The Meaning of War
Article XVI

GSR
Beirut, LB

The Sexual and Reproductive Health of Internally Displaced Women

Jennyfer Al Asmar

Abstract:

Internally displaced women and girls face significant sexual and reproductive health (SRH) challenges due to conflict, disasters, and displacement. Despite representing a substantial portion of the 68.3 million displaced individuals globally (UNHCR, 2021), the sexual and reproductive health needs of women within this population remain under-researched compared to those of refugees. This paper examines barriers such as limited access to care, heightened risks of sexual violence, and inadequate policies. It highlights evidence-based strategies for integrating SRH services into humanitarian responses, emphasizing the importance of addressing these critical needs to ensure equity and dignity for displaced populations.

1-Introduction:

Around 68.3 million people worldwide are internally displaced and forced to leave their homes but stay within their country's borders (UNHCR, 2021). Unlike refugees, who receive international support, internally displaced people (IDPs) often lack the same protections, making them very vulnerable to various health challenges. For internally displaced women and girls, one significant and usually neglected aspect of their health needs is sexual and reproductive health (SRH), which is vital for their well-being.

The main causes of internal displacement include armed conflict, environmental disasters, and climate change, all of which increase the risks of sexual violence, unwanted pregnancies, limited access to contraception, and poor maternal healthcare.

This paper explores the SRH needs of IDPs in conflict-affected areas. It reviews existing peer-reviewed studies, sheds light on the obstacles that hinder access to SRH services, and stresses the urgent need for targeted policies and initiatives. Addressing these issues is crucial for upholding the rights and dignity of displaced women and ensuring that they have fair access to SRH care.

2-Key biases and gaps in the literature:

Research on the health of internally displaced people (IDPs) remains limited, particularly compared to refugee studies or cross-border migration (Blanchet et al., 2017; Owoaje et al., 2016; Hendrickx et al., 2020). This gap is partly due to a lack of disaggregated health data specific to IDPs and a broader tendency to focus on displaced populations in high-income countries (HICs) over those in low- and middle-income countries (LMICs) (Morina et al., 2018). Within the existing IDP health literature, there is an overrepresentation of research on populations living in camps. This is likely because IDPs in camps are easier to identify and study compared to those integrated into local communities. However, this focus creates a significant bias, as the majority of IDPs globally do not reside in camps. Additionally, health research on IDPs often disproportionately emphasizes mental health issues, such as post-traumatic stress disorder (PTSD), depression, and anxiety, while sexual and maternal health remains understudied.

3- Struggles of IDPs:

Internally displaced people (IDPs) face numerous challenges that stem from both their displacement and the socioeconomic vulnerabilities that often precede it. IDPs typically come from marginalized and impoverished areas where violence and conflict are concentrated. Although most live within host communities, only a small percentage reside in camps. These factors create significant obstacles in identifying and addressing their needs, particularly as IDPs experience worse poverty and labor market outcomes compared to refugees and other populations.

Health outcomes among IDPs are markedly worse than those of their local counterparts. Contributing factors include exposure to new environmental hazards, the physical and emotional trauma of displacement, and the disruption of social support networks. Unlike refugees, IDPs lack formal international legal protection, which limits access to resources and assistance. They are also more likely to remain in conflict zones, where healthcare infrastructure is damaged, further exacerbating health vulnerabilities.

The risks of gender-based violence (GBV) among displaced populations vary across social categories such as age, education, changing social norms, and disruptions to social networks. Studies involving adolescent girls and young women, including IDPs in Lebanon (Beirut, Beqaa, and Tripoli) and displaced populations in Izmir, Turkey, highlight early marriage as a significant factor associated with increased GBV risks. Contributing factors include limited educational opportunities, financial difficulties, and isolation outside the home.

Additionally, urbanization can influence parents' perceptions of child marriage in displacement contexts. For example, in Lebanon, some parents view early marriage as a protective measure to ensure their daughters' safety and reduce familial responsibility. This shift in perspective underscores how displacement reshapes social and cultural norms, sometimes perpetuating practices that heighten vulnerability to GBV.

Sexual and reproductive health (SRH) issues are particularly critical among IDPs, yet they remain under-prioritized. Displaced women and girls face heightened risks of early and unintended pregnancy, unsafe abortion, female genital mutilation (FGM), child marriages, malnutrition, reproductive tract infections (like sexually transmitted infections (STIs)), sexual violence, and limited access to essential services such as prenatal care and contraception. Addressing SRH is a public health imperative and a fundamental human right, necessitating targeted, community-based interventions and policies prioritizing displaced populations' dignity and well-being.

3- Barriers to accessing sexual and reproductive health services:

Five main factors influence access to sexual and reproductive health services for internally displaced persons (IDPs). These factors are grouped into categories: geographic accessibility, availability and quality of services, financial accessibility, knowledge of sexual health, and stigmatization and cultural barriers. Each of these categories plays a role in constraining access to SRH care for IDPs during displacement**.**

3.1- Geographical Accessibility:

Geographic accessibility is a significant barrier to sexual and reproductive health (SRH) services for internally displaced women (IDW). Studies show that the distance to healthcare centers and a lack of transportation options often prevent IDPs from accessing necessary SRH care. Hart drew attention to the "inverse care law" in 1971, which describes that access to quality medical care often decreases as the need increases. Feikin et al. (2009) coined the term "distance-decay effect" as one example of the concept. The farther people live from a healthcare facility, the less likely they are to use its services. For instance, it was identified in a study in Ghana's rural Ahafo-Ano South district that distance was the primary factor influencing healthcare utilization, which isn’t only problematic in terms of access, but also in terms of outcomes. Higher rates of perinatal and infant mortality were linked to living more than 5 kilometers away from a health facility (Buor, 2003). All these geographical obstacles can limit access to sexual healthcare facilities, particularly in remote or conflict-affected areas with inadequate infrastructure. Women may face other challenges in reaching healthcare services, especially in urgent situations, which worsens their overall health outcomes. These barriers highlight the importance of improving infrastructure and transportation options in displacement settings to ensure equitable access to SRH services.

3.2- Availability and quality of services:

The availability of sexual and reproductive health (SRH) services for displaced populations faces significant challenges. Nine studies highlighted barriers such as the lack of essential medications, which often prevent women from receiving the necessary treatments for reproductive health conditions. Long wait times for care, exacerbated by understaffing and resource limitations in healthcare facilities, further delay access to SRH services, particularly in areas with high internally displaced population densities. Additionally, limited operating hours at healthcare facilities, with SRH services available only at specific times or days, create further hurdles, especially for women managing other responsibilities or facing logistical challenges (Falb et al., 2020).

Adolescent girls in these settings encounter difficulties in accessing menstrual hygiene products and contraception. For example, in the Kobe refugee camp, only 61.5% of girls had adequate access to soap and water, while fewer than 20% had access to menstrual cloth or pads during menstruation (Falb et al., 2020). Limited access to contraceptives, including condoms, was also reported, with 60% to 91% of adolescent girls in camps struggling to obtain them. These systemic gaps highlight an urgent need for targeted and sustainable interventions to ensure that displaced women and girls have consistent access to SRH services and resources.

Women seeking sexual and reproductive health (SRH) services often encounter negative attitudes and behaviors from healthcare providers, leading to emotional distress and dissatisfaction with care. Provider bias posed a significant barrier to post-abortion care (PAC) for IDW. For instance, one woman in Uganda recounted obtaining medication to terminate her pregnancy but was not given instructions on its use, resulting in severe bleeding. When she sought PAC at a clinic, staff questioned her decision to induce an abortion. Only after her friend pleaded with the doctors did she receive treatment. This delay was perceived as a punishment for attempting an abortion. Another woman who used an herbal abortifacient, endured weeks of sharp abdominal pain but delayed seeking PAC for nearly a month due to fear that providers would disclose her actions to her community (Sultana, 2020). The findings emphasize the critical need for healthcare providers to not only understand the legal framework but also offer compassionate, nonjudgmental, and confidential care to address complications from unsafe abortions.

3.3- Financial accessibility:

The financial burden faced by displaced girls and young women has a profound impact on their sexual and reproductive health (SRH), often leading to engagement in transactional sex or "survival sex" in exchange for food, money, or other essentials due to the lack of access to free or affordable services. This situation is exacerbated by widespread poverty and the lack of resources, which forces many girls to turn to sex for survival. One young woman in Nigeria shared, "Many girls in this camp sleep with men to survive. We are here in Nigeria with nothing and nobody to help us and we have to survive" (Harrison et al., 2019). These exchanges often result in unwanted pregnancies, unsafe abortions, and exposure to sexually transmitted infections (STIs). For example, 66.7% of sexually active females aged 15-24 in Harrison et al.’s study reported having a transactional partner in the past year, with only 16.7% using condoms during their last sexual encounter.

The United Nations High Commissioner for Refugees (UNHCR) has acknowledged that such dire circumstances drive individuals to sell or exchange sex, which creates unique health and protection needs that often go unmet. To address these, operational guidance was developed to improve access to essential health care, prevent HIV and STIs, reduce unintended pregnancies, ensure safety, strengthen community-led efforts, empower individuals economically, and combat stigma

and discrimination. This underscores the urgent need for targeted interventions to protect the health and well-being of those engaging in survival sex in displacement settings.

3.4- Knowledge of sexual health:

Six studies explored the level of sexual and reproductive health (SRH) knowledge among refugees. They displaced young women, highlighting significant gaps in understanding about contraception, HIV/AIDS, and sexually transmitted infections (STIs). Overall, knowledge about contraceptive methods was limited, with adolescents generally less informed about modern contraception than adults. Misconceptions were widespread, particularly regarding the side effects of contraceptive methods, their impact on fertility, and their appropriateness for unmarried individuals. These misconceptions, combined with the stigma surrounding sexual health and inadequate sex education, hindered the use of contraception among young women and girls.

Awareness of HIV transmission and STIs was low, with 25% of female youth unable to identify any correct routes of transmission and 28.7% unaware of any means of avoiding HIV. Knowledge of STIs was also lacking, with 33.2% of young women unable to identify symptoms of STIs. Married women had better knowledge of contraception and STIs, largely due to learning about them through health services like the UNFPA clinic. However, unmarried women—who were often sexually active—were less informed and faced problems accessing SRH services.

3.5- Stigmatization and cultural barriers:

Internally displaced women (IDWs) often face a range of taboos and stigmas that hinder their access to sexual and reproductive health (SRH) services. In many displacement settings, acts like reporting sexual violence or engaging in sexual activity outside of marriage are culturally prohibited. Such taboos create a significant barrier for women in need of SRH services, as fear of social rejection or retribution silences them. For example, women who experience rape or sexual violence may avoid seeking help due to the shame and ostracism associated with such acts (Cockett, 2010). Similarly, young unmarried women who exchange sex for survival may be discouraged from accessing SRH services due to the stigma surrounding premarital sex or transactional sex.

Additionally, taboos related to family planning and contraceptive use are prevalent. In some cultures, using contraception before marriage is considered immoral or unnatural, and unmarried women often face heightened discrimination for seeking these services (Tohit et al., 2024). These cultural pressures not only prevent women from taking control of their SRH but also create a cycle of silence and shame that leaves IDWs at heightened risk of poor sexual and reproductive health outcomes.

4- Conclusion:

In conclusion, internally displaced women and girls face significant barriers in accessing sexual and reproductive health (SRH) services, with challenges stemming from geographic, financial, and cultural factors. The lack of information and support systems further exacerbates their vulnerability, making it difficult for them to make informed decisions about their health.

To address these barriers, there is an urgent need for targeted education campaigns to reduce stigma and improve knowledge about SRH, especially among displaced youth and marginalized groups.

Financial accessibility should be improved by offering subsidized or free services, as well as support for transportation to healthcare centers. Additionally, healthcare providers need to be well-trained and sensitive to the unique cultural and social needs of IDPs.

Improving healthcare delivery in both camp and urban displacement settings is crucial. Programs must be designed with the active involvement of IDP communities to ensure that they are culturally appropriate and responsive to the specific challenges faced by displaced populations. These measures, coupled with continued research and cross-sector collaboration, will help enhance SRH outcomes for IDPs and ensure that their health needs are adequately addressed.

References:

Beyan, A. J. (2012). *Sudan: Darfur and the Failure of an African State* . By Richard Cockett. (New Haven, CT: Yale University Press, 2010. Pp. vii, 315. $22.00.). *The Historian*, *74*(1), 90–92. https://doi.org/10.1111/j.1540-6563.2011.00314_3.x

Blanchet, K., Ramesh, A., Frison, S., Warren, E., Hossain, M., Smith, J., Knight, A., Post, N., Lewis, C., Woodward, A., Dahab, M., Ruby, A., Sistenich, V., Pantuliano, S., & Roberts, B. (2017). Evidence on public health interventions in humanitarian crises. *The Lancet*, *390*(10109), 2287–2296. https://doi.org/10.1016/S0140-6736(16)30768-1

Buor, D. (2003). Analysing the primacy of distance in the utilization of health services in the Ahafo-Ano South district, Ghana. *The International Journal of Health Planning and Management*, *18*(4), 293–311. https://doi.org/10.1002/hpm.729

Falb, K., Asghar, K., Pardo, N. M., Hategekimana, J. D. D., Kakay, H., Roth, D., & O'Connor, M. (2022). Developing an Inclusive Conceptual Model for Preventing Violence in the Home in Humanitarian Settings: Qualitative Findings From Myanmar and the Democratic Republic of Congo. *Journal of Interpersonal Violence*, *37*(3–4), 1076–1105. https://doi.org/10.1177/0886260520922358

Feikin, D. R., Nguyen, L. M., Adazu, K., Ombok, M., Audi, A., Slutsker, L., & Lindblade, K. A. (2009). The impact of distance of residence from a peripheral health facility on pediatric health utilisation in rural western Kenya. *Tropical Medicine & International Health: TM & IH*, *14*(1), 54–61. https://doi.org/10.1111/j.1365-3156.2008.02193.x

Harrison, K. M., Claass, J., Spiegel, P. B., Bamuturaki, J., Patterson, N., Muyonga, M., & Tatwebwa, L. (2009). HIV behavioural surveillance among refugees and surrounding host communities in Uganda, 2006. *African Journal of AIDS Research*, *8*(1), 29–41. https://doi.org/10.2989/AJAR.2009.8.1.4.717

Hart, J. T. (1971). The inverse care law. *Lancet (London, England)*, *1*(7696), 405–412. https://doi.org/10.1016/s0140-6736(71)92410-x

Hendrickx, M., Woodward, A., Fuhr, D. C., Sondorp, E., & Roberts, B. (2020). The burden of mental disorders and access to mental health and psychosocial support services in Syria and among Syrian refugees in neighboring countries: a systematic review. *Journal of Public Health*, *42*(3), e299–e310. https://doi.org/10.1093/pubmed/fdz097

Mohd. Tohit, N. F., & Haque, M. (2024). Forbidden Conversations: A Comprehensive Exploration of Taboos in Sexual and Reproductive Health. *Cureus*. https://doi.org/10.7759/cureus.66723

Morina, N., Akhtar, A., Barth, J., & Schnyder, U. (2018). Psychiatric Disorders in Refugees and Internally Displaced Persons After Forced Displacement: A Systematic Review. *Frontiers in Psychiatry*, *9*, 433. https://doi.org/10.3389/fpsyt.2018.00433

Owoaje, E., Uchendu, O., Ajayi, T., & Cadmus, E. (2016). A review of the health problems of the internally displaced persons in Africa. Nigerian Postgraduate Medical Journal, 23(4), 161. https://doi.org/10.4103/1117-1936.196242

Sultana, S., Tofigh, S., Chowdhury, R., Rubayet, S., Samandar, G., & Edelman, A. (2020). Expanding access to comprehensive abortion care in humanitarian contexts: Case study from the Rohingya refugee camps in Bangladesh. *JSTOR*. https://www.jstor.org/stable/10.1363/46e0820

UNHCR . UNHCR; Geneva: 2021. Global Trends in Forced Displacement (2021). https://www.unhcr.org/globaltrends