September 2026

IMAP Statement on Migrant-Centred Sexual and Reproductive Health Services

1. Purpose and intended audience of the Statement

This statement is intended primarily to provide guidance to Member Associations and Collaborative Partners across the Federation who provide sexual and reproductive health (SRH) services and information, and to strengthen national services for migrants. It addresses the SRH needs of all migrants, giving particular attention to people who face a combination of structural barriers, including women, girls, adolescents, LGBTQI+ people, sex workers, and people with disabilities, and calls for approaches tailored to each group's circumstances. It is grounded in a rights-based approach, emphasizing accessibility, acceptability, and respect for

the agency, bodily autonomy, and dignity of all migrants. It is aimed at the IPPF Secretariat, SRH and humanitarian organisations, and the broader development community.

The statement aligns with IPPF's Feminist Principles in Humanitarian Contexts and is grounded in its guiding principles, particularly the centrality of protection; local empowerment; a human rights-based approach; and the centrality of sexual and reproductive health in emergencies (SRHiE) (1). The statement also reflects IPPF's core values of Dignity, Equality, and Justice (2), and aligns with the Come Together: IPPF's Strategy 2028 (3).

2. Defining the Migrant Population

Migration is both an inherent feature of a globalized world and a significant humanitarian challenge (4). By mid-2024, the number of international migrants was estimated at 304 million, representing 3.7% of the global population (5). The International Organization for Migration (IOM) Glossary on Migration (3rd edition) defines a migrant as 'any person who is moving or has moved across an international border or within a State away from his/her/their habitual place of residence, regardless of the person's legal status; whether the movement is voluntary or involuntary; what the causes for the movement are; or what the length of the stay is.' Critically, the IOM notes that no universally agreed definition of 'migrant' exists in international law, which has implications for legal protections, entitlements, and data collection (6).

Migration & Displacement, in eight terms (5-9):

Cross-border migration · Forced displacement · Legal status & emerging categories

Cross-border **International migrants**	People living outside their country of birth or citizenship for more than 12 months, per the UN statistical definition. Europe hosts the most (94M), then Northern America (61M) and Northern Africa/Western Asia (54M).[5]	**304M**[5] **(2024 · nearly double 1990's 154M · 3.7% of world pop.)**
Forced **Refugees**	People who have fled their country of origin due to a well-founded fear of persecution based on race, religion, nationality, political opinion, or social group, as set out in the 1951 Refugee Convention and its 1967 Protocol.[7]	**30.5M**[8] **(registered under UNHCR's mandate, mid-2025)**
Forced **Asylum seekers**	People who have applied for international protection but whose claim has not yet been determined.[7]	**8.4M**[8] **(pending claims worldwide, mid-2025)**

Forced **Internally displaced persons**	People forced to flee their homes but who remain within their own country, due to conflict, violence, natural disasters, or human rights violations. The largest displaced population by number.	**67.8M** [8] **(internally displaced, mid-2025)**
Legal status **Regular migrant**	Someone who moves to another country legally, holding the proper documents and authorisation — a valid visa, work permit, residence permit, or student visa.[6]	**–** **(no standalone global figure available)**
Legal status **Irregular migrant**	Someone who moves or lives in a country without the required legal permission — including people who entered without documents, overstayed a visa, or remained after an asylum claim was denied.	**–** **(no standalone global figure available)**
Legal status **Undocumented migrant**	A non-national who enters or stays in a country without the appropriate documentation, or who holds no documentation with which to be identified.[6]	**–** **(no standalone global figure available)**
Emerging **Climate migrants**	People displaced by environmental change, extreme weather, and climate-related disasters — a category with wide, still-forming projections rather than a settled current count.[9]	**25M – 1B** [9] **(projected to migrate by 2050)**

It is essential to recognise that these categories are not mutually exclusive; individuals may belong to multiple categories simultaneously, and legal status can change along the migration continuum. The IOM and WHO both advocate inclusive, rights-based approaches that recognise the diversity within migrant populations, including age, sex, gender identity, sexual orientation, disability status, and ethnicity, as determinants of SRH vulnerability (10,11).

2.1 Understanding the drivers of migration

Migration is one of the most significant global phenomena of the modern era. Its drivers rarely operate in isolation: conflict, violence, disasters and climate-related events, inequality, economic deterioration, and weakened health systems frequently occur simultaneously and reinforce one another, shaping both the decision to move and the conditions of migration and displacement (12). These interacting drivers unfold within a broader context of geopolitical tensions, anti-migrants' policies, borders enforcement, technological acceleration, the curtailment of migrants' rights, and environmental degradation, which in turn intersect with demographic change, uneven development, humanitarian crises, and tightening fiscal space

(12,13). An individual's migration should therefore not be attributed to a single cause, since people's experiences are shaped by overlapping and compounding circumstances, and the risk associated with migration vary dramatically by setting, environment and prevailing politics.

2.1.1 Conflict and violence

Armed conflict and violence remain the primary drivers of forced displacement worldwide. By the end of 2025, 117.8 million people worldwide were forcibly displaced due to persecution, conflict, violence, and human rights violations (12).

2.1.2 Conflict and socio-economic collapse

While conflict is often the immediate trigger of displacement, it frequently occurs alongside broader socio-economic collapse. An increasing number of people are being displaced by political instability, economic failure, and the erosion of basic services (11). The Venezuelan crisis is among the most striking examples. Multiple interconnected factors, including widespread poverty, hyperinflation, a lack of jobs, and the breakdown of public services, have compelled millions to leave (14 - 17).

2.1.3 Climate migration

Over the past 10 years, weather-related disasters have caused 220 million internal displacements, equivalent to approximately 60,000 displacements per day (18). By the end of 2024, about 45.8 million disaster displacements had been recorded across 163 countries and territories, the highest figure since the Internal Displacement Monitoring Centre (IDMC) began tracking the phenomenon in 2008, with cyclones triggering 54% of them. (8).

3. SRH and Migration

The World Health Organization (WHO) confirms that migrants' health is shaped by a specific set of determinants: sex and gender, age, socioeconomic status, legal status, and the conditions surrounding migration itself, before, during, and after the move. These determinants affect not only refugees and migrants themselves but also ripple outward to communities of origin, transit, and destination (10,19). A more recent WHO report on advancing this agenda highlights persistent obstacles to progress: gaps in data, insufficient funding, irregular and unregulated migration, trafficking and exploitation, limited access to regular migration pathways, rising xenophobia across many societies, and policy frameworks that remain inadequate (10).

Against this background, migrant-centred sexual and reproductive health (SRH) services are defined here as services organised around the needs, rights, and circumstances of migrants, rather than requiring migrants to adapt to existing health system arrangements. Building on the concept of "migrant-sensitive" and people-centred health services (3,20), the term denotes

services that (A) take account of cultural, religious, linguistic, and gender-related needs; (B) are available, accessible, acceptable, and non-discriminatory irrespective of migration status; (C) uphold confidentiality, agency, bodily autonomy, and dignity; and (D) support migrants in understanding and navigating the national health system (13, 20, 21).

3.1 Equitable Access to Quality SRH Services

Evidence consistently shows that migrants underutilise SRH services compared with host-country populations across multiple geographic and institutional contexts. A 2024 systematic review synthesised 28 studies (2018–2023) on migrant women's access to SRH services and identified a complex, multilayered pattern of underutilisation (22). The most commonly reported barrier was lack of information (57% of studies), followed by language difficulties (43%), cultural differences (39%), economic status (25%), administrative barriers (25%), and discrimination (14%) (22). Migrant women most often used peer- and community-based strategies to overcome access barriers, reflecting the inadequacy of formal health system responses (22).

A cross-sectional study investigated SRH service utilisation among women aged 15–49 years in high-migration communities across six Southern African countries (23). Factors independently associated with non-use of modern contraception included country, employment status, educational level, comprehensive SRH and HIV knowledge, fertility preference, partner's age, and partner's educational level (23). Migration status was associated with utilisation of intimate partner violence (IPV) services, while denial of access to a public healthcare facility was a strong predictor of non-utilisation of SRH referral services (23). A 2014 review documented low uptake of SRH services among migrants to European Union

Structural barriers to SRH access and utilization

01 **Financial barriers:** Irregular migrants often lack public health coverage, forcing them to pay out-of-pocket for SRH services. This limits access to contraception, ANC, STI testing, and safe abortion (22, 28, 40).

02 **Geographic and logistical barriers:** SRH services may be concentrated in urban centres, far from rural migrant settlements, camps, or border zones. Transportation costs, childcare responsibilities, and work schedules further restrict physical access (25, 28).

03 **Fragmented or absent health systems:** In humanitarian settings, conflict-related destruction of health infrastructure, lack of qualified SRH personnel, supply chain disruptions, and poor coordination create critical service gaps (25, 38).

04 **Legal status and documentation:** Undocumented or irregular legal status deters migrants from seeking SRH care due to fear of deportation, detention, or immigration enforcement at health facilities (18, 22, 25).

05 **Structural violence and trafficking:** Migrants using irregular routes face exposure to human traffickers, border violence, and exploitation by gatekeepers who control access to housing, food, and income, creating conditions for coerced transactional sex and GBV (9, 27, 46).

countries, with gaps in antenatal care (ANC), cervical cancer screening, and contraceptive services, driven by both supply-side and demand-side barriers (23).

Evidence suggests that global SRH service usage rates among immigrants remain lower than among non-immigrants, with young immigrant and minority adolescents facing compounded disadvantages due to intersecting barriers related to language, cultural identity, visa status, and stigma (24).

The Minimum Initial Service Package (MISP) for SRH has been widely endorsed as the standard of care in humanitarian settings to prevent excess maternal and neonatal mortality. A narrative review of MISP implementation during the Syrian refugee crisis in Lebanon found that, although a wide range of SRH services were delivered, significant gaps remained in reproductive health supply chain logistics, coordination, and continuity of care (25).

Demand-side barriers to SRH access and utilization

01 **Lack of knowledge** about their SRH rights, available services, and service locations in host and transit countries (22, 38).

02 **Language barriers** prevent migrants from effectively communicating with providers, understanding health information, navigating service systems, and giving informed consent (22, 23, 26, 47,49).

03 **Conservative cultural and religious norms** surrounding SRHR, and GBV disclosure create demand-side barriers (unwillingness to seek care) and delivery of care tensions (providers from the same cultural background may reinforce restrictive norms) (22, 26, 47).

04 **Discrimination and xenophobia:** Migrants report experiencing discrimination from health providers and host communities including disrespectful treatment, denial of care, and xenophobic attitudes (33, 48).

A rights-based analysis by Chen et al. demonstrates that barriers migrants face in accessing SRH care constitute violations of international human rights law, including the right to health under the International Covenant on Economic, Social and Cultural Rights (ICESCR), CEDAW, the Convention on the Rights of the Child, and the Convention on the Rights of Persons with Disabilities (24). Despite these legal protections, many governments deny migrants access to publicly funded SRH care, using immigration status as an eligibility criterion (27).

3.2 Family Planning and Contraceptive Use

Migrant women experience higher rates of unmet contraceptive need than non-migrant women, driven by a combination of supply-side constraints (unavailability of methods, particularly long-acting reversible contraceptives [LARCs]), demand-side barriers (low knowledge, cultural norms, partner opposition), and structural factors (cost, insurance exclusions, undocumented status) (22, 23, 28).

In Brazil, Bahamondes and colleagues interviewed 405 migrant Venezuelan women aged 18–49 in UNHCR shelters and found that unmet family planning needs were the most commonly reported

SRH issue, with inability to obtain contraceptives — particularly LARCs — despite their theoretically free availability through the Brazilian National Health Service (SUS) (25). Similar patterns have been documented among migrants in an evaluation conducted in Colombia (Profamilia). This finding is not isolated: underutilisation of contraceptive methods is a recurring consequence of access barriers faced by migrants in Morocco, throughout Europe, and at the Guatemala–Mexico border, suggesting that legal, financial, stigma-related, linguistic, and health system barriers systematically constrain access to family planning and contraception across geographic and policy contexts (22, 29, 30, 31).

These barriers are further compounded in situations of climate-induced displacement, where disruption to health infrastructure and services during transit and in emergency settings frequently cuts migrants off from access to contraception, contributing to elevated rates of unintended pregnancy and unsafe abortion (8). Taken together, these studies demonstrate that inadequate access to contraception is a persistent, cross-cutting issue for migrant populations, driven by intersecting structural and crisis-related factors that demand targeted policy attention to safeguard reproductive health and rights during migration.

3.3 Maternal and Newborn Health Outcomes

Migration dynamics can disrupt continuity of care and compromise access to antenatal care, skilled birth attendants (SBAs), and emergency obstetric care (EmOC) (32). Migrant women, particularly refugees and asylum seekers, experience disproportionately adverse maternal and newborn health outcomes, including higher rates of maternal mortality and morbidity, preterm birth, low birthweight, and neonatal mortality, compared with host-country populations (19, 22, 27).

For women in transit, access is shaped mainly by location, language, and financial capacity. A recent review found irregular antenatal care, limited knowledge of how to reach maternity services, and care that often-lacked interpreters, respectful treatment, and informed consent. Services were largely confined to camps and were weakened by understaffing and underfunding, including the closure of many UNICEF Mother and Baby Corners after the COVID-19 pandemic (49).

In Brazil, 24.0% of pregnant or postpartum Venezuelan migrant women in UNHCR shelters received no prenatal or postnatal care, despite a constitutional entitlement to public healthcare, while deliveries by Venezuelan migrants at the main public maternity hospital in Boa Vista rose from 3.4% of all deliveries in 2016 to 26.1% in 2019, placing enormous pressure on a health system unprepared for this shift (28).

For forcibly displaced adolescents, SRH needs, including antenatal care, safe delivery, and postpartum support, are particularly acute and often unmet, with elevated rates of adolescent pregnancy and maternal mortality compounded by limited access to youth-friendly SRH services (26).

3.4 HIV and Sexually Transmitted Infections (STIs)

Migrants, particularly those in precarious legal and economic situations, face elevated risks of acquiring and transmitting HIV and STIs compared with host-country populations (19, 24, 26, 27). These elevated risks are driven by multiple intersecting factors: interrupted treatment and loss of viral suppression among those living with HIV; engagement in survival sex or sex work due to economic hardship; high numbers of sexual partners in some migration contexts; limited access to and inconsistent use of condoms and STI testing; limited access to information and PreP/PEP services, and stigma that deters help-seeking (26, 32, 33, 34).

The collapse of Venezuela's health system has produced a crisis of access to HIV care. Approximately 77,000 Venezuelans living with HIV lost access to antiretroviral therapy (ART) as healthcare infrastructure collapsed, and approximately 8,000 people living with HIV left Venezuela in search of treatment, primarily to other Latin American countries (34). At least 1,700 sought care in Peru in 2019 (34), underscoring the need for host-country health systems to ensure continuity of treatment and for protection against the stigma and xenophobia that can deter migrants from seeking care (34).

Teng and colleagues (2023) conducted a global scoping review of barriers to access to HIV post-exposure prophylaxis (PEP) among transgender women, a group that includes migrants at high intersectional risk (35). Key barriers identified included cost, lack of healthcare provider awareness of transgender SRH needs, stigma, and, in some settings, legal barriers linked to immigration status (35).

3.5 Sexual and Gender-Based Violence (SGBV)

SGBV, encompassing physical, sexual, psychological, and economic violence based on gender, is pervasive across the migration continuum and is among the most severe SRH threats facing migrant women and girls (19, 25, 27, 29, 30).

In Morocco, 87.4% of 151 female migrants surveyed had experienced SGBV at least once in their lives, and 76.2% had experienced it during migration. Verbal abuse was the most common form (75.8%), though sexual and physical violence were also widely reported (29). Only a minority of SGBV victims had visited a healthcare facility or sought formal services, underscoring the significant gap between SGBV incidence and the formal health system's response. Additionally, 29.9% of participants reported experiencing female genital mutilation (FGM), a cultural practice that persisted after migration (29).

A study of gender-related risks among refugees in Uganda documented elevated rates of sexual violence and IPV in camp settings, where overcrowding, insecurity, economic dependency, and lack of privacy create conditions conducive to GBV, compounded by barriers to reporting, including fear of retribution, shame, and distrust of authorities (36). LGBTQI+ migrants face similar dangers throughout their migration journey: a 2017 Amnesty International report found

that two-thirds of LGBTQI+ migrants from Central America had experienced SGBV while in Mexico (37).

Refugee and asylum-seeking women fleeing armed conflict are particularly vulnerable to sexual violence used as a weapon of war, while migrants in transit — particularly those using irregular routes — face sexual exploitation and abuse by traffickers, border authorities, and other actors (27). Even after reaching destination countries, migrant women may face GBV due to legal and economic precarity, which forces dependence on perpetrators for shelter, income, or immigration sponsorship (27). Climate-induced displacement increases women's risk of SGBV, including domestic and IPV, sexual violence, forced marriage, and trafficking, particularly in overcrowded emergency shelters and in settings where male household members have migrated first, leaving women more vulnerable (9).

Refugees and migrant children and adolescents face heightened risks of sexual violence and exploitation throughout displacement, a pattern documented across distinct regional contexts. A scoping review of SRH among African migrant and refugee children identified sexual exploitation, trafficking, and rape as risks in overcrowded refugee camps, with unaccompanied adolescent girls facing an especially elevated risk of harassment, forced marriage, and trafficking (36). This pattern is echoed in the Northern Triangle of Central America, where a PAHO report documented high rates of sexual violence and trafficking along migration routes from Guatemala, Honduras, and El Salvador, identifying migrant women and unaccompanied children as most at risk (38). Together, these findings suggest that displacement conditions, whether in overcrowded camps or along perilous transit routes, create a pattern of exposure to sexual violence and exploitation, regardless of geographic setting.

3.6 Access to Safe Abortion Care

Unmet contraceptive needs, restricted access to safe abortion services, and the heightened risk of sexual violence, including pregnancy resulting from rape, contributes to elevated rates of unintended pregnancy and unsafe abortion among migrant women (9). Unsafe abortion is a leading cause of preventable maternal mortality worldwide and disproportionately affects populations with limited access to healthcare (8, 19, 22).

Evidence on abortion among migrants remains limited, constrained by legal restrictions in countries of origin and transit, as well as by the stigma surrounding disclosure. Even where asylum-seeking and refugee women are legally entitled to abortion services, bureaucratic hurdles, language barriers, cost, and restrictive policies frequently prevent access (22,39). This gap persists even where governments formally provide services: in Latin America, widespread information deficits leave many migrant women reliant on unsafe alternatives, increasing the risk of unsafe abortion, with some resorting to dangerous methods to terminate pregnancies (33, 34). Although small NGOs and grassroots organisations may try to fill this gap by providing information on, and access to, safe abortion care for migrant women and pregnant people, this work is not well publicised.

The MISP framework identifies the clinical management of abortion complications as a core SRH priority. A review of MISP implementation in Lebanon for Syrian refugees found that post-abortion care, although never legally restricted, was among the less consistently delivered components of the MISP, reflecting both supply-chain constraints and provider discomfort (25).

Climate-induced migration contexts are particularly high-risk settings for unsafe abortion, as the van Daalen et al. scoping review identifies an unmet need for contraception that results in unintended pregnancies and unsafe abortion, as documented in SRH outcomes in these settings (9). This heightened risk stems from a convergence of factors: disruption of contraceptive supply chains, the lack of safe abortion services in transit and in camps, and unintended pregnancies (9).

3.7 Mental Health and Psychosocial Impacts on SRH

Migration, particularly forced or irregular migration, is linked to significant psychological distress, including post-traumatic stress disorder (PTSD), depression, and anxiety, which, in turn, adversely affect SRH outcomes through multiple pathways (10,19, 26, 40).

In one study (40) among Venezuelan female sex workers in the Dominican Republic, 78% reported feeling depressed, 75% felt lonely or isolated, and 88% had difficulty sleeping.

For adolescent migrants, the disruption of migration, including separation from family, exposure to trauma, and social isolation, significantly impairs psychological development and is associated with elevated rates of depression, pos-traumatic stress disorder (PTSD), and difficulty forming healthy sexual and romantic relationships (26). A climate migration scoping review found that stressors associated with the migration process contribute to poorer mental health, including an increased risk of postnatal depression and poor maternal bonding, with downstream effects on infant's wellbeing (9).

The WHO World Report (2022) systematically documents that sex, gender, and exposure to discrimination and violence are key determinants of migrants' mental health outcomes, with women and LGBTQ+ populations at particularly elevated risk (19). The WHO World Report 2026 further identifies mental health as a cross-cutting issue across all SRH domains, calling for integrated mental health and SRH service delivery (10).

3.8 Menstrual Health

Menstrual health and hygiene management (MHM) remains a neglected dimension of SRH for displaced and migrant populations. Girls and women in displacement settings often lack reliable access to menstrual products, adequate water, sanitation and hygiene (WASH) infrastructure, and comprehensive menstrual health education (41). Inadequate WASH facilities, in particular, limit the safe and private spaces needed to manage menstruation with dignity (41). The consequences extend beyond hygiene: the literature links poor MHM in emergency contexts

to gender-based violence, adverse health outcomes, and the erosion of human rights among vulnerable groups (42). Responses such as dignity kits, improved WASH infrastructure, and menstrual health education exist but are implemented inconsistently, constrained by limited resources and cultural barriers (41). Migrant-centred SRH services should therefore integrate MHM as a core component, addressing both material needs and the stigma and information gaps that surround menstruation.

4. Multi-level strategies for strengthening SRH Access Among Migrant Populations

Drawing on evidence and experiences reported by diverse stakeholders — including the WHO, researchers, humanitarian actors, and health service providers — this section outlines interventions to address barriers to SRH access among migrant populations, organised at the individual, organisational, and structural levels, each targeting distinct but interconnected drivers of unmet need.

4.1 Individual-level interventions

(target knowledge, attitudes, behaviours, self-efficacy, and health-seeking capacity of migrants themselves)

Digital health delivery platforms: mHealth applications, telemedicine, and social media-based information dissemination to extend reach where in-person access is limited, particularly relevant to adolescents (26, 43).

Comprehensive sexuality education (CSE) / life-skills curricula: Implementation of programmes that integrate SRH literacy with psychosocial coping and resilience-building content— particularly useful for engaging migrant adolescents (44).

Male engagement/partner-inclusive programming: Structured inclusion of male partners in SRH to support contraceptive uptake, SGBV reduction, and PMTCT (23).

4.2 Organisational-level interventions

(target the health service/facility interface: providers, service configuration, communication)

Minimum Initial Service Package (MISP) implementation: Standardised intervention package for rapid deployment in humanitarian and acute-onset settings, targeting SGBV, STI and HIV transmission, contraception, maternal and newborn care, and comprehensive abortion care (25).

Linguistically and culturally adapted service delivery: Native-language SRH communication, culturally trained providers, and certified/professional (not ad hoc) interpretation (14, 22).

Cultural competency training for clinical and non-clinical staff: Training for healthcare providers, receptionists, and social workers in culturally sensitive, rights-based, trauma-informed care. Competency training alone does not guarantee utilisation if insurance or administrative barriers persist (43).

Community health worker (CHW) and peer navigator/peer education models: Deployment of trained peer educators, CHWs, and lay health advocates as intermediaries between migrant communities and formal health systems; associated with improved SRH knowledge, service utilisation, and SGBV disclosure across heterogeneous settings (2, 25, 38). Peer-led education is a key driver of improved SRH-related knowledge, attitudes, and behaviors (43).

Multi-sectoral/co-located service integration models: Integration of SRH services with food distribution, education, protection, legal aid, and mental health services. Reducing barriers to access for hard-to-reach populations, notably women, children, and adolescents (25, 38, 44).

Outreach and active case-finding at the facility/community interface: Community-based voluntary testing, home-visit outreach by trained community members, and mobile/embedded clinics, with organisational restructuring of service delivery integrated with individual education and national policy (22, 43).

4.3 Structural-level interventions

(target law, national policy, financing architecture, and rights frameworks)

Universal health coverage (UHC) frameworks with explicit migrant inclusion: Legal/constitutional mandates for migrant-inclusive UHC, function as structural enablers, though implementation gaps at point of care persist (28, 43).

Rights-based legal and accountability frameworks: International human rights instruments as normative SRH standards, with treaty bodies and special rapporteurs serving as accountability mechanisms.

Financing mechanisms targeting undocumented or precarious-status migrants: self-funded premium waivers, UNHCR-funded cash transfer programmes, and public–private partnerships for antiretroviral and medication access address the "ability to pay" dimension structurally rather than at the point of service (43).

Multilingual health-information infrastructure at national or regional scale: Use of platforms that offer SRH content in multiple languages represents a structural (cross-sector, government-backed) rather than a facility-level solution to the language barrier (44).

5. Recommendations for delivering rights -based and migrant-centred SRH services

5.1 Ensuring services are accessible: mobile outreach and self-care models

(bringing services physically and digitally closer to migrants who cannot reach fixed facilities)

- **Deploy mobile and outreach service delivery** along migration routes, at border crossings, transit sites and in informal settlements (taking into account security and safety conditions), complemented by pop-up or time-limited clinics timed to population movements, so that services follow migrants rather than requiring them to reach a fixed point of care.
- **Combine telemedicine with fixed services and referral pathways**, which should be embedded with in, not substituted for, a wider network of physical service points and referral pathways.
- **Support continuity of care across borders** for example through cross-border digital tools that help people locate services and maintain continuity of care as they move between countries, with confidentiality, consent and data protection built into their design from the outset.
- **Address the digital divide**, recognising that telemedicine and self-care platforms, while helpful mechanisms to increase access in some contexts, can also exclude the most marginalised migrants where connectivity, device access, language or literacy are limited. Guidance and funding should require offline or low-literacy alternatives alongside any digital channel.

Safe Passage

IPPF multi-regional SRHR and SGBV Initiative

Strengthens access to safe, inclusive SRHR, SGBV response and protection services for women, girls and marginalized communities on the move, combining fixed, mobile, community-based and remote delivery across Latin America and the Arab and African regions.

Promising practice

Combining telemedicine with fixed services and referral pathways – AMPF, Morocco



The Moroccan Association of Family Planning (AMPF) is combining mobile services, referral pathways and telemedicine to improve SRHR access for people on the move. A cross-border app is also in development to help people locate services and maintain continuity of care, with confidentiality and data security built into its design. The model shows how ***digital health*** can complement, not replace, face-to-face care: remote support is embedded within a wider network of physical points and referrals. For migrants facing geographic or mobility barriers, this hybrid approach can extend clinical reach while preserving pathways to diagnostics and higher-level care.

5.2 Service content

(defining what is delivered, not only how)

- **Implement the MISP as the standard of** care from the outset of any humanitarian crisis or acute displacement event affecting the populations they serve. This should include pre-positioning supplies, training staff, and coordinating with partners across the health, protection, food and livelihoods clusters, rather than waiting for a fuller response to be organised.

- **Formalise referral pathways** to public health facilities, UN agencies, civil society organisations, international non-governmental organisations, specialist sexual and gender-based violence (SGBV) response services, and mental health providers.

- **Integrate mental health and psychosocial (MHPSS) support into SRH service delivery**, recognising the bidirectional relationship between psychological wellbeing and SRH outcomes, rather than treating mental health as a separate referral-only pathway.

Safe Passage

IPPF multi-regional SRHR and SGBV Initiative

Promising practice

Linking HIV/STI screening to timely referral and continuity of care - INPPARES, Peru



INPPARES provides integrated SRHR and GBV services to people in transit, particularly women, girls and LGBTIQ+ people, in priority migration areas, including Tacna and Tumbes, alongside its fixed clinics across Peru. Recognizing that fear, stigma and concerns related to migration status can discourage people from approaching formal services, ***INPPARES has strengthened referral mechanisms with primary health care and protection*** actors and reinforced confidential counselling and survivor-centred referral procedures alongside testing.

The experience illustrates the importance of designing screening programmes for mobile populations around the full care pathway. After identifying a health need, people should be safely ***referred*** to appropriate treatment and follow-up despite the practical and protection barriers associated with migration.

- **Embed migrant-specific guidance into service delivery tools**, updating clinical guidelines, training curricula and quality-assurance checklists to reflect the specific legal, linguistic and mobility-related barriers migrants face, and ensure supply chains for LARC, self-care commodities and MISP kits reach MAs serving migrant and border populations.

5.3 Ensuring services are inclusive of community needs

(LGBTQI people, youth and adolescents, persons with disabilities, and other underserved groups within migrant populations)

- **Co-designing services with migrant communities**, giving them genuine decision-making power in the design, delivery, and evaluation of interventions, ensures that programmes reflect the actual barriers faced by women, girls, and other marginalised migrants.

- **Ensure LGBTQI-inclusive service provision**, including non-discriminatory intake procedures, gender-affirming language and documentation practices, staff training to recognise and respond to the elevated SGBV risk faced by LGBTQI migrants, and clear referral pathways to gender-affirming care where this falls outside an MA's scope.

- **Tailor services for migrant adolescents and youth** through confidential, age-appropriate service hours and spaces, consent protocols that do not require guardian presence where legally permissible, and youth-preferred digital and self-care channels; adolescent migrants consistently report low SRH literacy, access to comprehensive sexual education and limited awareness of confidential services compared with adults (45).

  Children and adolescents on the move have the right to safe spaces in which they can freely develop their personality, identity and sexuality, free from violence, discrimination and exploitation. Shelters, schools and health services should be designed to provide such spaces.

- **Make services accessible to persons with disabilities (PwD)** through accessible physical infrastructure in both fixed and mobile settings, accessible information (easy-read, sign language interpretation, Braille or audio where feasible), and disability-aware GBV risk assessment and referral.

- **Sustain male engagement as part of a whole-community approach** that involves male partners in SRH decision-making and education, as one element of a broader inclusive model rather than as a stand-alone intervention, to support contraceptive uptake, SGBV prevention and maternal and neonatal outcomes without diverting attention from marginalised and underserved groups.

A migrant-centred approach recognises the right to enjoy sexuality safely and pleasurably. Lack of privacy, insecurity, separation from partners, trauma and economic coercion during migration can undermine this right, so services should address sexual wellbeing alongside risk reduction.

5.4 Provider training: addressing stigma and legal barriers to abortion services

(equipping the workforce that determines whether entitlements on paper translate into care in practice)

- **Train all client-facing staff**, including receptionists, security and administrative staff, not only clinicians, in cultural competence, trauma-informed care and unconscious-bias reduction towards migrants, especially women and girls, people with disabilities (PwD), sex workers, LGBTQI and people seeking abortion care, with ongoing supervision rather than a one-off session.

- **Train providers to distinguish legal barriers from those imposed by institutions**, since documented obstacles to abortion access often stem from unnecessary documentation, spousal or guardian consent requirements, or informal refusals that exceed what national law requires. Providers need explicit, up-to-date guidance on what the law does and does not require for migrant clients.

- **Integrate migrant client feedback into quality-improvement cycles** so that experiences of stigma, discrimination or unlawful denial of care are captured and used to correct provider behaviour and institutional practice, not merely to measure satisfaction.

5.5 Advocacy and research

(the intersection of SRH and migration requires further visibility)

- **Integrate SRH explicitly** into climate adaptation and loss-and-damage financing frameworks (e.g., Conference of the Parties (COP) negotiations and National Adaptation Plans), which rarely mention reproductive health.

- **Commission dedicated studies** on the STI incidence and prevalence, mental health, and types of SGBV among marginalised migrants — treating marginalised communities as subjects with distinct needs rather than only as a comparison group or risk factor for women.

- **Social media and messaging platforms** are commonly used to share SRH information and facilitate access to services, but their use has not been systematically studied among migrants, refugees, and displaced people. Future research should examine whether these channels improve access and uptake, who they fail to reach, and what risks they pose, including misinformation and privacy concerns.

- **Challenge funding architectures** that concentrate migration health research budgets in high-income destination countries; support South-based research institutions as leads, not subcontractors, in these studies.

- **Prioritise community-based methodologies** (e.g., anonymous facility-based surveillance and respondent-driven sampling via trusted intermediaries) to estimate unsafe abortion incidence without exposing individuals to legal risk.

5.6 Essential components:

- **Advocate for data** disaggregation by legal status, migration type (voluntary vs. forced), gender, age, ethnicity, sexual orientation and disability status to inform the design of targeted interventions and decision-making on the adaptation of clinical services.

- **Lobby for migrants** to be explicitly named in national SRH strategies and Universal Health Coverage plans, which often implicitly assume residential stability. Engage Ministries of Health as accountable actors.

- **Partner with LGBTQI**, sex workers, people with disabilities, and migrant-led organisations to co-design interventions, programmes and research agendas. Advocate for protection-sensitive data collection protocols that don't expose respondents to legal risk.

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