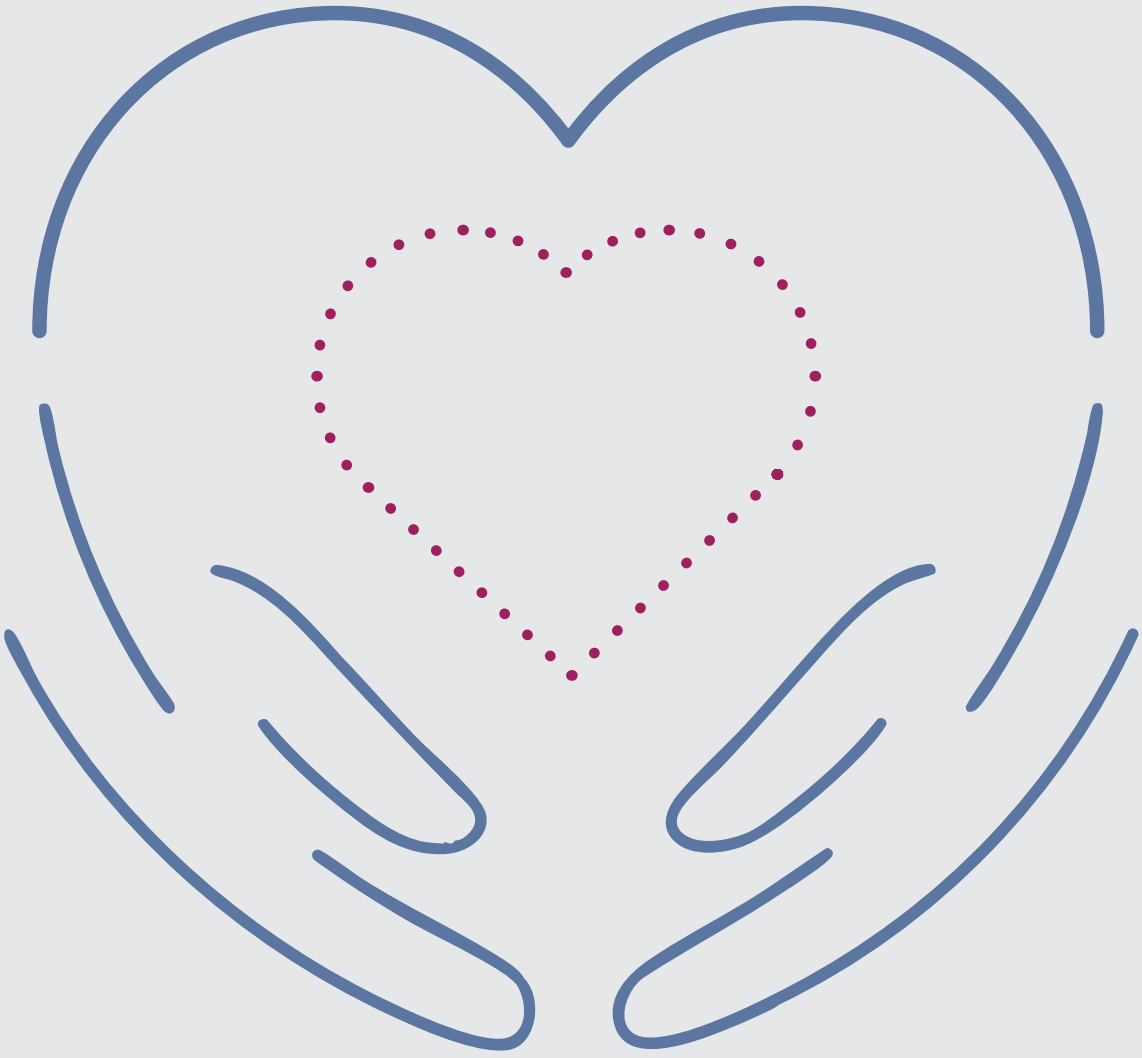
HER HEALTH, OUR FUTURE

The Case for Evidence-Based Abortion Care in Humanitarian Policy and Funding



CONTENTS

FOREWORD

At Elrha, we believe that humanitarian action must be grounded in evidence, driven by innovation and responsive to the realities faced by those most affected.

The right to health – including sexual and reproductive health (SRH) – is universal, and, in times of crisis, it becomes even more urgent as women and girls are at an increased risk of sexual violence and unintended pregnancy. Yet, safe abortion care remains one of the most neglected areas in humanitarian health responses despite the overwhelming evidence of need, supportive legal and policy frameworks, and the availability of effective, scalable solutions.

This evidence-based policy brief, Her Health, Our Future, presents a compelling case for integrating comprehensive abortion care into humanitarian policy and practice. It draws on research and field-tested innovations (including projects that we at Elrha are proud to have supported) to show that safe abortion care is not only feasible in crisis settings – it is essential. The evidence is clear: unsafe abortion is a leading cause of preventable maternal death, and the needs in crisis-affected settings are particularly acute. But solutions exist, and they work, as the evidence in this policy brief demonstrates. The evidence also shows that cultural, social and moral barriers to safe abortion provision can be overcome through proven interventions that address values, attitudes and understanding.

We are proud to support research and innovation that challenges the status quo and drives meaningful change. Through our Humanitarian Innovation Fund (HIF) and Research for Health in Humanitarian Crises (R2HC) programmes, we have seen firsthand how evidence-based approaches can transform health outcomes, empower communities and influence global policy. We are committed to ensuring that the voices of women and girls in crisis settings are heard, their rights respected and their health needs met. This policy brief is a call to action – for policymakers, funders, humanitarian organisations and global leaders. It is time to move beyond rhetoric and toward action that is bold, inclusive and grounded in evidence. Safe abortion care is life-saving healthcare. It is a human right. And it must be part of every humanitarian response.

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Kate Maina-Vorley
Chief Executive Officer, Elrha

CALL TO ACTION

The case for tackling an entirely preventable cause of maternal death in humanitarian crises.

Women and girls in humanitarian crisis settings face both increased risks of unintended pregnancy and barriers to safe reproductive care. Unsafe abortion is the only cause of maternal death that is completely preventable[1] – yet it accounts for 7.9% of maternal deaths globally and up to 25 to 50% in refugee settings.[1,2] Safe abortion care remains largely absent from humanitarian health responses, despite clear evidence of both urgent need and effective solutions.

This policy brief draws on robust evidence to define key terms and concepts, assess the scale of need for safe abortion care in humanitarian settings, review the policy and legal context, explore proven, scalable and affordable solutions and provide high-level policy recommendations. It is a clear call to action for humanitarian policymakers and coordinators operating at global, national and field levels (including governments), donors and humanitarian health-implementing organisations. Alongside ensuring access to contraception to prevent unintended pregnancy, safe abortion care must be recognised as a humanitarian priority.

Why we need to take action now

Humanitarian contexts face extreme challenges – limited resources, donor restrictions, political sensitivities and fragile health systems. Yet these very constraints make abortion care indispensable. When 84% of women resort to unsafe methods,[3] the cost of neglect far outweighs the modest investment required to prevent complications. Unsafe abortion consumes scarce emergency resources, whilst proven innovations – self-managed abortion (SMA), community distribution, rapid training – offer low-cost, scalable solutions that save lives and preserve health system capacity. Women and girls make up half of crisis-affected populations. They deserve the same rights and health protections as anyone else. The evidence, tools and legal obligations already exist – what remains is the will to act.

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What must be done

Alongside ensuring access to contraception so that women and girls can prevent unintended pregnancies, humanitarian actors must strengthen the provision of safe abortion care.

Governments must clarify and implement legal frameworks that enable abortion care, lead by example in funding and policy, and recognise reproductive rights in emergencies as both a legal duty and a measure of humanitarian leadership. Community-led solutions must be prioritised and resourced.

Donors must provide unrestricted funding in line with international law and medical standards, diversify resources for sustainability, and ensurewomen's SRH needs – including safe abortion – are explicitly supported and measured. Community-driven initiatives must be central.

NGOs must fully implement the Minimum Initial Service Package (MISP) for SRH (priority SRH activities, including comprehensive abortion care)[4] and integrate abortion care as standard practice in humanitarian health services.

They must also train staff through values clarification and attitude transformation (VCAT) and Sexual and Reproductive Health Clinical Outreach Refresher Trainings (S-CORTs).[5] Adopting innovative, community-adapted models – including SMA support, community-based distribution and digital health interventions – is also essential.

Lastly, NGOs must allocate sufficient resources, champion women's rights and use their influence to unify stakeholders around evidence-based strategies.

UN agencies must also ensure full implementation of the MISP,[4] ensure essential reproductive health supplies are present in emergencies and leverage their convening power to integrate abortion care into humanitarian coordination. They must also hold governments accountable to their international obligations.

The evidence is clear, and the moral imperative undeniable: safe abortion care saves lives, protects human rights and strengthens public health in humanitarian crises. Every day of inaction leads to preventable deaths, unnecessary suffering and violations of rights. The humanitarian community cannot continue to exclude half the population from essential, life-saving healthcare. What is needed now is decisive, collective action.

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72

The MISP is the global standard for SRH humanitarian response, with implementing organisations and Health Cluster Leads responsible for ensuring its implementation. It includes comprehensive abortion care as a priority action that should be initiated within the first 72 hours of an acute emergency. It was established by the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) and endorsed by humanitarian actors, including UN agencies, NGOs and donors.

Key terms and definitions

To ensure this policy brief is clear and actionable, we have included an introduction that defines key terms and concepts used throughout the document.

Comprehensive abortion care encompasses three interconnected components:[4,6]

- **Safe abortion care**: Abortions carried out using World Health Organization (WHO)-recommended methods appropriate to the gestational age, provided by someone with the necessary skills. This includes medication abortion (using misoprostol alone or in combination with mifepristone) and procedural methods such as manual vacuum aspiration (MVA).
- **Post-abortion care**: Medical and related interventions for managing complications from both spontaneous and induced abortions, whether safe or unsafe. Post-abortion care is a fundamental component of emergency obstetric care and should be universally available without delay, denial of service or breach of patient confidentiality.
- **Contraception counselling and related services**: Information and access to family planning methods to prevent future unintended pregnancies, recognising that abortion and contraception are complementary components of reproductive healthcare.

Minimum Initial Service Package (MISP) for SRH: A set of priority SRH activities to be implemented at the onset of every humanitarian emergency. It was established by the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) and endorsed by humanitarian actors, including UN agencies, NGOs and donors.[4]

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Specifically, abortion care is integrated across the following MISP objectives:

- **MISP Objective 2 (Prevent sexual violence and respond to the needs of survivors)**: Safe abortion care for survivors of sexual violence, including the provision of emergency contraception and access to safe abortion services regardless of national law.
- **MISP Objective 4 (Prevent excess maternal and newborn morbidity and mortality)**: Post-abortion care as an integral signal function of basic and comprehensive emergency obstetric and newborn care (BEmONC/CEmONC). Post-abortion care should be available without delay, denial of service or breach of patient confidentiality.
- **Other MISP Priority**: Safe abortion care available to the full extent of the law in health centres and hospitals, with provision of contraceptives as part of both post-abortion care and safe abortion care.

Values clarification and attitude transformation (VCAT): Structured workshops that help healthcare providers, policymakers and community stakeholders explore their personal values, attitudes and knowledge related to abortion in a safe, non-judgemental environment. Evidence shows VCAT significantly increases provider willingness to offer abortion services.

Community-based distribution (CBD): An approach where trained community members or non-physician providers deliver health services – including medication abortion information and supplies – at the community level, rather than at a medical facility.

Safe and unsafe abortion defined

Safe abortion

WHO recommends and recognises two primary methods of safe abortion:[6,7]

1. **Medication abortion**: Using medications to end a pregnancy, either with a combination of mifepristone (200mg) followed by misoprostol (800mcg for pregnancies under 13 weeks, 400mcg for 13 to 24 weeks), or misoprostol alone (800mcg every three hours). These methods are highly effective (87 to 98% success rates) and can be safely used in a facility or as part of a **self-managed abortion (SMA)**.[6,7] A SMA is where a person manages some or all steps of the process outside formal clinical settings. They are guided by accurate information and have access to clinical backup care, if necessary.[6]

2. **Procedural abortion**: Using MVA or other surgical techniques performed by trained healthcare providers. MVA is particularly appropriate for pregnancies under 14 weeks. It's recognised as a signal function (ie a specific, measurable medical activity that indicates whether a health facility has the capacity to provide a certain level of care) of basic emergency obstetric care.[6]

Unsafe abortion

This is a leading preventable cause of maternal mortality and morbidity worldwide.[1,8] According to WHO, unsafe abortion is a procedure for terminating a pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.[6] Unsafe abortion practices include the use of dangerous methods such as insertion of foreign objects, ingestion of caustic substances, external abdominal trauma, or carrying out traditional practices that lack medical evidence of safety or effectiveness.[6,8]

What are humanitarian settings?

For the purposes of this policy brief, humanitarian settings include contexts affected by armed conflict and post-conflict situations; natural disasters and climate-related emergencies; forced displacement (refugees and internally displaced persons); complex emergencies combining multiple crises (including outbreaks of infectious disease); and fragile health systems due to political instability or state fragility.

These settings share common characteristics: disrupted health infrastructure; limited access to services; heightened protection risks, particularly gender-based violence; breakdown of social support systems; and populations with urgent, often unmet health needs. Women and girls in these contexts face compounded vulnerabilities that increase both their risk of unintended pregnancy and barriers to accessing safe reproductive healthcare.

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1. CONTEXT AND EVIDENCE OF NEED

Humanitarian crises disproportionately affect women and girls, creating conditions that simultaneously increase both unintended pregnancy and barriers to safe abortion care.

Currently, over 300 million people worldwide require humanitarian assistance,[9] with women and girls comprising half of all displaced populations.[10] In crisis-affected settings, women face heightened risks due to sexual violence, disrupted family planning services, breakdown of social protection systems and collapse of health infrastructure.

Scale and drivers of need

Globally, nearly half of all pregnancies – 121 million – are unintended, with six out of ten ending in induced abortion.[11] In humanitarian settings, multiple drivers compound this challenge: sexual and GBV increases dramatically; contraceptive services and broader health systems are disrupted or unavailable; economic instability forces difficult reproductive choices; and social protection systems collapse, leaving women without support.[12,13]

Women and girls seek abortion for complex reasons: fear of community stigma when raising children born of rape; economic constraints due to displacement; lack of male family support due to conflict-related separation; and disrupted marital and social norms.[14] In many humanitarian settings, women face additional barriers such as the need to obtain a male family member's permission and/or have them accompany her to access reproductive healthcare services or facilities, which limits their ability to seek help independently.

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Severity of outcomes

Recent research provides unprecedented insight into the scale and severity of abortion-related harm in humanitarian settings. A study across refugee settings in Uganda and Kenya found that despite comparable abortion rates to host countries, outcomes for refugees having abortions are far more dangerous – they are significantly more likely to experience life-threatening complications requiring emergency medical intervention and face substantially higher risks of maternal death.[3] The study revealed that 84% of refugee women use non-WHO-recommended methods, with 88 to 98% experiencing warning signs of complications, yet only 5% seek care from formal healthcare systems.[3]

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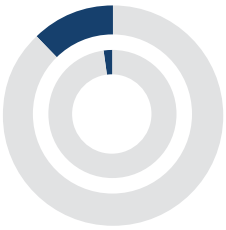

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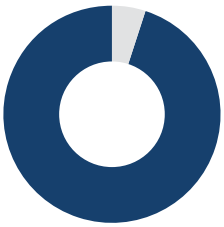


5%

yet only 5% seek care from formal healthcare systems.[3]

Figure 1: Recent research shows that outcomes for refugees having abortions are far more dangerous than in stable settings

Hospital-based studies reveal alarming severity patterns. Research from Central African Republic and Nigeria found that over 50% of abortion complications were severe, with over 65% classified as severe in the Nigerian hospital – significantly higher than in stable settings.[15] In some contexts, such as Central African Republic, abortion-related complications represent up to 30% of the country's maternal deaths.[15] Near-miss abortion complications were 1.6 times more frequent and severe life-threatening complications were seven times more frequent in humanitarian settings compared to African hospitals in stable settings.[15]

System failures

Current humanitarian responses fall critically short, including for abortion care. The MISP includes safe abortion care as a priority action, yet implementation remains inconsistent across organisations and settings.[4]

Multiple reviews have documented persistent gaps in sexual and reproductive health and rights (SRHR) service utilisation and provision across humanitarian contexts.[12,16] A baseline assessment by the Sexual and Reproductive Health Task Team, under the Global Health Cluster, found that only half of activated Health Clusters have fully established SRH working groups, highlighting coordination gaps that affect comprehensive service delivery.[17] Assessment data shows limited facility capacity, with only five of 27 health facilities surveyed in refugee settings reporting provision of safe abortion services.[3] Research examining progress and gaps in reproductive health services across three humanitarian settings has confirmed these systemic shortcomings.[16]

Research in northern Ethiopia's humanitarian setting found that only **64%** of women reported receiving person-centered care consistently, with communication gaps preventing women from asking questions about their treatment.[18]

Quality of care data reveals systematic deficiencies even where services exist. Research in northern Ethiopia's humanitarian setting found that only 64% of women reported receiving person-centred care consistently, with communication gaps preventing women from asking questions about their treatment.[18] A multi-country study of post-abortion care in African hospitals in humanitarian settings confirmed these patterns, finding that less than two-thirds of women reported receiving the best care all the time.[19] Post-abortion contraceptive counselling – critical for preventing repeat unintended pregnancies – is rarely provided despite client interest.[18,19]

The consequences of these shortcomings are devastating. Unsafe abortion is the only cause of maternal death that is completely preventable.[1] It accounts for 7.9% of all maternal deaths worldwide.[1] In humanitarian settings, this figure rises dramatically, with historical estimates suggesting 25 to 50% of maternal deaths in refugee settings result from abortion complications.[2] Despite this urgent need and the moral right to access reproductive healthcare,[20, 21] safe abortion care remains largely excluded from humanitarian health responses.[22, 23] A comprehensive scoping review of barriers and facilitators to safe abortion care in humanitarian crises has documented the multifaceted challenges preventing access.[24]

2. LEGAL, POLICY AND HUMAN RIGHTS FRAMEWORKS

Abortion care is aligned with, and enshrined in, legal, policy and human rights frameworks.

International humanitarian and human rights law provides clear protections for women and girls that include access to comprehensive reproductive health services, including abortion care.[13,20,21,25,26] The Geneva Conventions establish fundamental principles of medical neutrality and the right to healthcare without discrimination.[27] UN Security Council Resolutions 2106 and 2122 specifically address sexual violence in conflict and support access to comprehensive services for survivors, including abortion care regardless of national law.[25,26] Reproductive health is fundamentally recognised as a right for refugees and internally displaced persons under international frameworks.[13]

Figure 2: A timeline of key milestones for safe abortion care

- **1949** Geneva Convention relative to the Protection of Civillian Persons in Time of War (Fourth Geneva Convention)
- **1979** Convention on the Elimination of All Forms of Discrimination against Women
- **1994** International Conference on Population and Development Programme of Action
- **1999** Minimum Initial Service Package (MISP) for SRH
- **2003** Maputo Protocol adopted by the African Union
  World Health Organization Abortion care guidelines published
- **2013** UN Security Council Resolutions 2106 (sexual violence in conflict) and 2122 (women, peace and security)
- **2016** United Nations Human Rights Council. Resolution 32/32 on preventable maternal mortality and morbidity and human rights

Comprehensive abortion care in humanitarian crisis settings is aligned with, and enshrined, in multiple legal, policy and human rights frameworks endorsed by international actors and governments globally.

Human rights foundations

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) requires States parties globally to ensure access to healthcare services, including reproductive health, and eliminate discrimination in healthcare provision.[20] The International Conference on Population and Development (ICPD) Programme of Action recognises reproductive rights as human rights and calls for access to comprehensive reproductive health services.[21]

The Maputo Protocol, adopted by the African Union in 2003 and currently signed and ratified by 42 African states, explicitly guarantees women's right to reproductive autonomy and abortion in cases of rape, incest and threats to maternal mental and physical health.[28]

Evolving legal landscape

Recent legal developments strengthen these protections. The European Court of Human Rights has recognised that denying access to lawful abortion services can constitute torture or inhuman and degrading treatment.[29] UN human rights treaty bodies increasingly recognise that barriers to abortion access violate multiple human rights, including rights to life, health, privacy and freedom from torture.[30,31] The UN Human Rights Council has explicitly called for ensuring access to safe abortion services in humanitarian settings as a matter of international law.[30]

Humanitarian law protections

International humanitarian law provides specific protections that can supersede national restrictions in humanitarian contexts.[32,33] The principle of medical neutrality requires that healthcare be provided based on medical need without political interference.[32,33] Legal experts increasingly recognise that denying abortion services in humanitarian emergencies – where women face heightened risks of sexual violence and limited alternatives – can constitute a violation of international human rights law.[22,30]

> **WHO's 2022 Abortion care guideline provides authoritative clinical evidence-based recommendations demonstrating that quality abortion care is essential healthcare and can be safely provided by trained mid-level providers using medication or MVA at primary care level.[6]**

WHO's 2022 Abortion care guideline provides authoritative clinical evidence-based recommendations demonstrating that quality abortion care is essential healthcare and can be safely provided by trained mid-level providers using medication or MVA at primary care level.[6] WHO has also published comprehensive guidance on abortion more broadly.[7] Additionally, technical guidance is being developed through platforms such as the Global Health Cluster, Sphere standards and the IAWG to further operationalise safe abortion care in humanitarian settings.[4,34]

However, despite these robust legal frameworks and growing technical guidance, implementation remains critically limited. Weak political will and inadequate funding – rather than lack of evidence or technical knowledge – are the primary barriers preventing these frameworks and standards from being translated into life-saving practice on the ground.[22,23] The tools, evidence and legal obligations exist; what is lacking is the commitment to act.

Legal obligations for humanitarian actors

These frameworks create clear obligations for humanitarian actors, yet significant barriers prevent implementation. Weak political will, inadequate funding, restrictive donor policies, organisational resistance, stigma and misunderstanding of legal protections undermine compliance with international legal standards.[22,23,35]

States have primary responsibility for ensuring access to comprehensive reproductive health services for all populations within their borders, including refugees and displaced persons.[13,20] International organisations and NGOs have complementary obligations to provide services consistent with international law and professional medical standards.[6,27] Donors must enable – not obstruct – compliance with international legal obligations.[22,23]

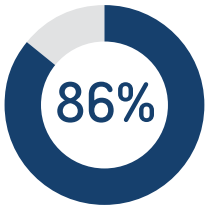
These legal frameworks exist but remain largely unenforced – not because they lack legitimacy, but because humanitarian actors have failed to prioritise implementation. Closing this gap requires confronting internal barriers, securing adequate funding independent of restrictive donors and building political courage to uphold legal obligations.[23,35]

3. IMPLEMENTATION MODELS

EVIDENCE FROM HUMANITARIAN SETTINGS

The evidence base demonstrates that safe abortion care is highly effective in humanitarian settings when proper support, training and political will exist.[5,35–39]

Safe abortion can be safely provided by trained mid-level providers using medication (misoprostol alone or in combination with mifepristone) or MVA at primary care level.[6,8] Multiple innovative delivery models have achieved remarkable success rates – with over 86% of abortions completed safely without requiring additional intervention, and complication rates under 5% – whilst maintaining safety and quality standards.[35–37]



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Self-managed abortion (SMA)

Evidence from both stable and humanitarian settings demonstrates transformative potential for SMA approaches. A comprehensive scoping review identified multiple models for delivering SMA care across diverse contexts – including telemedicine support, community-based accompaniment, hotline counselling and pharmacy-based provision – with effectiveness rates (defined as complete abortion without the need for additional intervention) consistently above 80% when proper support systems are in place.[40]

The first data on abortion incidence in humanitarian settings comes from Elrha's R2HC programme-funded research published in 2025. Using respondent-driven sampling among women in refugee and internally displaced persons settlements in Uganda and Kenya, Jayaweera et al. (2025) documented abortion incidence rates and found that self-managed medication abortion was common and generally safe when women had access to accurate information and quality medications, though complications still occurred when women used unsafe methods.[3] Studies from stable settings show that SMA with medication can achieve success rates of 87 to 98% when combined with appropriate counselling and follow-up support.[40,41]

Research specifically examining SMA potential in humanitarian contexts identifies key advantages, including increased privacy and autonomy, reduced facility burden and lower resource requirements.[42] Digital health interventions show particular promise: the Aya Contigo programme in Venezuela – a multi-faceted digital intervention providing remote counselling, abortion information and follow-up support via an app, a virtual platform and a hotline – demonstrated high user satisfaction, with 89% of users rating the service as excellent or very good, and 95% reporting they would recommend it to others.[43]

Evidence from a Médecins Sans Frontières (MSF) pilot in the Middle East demonstrates how self-managed medication abortion with telehealth support translates to humanitarian settings.[36] The programme achieved 86% success rates with minimal resource requirements – operating with just a mobile phone, internet connection and abortion medications – through a telehealth model providing remote counselling and support for medication abortion. Only three out of 22 cases required surgical intervention for incomplete abortion or ongoing pregnancy.[5]

Systematic scale-up in restrictive legal contexts

A comprehensive MSF initiative across ten projects in sub-Saharan Africa demonstrates that systematic implementation of safe abortion care is possible even in highly restrictive legal environments.[35] From 2017 to 2019, MSF implemented a six-component intervention package addressing internal organisational barriers, including VCAT workshops, clinical training, stakeholder engagement, security assessments, implementation planning and systematic data collection.[35]

The results were remarkable: provision scaled from three safe abortions in Q1 2017 to 759 in Q4 2019, with teams providing 3,640 first and second trimester abortions over the three-year period.[35] Over 99% were medication abortions using mifepristone and misoprostol, with 85% provided before 13 weeks' gestation and 14% between 13 and 22 weeks.[35] The overall complication rate was 4.29%, with only 0.3% experiencing severe, life-threatening complications such as infection or haemorrhage requiring blood transfusion – all successfully managed without a single maternal death.[35] Notably, no major security incidents were reported despite initial fears that providing abortion services would endanger staff and operations.[35]

However, the data also revealed important challenges that humanitarian actors must anticipate when introducing medication abortion and SMA services. Adolescents under 18 faced higher refusal rates compared to adults, with only 90% of adolescents receiving services compared to 96% of adults,[35.] highlighting the need for specific policies addressing adolescent access.

Patients seeking second trimester services faced even greater barriers, with only 75.8% receiving care compared to 99.5% of first trimester patients.[35] The complication rate for second trimester medication abortion (9.72%) was higher than in the first trimester (3.02%), though still manageable with additional misoprostol doses or procedures.[35]

Critical to success was addressing internal resistance through VCAT workshops, which increased staff support for providing abortion care from less than 50% to over 80%.[35] The experience demonstrates that barriers to safe abortion care in humanitarian settings are often more internal than external – related to stigma, fear and personal beliefs rather than actual legal or security constraints.[35] The MSF model provides a replicable roadmap for other humanitarian organisations seeking to move from abortion care policy to systematic implementation.

Community-based distribution and rapid scale-up

The Thailand-Burma border programme – a community-based distribution model where trained community health workers provided misoprostol and counselling for early abortion in a conflict-affected area with restrictive abortion laws – offers compelling evidence of safety and effectiveness even in legally restricted environments.[37] From 2012 to 2014, 918 women received early abortion care through community-based misoprostol distribution, with 96.4% success rates and no major complications.[37]

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The experience of Ipas in the Bangladesh Rohingya crisis response demonstrates that comprehensive services can be rapidly implemented even in acute emergency settings, when coordinated multi-stakeholder engagement, favourable legal frameworks, evidence-based service delivery and adequate funding align.[14] Within one month, over 300 healthcare workers were trained and more than 8,000 refugees received abortion care through 37 health facilities.[38]

Training and capacity building

A significant barrier to safe abortion care implementation is healthcare provider attitudes, stigma and personal beliefs about abortion, which can prevent services from being offered even where they are legally permitted and clinically feasible. VCAT workshops with health workers and NGO staff successfully address this barrier by shifting healthcare provider attitudes related to abortion provision.[5] In Nigeria, VCAT training significantly increased healthcare workers' willingness to provide abortion-related services within the legal framework, improving provider attitudes from 40% willing to 90% willing after training.[44]

VCAT is not about changing people's personal values or beliefs about abortion; rather, it creates a safe, non-judgemental space for healthcare providers to reflect on their professional obligations to provide legal, life-saving care regardless of their personal views. The workshops help providers distinguish between their personal beliefs and their professional responsibilities to ensure all patients receive quality care without discrimination.

Evidence from Nigeria shows that VCAT workshops provide opportunities for potential gatekeepers to explore their values, attitudes and knowledge related to abortion, with documented improvements in willingness to provide services increasing from 40% to 90%.[5,44] This demonstrates that addressing provider attitudes and fears is as critical as addressing legal and policy barriers.

Provider attitudes represent a critical determinant of care quality. Research in northern Ethiopia found that person-centered care – including respectful communication, privacy protection and opportunities for women to ask questions – was inconsistently delivered, affecting women's experience and willingness to seek care.[18] Addressing provider attitudes through VCAT must be paired with structural changes that enable providers to deliver quality, respectful care, including adequate time for consultations, private spaces and systems that protect patient confidentiality.

Addressing provider attitudes alone is insufficient if community stigma prevents women from seeking care. Research from North and South Kivu, Democratic Republic of the Congo, shows that community attitudes toward abortion can shift through engagement.[45] While abortion stigma was widespread in these conflict-affected settings, community attitudes became more nuanced when discussing specific circumstances like rape. A majority believed all women should have access to life-saving post-abortion care, indicating openings to destigmatise access even in challenging contexts.[45] However, fear of stigma significantly influences care-seeking behaviour, underscoring why protecting privacy and autonomy in service delivery is essential.[45]

Beyond addressing attitudes, healthcare providers need practical clinical skills and updated knowledge to provide safe abortion care confidently and competently. The S-CORTs model demonstrated that it is feasible to rapidly train large numbers of providers whilst maintaining quality – over 500 healthcare providers across Uganda, Nigeria and the Democratic Republic of the Congo showed documented improvements in knowledge scores and service quality indicators.[5] These training models prove that quality gaps can be addressed through targeted, evidence-based interventions.

Person-centered care and quality improvements

Research from northern Ethiopia's humanitarian setting reveals critical quality gaps in abortion care delivery that affect women's experience and outcomes. Only 64% of women receiving comprehensive abortion care reported consistently receiving person-centered care, with significant communication barriers preventing women from asking questions about their treatment.[18] These findings underscore the need for quality improvement initiatives that go beyond technical competence to address respectful, women-centered care practices, including building systems to protecting privacy and autonomy.[15,25]

Post-abortion contraceptive counselling remains a persistent gap despite its importance for preventing repeat unintended pregnancies. Studies across humanitarian settings consistently show that contraceptive counselling is rarely provided even when clients express interest.[18,19] This represents a missed opportunity to support women's reproductive autonomy and reduce future unintended pregnancies in crisis-affected populations.

Successful implementation of post-abortion care strategies in conflict-affected contexts, such as in Kinshasa, the Democratic Republic of the Congo, demonstrates that quality improvements are achievable with appropriate investment and commitment.[46]

Safe abortion care can be implemented regardless of legal contexts

The following case studies demonstrate that safe abortion care can be successfully implemented across diverse humanitarian contexts regardless of legal framework. These examples span conflict-affected areas (Thailand-Burma border, Bangladesh), protracted displacement settings (Ethiopia) and countries receiving large numbers of migrants fleeing humanitarian crises (Colombia).

Legal contexts range from highly restrictive (Thailand and Myanmar, with near-total bans) to progressive frameworks that permit abortion on broad grounds (Bangladesh's menstrual regulation policy, Colombia's decriminalisation up to 24 weeks). What unites these varied settings is the humanitarian imperative: populations affected by crisis, displacement or violence who face heightened reproductive health risks and barriers to accessing safe services. The evidence shows that where political will, adequate resources and strategic implementation approaches align, safe abortion care can be rapidly scaled even in the most challenging legal and operational environments.

Examples: safe abortion care in diverse humanitarian legal contexts

Colombia's experience demonstrates how legal frameworks enabling abortion can be operationalised effectively for migrant populations. In February 2022, Colombia's Constitutional Court decriminalised abortion up to 24 weeks of gestation, building on legal grounds established in 2006 that already permitted abortion in cases of rape, foetal abnormalities and risk to maternal health. Following this 2022 legal expansion, Profamilia Colombia saw abortion services for migrants increase by 50%, from 1,598 to 2,394 cases, with 92% of foreign nationals served being Venezuelan.[47]

The International Rescue Committee's dual-pronged harm reduction model – which combined community outreach to provide accurate abortion information and referrals with facility-based follow-up care for complications – reached 4,388 women in Ethiopia from January 2019 to December 2020, with 69% referred for self-management and 78% successfully following up for family planning services.[48] Research on estimating the incidence of induced abortion among women in refugee settings in Ethiopia has provided additional insights into the scale of need and service gaps.[49]

When adequate resources, training and support are provided – combined with innovative approaches adapted to local contexts – comprehensive abortion care can be delivered safely and effectively even in the most challenging humanitarian environments.

Abortion is healthcare. Donors have a once-in-a-lifetime chance to reverse decisions that will kill women and girls. Even as the United States's foreign aid cuts leave gaps, other donors should step up, as should governments with sufficient resources. The question is not whether we can afford to provide comprehensive abortion care – it is whether we can afford not to.

4. POLICY RECOMMENDATIONS

The evidence presented here demonstrates compelling reasons to take action.

Unsafe abortion is the only cause of maternal death that is completely preventable,[1] yet it accounts for 7.9% of maternal deaths worldwide and 25 to 50% in humanitarian settings.[1,2] Global classification of abortions by safety demonstrates the stark differences in outcomes between safe and unsafe procedures.[50]

We have good evidence around interventions that work – and can be delivered feasibly and rapidly in complex humanitarian crises with modest investment.[35–38,51] Quality abortion services save lives, prevent complications that strain already overwhelmed health systems and uphold fundamental human rights.[1,20,21] The moral argument is clear: women and girls have the right to access life-saving healthcare. Denying this access constitutes a violation of their fundamental human rights and dignity, and contributes to preventable maternal mortality.[1,20,21,30]

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Policy and funding actions

1. Clarify legal frameworks for humanitarian settings

Governments and international organisations should develop authoritative guidance clarifying that international humanitarian law protects the right to safe abortion care in emergencies and can supersede restrictive national laws, enabling healthcare workers to provide services without fear of legal consequences. This addresses systematic policy barriers that prevent service provision despite clinical capacity.

Clear policy statements are essential to protect staff, encourage them and hold them accountable if they deny a service. In many places, there is legal room for safe abortion care, but it's not provided due to a lack of policy and oversight pursuing the denial of services to which a woman or girl has the right. Once healthcare providers realise the consequences of denying a service, they may be more likely to comply.

Key actions include:

- Governments and humanitarian actors should establish clear protocols for implementing international legal obligations in humanitarian contexts.
- Health organisations should address situations where healthcare providers refuse to provide abortion services by claiming legal restrictions apply – when, in fact, the law permits abortion in the specific circumstance (such as to preserve a woman's mental and physical health, in cases of rape or when foetal abnormalities are present) and the provider has the clinical skills to provide the service.
- Governments should fully implement existing legal provisions that permit abortion under specific circumstances (to preserve a woman's mental and physical health, in cases of rape or when foetal abnormalities are present).
- International organisations should develop guidance superseding restrictive national laws where international humanitarian law applies, and commit to providing legal support to healthcare providers that are wrongly prosecuted.
- Health organisations, governments and humanitarian coordinators should develop and enforce clear organisational policies with accountability mechanisms to address denial of service, recognising that individual values, attitudes and fears – rather than legal constraints – are often the primary barriers. This includes establishing oversight systems to identify patterns of service denial, implementing performance evaluations that assess adherence to abortion care policies, and ensuring consequences for denial of legally permissible services alongside protections for staff who provide care.

Anticipated challenge:

Political barriers and national legal restrictions prevent service provision.

Evidence-based response:

Most countries permit abortion under some circumstances (such as to save a woman's life or in cases of rape), and these existing legal provisions should be fully implemented. International humanitarian law provides protections that can supersede national restrictions in emergency contexts. Legal analysis shows that denying abortion services in humanitarian settings – where women face heightened risks and limited alternatives – may violate international human rights law. The principle of medical neutrality requires healthcare provision based on medical need without political interference.

2. Integrate comprehensive abortion care into humanitarian health packages

Humanitarian health organisations and UN agencies must mandate inclusion of safe abortion care in all humanitarian health responses, including both acute phase MISP implementations and longer-term health system strengthening, with specific indicators and accountability mechanisms.

The MISP specifies that comprehensive abortion care should be initiated within the first 72 hours of an acute emergency:

- Post-abortion care as an integral function of emergency obstetric care.
- Safe abortion care for sexual violence survivors.
- Safe abortion care available to the full extent of the law in health centres and hospitals.
- Provision of contraceptives as part of post-abortion and safe abortion care.

Additional integration steps

- Donors and humanitarian organisations should require comprehensive SRH services as a standard component of humanitarian health funding proposals and programme design.
- Health organisations and training institutions should establish abortion care as an essential component of emergency obstetric and newborn care services and training curricula.
- Humanitarian coordinators and Health Cluster Leads should develop specific indicators and accountability mechanisms for consistent implementation across agencies.

Anticipated challenge:

Humanitarian settings lack resources, capacities and sustained funding for comprehensive abortion services, and other health priorities should take precedence.

Evidence-based response:

Safe abortion care can be offered by mid-level providers at primary care level using the same materials and competencies as post-abortion care, which is often already available as part of basic emergency obstetric and newborn care and MISP. WHO guidance confirms that medication abortion using recommended regimens is safe and effective across diverse settings.[6,8] Innovative delivery models require minimal infrastructure whilst maintaining high effectiveness. SMA achieved 86% success rates with minimal resource requirements,[36] whilst community-based distribution required no additional clinical facilities.[37]

The economic case for investing in comprehensive abortion care is compelling on multiple levels. Research from the conflict-affected Amhara region of Ethiopia demonstrates that comprehensive abortion care can be provided cost-effectively when properly integrated into existing health services.[51]

Understanding both the direct medical costs and the opportunity costs (including lost income, transportation and time) that women face are essential for designing accessible services.

Evidence shows that women and girls in humanitarian settings face substantial financial barriers to accessing abortion care, making the economic case for removing user fees and ensuring services are available close to where women live.[51] Cost-effectiveness evidence shows that preventing complications through early intervention reduces overall healthcare costs.

Early intervention actually reduces resource demands by preventing severe morbidity that requires high-level care. When considering the full picture – prevented maternal mortality, reduced long-term disability, improved quality of life for women and families, and positive impacts on existing children and family structures – the investment case becomes overwhelming. In resource-constrained settings, spending on prevention rather than treating severe complications represents sound fiscal policy.

European and other donors successfully fund comprehensive reproductive health services, as demonstrated in multiple humanitarian responses, including the Bangladesh Rohingya response. Donors of international humanitarian aid have provided life-saving reproductive healthcare for decades. The world's governments committed to this at the UN Sustainable Development Summit in December 2015 (SDG Target 3.7 Sexual and reproductive health).

Abortion is healthcare. Donors have a once-in-a-lifetime chance to reverse decisions that will kill women and girls. Even as the United States's foreign aid cuts leave gaps, other donors should step up, as should governments with sufficient resources. The question is not whether we can afford to provide comprehensive abortion care – it is whether we can afford not to.

3. Diversify and secure funding sources

Donors, governments and philanthropic organisations should mobilise European and other donors, philanthropic organisations, and private sector partnerships that fund comprehensive reproductive health services, given severe cuts to foreign aid by major donors.

Key funding strategies

- European governments, philanthropic organisations and private sector partners should increase funding for comprehensive reproductive health services in humanitarian settings.
- Donors and UN agencies should develop pooled funding mechanisms ensuring sustainable financing independent of individual donor restrictions (this allows multiple donors to contribute to a common fund, reducing the impact of any single donor's policy restrictions).
- Humanitarian funding mechanisms should create dedicated emergency funding streams that can be rapidly deployed for SRH services in the first 72 hours of acute humanitarian crises, before longer-term funding mechanisms are established.
- Humanitarian coordinators should replicate successful multi-donor coordination models, as was done during the Bangladesh Rohingya response, where United Nations Population Fund (UNFPA), The David and Lucile Packard Foundation, and non-US government donors coordinated funding to enable rapid scale-up of abortion services to 37 facilities within one month despite US policy restrictions.[38]

Service delivery improvements

4. Strengthen health system capacity

Health organisations and training institutions should develop standardised protocols for early identification and management of severe abortion complications to prevent women dying unnecessarily, given evidence of significantly worse outcomes in humanitarian settings.

Additional key capacity building actions

- Training organisations and Health Cluster Coordinators should scale successful training models like S-CORTs that demonstrated measurable improvements across multiple humanitarian contexts.
- Health organisations should implement continuous quality improvement programmes focusing on patient-centered care, communication and evidence-based practices.
- Health managers should address legal knowledge gaps in cases where providers cite policy violations despite having clinical capacity.

Anticipated challenge:

Safe and quality abortion services are too hard to deliver in crisis settings.

Evidence-based response:

Safe abortion care can be offered by mid-level providers at primary care level using medication or MVA.[6,8] SMA can be supported through community-based distribution by trained community health workers or pharmacy-based provision.[37,40,42]

Multiple studies demonstrate that quality care can be provided when proper training and support exist.[5,39] The S-CORTs training model proved that quality gaps can be addressed through targeted interventions across multiple challenging contexts.[5] The Thailand-Burma border programme demonstrated 96.4% success rates through community-based distribution,[37] whilst the MSF systematic scale-up achieved 4.29% overall complication rates with no maternal deaths across 3,640 abortions.[35] Quality is enhanced, not compromised, by providing comprehensive services that prevent dangerous alternatives.

5. Scale up innovative service delivery models

Health organisations and programme managers should pilot self-managed abortion programmes with appropriate support systems adapted to local contexts.

Additional innovation priorities

- Community-based organisations and health programmes should develop community-based distribution programmes for medication abortion where legally permissible.
- Health and protection organisations should establish 24/7 support systems through hotlines or alternative community-approved mechanisms.
- Health programmes should integrate digital health interventions following successful models like Venezuela's Aya Contigo programme.
- Community health programmes should implement accompaniment models validated through comprehensive research, including the Studying Accompaniment model Feasibility & Effectiveness (SAFE) Study.[48]

6. Ensure supply chain management

UNFPA, health organisations and supply chain managers should guarantee the availability of WHO-recommended abortion medications (misoprostol and mifepristone) through multiple procurement and distribution channels, following WHO-recommended regimens.[8]

Additional supply chain priorities

- UNFPA should ensure Inter-Agency Emergency Reproductive Health (IARH) kits (Kit 8) containing mifepristone-misoprostol combination packs are available in emergency responses.
- Humanitarian organisations should establish emergency stockpiles of essential medications and equipment for rapid deployment in acute crises.
- Supply chain managers should develop quality assurance systems for medication safety and efficacy in challenging storage and transport conditions.
- Logistics coordinators should address supply chain disruptions through innovative solutions, including buffer stocks and alternative supply routes.

Community engagement strategies

7. Address stigma and social norms

Health organisations, training institutions and community programmes should conduct VCAT workshops with health sector actors at all levels, including government and NGO staff, building on successful experiences that shifted provider attitudes and created enabling environments for service delivery.

Key stigma reduction actions

- Health organisations and training programmes should conduct VCAT workshops with health sector actors at all levels, including government and NGO staff, building on successful experiences that increased provider willingness from 40% to 90%.
- Community programmes should implement community-based stigma reduction programmes that leverage evidence showing community willingness to help women access post-abortion care despite stigma.
- Community health programmes should train female community members to provide accurate information about available services and help women navigate health systems.
- Community engagement programmes should include awareness-raising among men and community leaders where evidence supports such approaches and cultural contexts permit.
- Digital health programmes should leverage digital tools like e-health apps and WhatsApp hotlines for anonymous consultations and referrals to maintain privacy.

Anticipated challenge:

Abortion services conflict with local, cultural or religious values, and donors cannot fund services that violate their political, cultural or religious principles.

Evidence-based response:

Research shows community members express willingness to help women access post-abortion care when complications arise, indicating pragmatic acceptance despite cultural concerns. International humanitarian law requires medical neutrality and provision of care based on medical need rather than cultural preferences.

Donors have provided life-saving reproductive healthcare for decades. The world's governments committed to universal access to SRH at the UN Sustainable Development Summit in December 2015 (SDG Target 3.7 Sexual and reproductive health). Abortion is healthcare. When donors impose restrictions preventing access, they are directly responsible for preventable maternal deaths.

Donors have the power and obligation to save lives. If some create gaps through restrictive policies, others must step up. European governments, philanthropic organisations and governments with sufficient resources must demonstrate global leadership. For decades, the United States was a leader in this area – that leadership can be reclaimed. But the global humanitarian community cannot allow political decisions in any one country to determine whether women and girls in crisis settings live or die.

8. Promote community support systems and trauma-informed care

Health and protection organisations should develop alternative support systems to address barriers where women are required to have a male family member's permission or accompaniment to access healthcare, through community engagement and female community health worker programmes.

GBV and SRH programmes should integrate comprehensive abortion care within broader SRH and GBV services to ensure a holistic, survivor-centered response.

Additional community support priorities

- Health organisations should provide trauma-informed, client-centered abortion care that prioritises safety, trust, peer support, collaboration, empowerment and cultural sensitivity, drawing on guidance for trauma-informed care for abortion providers treating sexual violence survivors in humanitarian settings.[52]
- Health and protection organisations should create safe spaces and confidential services that protect women's privacy and autonomy whilst ensuring access to care.
- Programme managers should establish community feedback mechanisms to continuously improve service quality and accessibility.
- Health organisations should build on evidence that client satisfaction improves when women feel heard and respected in healthcare interactions.

Evidence generation, monitoring and accountability

9. Strengthen data systems

Health information managers and programme coordinators should implement standardised data collection on abortion incidence, methods used and complication severity within health management information systems.

Additional data system priorities

- Programme managers and evaluators should develop monitoring frameworks for innovative service delivery models, incorporating lessons from successful pilots and scaling approaches.
- Monitoring and evaluation specialists should include both routine programme monitoring and special studies to assess the effectiveness and safety of new approaches.
- Programme managers should establish regular programme evaluation using quality of care frameworks that include patient experience indicators.
- Quality improvement teams should recognise that technical quality alone is insufficient if services are not respectful, accessible and responsive to women's needs.

10. Invest in and build the evidence base

Research organisations, academic institutions and implementing partners should conduct operational research on effective implementation models to improve access and women's experience of abortion care, guided by the evidence priorities identified through global consultation.[53]

Additional evidence building priorities

- Operational research priorities should focus on SMA models to improve women's access and experience of care, including effectiveness studies of different delivery approaches (digital support, pharmacist-led, telemedicine, midwife-led and community-based models) across diverse humanitarian contexts.[12, 16, 36, 40, 42, 45, 47, 48, 50, 51, 53]
- Research organisations and health programmes should build on innovative research approaches like respondent-driven sampling that have provided unprecedented insights into abortion patterns in humanitarian settings,[3,19] and continue to document person-centered care gaps that affect women's experience and outcomes.[18]
- Research funders and academic institutions should prioritise research on user acceptability and person-centered care, including studies examining how different models of care (less medicalised approaches led by midwives, nurses or community providers) affect women's abortion experience, clinical outcomes and post-abortion contraceptive uptake.[18,53] Research in northern Ethiopia demonstrates that person-centered care remains inconsistently delivered even where services exist, highlighting the need for quality improvement research that addresses both technical competence and respectful care practices.[18]

- Research organisations should conduct implementation research on policy environments, examining effective strategies for ensuring comprehensive abortion care in both supportive and legally restrictive humanitarian settings, including documentation of legal protections for service providers and users.[53]
- Donors and research organisations should conduct cost-effectiveness analyses to strengthen economic arguments for investment, particularly tracking long-term outcomes of different service delivery approaches, including SMA, telemedicine and community-based models.[51,53] Research should examine both direct medical costs and opportunity costs (transportation, lost income, time) that create barriers for women and girls accessing abortion care in humanitarian settings.[51]
- Research organisations should prioritise operational research on service delivery innovations, including safety protocols for telemedicine platforms, hybrid models combining digital consultations with in-person referrals and digital accompaniment models adapted to crisis-affected settings.[53]
- Social science researchers and community programmes should research effective approaches to reducing abortion stigma and improving women's reproductive autonomy in diverse cultural contexts within humanitarian settings.[53]
- Implementing organisations and research partners should document and disseminate successful approaches to providing quality comprehensive abortion care in challenging humanitarian contexts. Particular attention should be given to innovations that have achieved high success rates with minimal complications and models that successfully integrate post-abortion contraceptive counselling.[18,19]
- Humanitarian research organisations and practitioners should collaborate to strengthen the evidence base on safe abortion care through open-access knowledge exchange platforms that support research development, validation and the contextual adaptation of comprehensive abortion services across diverse humanitarian crises.

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Author

The author of this policy brief is Dr Neha Singh, independent consultant to Elrha. Dr Singh is a specialist in interdisciplinary health policy and systems research, including on SRH, and is Associate Professor and Co-Director of the Health in Humanitarian Crises Centre at the London School of Hygiene & Tropical Medicine.

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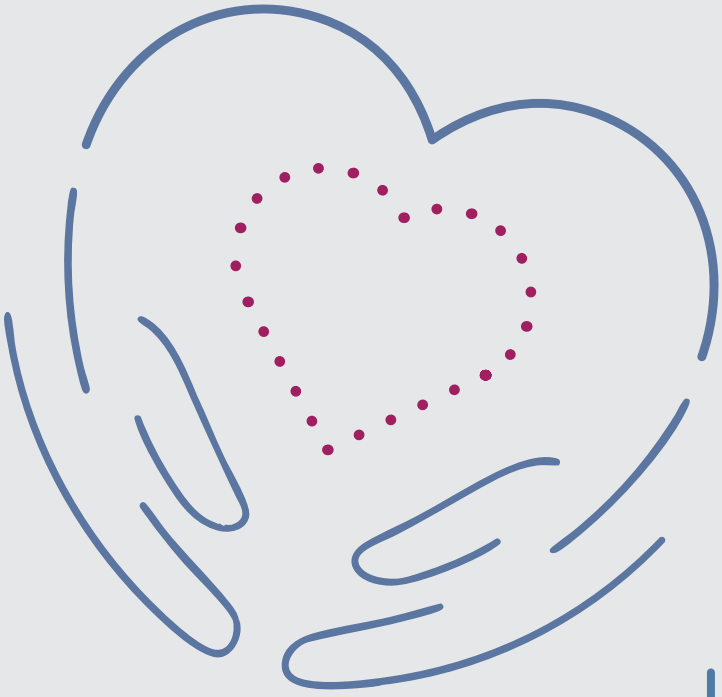

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