FORCED TO FLEE

Policy Brief

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Access to Sexual and Reproductive Rights and Criminalization of Women Forced Migrants in Host Countries

Summary

Forced To Flee is a non-profit organization focused on helping migrants, displaced people, refugees, and asylum seekers by researching public policies that improve their situation and well-being and protect their human rights. This policy brief is dedicated to one of the most fundamental breach of human rights that women and girls face when displaced: the exclusion from sexual and reproductive rights (SRR) and the criminalization of sexual and reproductive health (SRH) access.

This brief contextualizes the dangerous situation that many women and girls of reproductive age face in the context of forced migration when refused access to healthcare, focusing on the unique challenges that displaced individuals face when fleeing a country with limited access to these rights and the denial of care in host countries supposed to better protect them - looking at the root causes of barriers in accessing SRR.

Through the analysis of the international human rights framework and its failures in implementation, particularly in an international context of constriction of reproductive freedom and its implications in regards to women of reproductive age at risk of greater criminalization when seeking protection and assistance in their host countries.

This report aims to identify specific barriers by looking at the social, cultural, economic and legal barriers and provide considerations and recommendations to address these issues in a global context.

Understanding Sexual and Reproductive Rights in the Context of Displacement

The safety of women and girls globally continues to be violated, regardless of their location, creating a pervasive sense of insecurity. With over 42 million women and girls forcibly displaced today (Soerio et al., 2023), the risk of sexual and gender-based violence (SGBV) has reached unprecedented levels. Women are among the most vulnerable groups worldwide, often fleeing their homes due to the threat of SGBV - whether it's associated with conflict, poverty, crisis, discrimination or other -

only to face even greater risks as migrants, asylum seekers, refugees or displaced individuals. Displaced women and girls are disproportionately exposed to sexual exploitation, abuse, and human trafficking while traveling to their destination countries. A joined-report by the UNHCR, IOM and MMC estimates that “90 percent of women and girls moving along the Mediterranean route are raped” (2024), with survivors facing heightened risks of repeated violence even after reaching asylum countries. Doctors Without Borders recognizes that sexual violence must be treated as a medical emergency given its severe physical and psychological consequences (2014), yet the lack of access to sexual and reproductive healthcare compounds the suffering of survivors creating a dual burden of trauma and neglect.

For forcibly displaced women, pregnancy - whether resulting from sexual violence or consensual relationships - significantly increases life-threatening risks for both mothers and infants. According to the World Health Organization, displaced women and girls are subjected to “severe physical and psychological trauma, unwanted pregnancies, complications from unsafe abortions, and high rates of STIs infection, in particular HIV/AIDS” (Center for Reproductive Rights, 2001). Limited access to migration health services not only jeopardizes the physical, social, and mental well-being of migrants but also impacts public health in host countries.

After settling in host countries, displaced women often face additional challenges. According to the Center for Reproductive Rights, fertility rates may rise as women seek to rebuild their families after the loss of children, while the breakdown of family and community structures can lead to increased unprotected sexual activity (2001). With the loss of traditional roles and employment, men may turn to excessive drinking and violence. Finally, unsafe abortions also become more common, particularly in cases where rape was prevalent during displacement (Center for Reproductive Rights, 2001).

Access to sexual and reproductive rights is therefore critical for global health and the protection of women, girls, and children everywhere. These rights are defined by the World Health Organization (WHO) as encompassing “a broad range of services that cover access to contraception, fertility and infertility care, maternal and perinatal health, prevention and treatment of sexually transmitted infections, protection from sexual and gender-based violence, and education on safe and healthy relationships”. They are fundamental to the protection of women and girls, and the safety of individuals everywhere.

Women of reproductive age - defined by the WHO as individuals between the age of fifteen and forty-nine years old - often face additional barriers in host communities. Cultural, social, and linguistic divides, compounded by racial discrimination, frequently isolate them and hinder their access to vital healthcare services. These rights, while facing barriers of access, are part of the international human rights framework and are incorporated in most constitutions of host countries.

International Human Rights Framework

Modern, conventional understandings of sexual and reproductive health and rights can predominantly be attributed to a series of international conferences in the mid-1990’s, including the 1993 Vienna Conference, the United Nations International Conference on Population and Development in Cairo in 1994, and the Fourth World Conference on Women in 1995 in Beijing. During these conferences, there was a shift in the prominent global understanding of reproductive health towards a human rights-based framework,

shifting the global discourse that recognized women's rights as human rights, and understanding reproductive health as an issue of women's human rights rather than merely a healthcare concern (Vergara, 2021).

Following Casas & Vivaldi (2021),

> "The content of sexual and reproductive rights includes the power to make free, autonomous and informed decisions on all aspects of sexual and reproductive life, with access to health services, sex education and the means to do so. Decisions about sexual and reproductive life include aspects such as the determination of whether or not to have sexual relations, the use of anti-conception methods, the number and spacing interval between children, and informed consent to undergo medical treatment" (p.13).

In this regard, there are several dispositions contained in international human rights treaties that allow to articulate these rights.

The International Covenant on Economic, Social and Cultural Rights establishes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (art. 12), which includes sexual and reproductive health, without mention of citizenship or legal residency. Moreover, Article 2(2) states that these rights apply without discrimination of any kind as to "race, colour, sex, language, (...) national or social origin, property, birth or other status."

In this regard, the Committee on Economic, Social and Cultural Rights (CESCR) in its General Comment no. 22 (2016), regarding the right to sexual and reproductive health, has indicated that this right is intimately linked to civil and political rights that underpin the physical and mental integrity of individuals and their autonomy, such as the rights to life; to liberty and security of the person; to freedom from torture and other cruel, inhuman or degrading treatment; privacy and respect for family life; and non-discrimination and equality. "Because of women's reproductive capacity, the realization of women's right to sexual and reproductive health is essential to the realization of all their human rights (...) it is essential to their autonomy and their right to make meaningful decisions about their lives and health" (CESCR, 2016, para. 25). Furthermore, the Committee has stated that refugees, asylum-seekers and illegal immigrants are vulnerable and marginalized individuals protected by the treaty's nondiscrimination clause (Girard & Waldman, 2000).

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979) requires countries to eliminate gender-based discrimination in health care, and to address the specific health needs of women (Article 12); it requires countries to ensure women equal rights to make decisions about childbearing and to have access to the information, education and means to do so (Article 16(1)(e)); and guarantees the right of women to equal access to specific educational information, including information and advice on family planning (Article 10(h)).

In its General Recommendation 24 on Women and Health, the Committee on the Elimination of Discrimination Against Women, which oversees implementation of CEDAW, has stressed that special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women, refugee and internally displaced women, and that States parties should ensure that adequate protection and health services are provided for women in especially difficult circumstances, such as those trapped in situations of armed conflict and women refugees (UN Women's Rights Committee, 1999). The Committee has further stated that States must guarantee "access to safe and legal abortion

and to quality post-abortion care, especially in cases of complications resulting from unsafe abortions, (...) and ensure(s) women's right to freely decide over their bodies", and that "access to reproductive rights is at the core of women and girls' autonomy, and ability to make their own choices about their bodies and lives, free of discrimination, violence and coercion" (UN Women's Rights Committee, 2022).

In the Inter-American System, sexual and reproductive rights have been interpreted by the Inter American Court of Human Rights (IACtHR) as protected by Articles 5(1) (right to personal integrity), in relation to Articles 7 and 11(2) (free development of personality and right to privacy) of the American Convention on Human Rights (ACHR). Thus, the Court has established that an essential aspect of human dignity is the ability to self-determine and freely choose the options that give meaning to the person's life, in accordance with their own convictions and therefore the development of their personality (IACtHR, 2017).

In the case of I.V. v. Bolivia (IACtHR, 2016), the Court specified that the effectiveness of the exercise of the right to privacy is decisive for the possibility of exercising personal autonomy over the future course of events relevant to the person's quality of life, and in that context, the choices and decisions regarding maternity are an essential part of the free development of the personality of women.

In the same case, it was stated that sexual and reproductive health is particularly relevant for women because of their capacity for pregnancy and childbirth, and involves autonomy and freedom to make decisions about the body and health free of violence, coercion or discrimination. It includes access to health services, information and education to decide freely on the number of children and birth intervals

In addition to this, the Court has stated that the obligation of States to respect and guarantee the right to health takes on a special dimension with respect to the protection of persons in situations of vulnerability (IACtHR, 2018), which could be applied to migrant and/or refugee women. They are also protected by the provisions of article 1(1) ACHR, that guarantees the respect of the rights and freedoms recognized in it without any discrimination, particularly "for reasons of (...) national or social origin (...)".

Finally, the European Convention on Human Rights (ECHR) protects sexual and reproductive rights unreservedly under the scope of Article 2 (right to life), Article 3 (right to freedom from torture and ill-treatment), Article 8 (right to private and family life) and Article 14 (prohibition of discrimination). Despite there being no substantive right to health in the ECHR, including sexual and reproductive health, the case law of the European Court of Human Rights (ECtHR) has provided for these rights to be reinforced in many cases under the aforementioned articles; in particular under the protection of article 8, that refers to private life.

The notion of private life has a broad content encompassing, among other rights, the right to personal autonomy and development, the right to physical and psychological integrity and the freedom to decide whether or not to have children (ECtHR, 2024). In particular, this notion includes, in regard to sexual and reproductive health, the obligation for the State to provide a clear legal framework in terms of the procedures that are allowed and prohibited in the country, as well as to ensure that the person received objective medical counseling, and updated information on their rights. Additionally, the Court has found in its practice that Article 8 also pertains to home births; medically assisted procreation; prenatal medical testing; and sterilisation procedures (ECtHR, 2023).

In direct reference to health of migrants and/or refugees, already in 2005 the Court stated that social benefits as health services are a property right, irrespective of work or other contributions, and that denying health care to irregular migrants may also breach the right to be free from inhumane and degrading treatment (Keygnaert et al, 2013).

Unique Challenges in Accessing Sexual and Reproductive Rights for Forcibly Displaced Women and Girls

Even with the established international frameworks theoretically protecting them, women and girls are confronted with a complex web of challenges in accessing sexual and reproductive healthcare, many of which are uniquely tied to their status as displaced persons. Discrimination, poverty, restrictive policies, and the trauma of displacement often have an immediate impact on the health of migrants upon settlement and can pose a public health risk.

With an escalation of political discourse around migration over the last several decades, displaced individuals in host countries face ostracization regardless of their legal status or government initiatives to incorporate them into national systems. Out of the 449 million individuals living in the European Union in 2024, non-EU nationals accounted for 29 million people, or 6.4 percent, with between 2.6 and 3.2 million in irregular situations (Kierans, Vargas-Silva, 2024). Hosting the largest migrant population, the United States is home to 47.8 million migrants, including approximately 10 million unauthorized immigrants (Baken, Warren, 2024). While accessibility to healthcare is an international right, granting migrants to access healthcare is often perceived as an act of generosity in public opinion (Keygnaert et al., 2013), leading to friction and further ostracization of displaced people.

Systemic discrimination and legal restrictions serve as additional barriers for migrant women, particularly those with irregular status. In many host countries, irregular migrants are excluded from public healthcare systems, leaving them reliant on charitable services or forced to pay out-of-pocket for care (Thomasen, 2020). Even when services are available, fear of deportation or stigma often deters women from seeking help (Arcilla et al. 2025). Administrative requirements, such as health insurance or identity cards, can impose limitations on accessibility, especially for recently settled families, and frequently prevent displaced women from accessing emergency care (Keygnaert et al., 2013). A study on the sexual and reproductive health of migrants in Europe reported that facilities themselves have attested to being unclear about the level of care they were allowed to provide migrant groups due to blurry administrative legal systems (Keygnaert et al., 2013). The study pointed out that this exclusion was particularly dangerous for pregnant women, as delays in accessing care could lead to severe complications or even death (Keygnaert et al., 2013). The precarious situation of displaced families, compounded by the trauma of conflict, displacement, and gender-based violence (GBV), further exacerbates the challenges of accessing health services. Studies of Venezuelan pregnant migrants showed that while multiple women had “decided to migrate due to the several obstacles to accessing basic maternal care in countries of origin” (Cabieses et al., 2024) they had a difficult time accessing care beyond emergency assistance as undocumented migrants. Upon arrival in host countries, women often face additional stressors, such as cultural shock, social isolation, and household tensions, which can lead to emotional abuse and further mental health deterioration (Joireman, 2023).

Intersectional vulnerabilities intensifies these barriers, making displaced women one of the most marginalized groups in host countries. Racialized migrant women, particularly refugees and undocumented migrants, face compounded discrimination in maternal healthcare, including delayed care, disrespect, and abuse. Studies from Europe and North America reveal that racialized migrant women experience higher rates of maternal mortality, perinatal complications, and obstetric violence compared to native-born women (Arcilla et al., 2025). For example, research showed in Norway, sub-Saharan African women have been stigmatized by healthcare providers using racialized discourse, while in Ireland, Asian migrant women were marginalized through an "us versus them" narrative (Arcilla et al., 2025). Furthermore, racial and ethnic discrimination appears to directly impact pregnancy, as "migrant women born in sub-Saharan Africa, in Latin America and the Caribbean, or in Asia were at higher risk of severe maternal outcomes than the women in their host countries" while other origins did not show such distinction (Eslier et al., 2023).

These experiences of discrimination not only harm women's physical health but also erode their trust in healthcare systems, making them less likely to seek care in the future. In 2019, a US study showed that 17.3% of women who were pregnant between 2010 and 2016 experienced some form of obstetric violence, including physical abuse, violation of privacy, and non-consensual care (Arcilla et al., 2025). Western medical practices often fall short of properly addressing cultural boundaries, creating an unsafe environment for women who feel a lack of agency and feel they face cultural prejudice when seeking SRH care.

Cultural barriers further complicate access to care, creating unique challenges for displaced women. Many women in precarious migratory situations, with low educational levels, and coming from rural sectors were reported to face higher difficulties in accessing healthcare services and potential traditional values - particularly regarding contraception - that clashed with "modern health systems" and "affected the ties of trust between them and the doctor" (Metusela et al., 2017). Cultural constructions can also deter women from utilizing SHR services, such as beliefs around conception in some Latina and African communities (Metalusa et al., 2017). This cultural context, combined with limited knowledge of modern contraceptive methods, often leaves women reliant on traditional practices, which may not be effective in preventing unintended pregnancies. Even when women are aware of modern contraception, they may face resistance from partners or community members who view family planning as contrary to cultural or religious values. For example, studies among Somali and Sudanese refugee women in high-income countries like Australia and Canada have shown that partner influence and religious beliefs often deter women from using contraception, even when it is available (Chalmier et al., 2022).

Language barriers also worsen isolation for migrant women, making it difficult for them to navigate healthcare systems or communicate their needs. Research shows that migrant women were reported to face more challenges to learn the local language than migrant men (Cabieses et al., 2024), which can reduce their agency and autonomy in host countries. In many cases, healthcare providers lack access to interpreters or fail to provide information in languages that patients understand. This not only limits women's ability to access care but also increases the risk of misunderstandings or misdiagnoses (Thomasen, 2020). Women often avoid seeking care for sensitive issues, such as sexual violence or menstrual health, because they fear being misunderstood or judged by providers (Arcilla et al., 2025),

leaving them without the support they need to address their health concerns.

Finally, the lack of a comprehensive SRH education can exacerbate cycles of poor health outcomes among displaced women and girls. When the country of origin has restrictive policies on women's rights or when conflict has limited people's ability to access institutions, there can be a shortfall of knowledge of SRH topics, including menstrual health, contraception, and STI prevention. This increases the risk of unintended pregnancies, STIs, and maternal mortality. Adolescent girls and young women in humanitarian settings were reported to have "low use and knowledge of SRH services and commodities, including family planning" (Olena, Masna, Kemigisha, 2018), particularly regarding "modern contraception methods among married and in-union women of reproductive age" (Olena, Masna, Kemigisha, 2018). The 2023 World Bank report on Gender and Forced Displacement in Cities revealed that Syrian refugee girls in urban displacement settings reported feeling too embarrassed to purchase menstrual products or lacking the funds to do so (Joireman, 2023), highlighting the need for targeted interventions that address both education and economic barriers.

Criminalization of Women in Migration and Barriers to Healthcare Access

Displaced and migrant women face specific difficulties to access sexual and reproductive health, both because criminalization of migration, and criminalization of reproductive rights.

The 'criminalization of migration' affects migrants' realization of their right to health as their access to health care can easily be restricted; legal provisions on health at national level constantly overlook migrants or circumscribe their access to emergency care and core benefits solely (Keygnaert et al., 2014). Adding to this, lack of legal documentation, fear of deportation, and anti-refugee and anti-migrant discourse reduce the willingness of migrants to access health services, leading to late diagnosis and, consequently, poorer health outcomes (WHO, 2022).

For example, in Malaysia, Philippine and Indonesian migrants had reportedly faced delay of access to key services as a result of their citizenship status; in Australia, irregular migrants may not be entitled to free regular health services but only to free emergency care. In the WHO South-East Asia Region, fear of deportation because of migratory status as well as higher costs for primary care were reported by irregular migrants as barriers to accessing health care (WHO, 2022).

The negative impact of immigration detention on the health of women in this situation is also relevant, especially in terms of their menstrual hygiene and their sexual and reproductive rights. In this regard, the situations, demands, views and needs of migrant women in detention are often neglected, particularly with regard to their menstrual hygiene and sexual and reproductive rights. For example, pregnant women in detention centers may have to give birth in inadequate conditions or suffer a miscarriage. In particular, the UN Special Rapporteur on the human rights of migrants has condemned the detention and deportation of migrant women when they went to hospitals to check their pregnancies, as occurred in the Dominican Republic in 2021 (Ribeiro & González, 2022).

In direct relation with this, criminal law is applied in many countries to prohibit access to and provision of certain sexual and reproductive health information and services (WHO, 2015).

Laws that prohibit or criminalize the use of certain medical procedures represent, by definition, a barrier to access. Such laws and other legal restrictions may prevent

access to certain commodities needed for sexual and reproductive health (like contraceptives), they may directly outlaw a particular service (like abortion), or they may ban the provision of sexual and reproductive information through school-based or other education programmes (WHO, 2015).

For example, grounds for legal induced abortion remain severely limited in Poland, Cyprus, Finland, and in some countries and territories subject to UK laws, and even where restrictions may only be placed on the stage of pregnancy by which abortion is available, the complex legal and socio political situation often creates a precarious situation for women seeking to access abortion care. As Mecinska et al. (2020) state it: “the de jure and de facto criminalization of abortion across the EU and in the United Kingdom writes itself into a broader picture of heightened scrutiny, weaponized welfare oversight, and out-right criminalization of women’s bodies, and specifically pregnant bodies worldwide” (p. 392).

In the USA, the criminalization of reproduction extends to a wide array of prosecutions in the reproductive space—including the criminalization of stillbirth, miscarriage, breastfeeding, home births, and c-section refusals (Boone, 2022), and this situation impacts migrant and refugee women differently.

In Colombia, a particular situation has happened with women migrants and refugees. In Venezuela abortion is considered a felony, and it is only permitted when the mother's life is at risk. However, in Colombia abortion is lawful when performed after rape, when the fetus extra uterine life is not viable, and when the mother´s physical or mental health is at risk. The lack of knowledge of Venezuelan women on this legal framework -adding to other access barriers such as the unwillingness of the local authorities to guarantee this service, and lack of documentation- causes their assumption that this health procedure cannot be legally accessed in Colombia, and they do not request it in health institutions (Guerrero, 2021).

At the same time, health workers are often entrusted with private information by their patients; if individuals fear that confidentiality and privacy are not guaranteed in the health-care environment, they may avoid seeking services, thus putting their health in jeopardy. Many constitutions, national laws and regulations guarantee the right to privacy and confidentiality; however, in practice this may not be applied to the provision of sexual health services (WHO, 2015).

The criminalization of reproduction often occurs at an initial point of access to the health care system– at the hospital, the doctor’s office, the lactation consultant appointment, or the addiction treatment clinic. In this way, health care settings become gateways into the criminal justice system, and it is the attempt to access reproductive health care that results in criminal prosecution. The stigma associated with criminalization is just as likely to chill individuals’ willingness to access reproductive health care, as criminal prosecution carries with it a strong association that the criminalized individual has breached community standards of morality; thus even for those individuals who don’t realistically fear actual criminalization, there still exists the threat of stigma attaching to behavior that is perceived as potentially criminal (Boone, 2022).

Systemic discrimination coupled with increased baseline surveillance of certain populations results in a disproportionate criminalization of reproductive choices within vulnerable and disadvantaged groups than in more privileged groups (Boone, 2022). Marginalized women - those living in poverty, uninsured, migrants and asylum-seekers - or those simply too ill to

travel are often forced to turn to clandestine and potentially dangerous methods (Mecinska et al., 2020).

International and regional human rights bodies and national courts have increasingly called for the removal of all barriers interfering with access to sexual and reproductive health information and services, including the criminalization of access to and provision of such information and services, calling for the reform of laws that interfere with the equal enjoyment of rights by women, including those laws that criminalize and restrict medical procedures needed only by women and that punish women who undergo these procedures (WHO, 2015).

Considerations and Recommendations

Conclusion

The analysis of sexual and reproductive rights (SRR) access for migrant, refugee and asylum seeker women and girls reveals a pervasive violation of fundamental human rights, exacerbated by systemic barriers and the criminalization of migration and reproductive health. Women and girls fleeing conflict and persecution face compounded vulnerabilities, which hinder their access to essential healthcare services. The interplay of discrimination, cultural barriers, and legal restrictions not only jeopardizes their health and well-being but also contributes to a cycle of trauma and marginalization. International human rights frameworks have established robust protections for SRR; however, the failure to implement these protections effectively results in significant disparities in health outcomes for displaced women.

Women and girls make up a significant portion of forcibly displaced individuals globally, facing heightened risks of sexual and gender-based violence during and after displacement. The psychological and physical trauma associated with these experiences further complicates their access to SRH.

While international and regional conventions affirm the rights of women to access SRH services, the implementation of these rights remains inconsistent. Discrimination based on legal status, race, and gender continues to impede access, especially for undocumented migrants.

The existence of systemic barriers, such as discrimination, poverty, and restrictive legal frameworks create a complex web of challenges for displaced women in accessing healthcare. These barriers exist in countries of origin, transit and destination. Cultural norms and language barriers further isolate displaced women, hindering their ability to seek necessary healthcare services. The lack of culturally competent care often results in mistrust and reluctance to engage with healthcare systems.

In addition to this, the criminalization of both migration and reproductive health creates significant barriers, in a way that affects women, girls and birthing people. Many displaced women fear legal repercussions when seeking healthcare, which can lead to a reliance on unsafe practices and ultimately endanger their health.

Recommendations

1. Policy Reform and Advocacy:

It is necessary to examine and reform legal frameworks to remove barriers to accessing SRH services for all migrants, regardless of their immigration status. This includes decriminalizing abortion and other reproductive health procedures, and ensuring that reproductive healthcare is accessible without fear of legal repercussions.

One aspect of great relevance for migrants' access to health care, and that would

address the issue of criminalization of migrants and their healthcare services, is the establishment of “firewalls”. These are understood as the establishment of a strict separation between public services (in this case, health services) and the agencies in charge of enforcing immigration regulations and/or criminal prosecution, so that those services do not share information on the immigration status of the people they serve with the immigration agencies. Those cities that establish “firewalls” are known as “Sanctuary Cities”. The UN Special Rapporteur on the human rights of migrants has noted that States must ensure access to health services, including comprehensive sexual and reproductive health services, education, other social services and justice, and firewalls must be established between health services and immigration authorities so that women and girls, regardless of their immigration status, can effectively access these services without fear of detection, detention and deportation. (Ribeiro & González, 2022).

It is important to advocate for the implementation of international human rights standards at the national level, ensuring that women’s rights to health are prioritized in policies. Policymakers should adopt an intersectional approach when designing health services, recognizing the compounded vulnerabilities faced by racialized, undocumented, and economically disadvantaged women.

The intersectional approach requires **c**ommunity engagement with migrant communities in the design and delivery of health services that can enhance trust and improve access, as well to address their special needs and requests. Community health workers who understand cultural nuances can play a critical role in bridging gaps.

2. Enhancing Healthcare Access:

It is necessary to establish health services that specifically cater to the needs of displaced women, including mobile clinics and telehealth options to reach those in isolated or marginalized communities. It is also crucial to provide comprehensive training for healthcare providers on cultural competency, trauma-informed care, and the specific health needs of displaced women.

In this regard, it is also important to ensure the availability of translation and interpretation services in healthcare settings to facilitate effective communication between healthcare providers and displaced women, at least in the most utilized languages by migrants and refugees in the given destination country. This must be accompanied by the developing of multilingual health resources and educational materials in different languages, that are culturally sensitive and accessible.

3. Education and Awareness Programs:

It is suggested to launch targeted education campaigns focusing on sexual and reproductive health for displaced populations, addressing cultural misconceptions and providing information in multiple languages. Public services also should promote awareness of legal rights regarding SRH among displaced women to empower them to seek necessary care.

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