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SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF REFUGEES: EXAMINING ACCESS, UTILIZATION AND INTERVENTION STRATEGIES

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ABSTRACT: Sexual and reproductive health (SRH) is a critical component of public health, particularly for refugee populations who experience heightened vulnerabilities due to forced displacement, inadequate healthcare infrastructure, cultural barriers, and restrictive host-country policies. This review examines the complex barriers affecting refugees' access to SRH services, categorizing them into structural and logistical constraints, socio-cultural determinants, and economic and policy-related challenges. The findings reveal significant gaps in family planning and contraceptive utilization, often influenced by misinformation, partner opposition, and limited contraceptive availability. Additionally, the review evaluates the role of humanitarian interventions, including the Minimum Initial Service Package (MISP) and community-based SRH programs, in addressing both immediate and long-term healthcare needs. Case studies of successful interventions, such as refugee-led family planning initiatives in Guinea and integrated SRH service models in Bangladesh and Lebanon, demonstrate the efficacy of community engagement, policy reform, and improved coordination among stakeholders in enhancing SRH outcomes. The review underscores the urgent need for sustainable healthcare solutions, advocating for the integration of refugees into national healthcare systems, expansion of culturally sensitive SRH education, and strengthened humanitarian-development coordination. A multi-sectoral and rights-based approach is imperative to ensure equitable access to SRH services for displaced populations, ultimately improving health outcomes and gender equity in refugee settings.

INTRODUCTION: Sexual and reproductive health (SRH) is an integral component of overall human health and well-being, bearing substantial influence on quality of life, gender equality, and socioeconomic development.

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For refugee populations especially women and girls, this domain becomes even more critical due to their heightened vulnerability arising from forced migration, exposure to violence, and the breakdown of healthcare systems in conflict and crisis zones.

These compounded circumstances often result in inadequate access to healthcare services, leading to increased risks of sexually transmitted infections (STIs), maternal and neonatal complications, and gender-based violence (GBV) [1, 2, 3].

Despite frameworks such as the Minimum Initial Service Package (MISP) and commitments from humanitarian agencies, long-standing barriers continue to impede refugee access to SRH services. These include structural issues such as funding limitations, weak integration of services, cultural stigmatization, gender norms, and restrictive host-country policies [4, 5, 6]. This review further discusses these barriers in detail including trends in family planning and contraception use, and highlights interventions that have shown promise in improving SRH service delivery among refugee populations [7, 8, 9].

Barriers to Access and Utilization of SRH Services: Refugee women face multi-barrier access and utilization constraints relating to and deriving from various factors; these may be categorized into the following categories:

Structural and Logistical Barriers: Access to sexual and reproductive health (SRH) services among refugees is significantly hindered by multiple structural and logistical barriers, primarily healthcare infrastructure deficits, mobility constraints, and a shortage of skilled healthcare providers. Many refugee camps and urban settlements lack the necessary healthcare facilities to provide comprehensive SRH services, resulting in limited access to essential drugs, contraceptives, and trained medical personnel. The absence of well-equipped clinics within these settings further exacerbates the healthcare gap, leading to increased risks of maternal and neonatal complications, sexually transmitted infections (STIs), and unintended pregnancies. Additionally, geographical and financial barriers pose serious mobility constraints for refugees, as many reside in remote or marginalized areas with inadequate transportation infrastructure, making it difficult to reach healthcare centres [10].

Even when services are available, the lack of trained healthcare providers with expertise in culturally sensitive SRH service delivery further limits access. Many healthcare professionals lack specialized training in trauma-informed care and gender-sensitive SRH counselling, resulting in inconsistent and inadequate service provision [11]. Addressing these structural deficiencies requires investments in healthcare infrastructure, improved transportation networks, and targeted capacity-building initiatives to train healthcare professionals in refugee-centred, culturally competent SRH care.

Socio-cultural Barriers: Social and cultural norms significantly influence refugees' access to sexual and reproductive health (SRH) services, often creating barriers to contraceptive use, family planning, and SRH education. In many refugee communities, deeply rooted patriarchal structures and traditional beliefs contribute to stigma surrounding SRH services. Family planning and contraceptive use are frequently seen as threats to cultural norms of fertility and masculinity, leading to hesitation among both men and women in seeking SRH services. This reluctance is further reinforced by religious and ethical opposition, where certain refugee groups, due to faith-based beliefs, reject modern contraceptive methods and instead favour natural family planning techniques, which may be less effective in preventing unintended pregnancies. Additionally, language barriers and misinformation make it difficult for many refugees to access accurate information regarding their SRH rights and available services [11].

The lack of multilingual and culturally appropriate educational materials limits awareness of safe reproductive health practices, leading to misconceptions about contraception, maternal health, and STI prevention. Overcoming these socio-cultural barriers requires community-based education programs, culturally sensitive outreach efforts, and accessible SRH information in multiple languages, ensuring that refugees have the knowledge and resources needed to make informed decisions about their reproductive health while respecting their cultural and religious values.

Economic and Policy Barriers: Economic and policy-related barriers significantly hinder refugees' access to sexual and reproductive health (SRH) services, further exacerbating their vulnerability to poor health outcomes. Poverty remains a major challenge, as many refugees experience severe economic deprivation, making it difficult to afford healthcare services, transportation costs, and essential SRH resources, including contraceptives and maternal healthcare [11]. The financial burden limits their ability to seek timely medical care,

increasing the risks of untreated reproductive health conditions and unintended pregnancies. Additionally, legal and policy restrictions in certain host countries further constrain refugees' access to healthcare. Many national health policies exclude refugees from public healthcare programs, forcing them to rely on donor-funded clinics and NGO-operated services, which often lack sustainability and consistency [4]. These restrictions create disparities in healthcare access, leaving many refugees without continuous or adequate SRH support. Furthermore, distrust in healthcare systems is another significant barrier affecting healthcare utilization. Past experiences of discrimination, exploitation, and neglect by healthcare providers either in their home countries or during migration, have contributed to suspicion and reluctance among refugees to seek medical assistance [10].

This distrust further limits their engagement with available healthcare services, even when such services are accessible. Addressing these challenges requires inclusive healthcare policies, financial support mechanisms, and culturally competent healthcare delivery models to ensure that refugees receive equitable and uninterrupted access to SRH services.

Family Planning and Contraceptive use among Refugees: Despite relatively high approval of family planning among refugee populations, the actual utilization of contraceptive methods remains significantly low due to a combination of knowledge gaps, misconceptions, unmet contraceptive needs, and social resistance. Many refugees lack adequate information about modern contraceptive methods, their effectiveness, and their potential side effects, contributing to misconceptions and fear regarding their use. Studies among Rohingya refugees indicate that although there is broad support for family planning, awareness of different contraceptive options remains limited, with many individuals relying on misinformation and traditional beliefs rather than medically accurate guidance [12]. One of the most significant barriers to contraceptive use is the fear of adverse health effects, as many refugee women believe that modern contraceptive methods cause irreversible infertility, haemorrhaging, birth defects, or general bodily harm [13]. These concerns, often reinforced by cultural norms and community narratives, discourage many women from seeking reproductive health services, leaving them at higher risk of unintended pregnancies and maternal health complications. Additionally, the unmet need for contraception in refugee populations remains disproportionately high, often exceeding 30% in crisis settings, as many refugee women lack access to contraceptive supplies, experience healthcare shortages, or face opposition from partners and family members [14].

Limited access to healthcare infrastructure, disrupted contraceptive supply chains, and inadequate funding for family planning programs further hinder the ability of refugees to practice reproductive autonomy. However, some community-driven initiatives have successfully improved contraceptive access and acceptance within refugee communities, such as the refugee-led family planning program in Guinea, where trained refugee health workers provided peer education, counselling, and contraceptive distribution. This initiative demonstrated that leveraging trusted community members to deliver reproductive health services helps reduce stigma, correct misinformation, and increase contraceptive uptake. Similarly, integrating contraceptive services within maternal healthcare programs has proven effective, as it allows women to access family planning resources in a familiar, medical setting, reducing stigma and encouraging informed decision-making. To improve contraceptive utilization among refugees, a comprehensive approach is required, incorporating community-based education, culturally sensitive outreach, increased healthcare access, and policy-level support to ensure that family planning services are widely available, accessible, and accepted within refugee populations.

SRH Services in Humanitarian Settings: Sexual and reproductive health (SRH) service delivery in humanitarian settings is primarily structured around the Minimum Initial Service Package (MISP), a framework designed to ensure immediate access to lifesaving reproductive health interventions during emergencies. The MISP prioritizes essential maternal and newborn care, prevention and management of sexual violence, access to contraceptive services, and treatment for sexually transmitted infections (STIs) in crisis-affected

populations. While this framework plays a critical role in stabilizing SRH services during acute phases of displacement, transitioning from basic emergency SRH care to a comprehensive, sustainable healthcare system remains a significant challenge.

Key Challenges in Humanitarian SRH Service Provision: Despite the critical need for sexual and reproductive health (SRH) services in humanitarian settings, several key challenges hinder their effective delivery. One of the most pressing issues is short-term funding cycles, as the primary source of financial support for SRH programs in crisis settings comes from donor organizations, which often operate on a temporary funding basis. This inconsistent financial support leads to service disruptions, making it difficult to sustain essential reproductive health programs, including contraceptive access, maternal care, and STI prevention [3].

Without long-term investment, healthcare systems in refugee and conflict-affected settings remain fragile, under-resourced, and unable to meet the growing demand for SRH services. Another major obstacle is poor coordination among key stakeholders, including NGOs, governments, and UN agencies, which results in fragmented service delivery. The lack of a standardized and unified approach to SRH service implementation leads to duplication of efforts, resource misallocation, and service gaps in many humanitarian settings [4]. Effective inter-agency collaboration is essential to streamline resources, avoid redundancy, and enhance service accessibility for displaced populations. Additionally, a shortage of appropriately trained healthcare workers further exacerbates the crisis, as many professionals providing SRH services lack specialized training in trauma-informed and gender-sensitive care. Given the prevalence of gender-based violence (GBV), sexual exploitation, and reproductive health complications in conflict zones, healthcare providers must be equipped with the skills necessary to offer compassionate, culturally competent, and survivor-centred care [4]. Addressing these challenges requires long-term, sustainable funding mechanisms, stronger inter-agency coordination, and capacity-building initiatives to ensure that healthcare professionals are adequately trained to meet the complex SRH needs of refugee populations.

Success Stories: Effective Interventions and Programs: Several successful interventions and programs have been implemented to address the sexual and reproductive health (SRH) needs of refugee populations, demonstrating the impact of community-driven approaches, healthcare integration, and targeted capacity-building initiatives. One notable example is the Cox's Bazar Initiative in Bangladesh, where an intervention led by Ipas focused on renovating healthcare facilities and training healthcare providers to enhance family planning and post-abortion care services. The initiative resulted in a significant increase in contraceptive uptake while also contributing to a decline in unsafe abortion rates, highlighting the importance of strengthening SRH infrastructure and improving provider competency to ensure access to safe reproductive healthcare services [15].

Another impactful program is the refugee-led family planning initiative in Guinea, which demonstrated the effectiveness of community-based interventions. In this model, trained refugee health workers played a crucial role in providing contraceptive counselling and distributing family planning resources, leading to a marked increase in contraceptive use within the refugee community. This approach not only improved access to contraceptive services but also fostered trust and cultural acceptance by leveraging peer-led education and engagement strategies [13].

Similarly, the SRH service expansion program in Lebanon showcased the benefits of integrating reproductive health services within existing primary healthcare structures. A study on Syrian refugees in Lebanon found that when SRH services were incorporated into primary healthcare clinics, there was a notable improvement in both access and utilization of essential reproductive health services. This model demonstrates that integrating SRH services into broader healthcare frameworks enhances service availability and accessibility, reducing barriers to care and promoting continuity of reproductive health support for displaced populations [4]. These success stories underscore the importance of sustainable, community-centred and health system-integrated approaches in enhancing

SRH service delivery for refugees. By investing in healthcare infrastructure, empowering refugee-led initiatives, and promoting the integration of SRH services into primary healthcare, similar programs can be replicated and scaled in other humanitarian settings to ensure equitable and long-term access to reproductive healthcare for displaced populations.

Recommendations: To improve SRH outcomes among refugees, a structured and sustainable approach is necessary. Expanding community-based SRH education through culturally sensitive, community-led initiatives can enhance awareness, address misconceptions, and promote informed decision-making. Strengthening policy frameworks to integrate refugees into national healthcare systems is essential to ensure long-term access to SRH services beyond short-term humanitarian aid. Furthermore, enhancing humanitarian-development coordination is critical for transitioning from MISP-based emergency responses to comprehensive, sustainable healthcare solutions. Strengthened collaboration between governments, international organizations, and NGOs is required to develop integrated healthcare strategies that address both immediate needs and long-term SRH service accessibility for displaced populations.

CONCLUSION: The SRH of refugees remains a critical issue, shaped by a complex interplay of cultural, economic, structural, and policy-related barriers that limit access to essential healthcare services. Refugee populations, particularly women and girls, are disproportionately affected by unintended pregnancies, maternal health complications, limited contraceptive access, and increased vulnerability to gender-based violence. These challenges are further exacerbated by forced displacement, inadequate healthcare infrastructure, and policy restrictions in host countries. Although humanitarian organizations have implemented the Minimum Initial Service Package (MISP) to provide emergency SRH care, transitioning toward comprehensive and sustainable SRH services remains a significant challenge due to funding constraints, policy fragmentation, and coordination gaps. Addressing these barriers requires a multi-sectoral approach, combining policy reforms, strengthened healthcare infrastructure, and culturally tailored community engagement to ensure the effective and equitable provision of SRH services for displaced populations.

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REFERENCES:

1. Doumit MAA, Nabulsi D, Abou Saad M and Ismail H: Implementation of the MISP for sexual and reproductive health for women in a displacement setting: A narrative review on the Syrian refugee crisis in Lebanon. Reprod Health 2021; 18(1). https://doi.org/10.1186/s12978-021-01108-9
2. Darebo TD, Spigt M, Teklewold B and Badacho AS: The sexual and reproductive healthcare challenges when dealing with female migrants and refugees in low and middle-income countries. BMC Public Health 2024. https://doi.org/10.1186/s12889-024-17916-0
3. Amiri M, El-Mowafi IM, Chahien T and Yousef H: An overview of the sexual and reproductive health status and service delivery among Syrian refugees in Jordan. Reprod Health 2020; 17(1). https://doi.org/10.1186/s12978-020-01005-7
4. Fouad FM, Hashoush M, Diab JL and Nabulsi D: Perceived facilitators and barriers to the provision of sexual and reproductive health services in response to the Syrian refugee crisis in Lebanon. Womens Health 2023; 19. https://doi.org/10.1177/17455057231171486
5. Amran MY: Health in crisis: An integrative review of sexual and reproductive health in humanitarian settings. 2023. https://www.diva-portal.org/smash/get/diva2:1805079/FULLTEXT01.pdf
6. Chynoweth S: Rethinking humanitarian accountability: Implementation of SRH services in complex emergencies. 2015. https://repository.unsworks.unsw.edu.au/.../content
7. Ahmed R, Aktar B, Farnaz N, Ray P and Awal A: Challenges and strategies in conducting sexual and reproductive health research among Rohingya refugees in Bangladesh. Conflict Health 2020; 14(1). https://doi.org/10.1186/s13031-020-00329-2
8. Qaddour A, Tappis H, Lazieh S, Ward A and Spiegel P: The Humanitarian-Development Nexus and Sexual and Reproductive Health Interventions in Fragile Settings: A Scoping Review. medRxiv. 2024. https://doi.org/10.1101/2024.10.14.24315444
9. Diab JL, Daigle M, Spencer A, Samneh B and Afandi A: Sex, health and rights in displacement and humanitarian response. Overseas Development Institute. 2023. https://odi.cdn.ngo/media/documents/HPG_report-USAID-SRHR-final.pdf
10. Podolsky V and Medvedovska N: Reproductive health of refugees: barriers to accessing healthcare systems in host

countries. Ukr J Perinatol Pediatr 2023. https://doi.org/10.15574/pp.2023.95.107
11. Sawadogo P, Sia D and Onadja Y: Barriers and facilitators of access to sexual and reproductive health services among migrant, internally displaced, asylum seeking and refugee women: A scoping review. PLoS One 2023; 18. https://doi.org/10.1371/journal.pone.0291486
12. Tahir A, Adli S, Hashim R and Islahudin F: Reproductive Health Issues and Assessment of Knowledge, Attitude and Practice on Family Planning among Rohingya Female Refugees. Open J Social Sciences 2022. https://doi.org/10.4236/jss.2022.103006
13. Howard N, Kollie S and Souare Y: Reproductive health services for refugees by refugees in Guinea I: family planning. Conflict Health 2008; 2(12). https://doi.org/10.1186/1752-1505-2-12
14. Agbemenu K, Auerbach S, Ely G, Aduloji-Ajijola N and Wang H: Family planning trends among community-dwelling African refugee women. Public Health Nurs 2020. https://doi.org/10.1111/phn.12725
15. Mahmud M, Aktar S and Ahmed S: Evaluation of a sexual and reproductive health programme in Cox's Bazar, Bangladesh. J Glob Health 2024; 14. https://doi.org/10.7189/jogh.14.04146

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