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Health in Crisis: An Integrative Review of Sexual and Reproductive Health in Humanitarian Settings

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Abstract

Background: Sexual and Reproductive Health (SRH) is a cornerstone of overall health, particularly in fragile humanitarian contexts. Despite being recognized as a fundamental human right, access to quality SRH services is often significantly restricted in crisis situations. This limitation can lead to damaging health outcomes for women, children, and marginalized groups. Given this reality, there is an urgent need for an enriched understanding of SRH in areas impacted by conflicts, disasters, and population displacements. With global trends such as increasing forced migration and escalating crises, a thorough reevaluation of the challenges and potential solutions associated with SRH in these contexts is crucial.

Aim: The aim of the integrative review is to describe the current status of sexual and reproductive health (SRH) services and interventions in humanitarian settings and explore key challenges in sexual and reproductive health services in these settings.

Methodology: This integrative literature review analyzed and synthesized 22 research papers through inductive methodology by Elo and Kyngäs (2008).

Results: This in-depth review of studies from a wide range of humanitarian environments worldwide, has unveiled critical insights into the hurdles surrounding Sexual and Reproductive Health (SRH) services. Firstly, barriers to accessibility and awareness prevent individuals from acquiring vital SRH knowledge and services, and this prevention is often intensified by socio-cultural stigmas. Educational and language obstacles further amplify these challenges, particularly for migrants. This review also underscores the severe impact of gender-based violence (GBV) and early or forced marriages on SRH outcomes.

Conclusions: This analysis reveals key obstacles that obstruct the provision of SRH services in humanitarian settings. Acknowledging these issues enables decision-makers to plan effective strategies and interventions to address the SRH needs in these settings. Exploration of each barrier and seeking holistic solutions to overcome these challenges is suggested.

Keywords: Humanitarian setting, immigrants, GBV, integrative literature review, sexual and reproductive health
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Introduction

Sexual and reproductive health is an essential aspect of overall health and well-being, yet access to these services and information can be severely limited in humanitarian settings such as conflict zones, natural disasters, and refugee camps. The lack of access to comprehensive and quality SRH services can have detrimental effects on individuals and communities. In response to this pressing issue, it is important to examine the current state of sexual and reproductive health in humanitarian contexts. As a student who has firsthand experience living and working in a conflict-affected country, I am interested in exploring Sexual and Reproductive Health in Humanitarian Settings. Such environments can significantly affect the health and well-being of those impacted, especially sexual and reproductive health of individuals. Because of the vulnerability and specific health needs of women, children, and other marginalized groups in these situations, it is crucial to address SRH in humanitarian contexts.

Main Concepts and Definitions

Humanitarian settings are often crisis situations where individuals or communities face life-threatening hazards and require immediate assistance and protection, such as in natural disasters, armed conflicts, epidemics, and displacement (IASC, 2015).

Sexual and Reproductive Health and Rights (SRHR) are considered fundamental human rights and are defined as the right of individuals and couples to freely decide the number, timing, and spacing of children and to have access to the highest standard of sexual and reproductive health (SRH) information to make informed decisions (UNFPA, 1994).

A Refugee is a person who has fled their country due to a well-founded fear of persecution because of their race, religion, nationality, membership in a particular social group, or political opinion (UNHCR, 1951).

Internally displaced persons (IDPs) are individuals who have been forced to leave their homes due to factors such as conflict, natural disasters, or other crises but remain within their country's borders (OCHA, 1998).
**Contraception** refers to methods or devices used to prevent unintended pregnancy, encompassing barrier methods, hormonal contraceptives, intrauterine devices, sterilization, and emergency contraception (WHO, 2021).

**Intersectionality theory** is a framework for understanding how various social categories such as race, gender, class, and sexuality intersect and overlap, contributing to unique experiences of oppression or privilege for individuals. It emphasizes the interconnected nature of social categorizations and their ability to create complex systems of discrimination or advantage (Crenshaw, 1989).

**Gender-Based Violence (GBV)** is violence directed against someone based on their gender or that affects individuals of a certain gender disproportionately. It can include physical, psychological, sexual, economic, and emotional abuse (UN, 1993).

**Intimate Partner Violence (IPV)** is a subset of GBV and is defined as behavior by an intimate partner or ex-partner that causes physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviors. IPV can occur within both current and former romantic or sexual relationships, regardless of marital status (WHO, 2012).

**Child marriage**, Child marriage is any formal marriage or informal union where one or both of the parties are under 18 years of age. It is a violation of human rights and has widespread and long-term consequences for child brides and grooms. This practice often violates the rights of children, especially girls, depriving them of their health, education, and childhood and often subjecting them to a lifetime of economic and personal dependencies (UNICEF 2018).

**The Minimum Initial Service Package (MISP)** is a global standard in reproductive health for responding to humanitarian crises. It contains objectives and activities to prevent and manage the consequences of sexual violence, reduce HIV transmission, prevent excess maternal and newborn mortality, and plan for comprehensive reproductive health services (Inter-Agency Working Group on Reproductive Health in Crises, 2010).
Background

Access to quality SRH services is essential for the well-being of individuals, particularly in humanitarian settings where refugees, displaced persons, and migrants face numerous challenges. Addressing SRH needs in humanitarian settings is crucial for a number of reasons. Firstly, sexual violence and exploitation are often prevalent in such settings, leading to an increased risk of unintended pregnancies, sexually transmitted infections, and other health complications (Inter-agency Working Group on Reproductive Health in Crisis 2018; Casey et al 2015). Secondly, access to SRH services can help prevent maternal and infant mortality, as well as ensure safe deliveries and postnatal care (Blanchet et al., 2017). Thirdly, promoting SRH in humanitarian settings can help promote gender equality and human rights, as well as reduce the risk of gender-based violence and discrimination (Gibbs et al., 2016; Wirtz et al., 2018).

According to the United Nations Population Fund (UNFPA), an estimated 26 million women and girls in crisis settings are in need of lifesaving SRH services, including family planning, maternal health, and the prevention and treatment of STIs and HIV/AIDS globally (UNFPA, 2021). The limited availability of SRH services, particularly for conflict-affected populations, has led to increased risks for women and children. These risks include higher rates of sexually transmitted infections (STIs), unplanned pregnancies, unsafe abortions, and complications during pregnancy and childbirth (McGinn et al., 2011). Advocates mention that focusing on family planning (FP) services in humanitarian settings is critical, as access to FP services is often limited, leading to unwanted pregnancies and negative consequences for both the mother and child (Tanabe et al., 2015).

Improved access to SRH services is considered essential for sustainable development, as reflected in the United Nations' Sustainable Development Goal (SDG) target 3.7, which calls for "universal access to SRH services, including family planning, information, and education" by 2030 (United Nations, 2015). Providing SRH services to marginalized communities, including migrants and internally displaced persons (IDPs), is key to achieving this target (Foster et al., 2017).

McGinn pointed out that access to SRH services in humanitarian settings is limited and may bring negative consequences for individuals and communities, such as
increased rates of sexually transmitted infections, unintended pregnancies, maternal mortality, and gender-based violence (McGinn et al., 2011).

A study by Keygnaert et al. (2014) found that female migrants and refugees face unique SRH challenges such as limited access to SRH services and information, stigma, and discrimination. Despite these challenges, there have been numerous efforts to improve SRH services in humanitarian settings, including the development of guidelines and protocols, the integration of services into existing health systems, and the use of innovative technologies to provide remote care (Inter-agency Working Group on Reproductive Health in Crisis, 2018; Krause et al., 2015). Another study by Benage et al. (2015) found that Syrian refugee women in Lebanon had high rates of unintended pregnancy.

These findings highlight the need for continued research and attention to the issue of SRH in humanitarian settings in order to inform the development of effective and equitable SRH interventions for women and children in crisis. Women and children are often disproportionately affected by humanitarian crises, and their SRH needs are often overlooked in the rush to provide lifesaving services in emergency situations. Immigrant populations, including refugees and internally displaced persons, may face additional barriers to accessing SRH services, such as language barriers, cultural differences, and limited resources (Doocy et al., 2016).

Despite these barriers, there have been numerous innovations in SRH services in humanitarian settings in recent years. For example, the use of mobile clinics and telemedicine has helped increase access to care in hard-to-reach areas, while the integration of SRH services into existing health systems has helped ensure continuity of care for individuals affected by crises (Blanchet et al., 2017; Tappis et al., 2017). Additionally, the development of community-based programs and peer-to-peer support networks has helped address cultural and social barriers to accessing care, as well as promote awareness and education around SRH issues (Gibbs et al., 2016; El Ayoubi et al., 2021).

The Minimum Initial Service Package (MISP) plays a critical role in providing a set of priority interventions that should be implemented at the onset of an emergency. MISP is designed to address the most urgent SRH needs such as access to clean delivery kits for pregnant women and reduce morbidity and mortality among affected populations (Inter-agency Working
Some studies have highlighted the importance of MISP in improving access to SRH services in humanitarian settings (Krause et al., 2015; Spiegel et al., 2014). For instance, a study by (Krause et al 2015) demonstrated the effectiveness of MISP in providing essential SRH services to Syrian refugees in Jordan. Similarly, (Spiegel et al, 2014) argued that MISP can serve as a crucial tool for ensuring the integration of SRH services into emergency response efforts.

**Theoretical Perspective**

The Intersectionality Theory, initially developed by Kimberlé Crenshaw in the late 20th century, provides a comprehensive understanding of how various forms of social category interact, particularly within systems of oppression and privilege (Collins & Bilge, 2020). This theory is particularly relevant to the study of Sexual and Reproductive Health (SRH), as it helps to elucidate the array of obstacles and barriers individuals encounter due to their overlapping categories. In this study, I used the intersectionality theory as a guiding perspective to understand how different social factors overlap and impact sexual and reproductive health in humanitarian settings. I explained and connected these ideas in the discussion section. Intersectionality theory, rooted in the recognition of overlapping social categories such as gender, race, and class, has progressively been employed to understand disparities in health, particularly SRH (Bowleg, 2012). By focusing on how these categories intersect and contribute to unique experiences of privilege or oppression, intersectionality provides a comprehensive framework to explore SRH issues in humanitarian settings. For instance, a displaced woman's experience isn't solely shaped by her gender but is further influenced by intersecting factors like age, socioeconomic status, ethnicity, and prevailing cultural or religious norms (Davis, 2008; Bauer, 2014).

In the realm of SRH in humanitarian contexts, intersectionality can illuminate the nuanced challenges faced by individuals. Recent research has delved into how these intersections specifically impact SRH access. For example, a study by Alarcão, et al. (2021) leveraged an intersectional lens to scrutinize the barriers to SRH services among refugee women in Europe. Their findings illuminated that race, legal status, and age were critical determinants that intersected with gender, shaping these women's access to care.

Intersectionality theory allows us to comprehend how multiple stigmas overlap, intensifying the problems certain individuals encounter. For instance, a young woman seeking...
SRH services may face stigma due to societal perceptions of female sexuality. If she is also part of a minority ethnic group, she may face compounded stigma due to existing racial prejudices. Such intersecting stigmas can lead to feelings of shame and fear, and reluctance to seek necessary SRH services, thereby impacting health outcomes (Logie et al., 2019).

El Ayoubi et al. (2021) effectively utilized intersectionality in their study of SRH barriers faced by rural Lebanese women. The study showed that access to SRH was not merely a gender issue. Factors such as religious affiliation, age, and local customs played significant roles. For example, societal expectations of age-appropriate behaviour added an extra layer of stigma for older women, discouraging them from seeking SRH services like family planning or fertility treatments.

**Problem statement**

The pivotal role of Sexual and Reproductive Health (SRH) in comprehensive healthcare is well-known, especially in unpredictable humanitarian conditions. These situations tend to expose vulnerable groups such as women, children, and marginalized communities to increased risks associated with sexual health, childbirth complications, and gender-based violence. Previous studies have identified numerous obstacles to SRH access, from infrastructural deficits to sociocultural hurdles. However, a deeper understanding of these issues within the constantly evolving humanitarian landscape, intensified by the rise in forced displacements and conflicts, remains elusive.

Considering the extensive impact and the ever-changing global context, there is a need to enhance our understanding of SRH within these settings. This study seeks to fill this knowledge gap through a comprehensive analysis, spotlighting enduring challenges and proposing potential solutions. Undertaking such a study is not only critical for optimizing SRH service provision but also instrumental in formulating efficient policies designed for humanitarian contexts.

**Aims and research questions**

The aim of the integrative review is to describe the current state of sexual and reproductive health (SRH) services and interventions in humanitarian settings and find out key challenges in Sexual and Reproductive Health services.
The specific research questions are:

1. What are the key challenges and barriers to providing effective SRH services and interventions in humanitarian settings?
2. How can these be addressed?

**Methodology**

**Design**

An integrative literature review is chosen for the study to describe the current state of sexual and reproductive health (SRH) in humanitarian settings. This type of review was chosen because it allows to include both qualitative and quantitative research, providing a better picture of sexual and reproductive health (SRH) in areas affected by crises. And to ensure the rigor and structure of the review process, we employed the methodology proposed by Whittemore and Knafl (2005).

**Search Strategy**

The literature search for this study was based on a combination of relevant keywords related to SRH and humanitarian settings. Before conducting the search, a meeting and training session with the Dalarna University librarian was held to discuss the search strategy and identify the most appropriate databases to utilize.

During the search process, the PCC (Population, Concept, Context) method was used to narrow the search and ensure that the search terms were relevant to the research questions. This method involves specifying the population (P), concept (C), and context (C) of the study. For this study, the population was individuals in humanitarian settings, the concept was SRH, and the context was humanitarian settings, which is described in table 1 below.

<table>
<thead>
<tr>
<th>Category</th>
<th>Search Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>Individuals in Humanitarian Settings</td>
</tr>
<tr>
<td>Concept</td>
<td>SRH- Sexual and Reproductive Health, Sexual Education, MISP-Minimum initial Service Package</td>
</tr>
<tr>
<td>Context</td>
<td>Humanitarian Setting, Fragile setting</td>
</tr>
<tr>
<td>Additional terms</td>
<td>Humanitarian work, Access</td>
</tr>
</tbody>
</table>
The search strategy included relevant keywords, which are shown below in Table 2, and searches were made in two databases: PubMed, and Web of Science. Boolean operators AND and/or OR were used to refine and narrow down the search results. It ensured a comprehensive and inclusive search, capturing all potentially relevant literature on the subject of Sexual and Reproductive Health in humanitarian contexts.

**Table 2 Search Key Words**

<table>
<thead>
<tr>
<th>Database</th>
<th>Search block 1</th>
<th>Search block 2</th>
<th>Search block 3</th>
<th>Search block 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pub Med</td>
<td>Sexual and Reproductive Health OR SRH</td>
<td>AND Humanitarian Setting OR Humanitarian Work OR Fragile Setting</td>
<td>AND Sexual Health OR Sex Education</td>
<td>AND Minimum initial service package OR MISP</td>
</tr>
<tr>
<td>Web of Science</td>
<td>Sexual and Reproductive Health OR SRH</td>
<td>AND Humanitarian Setting OR Humanitarian Work OR Fragile Setting</td>
<td>AND Sexual Health OR Sex Education</td>
<td>AND Minimum initial service package OR MISP</td>
</tr>
</tbody>
</table>

After conducting the search, the search results were exported to Zotero (Zotero, 2022). For those unfamiliar with the tool, Zotero is a free, open-source reference management software designed to help researchers organize and cite their research materials efficiently. It assists in collecting, organizing, and generating citations and bibliographies, streamlining the academic writing process. Duplicate studies were removed, and the remaining studies were screened based on their titles and abstracts to determine their relevance to the research questions and inclusion criteria. The figure below describes the selection process.
Inclusion and Exclusion Criteria

For this integrative review, the selection of articles was guided by several inclusion criteria. First and foremost, only articles that were published within the past decade, between 2013 and 2023, were included in the review. This timeframe was chosen to ensure the relevance and currency of the data (Polit & Beck, 2017). Secondly, the articles had to be written in the English language to avoid any potential misinterpretations due to translation. The third criterium was that the articles must focus on Sexual and Reproductive Health (SRH) within humanitarian settings. This was to ensure that the articles directly contribute to the understanding of the research questions and the context at hand. Lastly, the articles needed to address the research question. This was a critical factor in ensuring that the review remained
focused and provided a comprehensive understanding of the barriers to SRH in humanitarian settings.

**Quality assessment**

In order to assess the data quality and ensure the methodological rigor of the studies included in this review, the Joanna Briggs Institute (JBI) critical appraisal tools were used (Joanna Briggs Institute, 2020). Each included study was meticulously evaluated using JBI tools, and a quality score was assigned to each study after a comprehensive assessment based on the criteria outlined by the JBI tools, which are specifically designed to evaluate diverse research designs, including cross-sectional and qualitative, which are used for this review. Articles getting a score of 8 or above were assumed to be of high quality and included in the review. The use of the JBI tools helped to ensure that the studies included in this review were of high quality and that their findings were reliable.

**Data Analysis**

The data analysis for this study adopted the content analysis methodology as proposed by Elo and Kyngäs (2008), specifically utilizing the inductive analysis approach. This approach allows for the generation of knowledge from the data itself rather than from preconceived theories or hypotheses (Thomas, 2006), making it suitable for exploratory research. Whittemore and Knafl's (2005) integrative review methodology was a foundation in the study, given its strength in synthesizing diverse research methods into cohesive findings. It served as a guide.

The first stage of the analysis was the preparation phase. This entailed repeatedly reading the collected studies to achieve a profound understanding of the content (Elo and Kyngäs, 2008). This stage is essential, as it forms the foundation for the subsequent stages of analysis and ensures that the researcher is thoroughly immersed in the data (Braun & Clarke, 2006). Following the preparation phase, open coding was conducted. During this stage, the extracted qualitative data was analyzed, and initial codes were identified based on the content. Subsequent to open coding, initial codes were grouped into broader categories based on their similarities and relationships. This categorization process, as Elo and Kyngäs (2008) suggest, is an essential step in content analysis as it enables the organization of codes into meaningful clusters. The final stage, abstraction, involved further condensing these categories into general, higher-order themes (Elo and Kyngäs, 2008). This is a crucial step in content analysis as it
allows the researcher to derive interpretations that illuminate the underlying meanings in the data.

In addition to the qualitative synthesis, quantitative data extracted from the selected studies played a pivotal role in strengthening the evidence base of the research. The quantitative findings were systematically organized to validate and reinforce the themes and patterns emerging from the qualitative data. This blending of qualitative insights with quantitative evidence validated the sexual and reproductive health challenges in humanitarian settings.

Throughout this entire process, an Excel spreadsheet was used to document all the codes and quotes, providing an organized and systematic approach to data management. The use of Excel as a data management tool has been endorsed by numerous researchers (Castleberry, A., & Nolen, A. (2018)). for its versatility and ease of use.

<table>
<thead>
<tr>
<th>Study</th>
<th>Quote</th>
<th>Codes</th>
<th>Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Marlow et al. 2022)</td>
<td>&quot;There were no induced abortion services available in the camp&quot;</td>
<td>Limited SRH service availability/ Lack of safe abortion services</td>
<td>Access to SRH Services</td>
</tr>
<tr>
<td>(Yameogo et al. 2017)</td>
<td>&quot;The limited availability of services, particularly in remote areas, was also identified as a challenge.&quot;</td>
<td>Limited SRH service availability/ Lack of safe abortion services</td>
<td>Access to SRH Services</td>
</tr>
<tr>
<td>(Tunçalp et al. 2015)</td>
<td>Nearly one in five health facilities nationally was at least partially damaged. Significant regional disparities were noted, with over 40% of facilities at least partially damaged in the Northern regions.&quot;</td>
<td>Infrastructure</td>
<td></td>
</tr>
<tr>
<td>(women Refugee Commission 2015)</td>
<td>&quot;Reported restrictions that limit their access to health services include non-accessible physical infrastructure, lack of suitable and affordable transportation, lack of assistive devices, and long wait times.&quot;</td>
<td>Financial</td>
<td></td>
</tr>
<tr>
<td>Author(s)</td>
<td>Summary</td>
<td>Topic</td>
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<td></td>
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<tr>
<td>El Ayoubi et al., 2021</td>
<td>&quot;Cultural barriers influenced the acceptance and utilization of SRH services in some humanitarian settings&quot;</td>
<td>Cultural barriers</td>
<td></td>
</tr>
<tr>
<td>Meyer et al., 2022</td>
<td>There is a lot of stigma around sexual and reproductive health issues, especially for girls. They are afraid to talk about it because they fear being judged or shamed</td>
<td>Stigma</td>
<td></td>
</tr>
<tr>
<td>Marlow et al, 2022</td>
<td>“Although there are services available to them in the camp, many young women and girls are reluctant to access them due to shame and stigma”</td>
<td>Cultural norms/ taboo</td>
<td></td>
</tr>
<tr>
<td>Meyer et al., 2022</td>
<td>&quot;Some participants reported that cultural norms and beliefs prevent them from accessing sexual and reproductive health services, especially if they are unmarried or young&quot;.</td>
<td>Information and awareness</td>
<td></td>
</tr>
<tr>
<td>McGinn &amp; Casey, 2016</td>
<td>“The Syrian refugee girls who participated in this study had fewer opportunities to access”.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>&quot;Most of the girls had insufficient information about the female reproductive system. The girls consulted their mothers to learn about SRH issues&quot;</td>
<td></td>
<td></td>
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<tr>
<td>Yount et al., 2016</td>
<td>&quot;Child marriage is associated with higher risk of intimate partner violence (IPV) perpetration and victimization, and this association is stronger for women who marry as children and remain married as adults.&quot;</td>
<td>Child Marriage/Violence</td>
<td></td>
</tr>
<tr>
<td>Pallitto et al, 2013</td>
<td>&quot;Providers also reported that they face challenges in providing high-quality care due to limited resources, including inadequate facilities, equipment, and supplies.&quot;</td>
<td>Data collection and reporting</td>
<td></td>
</tr>
</tbody>
</table>
Service providers often lack training and resources to provide accessible and inclusive SRH services.

"The challenge of working in unsafe or non-secure settings"

"There are numerous and diverse 'real life' challenges associated with collection of such data"

"The lack of time and on-the-ground capacity to collect data"

| Data collection, Monitoring | Research and Data Challenge |

(Dickinson 2016)

**Ethical considerations**

The ethical considerations in research are paramount, and this study was no different. Even though it did not involve any human subjects or personal data collection, and thus ethical approval was not required, the study still adhered to strict ethical guidelines.

All articles included in the study were meticulously assessed to ensure that they addressed ethical considerations. This was done to confirm adherence to the Ethical Principles of the Declaration of Helsinki, WMA (2008). These principles emphasize the importance of respecting the autonomy and dignity of research participants, ensuring the well-being and safety of participants over scientific interests, and the necessity for scientific and social value in research to warrant involving human participants. Additionally, the declaration mandates that research must undergo ethical review and stresses the significance of informed consent. Any articles that failed to meet these ethical standards were excluded from the study. Furthermore, all sources used in the study were accurately cited and referenced to avoid any instances of plagiarism and to give proper credit to the original authors. This was of utmost importance in maintaining the integrity of the research process. By abiding by these ethical considerations, the study ensured that the data used in the analysis was obtained in a responsible and ethical manner (Aromataris & Munn, 2020).

**RESULTS:**

The delivery of Sexual and Reproductive Health (SRH) services in humanitarian Settings is a multifaceted task, riddled with a complex array of challenges. An all-encompassing review of
22 studies from various countries and humanitarian settings, including Rwanda (n=1), Somalia (n=1), Myanmar (n=1), Nigeria (n=3), Lebanon (n=1), Brazil (n=2), Colombia (n=1), Venezuela (n=1), Nepal (n=3), Kenya (n=1), Uganda (n=1), Democratic Republic of Congo (n=1), Afghanistan (n=1), Albania (n=1), Bangladesh (n=3), Cameroon (n=1), Iraq (n=1), Jordan (n=1), Mali (n=1), South Sudan (n=3), and Sierra Leone (n=1), has revealed pertinent findings. These insights can be categorized into three categories and 7 subcategories, each representing the significant issues that affect the delivery of SRH services in these intricate situations. The figure below illustrates the barriers and challenges associated with SRH services in humanitarian settings, offering a visual representation of these pivotal challenges.

**Challenges in SRH Accessibility and Awareness**

**Direct Barriers**

One of the most salient issues in SRH across several humanitarian contexts is the challenge of access. Conflict zones and refugee camps, in particular, are often marked by a worrying lack of essential SRH services, a deficiency that leaves numerous individuals, particularly women and adolescents, devoid of vital information and resources to manage their
reproductive health. (Meyer et al.;2022; Kågesten et al.,2020; Marlow el al.,2022 and Kamaldeen et al,2022)

Studies by Meyer et al. (2022) and Kågesten et al. (2020) underline this deficiency, emphasizing how those in desperate need of SRH services are often those who can least access them. Marlow et al. (2022) and Kamaldeen et al. (2022) further highlight the dearth of basic SRH services in these settings, suggesting that this deficiency is a pervasive problem with severe consequences such as increased higher maternal mortality, rise in unintended pregnancies, unsafe abortions and gender based violence (Marlow et al. 2022 and Kamaldeen et al. 2022).

Casey et al. (2020) shed light on the specific issue of contraceptive use in the Republic of Congo, revealing that only a meager 16.5% of women aged 15-24 reported using modern contraceptives. Moreover, the study found that the unmet need for contraception was alarmingly high, with a staggering 63.5% of sexually active or married women in the same age bracket reporting an unmet need for contraception. These figures, especially the high percentage of unmet contraceptive needs, suggest significant barriers to accessing and utilizing SRH services. This underscores the deeply-rooted problem of access and availability of SRH services in such settings.

**Infrastructure and Resource Constraints**

In many humanitarian settings, infrastructure and resources pose a significant barrier to the accessibility of sexual and reproductive health (SRH) services. Damaged health facilities, a common consequence of conflict or natural disasters, significantly reduce the capacity to provide essential SRH services. Calderón-Jaramillo et al. (2020) highlight instances where health facilities are damaged, particularly in regions affected by natural disasters or conflicts. This physical damage is often compounded by a systemic lack of trained SRH professionals, creating a dual challenge that further exacerbates the crisis in access to care.

Balinska et al. (2015) emphasize the often overlooked but critical issue of menstrual hygiene management and the unavailability of hygienic pads for young women. The lack of such basic necessities can have severe implications for the well-being of women and is indicative of the broader neglect of SRH issues in these contexts.
While SRH is a fundamental right, for many affected populations, the direct costs associated with SRH services are far beyond their reach. Even if the services are affordable, other expenses, such as transportation to the facilities, can impose a financial burden on families already dealing with the hardships of displacement or conflict. This financial strain can effectively make SRH services inaccessible, as pointed out by Kamaldeen et al. (2020) and Bahamondes et al. (2020).

**Educational and Language Barriers**

A significant challenge in SRH in humanitarian settings is the pervasive lack of information among the affected populations. This lack of information often coexists with cultural and societal misconceptions about SRH, leading to misinformed decisions. Kamaldeen et al. (2020) and Kågesten et al. (2020) highlight this issue, emphasizing the need for comprehensive SRH education to bridge this knowledge gap.

Language barriers can significantly impact access to Sexual and Reproductive Health (SRH) services in humanitarian settings. These barriers are multi-dimensional and extend beyond simple linguistic differences. In the study by Bahamondes et al. (2020), the authors highlight the role of language barriers among Venezuelan migrant women in Roraima, Brazil. The women identified language as a major impediment to accessing necessary SRH services.

However, the issue does not stop at the language barrier. The provision of SRH services should not only be linguistically accessible but also culturally sensitive. The cultural norms and values of a given community can greatly affect how SRH information is received and how services are utilized (Bahamondes et al, 2020).

**Sociocultural Barriers in SRH**

The landscape of Sexual and Reproductive Health (SRH) in crisis situations is influenced by more than just the availability and accessibility of services. Sociocultural constructs play a substantial role in shaping SRH outcomes in humanitarian settings, especially among vulnerable populations such as young women and girls.

In many societies, and particularly in humanitarian settings, stigmas related to SRH are prevalent. These stigmas often prevent individuals, particularly women and girls, from
seeking necessary SRH services. According to a study by the Guttmacher Institute, stigma associated with sex outside of marriage and abortion services can deter individuals from accessing SRH services (Singh, et al., 2018). This stigma stems from deeply entrenched cultural and religious beliefs that perceive such behaviors as morally wrong.

Furthermore, research conducted in Rwanda by Katherine Meyer and colleagues in 2022 shed light on the manifold sociocultural barriers that adolescents and youth face, which prevent them from accessing or even discussing SRH issues (Meyer et al., 2022). A parallel study confirmed that these stigmas often lead to reluctance among health providers to treat younger patients due to their prejudiced views (Aktar et al., 2020). These findings underscore the need for a shift in societal attitudes towards SRH, particularly for girls who often suffer from the fear of judgment or ostracism.

Menstruation, a natural biological phenomenon, often becomes a contentious issue due to deeply ingrained societal taboos. These issues are exacerbated in humanitarian contexts. Practical challenges like acquiring menstrual hygiene products are further complicated by societal misconceptions and taboos surrounding menstruation, ranging from resource scarcity to shame associated with this natural physiological process (Calderón-Jaramillo et al., 2020; Balinska et al., 2015).

A study by Kågesten et al. in Somalia and Myanmar revealed that very young adolescent girls faced more barriers to accessing SRH information than boys did, and their primary source of knowledge was often family or friends (Kågesten et al., 2020). Marlow, in a separate study, highlighted the difficulties faced by girls and young women in internally displaced camps in dealing with unwanted pregnancies and unsafe abortions. Stigma, lack of privacy, and limited service availability were identified as the main challenges (Marlow et al., 2022).

Several studies (Meyer et al., 2022; Kågesten et al., 2020; Korri et al., 2021; Kamaldeen et al., 2020) collectively indicate that adolescents in humanitarian settings face distinct challenges concerning SRH. These aren't generic problems but specific issues that require tailored solutions. Refugees and displaced individuals face unique SRH challenges due to their precarious situations (Women's Refugee Commission, 2015).
GBV and Early/Forced Marriages

Gender-based violence (GBV) and early or forced marriages are significant barriers to SRH in humanitarian settings that disproportionately affect women and girls and lead to unwanted pregnancies, unsafe abortions, and sexually transmitted infections. (Calderón-Jaramillo et al., 2020; Yount et al., 2016; Yameogo et al., 2017). An alarming illustration of this issue is the Colombia-Venezuela border, where socio-political unrest has heightened GBV vulnerabilities and subsequently escalated SRH challenges, from unintended pregnancies to the transmission of sexually transmitted infections (STIs) (Calderón-Jaramillo et al., 2020).

Similarly, early and forced marriages often lead to early pregnancies, posing significant risks to the health of young girls. Child and forced marriages, a disturbing form of GBV, significantly hinder the autonomy of young girls, often forcing them into early and recurrent childbearing. Yount et al. (2016) demonstrated the correlation between such practices and an increased risk of IPV. The associated SRH problems extend beyond physical consequences, encompassing the psychological and emotional wellbeing of the impacted individuals.

Systemic Challenges to Sexual and Reproductive Health

Research and Data Challenges

The first systemic hurdle that impedes sexual and reproductive health (SRH) outcomes in humanitarian settings is the absence of reliable research and data. The mentioned studies (Emina et al, 2022; Aktar et al., 2020; Dickinson et al., 2016 and Tunçalp et al., 2017) underscore data collection and standardization as significant challenges. The accuracy and consistency of data are pivotal to understanding the magnitude of SRH issues and formulating effective interventions. However, the complex nature of humanitarian contexts often renders data collection a daunting task.

Emina et al. (2022) highlight the difficulties encountered while amassing data in the Democratic Republic of Congo. A dearth of training and resources, coupled with safety concerns, presents substantial hindrances, as noted by Aktar et al. (2020). Consequently, the lack of comprehensive, high-quality information obscures the complete picture of SRH challenges. Without this crucial information, it becomes arduous to tailor interventions that address the specific SRH needs of the affected community.
Healthcare Provider Challenges

The second systemic obstacle pertains to the attitudes and preparedness of healthcare providers, especially in addressing the SRH needs of younger individuals. Casey et al. (2020) underscore that healthcare workers might harbor negative views or be ill-equipped to cater to these needs. Such attitudes and incompetence not only impede the delivery of essential SRH services but also contribute to the stigmatization of sexual and reproductive health.

While external organizations such as NGOs and UN agencies play a vital role in offering SRH services, the need for regular healthcare systems to be more inclusive and understanding cannot be overstated. Tunçalp et al. (2017) stress the importance of fostering a healthcare environment that is non-judgmental, empathetic, and equipped to address diverse SRH needs. This encompasses training healthcare workers to handle SRH issues with the required sensitivity, promoting a culture of respect and understanding, and embedding these values within the healthcare system. This way, we can ensure that SRH services are not just available but also accessible, acceptable, and of high quality.

Discussion

Summary of key findings

This integrative review explored the barriers and challenges to effective sexual and reproductive health (SRH) services in various humanitarian settings. Drawing from a comprehensive review of 22 studies from diverse regions, reveals a multitude of challenges faced by conflict-affected regions and refugee settlements. One of the most significant issues is the lack of accessibility and awareness of SRH services. Many individuals living in these conditions are unaware of the existence of these services or cannot reach them due to geographical constraints or safety issues. Compounding the problem is the state of healthcare infrastructure in these regions. Many are severely damaged or non-existent due to ongoing conflicts or a lack of funding. This makes it extremely difficult to provide even basic SRH services, let alone comprehensive care. Additionally, the limited resources available are often stretched thin, further exacerbating the issue.

Financial barriers also play a significant role in restricting access to SRH services. Many individuals in these settings simply cannot afford to pay for these services, even if they are available. This leaves them vulnerable to a host of health risks and complications that could be prevented with proper SRH care. Language and education pose further hurdles to SRH
education. Many individuals in these settings may not speak the same language as the healthcare providers, making communication a significant challenge. Additionally, the lack of education or literacy can hinder individuals from understanding the importance of SRH and how to access services.

Sociocultural stigmas surrounding SRH also pose a significant barrier. In many cultures, discussing sexual and reproductive health is considered taboo, preventing individuals from seeking help or discussing their concerns openly. Furthermore, gender-based violence and early marriages are prevalent in these settings, and these practices further impede access to SRH services.

Lastly, systemic issues such as the lack of research data and biases among healthcare providers also contribute to the poor state of SRH in humanitarian settings. There is a dire need for more research to better understand the unique needs and challenges of these communities. Additionally, biases among healthcare providers can lead to judgmental attitudes and discriminatory practices, further discouraging individuals from seeking care.

**Results Discussion**

The results of the study echo the findings of previous research by Benage et al. (2015) and Patel et al. (2016), indicating that limited accessibility and lack of awareness are profound problems in the provision of SRH services.

Based on these findings, it is evident that improving accessibility and awareness of SRH services should be a priority. This could be achieved through educational initiatives, community engagement, investments in health infrastructure and capacity building. Greater efforts and resources should be directed towards these areas to ensure the provision of comprehensive, high-quality SRH services (Inter-Agency Working Group on Reproductive Health in Crises, 2018).

The lack of infrastructure and trained healthcare personnel, have been identified as significant barriers to the delivery of SRH services in the study. This is in line with the findings of Benage et al. (2015), Tappis et al. (2017), who reported similar challenges in crisis-stricken environments. The results reflect the complex reality of healthcare provision in areas of conflict and refugee settlements. Not only is infrastructure inadequate, but there is also a
dearth of trained healthcare professionals who are equipped to deliver SRH services. Based on these findings, it is crucial to address the infrastructure and human resources deficits in these settings. Investments should be made in building health facilities that are equipped to provide SRH services. Furthermore, training programs should be initiated to build the capacity of existing healthcare workers, and efforts should be made to attract and retain skilled professionals in these areas.

The results indicate that financial constraints significantly exacerbate the problems faced in the provision of SRH services, a finding that is also supported by Benage et al. (2015) and Patel et al. (2016). These financial constraints can prevent the acquisition of necessary equipment and hinder the provision of comprehensive services. Given this, the securing of necessary financial resources should be a critical focus. This could be achieved through increased funding and international aid. It is essential to ensure that sufficient resources are available to provide high-quality, comprehensive SRH services, regardless of the financial challenges faced.

Research has shown that educational and linguistic barriers can considerably impede the understanding and utilization of SRH services. This aligns with the findings of Keygnaert et al. (2014) and McGinn & Casey (2016), who reported similar barriers in accessing SRH services. With this in mind, it becomes evident that addressing these barriers, perhaps through the development of multilingual educational resources and programs, is crucial to improve the utilization of SRH services.

Sociocultural taboos and cultural prohibitions surrounding SRH topics are also significant impediments. This is consistent with the literature, deep-rooted societal norms and cultural beliefs significantly influence individuals' decisions to seek SRH services. Gender norms might limit women's mobility and decision-making power, thereby affecting their ability to access healthcare independently (El Ayoubi et al., 2018). Societal taboos surrounding topics like contraception or abortion further discourage service utilization (Keygnaert et al., 2014; McGinn & Casey, 2016). Therefore, it is critical to implement awareness programs that can help to challenge and change these deeply ingrained societal norms and taboos.

The results also points to gender-related violence as a substantial issue. This mirrors findings of McGinn & Casey (2016), who noted that gender norms can limit women's
mobility and decision-making power, thereby affecting their ability to access healthcare independently. The results suggest the need for interventions aimed at transforming gender norms, alongside measures to protect women and girls from gender-based violence (McGinn & Casey, 2016).

The intersectionality theory lens uncovers more profound layers to these challenges, which are not uniformly distributed among individuals. Societal misconceptions about SRH often disproportionately affect women, particularly adolescent girls, as highlighted by El Ayoubi et al. (2021). An intersectional approach helps us understand that a refugee adolescent girl faces barriers not only as a refugee, an adolescent, or a female, but these challenges are compounded due to her intersecting categories.

Furthermore, intersectionality theory sheds light on the heightened barriers faced by individuals at specific intersections. For instance, a displaced woman from an ethnic minority may not only face general displacement challenges but also discrimination based on her ethnicity, further impeding her access to vital SRH services (Hankivsky, 2012). Another significant study by Keygnaert et al. (2014) highlighted the susceptibility of sub-Saharan migrants in Morocco to sexual violence. By using intersectionality, the study revealed how their legal status, ethnicity, and gender combined to heighten their vulnerability.

In the context of community-awareness campaigns, intersectionality theory emphasizes the need for customized messaging that considers the unique experiences of individuals from multiple marginalized groups, as underscored by Chynoweth (2015). It's not sufficient to have generic campaigns; the information should resonate deeply with the targeted individuals, fostering meaningful change.

The lack of infrastructure, as viewed through an intersectional lens, disproportionately impacts those in marginalized categories. It underscores the need for SRH services that specifically address their unique challenges. Viewing the issue through this lens also encourages decision-makers to devise solutions that cater to the specific needs of the most marginalized individuals (Smith, 2020). Thus, intersectionality theory provides a comprehensive understanding of the SRH challenges and suggests the need for a more holistic, multi-sector approach to addressing these challenges.
Methodological Discussion

An integrative review method was used in this study to explore both qualitative and quantitative research papers on sexual and reproductive health (SRH) in humanitarian settings. This method facilitated a comprehensive understanding of the topic, examining diverse types of evidence to synthesize a holistic perspective of SRH in these challenging environments. The chosen integrative design provides strength to the study as it offers a broad view by amalgamating both qualitative and quantitative data. Whittemore and Knafl (2005) highlighted the integrative review's adaptability in synthesizing multiple study designs. However, while it offers breadth, a potential limitation is that it may not delve as deeply into specific phenomena as other designs might.

The collaboration with a librarian from Dalarna University significantly improved the confirmability of the review. This expert consultation added a new dimension to the search strategy, ensuring objectivity and reducing potential biases in the retrieval of pertinent articles. Despite the systematic search protocols guaranteed by the PCC method, the review's scope was limited to two databases. This restriction may have unintentionally excluded certain relevant studies, impacting the transferability of the findings.

The decision to confine the review to a ten-year span was made to prioritize recent and pertinent findings. However, this choice may inadvertently overlook influential studies conducted prior to this period. Additionally, by focusing solely on articles written in English, we may unintentionally miss significant insights from research published in other languages. Despite these considerations, it is crucial to define explicit criteria for the inclusion and exclusion of studies. This approach guarantees the consistent replicability of the review's methodology and directly addresses the objectives of the study, as emphasized by Moher et al. (2009).

The Joanna Briggs Institute's tools is used to consistently evaluate the quality of the articles. This approach ensured a systematic and rigorous assessment. However, even with these tools, there's a natural element of personal judgment. Additionally, the inductive content analysis method, as detailed by Elo and Kyngäs, was instrumental in ensuring the study's credibility. It provided a systematic pathway from raw data to the emergence of themes (Elo &
Kyngäs, 2008). The method involved a structured journey from initial coding to more abstract themes, following recognized standards in research. Lastly, employing Zotero and Excel for data management and organization enhanced the systematization, transparency, and overall trustworthiness of the review. While these tools are robust and endorsed by scholars (Miles et al., 2014), the possibility of human error in data input or organization remains. This constraint becomes especially relevant considering the diverse cultural and geographic expanse of humanitarian settings. Non-English research might offer specific regional hurdles to SRH that the current study did not capture.

Finally, by restricting the study's purview to the decade between 2013 and 2023, the research ensured that the findings were contemporary and relevant to the present. However, this decision also meant that any foundational research or vital insights on SRH in humanitarian settings that emerged before 2013 were not considered. Such older studies could provide a historical trajectory of SRH challenges and interventions, which could have been instrumental in understanding how the SRH services changed.

**Ethical Discussion**

Research ethics are at the heart of any academic endeavor, and this study was no exception. Although this research was based on previously published data and did not involve direct human contact, the ethical dimensions were deeply embedded in our work. Utilizing data from previously conducted studies demands an understanding of the ethical frameworks these primary studies adhered to. We ensured that the studies included in our review met the established ethical guidelines, such as those outlined in the Declaration of Helsinki (World Medical Association, 2013).

Accurate citation and referencing are about more than just academic protocol. They're at the core of intellectual integrity (Shamoo & Resnik, 2015). By giving due credit to the original authors, this study reinforced its commitment to fairness, transparency, and respect for the academic endeavors of others. Also, one of the study's cornerstones was the exclusion of articles that did not meet stringent ethical standards, which ensured the ethical integrity of the research. Ethical responsibility also encompassed ensuring that our interpretations, analyses, and conclusions were just, unbiased, and true to the data.
Conclusion

The integrative review highlights the intricacy of delivering sexual and reproductive health (SRH) services in humanitarian settings. These settings, often characterized by limited resources, displacement, and high levels of distress, pose significant challenges to the provision of comprehensive SRH services. The most prominent challenges include restricted physical access to services due to infrastructural damage or a lack of transportation. In addition, sociocultural barriers such as stigma, misconceptions, and cultural norms often deter individuals, especially women and girls, from seeking essential SRH services.

The review underscores the importance of adopting a comprehensive, empathetic, and culturally sensitive approach to SRH services. It advocates for the recognition and respect of human rights and dignity, especially in delivering SRH services. This approach requires a keen understanding of the socio-cultural context and individual beliefs that influence SRH behaviors. The review further suggests that to address these challenges effectively, attention must be given to both structural issues including improving infrastructure and access, and addressing deep-rooted cultural beliefs and practices that often impede uptake of SRH services.

Reiterating the importance of addressing SRH in humanitarian settings, the review presents a call for a holistic, multi-sectoral strategy. This strategy, aimed at improving the quality, accessibility, and effectiveness of SRH services, must involve collaboration with stakeholders at all levels, from policy-making to community-led initiatives. The potential impact of implementing the recommendations from this review is immense. It could lead to improved SRH outcomes, reduced maternal and infant mortality rates, and enhanced overall well-being of affected populations. Ultimately, addressing SRH needs in humanitarian settings is not just a health issue, but a matter of human rights and dignity.

Clinical implications and suggestions for Future Research

This review underscores significant gaps in Sexual and Reproductive Health (SRH) services in humanitarian settings, amplifying the urgency of improving healthcare practices and infrastructure. Crucial elements include upgrading health centers, providing necessary medical supplies, and enhancing professional training focusing on empathy, inclusiveness, and debunking SRH myths. Addressing sociocultural stigma and taboos should be prioritized, with special attention to adolescent specific SRH challenges. Community
involvement in planning and implementing SRH services can foster trust and ensure the services align with community values.

Future research should delve into understanding the unique struggles of specific marginalized groups, such as ethnic minority women or disabled individuals, in crisis situations. Long-term research approaches can reveal how SRH needs evolve in prolonged humanitarian crises. Moreover, the lack of reliable data in many humanitarian situations necessitates better data collection methods, potentially leveraging technology for efficient data gathering. Standardization of these methods can ensure consistent and comparable findings.
References


### Appendix:

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<tr>
<th>#</th>
<th>Author</th>
<th>Year</th>
<th>Design</th>
<th>Population</th>
<th>Setting</th>
<th>Key Findings</th>
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<td>1</td>
<td>Katherine Meyer et al.</td>
<td>2022</td>
<td>Cross-sectional study</td>
<td>Adolescents and youth in Mahama refugee camp and the surrounding host community</td>
<td>Rwanda</td>
<td>The SRH needs of adolescents and youth were not being met due to various barriers, including limited access to information and services, stigma, and cultural norms. The COVID-19 pandemic exacerbated these barriers and challenges, leading to disruptions in SRH services and increased isolation and vulnerability for adolescents and youth.</td>
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<td>2</td>
<td>Kågesten et al.</td>
<td>2020</td>
<td>Cross-sectional survey</td>
<td>young adolescents</td>
<td>Kobe refugee camp in Somalia and urban areas in Myanmar</td>
<td>Both settings had limited access to sexual and reproductive health (SRH) information, with girls reporting less access than boys. Family members were the most common source of SRH information, followed by friends and teachers. VYA in both settings faced barriers to accessing SRH services, including stigma, lack of privacy, and limited availability of services.</td>
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<td>3</td>
<td>Marlow et al.</td>
<td>2022</td>
<td>Qualitative study</td>
<td>Girls and young women of reproductive age (15-24)</td>
<td>Internally displaced persons' camp in northeastern Nigeria</td>
<td>Girls and young women in humanitarian contexts are particularly vulnerable to unwanted pregnancies, unsafe abortion, gender-based violence, and early and forced marriage. They face significant barriers to accessing sexual and reproductive health information and services, including lack of privacy, stigma, and limited availability of services.</td>
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<td>4</td>
<td>Korri et al.</td>
<td>2021</td>
<td>Qualitative study using focus group discussions</td>
<td>Syrian refugee adolescent girls</td>
<td>Urban setting in Lebanon</td>
<td>Syrian refugee adolescent girls face significant challenges in accessing sexual and reproductive health services due to cultural and social barriers, lack of knowledge and awareness, and limited availability of services. Girls reported experiencing shame, fear, and stigma related to menstruation, sexual activity, and pregnancy. They also expressed a desire for more information and education on sexual and reproductive health topics.</td>
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<td>5</td>
<td>Kamaldeen et al.</td>
<td>2020</td>
<td>Qualitative</td>
<td>Adolescent girls and young women</td>
<td>Internally displaced persons' camp in Nigeria</td>
<td>The study sheds light on the sexual and reproductive health context of adolescent girls and young women in a vulnerable population.</td>
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<td>6</td>
<td>Balinska et al.</td>
<td>2015</td>
<td>Qualitative</td>
<td>Populations affected by</td>
<td>Global</td>
<td>Reproductive health is a critical component of humanitarian response, but there is a lack of data and research on the topic. Key research priorities</td>
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</table>
humanitarian crises include improving access to family planning, antenatal care, and emergency obstetric care, as well as addressing gender-based violence and the needs of adolescents.

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<thead>
<tr>
<th></th>
<th>Soeiro et al.</th>
<th>2021</th>
<th>Cross-sectional study</th>
<th>Venezuelan migrant women</th>
<th>Northwestern border of Brazil</th>
<th>Adolescent and young women are a neglected group in humanitarian settings. Lack of access to menstrual hygiene products, safe and clean toilets, and privacy contribute to period poverty. Women resort to using unhygienic materials and face social stigma and shame.</th>
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<td>7</td>
<td>Calderón-Jaramillo et al.</td>
<td>2020</td>
<td>Mixed-methods</td>
<td>Migrant women and girls</td>
<td>Colombia-Venezuela border</td>
<td>Sexual and gender-based violence against migrant women and girls is prevalent at the Colombia-Venezuela border. Language barriers, discrimination, and lack of access to healthcare services exacerbate the problem</td>
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<td>8</td>
<td>Budhathoki et al.</td>
<td>2018</td>
<td>Cross-sectional study</td>
<td>Women and adolescent girls</td>
<td>Nepal</td>
<td>Lack of privacy, inadequate sanitation facilities, and limited access to menstrual products were major challenges for menstrual hygiene management. Women and girls also faced cultural taboos and stigmatization related to menstruation.</td>
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<td>9</td>
<td>Bahamondes et al.</td>
<td>2020</td>
<td>Cross-sectional study</td>
<td>Venezuelan women migrants</td>
<td>Brazil</td>
<td>The study found that Venezuelan women migrants in Roraima, Brazil faced significant sexual and reproductive health challenges, including limited access to antenatal and postnatal care, high rates of unintended pregnancies, and low contraceptive use. The study also identified several barriers to accessing sexual and reproductive health services, including language barriers, lack of information, and fear of discrimination.</td>
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<td>10</td>
<td>Women’s Refugee Commission</td>
<td>2015</td>
<td>Qualitative research</td>
<td>Refugees</td>
<td>Kenya, Nepal, and Uganda</td>
<td>Refugees with disabilities face multiple barriers to accessing sexual and reproductive health (SRH) services, including physical, communication, and attitudinal barriers. Many refugees with disabilities lack information about SRH and have limited decision-making power. Service providers often lack training and resources to provide accessible and inclusive SRH services.</td>
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<td>11</td>
<td>Emina et al</td>
<td>2022</td>
<td>Multi-methods</td>
<td>Humanitarian settings</td>
<td>Democratic Republic of Congo</td>
<td>The study found that there were significant challenges to collecting reliable SRMNCAH data in the field, including inadequate training, poor data quality, and limited resources.</td>
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<td></td>
<td>Authors</td>
<td>Year</td>
<td>Study Type</td>
<td>Setting</td>
<td>Country</td>
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<tr>
<td>13</td>
<td>Aktar et al.</td>
<td>2020</td>
<td>Multi-methods</td>
<td>Humanitarian settings</td>
<td>Bangladesh</td>
<td>The study found that it is feasible to establish a core set of SRMNCAH indicators in humanitarian settings. The study also identified challenges and opportunities for collecting reliable SRMNCAH data in such settings. The establishment of a core set of SRMNCAH indicators can improve the quality of data collection in humanitarian settings.</td>
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<td>14</td>
<td>Spiegel et al.</td>
<td>2020</td>
<td>Multicountry qualitative study</td>
<td>Humanitarian settings</td>
<td>Afghanistan, Albania, Bangladesh, Cameroon, the Democratic Republic of the Congo, Iraq and Jordan</td>
<td>The study found that sexual and reproductive health and rights (SRHR) are critical components of healthcare in humanitarian settings, but there are significant barriers and challenges to providing these services. These barriers include a lack of funding, inadequate infrastructure, limited access to trained healthcare providers, and cultural and social norms that stigmatize SRHR services. In addition, the study found that there is a lack of reliable and rigorously collected data on SRHR in humanitarian settings, which presents challenges for stakeholders in delivering effective interventions.</td>
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<td>15</td>
<td>Dickinson et al.</td>
<td>2016</td>
<td>Qualitative</td>
<td>Healthcare professionals</td>
<td>Humanitarian Settings</td>
<td>The study found that there are numerous and diverse challenges associated with the collection of SRHR data in humanitarian and emergency settings. Some of these challenges are common to research in any setting, while others are specific to humanitarian and emergency situations. The challenges specific to these settings include working in unsafe or non-secure environments, lack of time and on-the-ground capacity to collect data, and the fact that data being provided or collected pertain to traumatic experiences and loss. The lack of security was reported to be a determining factor impacting on the ability to collect data as well as the quality of data obtained.</td>
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<td>16</td>
<td>Casey et al</td>
<td>2020</td>
<td>Cross-sectional population-based survey</td>
<td>Adolescent and young women</td>
<td>Democratic Republic of the Congo</td>
<td>The study found that the prevalence of modern contraceptive use was low among adolescent and young women in the study area, with only 16.5% of women aged 15-24 reporting current use of modern contraceptives. The study also found that unmet need for contraception was high, with 63.5% of women aged 15-24 who were married or sexually active reporting an unmet need for contraception.</td>
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<td></td>
<td>Authors</td>
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<td>Study Type</td>
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<td>17</td>
<td>Tshipamba et al.</td>
<td>2018</td>
<td>Cross-sectional</td>
<td>Conflict-affected populations</td>
<td>Democratic Republic of the Congo</td>
<td>The study found that women living in conflict-affected areas in the Democratic Republic of the Congo faced significant sexual and reproductive health and rights (SRHR) challenges, including high risk of mortality or morbidity due to pregnancy-related causes, unintended or unwanted pregnancy due to lack of information or access to contraceptive services, complications of unsafe abortions, gender-based violence, and sexually transmitted infections including HIV.</td>
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<td>18</td>
<td>Tunçalp et al.</td>
<td>2017</td>
<td>Cross-sectional</td>
<td>Women of reproductive age</td>
<td>Mali</td>
<td>Conflict and displacement were associated with reduced availability of sexual and reproductive health (SRH) services in Mali. The study found that the availability of SRH services was lower in conflict-affected areas compared to non-conflict areas. The study also found that the availability of SRH services was lower in areas with higher levels of displacement.</td>
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<td>19</td>
<td>Yount et al.</td>
<td>2016</td>
<td>Longitudinal multilevel analysis</td>
<td>Married women</td>
<td>Bangladesh</td>
<td>Child marriage is associated with higher risk of intimate partner violence (IPV) perpetration and victimization, and this association is stronger for women who marry as children and remain married as adults. The association between child marriage and IPV is partially explained by women's lower education, lower autonomy, and greater acceptance of IPV.</td>
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<td>20</td>
<td>Yameogo et al.</td>
<td>2017</td>
<td>Qualitative study</td>
<td>Healthcare providers</td>
<td>Nepal, and South Sudan</td>
<td>the study also highlighted several barriers and challenges related to sexual and reproductive health and rights (SRHR) in these settings. These included security concerns, inadequate staffing and workloads in certain health facilities, staff turnover, and limited availability of services.</td>
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<td>21</td>
<td>Sami et al.</td>
<td>2017</td>
<td>Mixed Method</td>
<td>Newborn care in South Sudan displacement camps</td>
<td>South Sudan</td>
<td>Investigated the state of newborn care in displacement camps; identified gaps in facility-based deliveries</td>
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<td>22</td>
<td>McMahon et al.</td>
<td>(2016)</td>
<td>Qualitative study</td>
<td>Healthcare providers in Sierra Leone</td>
<td>Sierra Leone</td>
<td>Explored the social and emotional impact of delivering health services during Ebola epidemic</td>
</tr>
</tbody>
</table>