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Displacement and Disease: HIV Risks and Healthcare Gaps Among Refugee Populations

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Abstract: Forced displacement exacerbates health vulnerabilities, particularly regarding HIV prevention, diagnosis, and treatment. Refugees often experience heightened exposure to HIV due to precarious living conditions, sexual violence, and healthcare access barriers. Background: Structural inequalities, legal precarity, and stigma hinder HIV care for refugees, especially in resource-limited settings. Excluded from national health prog0rams, refugees often depend on underfunded humanitarian aid. Cultural stigma, limited awareness, and mobility constraints further heighten their vulnerability. Methods: This study draws on a review of peer-reviewed articles, policy documents, and case studies from refugee-hosting countries. It examines healthcare access, service provision gaps, and policy responses to HIV among displaced populations. Results: The article highlights systemic barriers to HIV services, including inadequate testing, inconsistent treatment availability, and cultural barriers to care. Policy frameworks often fail to integrate refugees into national HIV programs, exacerbating health disparities. Conclusions: The exclusion of refugees from national healthcare, compounded by stigma and mobility constraints, deepens health disparities and heightens HIV transmission risks. Without targeted interventions and inclusive health systems, refugees face disproportionate HIV-related morbidity, endangering broader public health in host communities.

Keywords: HIV and refugees; healthcare access; forced displacement; health inequalities

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1. Introduction

Forced displacement due to conflict, persecution, or climate change is a growing global crisis, with over 108.4 million people displaced worldwide as of 2023 [1]. Refugee populations face numerous challenges, including economic instability, food insecurity, and limited access to healthcare, all of which significantly increase their vulnerability to infectious diseases, including HIV/AIDS [2]. The intersection of displacement and HIV transmission is particularly concerning, as displaced populations experience higher rates of HIV infection compared to host communities due to disrupted healthcare access, social instability, and heightened risks of sexual violence and exploitation [3]. Despite international commitments to ensuring universal health coverage, many refugee populations remain excluded from national HIV prevention and treatment programs, exacerbating disparities in health outcomes [4].

While the relationship between migration and health has been well-documented [1], the specific vulnerabilities of refugees in relation to HIV remain underexplored in global health discourse. Refugees frequently live in conditions characterized by overcrowding, inadequate sanitation, and poor healthcare infrastructure, all of which create conditions

conducive to increased HIV transmission and poor health outcomes [5]. Legal barriers, lack of healthcare worker training, and stigma often prevent displaced populations from accessing essential antiretroviral therapy (ART) and preventive measures such as pre-exposure prophylaxis (PrEP) [6].

HIV among refugees is not merely a medical issue but a socio-political and structural crisis. Unlike other vulnerable populations, refugees face compounded risks due to displacement-related stressors, including sexual violence, transactional sex for survival, and lack of reproductive health services [7]. Women and adolescent girls in refugee camps are disproportionately affected, as they often experience gender-based violence (GBV) and coercion, which are strongly linked to increased HIV infection rates [8].

Despite the clear risks, most national HIV/AIDS programs fail to integrate refugees, often due to restrictive immigration and healthcare policies [9]. The exclusion of refugees from ART programs is particularly concerning, as it not only increases mortality rates but also contributes to the emergence of drug-resistant HIV strains due to interrupted treatment [10]. The COVID-19 pandemic has further exacerbated these vulnerabilities, as global disruptions in healthcare supply chains and lockdown measures limited refugee access to HIV testing, treatment, and care services [11].

The intersection of forced displacement and HIV vulnerability presents a critical yet under-explored public health challenge. With over 108 million people forcibly displaced globally, refugee populations face disproportionate health risks due to systemic exclusions from national healthcare systems, legal precarity, and compounded vulnerabilities such as gender-based violence and poverty. These factors create conditions that not only increase HIV transmission but also obstruct access to timely diagnosis and life-saving antiretroviral therapy (ART). Despite the existence of international legal frameworks advocating universal health coverage, in practice, refugees remain marginalized in both policy and service provision. Investigating these structural gaps is essential to foreground refugee health as a human rights imperative and to inform inclusive, sustainable healthcare responses that extend beyond short-term humanitarian aid. This research offers timely insight into a growing crisis that spans global health, migration governance, and international development, and it calls for urgent policy reforms to ensure that displaced populations are not left behind in the global fight against HIV/AIDS.

2. Objectives and Methods

This article addresses critical gaps in understanding and responding to HIV risks among refugee populations. It investigates how forced displacement increases HIV vulnerabilities. It examines the primary barriers to HIV prevention and treatment among refugees. The article evaluates the effectiveness and shortcomings of national and international policies in addressing these risks. To that end, the article aims to contribute to global discussions on refugee health by identifying structural gaps in HIV prevention and treatment services and advocating for policy changes that ensure inclusive healthcare access.

This study takes a multidisciplinary approach, integrating perspectives from public health, migration studies, and global policy frameworks. The analysis is based on peer-reviewed literature, policy reports from WHO, UNAIDS, and UNHCR, and case studies from refugee-hosting regions such as Sub-Saharan Africa, Southeast Asia, and the Middle East. It examines studies on HIV vulnerabilities, access to antiretroviral therapy (ART), and the impact of displacement on health, alongside guidelines from international and national health agencies on HIV interventions for refugees. Empirical research from refugee settings, including Dadaab in Kenya, Cox's Bazar in Bangladesh, and Bidi Bidi in Uganda, provides real-world evidence of challenges and interventions.

The literature search for this study employed a qualitative, multidisciplinary approach to identify and synthesize relevant research on HIV risks and healthcare access

among refugee populations. The search was conducted across major academic databases such as PubMed, Scopus, and Web of Science, using keywords including "HIV and refugees," "healthcare access," "forced displacement," and "structural barriers to HIV treatment." Additional grey literature, including policy reports from WHO, UNAIDS, UNHCR, and relevant government and NGO sources, was also reviewed to capture current policy frameworks and programmatic responses. The selection criteria prioritized peer-reviewed articles and official documents published between 2007 and 2024 that addressed HIV infections in refugee-hosting regions such as Sub-Saharan Africa, Southeast Asia, and the Middle East. To ensure comprehensive coverage, case studies were drawn from countries with significant refugee populations and varying degrees of healthcare integration. The final selection of sources was guided by relevance to the research questions, empirical rigor, and thematic alignment with the conceptual frameworks of structural violence and social determinants of health.

This evidence-based approach seeks to bridge the gap between research and policy, advocating for urgent, inclusive, and sustainable healthcare responses to the HIV infections among refugees. The intersection of displacement and HIV presents a major global health challenge that requires immediate attention. Refugees face unique and heightened risks due to factors beyond their control, yet they are often excluded from national HIV/AIDS programs. As displacement continues to rise worldwide, addressing HIV infections among refugees is not only a public health priority but also a fundamental human rights obligation.

The study utilizes a qualitative review of existing literature, policy reports, and case studies to analyse structural barriers to HIV prevention and care among refugee populations. The review process includes peer-reviewed journal articles on refugee health, migration studies, and global HIV/AIDS policies [5,11]. It also examines international policy documents from organizations like WHO, UNHCR, and UNAIDS, as well as national healthcare frameworks to assess how host countries implement HIV infections care policies for displaced populations. The study also incorporates case studies from major refugee-hosting regions, including Sub-Saharan Africa (Uganda, South Africa, Kenya), South and Southeast Asia (Bangladesh, Thailand, Malaysia), and the Middle East (Lebanon, Jordan, Turkey).

An interpretive approach is adopted to synthesize policy gaps, healthcare access challenges, and structural inequities in the provision of HIV services to refugee communities. The scope of this study is limited to refugee populations in low- and middle-income host countries that face significant displacement-driven public health challenges. Internally displaced persons (IDPs) and stateless populations are excluded, as their healthcare access is shaped by distinct political and legal dynamics. Due to data inconsistencies and underreporting, this research does not include individual-level epidemiological data on HIV prevalence among refugees but instead relies on existing large-scale assessments and qualitative studies.

The study evaluates healthcare policies and service delivery for HIV prevention and treatment through three key lenses. First, it examines policy inclusion versus exclusion by assessing whether refugees are integrated into national HIV/AIDS programs and healthcare coverage. Second, it identifies barriers to access, including legal, financial, and social constraints that prevent refugees from obtaining HIV testing, treatment, and prevention services. Third, it highlights best practices and policy recommendations by analysing successful models of refugee-inclusive healthcare programs, such as Uganda's progressive refugee health policies [12].

This study is motivated by the critical and underexamined intersection of forced displacement and HIV infections, particularly in low- and middle-income host countries. While previous literature has addressed general health disparities among migrants, there

is limited empirical and policy-oriented research that holistically examines how structural barriers—legal, social, and institutional—specifically affect HIV prevention and treatment for refugees. The novelty of this work lies in its integration of structural violence theory, social determinants of health, and the mobility paradox to analyze HIV-related infections in displaced populations across diverse geopolitical contexts. By synthesizing global case studies with a strong conceptual framework, the article not only highlights policy failures but also offers practical models of inclusion (e.g., Uganda, Germany), thus providing actionable insights for stakeholders at the nexus of public health, migration governance, and international human rights.

Limitations of the Methodology

While this study draws from a wide range of peer-reviewed literature, policy documents, and case studies to provide a comprehensive qualitative review, it is not without limitations. Chief among these is the inherent subjectivity involved in interpretive analysis, which relies heavily on the researcher's perspective in selecting, synthesizing, and interpreting existing data. This subjectivity introduces the potential for bias, as the researcher's disciplinary background, positionality, or regional familiarity may influence conclusions. The diverse contexts across refugee-hosting countries limit the generalizability of the findings, given that healthcare access, legal frameworks, and socio-political conditions vary significantly. The lack of standardized data collection across sources further complicates replication and may lead to inconsistencies in identifying structural barriers and policy outcomes. While the study avoids individual-level epidemiological data due to underreporting and ethical constraints, this restricts the granularity of its analysis. Acknowledging these limitations is essential to contextualize the findings and reinforce the need for cautious interpretation and future empirical validation.

3. Conceptual and Theoretical Framework

The complex relationship between displacement, health disparities, and HIV infections among refugees can be analysed through multiple theoretical frameworks. This section draws on structural violence theory [13], the social determinants of health framework, international human rights perspectives [14], and the mobility paradox to critically explore how forced displacement intensifies HIV infections and deepens barriers to healthcare access.

Structural violence, as conceptualized by Paul Farmer (2004) [14], refers to the systemic inequalities embedded in social, political, and economic structures that restrict access to essential resources and opportunities, ultimately leading to disparities in health outcomes. In the context of refugee populations and HIV, structural violence manifests in multiple ways, including restricted healthcare access, exclusionary policies, economic deprivation, and gender-based vulnerabilities. These structural barriers place refugees at heightened risk of HIV infection, while simultaneously denying them the means to seek testing, treatment, and long-term care.

Refugees frequently find themselves in precarious legal situations that prevent them from accessing national healthcare services. As a result, many are unable to receive timely HIV testing or treatment, leading to untreated infections, opportunistic diseases, and increased HIV-related mortality [15,16]. Women in refugee camps or urban displacement settings face additional layers of vulnerability, as they are often subjected to sexual violence, survival sex, and trafficking, all of which contribute to higher HIV transmission rates. For example, research in Kenya's Dadaab refugee camp has shown that economic desperation often forces women and adolescent girls into transactional sex, exacerbating their exposure to HIV [17].

Structural violence operates through several key mechanisms that heighten HIV infections among refugee populations. One major factor is legal and policy exclusion, where host countries often deny refugees access to public health services, including HIV testing and antiretroviral therapy (ART) [18]. Many national healthcare systems prioritize citizens, leaving refugees reliant on underfunded and inconsistent NGO support. In Lebanon, for instance, Syrian refugees have reported being denied HIV-related medical care due to restrictive healthcare policies [19].

Economic barriers further contribute to the crisis, as refugees frequently lack the financial means to afford life-saving medications and preventive healthcare. Many displaced individuals live in extreme poverty, struggling with food insecurity and inadequate shelter. In such conditions, some resort to high-risk coping mechanisms, including sex work, to survive. This has been well-documented in Southeast Asia, where Rohingya refugees in Cox's Bazar camps in Bangladesh face significant challenges in accessing formal healthcare services, leading to undiagnosed and untreated HIV cases [20].

Gender and power asymmetries also play a significant role in driving HIV transmission within refugee settings [21]. Women and girls in displacement camps are particularly vulnerable to coercion, forced prostitution, and intimate partner violence, all of which heighten their risk of contracting HIV [22]. Many refugee communities lack sufficient legal protections against gender-based violence, leaving survivors without access to essential reproductive health services [23]. In Uganda, despite progressive refugee policies, gendered barriers still prevent many displaced women from seeking HIV-related healthcare due to stigma and fear of retribution [24].

In some contexts, the criminalization of HIV and migration status further deters refugees from seeking medical help. In certain countries, HIV-infected migrants and refugees face the risk of deportation, discouraging individuals from undergoing voluntary testing or accessing ART. South Africa, for instance, has been criticized for denying undocumented migrants access to ART, resulting in higher rates of AIDS-related deaths among refugee communities [25].

Empirical studies highlight how these structural barriers result in stark health disparities between refugee populations and their host communities. Research in Sub-Saharan Africa, the Middle East, and Southeast Asia consistently demonstrates that refugees experience disproportionately higher rates of HIV infection due to systemic exclusion from healthcare services [26,27]. In South Africa, undocumented migrants report significant delays in receiving ART, leading to disease progression and increased mortality [28]. Without targeted interventions, these inequalities will continue to deepen, reinforcing a cycle in which displaced populations are disproportionately burdened by HIV while simultaneously being denied the means to prevent and treat the disease.

The social determinants of health (SDOH) framework, introduced by Marmot (2005), [28] provides a useful lens for understanding how economic, political, and social conditions influence HIV infections among refugees. According to the WHO (2022) [4], marginalization, legal precarity, and socioeconomic deprivation are among the strongest predictors of poor health outcomes in displaced populations.

One of the most significant determinants is legal status and healthcare exclusion. Refugees who lack legal documentation often find themselves shut out of national healthcare systems, preventing them from accessing ART and HIV prevention programs [29]. In many countries, proof of legal residency is required for free or subsidized medical services, creating additional barriers for displaced individuals [30]. For example, in Lebanon, restrictive policies prevent Syrian refugees from enrolling in public health programs, forcing them to rely on inconsistent and often inadequate humanitarian aid [31].

Economic marginalization is another major determinant of HIV infection among refugees. Poverty and food insecurity push many displaced individuals into survival

strategies that increase their exposure to HIV. This is particularly evident in regions like Southeast Asia and Sub-Saharan Africa, where limited economic opportunities force refugees into precarious informal labour or high-risk behaviours such as transactional sex. In Kenya's Dadaab refugee camp, economic desperation has led to a rise in sex work, heightening HIV infection among women and adolescents [32].

Social and cultural discrimination also plays a critical role in shaping HIV outcomes. Stigma and fear of discrimination often deter HIV-infected refugees from seeking medical assistance [33]. In many refugee communities, deeply ingrained cultural taboos surrounding sexuality and HIV/AIDS contribute to silence around prevention and treatment, making it difficult for those at risk to access the care they need [34,35]. This issue is particularly prominent in Middle Eastern refugee communities, where conservative cultural norms limit open discussions on sexual health, further exacerbating HIV-related infections.

The case studies illustrate how these social determinants create compounded vulnerabilities for refugees. In Lebanon, for example, Syrian refugees frequently encounter healthcare restrictions that prevent them from obtaining HIV testing and ART, leaving many undiagnosed and untreated [36]. Similarly, in Bangladesh's Rohingya refugee camps, the absence of formal health services has led to significant gaps in HIV detection and treatment [37,38]. These structural determinants make HIV prevention and treatment a significant challenge in refugee settings. Without systemic reforms to address legal, economic, and social barriers, displaced populations will continue to face disproportionate risks of HIV infection and disease progression.

Although there is a substantial body of literature on migration and health, the specific vulnerabilities of refugee populations to HIV—especially in low- and middle-income countries—remain insufficiently addressed in both academic and policy discourse. Most existing studies either treat migrants as a homogenous group or focus narrowly on clinical aspects without adequately exploring the socio-political determinants of HIV risks for displaced individuals. Furthermore, there is a paucity of comparative, regionally grounded analyses that highlight how structural violence, legal exclusion, and fragmented healthcare policies contribute to disparate health outcomes among refugees. This paper fills that gap by providing a systematic, multidisciplinary review of peer-reviewed literature, policy frameworks, and empirical case studies from Sub-Saharan Africa, Southeast Asia, and Europe. It uniquely synthesizes theoretical frameworks such as structural violence, the social determinants of health, and the mobility paradox to demonstrate the multilayered nature of healthcare access barriers. By foregrounding both institutional and community-level responses, the study contributes critical evidence for the development of integrated, rights-based healthcare policies for refugees.

4. International Commitments to Refugee Health

The right to healthcare is recognized in numerous international legal frameworks, yet its implementation remains inconsistent for refugee populations. The Universal Declaration of Human Rights [39] affirms that everyone has the right to medical care, but this principle is often not upheld for displaced communities [40]. Similarly, the WHO Constitution (1946) declares healthcare a fundamental right, yet many refugees experience systematic exclusion from national health systems due to bureaucratic and financial barriers. The UNHCR Refugee Health Guidelines emphasize the obligation of host countries to integrate refugees into HIV prevention and treatment programs, but compliance remains limited in many regions [41].

Despite these legal commitments, many host countries impose restrictions on refugee access to antiretroviral therapy (ART) and preventive healthcare services, citing financial burdens and political concerns [42]). This gap between legal obligations and real-world policy implementation often results in worsening health conditions among refugee

populations. For instance, in Malaysia, where undocumented refugees and asylum seekers are excluded from public healthcare services, many rely on costly private clinics or NGOs for HIV treatment, leading to inconsistent medical adherence [43]. Similarly, in Lebanon, where an ongoing economic crisis has strained public health infrastructure, access to ART for Syrian refugees remains severely restricted.

The mobility paradox describes the tension between forced migration and global health security, particularly in the context of managing infectious diseases [44]. While migration is often framed as a health risk, restricting access to healthcare paradoxically worsens public health outcomes. For example, when refugees are excluded from ART programs, HIV transmission rates increase within both refugee and host communities, exacerbating the overall disease burden [45]. In South Africa, where migrants and refugees often face discrimination in healthcare settings, studies have shown that limited ART access contributes to higher rates of drug-resistant HIV strains, posing a long-term public health challenge [46]. Moreover, policies that criminalize HIV-infected refugees discourage individuals from seeking testing and treatment, further driving the cycle of infection and increasing public health risks.

Addressing the mobility paradox requires inclusive policy approaches. Countries that integrate refugees into public health services have demonstrated better health outcomes. For instance, Uganda has a progressive refugee health policy that allows displaced populations access to the same healthcare facilities as citizens, leading to lower HIV transmission rates among refugees [47]. Cross-border HIV programs, such as those implemented in East Africa, have proven effective in reducing infection rates by ensuring uninterrupted ART access for mobile populations [48]. By applying structural violence theory, the social determinants of health framework, international human rights perspectives, and the mobility paradox, this analysis underscores how displacement exacerbates HIV infections among refugees. The exclusion of refugees from healthcare systems, economic stability, and legal protections perpetuates cycles of HIV transmission.

5. Structural Barriers to HIV Prevention Among Refugees

Refugee populations face immense challenges in accessing HIV prevention, diagnosis, and treatment services due to systemic barriers embedded in national health policies, legal frameworks, social norms, and resource limitations. The intersection of forced displacement and inadequate healthcare policies exacerbates HIV-related infections, resulting in higher transmission rates, delayed diagnoses, and inconsistent treatment adherence [49]. These structural challenges make refugees one of the most at-risk populations for HIV, yet they often remain excluded from national healthcare programs and face multiple obstacles when seeking treatment.

Despite global commitments to universal healthcare, many refugee-hosting countries do not extend HIV/AIDS services to displaced populations. Refugees are frequently classified as temporary residents, preventing them from accessing publicly funded healthcare, including antiretroviral therapy (ART) and prevention programs [50]. For instance, in Lebanon and Jordan, Syrian refugees encounter significant barriers in accessing HIV testing and treatment due to restrictive policies that prioritize citizens over displaced persons. Similarly, in Malaysia, undocumented migrants, including refugees, must pay out-of-pocket for healthcare, making HIV treatment prohibitively expensive and inaccessible for many. Even in South Africa, where HIV policies are relatively progressive, asylum seekers and undocumented migrants report being denied ART in public hospitals, highlighting inconsistencies between policy commitments and implementation.

Because refugees often lack access to national health programs, they rely heavily on humanitarian organizations for HIV care. However, funding for refugee health services is inconsistent, leading to shortages of essential medications and overburdened clinics.

Uganda presents a rare example of an inclusive model, where refugees are integrated into public healthcare services, allowing for more sustainable HIV care [50]. In contrast, Kenya's Dadaab refugee camp frequently experiences ART shortages, leaving patients without life-saving treatment. The dependence on external funding rather than integration into national health systems makes HIV services for refugees fragmented and unreliable.

Legal and institutional constraints further complicate access to HIV care for refugees. Many remain undocumented or exist in precarious legal conditions, preventing them from obtaining healthcare services. Fear of deportation deters undocumented refugees from seeking medical assistance, even when free or subsidized HIV care is available [51]. In Greece and Italy, for instance, asylum seekers often face prolonged delays in obtaining legal status, restricting their access to ART. In some countries, mandatory HIV testing for visa applicants has led to deportations of HIV-infected individuals, discouraging many from seeking help. The lack of legal protection results in healthcare disruptions, increased risk of untreated HIV progression, and higher transmission rates.

Cultural and social barriers also play a significant role in restricting access to HIV care among refugees. HIV-related stigma remains one of the strongest deterrents to seeking diagnosis and treatment. Many refugees come from communities where discussing HIV is taboo, making it difficult to promote prevention and early testing [52]. Fear of social rejection prevents many from seeking treatment, leading to delayed diagnoses and a higher likelihood of complications. Women and LGBTQ+ refugees face even greater risks. Sexual violence in refugee camps is a major driver of HIV transmission, particularly in conflict-affected regions such as the Democratic Republic of the Congo and South Sudan. LGBTQ+ refugees often experience double discrimination—as displaced persons and as sexual minorities—leaving them excluded from HIV services [53]. Without gender-sensitive and inclusive healthcare policies, these vulnerable groups continue to face disproportionately high risks of infection and lack access to appropriate treatment.

Resource constraints in refugee-hosting regions further limit the availability of HIV services. Many camps and settlement areas suffer from inadequate healthcare infrastructure and a shortage of medical personnel. Refugee clinics in Sub-Saharan Africa, for example, often operate with limited ART supplies, forcing medical providers to ration medications. In the Rohingya refugee camps of Bangladesh, healthcare workers report severe shortages of both medical staff and HIV treatment options [53]. Logistical challenges in maintaining consistent ART supplies also contribute to treatment interruptions, increasing the risk of drug resistance. When ART is inconsistent or unavailable, refugees are more likely to develop drug-resistant strains of HIV, making treatment more complex and expensive in the long run.

Mobility presents another significant barrier to continuous HIV treatment for refugees. Many experiences multiple displacements, making it difficult to maintain a stable healthcare routine. Border restrictions and forced repatriations frequently interrupt HIV treatment regimens, leading to higher viral loads and increased transmission risks [53]. South Sudanese refugees fleeing to Uganda, for instance, often experience delays in continuing ART due to bureaucratic and logistical challenges. When refugees lose access to treatment, they become more vulnerable to severe health complications, which in turn increases the public health burden on host countries.

Irregular access to ART also contributes to the rise of drug-resistant HIV strains, a growing concern in many refugee-hosting regions. Those who move between multiple host countries often find themselves without consistent healthcare access, which can lead to treatment failures and AIDS-related mortality [54]. Addressing these barriers requires the implementation of integrated healthcare policies that recognize refugees as part of

national health systems, legal protections that ensure their right to medical care, and sustained international funding to maintain uninterrupted access to ART.

The structural barriers to HIV prevention and care among refugees result in widespread health disparities, untreated infections, and rising transmission rates. Exclusion from national health systems, legal constraints, cultural stigma, resource shortages, and mobility-related healthcare disruptions collectively contribute to severe inequities in HIV treatment. Without urgent policy reforms, refugees will continue to face unnecessary health risks, and the global effort to control HIV/AIDS will remain incomplete.

6. Case Studies of Refugee-Hosting Countries

The provision of HIV prevention, treatment, and care for refugee populations varies significantly across different regional contexts. These variations are shaped by national policies, healthcare infrastructure, legal frameworks, and international humanitarian interventions. This section examines three case studies—Sub-Saharan Africa, Southeast Asia, and Europe—to analyze how different countries address, or fail to address, HIV vulnerabilities among refugees [54]. The comparative analysis highlights key lessons from regional approaches to HIV care for displaced populations.

Sub-Saharan Africa, particularly Kenya and Uganda, hosts some of the largest refugee populations in the world, primarily from South Sudan, Somalia, and the Democratic Republic of Congo. These two countries take markedly different approaches to HIV care for refugees, resulting in contrasting health outcomes [55]. In Kenya, which hosts over 500,000 refugees, most displaced people live in Dadaab and Kakuma refugee camps. Despite having one of Africa's most robust national HIV/AIDS programs, Kenya largely excludes refugees from state-funded HIV services, leaving them dependent on international organizations for care. As a result, refugees in these camps face frequent ART stockouts, inadequate viral load monitoring, and underfunded healthcare facilities. Legal barriers further complicate access to treatment, as undocumented asylum seekers are often denied healthcare subsidies and social services, making HIV treatment financially inaccessible.

Uganda, by contrast, has a much more inclusive approach to refugee healthcare, integrating refugees into its national health system. The country hosts over 1.5 million refugees and provides free HIV testing, ART, and sexual health services in both refugee settlements and national hospitals [55]. Its model includes peer-led interventions, where refugee community health workers provide HIV education and prevention services. Furthermore, Uganda collaborates with international organizations such as UNHCR and NGOs to ensure consistent ART supplies and comprehensive sexual health education. The contrasting models in Kenya and Uganda illustrate that inclusive healthcare policies lead to better health outcomes, while exclusionary policies result in higher transmission rates and treatment interruptions.

In Southeast Asia, Bangladesh and Malaysia have been the primary destinations for Rohingya refugees fleeing persecution in Myanmar. However, their approaches to HIV healthcare provision are limited and largely reliant on humanitarian organizations. Bangladesh hosts over 960,000 Rohingya refugees in Cox's Bazar, one of the world's largest refugee settlements [56]. The government does not officially integrate Rohingya refugees into its national health system, meaning that refugees must rely on NGOs such as Médecins Sans Frontières (MSF) for HIV care. This leads to major gaps in service provision, particularly in ART distribution, HIV testing, and sexual health education. The situation is worsened by reports of high rates of sexual violence among Rohingya women, increasing their risk of HIV transmission [57].

Malaysia, which hosts over 150,000 Rohingya refugees, presents additional challenges due to its legal framework (UNHCR, 2023) [1]. The Malaysian government does not legally recognize refugees, which excludes them from public healthcare, including

national HIV programs [57]. This forces refugees to pay out-of-pocket for treatment, making ART unaffordable for many. Some local NGOs provide HIV testing and treatment subsidies, but these services are inconsistent and underfunded, leading to fragmented healthcare access [57]. Both Bangladesh and Malaysia demonstrate the consequences of limited state intervention in refugee HIV care, where refugees are left to rely on humanitarian organizations that struggle with funding shortages and policy constraints.

In Europe, Germany and Greece offer different models of HIV care for Syrian refugees who have fled conflict in the Middle East. Germany follows a rights-based approach, allowing asylum seekers and refugees access to public healthcare, including free HIV testing and ART upon receiving asylum status. However, challenges remain, particularly due to language barriers, fear of deportation, and administrative delays that prevent timely access to HIV care [58]. Additionally, mental health issues among Syrian refugees, such as trauma-related disorders, contribute to higher-risk behaviors and barriers to HIV prevention.

Greece, as a key entry point into Europe for refugees, faces significant difficulties in providing HIV care due to economic constraints and an overburdened healthcare system [58]. Many public hospitals lack the capacity to serve the large refugee population, leaving many displaced individuals reliant on NGO-run clinics for HIV services. Furthermore, many Syrian refugees in Greece experience ART interruptions due to frequent displacement within the country and restrictive EU migration policies [58]. The comparison between Germany and Greece underscores the importance of a well-funded, asylum-based healthcare model for ensuring refugee access to HIV treatment, while also highlighting the vulnerabilities that arise when healthcare systems are overwhelmed or lack structural support for displaced populations.

These case studies demonstrate that inclusive, government-supported healthcare policies, such as those in Uganda and Germany, significantly improve HIV treatment outcomes for refugees. In contrast, restrictive policies, such as those in Kenya, Malaysia, and Greece, contribute to treatment interruptions, increased HIV transmission rates, and reliance on fragile humanitarian aid networks.

Key lessons from various refugee-hosting countries highlight the importance of policy approaches in ensuring effective HIV care for displaced populations. Full inclusion of refugees in national HIV programs, as seen in Uganda and Germany, leads to better health outcomes by providing stable and consistent access to prevention, testing, and treatment services. In Uganda, over 17,000 refugees receive antiretroviral therapy (ART) across health facilities in refugee settlements, where both refugees and nationals can access healthcare [59]. Similarly, Germany's policies enable refugees and asylum seekers to access HIV services under the same conditions as citizens, promoting equitable healthcare access.

In contrast, countries that rely heavily on non-governmental organizations (NGOs), such as Kenya, Bangladesh, and Greece, often experience fragmented and inconsistent HIV care due to funding uncertainties and service limitations. For instance, in Greece, undocumented migrants have limited access to healthcare, restricted primarily to emergency care until their condition stabilizes, leading to challenges in continuous HIV treatment. This reliance on NGOs can result in variability in service provision, impacting the continuity and quality of care.

Legal recognition also plays a crucial role in determining access to healthcare. In countries like Malaysia and Greece, refugees' ability to receive HIV services is directly impacted by their legal status, with undocumented individuals frequently facing barriers to care. In Malaysia, legal and policy environments have been identified as barriers to accessing health and HIV services for key populations, including refugees, due to restrictive laws and policies [54] (Table 1). Similarly, in Greece, undocumented migrants have

no access to health care except for emergency services, affecting their ability to receive continuous HIV treatment.

Table 1. Lessons from Different Regional Approaches.

Country/Region	Inclusion in National HIV Programs	Primary Barriers	Best Practices
Uganda (Africa)	Full inclusion	Resource shortages	Community-based healthcare
Kenya (Africa)	Exclusion from public programs	Reliance on NGOs *	International partnerships for ART ** supply
Bangladesh (Asia)	Excluded from national programs	Overcrowding, sexual violence	Humanitarian NGO interventions
Malaysia (Asia)	Exclusion due to legal status	Financial barriers	Informal healthcare networks
Germany (Europe)	Full inclusion	Bureaucratic delays, stigma	Free ART for asylum seekers
Greece (Europe)	Partial access	Health system strain	NGO support bridging gaps

* Non-governmental Organization; ** Antiretroviral Therapy.

Compared to earlier studies such as Spiegel et al. (2007) [4] and Abubakar et al. (2018) [5], which emphasized the general health challenges and elevated HIV risks in displaced populations, this article offers a more comprehensive and updated analysis by focusing on structural exclusion within healthcare systems and the consequences of non-integration into national HIV programs. Unlike earlier works that often focused on epidemiological trends, this study employs a socio-political lens to interpret disparities, drawing on more recent policy shifts (e.g., post-COVID disruptions, increasing border securitization). Furthermore, the study goes beyond descriptive accounts by identifying best practices from countries like Uganda and Germany, which contrasts with countries such as Kenya or Malaysia where refugees remain largely dependent on underfunded humanitarian aid. This comparative framing, rooted in contemporary data and a robust theoretical structure, advances existing literature by linking policy design directly to health outcomes and providing grounded recommendations for inclusive healthcare reform.

7. Policy Failures and Missed Opportunities

The intersection of displacement, healthcare access, and HIV risks presents a complex policy challenge at both national and international levels. While organizations such as UNHCR, WHO, and national governments have established frameworks for refugee health, the reality remains one of fragmented coordination, reliance on short-term humanitarian aid, and inconsistent national policies. These gaps in policy and implementation have left millions of refugees without sustainable access to HIV prevention, testing, and treatment services, further exacerbating their vulnerability to the disease.

One of the primary issues in addressing HIV among refugees is the lack of coordination between key international and national stakeholders. While UNHCR plays a critical role in emergency response, providing short-term medical assistance, it lacks the authority to enforce long-term healthcare integration policies in host countries. WHO and UNAIDS advocate for universal health coverage, but the actual implementation of these policies depends on national governments, many of which exclude refugees from public HIV programs [53]. National governments, citing financial constraints and political concerns, are often reluctant to incorporate refugees into their healthcare systems. The disjointed efforts of these actors result in inefficient service delivery, leaving many refugees without continuous or adequate HIV care.

The situation in Lebanon provides a clear example of how the lack of harmonized efforts between UNHCR, WHO, and national governments creates a healthcare vacuum. Lebanon hosts over 1.5 million Syrian refugees, yet the country has no national framework

to integrate them into its public healthcare system [50]. As a result, Syrian refugees must rely on humanitarian aid agencies for HIV treatment, leading to frequent shortages of antiretroviral therapy (ART), a lack of viral load monitoring, and restricted access to preventive measures such as pre-exposure prophylaxis (PrEP) and HIV testing [51]. The failure to establish a unified healthcare strategy has left many HIV-positive refugees without consistent care, increasing transmission risks both within refugee communities and the broader population.

In many refugee-hosting countries, HIV healthcare services remain heavily dependent on international humanitarian aid rather than structural integration into national health systems. This reliance on external funding creates a cycle of dependency, where healthcare services for refugees fluctuate based on donor priorities. When funding is inconsistent, ART availability becomes unreliable, and treatment adherence suffers [48]. Additionally, because many refugee health programs operate separately from national healthcare structures, they fail to build long-term medical capacity within host countries. Without integration into public healthcare, refugees are left vulnerable to abrupt service reductions when humanitarian aid declines.

The case of the Rohingya refugees in Bangladesh illustrates the limitations of an aid-based healthcare model. Nearly one million Rohingya refugees reside in Cox's Bazar, with HIV services primarily provided by international NGOs such as Médecins Sans Frontières (MSF) and the International Organization for Migration (IOM) [47]. While these organizations deliver crucial services, the lack of integration into Bangladesh's national HIV program creates persistent challenges. ART availability fluctuates depending on donor priorities, limiting treatment adherence [53]. Healthcare services are largely confined to refugee camps, making it difficult for urban Rohingya refugees to access HIV care. There are no long-term government-backed HIV prevention programs for Rohingya refugees, increasing future public health risks. Without national-level commitment to healthcare inclusion, refugee HIV responses remain fragile and unsustainable.

Some countries have already demonstrated successful models of refugee health integration. Uganda is widely recognized for its progressive refugee policies, allowing refugees full access to public healthcare, including HIV/AIDS treatment programs. Unlike many host countries that segregate refugee health services, Uganda provides ART through government-run clinics, ensuring treatment continuity and reducing dependency on NGOs [55]. The country also engages refugees in community-based healthcare initiatives, improving HIV awareness and testing rates. Uganda's partnership with WHO, UNHCR, and other international organizations has helped secure stable HIV program funding, avoiding the pitfalls of fluctuating donor support. As a result, Uganda has reported higher ART adherence rates among refugee populations, lower HIV transmission rates in refugee settlements, and a more sustainable, government-led refugee health strategy [57].

Germany also provides a strong example of inclusive HIV care for refugees. As part of its asylum system, Germany ensures full access to ART for all registered asylum seekers. The government funds HIV treatment for refugees, eliminating the risk of service interruptions due to donor dependency [59]. Additionally, Germany's multilingual health services help overcome language barriers, improving access to HIV education and prevention programs [59]. The country's strong collaboration between government agencies, WHO, and local NGOs has created a comprehensive support network for HIV-positive refugees [59,60]. This state-driven approach ensures equitable access to healthcare, improving public health outcomes for both refugees and host communities.

8. Conclusions

The intersection of displacement and HIV risks presents an urgent global health and human rights challenge. Refugee populations, disproportionately affected by structural

violence, legal exclusion, and economic vulnerability, face significant barriers to accessing HIV prevention, testing, and treatment services. Despite international commitments to universal health coverage, many refugee-hosting countries fail to integrate displaced populations into national healthcare frameworks, relying instead on short-term humanitarian aid. This fragmented approach not only exacerbates health disparities but also increases the risk of HIV transmission within both refugee and host communities.

The case studies examined in this article demonstrate that policy decisions play a critical role in shaping health outcomes for refugees. Countries such as Uganda and Germany, which have adopted inclusive healthcare policies, have seen improved ART adherence, reduced transmission rates, and overall better public health outcomes. In contrast, exclusionary policies in Kenya, Malaysia, and Greece have left refugees dependent on underfunded NGO services, resulting in inconsistent treatment access and heightened vulnerability. The structural and legal constraints imposed on refugees, particularly undocumented migrants and marginalized groups such as women and LGBTQ+ individuals, further reinforce cycles of HIV risk and poor health outcomes.

The study presents several fresh findings that contribute to both the migration-health and HIV policy discourse. First, it reveals a consistent pattern of systemic exclusion of refugees from national HIV programs, even in countries with progressive healthcare systems. Second, it documents how such exclusion is compounded by legal precarity, gender-based violence, and mobility-related disruptions in ART access. Third, the study highlights the emergence of fragmented healthcare governance where international aid substitutes rather than complements state responsibility, leading to service inconsistencies. These findings, drawn from case studies across Africa, Asia, and Europe, demonstrate that inclusive, state-led healthcare frameworks—such as those in Uganda and Germany—offer more sustainable and equitable models for HIV care. The paper thus fills a critical gap in the literature by offering a comparative and theoretically grounded understanding of how displacement exacerbates HIV vulnerabilities and how policy integration can mitigate these risks.

Addressing these challenges requires a paradigm shift toward long-term, integrated healthcare solutions. Governments must move beyond emergency aid responses and recognize refugees as a permanent part of their healthcare systems. Sustainable policies, such as the inclusion of refugees in national HIV programs, legal protections against discrimination, and increased international funding for refugee health, are essential steps toward closing the healthcare gap. Without immediate and coordinated action, the global effort to control HIV/AIDS will remain incomplete, leaving millions of displaced individuals vulnerable to preventable illness and premature death. Ensuring equitable access to HIV care for refugees is not just a public health imperative—it is a fundamental human rights obligation.

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Abbreviations

The following abbreviations are used in this manuscript:

HIV—Human Immunodeficiency Virus
AIDS—Acquired Immune Deficiency Syndrome
ART—Antiretroviral Therapy
PrEP—Pre-Exposure Prophylaxis
UNHCR—United Nations High Commissioner for Refugees
WHO—World Health Organization

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