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THE SILENT EPIDEMIC: HIV IN GAZA AMID HEALTHCARE COLLAPSE

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ABSTRACT

In Gaza, prolonged blockade, recurrent conflict, and systemic deprivation have turned HIV from an under-detected condition into an increasingly invisible humanitarian health concern. Before the 2023 escalation, about 125 people living with HIV/AIDS were officially recorded in Palestine, including 50 in Gaza – a figure likely shaped more by limited surveillance, stigma, and restricted testing than by low transmission. The destruction of healthcare infrastructure, displacement of medical staff, and collapse of supply chains have since disrupted treatment continuity and eliminated epidemiological visibility. Shortages of antiretroviral therapy (ART), damaged laboratories, and disrupted patient follow-up systems now expose people living with HIV to viral rebound, opportunistic infections, and increased mortality, while heightening transmission risks. Overcrowding, poverty, displacement, and weakened infection prevention and control systems further intensify vulnerability. Key populations – including women of reproductive age, people who inject drugs, and displaced communities – face barriers to prevention and care, while interrupted antenatal services threaten vertical-transmission (mother-to-child) prevention. Restoring ART supply, rebuilding surveillance, integrating HIV services into emergency care, and reducing stigma are urgent priorities.

Keywords: *HIV, human rights, Gaza, humanitarian crisis, healthcare collapse*

STRESZCZENIE

W Strefie Gazy długotrwała blokada, powtarzające się konflikty zbrojne oraz utrwalone niedobory zasobów przekształciły HIV z zakażenia o niskiej wykrywalności w narastający, słabo widoczny kryzys zdrowia publicznego o charakterze humanitarnym. Przed eskalacją konfliktu w 2023 roku oficjalnie odnotowano około 125 osób żyjących z HIV/AIDS w Palestynie, w tym 50 w samej Gazie; liczba ta wynikała jednak najprawdopodobniej z ograniczonego nadzoru epidemiologicznego, stygmatyzacji i niedostatecznego zakresu testowania, a nie z rzeczywiście niskiej transmisji wirusa. Zniszczenie infrastruktury ochrony zdrowia, przemieszczenie personelu medycznego oraz załamanie łańcuchów dostaw doprowadziły do przerwania ciągłości leczenia i uniemożliwiły skuteczne prowadzenie nadzoru epidemiologicznego. Niedobory terapii antyretrowirusowej, uszkodzenie zaplecza laboratoryjnego oraz przerwanie monitorowania pacjentów zwiększają ryzyko wznowy wiremii, zakażeń oportunistycznych i wzrostu śmiertelności, a także sprzyjają dalszej transmisji HIV. Przeludnienie, ubóstwo, przymusowe przesiedlenia oraz osłabienie systemów zapobiegania i kontroli zakażeń dodatkowo zwiększają podatność populacji na choroby zakaźne. Grupy kluczowe – w tym kobiety w wieku rozrodczym, osoby przyjmujące narkotyki iniekcyjnie oraz społeczności przesiedlone – napotykały istotne bariery w dostępie do profilaktyki i opieki zdrowotnej, a przerwanie opieki prenatalnej zagraża zapobieganiu transmisji wertykalnej (matka-dziecko). Do najpilniejszych działań należą przywrócenie ciągłości dostaw terapii antyretrowirusowej, odbudowa nadzoru epidemiologicznego, integracja świadczeń HIV z opieką medyczną w sytuacjach kryzysowych oraz ograniczanie stygmatyzacji.

Słowa kluczowe: *HIV, prawa człowieka, Gaza, załamanie systemu ochrony zdrowia, kryzys humanitarny*

INTRODUCTION

In Gaza – where years of blockade, recurrent conflict, and profound resource scarcity have weakened the health sector – the situation of people living with HIV has evolved into a largely invisible and increasingly urgent public-health concern, exacerbated by the ongoing conflict. Prior to the 2023 escalation, Palestinian Ministry of Health reports indicated a cumulative total of approximately 125 people living with HIV and AIDS in Palestine since 1988, including 50 in Gaza, although this figure likely reflects substantial underdiagnosis due to limited surveillance, stigma, and restricted testing (1). Evidence from earlier epidemiological reports suggests that heterosexual contact accounts for the largest share of recorded transmission routes in Palestine, while a smaller proportion has been linked to contaminated blood products and vertical transmission (2,3). Although nosocomial transmission has not been widely documented in available surveillance reports, the prolonged strain on infection-control systems and healthcare infrastructure raises concern about potential transmission risks in fragile health settings. Routine HIV screening in Gaza has primarily occurred in blood banks and among certain institutional groups, including pregnant women during antenatal care and individuals undergoing pre-employment medical screening (4).

In addition, voluntary testing services are limited and persistent HIV-related stigma and very low levels of comprehensive HIV knowledge within the population discourage individuals from seeking diagnosis. Surveys conducted in Gaza have shown that only a small proportion of respondents possess comprehensive knowledge about HIV transmission and prevention, while social stigma surrounding HIV remains high (4). These structural and social barriers, combined with limited community-based testing and surveillance mechanisms, suggest that the low number of reported cases may reflect restricted detection rather than the true absence of infection.

Since the escalation of hostilities in October 2023, the healthcare system in Gaza has experienced unprecedented collapse. By April 2026, 94% of hospitals are destroyed and only 1.5% of primary healthcare centers operate at full capacity (5). The war has also severely affected the health workforce, with many healthcare workers killed, injured, or displaced and numerous primary healthcare facilities and laboratories damaged or destroyed (6). As a result, diagnostic laboratories, surveillance systems, and routine public-health programmes have been severely disrupted. Today, with the destruction of medical facilities, mass displacement of health personnel, and acute shortages of essential medicines, the current HIV burden is unknown. The collapse of testing services, surveillance systems, and treatment continuity has

eliminated epidemiological visibility and intensified the precarity of those requiring lifelong care and treatment (6).

The aim of this article is to provide a narrative review of available evidence on the dynamics of the HIV epidemic in Gaza since 2023, including its implications for prevention, treatment, and control, and to outline urgent public health priorities in this context.

HISTORICAL CONTEXT

Epidemiology of HIV and risk behaviours. Before the current conflict, the West Bank and Gaza were considered low-prevalence areas for HIV, with a cumulative total of about 125 reported cases between 1988 and 2021, including 95 individuals with developed AIDS and 30 diagnosed with HIV infection. Historical data indicate that male youth were disproportionately affected (around 80%), with the majority of infections acquired through heterosexual contact (1). In Gaza, where official surveillance remains very limited, HIV transmission has historically been recorded primarily through heterosexual intercourse and, to a lesser extent, through blood transfusion and vertical transmission (1,3). However, existing reports fail to capture the full complexity of the socio-epidemiological landscape. Comprehensive studies of risk-taking behaviours and their “hidden epidemics” remain largely impossible under prevailing political and logistical constraints, including military checkpoints, border restrictions, fragmented Palestinian governance, forced or labour-driven mobility, and periodic escalations of armed conflict. Furthermore, limited public awareness and persistent HIV-related stigma, compounded by the years-long blockade, have contributed to the extremely low number of officially reported cases among Gaza’s approximately two million inhabitants. Direct epidemiological evidence quantifying underdiagnosis remains limited, and no large-scale seroprevalence surveys – such as those conducted among pregnant women or other sentinel populations – have been publicly reported. Therefore, while underdetection is plausible given structural barriers to testing and surveillance, it cannot currently be confirmed with available data. Taken together, these structural, political, and social factors may contribute to undiagnosed or unreported HIV infections. The officially low prevalence should therefore be interpreted cautiously, as it may reflect both low reported prevalence and possible underdetection rather than definitive absence of infection.

Over the past decades, however, Palestine has witnessed rising levels of substance use, particularly among young people. A 2017 report on illicit drug use among males estimated that 26,500 individuals engaged in high-risk drug use, including 1,188 who inject drugs, with 81% beginning before the age of 18. “High-risk” was defined as behaviour causing actual harm

(dependence or other health, psychological, or social problems) or placing individuals at a high probability of such harm (7). Research has repeatedly linked occupation- and conflict-related trauma to patterns of substance dependence among Palestinians: for example, reports following the 2008-2009 Israeli offensive on Gaza documented a surge in the misuse of opioid painkillers, particularly tramadol, alongside increased use of antidepressant medications (8), while the 2017 assessment noted increasing use of benzodiazepines and injected cocaine or heroin. Substance use is known to increase risk-taking behaviours – such as inconsistent condom use and needle sharing – which may facilitate the transmission of HIV, HBV, and HCV.

HIV treatment and prevention prior to the collapse. The Palestinian National AIDS Program (NAP) was established in 1998 (9). Historically, the development of HIV prevention and treatment frameworks in Gaza has depended on close cooperation between state institutions, international partners – including the World Health Organisation (WHO), United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA), the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United Nations Population Fund (UNFPA), the United Nations International Children’s Emergency Fund (UNICEF), and Agence Française de Développement – and non-governmental organisations. Together, these actors have worked to deliver services, raise awareness, and strengthen public health capacities despite chronic underfunding and the constraints of the blockade.

The Palestinian Ministry of Health has been responsible for providing free HIV diagnosis, antiretroviral therapy (ART), and patient support, with funding drawn from a combination of domestic resources and international donors, including global health initiatives and humanitarian aid programs (2). The Global Fund, which has supported WHO’s HIV/AIDS work in the West Bank and Gaza since 2008, provided resources for the procurement of antiretroviral medicines, condom distribution, and the expansion of HIV testing and counselling services. Thanks to this support, 25 NGOs subsequently became involved in prevention, awareness, and patient-support initiatives (10,11). The European Union has also contributed to the Palestinian Authority’s health sector by funding medical referrals to East Jerusalem hospitals, including specialised HIV care. Meanwhile, the Ministry of Education and UNFPA implemented peer education on sexual and reproductive health and rights (SRHR) in several Palestinian directorates. Around 2013, in cooperation with UNFPA, the Youth Peer Education Network (Y-Peer) was established, training around 100 peer educators in Gaza who reached an estimated 5,000 young people – including youth from refugee camps and Bedouin communities – through creative education methods such as theatre, role play, simulations, and social media campaigns (12,13). Civil society actors have also contributed significantly to HIV awareness

and prevention. The Palestinian Family Planning and Protection Association (PFPPA), for example, has prioritised reducing HIV transmission and ensuring the full protection of the rights of people living with and affected by HIV (14), while the Palestinian Medical Relief Society (PMRS) developed a smartphone application providing accessible information on sexual and reproductive health and rights (SRHR) (4). Despite these collaborative efforts, HIV prevention and treatment in Gaza have remained heavily dependent on external support and have been continually undermined by the political blockade, economic crisis, and fragile healthcare infrastructure.

Routine HIV screening was introduced for blood donors and some categories of government employees, but it was not consistently applied across all population groups. Systematic screening outside blood banks – particularly among key and priority populations, refugee communities, antenatal women, and the general population – remains poorly documented, with little publicly available data. For example, in 2011, thirty-seven healthcare facilities in Gaza provided HIV testing and counselling services, and more than 15,000 people were tested during the preceding year. However, most tests were conducted at the request of institutions or in connection with blood donation rather than through voluntary or community-based initiatives. NGOs and community activists supported additional testing through awareness campaigns, voluntary testing days, and confidential counselling, yet large segments of the population remained unscreened due to stigma, limited outreach, and cultural sensitivities (4).

Among Palestinian students surveyed in 2012-2013, the primary reason for endorsing voluntary HIV testing was the belief that it should be confidential, voluntary, and well-organised (15). The 2016 RAND-Youth Health Risk Survey similarly noted that topics such as sexual activity, drug use, and HIV remain highly stigmatised, making accurate self-reporting and open screening extremely difficult. Many young people are unaware of available services or avoid testing due to fear of social consequences (16). The 2021 Knowledge, Attitudes, and Practices among Men in the Gaza Strip study further documented very low awareness of HIV and STI prevention: fewer than 2% of men and women (n = 1,250) were able to correctly recognise HIV and other sexually transmitted infections when asked to identify conditions related to sexual and reproductive health in the survey questionnaire. These findings suggest that low awareness, persistent stigma, and limited institutional outreach remain major barriers to testing, case detection, and early linkage to care in Gaza (4).

PERSISTENT HIV-RELATED STIGMA

HIV remains highly stigmatized in Palestinian society, shaped by conservative social norms and widespread misconceptions about transmission. This stigma often discourages individuals from seeking medical care, even under ordinary circumstances. Findings from the 2011 Knowledge, Attitudes and Practices survey in the occupied Palestinian territory, indicated that 66.4% of respondents would prefer to keep the HIV status of a family member or close friend secret, reflecting strong social pressure toward concealment (17). A 2015 study among 492 students at Al-Azhar University in Gaza showed that, although participants demonstrated a moderate level of knowledge about HIV/AIDS, only about one-third were willing to maintain close contact or communicate with people living with HIV. Moral and religious framings of HIV and AIDS were also widespread: 20.7% of students viewed HIV/AIDS as a punishment from God, and 26% were uncertain; 15.3% believed that “a lack of religious and moral commitment could cause HIV/AIDS infection”, while 34.6% were unsure. Moreover, 52.4% of respondents thought that engaging in sports and maintaining good nutrition could protect them from HIV/AIDS – an indication of persistent misconceptions about transmission and prevention (15). Similarly, the 2015 MIFTAH Country Assessment for Palestine found that although more than 90% of respondents knew HIV could be transmitted through sex, blood, or injections, only 7.9% met the UN standard for “comprehensive knowledge” (18).

Taken together, these findings illustrate how social conservatism, shame linked to moralized epidemiological stereotypes, and low levels of accurate knowledge reinforce HIV-related stigma, fostering fear, avoidance, and discrimination in both everyday life and healthcare settings. This dynamic, in turn, contributes to reluctance to test, fear of diagnosis, and avoidance of visibility among people living with or at greater likelihood of acquiring HIV – patterns likely exacerbated by the current crisis, which further discourages individuals from coming forward for testing and treatment.

ESCALATED CHALLENGES AFTER 2023

Rapidly increasing AIDS numbers and collapsed surveillance. Currently, the exact number of people living with HIV in Gaza remains unknown due to the collapse of healthcare services and the disruption of diagnostic capacity. Prior to the 2023 escalation, HIV surveillance in Gaza relied on reporting from health facilities to the Palestinian Ministry of Health via paper-based records and limited digital systems, primarily covering blood banks, antenatal clinics, and institutional screening programmes. Data were aggregated at the Ministry of Health level, but systematic community-based surveillance as well as population screening programmes

were minimal. The most recent available data, from 2025, report a cumulative total of 159 people living with HIV and AIDS, with the number of people with fully developed AIDS surging from 95 in 2021 to 127 in 2024. In Gaza, the number of diagnosed HIV/AIDS cases in the Palestinian Ministry of Health's increased from 50 to 70 between 2021 and 2024. As the number of people living with HIV in the whole Palestine remained relatively stable over this period (30 in 2021 and 32 in 2024), the observed increase in Gaza appears to be driven primarily by a rise in cases of advanced HIV disease (AIDS). Also, available data suggest an increasing reporting of transmission routes beyond predominantly heterosexual contact, including cases classified as unknown, contact with a person living with HIV, and injecting drug use (19,20). This pattern may reflect heightened vulnerability in increasingly fragile and precarious settings. In the absence of routine testing, case registration, and public-health reporting mechanisms, HIV statistics remain fragmentary and outdated, obscuring the epidemic's actual scope (21).

Disrupted care and unmet legal obligations. The ongoing conflict has severely disrupted medical care, making it difficult for people living with HIV and those at greater likelihood of acquiring HIV to access testing, treatment, and other essential services. Reliable numbers on disrupted care are unavailable due to the health system collapse; however, reports indicate that most ART supplies have been depleted, and shipments of essential medicines were intermittently blocked for prolonged periods (5,6).

Severe shortages of essential medicines, including antiretroviral therapy (ART), have become a defining feature of Gaza's ongoing health crisis. The blockade, compounded by the destruction of medical facilities, border restrictions, and disrupted supply chains, has severely limited the import, storage, and distribution of life-saving medicines. As a result, patients face prolonged treatment interruptions, placing their health and survival at serious risk and undermining efforts to maintain continuity of HIV treatment and care (22). In early 2025, WHO and other humanitarian agencies warned that most essential medicines, including ART, were at "critical or zero stock levels" in Gaza's remaining health facilities (23). These shortages constitute a grave threat not only to people living with HIV but also to those with other chronic conditions, highlighting the urgent need for sustained humanitarian access and systemic interventions to restore the medication supply. It is crucial to emphasize that, under International Humanitarian Law (IHL), an occupying power cannot refuse the provision of humanitarian assistance to a civilian population. It must allow and facilitate the unimpeded passage of humanitarian relief to populations in need (24).

Increased vulnerability in a collapsed health system. The general instability, lack of resources, and overcrowded living conditions in Gaza have heightened the risk of transmission

for a range of infectious diseases, including HIV. The collapse of healthcare facilities and compromised infection prevention and control (IPC) practices constitute a direct risk factor for HIV transmission, particularly through unsafe injections or blood-handling practices. For people living with HIV, the collapse of healthcare infrastructure has severely disrupted ART coverage, patient monitoring, and continuity of care, preventing sustained viral suppression and leading to treatment interruptions. Recent assessments illustrate the scale of this breakdown: As of March 2026, antiretroviral therapy (ART) was available in approximately 2% of all health service institutions in Gaza, with only 12 of the 52 facilities expected to provide this service currently offering it (25). And by April 2026, 94% of hospitals are destroyed and only 1.5% of primary healthcare centers operate at full capacity (5), underscoring the near-total collapse of healthcare provision. This systemic paralysis has coincided with a rise in other infectious diseases: hepatitis A, B, and E outbreaks have been reported in overcrowded shelters; tuberculosis and waterborne infections are also increasing, further straining the public-health infrastructure (5,6).

This collapse of health services not only undermines HIV treatment continuity but also compromises vaccination programmes, maternal health services, and infection-control capacities, increasing the risk of both HIV progression and broader public-health crises. The breakdown of prevention and treatment systems has also left key and priority populations – including women of reproductive age, people who inject drugs, and displaced or conflict-affected communities – without reliable access to essential services and protective resources. The absence of routine maternal testing and follow-up threatens to reverse progress in the prevention of vertical transmission of HIV. In addition, the collapse of sanitation and healthcare systems has accelerated the spread of other infectious diseases – such as hepatitis, tuberculosis, and waterborne infections – placing further strain on an already fragile public-health infrastructure. However, HIV remains particularly vulnerable due to its dependence on continuous treatment and monitoring, making it highly sensitive to service interruptions and associated long-term risks. Also, the scarcity of medicines and medical supplies, coupled with frequent power outages and the destruction of health facilities, poses major challenges for healthcare workers, who are themselves exposed to infection risks while engaged in life-saving activities. These overlapping crises place both patients and healthcare providers under extreme physical and psychological pressure, further weakening Gaza’s already limited capacity to manage HIV prevention and care.

Ongoing humanitarian emergency and the right to health. The protracted conflict in Gaza has produced an acute public-health emergency, with particular concern for HIV

transmission, progression to AIDS and access to care amid the collapse of healthcare infrastructure and mass displacement. Although the true number of people living with HIV and AIDS in Gaza remains uncertain due to disrupted surveillance and testing systems, the current humanitarian crisis – characterized by the destruction of medical facilities and shortages of essential medicines – has created conditions in which infectious diseases, including HIV, may spread undetected. The humanitarian situation in Gaza corresponds to the United Nations International Strategy for Disaster Reduction (UNISDR) and World Health Organization (WHO) definitions of a complex humanitarian crisis – one that exceeds the response capacity of national institutions and results in severe and wide-ranging public-health consequences (26, 27).

The right to health – an inalienable entitlement of every Palestinian, and particularly of people living with HIV – is universally recognized as a fundamental human right. It is a core principle of international human rights law (IHRL) and remains applicable at all times, including during armed conflict and occupation. Defined as the right to enjoy the highest attainable standard of physical and mental health, it is articulated in several key international instruments:

- World Health Organization Constitution (1946) – affirms that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being” (28)
- International Covenant on Economic, Social and Cultural Rights (Article 12) – obliges states to ensure access to the conditions necessary for physical and mental health (29).
- Universal Declaration of Human Rights (Article 25) – recognizes the right to medical care as part of customary international law (30)
- Geneva Convention IV (Articles 23,55,91) – requires parties to armed conflict to allow the free and safe passage of medical supplies and humanitarian assistance services (31,32,33).

Together, these instruments establish the tripartite obligation of states to respect, protect, and fulfil the right to health. The normative architecture of international human-rights and global-health law also requires international cooperation and assistance, not only in times of stability but especially during humanitarian emergencies.

CONCLUSIONS AND RECOMMENDATIONS

The situation in Gaza underscores the urgent need for coordinated international intervention. Without immediate action to restore healthcare services, ensure access to essential

medicines, and address HIV-related stigma, the silent epidemic in Gaza will continue to grow unchecked. It is imperative that the global community steps forward to support the people of Gaza in this critical time.

1. It is vital to ensure uninterrupted access to antiretroviral therapy (ART) by securing reliable supply chains, protected humanitarian corridors, and simplified treatment protocols. Sustained ART delivery is essential to prevent disease progression, reduce mortality, and limit onward transmission, particularly in a context where interruptions in treatment have already contributed to worsening clinical outcomes.
2. At the same time, combating HIV-related stigma is essential to rebuilding trust in healthcare. This requires sustained public-awareness efforts, community-led education, and inclusive dialogue that challenge misinformation and foster social solidarity.
3. The establishment of reliable systems for HIV data collection, testing, and reporting is also critical. Without accurate information on infection trends and treatment access, it will be impossible to understand the true scale of the epidemic or to design effective, evidence-based interventions.
4. To address the unfolding crisis, governments and international organizations must make the restoration of Gaza's healthcare system an urgent priority. Ensuring the continuous availability of essential medicines and treatments, including ART, is vital for the survival and dignity of people living with HIV and those at greater likelihood of acquiring HIV.

Without urgent and coordinated international support, the silent HIV epidemic in Gaza will continue to progress unchecked, with profound implications for public health and human dignity.

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