coverage of the poorest 30 percent of the population according to the poverty levels determined annually by the Ministry of Social Solidarity in coordination with the MoF.
- Unable to work and ineligible for or exhausted unemployment benefits, including all dependent family members.
- Lacking family care and income, residing in social or healthcare facilities, or receiving shelter support—including children in foster care and both children and adults without family support.
- With disabilities that deem them unable to work and without a source of income not conflicting with the Law on the Rights of Persons with Disabilities, including all dependent family members.
- Residing in specific geographic areas temporarily affected by natural or man-made disasters.
- With insufficient total income to meet their own or their family's essential needs.

These criteria are subject to periodic review every other year, as per the UHIL. However, further examination is warranted to determine the government's approach to identifying and implementing the subsidy scheme for vulnerable individuals and households (ILO and UNHCR, 2023).

The UHIS also introduces significant structural and functional changes in healthcare financing, delivery, and regulation. Core principles include need-based services and the separation of funding and service delivery. Accordingly, it operates through four newly established independent agencies: the UHIA as the purchaser or financier, Egypt's Healthcare Authority[60] as the main medical service provider that oversees health services in public hospitals and implements healthcare reforms,[61] the General Authority for Healthcare Accreditation and Regulation as the accreditor or regulator, and the Egyptian Authority for Standard Procurement and Medical Technology Management as the central supply procurer (World Bank, 2020). The implementation of the UHIS is planned in six phases over a 15-year period, with the goal of providing coverage to the entire population by the end of 2032. The initial phase has already begun in the governorates of Port Said, Ismailia, Suez, South Sinai, Luxor, and Aswan (ILO and UNHCR, 2023).

The UHIS scheme's funds, managed by the UHIA, come from diverse sources, primarily including employees' premiums, employer contributions, beneficiary payments, returns to UHIA investment, treasury obligations for the vulnerable, solidarity tax, earmarked taxes on tobacco, road tolls, driving license fees, medical facility licensing fees, UHIA investment returns, and other funds in the common pool. Leaving little room to consider additional funding sources that the law has not already tapped into, these funding streams are expected to ensure the sustainability of the UHIS, facilitating the delivery of accessible and comprehensive healthcare services to the population[62] (see Annex Box).

There is anecdotal evidence that the implementation of the UHIS by the UHIA in the initial two governorates has faced challenges related to identifying various population and occupational groups, applying the contribution rates specified in the law, and collecting contributions (ILO and UNHCR, 2023). While the UHIA has entrusted the National Organization for Social Insurance (NOSI) with contribution collection, utilizing contribution rates and income estimates beyond UHIA regulation, challenges persist. Some informal sector workers are registered but inactive contributors, and few vulnerable households have engaged in the subsidy self-identification process (ILO and UNHCR, 2023). Promptly addressing these challenges is essential to ensure the successful implementation of the

[58] https://www.ilo.org/wcmsp5/groups/public/---dgreports/---ddg_p/documents/publication/wcms_891768.pdf.

[59] https://manshurat.org/content/thdyd-gyr-lqdryn-wdwbt-fyhm-mn-b-nzm-ltmyn-lshy-lshml-myyr-2023.

[60] Previously known as the General Authority of Healthcare.

[61] https://ihf-fih.org/members/egypt-healthcare-authority/.

[62] https://manshurat.org/content/thdyd-gyr-lqdryn-wdwbt-fyhm-mn-b-nzm-ltmyn-lshy-lshml-myyr-2023.

Table 1. The basic scheme design parameters in the UHIL

Population	Contribution Rates	Dependents	Benefit Package
Formal employees (civil servants, private sector, and other non-government employees)	1% of insurable salary by the employee + 4% of insurable salary by the employer	3% for a non-working spouse or one without a steady income + 1% for each child or dependent	1. Diagnostic, curative, rehabilitative, and palliative care provided by a family physician in PHC centers, outpatient clinics, or hospitals. 2. Admissions to secondary and tertiary hospitals, medications, and home visits when necessary.
Self-employed	5% of insured wage or wage according to tax declaration or the maximum insured wage, whichever is greater		
Migratory workers, temporary workers, and small-scale self-employed workers	5% of the insured wage Up to a maximum of 7% for each household with the public treasury paying the cost differential		
Pensioners	2% of the monthly pension value		
Widowed and beneficiaries of pensions	2% of the monthly pension value	Signed but not ratified	
Vulnerable	5% of the national minimum wage for each vulnerable person, with the subscription being covered by the public treasury for the vulnerable groups		

Source: https://manshurat.org/content/thdyd-gyr-lqdryn-wdwbt-fyhm-mn-b-nzm-ltmyn-lshy-lshml-myyr-2023; World Bank, 2022; ILO and UNHCR, 2023.

UHIS and comprehensive health protection for all residents of Egypt.

A financial sustainability analysis conducted by the MOF indicates positive outcomes for the UHIS over the next decade with the planned revenue sources. Nevertheless, the World Bank (2022) has identified several challenges facing Egypt's UHIS, including:

1. Financial deficits may arise due to the rapid expansion of the UHIS, with new governorates contributing minimally to premium collection while incurring higher medical expenses. This could deplete the reserves accumulated thus far.
1. Enrolling the informal sector poses difficulties, as many citizens in this sector may lack consistent income records or formal employment, making it challenging to collect premiums.
1. Careful assessment is needed for revenue generation, as current revenue sources may not be sufficient in the long term. Consideration of additional revenue sources, such as taxes on unhealthy goods, may be necessary to enhance fiscal sustainability.

Addressing these challenges is essential for the successful implementation and sustainability of the UHIS in Egypt. Continuous updates to the actuarial projection are also necessary as actual implementation data on revenue, enrollment, utilization, and costs become available, informing long-term financial sustainability (World Bank, 2022).

4. RAS health protection in Egypt

4.1. Current health protection coverage of RAS

4.1.1. Services Provided by the GoE

Since 2014, RAS have enjoyed access to PHC in Egypt's public facilities on par with Egyptian citizens, extending to secondary and tertiary healthcare in hospitals, covering over 85 percent of RAS (UN, 2022). Their inclusion in national health campaigns, such as anti-polio initiatives, breast cancer screening, the '100 Million Health Lives' Presidential Initiative, and the Early Detection and Rehabilitation of Hearing Deficit Campaign underscores the commitment to addressing health concerns, including the eradication of Hepatitis C by 2023 and reducing NCDs free of charge.[63] Also, the GoE included RAS in its COVID-19 response plan despite limited vaccine availability. The MoHP expanded access by adding an English language option to the vaccination registration website, allowing all non-Egyptians, including RAS, to access free COVID-19 vaccinations on par with Egyptian citizens (UN, 2022).

According to the UN (2022), a joint assessment titled "Rapid Assessment of Knowledge, Attitudes, and Practices around COVID-19 in Egypt," conducted by the MoHP and several UN agencies in 2020, revealed that approximately two-thirds of surveyed migrants had received information

[63] It is unclear whether RAS are included in all components of these initiatives.

about COVID-19 from at least three sources, a proportion similar to that reported by Egyptian respondents (61 percent). Among migrant respondents, around 60 percent considered the MOHP website and television as their most trusted communication channels, followed by WhatsApp (40 percent). However, migrants were less likely to be aware of the COVID-19 hotlines compared to Egyptian respondents. This highlights the need to increase awareness about available health services among migrant communities, using the communication channels trusted by RAS.

The GoE also provided RAS with primary, preventive, and curative healthcare services that are also available for migrants and non-Egyptian residents. For instance, PHC services provided by the MoHP have seen a significant utilization increase, with the number of refugee recipients quadrupling from 25,000 in 2015 to about 100,000 in 2019. Additionally, preventive care services are available to all residents in Egypt through 4,573 health offices located in 27 governorates. Specific initiatives, such as family planning convoys organized between June 2018 and September 2019, benefited around 2,792 Syrian refugees. These efforts aim to ensure that RAS receive essential healthcare services, including COVID-19 testing, treatment, and vaccination, on par with Egyptian nationals (UN, 2022).

4.1.2. Services provided by UN agencies

Despite the government's efforts to integrate RAS into the healthcare system, challenges persist. For example, as mentioned before, RAS are not included in national financial protection mechanisms such as the PTES, which enables access to public services that would otherwise be too expensive for a large segment of the population. This exclusion has led to reliance on the subsidiary schemes provided by UN agencies and NGOs (UN, 2022; ILO and UNHCR, 2023). NGOs collaborating with the UNHCR encompass implementing partners—such as Save the Children, Caritas-Egypt, and Refugee Egypt—along with operational partners—including the Egyptian Red Crescent, Médecins du Monde, Médecins sans Frontières, and Saint Andrew's Refugee Services. This collaboration yields the provision of PHC as well as the secondary and tertiary health needs of RAS, with Caritas-Egypt and Save the Children being the principal implementing partners, offering both outpatient and inpatient health services (ILO and UNHCR, 2023).

However, due to limited UNHCR resources, significant gaps persist in healthcare access and availability to RAS, prompting the UNHCR and partners to prioritize patients based on conditions' criticality and cost effectiveness (UN, 2022). Refugees outside UNHCR's criteria rely on NGOs or Egyptian healthcare providers. Within UNHCR programs, individuals may face barriers, such as the lengthy process of determining eligibility to receive subsidized chronic medication, involving multiple steps from diagnosis to dispensing. This process hinders access, leading to treatment interruptions and added expenses. Additionally, some refugees opt for brand-name drugs over UNHCR-approved generics, resulting in OOP expenses (ILO and UNHCR, 2023).

The UNHCR and its referral care partner have been working together to establish operational pathways for contracting MoHP secondary and tertiary health facilities. However, due to the lack of a formal agreement, the UNHCR and its partners often must resort to more expensive private hospitals. Negotiations are ongoing to operationalize the MoUs and action plans to optimize the utilization of MoHP services. The focus is on medical conditions where access is often impeded by high OOP expenditures, particularly for chronic diseases and secondary and tertiary healthcare. The UNHCR and its partners ensure sustained access to essential health services, including emergency care, medication supply for chronic conditions, management of complicated pregnancies, and mental health services. In 2021, the UNHCR supported 72,681 PHC consultations and 11,568 referrals to secondary and tertiary healthcare for RAS. In addition, 9,693 RAS received specialized care for chronic medical conditions (UN, 2022).

The UNHCR further supports national endeavors aimed at enhancing healthcare provision for refugees and the local population, particularly in regions with high refugee concentrations. For instance, in 2023, the Egyptian Red Crescent (ERC), in partnership with the UNHCR, extended medical assistance to over 32,000 refugees who fled the Sudan crisis. These services were delivered at border crossings and encompassed treatments for conditions resulting from the journey to Egypt, such as dehydration, heat stroke, insect bites, and infections, along with unattended chronic diseases like diabetes and heart failure. In critical cases, the ERC stabilized patients and facilitated their referral to hospitals in Abu Simbel or Aswan. Moreover, in 2023, more than 4,500 individuals received primary healthcare services, and over 900 underwent hospital treatment in Alexandria, Cairo, and Aswan (UNHCR - Egypt Fact Sheet, January 2024). Additionally, the UNHCR supports the MoHP to enhance its capacity, including training for health staff at facilities located in refugee-dense areas (UN, 2022).

Activities are coordinated by the Inter-Agency Working Group, the main coordination body for refugee response in Egypt, gathering UN agencies, international and national partners as well as donor countries to discuss policy issues and strategic priorities. UNHCR Egypt continues

to lead the interagency coordination structure under the "Regional, Refugee and Resilience Plan" (3RP), and "Egypt Response Plan for Refugees and Asylum Seekers from Africa, Iraq and Yemen" (ERP). The coordination of health interventions occurs at various platforms, including development partner forums and UNPDF/UNSDCF platforms (UN, 2022).

Despite the existing efforts outlined in the provision of healthcare services by both the GoE and UN agencies, the following findings of the Health Access and Utilization Survey (HAUS) conducted by UNHCR in 2021 shed light on critical challenges facing RAS in accessing healthcare:

1. Preference for Private Healthcare: Due to negative perceptions, and despite the financial strain, about 61 percent of RAS prefer private healthcare facilities despite their higher costs. Thus, 76.6 percent of surveyed RAS households incurred OOP expenses for healthcare, covering consultations, diagnostics, medication, and hospitalization, and birth delivery. To meet these healthcare costs, 24.4 percent oh RAS households resorted to loans and borrowing, and 19.8 percent depended on community support.
1. Chronic Disease Expenditures: A total of 16 percent of surveyed refugee households reported at least one member with a chronic medical condition requiring regular medication and follow-up. Respondents reported spending an average of E£400 (USD 25.5) monthly on chronic medication. Around 30.64 percent of household members couldn't access such medication due to financial constraints.
1. Access Challenges: Limited resources for the health sector have led to gaps in access to healthcare services. UNHCR programs focus on critical conditions, leaving others dependent on NGOs or public/private providers. The process of obtaining chronic medication involves multiple stages, causing barriers and additional expenses.
1. Inequality in Healthcare Access: Despite legal provisions ensuring equal access to healthcare for RAS in line with Egyptian nationals, socioeconomic status significantly affects RAS' access to healthcare. Accordingly, wealthier RAS enjoy relatively greater advantages, particularly given the exclusion of RAS from national financial protection mechanisms, thereby exacerbating socioeconomic vulnerabilities among them.

One recommendation to address these challenges involves prioritizing equitable subsidy and efficient healthcare allocation, as emphasized in comprehensive social policies (Fares and Puig-Junoy, 2021). Such policies can contribute to pro-poor welfare, addressing financial constraints and promoting inclusive access. These measures align with the principles of the 1951 Refugee Convention.

4.2. Health protection coverage for RAS through the UHIS: challenges and opportunities

As Egypt transitions to the UHIS, RAS face multiple challenges. Firstly, the implementation of the UHIS nullifies the MoUs governing RAS access to healthcare services, exacerbating the limitations already faced by RAS. In fact, there is evidence that RAS in Phase 1 governorates were excluded from certain public hospitals. With the impending transfer of public hospitals to the EHA, the restriction of healthcare access for RAS is expected to worsen as the UHIS expands (ILO and UNHCR, 2023).

Secondly, although Article 68 of Law No. 2 for 2018 theoretically permits the inclusion of refugees in a national insurance scheme, it lacks specificity regarding the timeline and operational details. This article categorizes RAS alongside other foreign citizens residing in Egypt for various purposes, which fails to acknowledge the unique rights of RAS under international conventions. The absence of clear guidelines on contribution amounts and service delivery locations postpones the equitable inclusion of RAS in the national insurance scheme, further exacerbating their healthcare access challenges.

Thirdly, the ILO and UNHCR (2023) show that there are financial challenges facing different poor categories of refugees in contributing to the UHIS. Extremely poor and poor refugees are unable to afford the required contributions, while the near-poor group (earning only half of the minimum wage)[64] also falls short of meeting basic needs.[65] This underscores the importance of including the near-poor as a vulnerable group in the UHIS to ensure their access to essential healthcare services without risking falling into poverty. Aligning with international social security standards—such as the ILO Social Protection Floors Recommendation, 2012 (No. 202)—highlights the need for solidarity in financing healthcare schemes, considering the varied contributory capacities of different population groups. Excluding the near-poor from the vulnerable group poses the risk of creating a "missing middle" and

[64] The minimum wage, which was EGP 2,400 at the time of the assessment, has undergone several revisions over time. As of February 2024, it stands at EGP 6,000 for employees in the government and public sector and EGP 3,500 for employees in the private sector.

[65] As per the last UNHCR Vulnerability Assessment (2018), the most recent publicly available version, with no updated assessment published on the UNHCR Egypt website as of June 2025, 19.3 percent of refugees fell into the extremely poor category, 20.3 percent into the poor category, 33.2 percent into the near-poor category, and 27.3 percent into the non-poor category.

subjecting the largest population of RAS to unaffordable contribution rates. The same concern is shared for near-poor Egyptians. Therefore, the ILO has offered technical assistance to support the government in addressing the challenges facing the poor and near-poor and ensuring equitable access to healthcare for all.

These challenges underscore the complexities involved in integrating RAS into the UHIS or a specialized national program. This inclusion necessitates substantial policy reforms, institutional capabilities, and financial investments. Simultaneously, advocating for equal access to healthcare services for RAS and nationals remains paramount in navigating these challenges.

Conversely, the phased implementation of the UHIS across six phases presents a gradual pathway for the inclusion of RAS. Since the majority of RAS are concentrated in Cairo and Giza, constituting 70 percent of the RAS population, their inclusion is slated for the final phase of implementation. The incorporation of RAS in Phase 1 governorates (2023-25), representing only one percent of the RAS population in Egypt, could serve as a valuable pilot program. This initial phase allows for the comprehensive testing of legal, operational, and financial frameworks before broader implementation. The approach of field-testing enrollment procedures has garnered positive reception from all stakeholders involved in the process (ILO and UNHCR, 2023).

5. Global experience for RAS integration in national health programs

5.1. Turkey

Turkey is currently the largest host of refugees worldwide, with 3.6 million registered refugees and nearly 320,000 persons of concern (POCs) from other nationalities as of 2022.[66] This number declined to 2.9 million as of end of 2024, mostly from the Syrian Arab Republic.[67] Initially, Turkey did not implement a significant integration policy, believing that the refugee crisis would be temporary. However, with the increase in their numbers, Turkey adopted an "out-of-camp" accommodation policy, allowing Syrian refugees to relocate to regions with economic incentives, particularly in the Western areas and metropolitan regions. While Turkey mainly hosts Syrian refugees, there are also sizable populations from Afghanistan, Iraq, and Iran.

In terms of rights and obligations for persons under temporary protection, Turkey has made efforts to improve its laws and regulations. RAS in Turkey have the right to access primary and secondary education, UHIS, and social assistance on equal terms with citizens. However, the effective inclusion of refugees depends on a combination of government and humanitarian programs supported by the European Union (EU) (Andrade et al., 2021).

Turkey's Constitution assigns the state the responsibility of regulating central planning and functioning of health services, including the establishment of a UHIS. The Social Insurances and Universal Health Insurance Law No 5510, enacted on 1 October 2008, established Turkey's UHIS as part of a broader social security reform. Turkey has been enacting legal and institutional changes to establish a robust national asylum system in line with global norms (Tumen, 2023). Alongside governmental efforts, comprehensive integration initiatives for refugees are in place, supported mainly by funding from the Turkish government and the European Commission via the EU Facility for Refugees in Turkey, with supplementary contributions from international organizations and NGOs (Tumen, 2023).

In 2014, Turkey implemented its inaugural asylum law—the Law on Foreigners and International Protection—ratified by the parliament.[68] This law introduced the 'conditional refugee' status for non-European refugees and the 'temporary protection' status for Syrian immigrants while establishing the Presidency of Migration Management as the central authority for policymaking and procedures concerning foreigners in Turkey. Conditional refugee status entails hosting in Turkey until resettlement to a third country, primarily for non-EU refugees, while temporary protection addresses immediate solutions for mass influx situations, mainly for Syrian refugees.[69] Additionally, Turkey also adopted the Temporary Protection Regulation (TPR) in 2014, outlining rights, obligations, and procedures for individuals granted temporary protection within the country.[70] The TPR outlines RAS' access to health services as part of the procedures and principles govern-

[66] https://www.unhcr.org/tr/en/refugees-and-asylum-seekers-in-turkey#:~:text=Türkiye%20currently%20hosts%20some%203.6,of%20concern%20from%20other%20nationalities. However, other sources such as the World Bank Report (2023) show an estimate of 500-700 thousand non-Syrian immigrants/refugees in Turkey

[67] Republic of Türkiye | UNHCR

[68] Ibid.

[69] https://en.goc.gov.tr/general-information2.

[70] https://www.unhcr.org/tr/en/refugees-and-asylum-seekers-in-turkey#:~:text=Türkiye%20currently%20hosts%20some%203.6,of%20concern%20from%20other%20nationalities.

Table 2. Contribution rates for UHI

Groups/Persons*		Contribution Rates (%)		Contributions Paid by
Economically Active Persons	Employed persons	12.5	of earnings subject to contribution	-
	Civil servants	12.5		
	Self-employed persons	12.5		
Economically NOT Active Persons	Voluntarily insured persons	12		
	Beneficiaries of unemployment benefit and short-time working allowance	12	of the national gross minimum wage	Turkish Employment Agency (ISKUR)
	Persons who are fulfilling their lawyer internship	6		Union of Turkish Bar Associations
	Unemployed people who are not eligible for unemployment benefit, non-employed people and people who are not working formally (informal workers) in case they are identified non-poor (not indigent) by the means test	3		Paid by Themselves
	Non-employed (not working) foreign nationals who are optionally insured	24		
	Foreign studets studying in Turkey without Turkish State scholarship	4		
	Foreign studets studying in Turkey with Turkish State scholarship	12		Paid by the State
	Indigent national according to the means test	4		
	Children under 18 years of age	4		
	Stateless persons and refugees	4		
	Specific groups who receive pensions from non-contributory pension schemes	12		
	Pensions of contributory invalidity, old-age and survivor's pensions	No contribution		Health ecpenditures covered by SGK
	Beneficiaries of permenant incapacity benefit and survivor's benefit in case of accident at work and occupational disease			

Source: SGK (2020).
Note: The list is not exhaustive.

ing temporary protection for foreigners arriving in large numbers to seek urgent, short-term protection. In practice, however, the effective inclusion of refugees depends on a mix of government and humanitarian programs supported by the EU (Andrade et al., 2021).

Currently, the UHIS covers almost the entire population in Turkey, including foreigners with residence permits and refugees. This system ensures access to healthcare services for all individuals residing in Turkey, regardless of their employment status or socioeconomic position, thereby providing comprehensive coverage. Once registered with the Provincial Directorate of Migration Management in their province of residence, RAS can obtain identification documents provided by Turkish authorities and become eligible for available assistance. They are included on an equal footing with Turkish citizens under the General Health Insurance provided by the Social Security Institution (SGK), which includes access to medication.[71] Public health centers in the province offer free healthcare services, while expenses must be paid at private hospitals and clinics. Non-registered individuals have free access to emergency services at public hospitals, with paid services available at private hospitals and clinics.

Under this social security reform, the Turkish government subsidizes one-fourth of the collected contributions for invalidity, old age, survivor's insurance, and UHI by the SGK each month. This financial arrangement encompasses four sources (Isik, Isik, and Kiyak, 2015):

- Funds provided by the Social Security Administration, which consist of taxes paid by employees and employers.
- Funds allocated from the central administrative budget, derived from taxes.
- OOP payments.
- Funds provided by private health insurance organizations, which come from private health insurance premiums.

[71] Ibid.

5.2. Uganda

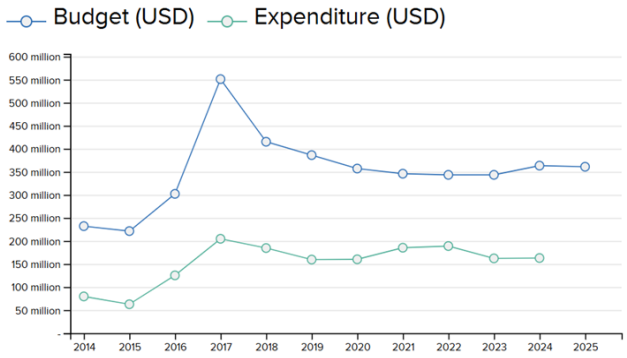
Uganda is recognized as one of the largest hosting countries in Africa and the third-largest host for RAS globally. As of 2023, the UNHCR estimates that there are approximately 1.5 million RAS in Uganda, primarily fleeing from South Sudan and the Democratic Republic of Congo. Around 92 percent of these refugees live in settlements, while the remaining eight percent reside in urban areas. Notably, the refugee settlements in Uganda are unique in their close proximity to host communities.

Uganda is renowned for having one of the most progressive sets of refugee laws and regulations in the world, positioning it as a global leader in promoting peaceful coexistence between RAS and host communities (UNHCR, 2022). RAS in Uganda have the right to work, freedom of movement, and access to national social services, including health and education. Refugees in Uganda can choose to settle in organized settlements or self-settle (World Bank, 2016). Furthermore, Uganda implements the Comprehensive Refugee Response Framework and Global Compact on Refugees (GCR), which prioritize the inclusion of refugees into national systems, particularly in education, health, and livelihoods, albeit to varying degrees. The Office of the Prime Minister in Uganda and the UNHCR have committed to installing infrastructure such as health centers and schools in affected districts to benefit both refugees and the Ugandan receiving communities, as aid agreements stipulate that assistance should directly target receiving communities (Bohnet and Schmitz, 2019).

Since 2016, Uganda has implemented the Refugee and Host Population Empowerment strategy, aiming to harmonize the refugee response by integrating refugee programming into the national development plan. This integration has led to improved access to PHC for both refugees and host communities. Additionally, the EU has provided significant support for humanitarian action in Uganda, allocating over EUR 278 million since 2017. While the amount of financial aid has decreased over time, the EU still allocated EUR 30 million in humanitarian aid to Uganda in 2023, aiding in the provision of rapid and effective emergency assistance to newly arrived refugees, as well as improving access to basic services, including primary healthcare, in refugee settlements.

However, Uganda's health sector remains significantly underfunded, relying heavily on private financing, particularly OOP spending (Zikusooka et al., 2009). Approximately 38 percent of Uganda's health expenditures are paid by individuals through OOP expenses, followed by contributions from development partners (41 percent),

Figure 2. Funding gap in UNHCR Uganda operations: budget vs. expenditure (2014–2025)



Source: Uganda | UNHCR.

the government (16 percent), and others (five percent) (Aloyo et al., 2022). Healthcare resources come from both public and private sources, including households, private firms, and not-for-profit organizations, with the government and donors providing the major public funds. Unfortunately, due to slower economic growth, the Ugandan government's contribution to the health sector has progressively declined, affecting the MoHP's budget. Limited financial resources exacerbate the substandard quality of services and the frequent unavailability of essential drugs and services in public health facilities, further hindering the health system's ability to adequately meet the needs of nationals.

Similarly, on the humanitarian front, UNHCR's operations in Uganda have been consistently underfunded, with only 44.8 percent of health sector financing needs met in 2024 (See Figure 2). In 2022, just USD 11 per person per year was allocated to ensure access to comprehensive PHC services for refugees and host communities. Of this amount, 90 percent was dedicated to health workers, referral healthcare, and operational costs. The situation worsened in 2023, when a USD 30 million funding gap led to a 50 percent cut in the health sector budget, reducing support to just USD 5 per refugee per year. This drastic reduction has inevitably strained service delivery, impacted the retention of health workers, and was expected to contribute to further deterioration in health outcomes (UNHCR, 2023).

The severe underfunding of the UNHCR's operations in Uganda jeopardizes the progress made in refugee self-reliance and economic inclusion (UNHCR, 2022). Urgent financial contributions are needed for the UNHCR and its partners to address the pressing needs of newly arrived refugees in Uganda. It is crucial to safeguard equity in the financing and use of health services by implementing policies that prioritize addressing the health needs of the poor while ensuring that the burden of financing health services does not fall solely on them.

5.3. Jordan

As of 2023, Jordan hosts approximately two million registered Palestinian refugees under the United Nations Relief and Works Agency (UNRWA), and 650,000 Syrian refugees—with 80 percent residing outside camps and 20 percent in camps—registered under the UNHCR.[72] Unlike Lebanon, Palestinian refugees in Jordan have the right to full Jordanian citizenship, including access to healthcare and participation in political and economic life.

While Jordan is not a party to the 1951 Convention on the Status of Refugees or its 1967 Protocol, nor the 1954 Convention on the Status of Stateless Persons or the 1961 Convention on the Reduction of Statelessness, it has had an MoU with the UNHCR since 1998.[73] This MoU establishes the framework for cooperation between the Government of Jordan (GoJ) and the UNHCR on issues related to RAS, outlining key principles of international protection, including the definition of a refugee.

Jordan is widely recognized for its modernized healthcare system, which encompasses the public sector, private sector, and nonprofit organizations. Health expenditures account for 7.2 percent of Jordan's GDP (Dator et al., 2018). The Jordanian government, in partnership with the UNHCR, has implemented comprehensive programs to address the health needs of refugees. The MoHP, Royal Medical Services, UNRWA, and the UNHCR provide healthcare services to Palestinian and Syrian RAS in Jordan, including those residing outside refugee camps. Syrians and Palestinians have successfully integrated into the healthcare system, enjoying equal access to services as Jordanian citizens.[74] However, Syrian refugees often face challenges in accessing healthcare due to limited employment opportunities and high OOP expenditures (Saleh et al., 2023).

Jordan's policy regarding access to public health services for RAS has undergone fluctuations over the years. In order to access public services, Syrian refugees need to have a Ministry of Interior (MoI) service card. Those who are unable to meet the requirements for the issuance of the card have to rely on humanitarian organizations and private donors for support. Between 2011 and 2014, Syrians with an MoI card could access healthcare for free and were treated like insured Jordanians. In 2014, the government changed its policy, enabling Syrians with the MoI cards to pay the same rates as uninsured Jordanians, while Syrians without the MoI service cards are treated like other foreigners accessing public services and are required to pay a foreigner's rate. In 2020, Syrian and non-Syrian refugees were required to pay non-insured Jordanian rates.[75]

The ongoing conflict in Syria, along with the growing number of refugees and the associated financial burden, has compelled the GoJ to implement measures to control utilization and costs. To encourage the integration of RAS into national health systems, a multi-donor account was established through contributions from Canada, Denmark, Qatar, and the USA under a USAID initiative. This account serves as funding and budget support for the Jordanian government. Humanitarian actors have mobilized resources to ensure access to essential services. Health services are provided to refugees in camps by humanitarian partners, who also establish referral systems to public and private providers for secondary and tertiary care. Syrian refugees who hold MoI service cards are still partly subsidized by the state and have to pay around 35-60 percent of the user fees paid by other foreigners in Jordan. Those without the MoI service cards are treated like foreigners accessing public services and pay the foreigner's rate, which is higher than the uninsured Jordanian rate.[76] The cumbersome, lengthy, and costly process of obtaining the MoI service card as well as the user fees imposed on the refugees with the card made the access to healthcare highly unaffordable and has left several refugees without access to healthcare services. Therefore, the UNHCR and other international donor organizations and NGOs have attempted to fill the gap to ensure access to healthcare services. The UNHCR covers the foreigner rate on behalf of refugees in referral cases, while UNRWA relieves the pressure on the Jordanian government by covering PHC costs for 1.6 percent of the population. Additional coverage is provided by professional unions (1.6 percent) and external sources (0.3 percent). Since 2018, the Jordanian Ministry of Health (JMoH) has focused on expanding and constructing health facilities, particularly in governorates hosting large refugee populations (WHO, 2023).

Jordan has taken commendable steps toward achieving universal health coverage (UHC), with 70 percent of Jordanians and 55 percent of the overall population having some

[72] https://www.unrwa.org/where-we-work/jordan.

[73] https://www.refworld.org/docid/3ae6b3a124.html.

[74] UNRWA provides healthcare services for nearly 56 percent of the registered Palestinian refugees in the country.

[75] https://theforum.erf.org.eg/2018/05/22/syrian-refugees-jordan-healthcare-food-security/.

[76] https://www.amnesty.org/en/documents/mde16/3628/2016/en/.

form of insurance, according to the latest population census. The gross annual cost per person for coverage by JMoH facilities alone is estimated at 126 Jordanian Dinars (JD) (USD 90). Meanwhile, it is estimated at JD 148 (USD 105) for coverage by the public sector alone, and JD 164 (USD 116) under the current Comprehensive Insurance Plan (public plus private). Despite the significant efforts of humanitarian agencies like the UNHCR and UNRWA to provide equal healthcare services to refugees, the implementation of a UHC plan is necessary. However, humanitarian agencies face funding shortages that may impact the refugee population. The main challenges to successful UHC integration lie in the financing, where the PHC in Jordan is underfunded and prioritized by the government. This is in addition to disparities in OOP expenses among different socioeconomic groups and geographic locations, with particularly high OOP expenditures for the uninsured and refugees (Khader et al., 2023). It is crucial for Jordan to address its financing gap by exploring sustainable solutions while simultaneously expanding healthcare infrastructure and the workforce to accommodate a larger population.

5.4. Lebanon

Lebanon, with a total population of six million, has the highest number of refugees per capita in the world. Syrians constitute 1.5 million of the total population, and an additional half a million are Palestinian RAS registered under the UNRWA (Saleh et al., 2022). Unlike other countries, Lebanon did not establish official refugee camps for Syrians, fearing long-term settlement. As a result, most RAS in Lebanon reside in low-resource areas, facing difficulties in accessing available healthcare services. Refugees, particularly those living in informal settlements, suffer from complex health issues arising from deteriorating living conditions, low wages, and deprivation.

Lebanon's healthcare system is highly fragmented—both in terms of service providers and target populations. Achieving Universal Health Coverage (UHC) is a significant challenge in this context. The system is composed of a complex mix of public and private actors, with funding coming from multiple sources. Nearly half the Lebanese population is covered by the National Social Security Fund (NSSF), government funds, or private insurance. However, 53 percent rely on the Ministry of Public Health (MoPH) as the 'insurer of last resort' (Saleh et al., 2022). Out-of-pocket (OOP) expenditures remain high, accounting for 33.2 percent of total health spending, exposing vulnerable households—including refugees—to serious financial risk.

There are approximately 238 primary healthcare (PHC) centers affiliated with the MoPH, of which 68 percent are operated by NGOs, 13 percent by municipalities, 8 percent through NGO-municipal partnerships, 10 percent by the government, and 1 percent by academic institutions. Syrian refugees have access to over 200 PHC facilities, primarily supported by UNHCR in coordination with the MoPH and implemented by NGOs. However, access to secondary and tertiary care remains limited due to cost, referrals, and bureaucratic barriers.

Palestinian refugees, in contrast, are not eligible for public healthcare services and rely almost exclusively on UNRWA, which functions as a parallel health authority. Together with UNHCR, these agencies manage separate health systems for refugees, operating outside the national framework. These parallel structures reflect both Lebanon's limited institutional capacity and its political reluctance to fully integrate refugees into national systems—especially given concerns that doing so would imply long-term settlement. Lebanon's national social assistance scheme—the National Poverty Targeting Program (NPTP), financed by the World Bank—was launched after humanitarian cash transfers for Syrian and Iraqi refugees had already been implemented for several years by WFP and UNHCR. The NPTP draws heavily on the humanitarian model, using the same targeting method (proxy means testing), transfer value, and payment systems, although the card colors differ (Seyfret and Quarterman, 2022). The program runs in parallel but is aligned with the humanitarian approach, illustrating how refugee-focused systems have shaped national social protection design.

Despite repeated public statements in support of refugee inclusion, full integration into the national health system remains politically sensitive and institutionally difficult. While a parallel system may be necessary in the short term, it is neither efficient nor sustainable in the long run. Moving toward gradual integration, while addressing Lebanon's structural inequalities, political instability, and economic crisis, is essential to building a more inclusive and resilient healthcare system for all.

5.5. Comparative analysis of health coverage modules

One notable observation from the studied country experiences is the limited availability of data on the financing of refugee inclusion in health insurance schemes, whether national or specifically designed for RAS. The limited economic integration and job opportunities available to refugees mean that refugees often struggle to earn sufficient income. Consequently, they may not have the financial means to contribute to healthcare programs, exacerbating the financial challenge of including them in national

healthcare initiatives. However, the few countries that have attempted to adequately address access to healthcare services for RAS were almost always significantly financially supported by international donors and organizations. Nonetheless, the same countries have cited sustainability as a major obstacle due to financial and political factors.

Lebanon and Jordan both rely on the involvement of international humanitarian organizations to enable RAS in access essential services, as these countries—like others in the region—face fragility in terms of context and capacity (Saleh et al., 2022). Both countries currently face limited sustainable resources and political will to officially integrate RAS into their national health systems, despite signing the Universal Health Coverage 2030 Global Compact. Jordan has taken steps toward social integration through the establishment of the Jordan Response Plan (JRP), which outlines the rights of refugees but still falls short in terms of human rights considerations. Lebanon has also stated that it will try to achieve UHC as a key goal of its National Health Strategy, but the feasibility of this goal is questionable.

On the other hand, the integration of RAS into Turkey's UHC scheme has yielded several positive outcomes. Providing refugees with access to quality healthcare has reduced the risk of disease transmission within the host community, which has been particularly crucial during the COVID-19 pandemic. By ensuring that refugees receive proper medical care, the overall health and well-being of both refugees and the host community are safeguarded. Furthermore, Turkey's implementation of an 'out-of-camp' approach has facilitated the movement of RAS from border regions to more dynamic locations. By dispersing refugees to health providers across various locations, the financial responsibility for healthcare services is shared more equitably, potentially relieving the strain on certain areas that may have initially borne a disproportionate burden. As a result, the economic situation of refugees has also improved, and the financial burden on the Turkish state has been reduced. This approach not only provides greater flexibility and autonomy for RAS but also contributes to their socioeconomic integration into Turkish society.

Whilst Uganda stands out as one of the first countries to integrate RAS into its national development planning, it also experiences multiple challenges in sustaining such efforts. The country's efforts at integration are challenged by weak social service delivery, poor infrastructure, and limited market opportunities in refugee-hosting settlement areas, which impact both refugees and host communities alike (Sarr et al, 2022). The severe underfunding of donor operations in Uganda poses a significant challenge. Without alternative sources of financing, there is a risk that the burden of shouldering the costs to maintain the health needs of the vulnerable population may become a reality.

6. Unlocking the inclusion of RAS into Egypt's UHIS: a call for global and regional shared-responsibility

In a world grappling with escalating conflicts and violence, the ever-increasing number of RAS—both in Egypt and globally—shed light on pressing humanitarian challenges. The integration of RAS into national social protection programs, such as social health insurance, remains inadequate, leaving a substantial portion underserved. Compounding this issue, a recent appeal by the UNHCR Commissioner emphasizes the severity of the situation, revealing an imminent financial shortfall that jeopardizes the fundamental principles of our shared humanity and exacerbates funding shortfalls for humanitarian aid.

Advocating for the socioeconomic inclusion of RAS remains crucial, highlighting the importance of addressing these challenges to fulfill their health needs through integration into the UHIS and, more broadly, into Egyptian society. Egypt, like numerous other low- and middle-income hosting countries, confronts multifaceted hurdles in delivering healthcare services to RAS newcomers amid internal constraints and competing demands. Striking a balance between the healthcare needs of RAS and the prevailing economic constraints necessitates strategic measures to bolster social protection and foster positive contributions to Egypt's socioeconomic fabric.

This section aims to provide a comprehensive and sustainable framework of solutions for integrating RAS into Egypt's UHIS while also addressing the financing needed for this integration. It is grounded in RAS' social and economic rights as outlined in international refugee and human rights law. The approach advocates for a fair shared responsibility among hosting countries, traditional donors, and new donors. Divided into two distinct subsections, the first explores sustainable solutions for Egypt to incorporate RAS into the UHIS while maximizing the efficiency of limited resources from international organizations. The second subsection examines how collective responsibility at the global and regional levels can augment resources for RAS, facilitating their ability to live in dignified conditions within host countries.

6.1. Bridging healthcare gaps for RAS in Egypt: a call for inclusive health services

6.1.1. Integration of RAS into Egypt's UHIS

The implementation of the UHIS will fundamentally change the social health insurance provided to the population as well as the landscape of healthcare provision, including the roles of various healthcare providers and necessitating a reevaluation of existing MoUs with the MoHP. However, the UHIS also presents an opportunity to overhaul current healthcare access for RAS by streamlining fragmented services offered by multiple organizations and UN agencies. Careful consideration must be given to integrating RAS into UHIS to ensure comprehensive and equitable healthcare coverage. The following is a set of strategic features of including RAS in Egypt's UHIS:[77]

- *Advocating for RAS inclusion in the UHIS:* To ensure comprehensive and equitable healthcare coverage for RAS within the UHIS, it is imperative to continue advocacy efforts aimed at government officials. This paper—along with the remaining papers of the 'Inclusive Social Protection for Refugees and Asylum Seekers' project—forms part of these ongoing advocacy endeavors. By engaging in proactive advocacy, awareness can be raised about the significance of RAS inclusion on par with Egyptians in the UHIS in accordance with international commitments and Article 68 of Law No. 2, and support can be garnered from key stakeholders within the GoE. These advocacy efforts will lay the groundwork for subsequent actions, including the incorporation of RAS in various social protection schemes, such as the UHIS. By securing buy-in and commitment from government officials, these efforts will facilitate a smoother process of RAS inclusion and ensure alignment with the expansion of national social protection programs. However, it is important to acknowledge that the GoE's commitment to fully incorporating RAS into these programs will depend on successfully addressing the financing challenges, ensuring that adequate resources are available to support both the national population and RAS without compromising the broader objectives of social protection.
- *Clear political guidance on the legal enactment of RAS inclusion in UHIS:* For the successful integration of RAS into the UHIS, the GoE must make a purposeful policy decision to enact Article 68 of the UHIS bylaws (Decree 909/Feb 2018). This includes providing clear guidelines to ensure that RAS are included in the UHIS at par with Egyptians, i.e., aligning contribution rates for RAS and protocols for assessing RAS income and vulnerability with those established for Egyptians as well as identifying the sources and mechanisms for subsidizing RAS without contributory capacity.
- *Establishing an Agreement Protocol between the GoE and the UNHCR (and other relevant partners)*: The deliberate political decision for RAS inclusion in the UHIS will provide an opportunity for the relevant UHIS agencies and ministries, namely the UHIA, GAHC, MoH, and MoF, to develop an agreement protocol with the UNHCR. This protocol framework will serve as a guiding document for the inclusion process, encompassing its operationalization and financing arrangements and delineating the roles of the GoE, the UNHCR, and other partners. It will also enable Egyptian agencies to strengthen their internal capacities and secure funding from various donors interested in strengthening social health protection overall and RAS inclusion specifically. As such, this protocol should mark a shift in the mandate of the UNHCR and other entities currently delivering healthcare services to RAS in Egypt, transitioning them from service providers to technical partners supporting the government with UHIS implementation, access, and quality improvements.
- *Leveraging the initial phase of RAS inclusion in the UHIS to improve legal, operational, and financial hurdles*: This strategic approach is particularly critical in the early stages of UHIS implementation as these phases encompass governorates with a lower RAS population density. The concept of field testing offers several advantages. It involves minimal costs in the initial phases, as Phase 1 (2023-25) is going to enroll only around one percent of the RAS population (ILO and UNHCR, 2023). This approach has garnered positive feedback from senior UHIA and MoSS officials, as well as RAS (ILO and UNHCR, 2023).

The outcomes of this first inclusion phase will be pivotal in identifying any challenges or shortcomings, enabling prompt adjustments to ensure the effectiveness of UHIS implementation for RAS. Due to the limited number of RAS residing in the first governorates, it is financially more feasible for partners to financially support the first inclusion rollout. Furthermore, the insights learned from this process may yield enhancements in healthcare access and delivery for nationals within the UHIS framework.

- *Issuing a health insurance card for RAS:* Given that Egyptians' enrollment in the UHIS is currently facilitated through the national identity card, which is unavailable to RAS, the UHIS should consider issuing a health insurance card for RAS, including an identifiable number. This would streamline RAS' access to healthcare services across all healthcare facilities.

[77] The recommendations provided in this section are guided by the proposed strategy outlined in the ILO and the UNHCR (2023).

This issuance process should be informed by the practices established in the UHIS phases already implemented. It is crucial to avoid linking the card's validity to the duration of residence, as this could impose unnecessary burdensome renewal procedures and hinder RAS' access to essential healthcare services.

6.1.2. Complementary strategic and operational measures to support UHIS enrollment

Given that the majority of RAS reside in governorates listed in Phase 6 of the UHIS rollout, it is evident that a significant portion of this population will face prolonged waits for coverage under this system. Consequently, it becomes imperative to introduce parallel measures that complement the UHIS enrollment process. The additional measures listed below are crucial in guaranteeing prompt access to healthcare services for RAS, mitigating the potential delays they may encounter:

- *Egypt's leadership in refugee documentation and residence process:* Refugee registration and documentation are fundamental aspects of managing RAS recognition in their hosting country. While the UNHCR currently oversees these processes in Egypt, the country's proactive involvement could significantly enhance efficiency and effectiveness. An important advantage would be affording Egypt a more comprehensive and expedited comprehension of the refugee population, enabling it to assume a more informed and proactive stance in meeting their needs. Entrusting the GoE with these processes would centralize responsibilities, thereby consolidating the oversight of registration, the issuance of residence permits, and the administration of service provisions. In other words, social protection schemes would be encompassed under a single entity. This consolidation of responsibilities could streamline operations, reduce bureaucratic hurdles, and ensure a more coordinated approach to RAS management. It would also enhance accountability and transparency in the process, benefiting refugees, the host country, and international partners. Furthermore, Egypt's leadership in refugee registration and documentation would strengthen its position on the global stage and demonstrate its commitment to shared global responsibilities. By taking proactive steps to address the needs of RAS, Egypt can showcase its dedication to upholding human rights and promoting social cohesion.
- *Egypt to assume responsibility for RAS Vulnerability Assessment:* The Central Agency for Public Mobilization and Statistics (CAPMAS) can include RAS in the Household, Income, Expenditure, and Consumption Survey. By actively participating in data collection efforts, Egypt can obtain a more accurate understanding of the economic circumstances and needs of the RAS population within its borders. Clear vulnerability profiles would help the government identify RAS who can pay their own contributions, thus enhancing the pool of health revenues, while distinguishing those who require subsidization from the GoE and partners. This information is crucial for informing policy decisions, resource allocation, and the development of targeted assistance programs aimed at supporting vulnerable individuals and households. Additionally, conducting vulnerability assessments can potentially help CAPMAS access funds from international partners to upgrade its internal capacities and improve the overall quality of the data collection process. It can also enhance coordination and cooperation between Egypt, the UNHCR, and international organizations, fostering a more comprehensive approach to addressing the needs of RAS. Ultimately, improved data collection efforts can contribute to more effective support systems for RAS, promote social inclusion, and strengthen Egypt's capacity to manage humanitarian challenges within its borders.
- *Integrating all RAS children attending school in Egypt into the School Health Insurance Programme (SHIP):* Administered by the HIO under Law No. 99, SHIP offers an avenue to provide RAS children with health insurance coverage before the full implementation of the UHIS. RAS students attend various types of schools, including public, private, and community schools. Given this diverse landscape, the UNHCR education program can conduct a comprehensive review of the current database of RAS students, examining factors such as their numbers, types of schooling, and any existing school healthcare provisions. Subsequently, in collaboration with the Ministry of Education (MoE), discussions can be held regarding the eligibility status of these children for school health insurance coverage. This collaborative effort ensures that RAS students receive essential healthcare services through SHIP while awaiting full integration into the UHIS framework (ILO and UNHCR, 2023).

This inclusion may be challenging due to logistical hurdles, such as identifying and registering all RAS children enrolled in various types of schools across Egypt. Moreover, there may be legal and administrative complexities associated with extending coverage to RAS children under the existing framework of Law No. 99, requiring careful navigation and potential policy adjustments. Finally, securing sufficient resources and funding to support the expansion of SHIP to accommodate RAS children may pose financial constraints. This challenge is compounded by the competing priorities within Egypt's healthcare system, as well as the humanitarian needs addressed by UN agencies

and donors. Balancing these demands and allocating adequate resources to ensure the effective implementation of SHIP for RAS children will require careful planning, collaboration, and resource mobilization efforts.

- *Supporting job opportunities for RAS in Egypt:* Like nearly 60 percent of the Egyptian workforce, RAS encounter considerable challenges accessing formal jobs in Egypt's labor market (Assaad and Krafft, 2021; Krafft et al., 2019). Yet, they face further hurdles as they are subject to the same legislations that apply to all foreigners (Andrade et al., 2021), thereby requiring a valid passport and work permit to get enrolled in Egypt's social insurance system and, consequently, in the UHIS. These two prerequisites are very hard for RAS to fulfill; hence, they considerably preclude them from getting access to social and health insurance systems (Hetaba et al., 2020; ILO, 2022).

The current restriction of RAS' access to job opportunities leads to dependence on humanitarian aid, straining both host countries' limited resources and international aid organizations. Enabling RAS to participate in the labor market not only fosters financial self-sufficiency and societal integration but also transitions them from aid recipients to active contributors to contributory social protection schemes and the wider economy. This transition reduces the overall costs of humanitarian aid budgets, enhancing the financial sustainability of social and health insurance systems (ILO, 2021; Hussam et al., 2022, Holmes and Lowe, 2023).

Research on the impact of the refugee influx on host countries' labor markets presents mixed findings. While some studies demonstrate positive outcomes, such as refugees establishing enterprises in Turkey (Altındağ, Bakış, and Rozo, 2020) or benefiting local farmers in Tanzania (World Bank, 2017), others reveal mixed effects, indicating potential gains but also highlighting labor market inefficiencies (Tsuda, 2022). For Egypt, this emphasizes the importance of a cautious approach to including RAS in the labor market, balancing economic opportunities with potential challenges. Phased integration allows for a thorough assessment of impacts, aligning with international conventions and enabling effective policy formulation.

It is crucial to dispel any perception among local residents who are competing for jobs that would otherwise go to nationals, thus mitigating xenophobic reactions (UNHCR, 2016). Our calculations indicate that refugees make up only around one percent of Egypt's total employment,[78] a proportion that is unlikely to increase significantly over time. With an estimated influx of 500,000 to 700,000 new entrants to the labor market each year, refugees are expected to represent a declining ratio of total employment, easing concerns about substantial job competition with nationals.

Private sector involvement in refugee contexts, although crucial, is still in its initial phases worldwide (Bridgespan Group and IFC, 2019; Wang et al., 2021). In Egypt, the feasibility of private sector engagement for refugees depends on their access to employment. To secure additional resources, potential support measures encompass blended finance for risk-sharing, performance-based incentives, or other risk mitigation tools; these ensure that investments in areas hosting refugees are financially sustainable (World Bank, 2023).

Implementing programs to support job opportunities for RAS is crucial, requiring action to overcome legal and administrative barriers hindering their access to employment (Barsoum and El Barrawi, 2024; Roushdy, 2024). Egypt must develop distinct legal frameworks tailored to address RAS' unique vulnerabilities, simplify permit processes, and reduce associated costs. Extending the validity of residence permits and recognizing UNHCR cards as valid IDs would streamline access. Efforts should also enhance social and health insurance schemes and their operationalization for informal sector workers, nationals, and RAS. Increasing RAS' awareness of employment rights and providing tailored vocational, entrepreneurial, and financial literacy training, as well as job search and placement services, would enhance employability and self-sufficiency among RAS. Finally, promoting and increasing access to novel financial services[79] among RAS living in Egypt is vital

[78] The proportion of RAS in total employment is calculated by dividing the number of economically active RAS by the total employment in Egypt. Based on data from the UNHCR, the number of RAS in Egypt ranges around 500 thousand. According to the ILO and UNHCR (2023), 57 percent of the total RAS population is economically active. For Egypt's total employment figures, data are from CAPMAS. (https://www.capmas.gov.eg/Pages/Publications.aspx?page_id=5106&YearID=16603) indicates it to be approximately 28.8 million. Therefore, the resulting proportion of RAS in total employment is approximately 0.99 percent.

[79] International evidence suggests that innovative financial support initiatives targeted at young people have effectively reduced barriers to entrepreneurship, such as cash grants in Uganda, in-kind grants in Chile, and business-plan competitions in Nigeria (Blattman et al., 2013). For instance, Lebanon's "Karama Cash for Work" program has assisted refugees in launching businesses (https://odi.org/en/publications/world-food-programme-cash-assistance-in-lebanon-protection-outcomes-for-syrian-refugees/). Similar tailored financial support programs should be designed and periodically assessed to address the unique circumstances of refugees and asylum seekers in Egypt.

for their self-reliance and economic independence.[80] Cooperation and coordination among all relevant stakeholders, including the government, NGOs, the private sector, international organizations, and donors are essential for effective implementation (Roushdy, 2024).

6.2. Global and regional responsibility sharing in financing international RAS assistance

In Egypt, the challenge of financing RAS' needs mirrors global trends. Securing only 49 percent of the UNHCR's requested resources by December 2024[81] resulted in cutbacks in essential services. Hosting countries, often grappling with economic limitations, struggle to bridge these financing gaps. This challenge is particularly pronounced in Egypt, where economic hardships persist, and the escalating needs of both the local population and refugees surpass current growth outcomes.

However, Egypt's responsibility as a host country transcends its national borders and economic capacity. While Egypt's specific obligations have been delineated earlier in this document, ensuring the well-being and integration of RAS necessitates broader international and regional cooperation, especially from nations endowed with larger economic resources. This subsection aims to elucidate the responsibilities of these nations at the global and regional levels in addressing the refugee crisis comprehensively.

All key actors recognize the urgent need for global cooperation and concerted efforts as vital in addressing the root causes of forced displacement, alleviating the economic and fiscal burdens on host countries, and contributing to sustainable solutions. A fair distribution of responsibilities within a global system, where countries share the responsibility of hosting asylum-seekers based on principles of solidarity and human rights protection, would enhance refugee protection and alleviate the strain on host countries.[82]

Although the 1951 Refugee Convention acknowledges the challenges faced by nations granting asylum (UN, 1952), it falls short of providing binding rules for the equitable distribution of responsibilities (World Bank, 2023). The 2018 GCR attempts to bridge this gap by establishing a framework for fair and predictable burden- and responsibility-sharing (UN, 2018). However, the absence of explicit legally binding rules remains a central concern in the international discourse on refugees.

Over the years, a comprehensive system of external assistance has been developed to support low- and middle-income countries hosting refugees. Official Development Assistance (ODA) spending on processing and hosting refugees reached an estimated USD 46.7 billion in 2018 and 2019, averaging USD 23.35 billion annually (OECD, 2021). In 2022, ODA in-donor refugee costs[83] soared to a record high of USD 29.3 billion, constituting 14.4 percent of the total ODA from Development Assistance Committee (DAC) member countries, which amounted to USD 204 billion.[84] Despite this progress, the 2022 ODA total falls short of the UN target of 0.7 percent ODA to Gross National Income (GNI[85]), highlighting the persistent inadequacy between available resources and the escalating needs of RAS. Additionally, competing demands for external financing, such as climate change and food security, pose constraints on financial support for RAS.

Apart from funding scarcity, the World Bank (2023) identifies four additional challenges in supporting refugees and host communities. These challenges include a narrow donor base, concerns about effectiveness and efficiency, uneven distribution of aid across countries, and an emergency-focused approach that hampers long-term solutions. Addressing the underlying causes of forced displacement necessitates international efforts in countries of origin. These efforts involve supporting peace, human rights, and the rule of law, as well as facilitating durable solutions like voluntary repatriation and reintegration (World Bank, 2023).

To tackle these challenges, the international community must recognize the urgency of providing adequate, consistent, predictable, and sustainable support for both host countries and refugees. Collaboration and commitment from a broader donor base are essential for translating the shared responsibility toward refugees into tangible actions that foster stability and well-being for all.

[80] The UNHCR, in collaboration with the Swedish International Development Cooperation Agency and the Grameen Credit Agricole Foundation, launched a program in Uganda promoting access to affordable financial and non-financial services for refugees, as well as vulnerable groups in host communities. This program has been providing selected financial service providers with debt-financing and technical assistance, to enable them to expand their lending operations and entrepreneurial and financial literacy training to over 100,000 refugees and host communities. See: https://www.unhcr.org/afr/events/conferences/5df234214/sida-unhcr-and-grameen-credit-agricole-foundation-join-hands-to-promote.html?query=SIDA.

[81] UNHCR-Egypt-Factsheet_DEC-2024.pdf | UNHCR Egypt

[82] Adapted from: https://www.coe.int/en/web/commissioner/-/europe-can-do-more-to-protect-refugees.

[83] This term specifically refers to the costs incurred by donor countries, members of the DAC, for hosting refugees within their own borders.

[84] https://www.oecd.org/dac/financing-sustainable-development/ODA-2022-summary.pdf.

[85] Adapted from: https://www.coe.int/en/web/commissioner/-/europe-can-do-more-to-protect-refugees.

6.2.1. Global responsibility-sharing: increasing the amounts and sustainability of financial resources

Addressing the intricate challenges of the global landscape requires the wealthiest nations—which are characterized by economic prosperity and political influence—to assume a profound responsibility: safeguarding refugees.

This obligation, grounded in moral, political, and legal imperatives, is reinforced by international conventions that emphasize the shared responsibility for global well-being. Their commitments to human rights, peace, and security necessitate active engagement in resolving crises that transcend geographical boundaries. Failing to act in the face of preventable suffering not only violates legal obligations but also undermines the credibility of the international legal framework. In this network of interconnected responsibilities, it is incumbent upon the wealthiest nations to take the lead, leveraging their power and resources to effect positive global change.

These affluent nations are often directly or indirectly involved in conflicts and climate change that lead to the displacement of individuals. Politically, they occupy a unique position to exert global influence and can proactively engage in conflict prevention and resolution. By empowering international bodies such as the UN and the Security Council, affluent nations can facilitate the enforcement of regulations that promote peace and stability on a global scale. This proactive approach goes beyond addressing the symptoms of displacement and aims to eradicate the root causes of conflicts in vulnerable regions.

Furthermore, there is an increasing trend among Western nations to shy away from hosting refugees within their own borders, instead delegating this responsibility to poorer or middle-income countries. Polls conducted in the UK, France, and the Netherlands revealed that less than 50 percent of respondents supported sharing the burden of refugees, contrasting with 80 percent support in Germany and Italy.[86] This indicates a willingness to assist refugees but a reluctance to accommodate them domestically. A striking illustration of this trend is the recent initiative by the UK government to deport asylum-seekers to Rwanda, an East African country, under the UK-Rwanda agreement.[87] In exchange for this arrangement, the UK provided Rwanda with USD 142 million, covering initial program costs and contributing to economic development projects. Similar strategies can be observed globally, such as the US-Mexico Migrant Protection Protocol and the US-Guatemala "third country safe" agreement, which are characterized as practices aimed at deterring migration from the Global South.[88]

To confront the myriad challenges posed by the global refugee crisis, a multifaceted strategy is essential, grounded in shared responsibility, financial commitment, and ethical governance. Acknowledging their moral, political, and legal obligations, the world's wealthiest nations should play an active role in preventing and resolving conflicts.
The following recommendations outline a pathway to meaningful change:

1. *Enhance Resources:* Undertake a sincere effort to increase ODA to meet the UN target of 0.7 percent of GNI, thereby augmenting the resources available for RAS support (OECD, 2022).
2. *Introduce a Transnational "Destruction Tax":* Implement a pragmatic solution by levying a transnational tax on arms and weapons, aiming to finance a "reconstruction fund" for RAS support. This innovative approach aligns with successful precedents in addressing negative externalities. While this is an intriguing idea, it poses challenges that require the cooperation of arms manufacturers and governments.[89]

The arms industry, generating substantial revenue, significantly benefits from conflicts, with disproportionately high costs borne by civilians and the environment. In 2024, the world witnessed a record-breaking global military expenditure of USD 2.46 trillion, an amount surpassing the year's UN global humanitarian appeal (USD 46 billion)[90] more than 53 times.[91] Notably, the combined revenue generated by the 100 largest arms manufacturers and military services companies globally reached USD 632 billion in 2023.[92] In 2024, global military expenditure reached a record USD 2.46 trillion—more than 53 times the UN's global humanitarian appeal of USD 46 billion for the same year. By contrast, in 2022, military spending was around 42 times

[86] https://www.theguardian.com/news/datablog/2015/oct/30/european-attitudes-towards-refugees-poll-eu.

[87] https://theconversation.com/western-countries-are-shipping-refugees-to-poorer-nations-in-exchange-for-cash-185758.

[88] Ibid.

[89] https://theconversation.com/should-we-tax-arms-manufacturers-to-finance-refugee-resettlement-118698, https://www.visionofhumanity.org/tax-arms-trade-fund-peacebuilding/.

[90] Global Humanitarian Overview 2024: UN launches $46 billion appeal for 2024 as global humanitarian outlook remains bleak [EN/AR] | OCHA

[91] https://www.oxfam.org/en/press-releases/top-five-arms-exporters-hit-yearly-sales-85-billion-9000-people-die-conflict-driven.

[92] World's top arms producers see revenues rise on the back of wars and regional tensions | SIPRI.

higher than the humanitarian appeal, underscoring a widening gap. This trend reflects not only a surge in global military spending, but also a shrinking humanitarian space, as appeals decline in both absolute and relative terms.

A hypothetical 10 percent tax on international arms transactions could yield up to approximately USD 60 billion annually, doubling ODA spending on humanitarian aid in 2022. Managed by a transnational body like the UN or the UNHCR, these funds could support various aspects of RAS, including reconstruction efforts, environmental remediation, and resettlement. By attributing a portion of destruction costs back to arms manufacturers and buyers, the tax aims to rebalance the distribution of costs and benefits associated with warfare.

However, important counterarguments exist against raising the idea of an arms trade tax, beyond the necessary political capital.[93] The pressing nature and gravity of the RAS situation in several countries could act as a catalyst, encouraging progressive voices to champion specific tax proposals. This would shed light on the ethical imperative of addressing the harmful outcomes of arms sales. The growing political momentum within influential entities creates a strategic opening to initiate discussions, paving the way for substantial proposals and, eventually, the implementation of the tax. This momentum is consistent with a wider trend of exploring fiscal measures to tackle the adverse effects of different products, showcasing a dedication to ethical and responsible governance.

3. *Leverage International Partnerships to Incentivize RAS Employment:* Under the umbrella of a responsibility-sharing framework, significant donor nations have the opportunity to extend grants, concessional loans, and favorable trade and investment agreements to specific Egyptian enterprises, contingent upon their commitment to employing a specified number or percentage of RAS. However, this would require legal adjustments to enable RAS to obtain work permits. Despite this requirement, a similar strategy, as demonstrated by the EU-Jordan partnership supporting Syrian refugees (Barbelet et al., 2018), has gained traction in Ethiopia. In this instance, Ethiopia successfully secured substantial external funding to establish new industrial zones, fostering employment opportunities for both local residents and refugees (EU, 2023). The implementation of such initiatives carries the potential to positively influence the social and political environment, contributing to enhanced refugee protection.
4. *Adopt a Sustainable Financial Framework:* A Medium-Term Financial Framework (MTFF) tailored for the evolving needs of RAS would ensure stability and sustainability in financial commitments. This framework, akin to an MTFF, should cover a five-year horizon, offering a medium-range perspective for fiscal planning and managing the evolving needs of RAS (ILO et al., 2023).
5. *Encourage Global Cooperation:* International collaboration is essential in executing these recommendations, fostering a collective effort to mitigate the refugee crisis and uphold the principles of justice and humanitarianism.

6.2.2 Regional responsibility-sharing: unveiling new sources of financing RAS inclusion in the UHIS

In strengthening the collective response to hosting refugees in Egypt, the pivotal role of regional initiatives cannot be overstated. Drawing inspiration from successful models, such as the collaborative efforts of Latin American countries in accommodating Venezuelan nationals, regional cooperation emerges as a promising approach. The World Bank (2023) underscores the effectiveness of Latin American nations, particularly through initiatives like the Quito Process,[94] in formulating a region-wide strategy that ensures uniform national responses amid crises, similar to the EU's successful strategy for Ukrainian refugees. This cooperative approach extends beyond middle- or high-income settings, as evidenced by the Intergovernmental Authority on Development (IGAD) in Africa, which has pioneered a regional peer-to-peer process to enhance refugee management across the Horn of Africa (UNHCR, 2021). These instances highlight the potential of regional collaborations in effectively addressing hosting challenges.

Crucially, regional cooperation and shared responsibility among Arab and Islamic countries gain paramount significance, considering that over 50 percent of the global refugee and internally displaced population hails from nations within the Organization of Islamic Cooperation (OIC).[95] By fostering collaborations in the Arab and Islamic world, nations can synergize resources, expertise, and strategies to more effectively manage refugee situations, ensuring the well-being and dignity of those displaced. This collaborative effort becomes a cornerstone in alleviating the burdens faced by individual countries and contributes to the broader goal of creating sustainable solutions for refugees and internally displaced persons across the Islamic world. As per Development Initiatives (2023), the Kingdom of

[93] https://www.visionofhumanity.org/tax-arms-trade-fund-peacebuilding/.

[94] For more information, see Proceso de Quito (dashboard), https://www.procesodequito.org/en.

[95] https://zakat.unhcr.org/عن-مم-ةصن-اةاكزلا.

Saudi Arabia (KSA) and the United Arab Emirates (UAE) ranked eighth and 11th among the top 20 public donors of humanitarian assistance in 2022, respectively. However, their contributions amounted to USD 0.8 billion (0.09 percent of GDP) and USD 0.4 billion (0.1 percent of GDP), respectively. Only six government donors allocated 0.1 percent or more of their GNI to humanitarian responses in 2022. On the other hand, data from the UNHCR (2023c) reveals that in 2023, KSA and the UAE collectively contributed approximately 0.6 percent to the total contributions to UNHCR funds, with shares of only 0.003 percent and 0.0001 percent of their GDP, respectively. Similarly, Kuwait's contribution accounted for 0.4 percent (0.009 percent of GDP), while Qatar's share was 0.3 percent (0.005 percent of GDP).[96] Evaluating the adequacy of this contribution requires a thorough and impartial assessment, extending beyond the scope of this report.

Zakat (almsgiving), a fundamental tenet of Islam and one of its Five Pillars,[97] emerges as an innovative financing tool with substantial potential to drive positive change and societal welfare. It holds the capacity to support developmental and humanitarian response efforts for refugee crises, addressing critical needs such as food, education, shelter…etc.[98] It is the right of the poor and needy in the wealth and income of the better-off. Zakat is thus mandatory and required of every adult Muslim to fulfill each year of their life as long as they meet a certain threshold (Nisab). The common minimum amount for those who qualify is 2.5 percent of a Muslim's total savings and wealth. From a religious perspective, Zakat extends its support to eight categories of beneficiaries, including the poor, needy, administrators of Zakat, those in bondage, and the wayfarer. The latter, encompassing millions of refugees globally forced to travel due to conflict or coercion, qualifies for Zakat as they find themselves in foreign lands without sufficient means.

Generally, there is a consensus that governments are not obliged to pay Zakat on their assets or resources. However, a debate among Muslim scholars arises regarding Zakat on state-owned oil. This matter was brought up at the First World Conference on Islamic Economics in 1976, held in Makkah, with some advocating for allocating 20 percent of petroleum revenue for Zakat. Nevertheless, this viewpoint was challenged by other participating jurists, asserting that it goes against the consensus of Muslims, which maintains that Zakat does not apply to state funds.[99] Instead, revenues generated from petroleum and subterranean minerals are directed toward public interests, including assisting the poor, needy, and Zakat recipients, making Zakat unnecessary in these cases.[100] Nonetheless, the proposal resurfaced in 2008[101] and 2014.[102] What this paper focuses on is the Zakat pertaining to the funds of sovereign funds, oil companies, and Zakat funds institutions in Muslim countries, distinct from individual Zakat or the debatable state Zakat.

Through a systematic and well-managed approach, Zakat has the potential to establish a sustainable financial solution with enduring effects, reflecting the principles of compassion, charity, and solidarity inherent in the Islamic ethos. Muslims contribute a substantial USD 76 billion annually through Zakat funds,[103] surpassing ODA spending on processing and hosting refugees in 2022 by 2.5 times. This figure could potentially increase to USD 356 billion with reliable and approved mechanisms.[104] Considering the UNHCR's approximate annual budget of USD 7.9 billion to meet the needs of refugees, internally displaced persons, and others under their care, Zakat emerges as a powerful solution to bridge the financing gap.[105] Consequently, efforts to support RAS can be significantly enhanced by harnessing tens of billions of dollars from Zakat funds and directing them towards the most pressing issues of our time. Additionally, ongoing charity (Sadaqah Jariyah)[106]

[96] Author's calculations are derived from contributions documented in the UNHCR (2023c) and GDP data sourced from the World Economics website (https://www.worldeconomics.com/Country-Data/). These contributions encompass aid from both governmental sources and private donors within the respective countries.

[97] Usually estimated at around 2.5 percent of accumulated savings annually.

[98] https://giving.unhcr.org/wp-content/uploads/2023/05/Islamic-Philantrophy-Annual-Report-2023-Arabic.pdf.

[99] https://erej.org/%D8%B2%D9%83%D8%A7%D8%A9-%D8%A7%D9%84%D9%86%D9%81%D8%B7-%D9%88%D8%A7%D9%84%D8%AB%D8%B1%D9%88%D8%A9-%D8%A7%D9%84%D9%85%D8%B9%D8%AF%D9%86%D9%8A%D8%A9/.

[100] Ibid.

[101] https://www.alarabiya.net/articles/2008%2F05%2F26%2F50464.

[102] https://arabic.cnn.com/middleeast/2014/07/17/ali-qaradahji-islamic-finance.

[103] https://www.alarabiya.net/aswaq/economy/2019/04/25/هام-ي-ةجاح-رثك-أل-ا-رس-أل-ل-نيئاجال-ةاكزل-ا-قودن-ص-ةمهاسم؟.

[104] Ibid.

[105] Ibid.

[106] Sadaqah jariyah is a continuous charitable contribution that continues to benefit others over time. Examples include sponsoring children or orphans, constructing schools and hospitals, providing access to water and sanitation for the impoverished, and similar endeavors.

and endowments (Awqaf)[107] represent other potential Islamic social financing instruments that can play a substantial role in addressing the humanitarian needs of the most vulnerable groups, including refugees and internally displaced persons.

While the idea is not completely untapped, there remains room for further development. Recognizing this significant financial resource, the UNHCR designed a fund to serve as a link between Zakat entities and their beneficiaries among refugees and internally displaced persons. The fund, endorsed by 15 fatwas from prominent scholars and institutions globally—including the Muslim World League, the OIC's International Islamic Fiqh Academy (IIFA), and Al-Azhar's Islamic Research Academy—[108] was launched in 2019 following a pilot program in 2017 and 2018. During this period, the UNHCR received approximately USD 14.4 million through the Zakat program, distributed as cash assistance to benefit 6,888 refugee families, mostly Syrian refugees in Jordan and Lebanon.[109]

In 2022, Zakat and Sadaqat funds received by the UNHCR reached almost USD 38.1 million, assisting nearly 1.6 million individuals in 17 countries,[110] including internally displaced persons in Afghanistan, Iraq, Nigeria, Somalia, and Yemen. Since its inception in 2017, Zakat and Sadaqat contributions received by the UNHCR fund have brought relief to over six million vulnerable refugees and internally displaced persons in 21 countries, including non-Muslim minorities displaced from countries with Muslim majorities.[111]

The amounts of contributions received by the UNHCR's Refugee Zakat Fund (RZF) (USD 38 million) remain minimal compared to both the needs of RAS support and the potential funds that can be collected from Zakat (ranging between USD 9.5 billion and USD 44 billion).[112] It seems that the UNHCR's RZF depends mainly on individuals' contributions, competing with a large number of other institutions that collect Zakat and Sadaqat. This might justify the complete lack of information about this fund. In fact, during the numerous in-depth KIIs conducted for this study, not a single mention of this fund was made. This lack of awareness of the existence of this RZF and the reliance on individuals' contributions may justify the minuscule amounts received. Therefore, we believe it would be more effective for the UNHCR to deal directly with the largest of these institutions and secure an agreement by which they provide a committed share to the refugee fund. Notably, the Egyptian Zakat and Sadaqat House has recently started assisting thousands of Muslim and non-Muslim refugees with the contributions received, signaling a positive step toward expanding the role of Islamic Zakat tools in addressing displacement crises in Egypt. However, the vision of utilizing Zakat and Sadaqat as a primary source for financing refugee support schemes remains in its nascent stages.

7. Summary and recommendations

7.1. Key findings

The global refugee crisis is a complex humanitarian, economic, and social emergency, characterized by 114 million refugees and displaced individuals worldwide. Most of these individuals are hosted by low- and middle-income countries, yet only 56 percent of the necessary funding for humanitarian assistance is being met. As of June 2025, Egypt hosts around 929,000 RAS, primarily from Sudan, Syria, and other African countries, with potential increases given the region's growing instability. This situation calls for urgent action to address both RAS' immediate needs and long-term integration and support. A comprehensive and coordinated approach is essential, involving not just humanitarian aid but also economic, social, and policy initiatives.

This study focused on the integration of RAS within Egypt's UHIS program and explored sustainable financing options for its implementation. Despite initiatives aimed at providing equitable healthcare access for RAS in Egypt, they still face significant challenges. These include the potential nullification of existing healthcare agreements with the progressive implementation of the UHIS, financial constraints, and the absence of a clear inclusion plan in national systems.

Public discourse often conflates migrants with RAS despite

[107] Waqf (singular of Awqaf), an Arabic term for assets donated or bequeathed for charitable causes, resembles the Western concept of endowment. It has led to the accumulation of significant societal wealth, supporting various causes such as poverty alleviation, healthcare, education, and heritage preservation. Beyond its religious significance, waqf holds relevance for broader development efforts.

[108] https://zakat.unhcr.org/africa/about-zakat.

[109] https://www.alarabiya.net/aswaq/economy/2019/04/25/مهام-صندوق-الزكاة-للاجئين-السوريين-في-الأردن-وتركيا؟.

[110] The largest recipients are refugees in Afghanistan, Algeria, Bangladesh, Egypt, India, Indonesia, Iran, Jordan, Lebanon, Malaysia, Mauritania, Pakistan, Somalia, and Tunisia. https://giving.unhcr.org/annualreport-2023/

[111] https://giving.unhcr.org/annualreport-2023/.

[112] These amounts represent 1/8 of the estimated USD 76-356 billion contribution from Muslims' Zakat.

their distinct characteristics and needs, which can dilute the rights and protections entitled to RAS under international conventions. Therefore, it is important to make a clear distinction between RAS—having official refugee or asylum seeker status according to the UNHCR—and migrants. Egypt adheres to international conventions such as the 1951 Refugee Convention and the 1967 Protocol, but it has made reservations to certain provisions and has not enacted a comprehensive national asylum law. While RAS have access to some basic services in healthcare and education, their employment opportunities are limited, often pushing them into the informal economy, where social and health insurance schemes are lacking. RAS in Egypt face high unemployment, poverty, and food insecurity, challenges that have been exacerbated by the COVID-19 pandemic and ongoing economic difficulties. In the meantime, the increasing number of RAS has strained resources and funding, with the UNHCR facing significant financial shortfalls, leading to inadequate support for this vulnerable population.

Egyptians benefit from a healthcare system that is a mix of public and private providers. The public sector, managed primarily by MoHP, provides subsidized services; however, OOP expenditures remain high. The HIO offers limited coverage, mainly for formal sector employees. This system suffers from low government spending, high OOP costs, and fragmented insurance schemes, resulting in inadequate financial protection and accessibility issues. Despite improvements in Egypt's health indicators, disparities based on gender, geography, and socioeconomic status persist. In response, the UHIS was introduced in 2018 to provide comprehensive healthcare coverage for all citizens, including subsidies for the vulnerable. Funded through various sources such as premiums, taxes, fees, and government subsidies, the UHIS aims to address these issues. However, it faces significant implementation challenges, particularly in identifying and enrolling informal sector workers and ensuring financial sustainability.

RAS have had access to PHC in public facilities on par with Egyptian citizens since 2014, extending to secondary and tertiary healthcare services, benefiting over 85 percent of RAS. National health campaigns—including those for polio eradication, breast cancer screening, and COVID-19 vaccinations—have included RAS, demonstrating the government's commitment to health inclusivity. Despite these efforts, RAS are excluded from national financial protection mechanisms like the PTES, leading to their reliance on subsidiary schemes provided by UN agencies and NGOs. Notable NGOs like Save the Children and Caritas-Egypt, in collaboration with the UNHCR, provide essential PHC and secondary healthcare services to RAS. However, significant gaps in healthcare access remain due to limited UNHCR resources, leading to a prioritization based on critical conditions. The UNHCR's collaboration with the Egyptian government aims to improve healthcare services for RAS, but operational challenges persist, including high OOP expenses and barriers to chronic disease medication.

As Egypt transitions to the UHIS, RAS face significant challenges. The implementation of the UHIS nullifies existing agreements governing RAS healthcare access, exacerbating their limitations. Article 68 of Law 2 (2018) permits the inclusion of refugees in the national insurance scheme but lacks specific guidelines, delaying their inclusion. Financial constraints further hinder RAS participation, highlighting the need for tailored solutions. The phased implementation of the UHIS offers a gradual pathway for RAS inclusion, with pilot programs providing valuable insights for future integration efforts.

Healthcare models in four host countries—Turkey, Jordan, Lebanon, and Uganda—offer insights into financing, benefits, and integration strategies for RAS. These models highlight that successful integration relies heavily on a combination of comprehensive legal frameworks and substantial international support.

Jordan and Lebanon showcase the role of humanitarian agencies in providing healthcare services amidst limited sustainable resources and high OOP costs.

For example, Turkey's effective integration policy, supported by extensive legal reforms and significant EU funding, ensures that RAS receive healthcare on par with Turkish citizens, improving the health and well-being of RAS while reducing disease transmission and financial burdens. On the other hand, Uganda demonstrates the importance of progressive refugee policies and the inclusion of RAS in national development plans; these strategies improve access to primary healthcare for both refugees and host communities but face sustainability challenges due to underfunded health sectors and reliance on OOP payments. Similarly, Jordan and Lebanon showcase the critical role of humanitarian agencies in providing healthcare services amidst limited sustainable resources and high OOP costs. While Jordan's healthcare system includes RAS with varied access levels based on registration and residency status, Lebanon relies heavily on NGOs and the UNHCR for RAS healthcare, reflecting a highly fragmented system. Both countries face significant barriers to fully integrating RAS into their national health systems, underscoring the need for comprehensive system reforms and enhanced collaboration between governments and international donors to ensure equitable and sustainable healthcare access for RAS.

In general, financial sustainability remains a challenge

in all four countries due to the limited national capacity for sustainable RAS integration. They rely on external humanitarian financing sources, while RAS-related operations are severely underfunded, highlighting the critical role of international funding and collaboration in sustaining healthcare services for RAS. Also, these cases emphasize the importance of robust legal frameworks and shared responsibilities among host countries, donors, and international agencies in integrating RAS into national health programs. Addressing financial, political, and infrastructural challenges, while ensuring global cooperation and the engagement of regional stakeholders to support the health needs of RAS, is essential for long-term success.

In brief, this study highlights several critical findings:

1. *Healthcare Challenges for RAS in Egypt:* Despite efforts by the GoE and various UN agencies, significant gaps remain in healthcare access for RAS. Many refugees prefer private healthcare due to negative perceptions of public facilities, leading to high OOP expenses that strain their financial resources. Chronic diseases pose a substantial burden, with many unable to afford necessary medications.
2. *Legal and Policy Frameworks:* The lack of specific guidelines for RAS inclusion in the UHIS delays their integration. Existing MoUs that govern RAS access to healthcare services are becoming obsolete with the transition to the UHIS, exacerbating the limitations faced by refugees. Moreover, financial constraints further hinder their participation, underscoring the need for tailored solutions.
3. *International Comparisons:* Lessons from countries like Turkey, Uganda, Jordan, and Lebanon reveal the importance of sustainable funding mechanisms and international cooperation. Turkey's integration of RAS into its UHC scheme has improved health outcomes and reduced economic strain. However, countries like Uganda face challenges due to underfunding, highlighting the need for comprehensive support from international donors.

7.2. Recommendations

Addressing the challenges of integrating RAS into Egypt's healthcare services requires a comprehensive strategy. The proposed strategy of including all POCs in the national UHIS has the following features:

- The inclusion of POCs in the UHIS should be based on a policy decision by the GoE to actualize Article 68 of the UHIS bylaws (Decree 909/Feb 2018), which provides room for such inclusion. To ensure comprehensive and equitable healthcare coverage for RAS within the UHIS, continued advocacy with government officials and securing buy-in from all relevant stakeholders are imperative.
- The inclusion in the Phase 1 governorates (2023-25) provides a good opportunity to test all legal, operational, and financial modalities. Therefore, it was agreed with the government to create a technical committee with representatives from different government entities to plan the initial rollout. Depending on these modalities, the operationalization, financing arrangements, and roles of the GoE, the UNHCR, and other partners will have to be adapted.
- For the Phase 1 governorates, an agreement protocol should be issued between the government (representing the UHIA, GAHC, MoHP, and MoF) and the UNHCR to guide the implementation process.
- The technical committee should explore the modalities for key policy decisions, including how contribution rates for POCs will be set, how their income will be assessed, who will cover POCs without contributory capacity, and how vulnerable POCs will be identified for subsidies.
- The UHIS should issue a Health Insurance Card for POCs (with an identifiable number) to access health services in all health facilities, guided by the current practice in Phase 1 governorates. It would be important not to connect the card's validity according to the residency period; otherwise, it would be too hectic for POCs to go through frequent renewal processes.
- It is important to evaluate possibilities for Egypt to assume leadership in the refugee documentation and residence process as well as for the RAS vulnerability assessment. Entrusting the GoE with these processes would centralize responsibilities, thereby consolidating the oversight of registration, the issuance of residence permits, and the administration of service provisions. That way, social protection schemes would be encompassed under a single entity. It could also be advantageous to include the vulnerability assessment in the government-led process and to ensure that vulnerability is assessed with the same criteria as nationals.
- The major concentration of POCs in Greater Cairo governorates (around 77 percent of the POC population) will not benefit from the UHIS until the last sixth phase, which calls for immediate actions to mitigate the current pressing health needs that are resulting in high OOP spending. One measure could be the inclusion of POC school students in the HIO's school health insurance under Law No. 99/1992 (the old insurance scheme).
- Moreover, programs on the national level need to support livelihood opportunities and poverty-reducing measures to enable non-poor POCs to contribute to the UHIS. The engagement of POCs in MoSS and other NGOs' capacity-building and human capital de-

velopment programs that enhance employability and economic self-reliance opportunities should be considered.

The financing of RAS' inclusion in the UHIS should be a joint effort by the international community and the GoE. According to international conventions, protecting refugees and addressing the refugee crisis will need global cooperation and shared responsibility for the well-being of the global community. Therefore, the global community's commitments to human rights, peace, and security necessitate active engagement in resolving crises that transcend geographical boundaries. Affluent nations, often involved directly or indirectly in conflicts or climate-related crises that drive displacement, have a particular responsibility to prevent and resolve such conflicts, thereby addressing root causes. Based on those international commitments, the international community can support the GoE in the inclusion of UHI through the following actions:

- Securing donors' agreement to extend grants to the Egyptian government to subsidize the contributions of vulnerable refugees to be included in the system at par with Egyptians. A special fund can be developed where different donors can contribute to cover vulnerable groups among refugees, with a plan for sustainability.
- A 10 percent transnational tax on arms transactions can be introduced to create a reconstruction fund for refugees, ensuring that those who profit from conflicts contribute to addressing their humanitarian impact.
- Large institutional Zakat Funds, which generate USD 76 billion annually, should be leveraged along with other Islamic social finance tools like Sadaqat and Awqaf to support the essential needs of refugees through structured mechanisms, rather than relying on individual contributions. Donors' agreements to extend grants, concessional loans, and favorable trade and investment agreements to Egyptian enterprises are contingent upon their commitment to employing a specified number or percentage of RAS.
- An MTFF tailored to the evolving needs of RAS should be adopted, ensuring stability and sustainability in financial commitments.
- International collaboration is essential for executing these recommendations, fostering a collective effort to mitigate the refugee crisis and uphold the principles of justice and humanitarianism.

As the hosting government, the GoE should also revisit its global pledges and evaluate possibilities to include RAS in national systems, such as the UHIS, using national funds to ensure sustainability. However, this is expected to occur only over the long term, once all Egyptians have access to the necessary services. In the interim, donor funding can support RAS inclusion, with a gradual transition of financial responsibility to the national government, thereby promoting long-term sustainability.

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Annex List: Key informant interviews

Category	Entities	Suggested Interviewee
Partners	United Nations Children's Fund (UNICEF)	Peter Ragno, Lina Nabarawy, and Ayman Ghaly
	UNICEF Regional Office	Ulugbek Olimov and Hashim Zaidi
	United Nations High Commissioner for Refugees (UNHCR)	Elena Ferrari
		Jacob Arheim
	International Labour Organization (ILO)	Aya Gabr
	World Health Organization (WHO)	Ahmed Yahya Khalifa
	The World Bank	Souraya Al Assiouty and Imane Helmy
		Avril Dawn Kaplan
		Ayodeji Gafar Ajiboye
	Resident Coordinator	Scott Stanley and Anne Poorta
	Ministry of Planning and Economic Development	Reham Rizk
International Donors/Actors	European Union Delegation in Egypt	Marco Migliorelli and Graziella Rizza
	Swiss Development Cooperation	Valerie Liechti
	Center for Social Research and Action	Dr. Marie Noelle Abi Yaghi
	Arab Reform Initiative	Farah Al Shami
	Embassy of Netherlands	Eugenia Boutylkova
	United States Agency for International Development (USAID)	Jason Taylor
Local Donors	Zakat and Sadakat House, Egypt	Dr. Sahar Nasr

Annex Box: Revenue generation strategies: fees and taxation for the UHIS

Fees and Taxation to raise revenue for UHIS

- EGP 0.75 of the price of each pack of cigarettes sold in the local market, whether of local or foreign production, and this amount shall be increased every three years by EGP 0.25 and capped at EGP 1.5
- 10% of the value of any sold tobacco item, other than cigarettes
- EGP 1 for each vehicle on a toll road
- EGP 20 per year when issuing or renewing a driving license
- EGP 50 when issuing or renewing a car license whose engine capacity is less that 1.6L
- EGP 150 when issuing or renewing a car license whose engine capacity exceeds 1.6L and is less than 2L
- EGP 300 when issuing or renewing a car license whose engine capacity is 2 L and more
- EGP 1,000 to EGP 1,500 when clinics, treatment centers, pharmacies, and pharmaceutical companies enter into contract with the UHIS
- EGP 1,000 for each bed when issuing licenses for hospitals and medical centers.
- A solidarity contributions tax of 2/1,000 out of the total of the sole proprietorships and companies, regardless of their nature, line of business, or the legal system they are subject to, as well as the economic public authorities
- 50 percent of the revenues collected in the self-revenues funds in public health facilities
- EGP 5 stamp tax on the applications submitted to the UHIA, HCO, and GAHAR
- Returns of the UHIA investments
- Fees for other services provided by the UHIA other than those provided for under the UHIL
- Foreign and domestic grants and loans concluded by the GOE for the UHIA
- Gifts, aid, donations, and bequests accepted by the UHIA's Board of Directors

Source: UHIL, Policy document

About the Authors

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Nour Khaled Abou-Ismail is a Policy Support Specialist at Food and Agriculture Organization (FAO).

ERF at a Glance: *The Economic Research Forum (ERF) is a regional network dedicated to promoting high-quality economic research for sustainable development in the Arab countries, Iran and Turkey. Established in 1993, ERF's core objectives are to build a strong research capacity in the region; to encourage the production of independent, high-quality research; and to disseminate research output to a wide and diverse audience. To achieve these objectives, ERF's portfolio of activities includes managing carefully selected regional research initiatives; providing training and mentoring to junior researchers; and disseminating the research findings through seminars, conferences and a variety of publications. The network is headquartered in Egypt but its affiliates come primarily from different countries in the region.*

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