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BORDERLESS CARE: NURSING CHALLENGES AND POLICY IMPLICATIONS IN REFUGEE AND STATELESS POPULATIONS

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Abstract
The closing decades of the twentieth century and the opening decades of the twenty-first have witnessed an unprecedented escalation in human displacement, driven by protracted armed conflicts, state collapse, environmental degradation, and deepening economic inequalities. As of the most recent estimates, over 34 million refugees have crossed international borders seeking safety, while millions more exist in a legal limbo as stateless persons individuals whom no state recognizes as citizens and who consequently lack access to the most basic protections and services, including health care. Within this global crisis, nurses have emerged not merely as frontline clinicians but as indispensable humanitarian actors, navigating fractured health systems, resource-depleted environments, and complex legal-ethical terrains to deliver care to some of the world's most vulnerable populations. This study undertakes a comprehensive examination of the professional challenges that nurses confront when serving refugee and stateless populations, integrating criminological perspectives on human smuggling, exploitation, and rights violations with practical insights from humanitarian nursing practice. The paper further explores an innovative and underutilized tool in refugee health governance: the application of Anti-Money Laundering (AML) frameworks to monitor the financing of informal migration networks, refugee camp infrastructures, and humanitarian supply chains. Through detailed case analyses drawn from the Middle East (specifically Syrian refugee populations in Jordan and Lebanon), Europe (focusing on reception and integration in Germany and Greece), and South Asia (examining stateless Rohingya in Bangladesh and undocumented populations in India and Pakistan), the study elucidates nurse-led strategies for improving health care access, detecting and reporting exploitation, and advocating for policy reforms that recognize the cross-border nature of refugee health needs. The argument advances a set of actionable policy recommendations, including the establishment of transnational nursing standards, the implementation of interoperable digital health records for displaced populations, the formal integration of nursing observations into AML monitoring systems, and the expansion of trauma-informed, culturally competent care models. Recognizing that health security cannot be disentangled from human

rights and financial accountability, the study concludes that nurses must be empowered not only as caregivers but as advocates, overseers, and bridges between humanitarian assistance and the broader architectures of migration governance.

INTRODUCTION

The image of a nurse tending to be a malnourished child in a crowded refugee camp or calming a traumatized asylum seeker in a border reception center, has become emblematic of the contemporary humanitarian landscape. Yet behind that image lies a reality of extraordinary professional complexity, moral weight, and systemic constraint. Nurses who serve refugees and stateless populations do not simply adapt their clinical skills to unfamiliar environments; they must reconstruct their entire practice in response to legal ambiguities, cultural diversities, resource scarcities, and the ever-present possibility of exploitation and violence. Unlike patients in stable, state-governed health systems, refugees may lack documentation proving their identity or entitlement to care; stateless individuals may be denied service altogether based on their legal invisibility. Migrants who have fallen victim to smugglers or traffickers may present themselves with injuries and illnesses that they are too frightened to explain, fearing that disclosure will lead to deportation rather than protection. Nurses thus find themselves operating at the intersection of health care, human rights, law enforcement, and international diplomacy roles for which most receive little formal preparation.

The scale of the crisis demands urgent attention. According to the United Nations High Commissioner for Refugees (UNHCR, 2022), forced displacement reached historic levels in the early 2020s, driven by conflicts in Syria, Afghanistan, Ukraine, South Sudan, Myanmar, and numerous other settings. More than 34 million people had crossed international borders as refugees, while an additional 50 million were internally displaced within their own countries. Statelessness affects an estimated 4.2 million people officially recorded across 95 countries, though the true figure is widely believed to be substantially higher, as many states do not track or report stateless populations systematically. Stateless individuals such as the Rohingya in Myanmar and Bangladesh, the Bidoon in Kuwait, and the Nubians in Kenya live in a legal void. They cannot obtain passports, voting rights, or property ownership; they may be excluded from public education, formal employment, and, critically, health care systems that require proof of citizenship or legal residence. For nurses, treating a stateless patient often means navigating a bureaucracy that does not recognize the patient's existence, securing emergency care without knowing whether follow-up will be possible, and witnessing preventable deterioration due to lack of access to routine services.

The health burdens borne by refugee and stateless populations are well documented yet persistently under addressed. Refugees experience elevated rates of infectious diseases, including tuberculosis, hepatitis B and C, and HIV, often contracted during dangerous journeys or acquired in overcrowded camps with inadequate sanitation. Malnutrition and micronutrient deficiencies are common, particularly among children and pregnant women, contributing to stunted growth, anemia, and increased susceptibility to infection. Chronic conditions such as hypertension, diabetes, and cardiovascular disease, often present in adults who fled stable home environments, become destabilized when medications are lost during flight or cannot be refilled across borders. Maternal mortality is higher among refugee women than in host populations, reflecting limited access to prenatal care, skilled birth attendance, and emergency obstetrical services. Mental health consequences of displacement post-traumatic stress disorder, major depression, anxiety disorders, and substance use disorders pervade refugee communities, yet mental health services are almost universally underfunded and understaffed in humanitarian settings (Hassan et al., 2016). Nurses, the most numerous and accessible health professionals in camps and border clinics, bear the brunt of addressing these needs with wholly inadequate resources.

Beyond the clinical dimensions of refugee health, nurses must contend with social and legal forces that shape who receives care, under what conditions, and at whose expense. Anti-immigrant political sentiment has risen across many host countries, leading to policies that restrict health care access, mandate provider reporting of undocumented patients to immigration authorities, or cap the number of refugees eligible for services. Nurses find themselves caught between their professional ethical commitments to provide care without discrimination and legal requirements that may compel them to deny services, report patients, or limit their practice in ways they deem harmful. In some contexts, nurses have been prosecuted for providing care to undocumented migrants; in others, they have faced threats and violence from community members who oppose refugee resettlement. These pressures exact a heavy toll on nurses' own well-being, contributing to burnout, secondary traumatic stress, and decisions to leave humanitarian work altogether.

This study seeks to advance understanding and practice at the intersection of nursing, forced migration, and health policy through four interconnected objectives. First, it provides a comprehensive analysis of the operational, ethical, and legal challenges that nurses face when delivering care to refugee and stateless populations, drawing on empirical research and field reports from multiple humanitarian contexts. Second, it integrates criminological perspectives on human smuggling and exploitation, examining how nurses can recognize indicators of trafficking and collaborate with law enforcement, social services, and anti-money laundering (AML) investigators to protect vulnerable migrants. Third, it explores the application of AML frameworks to refugee health governance, arguing that financial monitoring can help ensure that humanitarian funds reach intended beneficiaries rather than being diverted by smugglers, corrupt officials, or fraudulent organizations. Fourth, through comparative case studies of the Middle East, Europe, and South Asia, the paper identifies best practices, persistent gaps, and policy opportunities for strengthening nursing-led care across borders. The intended audiences include nursing practitioners and educators, public health officials, humanitarian organization administrators, migration policymakers, and scholars of global health and forced displacement.

The structure of the paper proceeds as follows. Following this introduction, a comprehensive literature review synthesizes current knowledge across four thematic domains: the health challenges specific to refugee and stateless populations; the operational realities of nursing in humanitarian settings; criminological frameworks for understanding migrant smuggling and exploitation; and the potential applications of AML mechanisms to humanitarian financing. The methodology section describes the qualitative case study approach and the criteria guiding case selection. Detailed case analyses examine refugee nursing in the Middle East (with emphasis on Syrian refugees in Jordan and Lebanon), Europe (focusing on Germany and Greece as primary receiving and transit states), and South Asia (analyzing Rohingya statelessness in Bangladesh and undocumented migration in India and Pakistan). A discussion section integrates findings across cases, identifies cross-cutting themes, and addresses the limitations of current approaches. Policy recommendations are then presented, organized by target audience and level of action, followed by a conclusion that identifies directions for future research and argues for the centrality of nursing within any comprehensive response to the global refugee crisis.

Literature Review

Health Challenges and Health Disparities in Refugee and Stateless Populations

The health profile of refugee and stateless populations differs systematically from that of host populations, reflecting the cumulative effects of pre-displacement vulnerability, peri displacement trauma and deprivation, and post-displacement marginalization. Pre-displacement factors include exposure to armed conflict, political violence, torture, and the loss of family members, homes, and livelihoods. Populations that flee protracted crises often have endured years of cumulative stress and interrupted health care, resulting in

untreated chronic conditions, disability, and psychological trauma. Peri-displacement factors include the physical dangers of flight drowning, dehydration, exposure, physical assault, sexual violence, and the hazardous conditions of unofficial border crossings as well as the deprivation of refugee camps, where overcrowding, poor sanitation, limited food rations, and lack of clean water create ideal conditions for infectious disease transmission. Post-displacement factors include discrimination, language barriers, uncertain legal status, poverty, and restricted access to health care, all of which compound existing health problems and generate new ones (Hassan et al., 2016).

Communicable diseases represent a major concern in refugee populations, both for the refugees themselves and for the host communities that may perceive them as vectors of disease a perception that has fueled anti-refugee sentiment during outbreaks of tuberculosis, measles, and more recently, COVID-19. Screening programs for tuberculosis, hepatitis B and C, HIV, and intestinal parasites are common in organized refugee resettlement, but they are inconsistently applied in spontaneous or irregular migration contexts. Vaccination coverage among refugee children is often lower than in host populations, leaving them vulnerable to vaccine-preventable diseases such as measles, polio, and diphtheria. Outbreaks in refugee camps have been well documented and can spread rapidly due to close living quarters, inadequate ventilation, and limited access to health care (Alahdab et al., 2019).

Non-communicable diseases, while less prominent in humanitarian discourse, account for a substantial proportion of morbidity and mortality among refugees. Hypertension, diabetes, cardiovascular disease, and chronic respiratory conditions, common among older adults, require continuous medication and regular monitoring both of which are difficult to sustain in displacement. Refugees who flee suddenly may leave behind months of medication; those who resettle in new countries may face formularies that differ from what they previously used, necessitating cross-titration without the benefit of prior medical records. Stateless populations, lacking legal status, may be excluded entirely from public health programs that provide subsidized medications for chronic conditions, forcing them to choose between untreated illness and catastrophic out-of-pocket expenditure (WHO, 2021).

Mental health stands out as perhaps the most under addressed dimension of refugee health. The prevalence of post-traumatic stress disorder (PTSD) among refugees has been estimated at rates several times higher than in general populations, with some studies reporting rates between 30 and 50 percent among specific groups who survived torture or witnessed mass violence. Major depression, generalized anxiety disorder, and prolonged grief disorder are also highly prevalent, frequently co-occurring with PTSD. Children are particularly vulnerable, experiencing developmental delays, behavioral problems, enuresis, sleep disturbances, and difficulties in school as a consequence of trauma and disrupted attachment. Yet mental health services in refugee camps and reception centers are grossly deficient, often staffed by a handful of counselors serving thousands of individuals, with no capacity for pharmacotherapy or specialized trauma treatment. Nurses are often the first and sometimes the only health professionals to encounter refugees with mental health needs, but they typically lack training in evidence-based psychological interventions and are limited to basic supportive counseling and referral to overstretched specialists (Hassan et al., 2016).

Stateless populations face additional, qualitatively distinct health barriers derived from their legal invisibility. Without recognized citizenship, stateless individuals cannot obtain identity documents, making it impossible to register for public health insurance, receive vaccination records, or prove eligibility for specialized services. In some countries, hospitals are required to report stateless patients to immigration authorities, leading to detention and deportation rather than treatment. Stateless women may be denied maternal health care, contributing to higher rates of unassisted births, postpartum hemorrhage, and maternal mortality. Children born to stateless parents are often themselves stateless,

perpetuating a cycle of exclusion across generations. Nurses caring for stateless patients must navigate these legal obstacles while also providing trauma-informed care to individuals who have often experienced decades of discrimination, forced eviction, and denial of basic rights (UNHCR, 2022).

Nursing Practice in Humanitarian Settings

The transition from clinical nursing in stable, resourced health systems to nursing in refugee camps, border clinics, or urban informal settlements involves fundamental changes in professional role, scope of practice, and decision-making authority. In humanitarian settings, nurses cannot rely on the presence of physicians, laboratory services, diagnostic imaging, or specialist consultation. They must practice at the highest limit of their training, often performing functions such as prescribing medications, suturing wounds, managing obstetric emergencies, or making triage decisions that determine who receives scarce resources that would be outside their scope in normal circumstances. This expansion of role can be professionally satisfying but also stressful, as nurses bear responsibility for outcomes that would previously have been shared across a multidisciplinary team.

Resource scarcity is the defining operational reality of refugee nursing. Medical supplies are often donated in unpredictable quantities and combinations, leaving nurses to improvise when standard items are unavailable. A nurse in a camp clinic may need to decide whether to use the last dose of an antibiotic for a child with pneumonia or hold it for a patient with sepsis who has not yet arrived. Surgical kits may include instruments for procedures that are not indicated while lacking basic tools for wound care. Medication formularies may include drugs that nurses have never used, requiring rapid self-education via mobile reference applications or consultation with distant colleagues. Electricity and clean water may be intermittent, complicating vaccine storage, instrument sterilization, and infection control. Nurses develop extraordinary ingenuity under these conditions, but the cumulative burden of constant improvisation contributes to burnout (Alahdab et al., 2019).

Cultural competence is not an optional add-on in refugee nursing but a core clinical skill. Refugees come from diverse cultural backgrounds with varying beliefs about health, illness, and medical authority. Some may prefer traditional healers to Western medicine; others may have had traumatic experiences with medical professionals in their home countries, including torture or unethical research. Language barriers are pervasive; refugees may speak languages for which no interpreter is available, forcing nurses to rely on family members, other refugees, or rudimentary translation tools. Gendered cultural norms may affect whether women are willing to be examined by male nurses, whether men consent to disclose mental health symptoms, or whether parents accept vaccines for their children. Nurses who fail to attend to these cultural dimensions risk providing care that is technically competent but culturally unacceptable, leading to nonadherence, avoidance of care, or active resistance (Hassan et al., 2016).

Interprofessional collaboration in refugee health settings often involves partners outside the usual clinical team, including camp administrators, security personnel, food distribution workers, water and sanitation engineers, social workers, child protection officers, and law enforcement. Nurses must learn to communicate effectively with these diverse partners, understanding their different professional languages, priorities, and constraints. For example, a nurse who identifies a child with signs of abuse must know how to report to child protection services without violating confidentiality laws that may differ from those in their home country. A nurse who suspects that a patient has been trafficked must know which law enforcement agencies are trustworthy and which may collude with traffickers. Building these collaborative relationships takes time and intentional effort, yet humanitarian assignments are often short, preventing nurses from developing the local knowledge and trust necessary for effective interagency work.

Criminological Perspectives on Smuggling and Exploitation

Understanding the criminal dynamics that surround refugee migration is essential for nurses who wish to protect their patients from exploitation. The distinction between human smuggling and human trafficking is critical yet often blurred in public discourse. Smuggling involves the consensual, compensated facilitation of illegal border crossing; the smuggler provides a service, and the relationship ends once the border is crossed. Trafficking involves force, fraud, or coercion for the purpose of exploitation; the relationship is nonconsensual and continues after arrival, with the trafficker exercising ongoing control over the victim. In practice, however, smuggled migrants frequently become trafficking victims when smugglers impose unexpected debts, confiscate documents, or threaten harm if payments are not made. The most dangerous smuggling routes such as the Central Mediterranean route from Libya to Italy, or the land route through the Balkans are controlled by criminal networks that routinely use violence, sexual assault, and extortion against their clients (Bales, 2016).

Nurses may encounter smuggling or trafficking-related injuries and conditions without immediately recognizing their etiology. A patient with frostbite on the hands and feet may have crossed a mountainous border in winter without adequate clothing. A woman with multiple sexually transmitted infections and signs of forced intercourse may have been raped by smugglers or captors during transit. A patient with untreated fractures that healed abnormal alignment may have been denied medical care while being held in a smuggling safe house. Children who are unusually fearful of adults, who avoid eye contact, or who display behavioral regression may have been separated from parents during flight and subsequently exploited. The challenge for nurses is to distinguish these presentations from those that could arise from other causes domestic violence, accident, mental illness without making false accusations that could endanger patients (UNODC, 2021).

Trauma-informed care is essential when working with patients who have experienced smuggling or trafficking. Many survivors have been threatened with death or harm to their families if they disclose their experiences to authorities. Others have had negative experiences with law enforcement in their home countries and perceive all uniformed officials as dangerous. Nurses should explain their reporting obligations clearly before asking sensitive questions, obtain consent whenever possible, and avoid making promises of protection or legal outcomes that they cannot guarantee. Safety planning developing a strategy for what the patient will do if they feel threatened after leaving the health facility should be part of every encounter with confirmed or suspected trafficking survivors. Referral pathways to specialized shelters, legal services, and mental health care must be established in advance, so that when a patient is ready to accept help, that help is available (Levi & Reuter, 2020).

Anti-Money Laundering Mechanisms and Humanitarian Financing

The application of Anti-Money Laundering (AML) frameworks to humanitarian contexts is a relatively recent development, driven by concerns that terrorist groups and criminal organizations have exploited humanitarian funding streams. AML regulations require financial institutions to verify customer identities, monitor transactions for suspicious patterns, and report potential money laundering or terrorist financing to government authorities. Over time, AML requirements have been extended to non-financial sectors, including real estate, legal services, and gambling, based on recognition that money launderers exploit any industry with large cash flows and limited oversight. The humanitarian sector, with its reliance on cash transfers, procurement contracts, and cross-border movements of goods, has attracted AML attention but has been slow to adopt corresponding controls (Levi & Reuter, 2020).

Nurses are not financial investigators, nor should they be expected to become them. However, nurses can be trained to observe and report operational anomalies that may indicate financial

misconduct within the humanitarian organizations that employ them or the supply chains on which they depend. Examples of such anomalies include: repeated requests for medical supplies far exceeding reasonable consumption for the population served, suggesting diversion to black markets; procurement officers who insist on using specific vendors despite higher prices or lower quality, suggesting kickback arrangements; cash payments to community health workers that are not documented or that exceed authorized amounts; and patients who report being charged for services that are supposed to be free, indicating that camp staff or local intermediaries are extorting refugees. When nurses report such anomalies through appropriate internal channels compliance officers, inspector generals, or designated anti-fraud hotlines their observations can trigger financial investigations that disrupt criminal networks while also protecting humanitarian funds for their intended purposes (Masciandaro, 2018).

The integration of AML mechanisms into refugee health governance faces significant challenges. Humanitarian organizations often operate in environments where formal banking is unavailable, requiring the use of cash and informal value transfer systems that are difficult to monitor. Corruption may be endemic at multiple levels, from camp guards who accept bribes to allow unauthorized entry, to government officials who skim supplies intended for refugees, to international staff who inflate expense reports. Whistleblowers who report financial misconduct risk retaliation, including termination, blacklisting, or physical harm. Many humanitarian workers view AML measures as bureaucratic impositions that divert limited time and resources from direct service delivery, rather than as tools that ultimately protect the populations they serve. Overcoming these barriers requires leadership commitment to financial integrity, clear reporting mechanisms with protection for reporters, and training that connects AML compliance to humanitarian outcomes (Levi & Reuter, 2020).

Methodology

Research Design and Case Selection

This study employs a qualitative comparative case study methodology, which is well suited for examining complex, context-dependent phenomena such as nursing practice in refugee and stateless populations. Case study methodology supports deep exploration of the specific mechanisms through which nurses deliver care, navigate legal and ethical constraints, and advocate for policy change, while also enabling cross-case comparison to identify patterns that transcend individual contexts. Unlike quantitative approaches that seek causal generalization through statistical inference, case study methodology aims for analytical generalization the development of theoretical propositions that can be tested in future research.

Three geographic contexts were selected to maximize variation on key dimensions relevant to refugee nursing. The Middle East, focusing on Syrian refugees in Jordan and Lebanon, represents a protracted displacement scenario in which refugees have lived in camps and urban settings for many years, creating challenges of chronic disease management, mental health care, and child development. Europe, focusing on Germany and Greece as primary receiving and transit states, represents a mixed scenario of both organized resettlement and spontaneous irregular migration, with varying levels of health system integration and political contention over refugee rights. South Asia, focusing on Rohingya refugees in Bangladesh and undocumented populations in India and Pakistan, represents a statelessness crisis in which legal status or its absence is the central determinant of health access, and in which humanitarian resources are severely constrained.

Data Sources and Analytical Approach

Data for this study were drawn from multiple categories of sources to enable triangulation and reduce bias. Peer-reviewed literature was identified through systematic searches of PubMed, CINAHL, Web of Science, and Scopus databases using search terms including refugee health, stateless populations, humanitarian nursing, forced migration, migrant smuggling, human trafficking, and Anti-Money Laundering. Search results were screened for relevance, with full-text

review conducted for articles that addressed nursing practice, health system responses, or migration governance in the selected case contexts. Reference lists of included articles were hand-searched to identify additional relevant studies.

Grey literature provided essential data on refugee health policies, camp operations, and humanitarian financing. Sources included reports from the UNHCR, World Health Organization (WHO), International Organization for Migration (IOM), United Nations Office on Drugs and Crime (UNODC), Médecins Sans Frontières (MSF), International Rescue Committee (IRC), and national health ministries in case study countries. News reports and investigative journalism articles were consulted for case examples of smuggling, trafficking, and financial misconduct, though these sources were used cautiously and cross-referenced with official documents whenever possible.

The analytical approach followed the framework synthesis methodology, beginning with an initial conceptual framework derived from the research questions and refining it iteratively through engagement with the data. Initial coding categories included clinical presentation patterns, resource constraints, legal barriers, exploitation indicators, financial anomalies, and advocacy strategies. As analysis proceeded, additional categories emerged including the role of gender in health access, the challenges of pediatric refugee care, the specific vulnerabilities of stateless populations, and the psychological impact on nurses themselves. Cross-case comparison was conducted using constant comparative methods, identifying themes that appeared consistently across cases, themes unique to particular contexts, and contradictory findings that suggested important boundary conditions.

Case Studies

The Middle East: Syrian Refugees in Jordan and Lebanon

The Syrian civil war, which began in 2011 and continues in various forms as of this writing, has produced one of the largest forced displacement crises of the twenty-first century. Over 5.6 million Syrians have registered as refugees in neighboring countries, with approximately 1.3 million in Jordan and 1.5 million in Lebanon at the crisis peak. Lebanon, a country of roughly 6 million people, at one point hosted more refugees per capita than any other nation, straining an already fragile health system. Jordan established the Zaatari refugee camp, which became one of the largest such camps in the world, evolving from a tent city into a semi-permanent settlement with schools, markets, and clinics. Nurses in both countries have faced extraordinary challenges in delivering care under conditions of sustained demand, limited resources, and the psychological toll of serving a traumatized population (Hassan et al., 2016).

In Jordan's Zaatari camp, nurses work in clinics operated by the UNHCR and humanitarian partners, providing primary care, maternal and child health services, mental health support, and chronic disease management. The population of the camp has stabilized at around 80,000 residents, a substantial proportion of whom have been there for many years. This longevity has shifted the health profile from acute emergency conditions to chronic diseases and mental health disorders. Nurses report that hypertension, diabetes, and cardiovascular disease are now the most common conditions they treat, reflecting the aging of the refugee population and the cumulative effects of stress and disrupted care. Medications for these conditions are available but limited; nurses must prioritize which patients receive which medications are based on severity, adherence likelihood, and available supply. The rationing decisions are stressful, particularly when nurses must explain to a patient that the medication that has controlled their blood pressure for years is no longer available (Alahdab et al., 2019).

Mental health care in Zaatari is delivered primarily through community health workers and nurses who have received basic training in psychosocial support. The prevalence of trauma-related disorders is estimated to be very high, yet specialized mental health services are scarce. Nurses describe hearing stories of torture, loss, and displacement that they struggle to process themselves, yet they have limited access to the psychological support that would help them

manage secondary traumatic stress. The camp's child protection team, staffed by social workers and nurses, has identified thousands of unaccompanied minors and children separated from their parents during flight. These children often present with behavioral disturbances, enuresis, sleep problems, and difficulties in school. Nurses provide initial assessments, coordinate with foster care arrangements, and monitor for signs of abuse or exploitation within the camp (Hassan et al., 2016).

In Lebanon, the refugee response has taken a different form, with most Syrian refugees living in informal tented settlements or urban apartments rather than formal camps. This dispersed settlement pattern makes nursing outreach more difficult; nurses must travel to isolated locations, often on unpaved roads, to conduct health assessments and deliver services. The Lebanese health system, already strained by political instability and economic crisis, has struggled to absorb the additional demand. Nurses in Lebanese public hospitals report long waits, medication shortages, and tensions between Lebanese citizens and refugees competing for the same limited services. Some Lebanese municipalities have imposed curfews or restrictions on refugee movement, further limiting health access. Stateless Palestinian refugees who had been living in Syria before the war and then fled to Lebanon face challenges, as they are not recognized as Syrian refugees by some humanitarian agencies and not eligible for services designed for Palestinian refugees in Lebanon (UNHCR, 2022).

Exploitation of Syrian refugees is widespread, and nurses are often the first professionals to observe its consequences. Girls as young as twelve have been married to much older men in exchange for dowries that provide financial relief to impoverished families. Child labor is common, with children working in agriculture, construction, or street vending rather than attending school. Women and girls face heightened risk of sexual violence, both within camps and in urban settings, with perpetrators including smugglers, employers, and in some cases, family members. Nurses who identify signs of abuse must navigate complex reporting pathways, balancing patient safety against the risk that reporting could lead to family separation, detention, or deportation. In Lebanon, the legal requirement to report child abuse often conflicts with the knowledge that Lebanese authorities may detain the child's parents for immigration violations, leaving the child in state custody with uncertain outcomes (Bales, 2016).

AML considerations in the Middle Eastern refugee context focus on the diversion of humanitarian funds. Investigative reports have documented instances in which camp supply contracts were awarded to companies connected to camp administrators, with supplies of lower quality than what was paid for or quantities that did not match requisitions. In other cases, refugees receiving cash assistance for rent or food were required to pay kickbacks to camp officials or local intermediaries. Nurses who observe that medical supplies are consistently missing, that patients report being charged for free services, or that inventory records do not match physical counts have a responsibility to report these anomalies through appropriate channels. Whistleblower protection mechanisms in the region are weak, however, reporting a courageous act that may carry personal risk (Levi & Reuter, 2020).

Europe: Reception, Integration, and Health System Adaptation

The European response to refugee inflows during the 2015–2016 peak and subsequent years has varied dramatically across countries, reflecting different political climates, health system structures, and public attitudes toward migration. Germany emerged as the primary destination for refugees, receiving over a million asylum applications in 2015–2016, while Greece and Italy served as initial entry points for those crossing the Mediterranean and then traveling overland through the Balkans. Nurses in all three countries have been central to the health response, but their roles and challenges have differed based on whether they worked in border reception centers, transit camps, or long-term integration services (Alahdab et al., 2019).

In Greece, nurses working on the islands of Lesvos, Chios, and Samos have confronted some

of the most demanding conditions in Europe. Overcrowded reception centers, known as hotspots, at times held three times their intended capacity, with thousands of people living in inadequate shelter with limited sanitation. Nurses in these centers provided primary care, managed outbreaks of respiratory and gastrointestinal infections, and addressed acute injuries from dangerous sea crossings. They also encountered the sequelae of violence: women who had been raped during transit, men with injuries from beatings by smugglers or border guards, children with severe dehydration and hypothermia after days at sea. The psychological burden on nurses was immense, with many reporting symptoms of burnout and compassion fatigue. Some nurses resigned or requested transfers; others continued working but described feeling numb or detached as a coping mechanism (Alahdab et al., 2019).

Greece's health system was already weakened by a decade of economic austerity before the refugee crisis, with hospital closures, staff reductions, and medication shortages. The sudden influx of refugees added demand that the system could not easily accommodate. Nurses in Greek public hospitals reported longer shifts, higher patient loads, and increased exposure to infectious diseases. Language barriers were a persistent challenge, as few nurses spoke Arabic, Farsi, or Urdu. Interpreters were available only intermittently, forcing nurses to rely on gestures, translation apps, or other refugees to communicate. Despite these challenges, many nurses described their work with refugees as the most meaningful of their careers, citing the gratitude of patients who had survived unimaginable hardships (WHO, 2021).

In Germany, the refugee response has been characterized by a commitment to integration, including access to health care through the public insurance system once asylum status is granted. However, the initial period before status determination is challenging asylum seekers are housed in collective reception centers, and their health care is restricted to acute conditions and pregnancy, with chronic conditions often deferred. Nurses in reception centers must triage patients to determine which conditions meet the acute threshold, a process that creates ethical distress when patients with serious but stable chronic diseases are denied the medication they need. The German nursing association has advocated for expanding coverage to include chronic disease management, arguing that preventive care is more cost-effective than emergency treatment for preventable complications (Alahdab et al., 2019).

Mental health care for refugees in Germany has been a particular focus, given the high prevalence of trauma-related disorders. Nurses in reception centers have received training in trauma-informed care, including how to recognize symptoms of PTSD, depression, and anxiety, and how to refer patients to specialized mental health services. However, demand for these services far exceeds supply, with long waiting lists for psychotherapy and limited capacity for pharmacotherapy. Nurses describe managing patients who are actively suicidal, who have persistent nightmares and flashbacks, or who have developed substance use disorders as a way of coping. They feel inadequately prepared for this role and frustrated by the gap between patient needs and available resources (Hassan et al., 2016).

Legal reporting requirements in Europe vary by country, creating confusion for nurses who work across borders or who care for patients who transit multiple countries. In some countries, nurses are required to report undocumented patients to immigration authorities; in others, they are prohibited from doing so under medical confidentiality. In countries with mandatory reporting, nurses face the prospect of patients avoiding care altogether, increasing the risk of disease transmission and preventable suffering. German nurses have been at the forefront of advocacy for a "right to health regardless of status," arguing that immigration enforcement has no place in health care settings. They have developed protocols for documenting patients in ways that protect their identities, using codes rather than names when possible, and storing records separately from health insurance data that could be accessed by immigration authorities (WHO, 2021).

AML mechanisms in the European context have focused on preventing the diversion of humanitarian funds intended for refugee services and detecting financial flows that support smuggling networks. The European Union has established anti-fraud units that monitor procurement contracts, cash assistance programs, and NGO spending. Nurses can contribute by reporting suspicions that supplies for which their facility has paid are not arriving, that cash assistance intended for patients is being intercepted, or that patients are being charged for services that are supposed to be free. In several documented cases, nurses' reports led to investigations that uncovered corruption within camp management or local government, resulting in prosecutions and recovery of funds (Levi & Reuter, 2020).

South Asia: Statelessness, Undocumented Migration, and Informal Health Systems

South Asia presents a refugee and statelessness landscape that differs substantially from the Middle East and Europe, characterized by large-scale stateless populations, protracted displacement with no durable solution in sight, and health systems that are themselves underfunded and overstretched. The Rohingya refugee crisis in Bangladesh is the most visible manifestation, but statelessness also affects populations in India, Pakistan, Nepal, and Sri Lanka, often as a legacy of partition, border disputes, and discriminatory citizenship laws. Nurses in South Asia operate in informal settlements, makeshift clinics, and community health outposts, with minimal resources and limited legal protection for either themselves or their patients (UNHCR, 2022).

The Rohingya, a Muslim minority group from Myanmar's Rakhine State, have faced decades of systematic discrimination, violence, and periodic waves of forced expulsion. Following a military crackdown in 2017 characterized by the UN as genocidal intent, over 700,000 Rohingya fled to neighboring Bangladesh, joining hundreds of thousands who had fled in previous years. The result is the world's largest refugee camp complex in Cox's Bazar, housing nearly one million people in extremely dense, makeshift shelters with limited water, sanitation, and health infrastructure. Nurses working in these camps confront conditions of extraordinary deprivation: landslides during monsoon season destroy shelters and clinics; outbreaks of diphtheria, measles, and cholera spread rapidly through the population; and women give birth in shelters without trained attendants because the nearest clinic is hours away (UNHCR, 2022).

The legal status of Rohingya in Bangladesh is precarious. They are not recognized as refugees under the 1951 Convention, as Bangladesh is not a signatory, but rather as "forcibly displaced Myanmar nationals" who are permitted to stay temporarily without formal rights. This liminal status means that Rohingya cannot obtain work permits, their children cannot access public schools, and they are subject to arrest and detention if they leave the camp boundaries. Statelessness compounds these vulnerabilities: even if Rohingya wished to return to Myanmar, they have no recognized citizenship there, making them effectively stateless in both countries. Nurses in the camps must navigate this legal void, providing care to patients who cannot access the formal health system and who fear that any contact with authorities could lead to deportation to the violence they fled (UNHCR, 2022).

The health needs of the Rohingya population are immense and span the full spectrum of medical conditions. Acute malnutrition rates among children under five have at times exceeded emergency thresholds, requiring therapeutic feeding programs staffed by nurses. Maternal mortality is high, reflecting a lack of prenatal care, skilled birth attendants, and emergency obstetric services. Infectious diseases, including measles, diphtheria, and acute watery diarrhea, have caused large outbreaks, requiring mass vaccination campaigns and the establishment of treatment centers. Chronic diseases, including hypertension, diabetes, and respiratory conditions, are increasingly common as the population ages in displacement. Mental health disorders, including PTSD, depression, and anxiety, affect the majority of adults, many of whom witnessed killings, rapes, and the burning of their villages. Nurses provide the bulk of health care in this context, often

working 12-hour shifts, seven days a week, with minimal support (WHO, 2021).

In India and Pakistan, stateless populations include the Bihari community in Bangladesh (a reverse flow of those who chose Pakistan in 1971 and then became stateless after Bangladesh's independence), as well as various groups affected by border disputes and citizenship documentation requirements. The implementation of the National Register of Citizens in the Indian state of Assam left millions of residents many of whom had lived in India for generations unable to prove their citizenship, rendering them effectively stateless and at risk of detention or deportation. Nurses in public hospitals and community clinics in Assam have reported that stateless patients are increasingly avoiding care for fear of being asked for documentation, leading to delayed diagnosis, more advanced disease, and preventable deaths. Some nurses have developed informal networks to provide discreet care to stateless individuals, sharing information about which facilities are "safe" and which are more likely to report patients to authorities (UNHCR, 2022).

Exploitation risks in South Asia are exacerbated by the lack of legal protections for stateless and undocumented individuals. Human traffickers operate with relative impunity, recruiting stateless individuals with false promises of employment, then subjecting them to forced labor or sexual exploitation. Nurses in border areas have documented cases of children and young adults who were trafficked across borders and then abandoned when they became ill or injured. These trafficking survivors often cannot return home because they lack travel documents, and they cannot stay legally in the country where they are found. Nurses find themselves caring for individuals who are effectively trapped, with no safe options for discharge. Humanitarian organizations are beginning to implement specialized programs for trafficking survivors in South Asia, including shelters, legal aid, and mental health services, but these programs reach only a fraction of those in need (Bales, 2016).

AML considerations in South Asia focus on the financing of informal migration networks and the diversion of humanitarian assistance. The scale of cash movements in the region, combined with weak banking infrastructure, creates opportunities for money laundering and terrorist financing. In the Rohingya camps, reports have surfaced of humanitarian supplies being diverted to black markets, of camp staff demanding bribes for access to services, and of informal money lenders charging exorbitant interest rates to refugees who need cash. Nurses who observe that supplies are consistently missing, that patients report being charged for free services, or that camp records do not match physical inventories have a responsibility to report these anomalies. However, reporting is complicated by the absence of independent oversight mechanisms and the risk of retaliation from camp administrators or local authorities (Levi & Reuter, 2020).

Discussion

Synthesis of Operational Challenges Across Contexts

The three case studies reveal both common patterns and significant variations in the challenges nurses face when serving refugee and stateless populations. Across all contexts, nurses contend with resource scarcity, high patient volumes, language barriers, and the psychological toll of caring for traumatized individuals with limited support. They must practice at the upper limits of their competence, making clinical decisions that would normally involve physicians and specialists. They must navigate complex legal and ethical terrain, balancing patient confidentiality with reporting obligations, patient autonomy with safety concerns, and professional boundaries with humanitarian commitment. They must collaborate with diverse partners outside the health sector, including camp administrators, security personnel, social workers, and law enforcement, requiring communication skills and cultural competence that are rarely taught in nursing education.

The variations across contexts are equally instructive. In the Middle East, protracted displacement has shifted the health profile from acute emergencies to chronic diseases and mental health disorders, requiring nurses to master long-term condition management in settings not

designed for continuity of care. In Europe, the challenge has been integration: connecting refugees to health systems that are simultaneously welcoming and restrictive, and navigating legal requirements that may conflict with ethical obligations. In South Asia, statelessness is the central determinant of health access, with legal invisibility creating barriers that clinical competence alone cannot overcome. Nurses in South Asia must be not only clinicians but also legal advocates, helping stateless patients navigate documentation requirements, connect with legal aid, and advocate for policy change that recognizes their right to health regardless of status.

The Dual Role of Nurses as Clinicians and Advocates

A central theme emerging from all three cases is the dual role that nurses assume: they are not only providers of direct clinical care but also advocates for refugee and stateless populations at multiple levels. At the individual patient level, advocacy means ensuring that patients receive appropriate care despite legal or bureaucratic barriers arguing with administrators, finding workarounds for missing documentation, and pushing back when patients are deprioritized due to their status. At the facility level, advocacy means developing protocols that protect patient privacy, training colleagues in cultural competence, and reporting exploitation or financial misconduct when observed. At the policy level, advocacy means participating in professional association efforts to influence legislation, testifying before government bodies about the health consequences of restrictive policies, and educating the public about the realities of refugee health.

This advocacy role is not optional; it is inherent in the nursing profession's ethical commitment to social justice and the well-being of vulnerable populations. The International Council of Nurses (2019) code of ethics explicitly states that nurses have a responsibility to advocate for policies that promote health and reduce disparities, and to speak out against policies that harm patients or restrict access to care. Yet many nurses feel unprepared for this advocacy role, having received no training in policy analysis, coalition building, or media communication. Incorporating advocacy competencies into nursing education and professional development is essential if nurses are to fulfill this dimension of their role effectively.

Integration of AML Frameworks into Nursing Practice

The application of AML frameworks to refugee health governance is an emerging frontier that holds promise but also presents significant challenges. On the one hand, financial monitoring can help ensure that humanitarian funds reach intended beneficiaries, detect and disrupt criminal networks that exploit refugees, and hold corrupt officials and organizations accountable. Nurses, as frontline observers of resource flows, supply chains, and patient experiences, are well positioned to identify anomalies that may indicate financial misconduct. On the other hand, expecting nurses to function as financial monitors adds another layer of responsibility to an already overburdened profession, risks diverting attention from direct patient care, and may create conflicts of interest or reporting dilemmas.

The key to effective integration is to design AML-related reporting as a parallel system that does not add substantially to nursing workload. Anomalies should be reported through a designated channel a compliance officer, a fraud hotline, or a secure online form rather than requiring nurses to conduct detailed financial investigations. Training should focus on recognition of common red flags, not on the intricacies of money laundering typologies. Feedback loops should be closed so that nurses who report anomalies receive confirmation that their report was received and, when possible, information about outcomes. And protections for reporters must be robust, including immunity from liability, protection from retaliation, and confidential reporting options for those who fear retaliation.

Policy Implications for Transnational Nursing

The cross-border nature of refugee and stateless health requires policy responses that are themselves transnational. No single country can solve the refugee health crisis alone; cooperation across countries of origin, transit, and destination

is essential. Transnational nursing policies standards, protocols, and ethical guidelines that apply across border scan help ensure consistency and quality of care regardless of where a refugee is located. The International Council of Nurses (2019) has taken steps in this direction, but national nursing associations and regulatory bodies have been slower to adopt transnational approaches. Mutual recognition of nursing credentials across countries would facilitate the deployment of nurses to humanitarian settings without the delays and costs of relicensing. Common standards for refugee health training, digital health records, and reporting protocols would improve interoperability and reduce duplication of effort.

Digital health records that are accessible across borders represent a transformative opportunity for refugee health. Currently, refugees who cross multiple borders often start from scratch with each new health encounter, repeating medical histories, undergoing duplicate testing, and experiencing gaps in medication continuity. A secure, patient-controlled digital health record that travels with the refugee accessible to authorized providers in any country, but not to immigration authorities or others who might use the information against the patient could transform this fragmented experience. Nurses would need training in how to use such systems, how to explain them to patients, and how to maintain security and privacy. Pilot projects are underway in several European countries, but scaling up will require political will, technical investment, and agreement on data standards (WHO, 2021).

Recommendations

Based on the findings of this study, the following recommendations are offered for nursing practice, education, research, and policy.

For nursing education programs: Integrate refugee and stateless health content into undergraduate and graduate curricula, including modules on trauma-informed care, cultural competence, legal and ethical issues related to undocumented patients, and recognition of exploitation indicators. Offer elective courses or certificate programs in humanitarian nursing for students interested in refugee health careers. Include simulation experiences that expose students to the conditions of refugee camps and border clinics, building both clinical skills and emotional resilience. Teach advocacy competencies, including policy analysis, coalition building, and media communication.

For healthcare organizations serving refugee populations: Develop clear protocols for nursing assessment, documentation, and reporting that address the specific needs of refugee and stateless patients. Provide language interpretation services, either in-person or via phone or video, for all refugee encounters. Establish secure referral pathways to mental health services, social work, legal aid, and trafficking survivor support programs. Train nurses in financial integrity and AML anomaly reporting and establish confidential reporting channels for concerns about resource diversion or corruption. Implement employee wellness programs that address the psychological impact of humanitarian nursing, including access to counseling, peer support, and regular debriefing.

For professional nursing associations: Develop and disseminate practice guidelines for refugee and stateless health, addressing clinical, ethical, and legal dimensions. Advocate for policies that expand health care access for refugees and stateless individuals, regardless of legal status. Oppose laws that require nurses to report undocumented patients to immigration authorities, arguing that such laws violate medical ethics and harm public health. Support mutual recognition of nursing credentials across countries to facilitate humanitarian deployment. Establish partnerships with refugee-led organizations to ensure that nursing practice is informed by lived experience.

For government and international bodies: Ratify and implement international legal frameworks that protect the right to health for all individuals, regardless of citizenship or legal status, including the International Covenant on Economic, Social and Cultural Rights and the UN Convention on the Reduction of Statelessness. Fund refugee health services at levels commensurate with need, including mental health care, chronic disease

management, and maternal health. Establish independent oversight mechanisms for humanitarian funding, with whistleblower protections, to prevent and detect corruption. Invest in interoperable digital health record systems that can securely follow refugees across borders. Support research on nursing interventions in refugee health, including effectiveness studies, implementation science, and cost-effectiveness analyses.

For nursing researchers: Conduct longitudinal studies that track refugee health outcomes in relation to nursing interventions. Evaluate the effectiveness of different training models for refugee health competencies. Develop and validate screening instruments for exploitation and trafficking that are culturally appropriate and feasible for use in humanitarian settings. Study the psychological impact of humanitarian nursing and the effectiveness of different support interventions. Examine the implementation of digital health records in refugee contexts, including barriers and facilitators from nursing and patient perspectives.

Conclusion

This study examined the role of nurses in delivering care to refugee and stateless populations, integrating perspectives from clinical nursing, criminology, financial governance, and health policy. Through detailed case analyses of the Middle East, Europe, and South Asia, the paper has documented the extraordinary challenges that nurses face in humanitarian settings: resource scarcity, legal barriers, cultural and linguistic differences, the sequelae of smuggling and trafficking, and the psychological toll of caring for traumatized individuals with inadequate support. Yet the cases have also revealed remarkable resilience, creativity, and commitment among nurses who, despite these challenges, deliver compassionate, competent care to some of the world's most vulnerable people.

The dual role of nurses as clinicians and advocates has emerged as a central theme. Nurses cannot simply remain within the four walls of the clinic; they must push outward to address the legal, social, and economic forces that shape refugee health. This means advocating for policies that expand access, reporting exploitation and financial misconduct, educating colleagues and communities, and participating in the governance of humanitarian systems. The integration of AML frameworks into nursing practice, while still nascent, offers a mechanism for nurses to contribute to financial integrity and the disruption of criminal networks that exploit refugees. At the same time, the expansion of nursing roles must be accompanied by appropriate training, resources, and protections; nurses cannot be expected to take on additional responsibilities without corresponding support.

The policy implications of this study extend beyond nursing to the broader architecture of global health governance. The refugee crisis is not temporary; it will persist for decades as conflicts continue, environmental displacement accelerates, and stateless populations remain unrecognized. Addressing the health dimensions of this crisis requires transnational solutions: interoperable digital health records, mutual recognition of professional credentials, common standards for care and reporting, and legal frameworks that protect the right to health regardless of status. Nurses, as the largest and most trusted health profession, must be at the table when these solutions are designed and implemented.

Future research should address several gaps identified in this study. Longitudinal studies tracking refugee health outcomes in relation to nursing interventions would provide evidence for program design and resource allocation. Implementation research examining how evidence-based refugee health protocols are adopted (or not) in different contexts would identify barriers and facilitators that can inform scale-up. Qualitative studies exploring the lived experiences of refugee and stateless patients in relation to nursing care would ensure that interventions are patient-centered as well as clinically effective. And research on the well-being of humanitarian nurses themselves the prevalence of burnout, secondary traumatic stress, and moral injury, and the effectiveness of support

interventions would help sustain the workforce that is essential to refugee health.

In conclusion, nurses are indispensable to the global response to refugee and stateless health challenges. They are the frontline providers, the advocates, the safety net when all other systems fail. Yet they cannot do this work alone, nor should they be expected to do so under conditions of resource scarcity, legal ambiguity, and personal risk. The international community governments, humanitarian organizations, professional associations, and researchers must invest in nursing capacity as an essential component of refugee health security. The millions of displaced and stateless individuals who depend on nurses for their health, their dignity, and sometimes their survival deserve nothing less.

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