

Emergency Healthcare Response in Settings of Forcibly Displaced People: A Review

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Universidade da Beira Interior, Covilhã 15 /02 /2024



Dedication

I would like to express my deepest appreciation and dedicate this master's project to the invaluable support and love provided by my parents, my sister, António Resendes, the rest of my family, and my dear friends. This work is also dedicated to all those who stand to gain from the outcomes of my research.

In a world marred by forced displacement, I am particularly compelled to dedicate this project to the resilient individuals who have been forcibly uprooted from their homes. Their strength and determination inspire me to delve into the complexities of their health and well-being, seeking to contribute to their betterment through this academic endeavour.

Furthermore, I extend this dedication to the remarkable humanitarian workers who devote their lives to uplifting forcibly displaced people. Their tireless efforts and unwavering compassion in the face of immense challenges deserve our utmost admiration and gratitude.

It is my sincere hope that this research can shed light on the unique healthcare needs and vulnerabilities faced by forcibly displaced individuals, fostering a deeper understanding and prompting actionable solutions.

Acknowledgements

To Doctor Juliana Sá and Doctor Gustavo Norte for agreeing to guide my master's thesis and for all the availability, help, and dedication they showed during the completion of this massive work.

To Doctor Romero Bandeira for his availability and the resources he provided, which enabled me to realize that knowledge is not a state, it is an act. And it is only as strong as our will to pursue it. "It's just that, even though today's man has his mind impregnated with doubts and fears, just like Greek or Renaissance man, scientific and technological advances have armed humanity with resources, but at the same time with systems, which, either because they are beyond human control, or because they provide us with potentialities, can quickly turn a situation of equilibrium and well-being into a situation of catastrophe." (1).

To Riga Stradins University and Faculty of Health Sciences, for providing me with the conditions to achieve my dream of graduating as a doctor and to all the employees who were always helpful.

To my loved ones, whose unwavering support has been an unwavering source of strength and inspiration, I am eternally grateful. Your belief in me and this project has been instrumental in its fruition, and I am profoundly thankful for your presence in my life and for being my pillar of strength.

May this dedication serve as a testament to the resilience and courage of forcibly displaced people and the unwavering dedication of humanitarian workers. Together, let us strive for a future where the health and well-being of every individual, regardless of their circumstances, are prioritised and protected.

Resumo

A tese intitulada "Emergency Healthcare Response in Settings of Forcibly Displaced People: A Review" centra-se na análise da literatura publicada sobre a resposta a cuidados de saúde de emergência em ambientes onde as pessoas foram deslocadas à força. A monografia explora os desafios e barreiras no acesso aos serviços de saúde nestes contextos, bem como as dificuldades enfrentadas pelos profissionais de saúde e organizações humanitárias que operam em cenários de deslocação forçada.

Ao longo desta revisão académica, a tese examina a eficácia de várias intervenções e práticas clínicas de saúde direcionadas a comunidades deslocadas à força. Avalia estratégias de prevenção de doenças, promoção da saúde e prestação de cuidados de saúde em ambientes de deslocação forçada. O objetivo principal é realizar uma análise abrangente das intervenções realizadas, identificando os desafios e oportunidades encontrados na resposta sanitária às populações deslocadas à força. Essa análise visa fornecer *insights* para aprimorar a eficácia da resposta sanitária de emergência.

As potenciais implicações e contribuições desta tese para o campo dos cuidados de saúde de emergência em contextos de deslocação forçada incluem a identificação dos principais desafios e oportunidades para uma resposta eficaz aos cuidados de saúde, a avaliação dos programas de saúde existentes, e *insights* para melhorar a resposta aos cuidados de saúde de emergência para as populações deslocadas à força.

Adicionalmente, a tese identifica áreas propícias para investigações futuras, destacando a necessidade de desenvolver modelos inovadores que considerem os determinantes sociais, políticos e ambientais da saúde na resposta aos cuidados de saúde de emergência em contextos de deslocamento forçado. Além disso, sugere-se a exploração do impacto desses determinantes na acessibilidade e disponibilidade dos serviços de saúde. As orientações oferecidas têm o potencial de ser valiosas não apenas para profissionais e decisores políticos envolvidos na área dos cuidados de saúde de emergência em situações de deslocamento forçado, mas também para a formulação de intervenções e políticas eficazes, visando melhorar o acesso equitativo e a qualidade dos cuidados de saúde para populações deslocadas à força.

Palavras-chave

Emergency;healthcare;refugees;disaster medicine;displacement;migration

Abstract

The thesis titled "Emergency Healthcare Response in Settings of Forcibly Displaced People: A Review" focuses on the analysis of the published literature on emergency healthcare response in settings where people have been forcibly displaced. The research explores the challenges and barriers to accessing healthcare services in these contexts and the difficulties faced by healthcare workers and humanitarian organisations operating in such situations.

Additionally, the thesis reviews the effectiveness of healthcare interventions and clinical practices for forcibly displaced populations and examines strategies for disease prevention and health promotion in displacement settings. The primary objective is to discern the challenges and opportunities intrinsic to efficient healthcare responses in these environments, thereby providing nuanced insights to enhance emergency healthcare provisions for forcibly displaced populations.

The potential implications and contributions of this thesis to the field of emergency healthcare response in settings of forcibly displaced people include the identification of key challenges and opportunities for effective healthcare response, the evaluation of existing healthcare programs, and insights for improving emergency healthcare response for forcibly displaced populations.

Furthermore, the thesis identifies promising areas for future research, emphasising the need to develop innovative models that consider the social, political, and environmental determinants of health in emergency healthcare response in forcibly displaced settings. Additionally, it suggests exploring the impact of these determinants on healthcare accessibility and availability. The provided guidance has the potential to be valuable not only for professionals and policymakers involved in the field of emergency healthcare in situations of forced displacement but also for shaping effective interventions and policies aimed at improving equitable access and healthcare quality for forcibly displaced populations.

Keywords

Emergency;healthcare;refugees;disaster medicine;displacement;migration

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List of Acronyms

ALNAP	Active Learning Network for Accountability and Performance in Humanitarian
CBIs	Cash-Based Interventions
COVID-19	Coronavirus Disease 2019
FATPs	First Aid Trauma Posts
HIV	Human Immunodeficiency Virus
IDPs	Internally Displaced Persons
IOM	International Organisation for Migration
ITS	Informal Tented Settlements
MEPs	Medical Evacuation Programs
MHPSS	Mental Health and Psychosocial Support
NCDs	Non-Communicable Diseases
NGOs	Non-Governmental Organisations
PFA	Psychological First Aid
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analysis
RAD	Refugee Aid and Development
SGBV	Sexual and Gender-Based Violence
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation

1. Introduction

In recent years, the global community has faced significant challenges in providing effective emergency healthcare in general settings and specifically for forcibly displaced populations. Simultaneously, forcibly displaced people, including refugees, asylum seekers, and internally displaced persons (IDPs), require specialized healthcare interventions and support due to their unique circumstances (2).

The goal of this thesis is to address a critical and urgent global issue by examining the provision of healthcare in the context of forcibly displaced populations during emergencies. The thesis aims to contribute to the existing knowledge and understanding of this topic, with the ultimate objective of enhancing the effectiveness and quality of emergency healthcare interventions for forcibly displaced individuals.

The importance of this thesis lies in several key aspects:

- (1) Addressing healthcare disparities: In humanitarian crises, forcibly displaced communities encompassing refugees, internally displaced persons, and asylum seekers grapple with an array of challenges and vulnerabilities, often marked by constrained access to vital healthcare services. This study embarks on a mission to bridge these disparities by zeroing in on emergency healthcare response. This strategic focus holds the potential to not only uplift the well-being but also ensure the survival of displaced individuals amidst critical circumstances.
- (2) Addressing a global crisis: The global displacement crisis has reached unprecedented levels, with millions of people uprooted from their homes due to conflicts, natural disasters, or other circumstances. By examining emergency healthcare responses in settings of forcibly displaced people, the thesis contributes to a better understanding of the complex healthcare needs and challenges faced by this population.
- (3) Improving healthcare delivery: By analysing healthcare interventions, clinical practices, mental health considerations, and preventive attitudes, the thesis aims to identify effective strategies and approaches to enhance emergency healthcare response. The findings of this research can guide policymakers, healthcare providers, and humanitarian organisations in improving the quality, accessibility, and efficiency of healthcare services for forcibly displaced populations.

- (4) Bridging research gaps: The thesis aims to fill existing gaps in the research landscape surrounding emergency healthcare response in settings of forcibly displaced people. By examining the available evidence and conducting a comprehensive analysis, this research contributes to a deeper understanding of the topic and helps to identify areas where further research and intervention are needed.
- (5) Impact on policy and practice: The findings and recommendations of this thesis can inform policy decisions and shape practical approaches to emergency healthcare response in settings of forcibly displaced people. By providing evidence-based insights, the research can influence the development of guidelines, protocols, and interventions that prioritise the healthcare needs of forcibly displaced populations during emergencies.

The organisation of the thesis in the proposed manner serves several key purposes, each contributing to a comprehensive and cohesive examination of emergency healthcare response in settings of forcibly displaced people: (1) logical progression; (2) comprehensive exploration; (3) evidence-based analysis; (4) holistic approach: the inclusion of mental health (Sections 3.1.2.3. and 4.2.3.) recognises the significant role it plays in emergency healthcare response. By exploring the specific challenges and provision of mental healthcare services, the thesis acknowledges the multidimensional needs of forcibly displaced populations. Healthcare is not solely about physical ailments; it also encompasses mental well-being, which includes mental health. Additionally, the examination of different types of forcibly displaced populations throughout the sections allows for a tailored approach to healthcare interventions, considering the unique characteristics and requirements of each group; (5) effectiveness of humanitarian healthcare: these sections (Sections 3.1.3. and 4.3.) provide insights into the broader impact of healthcare initiatives and address the importance of empowering forcibly displaced populations to take proactive measures in managing their health. In sum, it enables a thorough exploration of historical trends, healthcare and clinical interventions, mental health considerations, primary and secondary healthcare services, and effectiveness assessments.

1.1. Definitions

Two conditions must be satisfied before the United Nations High Commissioner for Refugees (UNHCR) declares an emergency. First, there is a humanitarian catastrophe or disaster that, absent rapid intervention, will seriously impact the rights or well-being of displaced and stateless people and has already caused or poses a serious threat of

causing further forced displacement, fatalities, or other serious harm. Second, the current capacities of the government and UNHCR are insufficient for a planned and successful response, so the humanitarian situation must demand extraordinary measures. The analysis of the operation and its current capabilities for readiness and response are both taken into consideration when declaring an emergency level (3).

According to the International Organisation for Migration (IOM), forced migration is “a migratory movement which, although the drivers can be diverse, involves force, compulsion, or coercion.” The definition includes a note that clarifies that “While not an international legal concept, this term has been used to describe the movements of refugees, displaced persons (including those displaced by disasters or development projects), and, in some instances, victims of trafficking. At the international level, the use of this term is debated because of the widespread recognition that a continuum of agency exists rather than a voluntary/forced dichotomy and that it might undermine the existing legal international protection regime.” (4).

Refugees, as defined by the 1951 United Nations Convention Relating to the Status of Refugees and its 1967 Protocol, are people who leave their home country out of a "well-founded fear" of being persecuted due to their race, religion, nationality, membership in a particular social group, or political opinion. Once they are outside of their country of nationality or permanent residence, they are unable or unwilling to return because of this fear. The 1951 Convention Relating to the Status of Refugees, the Protocol of 1967, the 1969 Organisation of African Unity Convention Governing the Specific Aspects of Refugee Problems in Africa, those recognised under the UNHCR Statute, Individuals Granted Complementary Forms of Protection, and Individuals Enjoying Temporary Protection are all included in the UNHCR. The refugee population also includes people in “refugee-like situations” (5).

People in a situation that resembles that of refugees include "groups of persons who are outside their country or territory of origin and who face protection risks similar to those of refugees, but for whom refugee status has, for practical or other reasons, not been ascertained" (6).

Internally displaced persons, according to the United Nations Guiding Principles on Internal Displacement, are "persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or to avoid the effects of armed conflict, situations of generalized violence, violations of human

rights or natural or human-made disasters, and who have not crossed an internationally recognized state border". The fact that IDPs are still entitled to all the same rights and protections as citizens and other habitual residents of their nation, despite being inside it, means that this classification is merely descriptive and does not grant any special legal status. As a result, it is primarily the responsibility of national authorities to stop forced displacement and to safeguard IDPs (7).

Asylum-seekers, in the words of UNHCR, are "individuals who have sought international protection and whose claims for refugee status have not yet been determined" (5).

Midway through 2022, the UNHCR added the category "other people in need of international protection" to its reporting system. This category includes "people who are outside their country or territory of origin, typically due to being forcibly displaced across international borders, who have not been reported under other categories (asylum seekers, refugees, or people in refugee-like situations), but who likely need international protection, including protection against forced return, as well as the previously labelled group of "Venezuelans displaced abroad" as well as individuals who were not included in other categories are now included in this category". Since 2018, the UNHCR has made modifications to its data that are retroactive (8).

Disaster-induced migration is the uprooting of people because of "a serious disruption of a community or society's functioning involving widespread human, material, economic, or environmental losses or impacts, which exceeds the affected community or society's ability to cope using its resources" (9).

Emergency healthcare response involves timely and comprehensive medical assistance during crises. It plays a crucial role in reducing morbidity and mortality rates by addressing urgent healthcare needs. However, delivering healthcare in emergency settings is complex and often hindered by limited resources, damaged infrastructure, disrupted supply chains, and overwhelmed healthcare systems (10).

A comprehensive emergency healthcare response strategy requires coordination among various stakeholders, including local and international healthcare providers, government agencies, Non-Governmental Organisations (NGOs), and other humanitarian actors. Collaborative efforts and information sharing are crucial for efficiently deploying medical personnel, supplies, and equipment to affected areas. According to the SPHERE Handbook, to establish a clear division of labour and duty and to detect gaps in coverage and quality,

coordination mechanisms, such as the cluster system, are needed. It is critical to avoid wasting time and resources and duplicating efforts. Along with cooperative planning and integrated actions, information and knowledge sharing among stakeholders can help organisations better manage risk and enhance response outcomes (11).

1.2. Healthcare in Settings of Forcibly Displaced People

According to recent data from the UNHCR, the number of forcibly displaced people worldwide has reached unprecedented levels. At the end of 2022, because of persecution, conflict, violence, human rights violations, or events seriously disturbing public order, it is estimated that there were 108.4 million people who have been forcibly displaced, including 35.3 million refugees (including refugees who are not covered by the mandate of UNHCR), 5.4 million asylum seekers, and 62.5 million IDPs. This means 1 in every 6 people on Earth has been forced to flee – a dramatic milestone that few would have expected a decade ago. These individuals often face significant barriers in accessing healthcare services due to factors such as limited resources, language barriers, and discrimination (8).

At the end of June 2023, an estimated 110 million people remained forcibly displaced, 1 per cent more than at the end of 2022, including 36.4 million refugees (including refugees who are not covered by the mandate of UNHCR), 6.1 million asylum seekers, and 62.5 million IDPs. The mid-year total represents an increase of 1.6 million compared to the end of 2022. More than 1 in 73 people worldwide remained forcibly displaced as a result, 88 per cent of them in low- and middle-income countries (12).

Providing healthcare in settings of forcibly displaced people requires a rights-based approach and addresses various aspects of healthcare access, protection, and psychosocial support. It involves ensuring access to essential healthcare services, including primary healthcare, reproductive health, mental health support, and emergency medical care. Additionally, addressing the specific health needs of marginalized groups, such as women, children, and persons with disabilities, is crucial for promoting inclusivity and equity in healthcare delivery (13).

Humanitarian organisations play a crucial role in delivering healthcare to forcibly displaced populations. Through their dedicated efforts, healthcare services, including primary care, vaccinations, reproductive health services, and mental health support, are provided in camps, settlements, and host communities. These organisations collaborate with local healthcare providers and community leaders to ensure culturally sensitive and equitable healthcare delivery (13).

The provision of healthcare in forcibly displaced settings requires a comprehensive approach that addresses both immediate medical needs and long-term health challenges. As noted by the World Health Organisation (WHO) Regional Office for the Eastern Mediterranean, “It is vital that basic services (such as continuity of health services, provision of life-saving medical supplies, timely responses to potential outbreaks and responses to urgent trauma needs) are provided for all the population, including those that are displaced. It is also just as important to have a good risk communication and community engagement plan in place to ensure that proven public health measures are adhered to. In all phases of health emergency and disaster risk management, including mitigation, preparedness, response and recovery, the needs of refugees and migrants must be adequately addressed.” (14).

2. Methodology

The present literature review was prepared according to the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) criteria and recommendations (15,16). This consists of a set of guidelines distributed over a list of 27 items considered essential for systematic reviews. Despite using the PRISMA methodology, the author deliberately chose not to conduct a systematic review of the thesis due to the research topic and available information. Systematic reviews, while valuable for comprehensive data overviews, may not always be the best approach for every research question. The study landscape and information available in the context of this thesis provided several restrictions:

(1) A substantial body of literature is already in existence.

(2) The necessity for various research methodologies arises from the nature of emergency healthcare response in contexts involving forcibly displaced individuals. These situations frequently require the utilisation of diverse research methodologies.

(3) The field of emergency healthcare response in settings involving forcibly displaced populations demonstrates a dynamic and rapid evolution. Constant developments, new interventions, techniques, and strategies are continually emerging. Systematic reviews may have limitations in terms of the relevance and applicability of their findings since they might not encompass the latest developments and evolving techniques in this field.

(4) The chosen approach is to concentrate on specific research questions within the realm of emergency healthcare response in forcibly displaced populations. This focused approach allows for the exploration of critical aspects, identification of gaps, and examination of pertinent issues present in the current literature. It facilitates insightful analysis and the provision of recommendations based on the available information.

A search was conducted in four databases, namely *PubMed*, *ScienceDirect*, *Emerald Insight*, and *Cambridge Core*, using the following keywords: "emergency" AND "healthcare" AND "refugees" AND "disaster medicine" AND "displacement" AND "migration". This search was conducted in February 2023 and covered articles published between 1992 and 2023 and written in English. Also, grey literature was used, and searched in the Active Learning Network for Accountability and Performance in Humanitarian (ALNAP) database, using the same keywords and search criteria.

Search filters were applied to ensure the inclusion of relevant studies and to refine the search results to obtain the most pertinent literature for the study. Thus, in addition to language restriction (studies published in the English language), the following inclusion criteria were applied:

(1) studies that included refugees, asylum seekers, or internally displaced persons who have been forced to flee their homes due to conflict, persecution, or other reasons and who are seeking emergency healthcare.

(2) focus on emergency healthcare services provided in refugee camps, makeshift settlements, or other temporary living arrangements.

(3) reported, original qualitative, quantitative, or mixed data.

(4) emergency healthcare services provided within the past 31 years;

(5) The primary topic was health-related: including clinical interventions used, analysis of the effectiveness of humanitarian healthcare methodologies, and preventive attitudes of the target group.

(6) Grey literature: The study will also include reports from NGOs and official institutions such as UNHCR, United Nations Office for Disaster Risk Reduction, United Nations (UN), United Nations Children's Fund (UNICEF), United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), WHO, European Council on Refugees and Exiles, International Committee of the Red Cross, International Federation of Red Cross and Red Crescent Societies, International Rescue Committee, IOM, UN Office for the Coordination of Humanitarian Affairs, Organisation For Economic Co-operation and Development, Amnesty International, Human Rights Watch and *Médecins Sans Frontières* if they are relevant to the study.

On the other hand, the following exclusion criteria were applied:

(1) individuals who are not refugees, asylum seekers, or IDPs.

(2) healthcare services provided in permanent or semi-permanent settlements, such as urban refugee communities or resettlement areas.

(3) articles that focus on individual case analyses, and diagnostic and therapeutic studies.

(4) data and information on emergency healthcare services provided before 1992.

(5) focused on integration aspects without any reference to healthcare accessibility and/or interventions.

(6) presented research methods, instrument development, and theoretical models without application.

The PRISMA criteria and the flowchart were fundamental to guiding the process, aiming to ensure transparency and decrease the risk of bias throughout the research process (15,16).

3. Results

From the 4 databases (*PubMed*, *ScienceDirect*, *Emerald Insight*, and *Cambridge Core*), a total of 882 articles were identified, of which 28 were duplicates. After evaluating the titles and abstracts regarding their relevance and the quality of the study design, 727 were excluded for not fitting the proposed themes and the criteria defined for this literature review. Of the 127 articles selected, 45 articles were chosen for data extraction, and 82 articles were excluded, considering the exclusion criteria. Also, from the grey literature, through the ALNAP database, 222 articles were selected with the same initial analysis criteria, of which 182 articles were excluded, considering the exclusion criteria, making a total of 40 articles eligible for data extraction. A total of 100 articles were included in the review, considering the additional texts identified in the 'relevant sources' search (n = 15). Figure 1 describes the flow of information through the different phases of the review, and shows the number of articles identified, included, and excluded.

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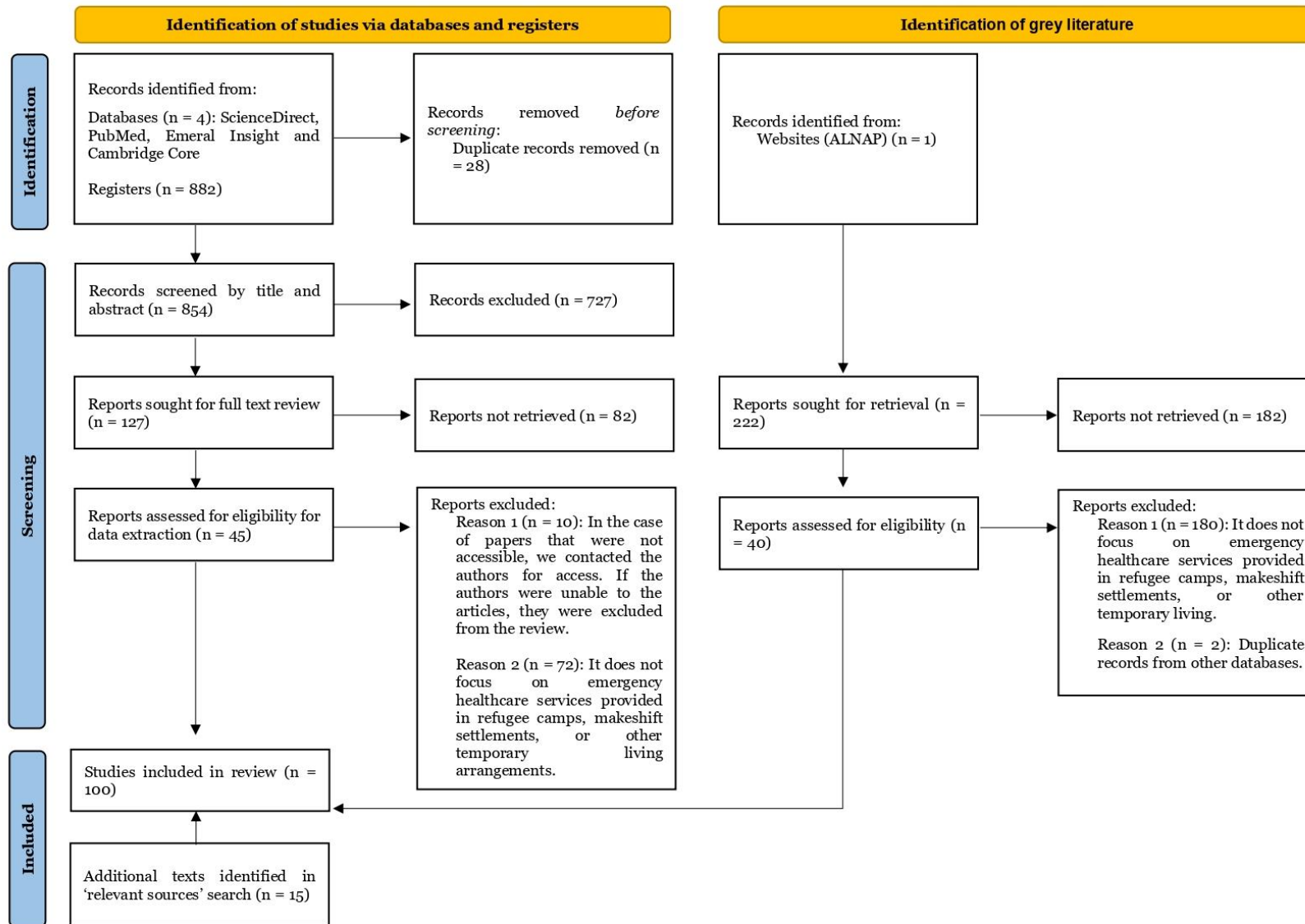


Figure 1 - PRISMA 2020 flow diagram.

3.1. Emergency Healthcare Response in Settings of Forcibly Displaced People

The following are the research results obtained from the one hundred studies included in this review.

3.1.1. Temporal Evolution of Research on Emergency Healthcare in Settings of Forcibly Displaced People / Year of Publication

Results from the literature search conducted from 1992 to 2023 revealed an evolution in research on emergency healthcare in settings of forcibly displaced people over time.

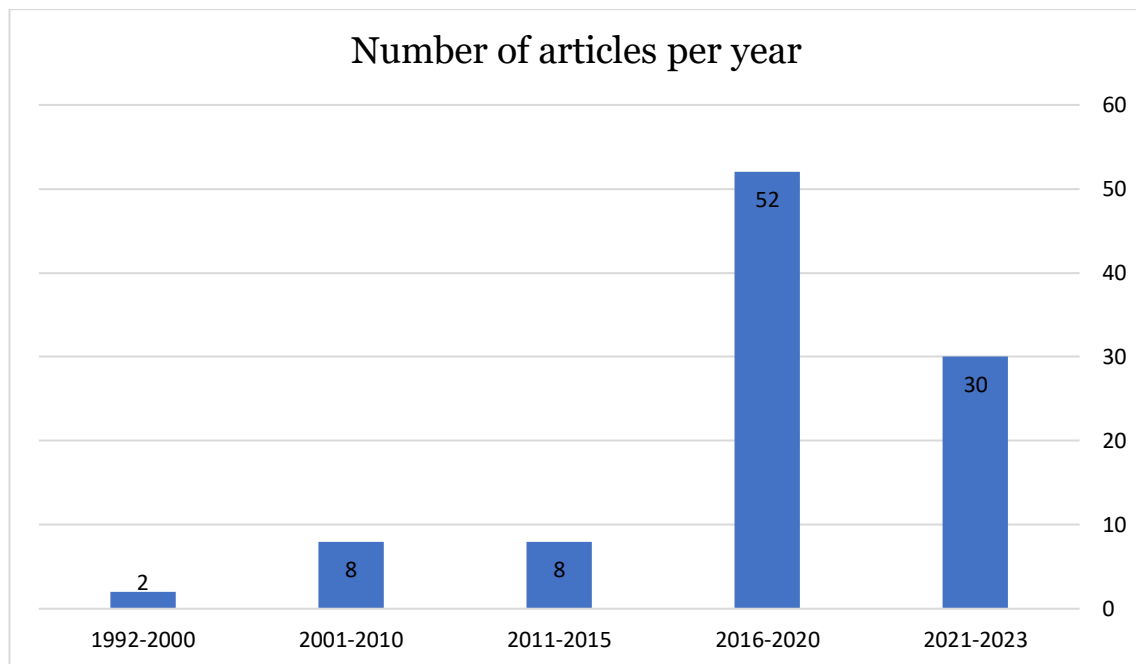


Figure 2 - Graphic of the number of articles per period of years.

3.1.2. Healthcare interventions and clinical practices

"Outliers" is a term commonly used in statistics and data analysis. In the context of this topic, referring to "outliers", represents distinctive and noteworthy aspects that require specialized attention and strategies for mitigation or resolution within their respective domains, as challenges and innovative approaches. These observations are based on the studies or conclusions of the studies.

3.1.2.1. Public Health Interventions

In the realm of public health interventions, a comprehensive analysis of twenty-seven articles reveals distinct patterns in the approaches taken.

3.1.2.1.1. Immunisation Campaigns and Vaccinations

The regular immunisation program in refugee camps in Zambia encompasses children under one year and women in the reproductive age group (14-49 years). Children receive immunisation against six infectious diseases, while women are protected against tetanus. Despite these efforts, the current vaccination coverage is unsatisfactory, with less than or equal to 80% of children being vaccinated against measles (17). The challenge persists as all health centres reported always being short of at least one antigen in the preceding year. Routine immunisations, including measles vaccinations, are integral components of healthcare initiatives within refugee camps. Additionally, deworming and measles vaccinations are administered regularly at the maternal and child health level following established international protocols. Healthcare programs for refugees extend to delivering vitamin A, folic acid, and iron whenever resources permit. The joint UNHCR-WHO evaluation in Zambia included vaccination campaigns for communicable diseases and maternal and child health services (18). Vaccinations against communicable diseases and maternal and child health services were vital components (19,20).

In refugee transit camps of Ivory Coast, two vaccination campaigns specifically targeted children aged 6 months to 15 years. Assessments revealed a measles outbreak, with 61.1% of tested cases positive for the disease. The primary goal of the vaccination campaigns was to manage measles and rubella outbreaks within the camps and prevent further transmission. Implementation was crucial to ensuring every child had access to measles immunisation and isolating sick children from healthy ones (20).

While maternal and child health services, including antenatal care, immunisation, and growth monitoring, are integrated, challenges such as vaccine hesitancy, logistical difficulties in reaching remote areas, and the need for sustained vaccine access were observed. Innovative vaccination campaigns showcased the significance of community involvement and strategic planning. The success of campaigns was attributed to awareness, utilizing social mobilisation and communication strategies, especially evident in the response to the measles outbreak (18,20).

3.1.2.1.2. Public Health Recommendations and Strategies

These encompass comprehensive recommendations to tackle public health challenges within refugee settings (21). They underscore the importance of assessing health and nutritional statuses, ensuring access to essentials like food and water, delivering preventive and curative healthcare, implementing disease control measures, and incorporating mental health and reproductive health programs (20,22–26). National policy integration, coordination, and consistent monitoring are also key aspects (27,28). Medical evacuation programs, as seen during the Kosovo crisis, demonstrate the importance of urgent medical care for displaced populations (29). This involves thorough data collection on case identification, transport, and follow-up care. Recommendations from an evaluation report on healthcare initiatives were disseminated to all implementing partners, the Ministry of Health, and UNHCR Sub-Offices (18).

3.1.2.1.3. Disease Surveillance and Control

Disease surveillance and control efforts are considered important in refugee settings, and the evaluation and collaboration with national institutions are key aspects of ensuring the prevention of outbreaks (18). Water, Sanitation, and Hygiene (WASH) services were also extended to ensure sanitary conditions (19,20). The Humanitarian Response Plan for Iraq 2016 recognised the importance of promoting healthy behaviours and preventing disease outbreaks through health education and awareness-raising campaigns (23). The Coronavirus Disease 2019 (COVID-19) pandemic brought about the need for adaptive interventions. Examples include establishing isolation centres, telemedicine services, and infection prevention measures. Challenges encompass limited resources, infrastructure deficiencies, and the mental health toll on refugees due to prolonged isolation and uncertainty (30–35).

3.1.2.1.4. Equitable Access to Healthcare Services

Addressing health inequities and social determinants of health, this topic emphasises the necessity of providing equitable access to healthcare services, including COVID-19 testing, treatment, and vaccination for migrants and refugees (34). Furthermore, additional challenges were encountered, including language barriers, cultural differences, and restricted access to vital medications and supplies (36). Outliers in this topic are political and social barriers that hinder the implementation of equitable healthcare policies. The study emphasises the importance of a development approach that goes beyond emergency responses and focuses on long-term resilience, livelihood support, and protection to reduce displacement by droughts (36).

3.1.2.2. Strengthening Health Systems

Healthcare delivery in conflict zones and humanitarian crises presents multifaceted challenges and opportunities. This section will explore the key findings and practices revealed across various articles, discussing common examples, and outliers by topic.

In conflict zones and humanitarian crises, the imperative is to strengthen healthcare systems to address the needs of affected populations (37). Common strategies involve the importance of enhancing the skills and knowledge of local healthcare staff through training and capacity-building initiatives (17,23,37,38); the construction and renovation of health facilities as pivotal for expanding healthcare access, particularly in resource-constrained settings (17,39) and the availability of essential medicines and medical supplies is a recurrent theme, with a focus on preventing stockouts and ensuring timely care (38,40,41).

Healthcare interventions in conflict and crisis settings encompass various approaches, including the deployment of mobile clinics to provide basic healthcare services in remote and hard-to-reach areas (42–45); Health Outreach Teams: these teams conduct home visits and follow-up care, especially for vulnerable populations (43,45); Ensuring a continuous supply of chronic medications is vital for individuals with pre-existing conditions (43); Enhancing the clinical skills and knowledge of healthcare providers in crisis settings is a recurring theme and referral systems: effective coordination and communication between healthcare providers are essential components of healthcare delivery (42–44). Addressing healthcare needs in urban conflict zones requires tailored approaches. Common strategies involve adapting humanitarian approaches to urban environments, coordinating emergency medical services, and providing essential services to displaced populations residing in urban areas (46,47). The impact of displacement on health is significant and complex, with efforts to ensure access to healthcare services and promote resilience in camp-like settings (48). Access to healthcare for migrants, including refugees and IDPs, is a global concern. Common strategies include advocating for strengthening primary healthcare services, providing mental health and psychosocial support, preventing, and managing diseases, offering reproductive health services, and addressing Non-Communicable Diseases (NCDs) (25,26,49–54).

Outliers in this context encompass a spectrum of unique practices. Culturally sensitive healthcare practices involve the use of interpreters to bridge language barriers (38,41) and engage community-based health workers to enhance healthcare access and acceptance among affected populations (38,39,55,56). Additionally, there is an emphasis on a coordinated surgical response in disaster and humanitarian settings, prioritising

procedures based on patient urgency (40,57), allocating resources for surgical teams, and providing essential mental health support to teams exposed to traumatic situations during operations (40). Innovative approaches to diabetes care in humanitarian crises, including telemedicine, task-shifting, and community-based care, stand as notable outliers (58). Moreover, community-based surveillance systems are highlighted for their value, involving training community members to identify and report disease outbreaks and health concerns (42–45,59). Notably, an outlier showcases the impact of UNHCR Cash-Based Interventions (CBIs) in significantly improving healthcare access (53,60).

3.1.2.2.1. Challenges in Healthcare Delivery to Refugees and Displaced Populations

Delivering healthcare to refugees and displaced populations presents unique challenges, with common examples including overcoming language differences between healthcare providers and refugees is essential for effective care (38,61); understanding and respecting the cultural background of patients is crucial to building trust and delivering quality care (38,61,62) and acknowledging that refugees often face restricted access to healthcare services due to factors like overcrowding in camps and resource shortages (39,61).

An outlier in this context is the provision of reproductive healthcare to internally displaced persons, involving services like family planning, antenatal and postnatal care, and management of complications related to unsafe abortions (63). References across these articles highlight the need for culturally sensitive healthcare practices when addressing the unique challenges of healthcare delivery to refugees and displaced populations (2,38,39,41,55,58,61–65).

3.1.2.2.2. Integration of Healthcare Services and Social Determinants of Health

Integrating healthcare services and addressing social determinants of health are central to improving overall health outcomes. Common examples encompass the integration of services (39,41,47,65,66), health education campaigns, and efforts to improve access to clean water, sanitation, nutrition, and housing (26,39,66–68). An outlier in this context is the protection of personal data in humanitarian assistance, particularly concerning medical information (52,60,69–72).

3.1.2.3. Mental Health Interventions for Refugees in Humanitarian Settings

In the domain of mental health interventions for refugees, a comprehensive examination of the existing literature reveals distinct themes and approaches, along with common examples and potential outliers.

3.1.2.3.1. Mental Health Services and Support

Globally, there has been a transition in Mental Health and Psychosocial Support (MHPSS) programming from vulnerability-based frameworks to resilience and recovery-based approaches. This shift acknowledges refugees and IDPs as proactive individuals who play an active role in their lives despite facing adversity (73). However, challenges related to resource constraints and cultural diversity pose as outliers (23,28,39,73–77).

Providing immediate Psychological First Aid (PFA) is a common practice (67,73,76–79). PFA is a methodology founded on the notion of human resilience, employing evidence-based principles. The strategic utilisation of respected local community structures, such as faith-based organisations and community leaders, greatly facilitated the mobilisation and awareness of the communities regarding the psychosocial services provided by IOM. These structures also played a crucial role in interpretation during the implementation phase. Throughout the project, the activities were conducted in community spaces provided by individuals whom the beneficiaries were familiar with and trusted. This approach greatly facilitated the process of acceptance and trust-building. These community spaces were conveniently accessible and conveniently located near many of the beneficiaries. Employing a combination of individual and group counselling approaches enabled survivors to engage and share their experiences, while also equipping them with the necessary tools to overcome trauma, negative thoughts, and distressing memories. This approach also allowed the survivors to focus on rebuilding their lives after experiencing painful and terrifying events (79).

PFA includes crisis counselling, psychoeducation, and community-based support (10,19,22–28,32,34,37,39,42,45,46,49,52,55,58,59,61,65–68,71–73,75,76,78–92).

The *refuKey* initiative has effectively facilitated the accessibility to mental health services for refugees through systematic identification of mental disorders, smoothing out the process of transitioning and enhancing connections among mental health institutions and sectors. The initiative has resulted in a more synchronised, problem-solving, and enduring approach to treatment through the collaboration of multiple professionals and the consistent utilisation of qualified interpreters. Experts involved in the initiative have communicated a decrease in distress and an increase in cross-cultural proficiency. The initiative has enhanced the planning and execution of treatment for refugees, rendering it more synchronized, problem-solving, and enduring (87).

The importance of integrating mental health and psychosocial support services with other sectors such as healthcare, education, and social services is also emphasised. The implementation of health interventions can be challenging due to many factors. Difficulties in reaching areas or providing support can create obstacles. Additionally, resistance from communities or logistical issues in organising activities can hinder the delivery of health interventions. In the context of the Middle East conflict, MHPSS practitioners may face challenges as they are sometimes seen as biased which complicates the provision of health support (73).

Furthermore, differences in economic and cultural backgrounds between MHPSS practitioners and refugees can impact the interaction and effectiveness of interventions. It is important to consider power dynamics to avoid situations where individuals feel subordinate and overly reliant, on the expertise of practitioners. Embracing a person-centred approach that emphasises genuine partnership and collaboration can contribute to empowerment and promote health among refugees and displaced people (73).

3.1.2.3.2. Integrating Mental Health into Humanitarian Response

Comprehensive mental health assessments play a pivotal role in humanitarian efforts (75). The integration of mental health into the humanitarian response is a widespread approach, ensuring that MHPSS are incorporated into initial assessments and recovery efforts (17,19,23,25–28,37,49,61,66,67,70,71,73,75,76,92,93). In some instances, psychotropic medication is employed as a common practice to manage severe mental health conditions, involving prescribing and monitoring medication (24). The trauma-informed care approach is highlighted as a common practice, emphasising the importance of creating a supportive environment. Common practices recognise the impact of trauma on individuals (51,74). A multidisciplinary team approach is often cited as effective, with common examples involving collaboration among professionals from various disciplines (40,64,82,83,87,89,94).

Specific contexts, like the crisis in Ukraine, bring unique challenges. Emergency healthcare interventions focus on mental healthcare utilisation, psychosocial support, and addressing limited access to healthcare in both camp and urban settings (83,88,95,96). WHO has collaborated with health authorities to minimise disruptions to the provision of essential healthcare services in neighbouring countries that are sheltering refugees, as well as within Ukraine. For instance, to prevent and treat diseases that can be prevented by vaccination, WHO funded multi-nation campaigns. WHO has physically inspected the state and capabilities of clinical diagnostic laboratories in Ukraine to guarantee the continued

operation of regular surveillance for COVID-19 and other infectious illnesses. In collaboration with the government, continuous immunisation campaigns against polio were initiated, specifically targeting internally displaced individuals. The response has included bolstering capacity to identify the importation of polio and other vaccine-preventable diseases, planning for outbreak response, and supporting refugee-receiving nations to ensure vaccination of Ukrainian refugees (97).

While challenges in accurately assessing the mental health needs of diverse refugee populations can be considered outliers (75), despite the commonality of integrating mental health into humanitarian response, outliers emerge, such as resistance to integration or shortages of trained personnel (76). Additionally, outliers encompass challenges in ensuring a consistent supply of medication (24) and coordinating multidisciplinary teams, as well as facing a lack of expertise in specific areas (40,64,82,83,87,89,94).

3.1.2.3.3. Capacity Building, Accessibility and Affordability

Building the capacity of local healthcare workers and community members is commonplace (2,17–19,23–26,28,30,37,39,41–44,46,51,52,54,55,57,59,63,66,68,69,71,73,75–77,79,84, 86,88–92,96,98–101). Training programs enable non-specialists to provide basic MHPSS services and culturally sensitive care. Ensuring accessibility and affordability of mental health services is crucial, including the identification and referral of individuals in need of specialised care. However, challenges related to resource constraints and cultural barriers exist as outliers (36,50,58,60,76,93).

Capacity building in mental health interventions involves strengthening the skills and resources of individuals, communities, and organisations to effectively address mental health issues. It is important to ensure that service users feel that their explanatory models of illness are recognised and integrated into the assessment and planning of care, which requires a culturally safe environment and respectful exploration of the perspectives of the clients. Psychosocial support interventions, which may not require clinical mental health services, can be provided in community-based settings such as community centres and programs for women. Clinical mental health services are provided to individuals with severe symptoms or an intolerable level of suffering, usually led by mental health professionals (73).

One paper highlights the need for mental health services in various regions of Lebanon. It also mentions the lack of psychiatric hospitalisation outside of Beirut and the need for proper management of psychiatric emergencies at the hospital level. This reference

indicates the importance of improving accessibility to mental health services in different areas of the country (37).

Capacity building for community-based social support groups, including community centres, is mentioned as an approach to activate psychological and social support for survivors and their families. The evaluation acknowledges the challenges faced by humanitarian organisations in providing mental health services in countries with underdeveloped mental health infrastructures. It highlights the need for resourcing or developing therapeutic solutions within the displaced community. The evaluation also mentions the importance of accessibility and affordability of mental health services for displaced people. It calls for humanitarian agencies to support avenues for displaced people to address and heal their trauma. The IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings are mentioned as an emerging consensus in the field. These guidelines emphasise the importance of accessibility and affordability of mental health services in humanitarian settings (76).

3.1.2.4. Primary and Secondary Healthcare Services

In the realm of primary healthcare services for forcibly displaced populations, several common examples and outliers emerge from the available literature (17,19,23–26,37,39,41,55,61,86,91).

Primary healthcare services encompass a range of vital medical provisions such as maternal and child health services, basic emergency obstetric care, and the management of prevalent diseases like tuberculosis and malaria (17). In Uganda, a collaborative effort between the government and humanitarian organisations ensures the delivery of primary healthcare services to refugees and host communities. These services are provided through health centres, mobile clinics, and outreach programs. They include preventive care, treatment for common illnesses, maternal and child health services, and health education (39).

Challenges in accessing healthcare due to conflicts or resource constraints are noteworthy outliers in the context of primary healthcare for forcibly displaced populations (41,55). Another outlier pertains to the difficulties in promoting sexual and reproductive health and rights among migrant populations. Addressing these needs requires healthcare interventions and clinical practices that are culturally sensitive and responsive to the specific requirements of these populations (86). Difficulties in providing consistent primary healthcare services across diverse refugee populations can also be outliers (23,91).

The response to the crisis in the Central African Republic focused on providing access to basic services, including healthcare services. The provision of healthcare services was one of the areas where the response achieved modest results. In the health sector, the response faced delays and did not fully achieve the reported health indicators. However, by 2015, new indicators were achieved by more than two-thirds, showing progress in the coverage of health centres. The response also contributed to preventing higher mortality through the provision of basic health services. Hundreds of thousands of internally displaced persons would not have survived without these services. However, the response fell short in addressing the specific needs of vulnerable groups and in achieving sector results in healthcare. Overall, while the response made progress in providing access to healthcare services, there were challenges and limitations in achieving the desired outcomes (27).

3.1.2.4.1. Reproductive Health

Reproductive health services, including antenatal care, family planning, and emergency obstetric care, are commonly provided to women and girls in humanitarian settings (17,18,25,41,63,91). The results of a survey conducted in the new camps in Balochistan in 2002 revealed limited antenatal care use among pregnant women. Among Afghan refugees in Pakistan, attendance for reproductive health visits varied: 37.40% attended one visit, 27.51% attended two, and 18.78% completed three. About 13.6% of married women used family planning methods, with 6.7% actively using contraceptives. Home childbirth was preferred by 93.5%, mostly assisted by relatives (78.0%) or health workers (19.0%). In the North-West Frontier Province, 21.23% attended three or more antenatal visits. Overall, 72.1% were aware of family planning methods, and 16.5% used contraceptives. These findings suggest areas for improved healthcare interventions (17).

Zambian refugee camps implement the safe motherhood program to minimise maternal and child health risks. Challenges like limited resources affect delivery services and contraceptive use. Efforts to address Sexual and Gender-Based Violence (SGBV) are ongoing, along with adolescent sexual and reproductive health services. Improving education, privacy for post-abortion care, service guidelines, and communication materials in local languages aims to enhance reproductive health services (18).

For Palestine refugees, UNRWA initiatives focus on distributing maternal health handbooks, providing access through mobile health clinics, and employing additional staff to ensure quality care, including midwives. These initiatives aim to reduce the impact of the crisis on health services for refugees and protect their reproductive health (91).

Iraqi camps offered reproductive health services supported by UNFPA and the Directorate of Health. These services aimed to strengthen healthcare for refugees and host communities, with consultations falling within expected rates (25). However, in Syria, the crisis significantly impacted reproductive health services, causing a decline in accessibility and quality due to damaged facilities and depleted resources. The damage to health facilities, depleted stocks, and lack of qualified health personnel have contributed to this decline. As a result, there has been a reversal of positive reproductive health indicators that the country had previously recorded. For example, the maternal mortality ratio, which had decreased to 52 maternal deaths per 100,000 live births in 2009, has shown signs of worsening. Additionally, there has been a decrease in the percentage of pregnant women receiving antenatal services and an increase in home deliveries without skilled birth attendants (41).

Additionally, agencies face challenges in delivering reproductive health services to IDPs, including resource constraints, ideological barriers, and competition between agencies. The absence of a legal instrument that recognises IDPs internationally contributes to the difficulties agencies face in reaching IDPs systematically. Differences in ideological, cultural, and faith-based values within governments and the donor community hinder effective collaboration between agencies. Dependence on government and donor policies negatively affects the provision of services by the agencies and coordination activities (63).

3.1.2.4.2. Chronic Disease Management

Managing chronic diseases such as diabetes and hypertension is of utmost importance, as these conditions are frequently prevalent among refugees (38). Articles also emphasise the significance of screening refugees for infectious diseases like tuberculosis and Human Immunodeficiency Virus (HIV) and providing appropriate treatment and follow-up care (18,38). Successful healthcare interventions and clinical practices in conflict-affected settings are noted. For example, the *3 by 5* initiative successfully increased access to antiretroviral therapy and improved health outcomes for people living with HIV in conflict-affected people, including those living with chronic diseases like HIV (10). Challenges arise in accessing medications and diagnostic tests, further hindering the provision of effective care for NCDs (81).

3.1.2.4.3. Emergency Medical Services

Emergency medical services, including ambulance services, emergency surgery, surgical care, trauma care, and emergency obstetric and newborn care, are crucial for populations

affected by conflict and displacement (26,40,41,55). For instance, the importance of these services is underscored in several articles (19,24,40,41,55,90,98). Timely and life-saving medical care is vital but often faces hurdles like insufficient healthcare, disrupted supply chains, and scarce emergency health kits. Strengthening referral hospital capabilities and securing essential medicines are crucial in emergency healthcare delivery (55).

Coordination is essential in humanitarian crises. Planning for surgical relief should involve team selection, preparation, specific needs assessment, and awareness of local limitations. Transitioning from short-term emergency surgical relief to longer-term health systems strengthening is a challenge. Team planning, appropriate medication and equipment use, and postoperative follow-up are crucial. Insecure environments demand organisational responses for security and resource allocation (40).

Studies emphasise challenges in obtaining antivenoms, particularly in crisis areas. These issues included the high cost of antivenoms, the unsuitability of some antivenoms for certain geographic regions, and the lack of international support, leading to increased surgical complications, long-lasting disabilities, and death (98). The crisis in Syria severely impacted medical services, causing damage or non-operational to health facilities and shortages of resources. It is vital to have trauma and surgical kits, along with other necessary medications, on hand to meet medical needs in an emergency (41).

UNRWA adapted its services by relocating clinics for internally displaced individuals, initiating a mobile health program in remote regions, and facilitating referrals to advanced care. Additionally, it financially supports a significant part of hospital stays and maintains stock levels in most health centres, despite challenges in restocking due to security issues (24). In this way, emergency healthcare is crucial, especially in conflict zones, where lack of care affects vulnerable groups like the elderly, women, and children. Furthermore, difficulties like isolated locations and inadequate technology capabilities can make it more difficult to respond to emergencies and disease outbreaks (55).

UNICEF has made notable progress in vaccine coverage and treating severe acute malnutrition. In general, South Sudan has benefited from the emergency healthcare services of UNICEF through higher immunisation rates, easier access to child health consultations, and more efficient treatment for severe acute malnutrition (19).

In HIV and infant feeding contexts, understanding the socioeconomic and cultural aspects of affected populations is crucial. Providing rapid HIV testing early in emergencies in high-

prevalence areas is vital. Support services like HIV counselling, infant feeding guidance, prophylactic medication, and condoms are essential to prevent transmission. Standard protocols should manage the health and nutrition of HIV-exposed infants (90).

3.1.2.4.4. Health Facility Rehabilitation

Rehabilitating and equipping health facilities that have been damaged by conflict is essential to ensure the provision of essential health services (26). Operational guidance documents provide recommendations for healthcare interventions and clinical practices in emergency contexts (89,90).

3.1.2.4.5. Specialised Healthcare Services

In discussing specialised healthcare services, the focus on tailored approaches for epilepsy care and palliative care is emphasised (99). These services, supported by various articles (61,81,91,94,99), encompass secondary and tertiary hospitalisations, specialist consultations, and outpatient care. Implementing interventions for infection control and environmental health improvements in UNRWA Health Centres aims to elevate patient safety and staff productivity and has also enhanced the calibre and effectiveness of health services, with a redistribution of duties among medical staff and increased consultation times (91). Additionally, research highlights the complexities in treating epilepsy among refugees, stressing the need for tailored training and precise guidelines. A more culturally aware approach to refugee care could lead to better outcomes, treatment adherence, and reduced emergency room visits (99).

Further research on multicultural aspects and increased awareness is crucial to enhance the understanding of seizures in displaced populations (99). Cultural nuances pose challenges – including an overworked healthcare system, scarce infrastructure and human resources, and a lack of knowledge about the language, customs, and language –, in delivering MHPSS services to Rohingya refugees, requiring a contextual and culturally sensitive approach (61). Diagnostic procedures play a crucial role in managing diseases like tuberculosis among refugees, demanding enhanced communication channels between refugees and medical professionals to gather accurate patient histories, direct diagnostic processes, and arrive at a definitive diagnosis (94). Chronic disease management in humanitarian settings faces resource constraints, funding issues, and gaps in access to medications, hampering effective care delivery for non-communicable diseases (81).

3.1.3. Effectiveness of Humanitarian Healthcare

In humanitarian healthcare, there is a pressing need to enhance access to quality care for forcibly displaced people. This entails adopting evidence-based interventions and emphasising better monitoring and evaluation of healthcare programs to ensure their effectiveness (62). However, assessing the effectiveness of humanitarian healthcare is often complicated due to the intricate nature of conflict settings and the multitude of factors that can influence health outcomes. Hence, it is crucial to incorporate principles of accountability and quality assurance. This involves grounding healthcare interventions in sound evidence, adequately training and supervising healthcare providers, and establishing mechanisms for ongoing evaluation (10,50). The overall effectiveness of humanitarian healthcare hinges on various factors, including resource availability, strong partnerships between humanitarian actors and local health systems, and a keen focus on addressing the specific needs and challenges faced by forcibly displaced populations (34).

3.1.3.1. Healthcare Challenges and Barriers

Humanitarian healthcare faces a multitude of challenges that hinder its effectiveness. These challenges encompass limited resources, inadequate funding, political obstacles, and difficulties in coordination (63,71,86,93). In conflict-affected areas, access to healthcare remains a persistent challenge due to resource limitations, insufficient infrastructure, and coordination issues (10,35,64,84,88). Specific healthcare challenges include the limited availability of essential medications, inadequate training for healthcare providers, and a lack of access to specialised care (99).

3.1.3.2. Successful Approaches of Healthcare Interventions

Healthcare interventions in humanitarian settings have achieved significant successes across primary healthcare, maternal and child health services, and mental healthcare (64). Notably, effective medical evacuation programs emphasising collaboration among organisations have demonstrated success (29). Innovations addressing snakebite envenoming with physiologically based triage skills and technology-enhanced training programs show promise (98). Additionally, CBIs have played a pivotal role in enhancing access to healthcare services and addressing underlying health issues (60). For example, the *Refugee Zakat Fund* significantly impacts the ability of UNHCR to provide essential cash assistance, covering needs like food, shelter, and healthcare for refugees and internally displaced persons. Besides immediate relief, the fund promotes self-sufficiency by distributing assets, initiating small-scale businesses, and supporting education for refugee

students. Its collaboration with Islamic philanthropic organisations enhances the well-being and livelihoods of displaced populations, fostering self-reliance and long-term stability (53).

Healthcare interventions have notably reduced morbidity and mortality rates among displaced populations, with a particular focus on maternal and child health services (67). Mobile clinics offering antenatal care, immunisation, disease control, and improved healthcare access have led to reduced child mortality and better health outcomes (18,22,23,25–27,37,42,67,91).

Healthcare approaches have expanded to encompass mental health, psychosocial support, and community well-being (43). Successful interventions include community health worker programs, community-based surveillance systems (38,56,59), telemedicine implementation (32), and effective vaccination campaigns against diseases like measles and rubella (20).

Some reports highlight effective strategies in diverse urban settings, engaging local communities in intervention design, strengthening health systems through training and infrastructure enhancement, employing mobile clinics for areas with limited healthcare, addressing mental health via psychosocial support, and ensuring coordinated healthcare interventions for efficient service delivery (46,51).

There are several ways of defining the effectiveness of an action in humanitarian healthcare response. For instance, in CBIs, several factors significantly impact their effectiveness in terms of protection outcomes. The presence of robust protection mechanisms and community-led reporting options, direct feedback channels with UNHCR staff, and effective communication during financial community meetings are crucial. However, patchy complaints handling and delays in resolution can undermine the effectiveness of CBIs, worsening protection issues. Targeting vulnerable households can enhance protection outcomes for those at higher risk, while multi-agency engagement is key for addressing protection risks and improving the effectiveness of CBIs (60).

Moreover, the effectiveness of disaster response actions depends on the pre-existing status quo and social developmental plans. Cultural and circumstantial factors influence the significance of medical care in conflict scenarios. Medical Evacuation Programs (MEPs) necessitate careful consideration of factors such as medical-surgical assessments, matching needs with international healthcare providers, multiple levels of transfer approval, and

logistics management. These factors significantly impact MEPs success, considering the stress on both injured individuals and initiating personnel. Additionally, the international movement of patients adds complexity, potentially creating tensions among involved parties. Assessing MEPs effectiveness involves evaluating patient admissions to specialised services. For example, during the Kosovo conflict, weekly reports on refugee admissions highlighted the distribution across medical specialties (29).

3.1.3.3. Mental Health and Psychosocial Support

Mental health and psychosocial support programs have showcased promise in improving mental health outcomes (10,28,83,85). These interventions have included evidence-based approaches like group-based cognitive behavioural therapy, trauma-focused therapy, and others, resulting in reduced symptoms of depression, anxiety, and post-traumatic stress disorder (10,19,22–28,32,34,37,39,42,45,46,49,52,55,58,59,61,65–68,71–73,75,76,78–92). Nonetheless, challenges persist, including the need to provide culturally appropriate care and the requirement for further research to determine effective interventions. For example, the *Daily Bread* intervention was positively received by participants and improved their understanding and application of psychological first-aid techniques (77). Initiatives such as the *Uganda Psychosocial Project* have demonstrated significant success in enhancing the psychosocial well-being of children and families affected by conflict and displacement. These initiatives have resulted in several key outcomes, including positive impacts on mental health, increased social support, enhanced parenting skills, capacity building for healthcare workers, and the establishment of sustainable community structures (79). Current approaches to triage and treatment in these settings often do not consider the unique challenges presented by complex emergencies, such as limited resources, high patient volume, and security concerns. They suggest that a return to physiologically based triage skills, combined with innovative technologies and training programs, can improve the effectiveness of humanitarian healthcare interventions in these contexts (57).

3.1.3.4. COVID-19 Management Strategies

Effective strategies are vital in managing crises like the COVID-19 pandemic among refugee populations (30–35). Inclusive measures, access to information, and socio-economic support are crucial during the pandemic (34). Preparedness is key to decreasing risks and preventing the spread of COVID-19, including having a national infection prevention and control program with WASH and livelihood support aid in mitigating risks (31).

Rohingya refugees in Bangladesh face difficulties in adhering to COVID-19 guidelines due to past traumas and distrust. Inadequate infrastructure and living conditions further increase their vulnerability. Addressing cultural narratives, improving healthcare facilities, and ensuring access to reliable information sources are key to effective management (30). In Lebanon, successful multi-sector coordination with government task forces, UN agencies, and local NGOs prevented COVID-19 spread in Informal Tented Settlements (ITSs). Local preventive mechanisms, awareness campaigns, disinfection, and health monitoring contributed to low infection rates in ITSs (35).

Adaptation measures during the pandemic involved switching to remote management of SGBV cases and expanding hotlines, improving access to services for refugee women and girls, the use of future advocacy-oriented reporting and dissemination of good practices (32).

In Europe, the limited availability of COVID-19 communications in migrant languages excludes them from the pandemic response. Governments must partner with NGOs for the inclusion of migrants in COVID-19 responses and ensure accessible health communications in their native languages. However, across 47 European countries, there is a lack of specific health information for migrants. While general materials cover disease education and prevention measures, information on testing procedures, healthcare access, and entitlements in migrant languages is scarce. Future research should focus on the effectiveness of tailored health communications, involving migrant communities and NGOs in developing policies that respond to their needs (33).

Effectiveness in humanitarian action is measured by various factors: adherence to evaluation principles, stakeholder engagement, and utilisation-focused reporting; strategies like remote case management and expanded hotlines enhancing service access during COVID-19 (32); government-produced risk communications in migrant languages and partnerships with NGOs defining COVID-19 management (33); challenges among Rohingya refugees, distrust towards healthcare, infrastructure, reliance on reliable sources, resource constraints, social resilience, and transparent communication impacting overall effectiveness (30); preparedness, real-time monitoring, collaboration, adherence to guiding principles, adaptability, and support for vulnerable groups shaping COVID-19 management (31); severity of crisis policy measures, adaptability amid crises, collaborative report authorship, risk recognition, and knowledge of healthcare laws affecting migrant actions (34); while the effectiveness of actions in Syrian informal tented settlements depends on

preparedness, successful implementation, awareness, resource availability, collaboration, and localised approaches (35).

3.1.3.5. Promoting Self-Reliance and Empowerment

One notable report sheds light on the efficacy of the Refugee Aid and Development (RAD) approach in Uganda, demonstrating its effectiveness in promoting self-reliance and empowerment among refugees. This approach has yielded several positive outcomes: (1) RAD interventions have notably enhanced food security and livelihoods for refugee households, fostering self-sufficiency and reducing dependency on external aid; (2) The provision of vocational training, business development support, and access to financial resources through RAD initiatives have empowered refugees to initiate their businesses, boost their income, and create employment opportunities, benefitting both themselves and their communities; (3) Education and psychosocial support offered via RAD programs have had a significant positive impact on the mental health and overall well-being of refugees, alleviating stress and trauma-related symptoms while enhancing social integration and (4) By involving refugees in the planning and execution of RAD programs, a heightened sense of ownership, participation, and self-determination has been cultivated. This empowerment enables refugees to exercise greater control over their lives and shape their futures (39).

3.1.3.6. Impact of Recommended Infant Feeding Practices

One case study demonstrates the positive impact of implementing recommended infant feeding practices on the health of infants in emergencies: following recommended infant feeding practices is essential to reduce the risk of HIV transmission from mother to child in emergency-affected areas. Exclusive breastfeeding provides infants with vital nutrients and antibodies, enhancing overall health and preventing infections and malnutrition. Counselling support for mothers ensures proper infant nutrition, fostering better growth and development. Special food supplements for HIV-positive women, unable to safely transition their infants from breast milk, prevent malnutrition. Promoting safe infant feeding practices also benefits maternal well-being, alleviating anxiety, and stress. The article reveals a drop-off in exclusive feeding among both breastfeeding and formula-feeding women. The findings emphasise the importance of counselling and support for mothers on infant feeding decisions, as health workers have a significant influence on these choices. The research identifies missed opportunities to prevent mother-to-child HIV transmission due to dropouts at various stages of the intervention. The study highlights the need for improved implementation of recommended infant feeding practices to reduce the risk of HIV transmission and improve the health outcomes of infants in South Africa (90).

3.1.3.7. Community-Based Surveillance Systems

Community-based surveillance systems have proven effective in responding to health crises in conflict-affected populations. These systems detect outbreaks, monitor disease trends, and promote community engagement. Common examples include (1) Effective Detection: in many conflict-affected regions, community-based surveillance has successfully detected outbreaks of diseases like cholera, measles, and polio. These systems allow for timely interventions to contain these outbreaks; (2) Early Treatment: community-based surveillance not only identifies outbreaks but also facilitates early treatment. Communities actively participate in monitoring and reporting potential health threats, ensuring prompt responses, and (3) Community Engagement: these systems foster community engagement and ownership of health interventions, empowering local communities to actively participate in safeguarding their health (59).

3.1.3.8. Palliative Care and Symptom Relief

Humanitarian crisis response often fails to fully integrate palliative care and symptom relief, despite the extensive loss of life and widespread suffering caused by these crises. The WHO recognises the necessity of integrating palliative care and symptom relief into responses to humanitarian crises and has published a guide on this integration. The WHO recommendations emphasise the importance of including palliative care as an essential part of humanitarian response, both medically and morally. The article highlights the need to ensure that palliative care is accessible for those affected by humanitarian crises (89).

Examples of impact: the integration of palliative care and symptom relief into humanitarian responses can help prevent and relieve suffering among those affected by crises. Palliative care and symptom relief are often not fully integrated into humanitarian crisis responses, despite their importance in preventing and relieving suffering. The WHO recognises the necessity of integrating palliative care and symptom relief into responses to humanitarian crises. The WHO has published a guide on integrating palliative care and symptom relief into humanitarian responses, emphasising their essential role in addressing the medical and moral needs of those affected by crises. The inclusion of palliative care in humanitarian responses can help ensure that those affected have access to pain relief, psychosocial support, and spiritual care. By integrating palliative care and symptom relief, humanitarian responses can improve the overall quality of care and alleviate suffering among those affected by crises (89).

3.1.3.9. Strengthening Health Systems through Clusters and Collaborations

In Afghanistan, according to the Humanitarian Response Plan, in the first half of 2016, health cluster partners faced challenges with a 20% increase in war-related injuries, treating 32,395 trauma cases in First Aid Trauma Posts (FATPs). Despite establishing 34 new FATPs, 24 districts lacked sufficient trauma care, straining healthcare facilities and impacting around 400.000 individuals. During this period, health cluster partners provided essential services in conflict zones, natural disaster areas, and internally displaced persons in 29 provinces and 123 districts. With 305 operational health facilities, they offered trauma care to over 32.000 patients and responded to disease outbreaks, despite some delays due to remote locations and limited access (55).

Funding for the health cluster remained insufficient, meeting only 16% of the annual requirement (55). However, the *Refugee Zakat Fund* established in 2019 significantly supported refugees in Jordan and Lebanon. By 2020, it reached over 2 million individuals across 13 countries (53).

4. Discussion

4.1. Temporal Evolution of Research on Emergency Healthcare in Settings of Forcibly Displaced People / Year of Publication

Results from the literature search conducted from 1992 to 2023 revealed a notable evolution in research on emergency healthcare in settings of forcibly displaced people over time. The analysis of articles published during this period provided insights into the changing landscape of knowledge and understanding in this field.

In the early years (1992-2000), research on emergency healthcare in forcibly displaced settings was relatively limited, with a primary focus on identifying basic healthcare needs and challenges faced by humanitarian workers. Two of the studies selected for this research primarily addressed issues related to access to primary healthcare, disease surveillance, and vaccination programs. These findings indicate the initial steps in understanding and addressing healthcare concerns in such settings (21,29).

In this research, eight studies conducted between 2001 and 2010 indicate a significant increase in attention and awareness regarding the health needs of forcibly displaced populations. Researchers during this period embarked on the exploration of a broader spectrum of topics, encompassing mental health, reproductive health, infectious diseases, and specific healthcare requirements tailored to distinct population groups. The research conducted within this timeframe underscored the profound impacts of armed conflicts, natural disasters, and complex emergencies on the health of displaced individuals (10,17,18,20,38,39,63,74).

Between 2011 and 2015, eight studies were incorporated into the research, illustrating an escalating focus on the effectiveness and quality of humanitarian health responses within forcibly displaced settings. These studies delved into the roles played by humanitarian organisations, coordination mechanisms, and partnerships in the delivery of emergency healthcare services. The research direction shifted towards the assessment of intervention impacts and the identification of best practices encompassing community engagement, culturally sensitive care, and long-term healthcare planning for displaced populations (6,23,40,41,64,73,75,76).

Most of the studies are from 2016 to 2020 and witnessed a growing recognition of the mental health needs of forcibly displaced populations. Research during this period highlighted the high prevalence of mental health disorders among displaced individuals and emphasised the integration of mental health services into emergency healthcare responses. The fifty-two studies included in the review explored the effectiveness of psychosocial support programs, trauma-informed care, and community-based approaches to address mental health challenges in displaced settings (2,4,5,9,11,13,19,22,24–28,31,33,35–37,42,43,49–52,55–62,65–71,77–79,84,89–92,94,95,100–102).

In recent years (2021-2023), there has been a focus on interdisciplinary research, innovation, and evidence-based approaches in emergency healthcare for forcibly displaced populations. The thirty articles highlighted the importance of digital health interventions, telemedicine, health information systems, and data analytics for improving healthcare delivery. Additionally, research has addressed the impacts of COVID-19 on displaced populations and the challenges faced in maintaining healthcare services during pandemics (3,7,8,12,14,30,32,34,44–48,53,54,72,80–83,85–88,93,96–99,103).

Overall, the results reflect a significant evolution in research on emergency healthcare in settings of forcibly displaced people. The findings demonstrate an increasing recognition of the unique healthcare needs of displaced populations and the importance of tailored and context-specific interventions. The literature highlights the significance of collaboration between humanitarian organisations, governments, and local communities to ensure effective emergency healthcare responses over time.

4.2. Healthcare interventions and clinical practices

In the context of healthcare delivery during periods of conflict and crisis, a comprehensive approach that incorporates medical, psychological, and social services is imperative. Although established methodologies and best practices serve as a basis for providing care, exceptional cases present unconventional solutions and unique obstacles that broaden our comprehension of humanitarian healthcare. These research findings emphasise the pivotal significance of adaptable and context-specific healthcare interventions, as well as the necessity for coordination, integration, and cultural sensitivity in the delivery of humanitarian healthcare.

In the field of healthcare interventions and clinical practices, our examination has revealed distinct and noteworthy elements known as "outliers" that necessitate specialised attention

and strategies. These outliers encompass both the challenges encountered and the innovative approaches implemented within their respective domains.

4.2.1. Public Health Interventions

In the sphere of interventions in public health, the comprehensive examination of twenty-seven articles brings attention to various customary practices and remarkable deviations. Health initiatives place great importance on immunisation campaigns, specifically targeting children under the age of one and women of reproductive age, as central components (18,20). Despite this concentrated effort, the coverage of vaccinations, particularly against measles, falls short of the desired levels, with less than or equal to 80% of children being vaccinated. A persistent challenge is the recurring scarcity of critical antigens in health centres (18). Routine immunisations, including measles vaccinations, are integrated into healthcare initiatives within refugee camps. The emergence of innovative vaccination campaigns has proven to be effective in addressing concerns such as vaccine hesitancy, logistical obstacles in reaching remote areas, and the need for consistent vaccine availability (18,20). These campaigns emphasise the significance of community involvement and strategic planning.

Within the framework of public health recommendations and strategies (21), the reports underline the necessity of evaluating health and nutritional statuses, ensuring access to fundamental necessities such as food and water, delivering preventive and curative healthcare, implementing disease control measures, and incorporating mental health and reproductive health programs (20,22–26). National policy integration, coordination, and consistent monitoring play pivotal roles in these endeavours (27,28). The provision of medical evacuation programs, as observed during the Kosovo crisis, brings attention to the importance of urgent medical care for displaced populations (29). Conversely, difficulties with data collection, case identification, transportation, and post-treatment care may be regarded as exceptional cases.

Efforts to surveil and control diseases are essential components in preventing outbreaks within refugee settings. These initiatives include immunisation programs against infectious diseases as well as the delivery of services related to maternal and child health (18). The practice of providing WASH services is a customary approach (19,20). The COVID-19 pandemic has necessitated adaptive interventions, which include the establishment of isolation centres, telemedicine services, and infection prevention measures (30–35). Despite these customary practices, challenges arise due to limited resources, deficiencies in

infrastructure, and the adverse impact on mental health experienced by refugees because of prolonged isolation and uncertainty.

In specific circumstances, such as the crisis in Ukraine, emergency healthcare interventions are directed towards the utilisation of mental healthcare and psychosocial support and addressing the limited access to healthcare in both camp and urban settings (83,88,95,96). While these practices are customary in crisis settings, they underscore the importance of tailored approaches.

The emphasis on ensuring equitable access to healthcare services underscores the necessity of providing COVID-19 testing, treatment, and vaccination for migrants and refugees (34). Nevertheless, challenges arise due to language barriers, cultural disparities, and restricted access to essential medications and supplies, which categorise them as exceptional cases within this domain (36).

4.2.2. Strengthening Health Systems

Common approaches involve enriching the competencies and expertise of local healthcare personnel through training and capacity-building initiatives (17,23,37,38), constructing, and renovating healthcare facilities (17,39), and ensuring a continuous provision of vital medications and medical supplies (38,40,41). Conversely, exceptional cases underscore the significance of culturally sensitive healthcare practices, employing interpreters to address language barriers (38,41), engaging community-based healthcare workers to enhance healthcare accessibility and acceptance among affected populations (38,39,55,56), and recognising the significance of a coordinated surgical response in disaster and humanitarian settings (40).

Encountering obstacles in delivering healthcare to refugees and displaced populations represents notable deviations (38,61,62). Overcoming linguistic disparities between healthcare providers and refugees, comprehending, and respecting the cultural background of patients, and acknowledging constrained access to healthcare services due to factors such as overcrowding and limited resources play a pivotal role (39,61).

4.2.3. Mental Health Interventions for Refugees in Humanitarian Settings

There is a discernible shift on a global scale from frameworks that centre on vulnerability to those emphasising resilience and recovery (73). The practice of immediate PFA is widely adopted (67,73,76–79), underscoring the significance of human resilience. However, there

are challenges arising from limited resources and cultural diversity (23,28,39,73–77). While the integration of mental health and psychosocial support services with other sectors such as healthcare, education, and social services is deemed important, difficulties associated with resistance to integration, or a dearth of adequately trained personnel may also be considered exceptional cases.

The pivotal factors of capacity building, accessibility, and affordability of mental health services cannot be overstated. It is a common practice to enhance the capabilities of local healthcare workers and community members. Nevertheless, challenges stemming from resource constraints and cultural obstacles may deviate from the norm (73).

4.2.4. Primary and Secondary Healthcare Services

Standard procedures include the provision of healthcare services for mothers and children, basic emergency care during childbirth, and the management of prevalent diseases (17,19,23–26,37,39,41,55,61,86,91). Moreover, there are certain outliers, such as the challenges in advancing sexual and reproductive health and rights among migratory groups (86). This requires healthcare interventions and clinical practices that are culturally sensitive and responsive to the specific needs of these populations.

Women and girls in humanitarian settings are typically provided with reproductive health services, such as antenatal care and emergency obstetric care (18,22,25–27,41,63,91). However, challenges in offering family planning, antenatal and postnatal care, and addressing complications linked to unsafe abortions are considered atypical. The delivery of reproductive health care services to IDPs poses challenges, encompassing difficulties in providing family planning, antenatal and postnatal care, preventing and managing sexually transmitted infections, and addressing complications linked to unsafe abortions (63). The management of chronic conditions like diabetes and hypertension is of paramount importance (38), yet there are challenges in obtaining medications and diagnostic tests (81).

Emergency medical services, comprising ambulance services, emergency surgery, surgical care, trauma care, and emergency obstetric and newborn care, are critical for populations impacted by conflict and displacement (26,40,41,55). However, the implementation of these emergency interventions can pose challenges due to factors such as limited access to antivenom and healthcare personnel (98).

The restoration and equipping of health facilities impaired by conflict are imperative to ensure the provision of essential health services (26). This is a complex but essential part of clinical practices and healthcare interventions in humanitarian circumstances, requiring significant time and resource investment.

4.3. Effectiveness of Humanitarian Healthcare

The findings presented offer insights into the effectiveness of humanitarian healthcare interventions in addressing critical healthcare needs for forcibly displaced populations in challenging environments. Despite facing challenges, successful approaches have emerged, showcasing the resilience of humanitarian organisations and the communities they serve.

Humanitarian healthcare encounters various challenges, including resource limitations, inadequate funding, political complexities, and logistical coordination issues (63,71,86,93). Resource scarcity and insufficient infrastructure in conflict-affected areas impede access to healthcare, thereby exacerbating the vulnerability of displaced populations (10,35,64,84,88). Shortages of essential medications and inadequate training for healthcare providers further compound these challenges (99). Addressing these challenges requires evidence-based interventions and prioritising quality assurance (10,50). This necessitates strong partnerships between humanitarian organisations and local health systems, as well as a commitment to meeting the unique healthcare needs of displaced populations (34).

The positive impact of humanitarian healthcare interventions is evident in the reduction of morbidity and mortality rates among displaced populations, particularly in maternal and child health services (67). Interventions such as mobile clinics that offer antenatal care and immunisation have played a pivotal role in improving health outcomes (18,22,23,25–27,37,42,67,91).

Despite these obstacles, humanitarian healthcare interventions have made significant progress in areas such as primary healthcare, maternal and child health services, mental healthcare, and crisis management (64). Notable successes include collaborative medical evacuation programs and advancements in snakebite envenoming management (98). The impactful mission of the *Refugee Zakat Fund* has played a crucial role in providing essential cash assistance to vulnerable refugees and internally displaced persons, ensuring basic needs like food, shelter, and healthcare are met (53).

Promising advancements in healthcare interventions have emerged. This involves the use of triage skills based on physiology and technology-enhanced training programs.

Additionally, CBIs have played a crucial role in improving access to healthcare services and addressing underlying health issues (60).

Mental health and psychosocial support interventions have exhibited promising outcomes in enhancing mental health results (10,28,83,85). These interventions, which incorporate evidence-based practices such as group-based cognitive behavioural therapy and trauma-focused therapy, have led to a decrease in symptoms related to depression, anxiety, and post-traumatic stress disorder (2,19,22,24–28,31,35–37,42,43,49–52,55–62,65–71,77–79,84,89–92,94,95,100–102).

Evidence-based guidelines for surgical care have positively impacted the quality of surgical care in disaster and humanitarian emergencies (40). Efforts to combat SGBV have involved the implementation of screening and referral protocols within healthcare settings (100).

Despite these encouraging outcomes, challenges persist, including the necessity for culturally sensitive care and further research to determine the effectiveness of interventions. Initiatives like the *Daily Bread* intervention have been well-received and have enhanced the comprehension and utilisation of PFA techniques of the participants (77). Furthermore, projects such as the *Uganda Psychosocial Project* have effectively improved the psychosocial well-being of children and families affected by conflict, resulting in enhanced mental health, increased social support, and capacity building for healthcare professionals (79).

Effective healthcare interventions and clinical practices play a crucial role in managing crises, such as the COVID-19 pandemic among refugee populations (30–35). These interventions address challenges such as shortages of vital medical supplies, disruptions in supply chains, and obstacles to healthcare access. Effective crisis management for refugee populations during events like the COVID-19 pandemic relies on inclusive measures, access to healthcare, socio-economic support, and addressing protection concerns (34). To mitigate risks, a national infection prevention and control program with WASH standards in healthcare facilities is crucial. Additionally, providing livelihood support through cash transfers and technical assistance helps meet basic needs during such crises (31).

Needs assessments have played an indispensable role in informing humanitarian responses, facilitating the distribution of relief items, prioritising assistance, and guiding the allocation of resources (70). This data-driven approach ensures that resources are allocated efficiently and effectively to address the most urgent needs of displaced populations (70).

Promoting self-reliance and empowerment among displaced populations, as demonstrated by initiatives like the RAD initiative in Uganda, enhances food security, livelihoods, mental health, and overall well-being (39).

Recommended infant feeding practices significantly impact infant health in emergencies, reducing the risk of HIV transmission and benefiting both infants and mothers (90).

Community-based surveillance systems effectively respond to health crises, empowering local populations to monitor and report potential threats (59). Integration of palliative care and symptom relief is crucial for alleviating suffering during humanitarian crises, recognising its importance from both medical and moral standpoints (89).

Efforts to strengthen health systems are essential, particularly in responding to the increasing number of trauma cases due to conflict. Collaboration within health clusters plays a pivotal role in providing essential healthcare services to conflict-affected regions and internally displaced persons, addressing challenges posed by ongoing insecurity and the closure of health facilities (55).

The findings presented in this section provide insight into the effectiveness of humanitarian healthcare interventions in addressing the critical healthcare needs of forcibly displaced populations in challenging and conflict-affected environments. Despite encountering numerous challenges, several successful approaches have emerged, demonstrating the resilience of both humanitarian organisations and the displaced communities they serve.

4.4. Limitations of the Study

This study, while attempting to provide a comprehensive analysis of emergency healthcare response in settings of forcibly displaced people, is not without its limitations. These limitations, inherent to the research process and interpretation of results, should be considered:

The study was conducted by a single researcher, potentially introducing biases associated with individual viewpoints and prior experiences. Given the background of the researcher and experience in the field, there is a risk of confirmation bias, where pre-existing beliefs or knowledge may unintentionally influence the analysis and interpretation of findings.

Furthermore, the scope of this study was confined to specific research questions within the domain of emergency healthcare response in settings of forcibly displaced people.

Consequently, some relevant subtopics or aspects of the broader field may not have been explored in depth. It lacks an extensive exploration of the political and legal dimensions influencing healthcare access, such as asylum policies, human rights concerns, and governance challenges. Additionally, socioeconomic factors like poverty, inequality, inadequate sanitation, and environmental issues - significant determinants of health in displaced populations - are not deeply examined. Disease prevention programs, health education initiatives, and strategies promoting healthier practices among displaced communities are also not extensively covered. One such area involves examining the humanitarian action versus voluntourism discourse. This includes critical analyses of the repercussions, effectiveness, and ethical considerations surrounding volunteer activities in humanitarian crises. Discussions could encompass the sustainability of these endeavours, the role of volunteers in humanitarian contexts, the disjunction between volunteer expectations and reality, and their impact on displaced communities.

Moreover, the study overlooks discussions on innovative technologies like telemedicine or digital health solutions that could potentially enhance healthcare delivery in such challenging contexts. Furthermore, specific healthcare strategies tailored for rapid humanitarian crises or unexpected catastrophic events in displaced settings are not extensively discussed within the limitations of the study. These unexplored areas could offer valuable insights into the complexity of emergency healthcare responses in forcibly displaced populations.

An additional constraint lies in the variability of how interventions are assessed, posing challenges in conducting a standardized and equitable comparative analysis among different interventions.

The findings and conclusions drawn from this study may not be universally applicable to all contexts and populations within forcibly displaced settings. Variability in healthcare infrastructure, cultural factors, and resource availability can limit the generalisability of the results.

The reliance on existing literature means that the data may not be entirely up-to-date or comprehensive. The relevance and applicability of findings can be constrained since they may not have considered the most recent developments and emerging techniques in the field.

Moreover, the focus of the study on English-language literature may exclude valuable insights from research published in other languages. Another limitation of the study is the utilisation of occasional references selected by the author (grey literature).

Despite these limitations, this study aims to contribute to the understanding of emergency healthcare response in forcibly displaced populations and provide valuable insights for further research and policy development in this critical area.

5. Conclusions

The systematic evaluation of one hundred studies has significantly advanced our understanding of emergency healthcare in settings of forcibly displaced people. This research has revealed the importance of customized healthcare for this vulnerable population, particularly in addressing mental health issues and providing specialised interventions. Moreover, it underscores the significance of evaluating healthcare efficacy and quality, emphasising the vital roles of humanitarian organisations, coordination systems, and partnerships in delivering emergency healthcare services.

What emerges from this body of work is a growing appreciation for multidisciplinary research, innovation, and evidence-based approaches in the realm of emergency healthcare for forcibly displaced populations. We now recognise that healthcare should not merely be seen as a goal but as a valuable resource that encompasses physical, social, and mental well-being. Collaboration among humanitarian organisations, governments, and local communities remains pivotal for the sustained effectiveness of emergency healthcare solutions.

Despite these advancements, persistent challenges demand continued attention. Promoting preventative attitudes within the target population and enhancing access to quality healthcare services remain imperative. Furthermore, the empowerment and active participation of affected communities must be prioritised. Embracing technology and innovation can further revolutionize healthcare delivery in humanitarian contexts. Similarly, there is a persisting need to standardize the evaluation of interventions and programs to better analyse and compare interventions.

Finally, while addressing the healthcare needs of forcibly displaced populations is paramount, we must adopt a comprehensive approach encompassing social, psychological, and environmental factors. By recognising the agency and resilience of forcibly displaced individuals, fostering inclusivity, addressing root causes, and leveraging innovation, we can collectively work toward a more compassionate, equitable, and inclusive world where the well-being of all is upheld, regardless of their migratory status.

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