Systematic Review

Provision of sexual and reproductive health services to internally displaced women and refugees in Africa: a systematic review

Atenchong Ngwibete[1], Olayinka Ogunbode[2], Timothy Oluwasola[2], Akinyinka Omigbodun[2]

1. Pan African University Life and Earth Sciences Institute (including Health and Agriculture), PAULESI, University of Ibadan, Ibadan, Nigeria
2. Department of Obstetrics & Gynaecology, College of Medicine, University of Ibadan and University College Hospital, Ibadan, Nigeria

***Corresponding Author: Atenchong Ngwibete**; E-mail: atenchongngwi@gmail.com

Abstract

Aim

The objective of this review is to identify the types of sexual and reproductive health (SRH) services that had been provided to internally displaced persons(IDP) and refugees in Africa, the key stakeholders and partners who provide these services, and the modes of service delivery.

Method

A systematic review was done using published quantitative and qualitative study designs, and grey literature, the provision and delivery of SRH services for displaced persons was reviewed. Studies included met at least two criteria. Only studies carried out from 2010 till date were included. Data of interest were extracted and the mixed-methods appraisal tool (MMAT) was used to evaluate the quality of each study. Primary outcomes included SRH services delivery, including family planning services; sexually transmitted infections (STI); reproductive cancer prevention, diagnosis, care and treatment; and response to sexual gender-based violence (SGBV).

Results

Twenty-one publications met the criteria for the review. While some SRH services are available for women in IDP and refugee camps, adolescent SRH services, preventive care for gynaecological cancers and voluntary abortion care were generally not available. Service delivery was faced with some limitations, including lack of funds, authorization and policy issues, training gaps and lack of supplies. Nurses, midwives, community health workers (CHWs) and lay refugees were the key personnel providing services. They were overworked in most places. Services were primarily funded by the United Nations (UN) and non-governmental organizations (NGOs), but governments, private enterprises and community-based organizations (CBO) worked together to provide care.

Conclusion

There is a need to expand service delivery for women IDPs and refugees in Africa to include comprehensive SRH care. Deploying more qualified/trained personnel can improve the effectiveness and reliability of the care provided. Better funding for SRH care can help to improve service delivery and the incorporation of other aspects of SRH into care provision.

Key words: Sexual and Reproductive Health; Displaced Women; Humanitarian Settings; Care Delivery; Africa

Introduction

Comprehensive sexual and reproductive health (SRH) intervention for internally displaced women and refugees is critical to meeting the health needs of this segment of the population. The types of reproductive health (RH) services provided and their mode of delivery are crucial to ensuring that service delivery is adequate and will yield a positive SRH outcome. The United Nations High Commission for Refugees (UNHCR) proposed the Minimum Initial Service Package (MISP) in the event of a humanitarian disaster[1]. The MISP for SRH is a set of critical, life-saving actions that must be carried out to meet the SRH needs of impacted populations[2]. According to the UNHCR, the MISP centers around the provision of SRH services by the health sector to prevent violence, respond to the need of survivors, prevent transmission, morbidity and mortality of HIV and other sexually transmitted infections (STIs), prevent maternal and newborn deaths, prevent unintended pregnancy and plan for overall SRH service integration in primary health care for refugees and Internally Displaced Persons (IDP).

However, these requirements are frequently neglected, with possibly fatal effects[3]. There have been increasing reports of conflicts and other humanitarian disasters during the last few decades. According to the UNHCR, over 100 million people are displaced in the world with over 86% from developing countries[4] and over 18 million displaced people in Africa[5]. These persons are prone to SRH issues and need services that will mitigate these challenges. This can be achieved if SRH care is provided as an essential primary health care component in humanitarian situations. Moreover, Sustainable Development Goal (SDG) goal 3.7 aims at promoting universal access to sexual and reproductive health care, including family planning information and education, as well as the integration of reproductive health into national plans and initiatives[6]. Despite these agreements, millions of women still go without modern contraception and safe abortions each year, and men and women go without treatment for treatable STIs. Adolescent-specific programming is still not prioritized, and other pressing

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issues, such as the growth of reproductive malignancies, are becoming more prominent[7,8]. Furthermore, these are critical unmet needs in both development and humanitarian situations[2]. Previous systematic reviews have focused on utilization and access, health knowledge, experiences and interventions on SRH services that are being provided in displaced/ humanitarian settings[9–12]. However, these notable gaps of knowledge that shed more light on the provision of holistic SRH services in dilapidated settings in SSA still exist, despite the commendable effort of these studies. While the study by Ivanova et al.'s done in 2018 focus offered a glimpse of the challenges faced in humanitarian settings, it failed to comprehensively assess what types of SRH services are provided to displaced persons in these settings and how these services are delivered[11]. A more similar scoping review by Tirado et al. provided a global perspective on barriers and facilitators but lacked the specificity required to unravel the nuanced dynamics within the African context[10]. A review focusing on the types of service provision to refugees and IDPS in displaced settings ins SSA is, therefore, necessary to provide and update on the knowledge about gaps in service provision and service delivery methods on the continent. The objectives of this review are to identify the types of SRH provided to IDP and refugees, explore the modes of delivery of these services and identify the key stakeholders and partners who provide these services.

Materials And Methods

The protocol for this review was registered and approved with PROSPERO: CRD42022306335. The PICO (population, intervention, and comparison) framework was used to formulate the research questions for this review; however, no comparison on groups was used for the study. The population of the study included internally displaced persons (IDP) and refugees. Interventions were those that focused on sexual and reproductive health (SRH) services. Outcomes included types of SRH services, modes of delivery of these services, and stakeholders involved in the service provision.

Information Sources

The systematic review entailed a search on EMBASE, Google Scholar, PubMed, Psych INFO, using search terms and keywords that were employed in other SRH-related reviews in crisis-affected areas. These terms included sexual and reproductive health, pregnancy, family planning, contraception, abortion, prenatal healthcare, antenatal health care, HIV/AIDS, STIs, cancer screening, prevention of mother-to-child transmission (PMTCT), maternal and newborn health, gender-based violence, and adolescent sexual health[11,13]. The researchers also scanned through the reference lists of similar articles to get relevant articles that match the study objectives. The inclusion and exclusion criteria for data used in this review are shown in Table I.

Search Strategy

The search strategy included a combination of the search terms together with; SRH, IDP/refugee and humanitarian crisis, service delivery and utilization and Africa/specific African countries. Search in each database was limited to articles published from 2010 till 2022. The reference list of relevant articles was also checked for suitable articles. Grey literature that focused on the study subject was also used for the study. For non-open access literature that suits the area of interest, the researchers, reached out to the author explaining the need for the article. All open access studies and those for which the researchers got full-text versions via email from corresponding authors were used for the study. See Table II

Selection Process/ Data Synthesis

The inclusion and exclusion criteria were clearly defined before the study, and a structured data collection check list was adopted for data collection to minimize the chances of bias during article selection and data synthesis. The web search yielded a total of 706 articles. These articles were imported into Endnote version 20. The duplicate remove function was used to remove all articles which had the same titles and authors and were published in the same year. A total of 67 articles were duplicates After this, title and abstracts independently were screened by two reviewers and non-related articles were removed. This led to a total of 560 articles being deleted. Out of the 79 articles left, 62 were excluded following a full article review as these articles did not meet the inclusion criteria. A total of 17 articles met the inclusion criteria for the study. Three additional articles were obtained from the reference list of other articles and one article was received from the author. This gave a total of 21 articles for the review. Relevant information from these articles were extracted using a data extraction form (See table II). The Mixed Methods Appraisal Tool (MMAT), version 2018, was used to appraise the quality of studies used for the systematic review[14]. A narrative approach was used for data synthesis. Data extraction was based on the set objectives. Themes included information on SRH care provision; type of SRH care provided and key stakeholders and partners who provide SRH services in humanitarian settings in Africa. Specific themes on SRH care provision included; Family planning service, antenatal care service, labor and delivery care, postpartum and new borne care, care of sexually assaulted persons, abortion care, STI and reproductive tract infection (RTI) care and adolescent health care.

Results

The number of articles identified from the search and their disposal is shown in Figure 1. Studies were included from 9 countries namely Guinea, Mali, Uganda, Burkina Faso, Democratic Republic of the Congo (DRC), South Sudan, Djibouti, Kenya and Nigeria. Results of these studies are reported as guided by the objectives of the study. Table III show a summary of the findings of the study.

Key Stakeholders and Partners Who Provide Services in Humanitarian Settings in Africa.

Key stakeholders who deliver services in humanitarian settings according to the review include; Non-Governmental Organizations (NGOs), Community Based Organizations (CBOs), Government agencies, private organizations and United Nations (UN) agencies. In all the studies, the main supporting partners for care provision was the UN and NGOs who worked in collaboration with other agencies. UN and NGOs funded and provided staff for services while governmental organizations and other agencies provided support[17,32]. Ante-natal care (ANC) services and services for sexual assault were primarily funded by the UN and NGOs[20,23,25,26,31,33–35]. Government agencies teamed with NGO/UN in STI/HIV service provisions[25].

Table I: Inclusion and Exclusion Criteria

Category	Included	Excluded
Population of interest	Women IDPS and refugees receiving humanitarian health assistance in African countries including refugees and internally displaced persons	
Health outcomes or outputs	Primary outcomes (SRH services delivery including family planning services, STI /reproductive cancers prevention, diagnosis, care and treatment, response to gender-based violence,), Maternal and new-born care, secondary outcomes (reported condom use, ANC, labour and delivery) and primary outputs (health service provider, stakeholders, facility delivery, contraception uptake, SRH health education)	
Intervention	Any sexual and reproductive health-related intervention that is not one-off and seeking to strengthen an already existing SRH service being provided to women IDPs or refugees.	Sexual and reproductive health-related interventions that are one-off(one-time occurrence/temporal) or lasted for 1 year or less.
The phase of humanitarian crises	Studies conducted during a humanitarian crisis among IDPs and refugees	Studies conducted before or after a crisis has stabilized
Study types and designs	All quantitative and qualitative study designs and grey literature that discusses SRH service provision and delivery in crisis setting. Studies must specify clearly that it was conducted in a crisis related setting. These studies most address at least two of the objectives.	Qualitative and quantitative studies that do not include provision or delivery of SRH services; discussion papers and literature reviews; Studies not clearly stating site it was done
Publication date	Studies 2010 till date	
Language	English	Other languages

Government agencies also provided staff for outreach programs[15,17]. In most of the studies, government hospitals attended to referral cases from the health centers in humanitarian settings. CBO provided outreach SRH services while private hospitals cared for patients at a cost[15,19,22,33].

Types of SRH Services Provided

According to the study, services were provided differently in each setting was provided; however, it was sometimes limited due to a lack of available resources. The list of services provided included antenatal, perinatal, postpartum, and newborn care; family planning services; abortion services; STIs, including HIV services; and care for victims of sexual violence.

Family Planning Services

Family planning (FP) services were provided in the refugee camps. This was reported in 11 studies. Service delivery for family planning services was mostly facility-based in most countries[16, 17, 20–22, 29, 30, 36, 37]. Contraceptives were also available for free at facilities, sold at pharmacies, and local-traditional contraceptives administered by IDPs or refugees themselves or traditional practitioners. In all settings, mainly short-acting contraceptives were provided: condoms, oral contraceptive pills (OCP), injectable contraceptives, while two main long-acting contraceptives (LARC) were used: IUDs and implants. Emergency contraceptives (EC) were present in some facilities; however, these studies report its use only for sexually assaulted victims[18,19,22]. Only 5 of the 11 studies mentioned the use of LARC as a family planning option[16,17,23,39,30]. Family planning services were provided by healthcare workers, including trained health care workers. Specifically, doctors, nurses, midwives, pharmacists, lay refugees, health workers, and community health workers (CHW). However, nurses, midwives, CHWs, and lay refugees seem to provide health services in most settings[20,21,36]. The use of lay refugees as health workers in a study in Guinea improved service uptake[36]. Effective counseling was reported to be given along with FP service uptake[36,38]. There were reports of training gaps by providers in the studies[18,20, 22,38]. Casey et al. also reported that providers had biases that harmed the delivery of high-quality care[20]. Modes of service delivery included facility base (8studies), mobile-based outreach services (1study), and self-care (1study). Mobile and outreach family planning services were made in an attempt to improve access to contraception among refugees. This was the case in Djibouti[21]. FP service delivery points were reported to be scarce in humanitarian settings, and in some countries like South Sudan, they were nonexistent[20].

Table II: Data Extraction Sheet

SN	Author (year)	Title	Country	Population of study	Design	Outcome of interest	Quality of Studies (MMAT)
1.	Howard (2011) (36)	Reproductive health for refugees by refugees in Guinea III: maternal health	Guinea	Female refugees of reproductive age (15 to 49yrs)	Cross-sectional survey	The refugee population received reproductive health information, referrals, and contraceptives from nurses and midwives as well as trained refugee laywomen. The presence of refugee-trained personnel enhanced the likelihood of a woman giving birth in a facility. Other services include ANC, immunizations	100%
2.	Woodward (2011) (39)	Reproductive health for refugees by refugees in Guinea IV: Peer education and HIV knowledge, attitudes, and reported practice	Guinea	Male and female refugees of reproductive age (15 to 49 yrs)	Cross-sectional survey	Refugee led health education significantly improves HIV knowledge, attitudes and practices	100%
3.	*(Lamarche 2021)(15)*	A Crisis of Care: Sexual and Reproductive Health Competes for Attention Amid Conflict and Displacement in Mali	Mali	Self-Care Traditional Medicine	Report. Mixed method	Free sexual and reproductive health (SRH) care is present in some refugee camps in the regions. Women self-administer SRH care due to cost and a lack of formal treatment (including abortion). Many locations have low rates of assisted deliveries, and unassisted deliveries are risky. According to the Malian midwife door-to-door, community-based services or mobile care does not cater directly to the SRH needs of the IDPs.	
4.	WHO(2021) (16)	Improving Sexual and Reproductive Health services among refugees and internally displaced people	Congo	Adolescent girls and women aged 12-49 yrs	Cross-sectional	Most hospitals do not provide services for GBV and rape. According to the poll, only 27% of health centres were fully equipped to provide post-rape care, 19% had standard operating procedures for clinical rape management, and just under 10% had a specialized post-abortion care room. Condoms, injectables, and birth control tablets are some of the most used contraceptive methods. For most staff, training was recommended	100%
5.	Ivanova *et al.*, 2019)(17)	A cross-sectional mixed-methods study of sexual and reproductive health knowledge, experiences and access to services among refugee adolescent girls in the Nakivale refugee settlement, Uganda	Uganda	Adolescent girls 13-19 years old	Cross-sectional survey	Health centres were underutilized and only approximately 2.5% of them obtained contraceptive methods. Staff in these facilities were trained, although there were some gaps in their knowledge of long-acting contraceptive techniques, as well as frequent stock-outs. Some of the girls who refused to return to the facilities cited a lack of privacy as well as a lack of resources, such as medicines, in the centres, as reasons for their problems not being resolved by the health staff.	50%
6.	Women's Refugee commissio n(2011) (42)	Baseline Study: Documenting Knowledge, Attitudes and Practices of Refugees and the Status of Family Planning Services in UNHCR's Operations in Nakivale Refugee Settlement, Uganda	Uganda	Refugees	Cross-sectional survey	According to health facility assessments, none of the facilities offers clients long-acting or permanent contraception, nor is there a functioning referral system for those who want to utilize these methods. Short-term methods, such as oral contraceptive tablets and condoms, are frequently out of stock in facilities. There are staffing issues, as well as a lack of FP training. Emergency contraception (EC) is only accessible for sexual assault.	75%
7.	The World Bank, (2020) (19)	Linking, Aligning, and Convening Gender-Based Violence and Violence Against Children Prevention and	Uganda		Cross-sectional and mapping	During care provision, the physical impacts of sexual violence, such as pregnancy and HIV, are frequently the focus of government-run and NGO-supported health institutions, which pay less attention to mental health and psychological effects. In most facilities, the counselling that is provided does not include the deeper therapeutic engagement	75%

Stock-outs of contraceptives, authorization to use FP supplies, and cost of getting contraceptives were reported in the studies as factors that limited use[17,18, 20,22,38–40]. In Kenya, the cost of FP service as well as the limited availability of certain methods, particularly long-acting and permanent methods, were issues. In Mali, the cost of service made IDPs resort to self-care or traditional care[15]. In Nakivale, Uganda, there was no referral system for long-acting or permanent methods[18, 38]. This was not the case in Guinea, where referrals for contraceptives were provided[36]. Most providers of FP services reported the need for training or an update in the delivery of FP services and new technologies[15,17,18,20,30,38]. The workload on facility staff was reported as a factor that affected comprehensive FP service delivery[21].

Antenatal Service Delivery

Antenatal care was reported in 5 studies[17,25–27,32]. This service was offered mainly at the facility. Care provision was principally provided by doctors, nurses, midwives, TBAs, and CHWs present in health centers. Most women were attended to by only CHW throughout their pregnancies[26]. ANC seems to be accessible to very few IDPs or refugees[27,32]. According to Ohihoin et al., ANC services are present in IDP camps in Nigeria, but they are accessible to only 20%

		Response Services in Uganda's Refugee-Hosting Districts				that is required to aid mental health and psychosocial recovery. Notably, none of the health facilities examined was using formal therapeutic methods for trauma, UNHCR and partners have funded infrastructure expansion in some facilities and supplied them with the necessary supplies and personnel.	
8.	Casey *et al.*, (2015) (44)	Progress and gaps in reproductive health services in three humanitarian settings: mixed-methods case studies	Multi-country: Burkina Faso, Democratic Republic of the Congo (DRC), and South Sudan.	Selected health facilities	Cross-sectional, mixed-methods case study	There were facilities available that were structurally capable of providing RH services. Functioning FP service delivery stations were scarce, and in South Sudan, they were non-existent. There was a shortage of FB supplies reported, and no facility reported having LARC on hand. Emergency obstetric and newborn care was provided by facilities. A referral system for emergency obstetrics was in place at all of the camp's health institutions. Service delivery generally was limited by a lack of authorization and supplies. There were reports of self-administered SRH care Caregivers lacked key RH expertise, and others had biases that harmed the delivery of high-quality care. Despite substantial sexual violence documented in the area, few health clinics delivered Clinical management of rape (CMoR). Few facilities had at least one clinician trained to administer adolescent-friendly RH service across all settings. Hospitals in South Sudan had no STI and HIV/PMTCT services. Services were unavailable as commodities were out of stock or they lacked authorization to provide anti-retroviral drugs (ARVs). Post Abortive Care(PAC) was available Induced abortion services were not available however, admitted to performing induced abortions	75%
9.	Tanabe *et al.*, (2015)(21)	Family planning in refugee settings: findings and actions from a multi-country study	DJIBOUTI Kenya Uganda	A multi-country analysis of health facilities Women of reproductive age	Mixed method	Only short-acting methods: male and female condoms, oral contraceptives, emergency contraception, and injectables were available. According to facility assessments, there was a dearth of FB services and employees in Kenya and Djibouti. The cost of FP service, as well as the limited availability of certain methods particularly long-acting and permanent methods, was an issue (Kenya). There was no referral system for long-acting or permanent methods. There were no adolescent services provided. Midwives in Nakivale were particularly overworked. All providers acknowledged competence deficiencies and sought refresher training, as well as training on long-acting methods and new contraceptive technology. No referral system for LARC was available in Djibouti and Uganda	75%
10.	(Women's Refugee Commission, 2020)(22)	The gap between Supply and Demand for Contraceptive Services in Northeast Nigeria	Northeast Nigeria	key informant interviews with the UNFPA and non-governmental organization (NGO) health and SRH program managers; health	Mixed method	Only four types of contraception were available, all of which were short-acting: OCPs, injectables, implants, and IUDs. NGOs support five of the seven facilities. Only two facilities have a contraceptive service delivery location that was qualified. Only sexually assaulted individuals were given EC. Two of the four locations met the criteria for being a functional PAC service delivery point. Some respondents claimed that health facilities are understaffed, with some relying on a single nurse or midwife to provide all services. Training needs for providers was identified. MOH relied on other organizations to provide training	75%

of displaced persons in the Northeast[27]. In one study, very few women had at least 3 ANC visits[25]. ANC was also one of the most seen services delivered in health centers in IDP camps[26]. Tanabe et al. reported that ANC was a service that overworked health care providers in humanitarian services[38]. Also, referrals for women with high-risk pregnancies were available[17,25,27,34]. Only one study reported that ANC services were mainly supported and provided by NGOs[32].

Labour and Delivery Care

Five articles in the study reported caring for women in labor and delivery[15,25,26,29,34]. Although basic and comprehensive emergency obstetric care (EMOC) was reported in health centers, few were able to deliver services competently. According to Casey et al., in a study in Burkina Faso, the DRC, and South Sudan, only one facility in Burkina Faso was fully capable of delivering comprehensive emergency obstetric and newborn care, or CEmONC[20]. Facilities reported a lack of supplies and equipment for service delivery, a lack of authorization to use supplies, and a lack of training[15,34]. This affected the quality of care and was

				facility assessment			
	UNFPA, (2016)(23)	Sexual and gender-based violence assessment in north-east Nigeria	Nigeria	Key informants Women of reproductive age	Cross-sectional survey	More than 80% of the facilities provided HIV testing and counselling, as well as family planning, postnatal care, SGBV prevention and management, and specialized antenatal care. PMTCT, HIV monitoring and treatment, STI diagnosis and treatment, and psychosocial support were all available at least half of the sites. Only about half of the clinics offered sexual and reproductive health services. Although fewer facilities had peer educators for SGBV survivors, less than half had staff training on how to provide SGBV services. Few of the facilities had SGBV treatment methods protocol and instructions available. HIV post-exposure prophylaxis was administered. Only a few facilities provided post-abortion care.	100%
11.	Relief web 2021.(24)	Crisis in Tigray: gender based violence AOR	Ethiopia	Health facility	Cross-sectional survey	Clinical Management of Rape (CMR) services is available in 29% of facilities. GBV awareness, dignity kits, psychosocial support, referral, and GBV capacity building have all been implemented so far.	50%
12.	Amsalu et al(2019)(25)	Essential newborn care practice at four primary health facilities in conflict-affected areas of Bossaso, Somalia: a cross-sectional study	Somalia	Women aged 15-49 years	Cross-sectional	87 percent of women who delivered at the facility had at least one ANC attendance only 14% had attended at least 3ANC sessions. Most women had been diagnosed with UTI and 97% had received antibiotics. In 95.7 percent of deliveries, a qualified health worker was present. Approximately one-third of all newborns require some form of newborn care. Essential newborn care was provided by facility staff Pregnant women who showed signs of complications were referred to the hospital.	
13.	Sami et al (2017)(26)	State of newborn care in South Sudan's displacement camps: a descriptive study of facility-based deliveries	Sudan	Mother (aged 15 and old)-newborn pairs and birth attendants who provided delivery services	Cross-sectional descriptive design	Few facilities had skilled health care providers 24/7 hours in the facility. In two-thirds of the cases, more than one health worker assisted with the delivery, however, TBAs delivered 25.4 percent of the time. The time spent in contact with the patient accounted for 40.2 percent of the midwife's time, ANC (53.2 per cent) was the most common activity observed along with inpatient care, followed by delivery care (31.4 percent). Most mothers in all facilities attended at least one ANC visit. Supplies for new borne care were not available. Essential newborn care was provided to all babies.	75%
14.	Ohihoin et al(2021)(27)	Challenges to Accessing Ante-Natal and Postnatal Carein Internally Displaced Persons (IDPs) Camps in Nigeria	Nigeria	Females	Descriptive cross-sectional mixed methods	Doctors, nurses, and midwives were among the health professionals who offered antenatal care. Only 40.5 percent of the displaced people had access to post-partum care of any kind.	50%
15.	Tucalp et al (2015)(28)	Provision of Health Services to the	Nigeria	Government officials,	Mixed method	In order to meet healthcare needs, there is a high level of collaboration among agencies.	50%

evident in increased maternal and child-related deaths and complications in birthing[34]. Birthing was both assisted and unassisted and was carried out by TBAs, nurses, and midwives at the facility or home[15,25,26]. In 2/3 of cases, facility delivery was managed by at least 2 health care providers[26]. Deliveries were however reported to be done by TBA either at the facility or at home[15,26] in Mali. The decrease in the number of births attended to by a health care professional was attributed to the crisis[29]. Referral was also reported in most studies[15,26,29].

Postpartum and Newborn Care

Postpartum and newborn care was reported in 3 studies[25–27]. In a study in camps in Nigeria, 40% of women had access to postpartum care of any kind[27]. Care was provided by TBA, CHW, nurses and midwives[25–27]. Essential newborn care was provided to all babies born in the facility: cleaning, warming, breastfeeding, use of tetracycline ointment among others. However, 1/3 of all newborns required some form of specialized newborn care[25]. Often, supplies for newborn care were not available, but referrals to hospitals were available[25,26].

Care of Sexually Assaulted Survivors

Several articles reported services for GBV, including rape and sexual assaults[16,19,20,23,24,31]. Care delivery was reported in health care centers and was delivered by nurses, midwives, CHWs, and trained refugees, or IDPs. Since most SGBV victims were female, female health workers attended to these victims[23]. Services available for clinical management of rape (CMOR) included the provision of emergency contraceptives (EC), post-exposure prophylaxis for HIV (PEP), and antibiotics for preventing STI[20,23,24,31]. Only a few health centers in each study reported the provision of CMOR. There were reports of a lack of supplies to deliver services[20,31]. Care provided for sexually assaulted victims focused on HIV/STI and pregnancy prevention and generally ignored the mental health of the individual involved[16,19]. The World Bank, in its study in Uganda, reported that referral services were available

	Olufemi (2019)(32)	Internally Displaced Persons in Maiduguri, Borno State, Nigeria: Collaborative Approach		NGOs, and IDP		Collaboration takes place at the level of referrals from NGOs' clinics to the state's specialty hospital. In their numerous camps, women have access to antenatal care. Pregnant women are cared for by competent health personnel assigned by the agencies. In the fight against STDs, particularly HIV/AIDS, agencies collaborated. Government health personnel can only be found in official camps, which also have NGOs, but only NGOs provide antenatal services to pregnant women.	
16.	MUUO (2020)(33)	Barriers and facilitators to care-seeking among survivors of gender-based violence in the Dadaab refugee complex	Kenya	Emancipate d female minors (15–17) and females 18 above years, professional staff of UN and NGO	Qualitative mixed method	The IRC or CARE GBV offices, as well as the UNHCR, were the most commonly visited agencies for GBV care. 53.6 percent of the women surveyed at baseline reported visiting the IRC or CARE GBV support centres. Most of them reported forced sexual. Case-specific management was received from professional staff, locally referred to as "officers" (skilled GBV case managers and counsellors), and Refugee Community Workers (RCWs), also known as "incentive workers."	50%
17.	Landegger (2011)(35)	Strengths and weaknesses of the humanitarian Cluster Approach in relation to sexual and reproductive health services in northern Uganda	Uganda	UN, NGO and government staff	Qualitative	The GBV Sub-Cluster was acknowledged as a factor that improved the quality of GBV services provision by the implementation of the common methods following training and the use of monitoring tools. Respondents saw these as opportunities to participate in collaborative learning and contribute to the development of standards. Monitoring and evaluation, as well as training needs assessments, were not generally included in GBV trainingmanuals for the Sub-Cluster, according to aninternational NGO's examination.	
18.	Ataullahjan et al (2020)(29)	C'est vraiment compliqué: a case study on the delivery of maternal and child health and nutrition interventions in the conflict-affected regions of Mali	Mali	UN, NGO and government representati ve	Mixed-methods approach	Deliveries were attended to by health care professionals. Some neonates got postnatal care within two days after delivery. Individuals in Northern Mali have limited access to services. Jihadists monitor health visits to ensure they do not seek family planning services. Due to funding constraints and/ or limitations, organizations were forced to carry out only some SRH activities, even though they believed full services were required in conflict zones. Personnel shortages was a persistent issue in the government own facilities	
19.	Curry et al (2015)(30)	Delivering High-Quality Family Planning Services in Crisis-Affected Settings II: Results	Chad, the DRC, Djibouti, Mali,	Service delivery data	Quantitative	In Chad, the Democratic Republic of the Congo (DRC), Djibouti, and Mali, CARE's continuous Supporting Access to Family Planning and Post-Abortion Care in Emergencies (SAFPAC) initiative is active. LARC techniques were not available in the nation. Implants have dominated the two LARC techniques in African countries.	
20.	Roka et al (2014) (31)	One Size Fits All? Standardized Provision of Care for survivors of Sexual Violence in Conflict and Post-Conflict Areas in the Democratic Republic of Congo	DRC	Hospital records	Quantitative	MSF provided services for Survivors of Sexual Violence. The efficacy of medical care is highly dependent on the time it takes to seek medical care, and HIV PEP and STI prophylaxis are most effective when started within 72 hours of exposure. HIV testing was available, but facilities were always short of testing kits, and up to 60% of cases remained untested at first contact, illustrating this challenge and potentially reducing survivors' trust in the services provided.	

in some settings for rape victims. In Nigeria and Ethiopia, comprehensive management of rape victims was reported. Services included psychosocial support and referrals[23,24]. All studies, however, reported the non-availability of SGBV treatment protocols, and very few reported finding written sexual gender-based violence (SGBV) care instructions in humanitarian health care settings. The studies also reported that care providers needed training in the management of cases of SGBV.

Abortion Care

Post abortion care (PAC) was reported in 4 studies [15,20,22,23]. PAC was reported to be provided in few health facilities in humanitarian settings in different countries[20,23]. The major PAC services provided included manual vacuum aspiration (MVA) or misoprostol administration to post-abortion clients and offering of at least one family planning technique. Despite the fact the PAC delivery was mentioned as being delivered, some facilities did not meet eligibility criteria for PAC service delivery[22]. In some settings, PAC service delivery was limited by lack of permission or training on PAC[20,22]. Although there was no service in health settings to deliver voluntary abortions to refugees or IDPs, some health personnel in the DRC, Burkina Faso, and South

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Table III: Summary Table on SRH Service Delivery for IDPs/Refugee Women in Africa

	Types of SRH Service,	Modes of Service Delivery.	Key Stakeholders Providing the Services
1.	Family Planning services (condoms, oral contraceptive pills (OCP), Injectable contraceptives, IUD, Implant)	Facility-based pharmacies mobile-based outreach services, self-care and traditional care	Nurse, Midwives, CHW, IDPs
2.	ANC care (immunization, health education, referrals)	Facility-based	Doctors, Nurses, Midwives, TBA And CHW
3.	Labour and Delivery Care (EMOC, referrals)	Facility-based Self-care Traditional care	Nurses, Midwives, TBA and CHW, IDPs/Refugees
4.	Postpartum and Newborn Care (immunization, breastfeeding, cleaning, warming, use of tetracycline ointment, referral)	Facility-based Self-care Traditional care	Nurses, Midwives, TBA and CHW
5.	Care of sexually assaulted victims (PEP, contraception, antibiotics, CMoR, counselling)	Facility-based	Nurses, Midwives, CHW and Trained Refugees or IDPs
6.	Abortion care (Manual Vacuum aspiration (MVA) or misoprostol and contraception)	Facility-based Self-care	Nurses, Midwives, CHW and Trained Refugees or IDPs
7.	STIs, including/HIV, Reproductive Tract Infections (HTS, Counselling ART, PMTCT, PREP, Antibiotics)	Facility-based	Nurses, Midwives, CHW and Trained Refugees or IDPs
8.	Adolescent Health Services.	Facility-based	Nurses, Midwives, CHW

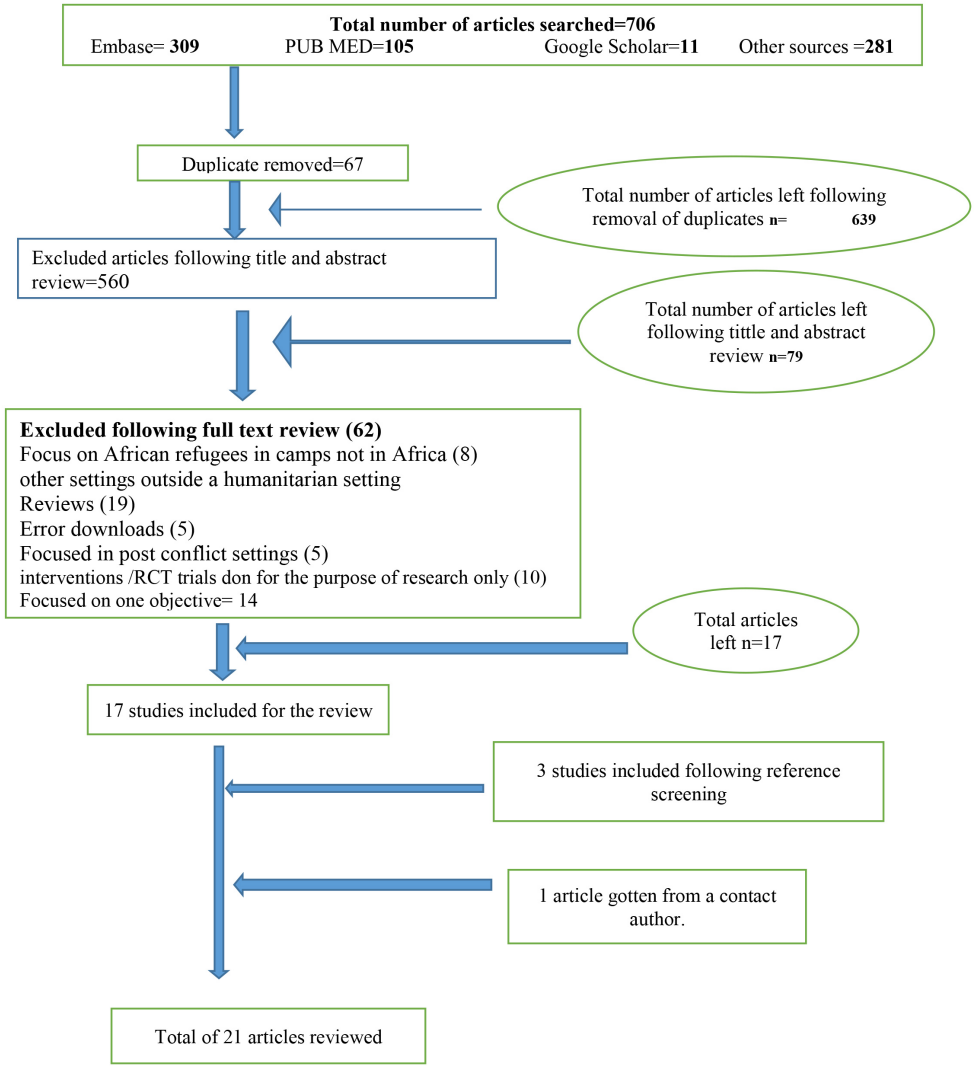

Figure 1: Results

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Sudan reported providing induced abortions to refugees[20]. Self-administered abortions were also reported. This was attributed to the lack of formal care and the lack of money to afford the cost of treatment[15].

STIs (including/HIV) and Reproductive Tract Infections

STI and HIV care was reported in 5 studies[23, 25, 31, 32, 34]. Services were provided mainly at ANC[25] during the care of rape victims[23,31] or as HIV/STI clinical care[23,32, 34]. The main HIV services provided were HIV testing and counseling[23]. Stock outs of supplies were reported to affect care. Testing kits, antibiotics, and ARVs were not available most of the time[23,25,31,34]. According to a study by Roka et al. in the DRC these affected users' trust in health service provision[31]. In a study in Nigeria, the fight against HIV and STIs in camps is a joint effort of both NGOs and government agencies[32]. In some countries, these services were reported to be provided in some facilities only. According to the UNFPA (2019), only half of the 24 facilities that cater to displaced persons provide SRH, including HIV services, in Nigeria[41]. PMTCT was also provided in some settings[20,23], but these services were completely absent in some settings, like in Sudan[20].

Adolescent Health Services

Provision of adolescent-friendly services was reported in 3 studies[17,20,38]. In most humanitarian settings, there were no adolescent-friendly services[38], or very few services for adolescents[20]. These services were provided by nurses, midwives or CHW. Ivanova reported that lack of privacy made adolescent girls refuse uptake of care in humanitarian settings[17]. According to Casey et al adolescents shied from receiving care at the facility because of a lack of privacy and treatment supplies[20].

Discussion

The existing evidence on the provision of SRH services for IDPs and refugees in humanitarian settings in Africa demonstrated important gaps in the types of services available and their modes of delivery. These factors included the inadequacy of facilities to provide services (e.g. PAC, CMOR), limitations in the availability of supplies (LARC, EC, and other SRH commodities), the cost of services, the work load on SRH care staff, crises, the absence of certain SRH services (adolescent clinics, PMTCT), and incompetencies in the delivery of certain services (Emoc, CMOR). Previous reviews on SRH health for IDPs and refugees in Africa have focused on SRH intervention studies, evaluation of MISP implementation, knowledge of SRH, and SRH care delivery.SRH experiences and access to SRH among IDPs and refugees in Africa. This review adds to what is known by identifying the service provision gaps. Specifically, the kind of services provided, the modes of delivery of these services, and the key stakeholders in the implementation of SRH service provision in crisis situations in Africa as reported in previous studies have been collated. These findings show that there are several SRH services provided by humanitarian services in Africa. They include ANC, labor and delivery, postpartum and newborn care, care of sexually assaulted victims, abortion care, STIs, including HIV, reproductive tract infections, and adolescent health services. The services delivered conformed with the minimum requirements recommended by the UNHCR in its Minimum Intervention Service Package (MISP) for refugees and IDPs[1,42]. Generally, most services provided were delivered free of charge, although there were reports of self-care for the delivery of some services, such as labor, delivery, childcare, and abortion care services[15,20,27,43]. This was likely due to facilities not being accessible to some of the displaced individuals[15]. According to Ivanova et al. (2019), some displaced adolescents resorted to self-care because the facility did not meet their needs due to a lack of privacy as well as a lack of resources, such as medicines in the centers. Traditional care was also patronized by refugees and IDPs generally; safe abortion, adolescent health care, care for sexually assaulted victims, and family planning services were not systematically offered in a full package at the facilities. This can affect trust in service delivery and deprive displaced persons of the privilege of full SRH basic care[31]. LARC was not available in up to six of the studies, and in most cases, a referral for LARC was not available. Recommendations have centered on guaranteeing the availability of long-acting methods, which are increasingly acceptable and viable in humanitarian situations[38].

In most cases, care for sexual assaults was limited to the prevention of pregnancy and STI/HIV. Patients' mental health was not taken into consideration during SGBV in most facilities. According to the World Bank (2020) medical social workers, psychotherapists and clinical psychologists are among the really important personnel that most clinics lacked, especially in humanitarian settings. Furthermore, in Africa, formal therapies for trauma, such as cognitive-behavioral treatment, are underutilized by both government and nongovernmental groups. Referral services were present mostly for ANC, intrapartum care and postpartum care. Although PMTCT services were completely absent in some settings, like in Sudan, facilities that offered HIV care offered both ART and PMTCT services. In South Sudan, however, these services were not available due to a lack of authorization (policy restrictions) and a lack of ARVs, as reported by the health care workers in the study[44]. Although some national policies may restrict RH service implementation in Sudan, Casey et al. (2015) explained that a lack of providers' knowledge of supportive policies and protocols restricted HIV treatment services as providers had incorrect knowledge about Ministry of Health policies. Generally, safe abortions were not offered in any of the facilities because of a lack of authorization. According to Casey et al., adolescents in developing countries are more likely to have unsafe abortions, and adolescents living in crisis-affected areas have extra risks and vulnerabilities to unsafe abortions. However, PAC was offered in a few of the facilities[20]. Generally, there was also poor delivery of some services. Postpartum care and abortion services were generally poor in most humanitarian settings in the study. In sub-Saharan Africa, most countries have weak healthcare systems[44]. In rural areas, the problem may be worse as there is a compounded effect of weaker health services and service infrastructure. This may apply to service provision to IDPs and refugees, who are most often found in remote or rural settings in SSA countries. Primary prevention services for gynecological cancers, such as cervical cancer screening or breast self-examination, were not documented in any of the studies. Considering the vulnerability of IDPs and refugees to gynecological cancers such as cervical cancer, these services are crucial and should be part of SRH care. According to the Africa Health Organization, cervical cancers account for up to 22% of all female cancers and 12% of all newly diagnosed cancer in both men and women[45]. Also, these

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services are cheap to provide and require simple skills that can be provided by lay healthcare workers[45]. Although the review did not uncover specific explanations for the unavailability and shortage of some services, it is reasonable to assume that insufficient funding and a scarcity of trained health personnel could be reasons. Each service delivery is led by an organization, mostly NGOs, which partner with other NGOs. CBOs and government agencies to deliver care. According to the UNFPA, delivery of MISP for SRH services requires that each Health The sector or cluster should identify an organization to lead the implementation of the MISP[1]. Although there were reports of other forms of care delivery, facility care delivery was the most common. According to Lamarche, the use of mobile clinics and outreach did not cater to the SRH needs of refugees, who are usually displaced and always on the move[15]. There was evidence of strong collaboration between agencies in the delivery of reproductive health services. According to Ataullahjan et al., who reported a case study of maternal and child health service delivery in times of crisis in Mali, government systems are usually weakened and need support from other agencies[29]. Hence, collaboration to provide services is an effective way of delivering care. More still needs to be done to improve service delivery, as many gaps exist in care provision, which affect the visible efforts of all partners involved. In most settings, services were delivered by nurses, midwives, CHWs, or lay refugees. The use of trained refugees is a cheap and effective strategy that yields positive health outcomes in humanitarian settings[36,39]. However, the use of trained refugees comes with mixed findings, as the replacement of professionals with lay health care workers might cause some harm due to the extensive knowledge and skill gap. However, more research is needed to assess the extent of good over harm this might cause to a community[51]. Nurses and midwives seemed to be the only group of qualified providers actively present in most camps and are usually overworked[18,38]. They are also faced with the issue of being understaffed and not being exposed to training updates for care provision[18,22]. Nurses, midwives, and CHWs have also been reported as key health care providers in humanitarian settings in other studies in crises affected areas[30,37,45,47]. This can be justified by the fact that nurses and midwives make up a majority of the health workforce[48]. Working conditions, job satisfaction, financial concerns, management capacity, workplace safety, personal and lifestyle-related factors (such as living situations) are all factors that affect health care workers' retention in humanitarian settings[49,50]. This may be the reason for the low number of health care workers in humanitarian settings and the high pressure on the available care providers Other factors identified as affecting service delivery included frequent stock-outs of supplies in health centres, lack of authorization (policy restrictions) to use supplies, policies that restrict the provision of some services such as ART services and abortion services, lack of training of healthcare personnel in some modes of care delivery and other miscellaneous issues. According to our findings, collaborations exist between UN and government agencies working with NGOs/CBOs/private sector in the delivery services. However, in most settings, UN agencies and NGOs where the main sponsors for human resource development and ensuring care provision in the displaced settings. According to literature most African health systems are mainly funded by INGO[51]. Although health is considered a priority in most African countries, bad policies, along with neglect by political decision makers in these nations, have caused poor resource allocation and utilization in the health sector.

Limitations

Although the literature search was thorough, there were certain limitations to this systematic review, including possibly overlooking some relevant papers during the initial filtering. Secondly only articles written in English were considered, implying that papers in other languages which may have fitted the inclusion criteria would have been left out. This also may be the reason why papers from other crisis-affected regions in Africa, such as Cameroon and the Central African Republic, were not included in the study. In addition, the diversity of study topics and design methodologies made the comparison of results quite difficult.

Conclusion

The UN, NGOs and government agencies are the key stakeholders involved in funding care provision in humanitarian services in Africa. Most SRH services are available in IDP camps in Africa. However, they are not comprehensive due to lack of resources, authorization and policy issues, training gaps and lack of supplies. Services that were not reported to be provided in humanitarian settings included adolescent health services, preventive care for gynecological conditions (such as cervical cancer screening and breast self-examination services) and voluntary abortion care. Available services are mostly delivered at health facilities by nurses, midwives CHWs or trained lay refugees. The use of trained lay refugees was mentioned in some studies as a cheap, effective way for SRH service provision to IDP/ Refugees. Health facilities are understaffed in terms of health care providers and they are faced with the challenge of inadequate training in most situations. There is a general need to scale up service delivery for IDPs and refugees in Africa to include comprehensive SRH care provision. Deploying more qualified staff and training the existing personnel can improve the effectiveness and reliability of care provided. Increasing funding for SRH care can go a long way in improving service delivery and incorporating other aspects of SRH into care provision.

References

1. United Nations Population Fund. Minimum Initial Service Package (MISP) for SRH in Crisis Situations | UNFPA - United Nations Population Fund [Internet]. 2020. Available from: https://www.unfpa.org/resources/minimum-initial-service-package-misp-srh-crisis-situations

2. Amiri M, El-Mowafi IM, Chahien T, Yousef H, Kobeissi LH. An overview of the sexual and reproductive health status and service delivery among Syrian refugees in Jordan, nine years since the crisis: a systematic literature review. Reprod Health. 2020;17(1):1–20.

3. UNCHR. UNHCR - Sexual and Reproductive Health [Internet]. 2021. Available from: https://www.unhcr.org/reproductive-health.html

4. UNHCR. UNHCR 'S initiative on internal displacement Population figures. 2021; Available from: https://reporting.unhcr.org/sites/default/files/UNHCR Initiative on Internal Displacement 2020-2021.pdf

5. The World Bank. On forced displacement we can learn from Africa [Internet]. Africa Renewal. 2021. Available from: https://www.un.org/africarenewal/news/forced-displacement-we-can-learn-africa

6. UNFPA. UNFPA & the Sustainable Development Goals | UNFPA - United Nations Population Fund [Internet]. 2020. Available from: https://www.unfpa.org/sdg

7. Desrosiers, A., Betancourt, T., Kergoat, Y. et al. A systematic review of sexual and reproductive health interventions for young people in humanitarian and lower-and-middle-income country settings. BMC Public Health 20, 666 (2020). https://doi.org/10.1186/s12889-020-08818-y

8. Salam RA, Faqqah A, Sajjad N, Lassi ZS, Das JK, Kaufman M, et al. Improving Adolescent Sexual and Reproductive Health: A Systematic Review of Potential Interventions. J Adolesc Health [Internet]. 2016 Aug 1 [cited 2021 Sep 29];59(4S):S11–28. Available from: https://pubmed.ncbi.nlm.nih.gov/27664592/

9. Munyuzangabo M, Khalifa DiS, Gaffey MF, Kamali M, Siddiqui FJ, Meteke S, et al. Delivery of sexual and reproductive health interventions in conflict settings: a systematic review. BMJ Glob Heal [Internet]. 2020 Jul 1 [cited 2021 Nov 24];5(Suppl 1):e002206. Available from: https://gh.bmj.com/content/5/Suppl_1/e0022

10. Tirado V, Chu J, Hanson C, Ekström AM, Kågesten A. Barriers and facilitators for the sexual and reproductive health and rights of young people in refugee contexts globally : A scoping review. 2020;1–25.

11. Ivanova, O.; Rai, M.; Kemigisha, E. A Systematic Review of Sexual and Reproductive Health Knowledge, Experiences and Access to Services among Refugee, Migrant and Displaced Girls and Young Women in Africa. Int. J. Environ. Res. Public Health 2018, 15, 1583. https://doi.org/10.3390/ijerph15081583

12. Warren E, Post N, Hossain M, Blanchet K, Roberts B. Systematic review of the evidence on the effectiveness of sexual and reproductive health interventions in humanitarian crises. BMJ Open. 2015;5(12).

13. Lauren J, Allison A, Caroline, M J, Anne, M T, Alison M B. Implementation strategies to improve cervical cancer prevention in sub-Saharan Africa: A systematic review. Implement Sci. 2018 Feb 9;13(1).

14. Hong QN, Pluye P, Fàbregues S, Bartlett G, Boardman F, Cargo M, et al. Mixed Methods Appraisal Tool (MMAT), Version 2018. User guide. McGill [Internet]. 2018;1–11. Available from: http://mixedmethodsappraisaltoolpublic.pbworks.com/w/file/fetch/127916259/MMAT_2018_criteria-manual_2018-08-01_ENG.pdf%0Ahttp://mixedmethodsappraisaltoolpublic.pbworks.com/

15. Lamarche DC and A. A Crisis of Care: Sexual and Reproductive Health Competes for Attention Amid Conflict and Displacement in Mali - Mali | ReliefWeb [Internet]. 2021. Available from: https://reliefweb.int/report/mali/crisis-care-sexual-and-reproductive-health-competes-attention-amid-conflict-and

16. WHO. Improving Sexual and Reproductive Health services among refugees and internally displaced people [Internet]. 2021. Available from: https://www.who.int/health-cluster/news-and-events/news/SRH-refugees-IDPs/en/

17. Ivanova O, Rai M, Mlahagwa W, Tumuhairwe J, Bakuli A, Nyakato VN, et al. A cross-sectional mixed-methods study of sexual and reproductive health knowledge, experiences and access to services among refugee adolescent girls in the Nakivale refugee settlement, Uganda. Reprod Health. 2019;16(1):1–11.

18. Women's Refugee commission. Baseline Study : Documenting Knowledge , Attitudes and Practices of refugees and the status of family planning services in UNHCR's Operations in Nakivale Refugee Settlement, Uganda. www.womensrefugeecommission.org. 2011;(August):1–22.

19. The World Bank. Linking , Aligning , and Convening: Gender-Based Violence and Violence Against Children Prevention and Response Services in Uganda ' s Refugee-Hosting Districts. 2020; Available from: https://reliefweb.int/sites/reliefweb.int/files/resources/Linking-Aligning-and-Convening-Gender-Based-Violence-and-Violence-Against-Children-Prevention-and-Response-Services-in-Uganda-s-Refugee-Hosting-Districts.pdf

20. Casey SE, Chynoweth SK, Cornier N, Gallagher MC, Wheeler EE. Progress and gaps in reproductive health services in three humanitarian set...: EBSCOhost. Confl Health [Internet]. 2015;9(Suppl 1):1–13. Available from: http://web.a.ebscohost.com.proxy.lib.sfu.ca/ehost/pdfviewer/pdfviewer?sid=0e29cfd9-23e5-4ede-a48a-b9f16afba15a%40sessionmgr4006&vid=1&hid=4201

21. Tanabe M, Schaus K, Rastogi S, Krause SK, Patel P. Tracking humanitarian funding for reproductive health: a systematic analysis of health and protection proposals from 2002-2013. (Special Issue: Taking stock of reproductive health in humanitarian settings: 2012-2014 Inter-agency Working Group on Reproduct. Confl Health. 2015;9(Suppl 1):1–13.

22. Women's Refugee Commision. Gap between Supply and Demand for Contraceptive Services in Northeast Nigeria Case Study. 2020;(May).

23. UNFPA. Sexual and gender-based violence assessment in North East Nigeria. 2016;

24. GBV AoR. Response Update - Crisis in Tigray: Gender based violence AOR, June 2021 - Ethiopia | ReliefWeb. 2021;6(June):23–6. Available from: https://reliefweb.int/report/ethiopia/response-update-crisis-tigray-gender-based-violence-aor-june-2021

25. Amsalu R, Morris CN, Chukwumalu K, Hynes M, Janjua S, Couture A, et al. Essential newborn care practice at four primary health facilities in conflict affected areas of Bossaso, Somalia: A cross-sectional study. Confl Health. 2019;13(1):1–13.

26. Sami S, Kerber K, Kenyi S, Amsalu R, Tomczyk B, Jackson D, et al. State of newborn care in South Sudan's displacement camps: A descriptive study of facility-based deliveries. Reprod Health. 2017;14(1):1–12.

27. Ohihoin AG, Herbertson C., Bamidele T, Musa AZ, Afocha EE, David AN, et al. Challenges to Accessing Ante-Natal and Postnatal Care in Internally Displaced Persons (IDPs) Camps in Nigeria. Ann Med Heal Sci Res. 2021;11:1366–9.

28. Tunçalp Ö, Fall IS, Phillips SJ, Williams I, Sacko M, Touré OB, et al. Conflict, displacement and sexual and reproductive health services in Mali: Analysis of 2013 health resources availability mapping system (HeRAMS) survey. Confl Health [Internet]. 2015;9(1):1–9. Available from: http://dx.doi.org/10.1186/s13031-015-0051-8

29. Ataullahjan A, Gaffey MF, Tounkara M, Diarra S, Doumbia S, Bhutta ZA, et al. C'est vraiment compliqué: A case study on the delivery of maternal and child health and nutrition interventions in the conflict-affected regions of Mali. Confl Health. 2020;14(1):1–17.

30. Curry DW, Rattan J, Huang S, Noznesky E. Delivering high-quality family planning services in Crisis-Affected Settings II: Results. Glob Heal Sci Pract. 2015;3(1):25–33.

31. Roka JL, Van Den Bergh R, Au S, De Plecker E, Zachariah R, Manzi M, et al. One size fits all? Standardised provision of care for survivors of sexual violence in conflict and post-conflict areas in the democratic republic of Congo. PLoS One. 2014;9(10):1–8.

32. Olufemi IO, Liberty F, Uthman H. Provision of Health Services to the Internally Displaced Persons in Maiduguri, Borno State, Nigeria: Collaborative Approach. Can Soc Sci [Internet]. 2019;15(12):28–36. Available from: www.cscanada.netwww.cscanada.orghttp://www.cscanada.net/index.php/css/article/view/11451DOI:http://dx.doi.org/10.3968/11451

33. Muuo S, Muthuri SK, Mutua MK, McAlpine A, Bacchus LJ, Ogego H, et al. Barriers and facilitators to care-seeking among survivors of gender-based violence in the Dadaab refugee complex. Sex Reprod Heal Matters [Internet]. 2020;28(1). Available from: https://doi.org/10.1080/26410397.2020.1722404

34. Casey SE. Evaluations of reproductive health programs in humanitarian settings: A systematic review. Confl Health. 2015;9(1):1–14.

35. Landegger J, Hau M, Kaducu F, Sondorp E, Mayhew S, Roberts B. Strengths and weaknesses of the humanitarian Cluster Approach in relation to sexual and reproductive health services in northern Uganda. Int Health [Internet]. 2011;3(2):108–14. Available from: http://dx.doi.

org/10.1016/j.inhe.2011.03.005

36. Howard N, Woodward A, Souare Y, Kollie S, Blankhart D, Von Roenne A, et al. Reproductive health for refugees by refugees in Guinea III: Maternal health. Confl Health. 2011;5(1):1–8.

37. Munyuzangabo M, Khalifa DiS, Gaffey MF, Kamali M, Siddiqui FJ, Meteke S, et al. Delivery of sexual and reproductive health interventions in conflict settings: A systematic review. BMJ Glob Heal. 2020;5:1–14.

38. Tanabe M, Myers A, Bhandari P, Cornier N, Doraiswamy S, Krause S. Family planning in refugee settings: findings and actions from a multi-country study. Confl Health. 2017;11(1):1–12.

39. Woodward A, Howard N, Souare Y, Kollie S, Von Roenne A, Borchert M. Reproductive health for refugees by refugees in Guinea IV: Peer education and HIV knowledge, attitudes, and reported practices. Confl Health. 2011;5(1):1–10.

40. Fathalla M. Issues in reproductive health: Health and being a woman [Internet]. 2015 [cited 2021 Sep 29]. Available from: https://www.un.org/womenwatch/daw/csw/issues.htm

41. WHO, UNFPA. Ensuring human rights within contraceptive service delivery: implementation guide. 2015;53. Available from: www.unfpa.org

42. Women Refugee Commission. Inter-Agency Working Group on Reproductive Health in Refugee Situations. 2010;2 p. Available from: http://misp.rhrc.org/pdf/cheat sheet/MISP cheat sheet rev.04 2010.pdf

43. UNFPA. Universal Access to Reproductive Health. 2016;(January):7–13. Available from: https://www.unfpa.org/publications/universal-access-reproductive-health-progress-and-challenges

44. Casey SE, McNab SE, Tanton C, Odong J, Testa AC, Lee-Jones L. Availability of long-acting and permanent family-planning methods leads to increase in use in conflict-affected northern Uganda: Evidence from cross-sectional baseline and endline cluster surveys. Glob Public Health [Internet]. 2013;8(3):284–97. Available from: http://dx.doi.org/10.1080/17441692.2012.758302

45. Jody L, Christina M, Kristy M. Home-Based Life-Saving Skills in Liberia: Acquisition and Retention of Skills and Knowledge. J Midwifery Women's Heal [Internet]. 2010;55(4):370–7. Available from: http://dx.doi.org/10.1016/j.jmwh.2009.09.016

46. Singh NS, Smith J, Aryasinghe S, Khosla R, Say L, Blanchet K. Evaluating the effectiveness of sexual and reproductive health services during humanitarian crises: a systematic review. PLoS One. 2018 Jul 1;13(7):e0199300.

47. WHO. Physicians (per 1,000 people) | Data [Internet]. World Health Organization's Global Health Workforce Statistics. 2016. Available from: http://data.worldbank.org/indicator/SH.MED.PHYS.ZS?locations=ZM%5Cnhttp://data.worldbank.org/indicator/SH.MED.PHYS.ZS

48. Koh D, Naing L. Health, Workers'. Wiley Blackwell Encycl Heal Illness, Behav Soc. 2014;1132–7.

49. Dieleman M, Harnmeijer JW. Improving health worker performance: in search of promising practices. Vol. 27, WHO. 2006.

50. Dieleman M, Harnmeijer JW. Improving health worker performance: in search of promising practices. Vol. 27, WHO. 2006.

51. Lewin, S., Munabi-Babigumira, S., Glenton, C., Daniels, K., Bosch-Capblanch, X., van Wyk,B. E., Odgaard-Jensen, J., Johansen, M., Aja, G. N., Zwarenstein, M., & Scheel, I. B.