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Sexual, Reproductive and Menstrual Health of Internally Displaced Women and Girls in the Middle East: Gaps, Challenges and Recommendations

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Abstract

The Middle East, prone to conflict and disasters, is the host of some of the largest internally displaced populations in the world.. Therefore, providing practical, sustainable, culturally appropriate and acceptable sexual, reproductive and menstrual health services for women and girls should be integral to responses to internal displacement. This document identifies gaps, challenges and current responses in the Middle East and provides recommendations for improvement in the response in the context of the Middle East.

Keywords

Internally displaced persons; internal displacement; sexual and reproductive health; menstrual health and hygiene management; women; girls; Middle East

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1. Introduction

Over 59 million people were living in internal displacement as of 2021. Conflict and violence have brought over 53 million internal displacements and natural disasters have led to 5.9 people becoming displaced internally by the end of 2021 (IDMC, 2022). According to the Internal Displacement Monitoring Center database, just in 2021, more than 17,887,150 individuals experienced displacement at the Middle Eastern level (IDMC, 2022). Internally displaced persons (IDPs), like refugees, are being forced to leave their homes and due to unstable conditions, they cannot return. However, IDPs, contrary to refugees, stay within the borders of their own country and therefore tend to become deprived of receiving support from the UN and other international agencies, as presumably, their national government is responsible for providing protection and assistance.

At the same time, ample evidence indicates that IDPs are more likely to have inequitable access to facilities than host/refugee communities (Macklin, 2009; Daoud et al., 2012; Lafta et al., 2016; Boyd et al., 2017; DeJong et al., 2017; Austin et al., 2018; Cantor et al., 2021; Roberts et al., 2022). Given the limited response capacity of most countries in the Middle East region—particularly those burdened with the continued and protracted displacement—external support from the United Nations and other international humanitarian organizations is necessary (Thomas, 2004; Bile et al., 2011; Taleb et al., 2015; Cazabat et al., 2020).

In 2015, the 2030 agenda for sustainable development was the first international document to acknowledge the importance of including IDPs in countries' development plans. Though the sustainable development goals (SDGs) do not define specific targets for IDPs, they recognize them as vulnerable groups with particular needs (DeJong et al., 2017; Aburas et al., 2018). Hence, if internal displacement-affected Middle Eastern countries, where the majority of IDPs and protracted crises come from, aim to attain SDGs by 2030, they must be aware of and surmount obstacles IDPs face by providing long-term and sustainable solutions to the needs of IDPs (Rass et al., 2020; Roberts et al., 2022).

This document aims to summarize the status of and provides recommendations on sexual, reproductive and menstrual health responses to the needs of women and girls impacted by internal displacement in the Middle East. A desktop review of grey and peer-reviewed literature was conducted using both cited references and keyword searches through multiple databases, including PubMed, Google Scholar, Scopus and ScienceDirect, as well as Google engine, along with scanning the references in the literature. Inclusion criteria were as follows: literature was required to be full text, carried out in English or translated into English and focus on challenges and barriers internally displaced women and girls in the Middle East face challenges and obstacles concerning sexual, reproductive and menstrual health, or there were no any challenges and barriers found and internally displaced Middle Eastern women and girls have access to proper resources and services and able to address their needs without facing any particular issues.

2. Populations of internally displaced women and girls in the Middle East

By 2018, the disaggregated data showed that conflict and violence are responsible for displacing 6,489,000 women and girls in the Middle East (Cazabat et al., 2020; IDMC, 2022). Research indicates that health outcomes among IDPs compared with either refugee and host communities, especially women and girls, are unsuitable (Laurie & Petchesky, 2008; Lafta et al., 2016; Cantor et al., 2021; Le Voir, 2022; Roberts et al., 2022). Internal displacement has created more health challenges for IDPs with a weakened health system, especially women and girls in the Middle East, due to disrupted societal support structures and the collapse of the healthcare system in conflict/natural disaster-zone areas (Al Gasseer et al., 2004; Mowafi, 2011; Daoud et al., 2012; MSF, 2014; DeJong et al., 2017; Baatz et al., 2022).

Hence, it is essential to consider the needs of internally displaced women and girls as they experience displacement differently, are more at greater risk than men and boys and face specific challenges that must be better understood to address their needs (Laurie & Petchesky, 2008; Westhoff et al., 2008; Akesson, 2008; Testoni, 2019; Taha & Sijbrandij, 2021). Internally displaced women and girls face unique challenges in accessing healthcare, particularly sexual and reproductive healthcare, e.g., family planning and maternal health services, access to menstrual health products, services for the prevention of child marriage and gender-based violence (GBV) and support services for survivors of GBVs, due to taboo and stigma around this topic and limited freedom of movement (Laurie & Petchesky, 2008; Westhoff et al., 2008; Akesson, 2008; Daoud et al., 2012; Lafta et al., 2016; Tanyag, 2018; Testoni, 2019; Jones et al., 2021; Taha & Sijbrandij, 2021).

Although sexual, reproductive and menstrual health (SRMH) concerns are among the most prevalent in the region, they are still not considered a public health concern, especially in the Middle Eastern context and displacement further aggravates situations for Middle Eastern women and girls (Mowafi, 2011). Furthermore, humanitarian organizations, donors and governments usually do not consider providing SRMH services a priority during and after conflicts and disasters (Thomas, 2004; Westhoff et al., 2008). However, providing appropriate and culturally acceptable SRMH services proves necessary to ensure that one of the most vulnerable groups affected by internal displacements, such as women and girls, has access to sustainable SRMH services tailored to their needs (Mowafi, 2011; Aburas et al., 2018).

3. The SRMH of women and girls in the Middle East

To provide internally displaced Middle Eastern women and girls with the proper SRMH resources to meet their health-specific needs, understanding the current situation of SRMH in the region is required. Evidence indicates that women and girls are not provided with the needed sex education and resources to protect themselves from sexually transmitted infections (STIs), child marriage, menstrual stigma, unwanted pregnancy, GBV and female genital mutilation (FGM). Moreover, in many countries, SRMH services such as abortion, infertility and contraception are considered illegal by laws and policies, resulting in unsafe abortion (DeJong & El-Khoury, 2006; Ilkkaracan, 2015; DeJong & Bashour, 2016; UNFPA, 2017; UNFPA, 2019; Jones et al., 2021). Additionally, the Middle East is tackling enormous challenges of discrimination and violence

against the LBTQI women and girls deprived of access to proper and required SRMH services (Ilkkaracan, 2015; Habib & Khalik, 2021).

Furthermore, due to the region's cultural taboo and stigma around SRMH, young boys and men are not usually involved in providing services and education, making it harder to address gender inequality and adopt sustainable solutions to the SRMH needs of women and girls (DeJong & El-Khoury, 2006; Ilkkaracan, 2015; DeJong & Bashour, 2016, UNFPA, 2017; UNFPA, 2019).

In general, displacement tends to reinforce pre-existing discrimination and worsen already limited access to safe menstrual products and adequate facilities for menstrual health and hygiene management (MHM) (such as access to water, sanitation and hygiene facilities (WASH)), universal access to family planning and modern contraceptive methods, safe abortion, prevention, testing and treatment of HIV and STIs, age-sensitive reproductive health counseling and education, GBV and FGM prevention and response services and essential antenatal, prenatal and postpartum care (Tanyag, 2018).

4. The SRMH of internally displaced Middle Eastern women and girls

Evidence indicates displacement is directly linked to poor SRMH status. In other words, displacement leave women and girls more vulnerable to maternal mortality, STIs, GBV, unintended pregnancies, early or forced marriage and sexual exploitation (Sharp et al., 2002; Thomas, 2004; Laurie & Petchesky, 2008; Westhoff et al., 2008; Mowafi, 2011; Daoud et al., 2012; Taleb et al., 2015; McAlpine et al., 2016; DeJong et al., 2017; van Berlaer et al., 2017; Aburas et al., 2018; Balinska et al., 2019; Mumtaz et al., 2020; Alhaffar & Janos, 2021; Bendavid et al., 2021; Cantor et al., 2021; Taha & Sijbrandij, 2021).

Women and girls have health-specific needs that can be more difficult to attain during displacement due to the collapse of public health infrastructure, limited healthcare facilities and lack of healthcare workers, the stigma around SRMH and the absence of proper gender-sensitive information (Laurie & Petchesky, 2008; Westhoff et al., 2008; Taleb et al., 2015; Lafta et al., 2016; Akbarzada & Mackey, 2017; Higgins-Steele et al., 2017; Taghizadeh Moghaddam et al., 2017; Tanyag, 2018; Cazabat et al., 2020; Khan et al., 2021; Baatz et al., 2022). Internally displaced Pregnant women and girls usually receive less antenatal care and specialized healthcare services and are more likely to give birth outside a healthcare facility or by a skilled healthcare worker, increasing the risk of maternal mortality and morbidity. Moreover, internally displaced women and girls are more exposed to violence, poor hygiene conditions and lack of privacy (Thomas, 2004; Laurie & Petchesky, 2008; Westhoff et al., 2008; Taleb et al., 2015; McAlpine et al., 2016; Akbarzada & Mackey, 2017; DeJong et al., 2017; van Berlaer et al., 2017; Taghizadeh Moghaddam et al., 2017; Tanyag, 2018; Vernier et al., 2019; Balinska et al., 2019; Cazabat et al., 2020; Alhaffar & Janos, 2021). Evidence also highlights that internally displaced women and girls who live with the host communities rather than in camps or settlements have less access to healthcare services, especially SRMH services (Laurie & Petchesky, 2008; Le Voir, 2022; Roberts et al., 2022).

To alleviate the consequences of conflict or natural disasters on accessibility to essential SRMH resources, the Inter-Agency Working Group on Reproductive Health in Crisis Settings (IAWG) created the Minimum Initial Service Package for Reproductive Health in Crisis (MISP). In 1999, IAWG launched the *Reproductive health in refugee Situation: an inter-agency field manual* that developed a minimum set of prior targeted-program interventions to effectively and promptly respond to the SRMH needs of refugees and IDPs, with the focus on women and girls (IAWG, 2018; UNFPA, 2020b). As a result, this document highlights relevant main SRHM issues internally displaced Middle Eastern women and girls encounter during displacement.

4.1 Antenatal and obstetric care

Pregnant women are a part of any internally displaced population. As a result of the destruction of healthcare services and deaths or displacement of healthcare workers, pregnant women's lack of access to routine maternity care puts childbearing women at risk (Al Gasseer et al., 2004; Thomas, 2004; Mowafi, 2011; MSF, 2014; Taleb et al., 2015; Lafta et al., 2016; Aburas et al., 2018; Vernier et al., 2019; Alami et al., 2019; Khan et al., 2021; Alhaffar & Janos, 2021). Field experience and research indicate that cesarean section is the most common major operation due to conflict and natural disasters. However, given the inadequacy of surgical capacity in most internal displacement-affected Middle Eastern countries, the healthcare system cannot provide required services during conflicts or natural disasters (Al Gasseer et al., 2004; Akesson, 2008; Laurie & Petchesky, 2008; Mowafi, 2011; MSF, 2014; Zha et al., 2016; Aburas et al., 2018; Balinska et al., 2019; Alami et al., 2019; Alhaffar & Janos, 2021). During displacement, maternal mortality increases due to postpartum hemorrhage, pre-eclampsia/eclampsia, sepsis and unsafe abortion (Laurie & Petchesky, 2008; MSF, 2014; Lafta et al., 2016; DeJong et al., 2017; Aburas et al., 2018; Alhaffar & Janos, 2021). Therefore, it is needed to ensure that the displaced pregnant women have access to qualified healthcare workers with direct access to operable healthcare services, where they can provide emergency obstetric care to save pregnant women's lives (Mowafi, 2011; MSF, 2014; Zha et al., 2016; Durrance-Bagale et al., 2020; Cantor et al., 2021).

Furthermore, to ensure the usage and acceptance of the services by internally displaced pregnant women and their families, awareness-raising and health promotion activities, particularly by internally displaced healthcare workers, are required alongside providing the services (Sharp et al., 2002; Thomas, 2004; Nuwayhid et al., 2006; Bile et al., 2011; Ehiri et al., 2014; MSF, 2014; Austin et al., 2018; Vernier et al., 2019; Durrance-Bagale et al., 2020; Rass et al., 2020; Cantor et al., 2021). Moreover, as internally displaced pregnant women and adolescent girls go through psychosocial stress during displacement, they need mental health and psychosocial support (MHPSS) to decrease the likelihood of adverse birth outcomes resulting from displacement-induced stress. Hence, the healthcare system, the UN or international agencies and other primary actors need to integrate different MHPSS into their ongoing programs for internally displaced pregnant women, focusing on adolescent girls to minimize stress levels (Akesson, 2008; Jones et al., 2021; Seidi et al., 2022).

4.2 Gender-based violence

A minimum of 40% of Middle Eastern and North African females experience some form of GBV, such as sexual or intimate partner violence, during their lifetime (MSF, 2014; Lafta & Al-Nuaimi, 2019; World Bank, 2021). Conflict and violence simulate conditions for GBV, resulting in internally displaced women and girls at higher risk of GBV in displacement situations (Al Gasseer et al., 2004; Laurie & Petchesky, 2008; Westhoff et al., 2008; MSF, 2014; Lafta et al., 2016; Lafta & Al-Nuaimi, 2019). Families are often separated during displacement, leaving solo women and girls more vulnerable to sexual violence and long-term psychological and physical injuries (Thomas, 2004; Mowafi, 2011; Levy & Sidel, 2013; MSF, 2014; van Berlaer et al., 2017; Aburas et al., 2018; Austin et al., 2018; Taha & Sijbrandij, 2021). In the insecure environment, women and girls may be forced into sexual coercion and child marriage for different reasons (e.g., financially supporting their families, exploited by those in power, or even traveling to distribution points, collection areas, or toilets) (Laurie & Petchesky, 2008; Westhoff et al., 2008; Mowafi, 2011; MSF, 2014; McAlpine et al., 2016; Lafta et al., 2016; Akbarzada & Mackey, 2017; van Berlaer et al., 2017; Behnke et al., 2018; Balinska et al., 2019; Jones et al., 2021; Seidi et al., 2022).

To effectively prevent and respond to GBV at all stages of displacement, the following actions are suggested: 1) Providing gender-disaggregated WASH facilities (Beyani, 2014; Laurie & Petchesky, 2008). 2) Direct distribution of items and resources to internally displaced women and girls. 3) Improving security measures and increasing the proportion of female police officers in all locations with internally displaced women and girls (such as host communities, settlements, camps, etc.) (Beyani, 2014). 4) Providing victims of GBV with accessibility to a wide range of resources such as medical first aid, STI prevention medicine, emergency contraception, vaccinations, MHPSS, legal aid providers and other necessary support (Al Gasseer et al., 2004; Beyani, 2014; Akesson, 2008; Sharp et al., 2022; Mumtaz et al., 2020; Taha & Sijbrandij, 2021). 5) Involving men in all stages of prevention, protection and response measures (Laurie & Petchesky, 2008; Beyani, 2014; Rass et al., 2020). 6) Conducting awareness-raising sessions and campaigns by internally displaced women and girls targeting individuals and communities (Akesson, 2008; Beyani, 2014; Alami et al., 2019; Rass et al., 2020; Mumtaz et al., 2020; Durrance-Bagale et al., 2020; UNHCR, 2020). 7) Ensuring provision of support for internally displaced women and girls with disabilities at risk of GBV (Beyani, 2014). 8) Establishment of internally displaced women-led groups to enhance outreach and communication on GBV preventive and response measures (Al Gasseer et al., 2004; Laurie & Petchesky, 2008; Ehiri et al., 2014; Beyani, 2014; Rass et al., 2020; UNHCR, 2020). 9) Training IDPs as healthcare workers and providing regular training and tools, enabling them to prevent and respond to GBV (Nuwayhid et al., 2006; Westhoff et al., 2008; Akesson, 2008; Ehiri et al., 2014; Beyani, 2014; Durrance-Bagale et al., 2020; Rass et al., 2020).

4.3 Family planning

Women and girls affected by internal displacement do not usually have access to family planning services because of being displaced or the disruption of healthcare facilities. Internally displaced women and girls with unintended pregnancies will likely resort to dangerous measures without access to/availability of appropriate SRMH services, including abortion services (Al Gasseer et

al., 2004; Laurie & Petchesky, 2008; Mowafi, 2011; Aburas et al., 2018; Austin et al., 2018; Packer et al., 2020). Providing family planning services to internally displaced women and girls is far more vital as they are displaced due to violence or natural disasters and need support for their SRMH. Family planning services are crucial to reducing the likelihood of unintended/unplanned pregnancy or unsafe abortion and, in turn, could minimize maternal mortality and save the lives of women and girls. However, due to cultural or legal barriers in some Middle Eastern countries, women and girls cannot use family planning methods; hence, the UN and other international agencies must advocate for family planning services (Al Gasseer et al., 2004; Yamin, 2004; Austin et al., 2008; Mowafi, 2011; Tanyag, 2018; Balinska et al., 2019; Packer et al., 2020). In those countries with national policies and programs, the needs of vulnerable women and girls, such as those affected by internal displacement, have not been recognized. Hence, there is a need to integrate the family planning needs of internally displaced women and girls into national policies and programs (Shrestha et al., 2019).

4.4 Menstrual health and hygiene management

Many menstruating women and girls in the Middle East deal daily with menstrual inequity due to gender inequality, discrimination, cultural taboo and stigma around SRMH, especially menstruation (Laurie & Petchesky, 2008; UNFPA, 2020a; Alhaffar & Janos, 2021). The existing vulnerabilities tend to become exacerbated during displacement. Menstruators face more challenges of the scarcity of clean and secure WASH facilities, hygiene resources (e.g., toilet paper, menstrual products, soap, a clean supply of running water, etc.), waste disposal facilities and privacy. Displacement leads to menstruators being more exposed to GBV, transactional sex, reproductive tract infections and mental health issues. Moreover, due to the unavailability of proper education infrastructure and disrupted social support systems, adolescent menstruators, who have experienced menstruation for the first time, are more likely to experience fear and confusion in managing their menstruation (Sommer, 2012; Schmitt et al., 2017; Behnke et al., 2018; Visecek, 2020; UNFPA, 2020a; Alhaffar & Janos, 2021). Hence, with the displacement situation in the Middle East, it is essential to mainstream MHM into sexual and reproductive health programs and other sectors (e.g., education, WASH, etc.) to ensure that all internally displaced menstruators have safe and adequate access to menstrual supplies and appropriate information and education. It is also essential to consider that even though all internally displaced Middle Eastern menstruators might face similar MHM issues with similar needs, the solutions to address the problems for each context should be contextualized in culturally appropriate and acceptable ways (Sommer, 2012; UNFPA, 2020a).

5. Addressing SRMH needs of internally displaced Middle Eastern women and girls

Two main gaps are identified in the current response to SRMH in internal displacement. First, the unavailability of sufficient data on why full integration of SRMH as a standard part of the response has not been achieved, including the barriers to implementation and solutions to overcome such obstacles to ensure those vulnerable internally displaced girls and women's SRMH needs are effectively addressed on time. Second, inadequate documentation on standard

practices in assessment or response to SRMH needs in internal displacement has led to the absence of a systematic SRMH response based on documented experience and evaluation.

Correctly estimating the population of internally displaced Middle Eastern women and girls is a foundational step to facilitating effective SRMH response, including assessing the scale of the crisis and required resources and monitoring the internally displaced women's and girls' health status and access to SRMH services. However, there is a lack of correct data on the population size and composition estimates of internally displaced women and girls. Therefore, the primary challenge is the provision of the resources needed and access to information, as some governments may be reluctant and sensitive to share or collaborate on data collection due to indicating and revealing the magnitude of problems internally displaced Middle Eastern women and girls face (WHO EMRO, 2015; Ratnayake et al., 2022).

Conflict or natural disasters cause widespread devastation to the health system's infrastructure, incrementally or immediately, such as the destruction of health facilities and healthcare workers killed, injured, or displaced themselves, leaving under-resourced healthcare facilities and workers overburdened. This condition results in vulnerable internally displaced women and girls facing more difficulties accessing healthcare resources, especially SRMH, due to a complete lack of services, distance, transport barriers, finances and uncertainty about available services (WHO EMRO, 2015).

The SRMH needs of internally displaced Middle Eastern women and girls must be addressed urgently to mitigate mortality and morbidity. The MISP can guide governments and other actors to conduct SRMH interventions without new needs assessments, as the formulated package is evidence-based. However, efforts to comprehend and effectively address SRMH needs may be complex in an emergency in practice, given there is still a lack of evidence that many SRMH interventions effectively work in internal displacement situations (Sharp et al., 2022).

6. Recommendations for improving SRMH responses for internally displaced Middle Eastern women and girls

Organizations and donors are reporting a new commitment to better addressing the SRMH needs of internally displaced women and girls. The challenge is translating this commitment into a more practical commitment assuring SRMH is systematically, sensitively, efficiently and effectively incorporated into all health programs targeting internally displaced women and girls in various contexts and situations. Based on the review of the existing documents, considering the diversity of cultures and conditions within the Middle East region, eleven comprehensive principal recommendations that are adaptable to a variety of contexts emerged:

- (1) A delineated systematic response to SRMH with a clear assignment of roles that incorporates the multi-disciplinary components of an SRMH response is required (Sharp et al., 2002; Thomas, 2004; Yamin, 2004; Laurie & Petchesky, 2008; Aburas et al., 2018; Khan et al., 2021; Ekezie et al., 2022; Roberts et al., 2022).

(2) A coordinated assessment and response are enacted by including the relevant main actors and sectors (e.g., policymakers, health, education, WASH, internally displaced females, etc.) (Al Gasseer et al., 2004; Yamin, 2004; Laurie & Petchesky, 2008; Westhoff et al., 2008; Ekezie et al., 2022).

(3) Improved and detailed guidance on assessing, intervening, evaluating and monitoring SRMH responses tailored to the needs of internally displaced women and girls is required. Hence, those operating know how best to gather information and act on it (Thomas, 2004; Packer et al., 2020; Nabulsi et al., 2021; Ekezie et al., 2022).

(4) NGOs, UN agencies, or other organizations should consider mapping countries' traditional practices and beliefs around SRMH and designing appropriate tools to respond through local collaborators and internally displaced women and girls (Al Gasseer et al., 2004; Laurie & Petchesky, 2008; Westhoff et al., 2008; Akesson, 2008; Mowafi, 2011; Tanyag, 2018).

(5) Participation and integration of internally displaced women and girls and ensuring the inclusion of diverse groups (e.g., the disabled, LBTQI women, etc.) into all decision-making stages and in the project design, implementation, monitoring and evaluation (Al Gasseer et al., 2004; Nuwayhid et al., 2006; Laurie & Petchesky, 2008; Macklin, 2009; Beyani, 2014; Rass et al., 2020; Packer et al., 2020). To mainstream gender in response to internal displacement, coordination and cooperation between different national and international actors are required (Al Gasseer et al., 2004; Thomas, 2004; Laurie & Petchesky, 2008; Akesson, 2008; Macklin, 2009; Mowafi, 2011; Tanyag, 2018; Ekezie et al., 2022).

(6) Adequate and clear funding streams must be identified to ensure all the SRMH components can be incorporated into programs targeting internally displaced women and girls (Aburas et al., 2018; Roberts et al., 2022).

(7) Strengthening data collection on IDPs disaggregated by gender, age and locations (e.g., camps, settlements, host or return communities, etc.) and using gender analyses in national action plans (Al Gasseer et al., 2004; Laurie & Petchesky, 2008; Macklin, 2009; Beyani, 2014; Cazabat et al., 2020).

(8) Involving internally displaced males of all ages in the community and healthcare settings and improving healthcare infrastructure and service delivery to include males (Laurie & Petchesky, 2008; Ehiri et al., 2014; Beyani, 2014; Alami et al., 2019; Rass et al., 2020; Packer et al., 2020; Ekezie et al., 2022). By engaging males in the SRMH, males tend to a) become supportive partners (e.g., respect and support females' choices and needs in SRMH and b) act as agents of change and advocates (e.g., educating their communities and addressing gender inequalities and ending harmful practices). To sustain the involvement of males in SRMH programs and activities, developing and implementing policies that explicitly direct health providers to have males involved routinely in SRMH service delivery are required.

(9) Ensuring Middle Eastern countries create equal opportunities for internally displaced women and girls and refugee and host communities to have equitable access to SRMH services (Tanyag, 2018; Durrance-Bagale et al., 2020; Cantor et al., 2021).

(10) Adoption of displacement-specific indicators for gender equality in all Middle East countries' national indicator frameworks and include the SRMH needs of internally displaced women and girls in their national action plans (Al Gasseer et al., 2004; Yamin, 2004; Macklin, 2009; Mowafi, 2011; Boyd et al., 2017; Tanyag, 2018; Packer et al., 2020).

(11) Implementing all six objectives of MISP by ensuring SRMH services are fully comprehensive and integrated into other healthcare services (UNFPA, 2020b; Nabulsi et al., 2021).

7. Conclusion

Access to safe, effective, acceptable and affordable SRMH resources is every female's right, including internally displaced women and girls. SRMH requires an environment free from sexual violence and discrimination threatening the health and well-being of internally displaced Middle Eastern women and girls. Implementing a set of collective actions is a prerequisite to ensure and secure the rights of internally displaced Middle Eastern women and girls to comprehensive health services. These actions can include:

(1) Removing legal and regulatory barriers to SRMH services;

(2) Reviewing national strategies to ensure they are aligned with the SRMH needs of IDPs;

(3) Creating laws to guarantee access to SRMH resources for internally-displaced women and girls as well as those with unique needs, such as LBTQI and the disabled;

(4) Mainstreaming gender into all health services is a pre-condition to ensure the SRMH needs of internally displaced women and girls are addressed;

(5) Destigmatizing and normalizing the usage of SRMH services through awareness-raising and educational programs;

(6) Ensuring women, mainly internally displaced women are integral to gender-inclusive legislation and law-making processes;

(7) Promoting mechanisms to raise capacity for SRMH-related planning with the focus on the needs of internally-displaced women and girls; and

- (8) Involving internally displaced women, girls and males in SRMH activities and programs and position them as catalysts to raise and address SRMH issues.

As conflict and violence continue unabated and disasters are more likely to affect the region, governments, policymakers and other primary players should ensure that SRMH services are available, accessible, affordable and acceptable to internally displaced Middle Eastern women and girls. At the same time, laws and policies enforcing gender inequality in Middle Eastern countries have resulted in the inaccessibility of equal and fair SRMH resources for women and girls, particularly those in vulnerable conditions such as IDPs. Hence, besides conducting various actions inside the Middle Eastern countries countering discrimination against access to SRMH services and resources, UN agencies and other international actors at the global level need to make effective international interventions. For example, enacting international policies and regulations can act as an external commitment to hold Middle Eastern governments and policymakers accountable for ensuring rights to universal access to SRMH services for all Middle Eastern women and girls, including those living in different situations such as IDPs.

The full and sustained support and commitment from governments and national, regional and international decision-makers and stakeholders are imperative to ensure the inclusion of internally displaced women and girls in governments' development plans: First, setting up effective coordination mechanisms and linkages at different levels by designating focal points are needed to facilitate coordination between relevant actors and sectors (e.g., the Ministry of Health, national and international organizations and internally displaced women and girls) as well as strengthening partnerships at local, national, regional and international levels which could lead on adopting practical solutions with a comprehensive gender-responsive approach to integrate the SRMH needs of internally displaced women and girls in varying development plans (e.g., social, economic).

Second, evidence-based data is essential to design effective policy and strategic plans and showcase the positive impact of the integration of SRMH into health and other sectors. Therefore, it is crucial to record data on the SRMH-specific needs of internally-displaced women and girls in affected countries worldwide by creating accessible, unified statistical databases applicable and contextualizable at national, regional and global levels. These databases can enable national, regional and international policymakers and actors to employ the obtained data to apply comprehensive gender- and IDPs-responsive planning, allocating resources and prioritizing actions at national, regional and global levels. Moreover, through evidence-based data, governments and other domestic, regional and international actors can advocate financial assistance to address the SRMH needs of women and girls affected by continued internal displacement.

Third, inclusive policies, mandates and advocacy strategies are paramount to ensure that the SRMH needs of internally displaced women and girls are met. Therefore, UN agencies and other international organizations need to build the capacity of domestic organizations and governments by technically and financially supporting them to develop and adopt ender-mainstreamed policies and strategic plans and to identify and address the SRMH needs of internally displaced women and girls, including LBTQI women and those with disabilities. These collaborations and partnerships can foster political commitments from the Middle Eastern governments and other countries affected by internal displacement to avoid gender- and IDP-blind policies and strategies that leave internally displaced women and girls and exacerbate existing gender inequality.

Last but not least, internal displacement impedes the achievement of SDGs; therefore, the needs of IDPs, particularly women and girls, should garner full and due attention. Eight years remain to achieve SDG goals, including SRMH-related SDGs such as SDG 3 (good health and well-being), SDG 5 (gender equality) and SDG 6 (availability and sustainable management of water and sanitation for all people). Hence, this is a crucial time for world leaders to incorporate SRMH into all action plans, as SDGs achievement is unfeasible without meeting the SRMH needs of women and girls, including IDPs.

Finally, there seems to be a substantial and growing interest in better addressing internally displaced Middle Eastern adolescent girls' and women's SRMH needs during and after humanitarian situations, given a lack of systemic guidance on how to respond most effectively. This document aimed to summarize the status of SRMH responses to the needs of women and girls impacted by internal displacement in the Middle East. Moreover, it could further provide detailed insights into SRMH and IDPs for those seeking to strengthen the IDP issues in the SRMH agenda while progressing in the area of gender equality rights. Even though this document does not assess the SRMH needs of IDPs in other regions, the recommendations can be contextualized to deliver feasible solutions to meet the SRMH needs of internally displaced women and girls in different contexts.

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