



A 10-Year (01 January 2014 to 31 December 2024) Systematic Review on Healthcare Barriers Faced by Refugees and Asylum Seekers in India

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Abstract

Despite India's long-standing role as a host to diverse refugee populations; including Rohingyas, Sri Lankan Tamils, Afghans, and Tibetans; there remains a notable gap in systematic, context-specific research on healthcare access within this population. Existing global literature tends to generalise refugee health challenges, with minimal attention to India's unique legal ambiguity, decentralised healthcare governance, and sociopolitical complexities. This systematic review, registered with PROSPERO (CRD420250654398), investigates the structural barriers to healthcare access faced by refugees and asylum seekers (RAS) in India. A PubMed search was conducted for studies published between 01 January 2014 and 31 December 2024 using date range option in PubMed. The initial search yielded 311 records; after applying inclusion and exclusion criteria, 47 studies were included in the final synthesis. The review identifies four interrelated structural barriers that impede equitable access to healthcare for RAS in India: (1) the absence of legal recognition, which excludes individuals from national health schemes and deters service utilisation due to fear of detention or deportation; (2) systemic financial constraints, including high out-of-pocket expenses, ineligibility for insurance, and economic precarity; (3) linguistic barriers, marked by inadequate access to trained interpreters and culturally competent communication; and (4) cultural and gender-based obstacles, including stigma around mental and reproductive health and a lack of gender-concordant care. These factors operate synergistically to form a system of exclusion, disproportionately affecting vulnerable subgroups such as women, children, and trauma survivors. This review addresses this critical gap by synthesising the multifaceted and intersecting barriers experienced by RAS in India, and offer an evidence-based foundation for the development of inclusive, rights-based health policies and targeted interventions to reduce healthcare inequities among forcibly displaced populations in low- and middle-income countries (LMIC) contexts.

Keywords: Healthcare; Low-Income Countries (LICs); UNHCR (United Nations High Commissioner for Refugees)

Introduction

In India, access to healthcare among refugees and asylum seekers is highly fragmented and, in most cases, disrupted by displacement to a great degree. The UNHCR (United Nations High Commissioner for Refugees) Global Trends Report states that approximately 79.5 million people worldwide were forcibly displaced in 2019 [1] due to armed conflicts and natural disasters, the figure has doubled from 40 million in 2010 [2]. Based on data from UNHCR, the global displaced population reached an unprecedented 122.6 million, comprising 37.9 million refugees and 8 million asylum seekers by mid-2024. Within this context, registered refugees account for 26 million of the total 82 million forcibly displaced individuals [3], with over 60% residing in low-income countries (LICs), where access to essential services, including healthcare, remains deeply constrained.

The 1951 Refugee Convention, as amended by the 1967 Protocol, defines a refugee as someone who, "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of their nationality and is unable or unwilling to avail themselves of the protection of that country" [4]. Asylum seekers leave their home country in search of protection although they have yet to be officially declared refugees. The two groups are under obligation to enjoy fundamental human rights including the right to health, irrespective of their legal status. It is the State duty to prevent xenophobic violence, forced labour as well as exploitation of migrants including refugees and asylum seekers as well as avoiding denial of vital services like healthcare.

India, which currently hosts more than 46,000 refugees, mainly from Myanmar and Afghanistan, faces specific challenges in the governance of refugee healthcare [4]. Notably, India has not ratified the 1951 Refugee Convention or its 1967 Protocol, resulting in the absence of a formal legal framework to protect refugees [5]. Consequently, India's approach to refugee governance is categorized by strategic ambiguity, shaped by domestic political considerations such as national security and public sentiment [6]. This has led to the inconsistent application of protection measures, often influenced more by foreign policy concerns than humanitarian need [7].

Despite this, India has demonstrated a degree of informal acceptance of refugees. As of 2020, UNHCR had registered 9,458 refugees in the country, in addition to approximately 160,000 individuals holding UNHCR-issued identity documents. This diverse refugee population includes individuals from Afghanistan, Bangladesh, Myanmar (including Rohingyas), Somalia, Sri Lanka, Yemen, Tibet, and Palestine. However, the absence of legal recognition and structured refugee policy has severely constrained access to healthcare and other basic services, exposing these populations to ongoing vulnerability and marginalization [8-10].

It is within this complex background that this systematic review aims to understand and summarize what has already been documented about the healthcare access barriers to refugees and asylum seekers living in India. The review will target key themes, gaps in policy, and possible interventions to facilitate access to healthcare in this vulnerable population, through an evidence-based analysis.

Background of refugees

The Rohingya, Myanmar's largest Muslim minority group, have endured longstanding persecution marked by institutionalized discrimination, resulting in large-scale displacement both within Myanmar and across several countries, including Bangladesh, India, Indonesia, Malaysia, Pakistan, Saudi Arabia, and Thailand [11,12] (Figure 1). A document submitted to the Supreme Court in 2017 revealed that approximately 40,000 Rohingyas had entered and settled in India between 2012 and late 2017. Out of these, the United Nations High Commissioner for Refugees (UNHCR) granted refugee identity cards to 16,000 individuals who had registered with the agency [4,13]. Unlike the Chin Buddhists, who were approved for official refugee status in India, the Rohingyas were denied such recognition [14]. In 2012, Rohingyas organised a month-long protest outside the UNHCR office in New Delhi, demanding refugee status.

Although the Indian government refused to formally acknowledge them as refugees, a limited number received extended stay visas. The Rohingya population continues to be referred to as "nowhere people," lacking state citizenship and basic rights, and often described as non-citizens or "the lost generation" [14,15]. Similarly, Sindhi refugees who were displaced during the 1947 Partition have grappled with questions of recognition, acceptance,

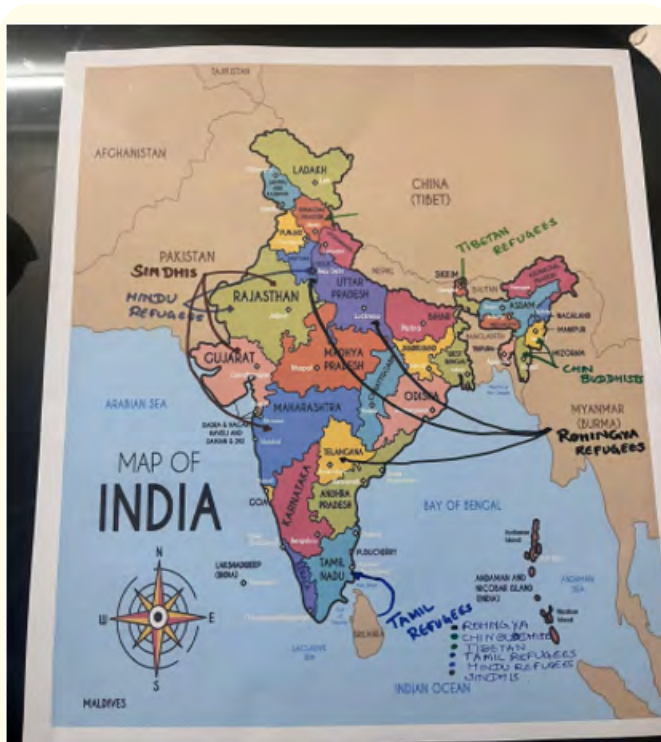


Figure 1: Map showing the migration of refugees from different parts of the world into India. The main refugee groups from the east are Rohingya refugees and Chin Buddhists, both from Myanmar. The main refugee group from the south is Tamil refugees from Sri Lanka. The main refugee groups from the west are Sindhi refugees and Hindu refugees from Pakistan. The main refugee group from the north is Tibetan refugees from China (Tibet).

and inclusion in India. The migration of Hindu Sindhis to India and the division from Muslim Sindhis who remained in Pakistan fragmented the community. [16] highlights the plight of Sindhi refugees residing in the Banni border region, where invisible border controls and prevailing geopolitical tensions significantly disrupt their everyday lives.

Following the brutal Tamil pogrom in Sri Lanka in 1983, thousands of Sri Lankan Tamil refugees sought refuge in India [17]. The civil conflict continued until 2009, and during its final phase, official Indian records indicate that 8,450 families comprising 24,527 individuals arrived between January 12, 2006, and 2010. According to the Ministry of Home Affairs, Government of India

(2019–20), a total of 304,269 Sri Lankan Tamil refugees entered India between July 1983 and August 2012, although nearly 250,000 were eventually repatriated during intermittent periods of peace between the Sri Lankan government and Tamil militant groups. As of April 1, 2019, 60,438 refugees were residing in 107 camps, including a special camp across 25 districts in Tamil Nadu. Additionally, 34,684 refugees were living outside these camps as of March 31, 2019 [18].

Tibetan refugees in India have historically received sustained governmental support since the arrival of the 14th Dalai Lama in 1959, which enabled them to obtain refugee status and associated rights [4,19], and observes that Tibetan refugees have maintained their cultural identity through the preservation of language, religion, and traditions. Saklani [20] documented how structured Tibetan settlements enabled both economic self-sufficiency and cultural resilience. Yet, the aspirations of younger generations to migrate abroad have introduced uncertainty about the community's long-term future [21].

Another marginalised group includes the Hindu refugees from Pakistan, who have suffered persistent discrimination and neglect in India's policy framework. Roughly 40,000 of them currently reside in refugee camps in Rajasthan, predominantly in the Jodhpur area [22]. Poor living conditions, limited infrastructure, and restricted access to basic healthcare and sanitation facilities mark these camps [23].

Research gap and aim of this systematic review

Despite India's long-standing role as a host country for varied refugee populations; including Rohingyas, Sri Lankan Tamils, and Afghans; there remains a significant lack of scholarly attention to the healthcare barriers experienced by these groups. Existing literature predominantly focuses on refugee camp responses and humanitarian interventions in emergency contexts [14,24], while largely overlooking the lived realities of urban refugees and asylum seekers. Moreover, most global studies generalize refugee health challenges without context-specific analysis of India's unique socio-political and legal environment. Urban refugees in India face compounded obstacles due to legal exclusion from national healthcare systems, financial precarity, and socio-cultural marginalization [25,26]. However, there is a dearth of systematic reviews that critically synthesize these multifaceted barriers

within the Indian context. This review addresses this gap by exploring the intersection of legal, socio-economic, institutional, and cultural factors that hinder access to healthcare for refugees and asylum seekers in India, an area underrepresented in existing research. Hence, what are the major barriers in healthcare access for refugees and asylum seekers in India?

The primary aim of this systematic review is to critically examine the existing literature to identify and synthesise the major barriers that impede access to healthcare for refugees and asylum seekers residing in India. Given the complex socio-political landscape and legal status of these populations, this review seeks to provide a comprehensive understanding of the structural, socio-economic, legal, and cultural challenges they face in accessing essential health services.

Methods

This systematic review adheres to the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) framework, which provides a structured and systematic approach to the identification, screening, and selection of studies [27] to enhance the methodological rigour and reliability of its findings [28,29].

Search strategy

A PubMed search was performed on 01 March 2025 to identify studies published between 01 January 2014 to 31 December 2024 with the following search terms, (healthcare OR "health-care" OR "health care") AND barrier AND (refugee AND asylum); and using date range option in PubMed for indexed articles between 01 January 2014 to 31 December 2024; resulting in the following search URL: [https://pubmed.ncbi.nlm.nih.gov/?term=\(healthcare+OR+"health-care"+OR+"health+care"\)+AND+barrier*+AND+\(refugee*+AND+asylum\)&filter=dates.2014/1/1-2024/12/31](https://pubmed.ncbi.nlm.nih.gov/?term=(healthcare+OR+). A repeat of the search was performed on 01 August 2025 to ensure that articles delayed in indexing into PubMed were captured.

Inclusion/exclusion criteria

The eligibility criteria for this systematic review included studies focusing on refugees or asylum seekers who had been residing in India for at least six months, examining healthcare

access, experiences, or barriers. Only full-text articles published in English and presenting original empirical research, such as surveys, interviews, or observational studies, were considered. Studies were excluded if they were not published in English (Criteria A), were non-primary research such as reviews, opinion articles, or commentaries (Criteria B), did not focus on healthcare barriers (Criteria C), were not relevant to refugees or asylum seekers (Criteria D), or were unrelated to healthcare (Criteria E).

Data extraction and synthesis

A thematic synthesis approach will be used identify key healthcare barriers encountered by refugees and asylum seekers residing in India. Information will be gathered using a standardised extraction form, capturing study details such as author, publication year, study design, and country. Additional data points will include refugee populations studied (e.g., Rohingya, Sri Lankan Tamils), types of barriers (e.g., legal, financial, cultural, gender-specific), healthcare access issues (e.g., infrastructure limitations, language barriers), health outcomes (e.g., mental health, maternal health), and any reported interventions or policy recommendations.

Data extraction will also be guided by the PICO framework (Population, Intervention, Comparison, Outcome), which provides a structured approach for identifying and organising relevant evidence in systematic reviews [30]. The population is the refugees and asylum seekers (RAS) in India, with access to healthcare services as intervention. Hence, the identified barriers to healthcare and its potential solutions will be the outcome by comparing RAS and general population in India.

Registration of protocol

This review protocol was prospectively registered with the International Prospective Register of Systematic Reviews (PROSPERO) [31] as CRD420250654398 (<https://www.crd.york.ac.uk/PROSPERO/view/CRD420250654398>).

Results and Discussion

A total of 311 records were initially identified through PubMed search on 01 March 2025. A repeated search performed five months later, on 01 August 2025, yield the same number of records. After removing duplicates and screening for relevance based on titles and abstracts, 247 records were selected for full-text review.

After applying all screening and eligibility criteria, a total of 47 studies were included for this review (Figure 2; see supplementary material for the full listing of all 311 articles and flow through the exclusion criteria).

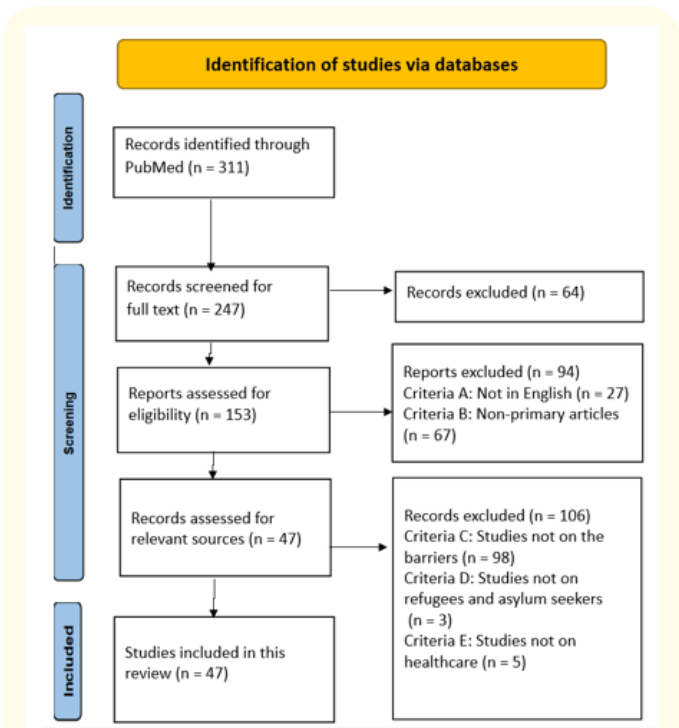


Figure 2: PRISMA Flowchart. Of the 311 studies identified from PubMed search; 264 studies were excluded by the exclusion criteria, resulting in 47 studies included in this review.

Language barriers

Language barriers consistently emerged as a significant obstacle to healthcare access for refugees and asylum seekers across multiple studies. Limited proficiency in the host country’s language affects refugees’ ability to communicate symptoms, understand diagnoses, and navigate healthcare systems effectively [32,33]. This often results in miscommunication, delayed treatment, and reduced trust in the healthcare system. In many cases, refugees reported being unable to articulate their concerns during consultations, particularly when they were anxious or unwell, even if they possessed basic conversational skills [34].

One prominent theme across the literature is the inadequacy and inconsistency of interpretation services. Even where interpreters are available, barriers remain due to dialect mismatches, cultural misalignment, and insufficient knowledge of medical terminology [35–37]. These issues compromise the accuracy and effectiveness of communication. In one case, a misunderstanding related to insulin dosage due to dialect issues resulted in a severe hypoglycaemic episode, highlighting the clinical risks of such barriers [36]. The absence of professional interpretation also leads to reliance on untrained individuals such as family members, volunteers, or even children. This raises concerns regarding confidentiality, accuracy, and ethical practice [38,39]. For example, a refugee’s attempt to use a mobile app and limited English to communicate was met with irritation by a receptionist, leading to public humiliation and emotional distress [40]. In some instances, children were asked to interpret or consent on behalf of adults, which presents serious ethical and clinical implications [34]. In certain settings, limited interpreter availability, particularly for less common languages like Rohingya, further erodes trust. In one state, only two interpreters were available to serve an entire refugee community, making access to accurate and confidential services nearly impossible. Community interpreters, while helpful, can sometimes increase stigma due to concerns over privacy, especially in smaller or close-knit communities [35,41]. In some cases, this overreliance led to burnout and blurred boundaries between professional and personal roles [42].

Another theme relates to the implications of language barriers in mental health services. Refugees often struggle to access psychological care due to communication difficulties. In Germany, for example, interpreters are not funded by public health insurance once refugees enter the general healthcare system, effectively excluding non-German speakers from therapy [42]. This structural barrier is compounded by cultural stigma around mental health and a lack of awareness about available services [43]. Healthcare providers have described mental health consultations without interpretation as “groping in the dark” [44], with consequences for diagnostic accuracy and emotional rapport.

Language barriers also affect medication adherence and health literacy. Refugees often report difficulty understanding prescriptions, treatment plans, and medical instructions [39]. In England, refugee parents identified language, not cost or

access, as the primary barrier to obtaining medicine for their children [45]. Misinformation due to poor translation, digital tool misuse, or unfamiliar medical forms can lead to serious health consequences. Some participants preferred verbal or community-based explanations over written leaflets, especially when literacy was limited [32,46].

Issues of cultural sensitivity and patient-provider interaction also emerged. Negative attitudes from healthcare staff, especially when communication is strained, contributed to feelings of exclusion and reluctance to seek care [47]. This was particularly harmful in gender-sensitive contexts, where the absence of trained female interpreters could retraumatise survivors of gender-based violence [41]. In countries like Germany and the UK, bureaucratic shortcomings, limited interpretation support, and fragmented communication continue to amplify these challenges [48,49].

Despite these challenges, several studies highlight promising community-based solutions. Volunteer interpreters, peer health educators, and medical student-led workshops have helped bridge communication gaps [50]. These initiatives promote trust, improve health literacy, and foster more culturally sensitive healthcare delivery. Empathy, non-verbal communication, and flexibility in communication formats were identified by both refugees and providers as critical components of effective care [32]. While some research indicates that trained interpreters can help mitigate language barriers effectively [51], most studies underscore the need for systemic reform. Recommendations include sustainable public funding for interpretation services, multilingual health communication strategies, healthcare provider training in cultural competence, and greater involvement of refugee communities in service design [52].

Cultural and gender-related barriers

Refugees and asylum seekers often carry with them deeply ingrained cultural norms, beliefs, and traditions from their countries of origin, which can sharply contrast with those of their host countries. These cultural differences extend beyond language barriers and significantly influence how individuals perceive health, illness, and healthcare interactions [53,54]. Such divergences can create emotional discomfort, misunderstandings, and mistrust during healthcare encounters, ultimately hindering effective care delivery [55].

Cultural beliefs and practices significantly influence healthcare behaviours, including medication use and symptom reporting. For example, Muslim refugees may refuse medications containing alcohol or pork derivatives due to religious dietary restrictions, illustrating the need for culturally sensitive pharmaceutical practices and effective cross-cultural communication by healthcare providers [45,56]. Similarly, traditional medicine preferences among Chinese and Southeast Asian refugees reflect a cultural familiarity that can lead to reluctance to engage with conventional treatments if healthcare professionals lack cultural competence [56,57].

The interpretation of illness and symptom presentation often varies by culture, which can complicate diagnosis and treatment. Somali refugees, for instance, may not identify with Western psychiatric terms like “depression,” instead describing similar experiences with culturally distinct concepts such as “complete madness” [35]. Refugee children with mental health conditions may present physical complaints instead of emotional symptoms, creating potential for misrecognition by healthcare workers unfamiliar with these cultural expressions [58]. Such differences emphasize the critical need for healthcare providers to develop intercultural sensitivity beyond basic language translation [59].

Gender dynamics compound these cultural barriers, especially for refugee women from conservative backgrounds. Many women express a strong preference for same-gender healthcare providers during sensitive care related to reproductive or intimate health, due to cultural and religious norms [60,61]. Failure to accommodate such preferences can result in avoidance of necessary care and delayed treatment. In addition, gender norms affect participation in research and healthcare engagement, necessitating gender-matched interviewers and flexible scheduling to ensure equitable access [61].

Cultural stigma surrounding mental health and sexual and reproductive issues further hinders healthcare access for refugee women. Among Rohingya communities, normalized intimate partner violence (IPV) and fears about confidentiality, legal repercussions, and social judgment discourage women from seeking formal healthcare, often pushing them towards informal support networks [62]. Moreover, cultural expectations regarding pain expression during childbirth, contraception, and male

circumcision pose additional challenges in providing culturally appropriate maternal and perinatal care [46,63].

At the systemic level, healthcare services often lack sufficient cultural proficiency and fail to accommodate the diverse cultural needs of refugees and asylum seekers [64]. Limited cultural competence among healthcare professionals – exacerbated by time constraints and insufficient training – can erode trust and result in communication breakdowns, misdiagnoses, and poor treatment adherence [32,36]. The absence of structured intercultural mediation and professional interpretation services further widens this gap, as reliance on untrained bilingual staff or online translators often fails to capture the nuanced cultural context essential for effective care [41,52]. Successful interventions underscore the importance of culturally adapted mental health programs that incorporate cultural idioms, spiritual beliefs, and community coping mechanisms to reduce stigma and improve engagement among refugees [65,66]. Embedding culturally sensitive practices including training healthcare professionals on cultural competencies, employing intercultural mediators, and developing policies that prioritize cultural responsiveness is critical to bridging these barriers and achieving equitable healthcare access for refugee and asylum seeker populations.

Legal status as a structural barrier

Legal status serves as a powerful structural determinant in shaping access to healthcare and broader wellbeing outcomes for refugees and asylum seekers (RAS) across the globe. Far beyond being a bureaucratic label, legal status functions as a form of structural violence, wherein institutionalized laws, policies, and administrative procedures systematically marginalize RAS by limiting their access to essential services. This exclusion is not incidental but is embedded within national frameworks that condition healthcare entitlements on immigration status, as seen in Germany, Canada, Israel, South Korea, and Malaysia [62,67,68]. Refugees in these contexts often experience delayed treatments, limited outpatient coverage, and dependence on welfare authorities for care approval, all of which increase psychological distress and reinforce cycles of inequality.

Even where formal refugee status is granted, such as under the Geneva Convention, bureaucratic hurdles, inconsistent implementation of entitlements, and lack of healthcare documentation continue to exclude many from care, particularly

asylum seekers with pending or denied claims [51,52]. The precariousness of this legal limbo prevents timely healthcare utilization, especially in critical cases like maternal health, mental health, and gender-based violence [41,63]. In Switzerland, for instance, victims of GBV (gender-based violence) often delay disclosure and treatment until after their legal status is confirmed. Similarly, in Germany, access to psychotherapy is severely restricted in the early asylum period, where treatment requires healthcare vouchers and case-by-case cost approvals [43].

Legal insecurity also erodes trust in host healthcare systems. Participants in studies from Switzerland, Latin America, and Libya described how prior exposure to trauma, exploitation, and state-led violence, including torture and detention, left them reluctant to seek healthcare or disclose sensitive information [41,69,70]. This is further aggravated by the fear of deportation and the absence of safe reporting mechanisms for undocumented individuals, as observed in Malaysia, where even minor healthcare interactions could lead to arrest or abuse [57]. Legal ambiguity is thus a barrier not only to services but also to establishing protective and ethical care environments.

Healthcare providers themselves are often placed in ethically conflicted positions. In the UK, limited awareness of NHS (National Health Service) charging regulations among healthcare professionals led to misinformation and inappropriate service denial, even in emergency situations [49]. Similarly, in Southeast Asia, clinicians expressed discomfort with being tasked with immigration enforcement roles, especially in countries not signatory to the 1951 Refugee Convention [71]. These dual pressures – medical duty versus legal compliance – create fragmented, inconsistent care practices and expose gaps between national law and global health ethics. Moreover, legal status determines who is seen and who remains invisible within health systems. As described in Turkey, the absence of neighbourhood-level data and the high mobility of undocumented migrants create practical challenges in both research and care delivery [61]. This invisibility is compounded by societal mechanisms of ‘othering’, termed the “pathologized presence, normalized absence” [35], where refugees are viewed as problems rather than patients, with their human rights subordinated to national security or resource concerns. In this climate, even legally entitled refugees face barriers rooted in xenophobia, misinformation, and administrative opacity.

In summary, legal status is not a static category but a dynamic and powerful structure that influences every dimension of healthcare access, from eligibility, affordability, and provider trust to service quality and health outcomes. Its impact is transnational, persistent, and deeply embedded in the intersection of law, policy, and public health practice. Redressing these inequities requires not only legal reform that decouples healthcare access from immigration status but also a transformative shift toward rights-based, culturally competent, and trauma-informed care (TIC) systems. Only through such integrated approaches can health systems fulfil their ethical obligation to provide universal health coverage, regardless of an individual's legal status.

Systemic financial barriers to healthcare access

Financial constraints represent one of the most pervasive and debilitating structural barriers impeding healthcare access for refugees and asylum seekers. Unlike citizens and documented residents who often benefit from public health insurance schemes, asylum seekers are frequently excluded from these safety nets due to their uncertain legal status or lack of formal recognition. In South Korea, for instance, 98.2% of the domestic population is covered under the National Health Insurance Service (NHIS), enabling widespread access to affordable healthcare. However, asylum seekers without legal residency, such as those lacking an F-2-4 humanitarian visa, are ineligible for enrolment, thereby facing prohibitively high out-of-pocket costs [46]. These financial burdens are particularly acute during critical health episodes, such as childbirth, emergency care, or chronic disease management, when the lack of insurance coverage often results in delayed or foregone medical treatment. Furthermore, the absence of subsidized or free services in many regions necessitates long-distance travel to access care, thereby increasing indirect costs such as transportation, lost wages, and childcare, which further deters healthcare utilization [46,57]. These financial burdens often deter migrant families from seeking timely care, further deepening existing health disparities and reducing their ability to maintain consistent healthcare engagement [49,72].

Beyond individual costs, the complexity of navigating healthcare financing systems creates another layer of exclusion. Many asylum seekers lack the knowledge, language proficiency, or institutional support necessary to understand available healthcare options or to apply for subsidies and insurance schemes, when such mechanisms exist [73]. This lack of guidance not only limits access

but also fosters mistrust and confusion, often leaving refugees dependent on irregular, community-based, or charitable services. From the healthcare provider's perspective, financial disincentives such as uncompensated care, administrative burdens, and unclear reimbursement pathways discourage the treatment of uninsured and low-income patients [74]. In some contexts, providers are reluctant to engage with asylum seekers altogether, particularly when financial viability is at risk or when there is inadequate institutional support for cross-cultural or linguistically competent care.

Moreover, broader socioeconomic instability further compounds these challenges. Asylum seekers often experience insecure employment, unstable housing, and limited access to social welfare programs, which force them to prioritize immediate survival needs such as food and shelter over health [64]. This results in delayed health-seeking behaviour and increased vulnerability to preventable and exacerbated health conditions. Even when low-cost or subsidized insurance schemes are introduced, such as the REMEDI program in certain host countries, uptake remains limited due to low awareness, poor coverage, or administrative complexity [57].

Interestingly, some refugees express a willingness to pay for health insurance despite financial hardship, suggesting that structural barriers, rather than economic capacity alone, are the dominant deterrents to healthcare access [73]. However, without targeted policy reform that integrates humanitarian migrants into existing national health systems or establishes parallel, adequately funded health safety nets, such willingness cannot translate into meaningful health equity.

Financial exclusion also intersects with other systemic issues, such as language barriers and cultural insensitivity, which can undermine care even when accessed. For example, the lack of funding for trained interpreters often results in the use of unqualified translation services, leading to medical errors, breaches of consent, and compromised treatment outcomes [75]. In mental health care, particularly, the absence of fully subsidized psychotherapy services under public insurance further marginalizes those with limited financial resources, denying them access to critical psychological support.

Collectively, these financial barriers not only impede access to care but also perpetuate a cycle of health inequity, poor health outcomes, and social exclusion among refugee and asylum-seeking populations. Addressing these systemic financial impediments requires not only targeted healthcare interventions but also cross-sectoral strategies that improve economic security, legal inclusion, and institutional accountability within host country systems.

Interplay of Structural Barriers: A Syndemic of exclusion in refugee healthcare access

Barriers to healthcare access for refugees and asylum seekers are not isolated; rather, they are deeply interconnected, forming a complex web of systemic exclusion. Legal status, often the first determinant of access, serves as a structural gateway or blockade to healthcare entitlements, thereby triggering a cascade of financial, linguistic, and cultural marginalisation [46,57,67]. For example, exclusion from national insurance schemes due to irregular or pending legal status not only imposes unaffordable out-of-pocket costs but also discourages early care-seeking, particularly during maternal health episodes or medical emergencies [46,63]. This financial precarity is compounded by language barriers, which obstruct refugees' ability to navigate care systems, understand diagnoses, and comply with treatment plans, especially in the absence of trained interpreters [32,34,75]. Miscommunications due to dialect mismatches or inadequate interpretation services have led to adverse health outcomes, including serious clinical incidents such as insulin overdoses [36].

Language challenges intensify cultural and gender-based mismatches, particularly in interactions between providers and refugee patients. For instance, female refugees from conservative societies often avoid reproductive healthcare when male providers or untrained male interpreters are present, thereby reinforcing gendered inequalities in health access [60,76]. In such instances, linguistic, cultural, and gendered exclusions converge, particularly when interpreter shortages for minority languages like Rohingya compound fears around privacy and stigma [39,41]. These effects are exacerbated by legal precarity, which leaves refugees without safe avenues to report violations or discrimination, especially in contexts where healthcare contact may lead to deportation or detention [57,70].

Financial barriers not only operate independently but also worsen the impact of other exclusions. The lack of public funding for interpretation services; for example, restricts access to quality communication, especially in mental healthcare, where interpreters are often not covered once refugees enter the general healthcare system. As a result, providers describe sessions as "groping in the dark" [44] underlining how financial and language barriers co-produce unsafe clinical conditions. Additionally, cultural expectations such as religious prohibitions on certain medications or stigma surrounding mental illness often go unmet due to providers' limited intercultural training, which is rarely prioritised within resource-constrained systems [35,45].

Moreover, these systems of exclusion reinforce one another in cyclical and compounding ways. Lack of legal status leads to economic marginalisation, which then limits access to both healthcare and interpretation services [64]. Financial hardship discourages care-seeking, but even when refugees access care, language and cultural mismatches can result in poor adherence or service refusal [34,73]. The interaction of legal, financial, linguistic, and cultural barriers creates a self-reinforcing cycle of exclusion, particularly affecting vulnerable groups like women, children, and trauma survivors. Each barrier amplifies the others, deepening health disparities and entrenching long-term neglect. This feedback loop perpetuates systemic inequities, making it harder for refugees and asylum seekers to access care. Effective solutions require integrated, rights-based approaches that address legal inclusion, financial protection, culturally sensitive care, and language access simultaneously to break this cycle and promote health equity [33,52,62].

Contextualising Interconnected Barriers in the Indian Refugee Context. While international literature extensively illustrates a cyclical interplay between legal insecurity, financial hardship, linguistic exclusion, and gendered inequalities in refugee healthcare access [35,46,52]. There remains a significant gap in applying these systemic insights to the Indian refugee context. India, though not a signatory to the 1951 Refugee Convention or its 1967 Protocol, continues to host a diverse and sizeable refugee population, including Rohingyas, Sri Lankan Tamils, Afghans, Tibetans, and Sindhi Hindus [4,77,78]. However, the legal and structural conditions shaping their lived realities differ substantially from those in refugee-receiving countries with

codified asylum systems. In the Indian context, these barriers not only persist but are intensified by the absence of a national refugee protection framework, fragmented healthcare governance, and sociopolitical ambivalence toward non-citizens. As such, global thematic frameworks must be adapted to account for the distinct structural and institutional realities that shape healthcare access for refugees and asylum seekers in India.

The cornerstone of this systemic exclusion in India is the precarious legal status of refugees, which arises from the absence of a formal asylum law [4]. Instead, India continues to rely on the colonial-era Foreigners Act of 1946, which makes no legal distinction between refugees, asylum seekers, and undocumented migrants [4]. Legal ambiguity gives the state unchecked power, exposing refugees to detention and deportation while denying them access to rights-based protections, including health insurance schemes like Ayushman Bharat that require official documentation [79,80]. This exclusion initiates a cascade of barriers; bureaucratic, financial, and psychological; making healthcare access a highly uncertain and inconsistent process.

The effects of this legal void are particularly acute for groups such as the Rohingya and Sri Lankan Tamils, many of whom lack recognised documentation and reside in informal settlements or camps under constant surveillance. These conditions engender profound fear and mistrust toward government institutions, further discouraging engagement with public health services. Reports indicate that such refugees are often reluctant to seek even emergency care due to fears of arrest or deportation [78,81]. In this context, legal insecurity is not just a bureaucratic barrier; it produces a psychological environment of fear that directly compromises health-seeking behaviours.

Intersecting with legal insecurity is financial exclusion, another major determinant of limited healthcare access. Most refugees in India work in the informal sector with irregular income, and are not eligible for subsidised health services or welfare benefits typically reserved for Indian citizens. Even among the long-settled Tamil refugee population, access to education and health subsidies varies by state, reflecting the fragmented nature of India's federal governance [82,83]. Without legal recognition or targeted welfare policies, out-of-pocket expenses for healthcare become a major burden, especially for families with chronic illnesses or pregnant

women. The absence of income security, employment protections, and housing stability further compounds health vulnerability, particularly among refugees living in overcrowded urban slums or rural settlements with limited health infrastructure.

Language barriers form another significant challenge, especially for newly arrived or marginalised refugee groups such as Afghans, Rohingyas, and Sindhi Hindus. India's public healthcare system rarely offers professional interpretation or multilingual services, particularly in rural or primary health settings. Refugees who do not speak the dominant regional language are often forced to rely on informal interpreters, typically male family members, which compromises confidentiality, autonomy, and clinical accuracy [18]. Miscommunication in clinical settings can lead to misdiagnoses, mistrust in health providers, and an overall sense of alienation from public services.

Cultural barriers further intensify gendered exclusions. Women from Afghan, Rohingya, and Sindhi communities face layered challenges when accessing healthcare services. These include not only logistical and linguistic hurdles but also deep-rooted stigma surrounding reproductive and sexual health. Cultural taboos, along with the lack of female healthcare providers or culturally sensitive services, discourage women from seeking antenatal, contraceptive, or gynaecological care [25,77].

Legal, financial, linguistic, and cultural barriers faced by refugees in India interact, reinforcing one another and creating systemic exclusion. For example, lack of legal documentation can prevent access to subsidised care, force reliance on untrained interpreters, and lead to treatment avoidance due to cultural stigma. India's fragmented legal framework, state-level disparities, and politically driven refugee policies further worsen these challenges. This systematic review fills a gap by analysing how global barriers manifest in India's unique context. By combining international themes with local realities, it offers an evidence-based foundation to guide inclusive, rights-based healthcare interventions for refugees and asylum seekers.

Policy and practice recommendations

The evidence synthesized in this review demonstrates that healthcare access for refugees and asylum seekers in India is obstructed by intersecting legal, financial, linguistic, and cultural

barriers that function as structural determinants of health. Addressing these challenges requires both policy-level reform and practice-based innovation to dismantle the systemic exclusions that persist within the Indian context.

One of the most critical policy imperatives is the establishment of a comprehensive legal framework for refugee protection in India. The country's current reliance on the Foreigners Act of 1946 and its non-signatory status to the 1951 Refugee Convention has resulted in a legal vacuum where refugee rights, including access to healthcare, are neither guaranteed nor uniformly implemented [4,80]. Without formal legal recognition, refugees are excluded from state welfare schemes and live under the constant threat of surveillance, detention, and deportation, which discourages care-seeking, especially for vulnerable populations such as women and trauma survivors [70,81]. Legal reform that recognises refugees and asylum seekers under a dedicated national policy would establish a foundation for inclusive healthcare entitlements and create legal firewalls between healthcare provision and immigration enforcement, ensuring that undocumented individuals can access care without fear [52].

In parallel, integrating refugees into national healthcare schemes such as Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) is essential to overcoming financial barriers. Refugees in India are currently excluded from these programs due to the absence of Aadhaar cards or other citizenship-linked identifiers, leaving them to bear high out-of-pocket costs for even basic services [79,82]. In contexts such as South Korea and Germany, public insurance has been selectively extended to asylum seekers, thereby reducing inequities in service access [67,68]. Similar mechanisms in India using UNHCR-issued documentation or NGO (non-governmental organizations)-provided identity cards could facilitate refugee enrolment in health insurance schemes, thereby reducing financial hardship and promoting preventive care.

Another vital policy area involves institutional funding for interpretation and cultural mediation services. Language emerged in this review as a consistent and severe barrier to healthcare access, particularly in maternal, reproductive, and mental health contexts [32,36]. Refugees frequently report difficulties

in communicating symptoms, understanding diagnoses, and adhering to treatment plans due to the lack of professional interpreters [34,41]. In many cases, interpretation is provided by male relatives or children, which compromises confidentiality and may retraumatise survivors of gender-based violence [39,76]. Establishing a government-funded interpreter system, supported by trained community health workers, would bridge this gap, as seen in countries like Canada and the UK, where interpretation is legally mandated in medical settings [52].

Furthermore, anti-discrimination measures must be embedded into India's public health infrastructure. Refugees often report experiencing xenophobia, cultural insensitivity, and neglect in health facilities, particularly in urban public hospitals [18,73]. These discriminatory practices, often based on religion, ethnicity, or perceived illegitimacy of legal status, dissuade individuals from seeking care or returning for follow-up services [64]. Legal and administrative policies should mandate cultural competence training for healthcare workers, establish accessible grievance redress mechanisms, and protect against service denial based on documentation status [62].

In terms of practical implementation, mobile health units (MHUs) and refugee-focused clinics have been shown to be highly effective in reaching underserved populations. Refugees often reside in densely populated urban slums or informal settlements with limited access to primary care infrastructure [84]. MHUs equipped with multilingual staff and diagnostic tools can deliver services directly to refugee communities, particularly for antenatal care, immunisation, and mental health support [25,45]. NGO-supported clinics, such as those operated by Médecins Sans Frontières in similar global contexts, have successfully delivered quality care in the absence of state-led programs [85]. In the Indian context, collaboration between state health departments, municipal bodies, and refugee-serving NGOs can facilitate the deployment of such decentralised service models.

Healthcare providers must also be trained in trauma-informed and culturally responsive care. Refugees often present with complex trauma histories, compounded by cultural stigma around health issues such as mental illness, sexual and reproductive health, or chronic disease [35]. Providers unfamiliar with these sociocultural realities may misinterpret symptoms, resulting in misdiagnosis

or treatment refusal [57]. Incorporating trauma-informed care (TIC) into medical curricula and continuous training programs can enhance diagnostic accuracy and patient-provider rapport [65]. Equally important is training in gender-sensitive service provision, such as accommodating requests for same-gender providers or interpreters during reproductive health consultations, to reduce gender-based barriers and increase trust [86].

Multilingual, gender-sensitive health education is another essential strategy for improving access and health literacy. Refugees frequently lack information about available services, entitlements, and preventive care due to language and literacy barriers [32,39]. Public health campaigns should be tailored to linguistic needs through community radio, WhatsApp messaging, illustrated guides, and peer educators. In Bangladesh and Jordan, such outreach has increased vaccine uptake and improved maternal health service utilisation [50]. In India, leveraging community leaders and refugee youth as peer health educators can enhance the reach and credibility of health messages, especially in conservative or close-knit communities [18].

Finally, involving refugees in the co-design and evaluation of health services is critical for building trust, ensuring relevance, and improving uptake. Evidence from participatory models in Europe and East Africa suggests that community engagement increases service acceptability and ownership [52]. In the Indian context, establishing refugee advisory boards and feedback channels can guide the development of responsive healthcare interventions. This may include participatory needs assessments, co-production of educational materials, and inclusion in monitoring frameworks. Community involvement also promotes accountability and helps uncover hidden barriers such as fear of discrimination or confusion around entitlements [39].

In summary, the syndemic nature of healthcare exclusion for refugees and asylum seekers in India demands integrated and systemic solutions. Legal inclusion, financial protection, linguistic accessibility, cultural responsiveness, and participatory planning must be addressed simultaneously. Without such a coordinated approach, efforts to improve health equity for displaced populations will remain fragmented and insufficient. The recommendations outlined above offer a multidimensional framework that aligns with global best practices while responding to India's specific legal and healthcare landscape.

Strengths and limitations of this systematic review

This review is one of the first to synthesise and contextualise global themes of exclusion – legal insecurity, financial hardship, language barriers, and cultural mismatches – within the Indian refugee governance framework. In doing so, it provides a much-needed bridge between international literature and India's under-examined socio-legal landscape, offering a grounded lens that enhances both local relevance and global understanding. This review is structured around the PRISMA framework and applies a systematic, stepwise approach to literature selection, screening, and data extraction [87]. The use of the PICO framework ensured consistent and targeted inclusion of relevant evidence. This disciplined process minimises selection bias and enhances reproducibility [88]. Furthermore, the application of thematic synthesis as an analytical approach enables the study to go beyond mere listing of barriers, allowing for the development of interconnected thematic narratives that capture the syndemic nature of exclusion experienced by refugee populations.

However, the review does have a few limitations. The most evident constraint is the reliance on PubMed as the primary database, which may have limited access to relevant literature published in social science, law, or public policy domains. As such, it is crucial to note that this systematic review is based on only articles indexed in PubMed. Given that refugee healthcare access in India is an interdisciplinary issue, expanding future reviews to include databases such as Scopus, Web of Science, and regional repositories could capture a more comprehensive evidence base. However, this limitation was partly mitigated by the inclusion of grey literature, allowing for a more balanced and contextually grounded synthesis. More importantly, there is a lack of direct engagement with refugee voices, as this review is based entirely on secondary sources. While many of the included studies incorporate participant perspectives, the absence of original fieldwork limits the depth of experiential insights, particularly around emerging issues such as informal coping mechanisms, discrimination during service delivery, and trust in health systems.

Conclusion

This systematic review set out to critically examine the major barriers that impede healthcare access for refugees and asylum seekers in India. Our thematic analysis reveal that healthcare access

is influenced by a syndemic interaction of structural exclusions. Legal precarity, exclusion from financial protections, language barriers, and gender-based inequalities do not operate in isolation but compound one another, creating a cycle of systemic exclusion. Vulnerable subpopulations, such as women, children, trauma survivors, and those with chronic or mental health conditions, are particularly affected [25,64].

One of the central findings of this review is the foundational role of legal status as a structural determinant of health. Refugees in India exist in a legal grey zone, governed not by refugee law but by the Foreigners Act of 1946, which is a colonial-era regulation that fails to distinguish between undocumented migrants and individuals fleeing persecution [4,6]. India's decision not to ratify the 1951 Refugee Convention or its 1967 Protocol means that refugees are not formally recognised in domestic law and, as a result, lack access to rights-based protections [5]. Without legal status, refugees are unable to obtain Aadhaar cards or other identity documents that serve as gateways to national health schemes like Ayushman Bharat [18,79], or better employment opportunities. As a result, they face exclusion from subsidised care and are constantly at risk of surveillance, detention, or deportation, discouraging timely care-seeking behaviour [81]. Addressing these structural barriers is not only a moral imperative aligned with global health equity principles but also a necessary step toward fulfilling India's obligations under international human rights norms.

Supplementary Materials

Supplementary materials can be downloaded from https://bit.ly/Refugees_Healthcare.

Conflict of Interest

The authors declare no conflict of interest.

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