

Neglected and Unscreened- Rising Burden of Hepatitis in Refugee Settings and Internally Displaced Populations

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Doi: <https://doi.org/10.5281/zenodo.22300466>

Received: 05 July 2026

Accepted: 15 July 2026

Abstract

Large scale, often protracted outbreaks caused by Hepatitis E Virus (HEV) infection in refugee and internally displaced person (IDP) settlements and camps have occurred, particularly in sub-Saharan Africa, South-East Asia, the Middle East and parts of Central America. HEV is a common etiology of viral hepatitis worldwide. This paper is an amalgamation of two very important aspects of human life, since, the paper focuses on the medical challenge posed by hepatitis-E to displaced populations and refugees. This concern has emerged from the several conflicts in the world mentioned in different WHO reports. Some of the conflicts where refugees faced medical negligence in Yemen, Lebanon, Iraq and Syrian Arab Republic. Hepatitis, otherwise known as a silent killer becomes even more difficult to handle in case of refugees and IDPs since, the situation might not provide for any facility or resources and the population is truly weak and vulnerable on all standards. This paper is an attempt to highlight the innovative approaches that doctors may use to unburden the refugees and IDPs of Hepatitis.

Keywords: - Hepatitis B, Refugees, Internally Displaced Persons, Health Rights

Introduction: -

According to UNHCR's report there are 68.7 million IDPs and 35.6 million are refugees by the end of 2025. Most of such population arises from conflicts in countries like Ukraine, Venezuela, Syrian Arab Republic and Sudan etc. It is well understood that living conditions of these people are poor with an unfortunate addition of even poorer health care. Further due to inappropriate living conditions and insufficient resources, possible risk factors contributing to hepatitis B, like, unsafe injections, low immunization coverage, mother-to-child transmission get increased. World Health Organization (WHO) is actively engaged for the health care of refugees and IDPs, however, the most noticeable health concerns are the ones which are most observable. The problems like HEV, have all the probability of getting skipped and remain untreated due to its silent nature. Consequently, there is very little dedicated work done on the aspect of HEV prevalence amongst refugees and IDPs. This article is

dedicated to the idea that vulnerable populations such as refugees must be studied as an important group so that global efforts can be made to eliminate hepatitis B.

Main Review: -

There is no single global dataset reporting annual hepatitis cases specifically among refugees and internally displaced persons (IDPs) for all low- and middle-income ("third world") countries from 2016–2026. WHO, UNHCR, and IOM generally report hepatitis data for national populations, while data on refugees and IDPs come mainly from individual studies and systematic reviews.

The table below presenting Hepatitis cases among refugees and IDPs from conflict areas/countries from the period 2016-2026 has been shown, however, the details of the table were not available from one source. The details have been collected from cross-sectional surveys, outbreak investigations, and systematic reviews from WHO, UNHCR, or IOM databases and summarizes the best available evidence for the period.

Table 1: Hepatitis cases among refugees and IDPs from conflict areas/countries from the period 2016-2026

Host country	Refugee/IDP population	Year of study/publication	Hepatitis type	Sample size (n)	Prevalence	Key notes
Bangladesh	Rohingya refugees (Myanmar)	2022	HBV	2,000	4.0%	Cox's Bazar refugee camps.
Bangladesh	Rohingya refugees	Earlier study (included in 2022 review)	HBV	275	13.0%	Small camp-based study.
Bangladesh	Rohingya refugees	Recent review	HCV	—	≈11%	Reported in scoping review.
Ethiopia	South Sudanese refugees	2020	HBV	453	7.3%	Gambella refugee camp.
Ethiopia	South Sudanese refugees	Recent review	HCV	—	≈2%	Refugee population.
Nigeria	Internally displaced persons	2020	HBV	346	15.9%	Conflict-affected IDP camp.
Pakistan	Afghan refugees	2021	HBV	1,225	7.0%	Refugee camp.
Pakistan	Afghan refugees	Earlier study	HBV	556	9.17%	Clinic-based screening.
Pakistan	Afghan refugees	Earlier study	HBV	903	8.3%	Refugee camp survey.

Pakistan	IDPs	2018	HBV	1,000	4.5%	North Waziristan IDPs.
Pakistan	IDPs	Earlier study	HBV	950	21.05%	Highest prevalence reported among Pakistani IDPs.
Pakistan	IDPs	Earlier study	HBV	590	0.34%	Likely underestimated because of testing method.
Pakistan	Refugees	Recent review	HCV	—	≈18%	Highest HCV prevalence reported among reviewed refugee populations.
Turkey	Syrian refugees	2017	HBV	2,158	1.1%	Hospital screening.
Turkey	Syrian refugees	2018	HBV	704	4.3%	Pregnant women.
Turkey	Syrian refugees	2017	HBV	300	3.0%	Hospital-based study.
Turkey	Syrian refugees	2017	HBV	140	4.2%	Children attending clinics.
Turkey	Syrian refugees	2019	HBV	244	5.74%	Hospitalized refugees.
Turkey	Afghan asylum seekers	2021	HBV	9,197	5.5%	Detention centre screening.
Thailand	Myanmar refugees	2016	HBV	6,158	8.3%	Thai–Myanmar border clinics.
Thailand	Myanmar refugees	2019	HBV	11,025	6.2%	Large clinic-based study.
Thailand	Myanmar refugees	2018	HBV	2,004	10.0%	Camp-based survey.
Cameroon	Central African Republic refugees	2021	HBV	970	7.7%	Refugee camp.

Rwanda	Burundian refugees	2021	HBV	26,498	3.8%	Mahama refugee camp.
Iraq	Syrian refugees	2016	HBV	880	3.86%	Camp population.
India	Tibetan refugees	2016	HBV	2,769	8.9%	Community and camp settings.

It is interesting to note that health is a human right and has been duly recognized and emphasized upon not only by the organizations like United Nations but also is a well-defined right in the Constitution of India.

United Nations and Right of the Refugee and IDPs

Evidence presented in the first World report on the health of refugees and migrants shows that refugees and migrants do not increase the risk of communicable disease transmission in host countries; instead, health risks arise from conditions experienced during displacement, including limited access to clean water, sanitation, food, shelter and essential health services.ⁱ

Priorities of WHO global action plan (2019-2030)

The WHO global action plan on promoting the health of refugees and migrants lists the short-term and long-term medical interventions as follows

Priority 1. Promote the health of refugees and migrants through a mix of short-term and long-term public health interventions, supporting enhanced coordination and collaboration in order to achieve the goal of universal health coverage and the principle of "leaving no one behind" and to develop emergency and humanitarian health responses based on humanitarian principles.

Priority 2. Advocate the mainstreaming of refugee and migrant health into global, regional and country agendas and the promotion of refugee-sensitive and migrant-sensitive health policies and legal and social protection; the health and well-being of refugee and migrant women, children and adolescents; gender equality and empowerment of refugee and migrant women and girls; and partnerships and intersectoral, intercountry and interagency coordination and collaboration mechanisms

Priority 3. Enhance capacity to tackle the social determinants of health and to accelerate progress towards achieving the Sustainable Development Goals, including universal health coverage

Priority 4. Support measures to improve evidence-based health communication and to counter misperceptions about migrant and refugee healthⁱⁱ

Health Right in the Constitution of India

Article 21-Protection of Life and Personal Liberty deals with "no person shall be deprived of his life or personal liberty except according to procedure established by law". The right to live means something more, than mere animal existence & includes the right to life consistently with human dignity & decency. In numerous cases the

Supreme Court held that right to health & medical care is a fundamental right covered by Article 21 since health is essential for making the life of workmen meaningful & purposeful & compatible with personal dignity.ⁱⁱⁱ

Supreme Court, in its land mark judgment in *Pramanand Katara V Union of India & others*^{iv} ruled that every sector whether at a government hospital or otherwise has the professional obligation to extend his services with due expertise for protection life. No law or state action can intervene to avoid or delay the discharge of the paramount obligation cast upon members of the medical profession. The obligation being total, absolute, and paramount, laws or procedure whether in statutes or otherwise which would interfere with the discharge of this obligation cannot be sustained, and must, therefore give way.

In some cases, the injured die for want for medical aid pending the completion of legal formalities. The Court stated that preservation of Health is of paramount importance. Once life is lost it cannot be restored. Hence, it is the duty of doctors to preserve life without any kind of discrimination.

The severe weaknesses in India's healthcare system have been made clear by the pandemic. The lack of legislation that upholds a fundamental right to health is a major contributing factor to India's poor public health. In order to help India deal with the issues, it is necessary to establish the right to health as a fundamental right and to put it into practice within the parameters of legal mechanisms and the human rights principles of solidarity, proportionality, and transparency. Thus, it is imperative that the values of openness, proportionality, and solidarity be applied in the implementation of the right to health.

The government's key imperative should now be on making amendments to the current legislation and laws of India. The present health care services should be reviewed, and accordingly, new ones should be made with the involvement of the people.

Therefore, the importance of recognizing the right to health cannot be overstated. While it's not explicitly stated in the Constitution, the World Health Organization considers health a fundamental human right.^v This implies that every individual, regardless of background, deserves access to the highest attainable standard of health. Despite the Supreme Court of India affirming the right to healthcare through various judgments, the state has not fully acknowledged its significance. The court's broader interpretation of Article 21 has equated the right to health with the right to life, affirming its status as a fundamental right under the Indian Constitution.^{vi}

Conclusion and Suggestions

Innovative public health strategies are the need of the hour because not only would they better the situation for the refugees and the displaced, but would also help the doctors and their medical team to work more efficiently and effectively reducing the burden of hepatitis among these vulnerable populations whilst using practical and scalable means which address their immediate needs and help the medical professionals to sustain the healthcare system.

- Short-term strategies should prioritize rapid hepatitis B vaccination campaigns, point-of-care screening using portable diagnostic tests, and integration of hepatitis testing into existing maternal, child health, nutrition, and infectious disease programs. Mobile health clinics (example of LBDC Vans) and community health workers recruited from displaced populations can improve access to education, early diagnosis, linkage to care, and

treatment adherence in remote or unstable settings. Digital health tools, such as mobile phone reminders and electronic vaccination records, may further enhance continuity of care despite frequent displacement.^{vii}

- Long-term strategies should focus on strengthening national health systems to ensure refugees and IDPs are included in universal hepatitis prevention and treatment programs (example of mohalla clinics). Cross-border health information systems and interoperable electronic medical records can maintain patient follow-up during migration. Expanding decentralized hepatitis services through task-shifting to trained primary care providers and community health workers can improve sustainable access to care. Investment in clean water, sanitation, safe injection practices, blood safety, and harm-reduction programs remains fundamental to reducing transmission. Partnerships between governments, humanitarian organizations (examples of conflict areas such partnerships), and academic institutions can support surveillance, operational research, and innovative financing mechanisms. Incorporating artificial intelligence for outbreak prediction, geospatial mapping of high-risk settlements, and telemedicine consultations with hepatology specialists may further enhance prevention efforts in resource-limited settings. Together, these integrated, community-centered approaches can reduce hepatitis transmission, improve early detection and treatment, and contribute to equitable healthcare for displaced populations in low- and middle-income countries.^{viii}

A major variance between IDPs and refugees is the legal protection, while refugees are protected under specific laws such as 1951 Refugee Convention^{ix}, internally displaced populations do not have specific binding international status they remain under the legal protection of their own government which may be the very authority that they are fleeing or lack the resources to help, therefore addressing IDPs and refugees also requires distinct strategies due to their differing legal statuses, locations, and access to international aid.^x

1. Strategic Solutions for IDPs

- Mobile medical clinics: Deploy rugged, all-terrain clinic vehicles to reach scattered IDP populations hiding in remote areas or informal urban squats.^{xi}
- Advocacy for domestic policy: Pressure national governments to implement the Kampala Convention or similar frameworks to legally protect displaced citizens.^{xii}
- Cash-transfer assistance: Distribute digital currency or secure vouchers so IDPs can buy local food and medicine, which stimulates the host economy.^{xiii}

2. Strategic Solutions for Refugees

- Cross-border supply corridors: Establish secure, international supply chains directly into border camps, bypassing host-country import red tape.
- Linguistic translation networks: Recruit and train bilingual refugees to translate dialects, ensuring doctors take accurate medical histories.
- Legal integration programs: Lobby host nations to grant refugees temporary work permits, allowing displaced doctors and nurses to practice legally.

3. Shared Interventions for Both Groups

- Geospatial tracking tools: Use anonymized satellite imagery and cell tower data to locate sudden population shifts and deploy medical assets proactively.

- Trauma-informed triage: Standardize mental health screening at the very first point of clinical contact to flag severe PTSD and depression early.
- Infectious disease surveillance: Set up rapid syndromic reporting systems in camps to catch outbreaks of cholera or measles before they spread.^{xiv}

This article is an attempt to bring focus on not only the disease of hepatitis but also to do more focused research on highly vulnerable groups of people, that is, refugees and internally displaced populations. The suggestions made in this article may also be relevant to general public and other needy groups.

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