Journal of Pioneering Medical Sciences
Received: April 20, 2025 | Accepted: July 15, 2025 | Published: September 05, 2025
Volume 14, Issue 08, Pages 124-134

DOI https://doi.org/10.47310/jpms2025140816

Health Consequences of Refugee Displacement: A Comprehensive Review of Risks, Barriers and Systemic Challenges

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Abstract **Background:** Refugee displacement, driven by conflict, persecution and human rights violations, poses significant public health challenges. Displaced populations often face adverse living conditions, limited healthcare access and increased exposure to physical and mental health risks. **Methods:** This narrative review synthesizes current literature on the health impacts of refugee displacement. Sources were identified through a targeted search of peer-reviewed journals, international reports and organizational databases, focusing on global refugee health trends, risks and healthcare access barriers. **Results:** Refugees are disproportionately affected by communicable diseases, malnutrition and non-communicable conditions due to overcrowded shelters, disrupted preventive care and strained healthcare systems. Vulnerable groups, including women and children, face elevated risks related to reproductive health, child mortality and poor sanitation. Mental health disorders such as PTSD and depression are widespread, compounded by trauma and limited psychosocial support. Structural barriers-including language, discrimination and financial constraints-further restrict healthcare access. **Conclusion:** The health disparities faced by refugees require urgent, evidence-based responses from host countries, global health organizations and policymakers. Strengthening healthcare infrastructure, ensuring cultural and linguistic inclusivity and integrating refugee needs into national health strategies are critical to achieving equitable health outcomes.

Key Words Refugee, displacement, health disparities, communicable diseases, mental health, healthcare access

INTRODUCTION

Refugee displacement is the involuntary movement of individuals resulting from persecution, armed conflict, violence, or systematic human rights violations. Refugees often face life-threatening conditions in their countries of origin and are compelled to seek safety elsewhere, typically in foreign nations or unfamiliar regions [1]. This displacement exposes them to numerous health challenges, including physical trauma, infectious disease risks and psychological distress. Compounding these issues are poor living conditions in refugee camps or temporary shelters, which further increase the likelihood of disease transmission and mental health deterioration [2].

Most refugees are hosted in low- and middle-income countries, where healthcare systems are frequently under-resourced. The influx of displaced populations places additional pressure on already fragile infrastructure, leading to limited access to healthcare for both refugees and host communities. Barriers such as high out-of-pocket costs, geographic inaccessibility, language differences and discriminatory practices often prevent refugees from receiving timely medical care [3].

Recent data show that global forced displacement reached an unprecedented 122.6 million individuals by mid-2024, including 43.7 million registered refugees-a sharp increase from 35.3 million in 2022. Children now account for 40% of the displaced population [4]. Major countries of origin include Afghanistan and Syria (6.4 million each), Venezuela (6.1 million) and Ukraine (6.0 million), while the ongoing conflict in Sudan has displaced nearly 13 million people, constituting the world's largest current humanitarian crisis [5].

METHODS

This article is based on a narrative literature review, designed to explore and synthesize existing research on the health impacts of refugee displacement. A narrative approach was chosen due to the breadth and complexity of the topic, which spans diverse health domains and refugee populations across various global contexts. The goal was to provide a comprehensive yet accessible overview of the major health challenges faced by displaced individuals, without limiting the analysis to a narrow or purely clinical lens.

Search Strategy and Data Sources

To gather relevant literature, an extensive search was conducted across several academic and public health databases, including:

- PubMed
- Google Scholar
- Scopus
- WHO and UNHCR official publications
- CDC, Médecins Sans Frontières (MSF) and other global health agency reports

In addition, grey literature from international organizations and government health agencies was reviewed to ensure the inclusion of current and context-specific data.

Keywords and Search Terms

The following keywords and Boolean operators were used in various combinations:

- "Refugee health"
- "Displacement AND health outcomes"
- "Refugees AND communicable diseases"
- "Mental health of displaced populations"
- "Access to healthcare for asylum seekers"
- "Non-communicable diseases in refugee settings"
- "Maternal and child health AND refugees"
- "WASH AND refugee camps"
- "Climate change AND displaced populations"

Search filters were applied to prioritize peer-reviewed publications, systematic reviews, policy briefs and epidemiological studies.

Time Frame

The literature reviewed was primarily published between 2015 and early 2025, with a few foundational documents and legal frameworks (e.g., the 1951 Refugee Convention) included to provide historical and legal context.

Inclusion and Exclusion Criteria

Studies and reports were included if they:

- Focused on refugee or forcibly displaced populations
- Addressed health outcomes, health access, or determinants of health
- Were published in English
- Were accessible in full-text form

Excluded materials:

- Studies focused solely on economic or political integration
- Publications without clear relevance to health outcomes
- Duplicates or non-peer-reviewed opinion pieces

Data Extraction and Synthesis

A total of approximately 90 sources were initially identified. After screening for relevance and removing duplicates, 40 key references were selected for detailed review and citation. The information was then categorized thematically (e.g., communicable diseases, maternal health, mental health, barriers to care) to identify recurring patterns, disparities and gaps in the literature. This thematic synthesis informed the structure and content of the article.

RESULTS

Significance of Studying the Health Impact of Displacement

Understanding the health impact of displacement is critical from multiple perspectives:

- **Humanitarian Perspective:** Displacement disrupts access to basic services and healthcare. Identifying these disruptions enables targeted interventions that address the urgent needs of displaced individuals [6]
- **Public Health Implications:** Refugee settlements often lack adequate sanitation, clean water and healthcare access-conditions that amplify the risk of communicable disease outbreaks. Studying these risks informs preventative strategies [6]
- **Mental Health and Psychosocial Well-being:** The trauma of displacement-often involving violence, separation from family and the breakdown of social structures-leads to high rates of mental health issues, including PTSD and depression [7]
- **Health Disparities and Equity:** Displaced populations encounter numerous healthcare access barriers, such as language, cultural misunderstanding and social exclusion. Research helps identify and address these inequities [7]
- **Policy and Advocacy:** Evidence-based insights support the development of inclusive health policies and advocacy efforts that prioritize displaced populations and ensure their integration into health systems [7]

The Right to Health

Health is defined as a complete state of physical, mental and social well-being-not merely the absence of disease. The right to the highest attainable standard of health is universally recognized and must apply equally to displaced populations.

Key elements of the right to health include:

- Its interconnection with other rights, such as access to clean water, adequate food and a safe environment [8]
- The obligation to provide healthcare services without discrimination
- The requirement that healthcare services be available, accessible, acceptable and of high quality

The Sustainable Development Goals (SDGs) reaffirm this right, particularly Goal 3: "Ensure healthy lives and promote well-being for all at all ages." Target 3.8 emphasizes the importance of achieving universal health coverage (UHC) by 2030. UHC encompasses a broad range of services-from disease prevention and treatment to rehabilitation and palliative care-while ensuring financial protection and equitable access to medicines and vaccines [9].

The Right to Health of Displaced Populations

The 1951 Refugee Convention and Its 1967 Protocol: At the heart of international refugee protection lies the 1951 Refugee Convention and its 1967 Protocol. These foundational documents not only define who qualifies as a refugee but also lay out the rights and protections that must be guaranteed to them. Together, they serve as the legal compass for the work of the United Nations High Commissioner for Refugees (UNHCR), guiding how governments should treat individuals who have fled their home countries due to fear, violence, or persecution [1].

Core Principles

One of the Convention's most vital protections is the principle of non-refoulement, which prohibits returning refugees to countries where they may face life-threatening dangers. Beyond this, the Convention ensures access to basic rights like housing, employment and education-key elements that allow displaced people to maintain dignity and rebuild their lives while in exile [1].

Role of UNHCR

The UNHCR, often referred to as the UN Refugee Agency, operates in more than 130 countries worldwide. Its mission extends beyond emergency response-it actively works to protect the rights of displaced individuals and support their access to essential services like healthcare, education and economic opportunities. In doing so, it strives to empower refugees to live not just safely, but with dignity [2].

Recognizing the health vulnerabilities of displaced populations, UNHCR collaborates with national health systems to improve healthcare services in high-need areas. This includes initiatives focused on chronic disease care, mental health services and psychosocial support-especially critical for individuals affected by trauma and instability [3,4].

Determinants of Refugee Health

Health does not exist in a vacuum. For refugees, it is shaped by a complex mix of personal experiences, social conditions and the environment in which they find themselves. Understanding these determinants of health is key to developing effective, compassionate support systems [6]:

- **Socioeconomic Status:** Displacement often results in job loss, interrupted education and poverty. These challenges limit access to nutritious food, secure housing and quality healthcare-all of which are vital for good health
- **Social Support:** A strong community can be a powerful buffer against stress. But refugees frequently experience isolation, both from the loss of their home networks and the struggle to integrate into host societies. This lack of support takes a toll on their mental and emotional well-being [10,11]
- **Access to Healthcare:** Refugees often face formidable obstacles in seeking medical care. Language differences, unfamiliar healthcare systems, cultural misunderstandings and lack of insurance create delays and disparities in treatment [10]
- **Environmental Conditions:** Many live in overcrowded camps or informal shelters where clean water, proper sanitation and safe housing are in short supply. These conditions increase exposure to diseases and make it difficult to maintain basic hygiene
- **Cultural and Language Barriers:** Health beliefs and communication styles vary across cultures. Without interpreters or culturally sensitive providers, refugees may struggle to explain symptoms, follow medical advice, or trust the healthcare system [10]
- **Legal and Policy Frameworks:** The rules set by host countries-regarding legal status, healthcare access and social services-can either help refugees get the care they need or create further hurdles. Supportive policies lead to better health outcomes, while restrictive ones can worsen inequality [11]
- **Trauma and Mental Health:** Many refugees carry invisible wounds from war, violence and displacement. Conditions like PTSD, anxiety and depression are common and often untreated. Addressing these mental health challenges requires not only clinical care but also community understanding and long-term support [10] (Table 1)

Health Disparities Among Specific Refugee Populations

Not all refugee populations face the same health risks. Health disparities refer to the unequal distribution of disease burdens and access to care across different refugee groups, often shaped by a combination of factors such as prior health conditions, trauma, socioeconomic status and barriers in host countries [11,12]. These disparities are deeply rooted in the unique experiences and contexts of each displaced community.

Syrian Refugees

The Syrian conflict has led to one of the largest displacement crises of the 21st century, leaving millions without homes or safety. For Syrian refugees, the health toll has been immense. Years of exposure to war-related trauma have contributed to high rates of mental health disorders, including PTSD, depression and anxiety. Sadly, host countries often lack the mental health infrastructure needed to meet this growing need, which worsens outcomes for affected individuals [13].

Rohingya Refugees

The Rohingya, having fled systematic persecution and violence in Myanmar, now live in overcrowded and

Table 1: Comparative Health Challenges and Barriers Among Major Refugee Populations

Refugee Group	Key Health Issues	Living Conditions	Determinants of Health	Healthcare Access Barriers
Syrian Refugees	• High prevalence of PTSD, depression and anxiety • Rising cases of chronic diseases (e.g., diabetes, hypertension) • Underdiagnosed non-communicable diseases (NCDs)	• Often housed in urban slums or informal shelters • Overcrowding and inadequate sanitation	• Loss of income and social status • Trauma from conflict and displacement • Poor continuity of care	• Limited availability of Arabic-speaking health professionals • Mental health stigma • Fragmented health services
Rohingya Refugees	• Endemic infectious diseases (malaria, cholera, acute respiratory infections) • High maternal and infant mortality • Nutritional deficiencies and stunting	• Densely packed refugee camps (e.g., Cox's Bazar) • Poor water and sanitation infrastructure	• Stateless status limiting rights • Inadequate shelter and hygiene • Restricted mobility and aid dependency	• Severe shortage of health facilities • Cultural/language disconnect with providers • Limited reproductive care
South Sudanese Refugees	• Acute malnutrition, especially in children • Tuberculosis and malaria outbreaks • Undiagnosed mental health conditions	• Tented settlements in under-resourced host regions (e.g., Uganda, Sudan) • Unsafe water sources and limited latrines	• Displacement due to protracted civil war • Disrupted education and social structures • Food insecurity	• Geographic isolation • Lack of trained health personnel • Low health literacy and outreach

unsanitary camps, primarily in Bangladesh. These harsh conditions have made them especially vulnerable to infectious diseases such as malaria**,** respiratory infections and diarrheal illnesses. Reproductive and maternal healthcare is severely limited, contributing to elevated maternal and child mortality rates, making health outcomes particularly dire for women and children [14].

South Sudanese Refugees

Displacement due to ongoing conflict has forced thousands of South Sudanese into refugee status, many of whom face chronic malnutrition, especially among children. Stunting and wasting are alarmingly prevalent. Furthermore, communicable diseases like malaria and tuberculosis are widespread, largely due to poor sanitation and lack of access to clean water. These conditions compound health risks and strain already limited health services in host regions [15].

Impacts of Refugee Displacement on Health

Housing Barriers and Living Condition Challenges: Where and how refugees live significantly impacts their health. Many displaced people reside in makeshift shelters, informal camps, or detention centers for extended periods. These dwellings often lack ventilation, are overcrowded and provide little protection from the elements. Such conditions contribute to the spread of respiratory illnesses and other infectious diseases while also affecting mental health due to stress and lack of privacy [16].

Access to Safe Drinking Water and Sanitation

Basic resources like safe drinking water remain out of reach for many refugees. Problems such as poor maintenance of water sources, long travel distances and misperceptions about water safety put individuals at risk of consuming contaminated water. Inadequate chlorination and storage facilities further worsen the situation [17].

Sanitation facilities, where available, are often overused or poorly maintained. This is especially dangerous for women and girls, who face increased risks due to the lack of gender-specific toilets**.** Privacy, safety and hygiene are daily challenges in many refugee settings [17].

Water, Sanitation and Hygiene (WASH) Interventions

To combat hygiene-related health risks, WASH programs aim to provide clean water, improve sanitation and encourage hygiene practices. Despite these efforts, handwashing facilities and hygiene supplies are often limited. The high population density in camps makes it difficult to maintain hygienic conditions, which in turn heightens the risk of disease outbreaks, particularly among children and immunocompromised individuals [17].

Traumatic Injuries

The journey of displacement is often fraught with danger. Refugees may face violence, landmines, or unsafe travel routes that lead to traumatic injuries. Unfortunately, healthcare systems in many host countries lack the capacity to provide immediate care or follow-up services like rehabilitation**,** prosthetics, or physiotherapy. For many, this means prolonged suffering and lasting disability [16]. In resource-limited environments, these critical services remain inaccessible [11].

Communicable Diseases

Transmission of Infectious Diseases: Living in close quarters without adequate sanitation creates the perfect storm for the rapid spread of infectious diseases.

Refugee camps often lack proper waste disposal, clean water and preventive healthcare, which together contribute to a high burden of communicable illnesses [18].

Respiratory Infections

Respiratory illnesses-such as tuberculosis (TB), influenza and other acute infections-are especially common in crowded shelters with poor airflow. Delayed access to medical treatment and lack of screening contribute to the severity and spread of these diseases [19].

Diarrheal Diseases

Diseases like cholera, typhoid and dysentery are widespread in camps where clean water is scarce and waste management is poor. Young children are particularly vulnerable, with diarrheal diseases remaining a leading cause of preventable death [19].

Vector-Borne Diseases

Conflicts and displacement often interrupt vector control programs, which leads to the resurgence of illnesses such as malaria, dengue fever and leishmaniasis. Refugee settlements-particularly in tropical regions-can become breeding grounds for disease-carrying mosquitoes. Alarmingly, studies show that malaria prevalence among refugee children can be more than twice that of local children in nearby communities [18,19].

Vaccine-Preventable Diseases (VPDs)

Children affected by forced displacement are especially vulnerable to vaccine-preventable diseases (VPDs). In the chaos of migration, routine immunizations often get interrupted or skipped entirely. Diseases such as measles, polio and tuberculosis (TB), which had been controlled or eliminated in some regions, are now re-emerging in displaced populations. For instance, Syria, once free of polio since 1999, witnessed a resurgence of the disease in 2013 following mass displacement and the breakdown of vaccination infrastructure [18].

Inadequate Vaccination Coverage and Limited Preventive Measures

Vaccination rates among refugee populations remain dangerously low, exposing both displaced individuals and host communities to disease outbreaks. Several factors contribute to this gap: vaccine hesitancy, lack of access to health services, fragile health systems and logistical issues like cold chain failures. Surveillance systems in refugee settings are often weak, making it harder to track and respond to disease outbreaks in time. Resource constraints further limit the scope and effectiveness of preventive healthcare [19].

Non-Communicable Diseases (NCDs)

While much of the focus in refugee health revolves around infectious diseases, non-communicable diseases (NCDs) such as diabetes, hypertension and cancer present an equally serious but often overlooked threat. Displacement severely disrupts the continuity of care required for NCD management. Refugees frequently lose access to medication, treatment facilities and trusted healthcare providers, resulting in poor disease control and rising healthcare costs [20].

Diagnosis and screening for NCDs are rare in refugee settings, leading to missed opportunities for early detection and intervention [40]. Many healthcare systems serving refugees are geared toward emergency or acute care, leaving chronic conditions unaddressed [21]. On top of that, poverty, stress, trauma and limited education elevate the risk of NCDs. Cultural differences and low health literacy make disease management even more difficult, as refugees may struggle to understand or trust the care they receive [42,43].

Malnutrition and Food Insecurity

Food insecurity and malnutrition are daily realities for many refugees. With limited access to nutritious food, displaced families often survive on diets lacking in essential vitamins and minerals. This leads to micronutrient deficiencies, poor growth in children and weakened immune responses across all age groups [22].

The most vulnerable groups-children, pregnant women and nursing mothers-bear the brunt of food scarcity, facing long-term health and developmental risks [22]. Inadequate sanitation compounds the problem, as waterborne illnesses reduce nutrient absorption and worsen malnutrition [23]. Infrastructure challenges, such as poor food storage and transportation, disrupt food delivery. Additionally, cultural preferences and unfamiliarity with food aid contents can limit dietary intake [23].

Maternal and Child Health

For refugee women, the journey through displacement can be especially perilous when it comes to reproductive health. Many experience unintended pregnancies due to unmet contraceptive needs and lack access to antenatal care because of resource shortages, language barriers, or remote locations [24].

Even when care is available, it is often inconsistent. Services like prenatal screenings and skilled birth assistance are limited, putting both mothers and newborns at risk [25]. Postpartum care is rarely prioritized and in many cases, refugee women's overall maternal health outcomes are worse than those of host populations [25]. Privacy concerns and a lack of access to menstrual hygiene resources further compromise their dignity and well-being [25].

Child Mortality, Growth and Development

The health and development of children in refugee communities face serious threats. High rates of child mortality persist due to poor nutrition, limited medical care and exposure to unsanitary conditions [24,25]. Malnutrition and inadequate infant feeding practices impair immune function and hinder physical growth [24,25].

The risk of waterborne illnesses from unsafe drinking water and poor sanitation is particularly dangerous for young children, whose developing systems are less equipped to fight infections. Refugee camps also facilitate the rapid spread of infectious diseases, compounding these threats [24,25].

Beyond physical health, children's cognitive and emotional development is severely affected. The absence of early childhood education programs, along with language barriers, discrimination and the emotional trauma of displacement, undermines their ability to learn, socialize and thrive. These early setbacks can carry lifelong consequences [24,25].

Mental Health Impacts of Refugee Displacement

The mental toll of displacement is often as profound as its physical effects. Refugees experience significantly higher rates of mental health disorders than the general population, largely due to the trauma of conflict, forced migration and the uncertainty that follows [26]. Among the most common conditions are post-traumatic stress disorder (PTSD), depression, anxiety and a range of somatic symptoms that reflect the psychological burden on the body.

PTSD is particularly widespread, triggered by direct exposure to violence, war, or persecution. It can manifest in debilitating ways-flashbacks, nightmares, emotional numbness and severe distress in response to reminders of past trauma [26]. Depression and anxiety are also prevalent, often tied to the loss of loved ones, displacement from home and the uncertainty of the future [27].

Some refugees endure complex trauma, resulting from repeated traumatic experiences over time. This can lead to deep emotional challenges, including difficulties with self-worth, relationships and emotional regulation [27]. Comorbid conditions, such as PTSD co-occurring with depression or anxiety, are common and make diagnosis and treatment more complicated. Yet, many refugees suffer in silence-stigma, language barriers and cultural taboos often discourage people from seeking mental health support [60].

At the same time, protective factors such as community resilience, social connection and access to culturally sensitive support systems can foster emotional recovery and better outcomes [27].

Impact on Children and Adolescents

For refugee children and adolescents, the effects of displacement are often compounded. In addition to the trauma they may directly experience, many are deeply affected by the emotional struggles of their parents or caregivers [28]. This secondary exposure can lead to PTSD, anxiety, depression and behavioral symptoms such as aggression, withdrawal, or emotional instability [28].

Displacement can also derail key developmental milestones. Children may experience delays in language acquisition, cognitive growth and social-emotional development [29]. Interrupted schooling, language barriers and social exclusion contribute to academic difficulties and low self-esteem. In more severe cases, children may experience self-harm or suicidal ideation, particularly when chronic stress goes unaddressed [29].

Social Health Problems of Refugee Displacement

The social fabric of a refugee's life is often torn apart by displacement. The loss of home, identity and community has lasting effects on emotional and psychosocial well-being. Trauma, grief and cultural dislocation are widespread, leaving many refugees struggling to adapt to new environments [30].

Learning new societal norms while facing language barriers, discrimination and social exclusion can lead to feelings of isolation and alienation. This is especially true for those who arrive without family or community support. Many experience family separation, compounding the psychological strain and further impeding resettlement and recovery [30].

Violence

Refugees-particularly women and girls-face heightened exposure to violence, including sexual and gender-based violence (SGBV). This can occur during transit, within camps, or even in host communities [31]. Beyond SGBV, refugees may also experience interpersonal violence, hate crimes, discrimination and exploitation, especially if they are minors or undocumented [32]. Importantly, male survivors, including boys and men, are often overlooked and sexual violence against them remains significantly underreported due to stigma and cultural taboos [33].

Substance Abuse

In the face of prolonged stress and limited support, some refugees turn to substance use as a coping mechanism. Alcohol, tobacco and other substances may offer temporary relief but often worsen long-term mental health outcomes. The stress of resettlement, cultural displacement and social isolation all contribute to substance misuse [35]. Additionally, peer influence, lack of community structures and normalization of substance use in difficult settings can exacerbate the problem [36].

Barriers to Healthcare Services

Despite pressing health needs, many refugees are unable to access the care they require. Legal barriers, such as immigration status or documentation requirements, often

block entry into national health systems [37]. Language and cultural differences further complicate communication between healthcare providers and refugees, leading to misunderstandings or misdiagnoses.

Financial constraints and the absence of health insurance are major obstacles, particularly in low-resource settings. For those living in remote or overcrowded camps, the nearest health facility may be hours away, making care physically inaccessible. Additionally, discrimination and stigmatization in healthcare environments discourage many refugees from seeking help, especially for mental or sexual health concerns [37].

Weather Extremes and Health Challenges

Refugees often live in environments that leave them vulnerable to extreme weather events, which significantly impact health and survival. During heatwaves, poorly ventilated shelters and a lack of cooling systems expose displaced people to heat-related illnesses, especially the elderly, children and those with chronic conditions [38].

In colder climates, inadequate housing, insufficient clothing and poor insulation make refugees susceptible to cold-related conditions, such as hypothermia and respiratory infections [38]. Flooding and severe storms, which are becoming more frequent due to climate change, can destroy shelters and contaminate water sources, heightening the risk of waterborne diseases. These environmental stressors can also intensify mental health challenges, triggering trauma from previous disasters or loss [38].

Occupational Health of Refugees

For many refugees, survival in a new country depends on taking whatever work is available-even if it puts their health and safety at risk. Refugees frequently find employment in the informal sector, where job protections are minimal or nonexistent. These so-called "3D jobs"-dirty, dangerous and demanding-are often physically hazardous and mentally taxing, with few legal safeguards in place [40].

In these environments, workers face a high risk of injuries, toxic exposure, exploitation and chronic stress. Language barriers and unfamiliarity with local labor rights make it difficult for refugees to report unsafe conditions or advocate for fair treatment [39]. Access to occupational health training, protective equipment and workplace healthcare services is limited, placing refugees at a greater risk of harm compared to native workers [39,40].

Health Management for Refugee Populations

Effectively managing refugee health requires a coordinated and compassionate response-one that addresses both immediate needs and long-term well-being. This responsibility is shared across governments, non-governmental organizations (NGOs), international agencies and host communities. A successful approach depends on integration, accessibility and cultural sensitivity.

Healthcare Systems and Services

Refugees receive care through a variety of channels-refugee-specific clinics, mobile medical units and ideally, integration into the host country's national health system. The World Health Organization (WHO) and UNHCR play leading roles in offering guidance, funding and technical support to ensure that healthcare services reach displaced populations [41,42].

However, many systems struggle to meet demand. Language differences, shortages of trained professionals and resource limitations continue to hinder service delivery. Expanding culturally competent care and investing in healthcare infrastructure remain critical to meeting refugee health needs [41,42].

Preventive Care and Disease Control

Prevention is a cornerstone of refugee health. Vaccination campaigns, sanitation improvements and public health education are essential to reducing the spread of disease in overcrowded settings. Robust disease surveillance systems help detect and respond quickly to outbreaks like cholera or malaria. Vector control, clean water access and nutritional programs also play a vital role in prevention [41,42].

Mental Health Support

Mental health is often overlooked in crisis response, but for refugees, the psychological wounds of conflict, displacement and loss run deep. Access to trauma-informed care, counseling services and community-based psychosocial support can significantly aid recovery. Yet, such services remain underfunded and understaffed especially in emergency settings [43,44]. Reducing stigma, training local providers and scaling up accessible interventions are key priorities.

Chronic Disease Management

Non-communicable diseases (NCDs), such as hypertension, diabetes and cardiovascular illness, are common among adult refugee populations. But access to regular screenings, medications and long-term management plans is often inadequate. Health systems in refugee settings are typically focused on acute or infectious conditions, leaving chronic disease care underdeveloped. Integrating NCD services into primary care can greatly improve health outcomes and reduce long-term complications [41,44].

Emergency and Humanitarian Response

In the wake of war, natural disasters, or sudden displacement, emergency medical care can mean the difference between life and death. Humanitarian response teams deliver first aid, maternal care, child health support and disease prevention in the critical first days and weeks.

Table 2: Thematic Summary of Refugee Health Issues, Barriers and Intervention Priorities

Health Domain	Key Issues	Common Barriers	Recommended Interventions
Communicable Diseases	• Tuberculosis, malaria, respiratory infections, diarrheal diseases • Vaccine-preventable outbreaks (measles, polio, hepatitis)	• Overcrowded camps and poor sanitation • Limited immunization coverage • Inadequate disease surveillance	• WASH (Water, Sanitation, Hygiene) infrastructure • Mass vaccination campaigns • Strengthening infectious disease surveillance systems
Non-Communicable Diseases (NCDs)	• Diabetes, hypertension, cardiovascular diseases • Limited continuity of care • Undetected cancers	• Disrupted treatment due to displacement • Inadequate screening and diagnostics • Shortage of NCD-trained providers	• Integrate NCD care into primary healthcare • Supply essential medications • Train providers in low-resource NCD care
Nutritional Health	• Acute and chronic malnutrition • Micronutrient deficiencies • Poor maternal/child nutrition	• Food insecurity • Inadequate access to diverse diets • Weak infant feeding support	• Nutritional screening and supplementation • Support programs for mothers and children • Culturally appropriate food aid
Mental Health	• PTSD, depression, anxiety • Emotional distress in children • Stigma and underreporting	• Cultural stigma • Language and trust barriers • Shortage of trained professionals	• Community-based psychosocial services • Culturally sensitive mental health campaigns • Trauma-informed counseling
Maternal and Child Health	• Limited antenatal/postnatal care • High child mortality • Poor reproductive health access	• Lack of skilled birth attendants • Infrastructure shortages • Menstrual hygiene barriers	• Mobile maternal health clinics • Train midwives and community health workers • Improve access to contraceptives and maternal hygiene supplies
Social and Occupational Health	• Sexual/gender-based violence (SGBV) • Child exploitation • Unsafe working conditions	• Legal status uncertainty • Social exclusion and discrimination • Hazardous informal labor	• Legal protection for refugee workers • Community awareness programs • SGBV protection and reporting mechanisms
Access to Health Services	• Inequitable access • Service fragmentation • Discriminatory practices	• Language and cultural barriers • Lack of insurance/financial protection • Geographical inaccessibility	• Integration into national health systems • Interpreter and translation services • Inclusive health policy development
Environmental & Climate Health	• Heat-related illness, hypothermia • Waterborne disease outbreaks • Health infrastructure damage due to flooding	• Poor shelter design • Lack of early warning systems • Environmental exposure in camps	• Climate-resilient shelters • Seasonal health response planning • Disaster risk reduction in refugee settings

Effective coordination among government bodies, NGOs and international partners ensures that care reaches the most vulnerable populations. Innovative tools like mobile clinics and telemedicine are increasingly used to bridge access gaps in remote areas [44] (Table 2).

DISCUSSION

This review highlights the multifaceted health challenges faced by refugees globally, drawing attention to critical gaps in healthcare access, systemic inequalities and the need for comprehensive, context-sensitive responses.

Key Findings and Cross-Cutting Themes

Refugees consistently experience a disproportionate burden of both communicable and non-communicable diseases (NCDs), compounded by barriers to care rooted in legal, cultural and structural inequalities. Communicable diseases such as tuberculosis, malaria and diarrheal infections are widespread in overcrowded and poorly sanitized refugee settlements, especially among the Rohingya and South Sudanese populations [14,15,18]. At the same time, NCDs-typically overlooked in emergency settings-are increasingly affecting refugee populations due to disrupted care pathways, limited screening and poor access to long-term medication [20,21].

Mental health emerged as a cross-cutting theme, with nearly all refugee populations-adults and children alike-exhibiting elevated levels of Post-Traumatic Stress Disorder (PTSD), depression and anxiety due to exposure to violence, displacement trauma and socio-environmental stressors [26-28]. The stigma surrounding mental illness, compounded by a lack of culturally competent care, often leaves these needs unmet [10,27].

Social health determinants-particularly poverty, poor nutrition, exposure to violence and discrimination-interact with legal status and living conditions to shape health outcomes [6,10,30]. Additionally, climate extremes (e.g., floods, heatwaves) disproportionately affect refugees living in fragile shelters, intensifying both physical and mental health risks [38].

Contradictions and Gaps in the Literature

Despite an abundance of literature describing refugee health challenges, few studies offer comparative analyses across

different regions or populations, limiting generalizability. Some research, particularly in high-income settings, suggests improved health outcomes due to better resources [13,27]; however, this contrasts with data from refugee camps in low- and middle-income countries, where care remains limited and infrastructure strained [15,17,18].

Furthermore, mental health needs are well-documented, yet few interventions are scaled or sustained, pointing to a disconnect between evidence and implementation [21,27]. There is also inconsistency in measuring health outcomes, with some studies using clinical assessments while others rely on self-report data, leading to variability in findings [12,13].

Policy Implications

A central theme emerging from this review is the need for integrated, equitable and culturally responsive health systems. Refugee health must be embedded into national healthcare strategies to ensure universal health coverage as outlined in SDG 3.8 [9]. This includes strengthening health infrastructure, training healthcare providers in cultural competency and ensuring legal access to health services regardless of refugee status [6,11,42].

Public health strategies must also extend beyond infectious disease control to address chronic illness, maternal and child health and mental well-being. Mental health services must be decentralized, community-based and culturally adapted [21,27]. Water, sanitation and hygiene (WASH) services, nutritional programs and shelter resilience should be prioritized in humanitarian settings [17,22,38].

Moreover, occupational protections for working refugees are urgently needed to address exploitative labor practices and ensure workplace safety, especially for those in informal and precarious employment [39,40].

Bridging Evidence and Action

This review reinforces the urgent need for evidence-based, rights-centered policy frameworks that recognize health as a human right for all-including displaced populations [8]. Health strategies must account for the full continuum of care-from emergency response to chronic disease management-and prioritize inclusivity, dignity and equity.

Building sustainable health systems for refugees is not only a humanitarian imperative but a public health necessity. Coordinated action across governments, international agencies and local actors is vital to ensure that no refugee is left behind.

CONCLUSIONS

In conclusion, this review underscores the urgent and complex health challenges faced by refugee populations globally, encompassing communicable and non-communicable diseases, mental health disorders, malnutrition, reproductive health issues and social vulnerabilities. These challenges are deeply intertwined with structural barriers such as limited healthcare access, legal restrictions, cultural differences and fragile living conditions. Refugees are often forced to navigate broken systems while coping with the lasting impacts of trauma, displacement and poverty. Despite international legal protections and growing recognition of the right to health, significant gaps persist in service delivery, data availability and policy responsiveness. Addressing these issues requires a coordinated, rights-based and context-sensitive approach that integrates refugees into national health systems, promotes culturally competent care and prioritizes mental health and chronic disease management alongside emergency response. Strengthening health infrastructure, investing in inclusive research and advancing equitable health policies are essential to ensure that refugee health is not treated as an afterthought but as a critical dimension of global public health and human dignity.

Recommendations

- Strengthen healthcare infrastructure and services in regions with large refugee populations to ensure capacity and quality
- Provide comprehensive health screenings on arrival to detect and treat health conditions early
- Develop mental health programs that are trauma-informed, culturally sensitive and easily accessible
- Improve access to care by addressing systemic barriers such as language, transportation and discrimination.
- Support evidence-based policy through ongoing research into refugee health needs and outcomes

Limitations

While this review synthesizes a broad spectrum of existing literature on refugee health, several limitations must be acknowledged. First, the availability and quality of data across regions and refugee populations vary significantly, with many studies relying on small sample sizes, self-reported outcomes, or outdated statistics. This limits the generalizability and comparability of findings. Second, there is a risk of publication bias, as studies with significant results or from more visible humanitarian crises are more likely to be published and cited, potentially overshadowing less-documented contexts. Third, there are notable gaps in refugee-specific health research, especially regarding non-communicable diseases, occupational health and long-term mental health outcomes. Research focusing on marginalized subgroups, such as persons with disabilities or LGBTQ+ refugees, also remains scarce. These limitations highlight the need for more inclusive, longitudinal and methodologically rigorous studies to guide evidence-based interventions for displaced populations.

Conflicts of Interest

The author declares no conflict of interest. This review was conducted independently, without any personal, financial, or

institutional relationships that could be perceived as influencing the interpretation or presentation of findings.

Ethical Statement

As this study is based solely on a review of publicly available secondary literature, no human participants were involved and therefore, ethical approval was not required. Nonetheless, the review adheres to ethical scholarship standards by appropriately crediting all sources, avoiding plagiarism and critically engaging with the literature in a fair and unbiased manner. Care was taken to ensure that no content misrepresents the original studies or undermines the dignity and experiences of refugee populations discussed.

Acknowledgement

The authors extend their appreciation to Deputyship for Research and Innovation, Ministry of Education in Saudi Arabia for funding this research work through the project number "NBU-FFR-2025-210-02".

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