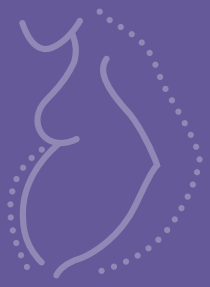
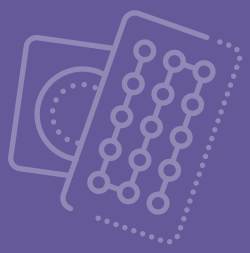
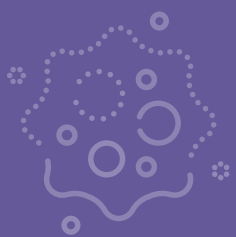
Sexual and Reproductive Health and Rights in Humanitarian Settings: An Implementation Research Agenda

Focus on Comprehensive Abortion Care







ACKNOWLEDGEMENTS

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About us

We are a global organisation that finds solutions to complex humanitarian problems through research and innovation. We are an established actor in the humanitarian community, working in partnership with humanitarian organisations, researchers, innovators and the private sector to tackle some of the most difficult challenges facing people all over the world. Through our globally recognised programmes, we have supported more than 200 world-class research studies and innovation projects, championing new ideas and different approaches to evidence what works in humanitarian response. R2HC aims to improve health outcomes for people affected by humanitarian crises by strengthening the evidence base for public health interventions. Our globally-recognised research programme focuses on maximising the potential for public health research to bring about positive change and transform the effectiveness of humanitarian response.

The R2HC programme is funded by the UK Foreign, Commonwealth & Development Office (FCDO), Wellcome and the Department of Health and Social Care (DHSC) through the National Institute for Health Research (NIHR).

> We equip humanitarian responders with knowledge of what works, so that people affected by crises get the right help when they need it most.

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The **Steering Committee** included: Dr Gillian McKay (Chair), Senior Humanitarian Health Research Advisor, Elrha; Gloria Seruwagi, affiliated with Makerere University and Population Council; Dr Wahid Majrooh, Founder and Director, Afghanistan Center for Health and Peace Studies; Dr Lale Say, Unit Head, SRH Integration in Health Systems, World Health Organization (WHO); Nadine Cornier, Head of the Response and Technical Support Unit, Humanitarian Office, United Nations Population Fund (UNFPA) and WHO SRHR Task Team; Nelly Staderini, Medical Leader, Women's and Children's Health Unit and SRH/SV Advisor, Médecins Sans Frontières (MSF), Geneva; Diana Pulido, Humanitarian Technology Lead, International Planned Parenthood Federation (IPPF), Colombia; Nathaly Spilotros, Sexual and Reproductive Health Lead for Research & Innovation at the International Rescue Committee (IRC), covering maternity leave for Naoko Kozuki, Director of Research, IRC, USA; Qamar Mahmood, SRHR Focal Point for the International Development Research Centre (IDRC), Jordan; Kathleen Myer, Co-Chair, SRH in Crises Donor Group, United States Agency for International Development (USAID) Bureau for Humanitarian Assistance (BHA); and Cammie Lee, Senior Program Officer, Maternal, Newborn, Child Nutrition & Health (MNCNH), Gates Foundation.

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Most importantly, we extend our sincere gratitude to all of the 91 experts who contributed their valuable time and experiences to helping shape, craft and refine the research questions and related interventions, and to all 271 experts who spent time to reflect on and contribute to the prioritisation survey – who have collectively determined the SRHR in crises research agenda shared in this report.

EXECUTIVE SUMMARY

This report presents findings from a global consultation that resulted in a new research agenda for SRHR in humanitarian settings.

Why a new research agenda for SRHR in humanitarian settings?

SRHR needs rise sharply during conflict, displacement and climate-related disasters, yet only a fraction of operational questions have been rigorously answered. Earlier global exercises provided an invaluable start, but did not cover newer challenges such as digital self-care, climate resilience or service integration at scale. Through our R2HC, we commissioned a fully updated prioritisation exercise spanning nine SRHR Domains and six World Bank regions to steer investments for the next three to five years.

What is the scope of the prioritisation exercise?

The agenda spans the full range of sexual and reproductive health (SRH) across nine SRHR Domains: Comprehensive Sexuality Education (CSE); Sexual Health and Wellbeing; Family Planning (FP) and Contraception; Cancers of the Reproductive System; Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV); Maternal and Newborn Health (MNH): Antenatal/Perinatal Care; Maternal and Newborn Health (MNH): Postnatal/Newborn Care; Comprehensive Abortion Care; Clinical Management of Rape; and three crosscutting domains: Stakeholder Engagement, Service Delivery and Health Systems, and Climate Resilience. The scope includes humanitarian settings affected by conflict, forced displacement, climate-related emergencies and other crisis conditions. While global in outlook, the focus is on low- and middle-income countries (LMIC).

Only research questions amenable to implementation research were included, ie, those concerned with how to adapt, deliver, integrate or scale known SRHR interventions in real-world crisis contexts. Questions solely focused on describing needs or estimating prevalence were excluded, except where such data collection was explicitly positioned as a baseline or implementation input.

How the priorities were identified

Evidence-informed foundation: From over 350 ideas gathered through literature and consultations, 73 operational questions were curated, incorporating 31 questions from earlier global exercises.

Broad and inclusive consultation: 91 experts – 44% from non-governmental organisations (NGOs) and 24% from academia – took part in 11 virtual regional workshops and nine language-specific sessions. Many remained engaged through follow-up discussions and email feedback.

Participatory prioritisation: A global survey engaged 271 practitioners, researchers and policymakers with more than five years' SRHR-in-crises experience. Respondents were asked to allocate a hypothetical $100 per domain across the research questions they felt would have the greatest impact, feasibility and relevance. Participation was strong overall (more than 170 responses in most domains) but thinner in Europe and Central Asia (ECA), Latin America and the Caribbean (LAC), and East Asia and the Pacific (EAP) despite a two-week extension and targeted outreach.

Quantitative analysis: Mean scores and standard deviations (SDs) were calculated by domain and region. Wide SDs or overlapping interquartile ranges (IQRs) indicate divergence of views, while narrower distributions signal stronger consensus.

Who participated?

Experience and roles: All respondents had five years or more experience in SRHR in humanitarian settings; 48% had between five and nine years and 33% had ten years or more. A balanced mix of professional profiles were represented, including clinical services (14%), research (14%), public health programming (8%) and humanitarian response management (7%), with many also combining service delivery and research roles.

Geography: 63% of respondents contributed to the Sub-Saharan Africa (SSA) region, 22% to the Middle East and North Africa (MENA) region; other regions accounted for between 10 and 17% per region.

This document focuses on one of the nine domains of SRHR that were studied in the broader Research Priority Setting exercise.

To learn more about the scope of the study, methodology, the other eight SRHR domains (and the three cross-cutting issues: stakeholder engagement, service delivery and health systems and climate resilience), please scan the QR code or visit **elrha.org**.

Summary scorecard showing the top three or four ranked research topics by SRHR Domain for all respondents globally

1. Comprehensive Sexuality Education (CSE) (n=172)	Score (mean)	SD
Effective delivery models for CSE	21.80	11.4
Engaging parents and caregivers in CSE	16.86	8.0
Training and supporting CSE facilitators	16.35	8.1
Integrating CSE into adolescent-friendly health services	16.34	10.8
2. Sexual Health and Wellbeing (n=181)		
Integration of sexual and reproductive health and rights (SRHR) and mental health	15.78	8.3
Strengthening SRHR and mental health training for providers	15.56	7.9
Overcoming stigma and barriers to mental health and SRHR access	14.06	8.1
3. Family Planning (FP) and Contraception (n=216)		
Ensuring reproductive choice in humanitarian settings	16.71	10.6
Increasing adolescent access to contraception	14.90	7.8
Overcoming barriers to long-acting reversible contraceptives (LARC) access and acceptance (demand-side)	14.37	7.9
4. Cancers of the Reproductive System (n=116)		
Equitable human papillomavirus (HPV) vaccination	34.78	14.2
Integrating HPV-based cervical cancer screening into existing SRHR services	34.74	11.9
Raising awareness where treatment is accessible	30.47	16.1
5. Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV) (n=174)		
Scaling up STIs and HIV testing for displaced and high-risk populations	17.35	7.7
Preventing STIs in forced migration settings	14.78	6.8
Scaling up STI prevention and post-exposure prophylaxis (PrEP), STI management and post-exposure prophylaxis (PEP)	14.64	9.1
6. Maternal and Newborn Health (MNH): Antenatal/Perinatal Care / continuity of care (n=190)		
Strengthening basic emergency obstetric and neonatal care (EmONC)	21.76	8.9
Context-specific approaches for increasing access to MNH	20.95	10.0
Emergency referral mechanisms	19.65	10.0

7. Maternal and Newborn Health (MNH): Postnatal/Newborn Care (n=184)	Score (mean)	SD
Essential newborn care in conflict settings	28.27	12.20
Community-based postnatal care (PNC)	26.44	11.67
Mitigating and managing postnatal depression	24.95	12.84
8. Comprehensive Abortion Care (n=149)		
Improving women's experience of and access to abortion care	16.49	8.1
Policies	16.33	9.2
User acceptability, quality and person-centred abortion care	14.73	7.0
Service delivery innovations for comprehensive abortion care	14.46	7.5
9. Clinical Management of Rape (n=114)		
Increasing timely access to post-rape care in legally restrictive settings	20.25	12.2
Increasing health-seeking behaviours and referrals	16.49	8.1
Task sharing the clinical management of rape	14.39	6.0
Expanding the clinical management of rape access for marginalised and key populations	14.27	7.3
Crosscutting – Stakeholder Engagement (n=219)		
Community-led interventions to increase access	18.35	9.5
Preventing mistreatment and ensuring respectful care	16.95	9.1
Community engagement and equity	15.00	6.9
Crosscutting – Service Delivery and Health Systems (n=215)		
Training models for sustained community health worker (CHW) learning	16.01	10.8
Digital information, education and communication (IEC) to increase SRHR knowledge and access	15.58	9.4
Service delivery during pandemics and large-scale emergencies	14.71	7.4
Increasing SRHR services for people-on-the-move	14.37	8.0
Crosscutting – Climate Resilience (n=153)		
Resilient SRHR service provision	35.59	16.0
Mitigating climate effects in MNH	34.63	18.0
Distribution of SRHR commodities	29.77	13.5

Key insights from the domain scores

Rather than producing a definitive 'top three' for each domain, the data reveal clusters of closely ranked priorities. Across most domains, the gap between the first- and third-ranked questions was fewer than three to five points on a 0 to 100 scale. This affirms the relevance of the full long list and suggests that several research questions within each domain need attention.

- **CSE** – Community-supported delivery and caregiver engagement ranked highest overall. LAC elevated gender-transformative approaches; ECA prioritised adolescent-focused services.
- **Sexual Health and Wellbeing** – Mental health (MH) integration dominated globally; however, stigma reduction was ranked first in ECA, and menopause entered the top three in several regions.
- **FP and Contraception** – Reproductive choice and adolescent access ranked highest overall. ECA prioritised support for vulnerable groups.
- **Cancers of the Reproductive System** – Human papillomavirus (HPV) vaccination and cervical screening consistently ranked first and second in all regions.
- **STIs and HIV** – Testing and prevention access were key themes. STI vaccines drew particularly high interest in ECA.
- **MNH: Antenatal/Perinatal Care** – Basic emergency obstetric and neonatal care (EmONC) and context-specific access strategies led globally. EAP prioritised community-based care.
- **MNH: Postnatal/Newborn Care** – Newborn care in conflict settings and community postnatal care (PNC) led. Polarised views on postnatal depression were most evident in ECA.
- **Comprehensive Abortion Care** – Improving access and autonomy were consistent priorities; user acceptability and cost were more emphasised in Latin America and Europe.
- **Clinical Management of Rape** – Timely post-rape care was universally prioritised. ECA valued services for marginalised groups; EAP prioritised task-sharing.
- **Crosscutting – Stakeholder Engagement** – Community-led access and respectful care were top-ranked.
- **Crosscutting – Service Delivery and Health Systems** – Training for community health workers (CHWs) and digital information, education and communication (IEC) were most valued, but services for people-on-the-move and supply-chain preparedness showed high regional volatility.
- **Crosscutting – Climate Resilience** – All three questions (resilient provision, commodities, MNH adaptation) received nearly equal support, reflecting their interdependence.

How to use the agenda

This agenda is designed as a navigation tool for donors, governments, implementers and researchers to identify high-priority, practice-relevant research questions in SRHR in humanitarian settings. The focus on delivery, equity and system resilience makes the questions well suited to implementation studies, operational pilots and embedded research.

At the same time, the agenda should be read with context in mind. Each World Bank region aggregates a wide variety of settings: urban displacement, hard-to-reach rural areas, protracted and sudden-onset emergencies. Priorities that look similar on paper may translate into very different research or programme needs on the ground. Users are therefore encouraged to treat the domain rankings as a starting framework: adapt them to local epidemiology, legal constraints, community preferences and service-delivery realities, and document how those contextual factors change both questions and methods in consultation with local stakeholders. In short, the agenda guides 'where to look first', but context determines the final shape of the work.

SRHR Domain 8: Comprehensive Abortion Care

Highlight: Improving women's experience and access to care ranked highest overall. Experts proposed user-centred models such as digital accompaniment and hybrid telemedicine, including in legally restricted settings.

In this SRHR Domain, the highest-ranked questions focused on improving women's experience and access to abortion care, specifically the effectiveness of different models of self-managed medical abortion (Q4; mean: 16.49) and supportive policy (including legally restrictive) environments (Q1; mean: 16.33), both appearing among the top-ranked in most regions. Q4 led in LAC, while Q1 took first place in MENA, reflecting emphasis on both structural and experiential dimensions of care.

Q3 (user acceptability, quality, and person-centred/less medicalised care) also ranked highly overall (14.73) but stood out sharply in ECA, where it received the highest mean (23.18), indicating particularly strong regional focus on care experience and quality standards.

While the top four questions were relatively close in score, there was greater clarity in the questions receiving the least prioritisation. Q6 (reproductive autonomy and interventions that contribute to changing social and gender norms around abortion stigma) and Q7 (provider support and wellbeing) were ranked lowest overall, with means of 12.46 and 12.99, respectively. They consistently fell in the bottom tier across all regions except South Asia and SSA, where Q7 rose slightly in rank. This suggests a shared de-emphasis on provider-centred and autonomy-focused research in the current landscape, though not uniformly.

Expert advisers proposed implementation strategies to support top-ranked areas. For Q1 and Q4, suggestions included policy reform analysis, legal support services and community-led accompaniment models. For Q3, they highlighted person-centred quality standards, feedback mechanisms and models of respectful abortion care. On Q2 (financing and cost barriers, 12.54), recommendations included voucher schemes, insurance integration and cost reduction mechanisms, especially for vulnerable populations.

Scorecard for SRHR Domain 8: Comprehensive Abortion Care

Region:	All	Latin America and the Caribbean	East Asia and the Pacific	Europe and Central Asia	Middle East and North Africa	South Asia	Sub-Saharan Africa
Total number of respondents:	149	29	15	11	33	28	96
Research topic	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)
1. Policies	16.33	15.24	17.07	15.55	20.48	14.39	16.23
2. Financing and cost barriers	12.54	10.83	12.87	12.18	10.45	12.25	12.27
3. User acceptability, quality and person-centred abortion care	14.73	14.31	15.07	23.18	11.09	16.32	15.26
4. Improving women's experience and access to abortion care	16.49	20.31	15.47	18.00	14.12	18.29	15.93
5. Service delivery innovations for comprehensive abortion care	14.46	14.48	15.13	14.00	12.12	13.29	14.72
6. Addressing barriers to reproductive autonomy and ability to choose	12.46	14.93	11.60	7.18	8.45	11.64	12.40
7. Provider support, wellbeing and training	12.99	7.79	12.80	9.91	9.06	13.82	13.20

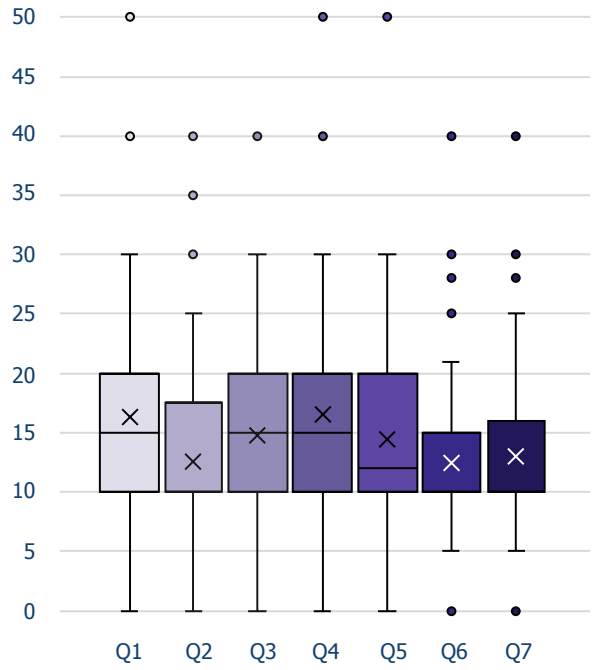
Boxplot figure 8: Mean dollar allocation (scores) for each question for SRHR Domain 8 – Comprehensive Abortion Care

Research topic

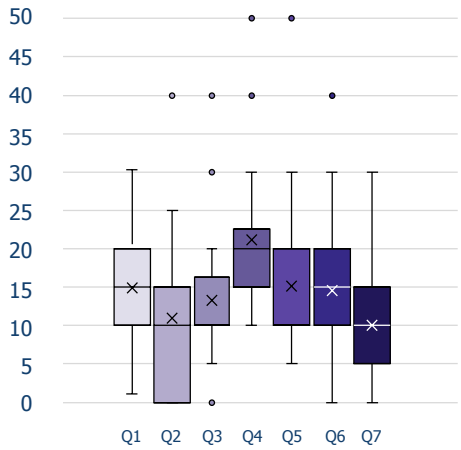
1. Policies
2. Financing and cost barriers
3. User acceptability, quality and person-centred abortion care
4. Improving women's experience and access to abortion care
5. Service delivery innovations for comprehensive abortion care
6. Addressing barriers to reproductive autonomy and ability to choose
7. Provider support, wellbeing and training

Box and whisker plots showing mean score (X); interquartile range marked by box; range marked by whisker and outlier scores.

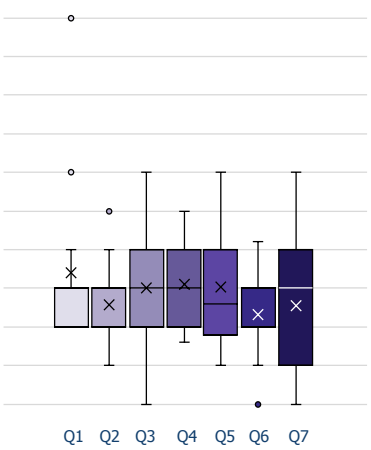
All respondents (n=149), Comprehensive Abortion Care



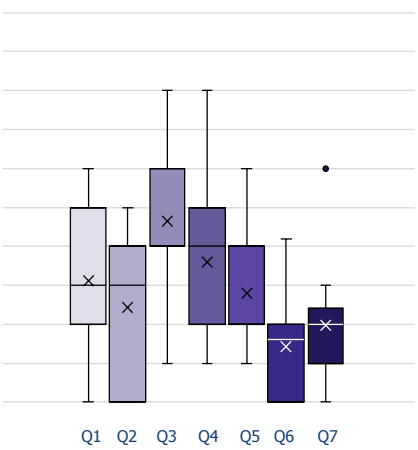
Latin America and the Caribbean (n=29)



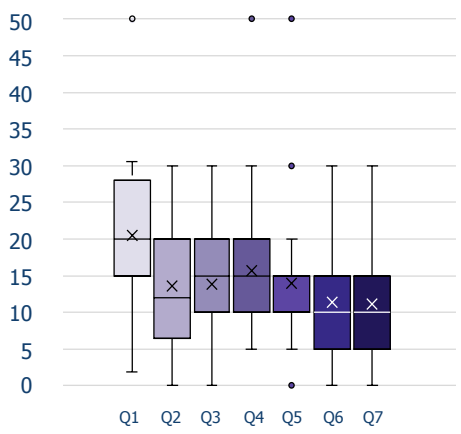
East Asia and the Pacific (n=15)



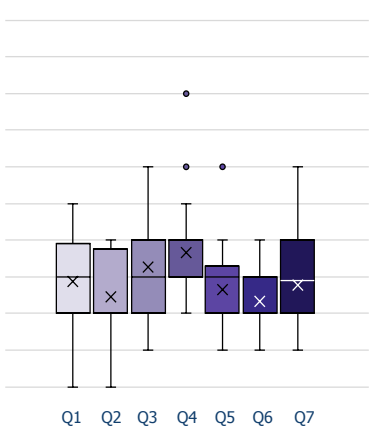
Europe and Central Asia (n=11)



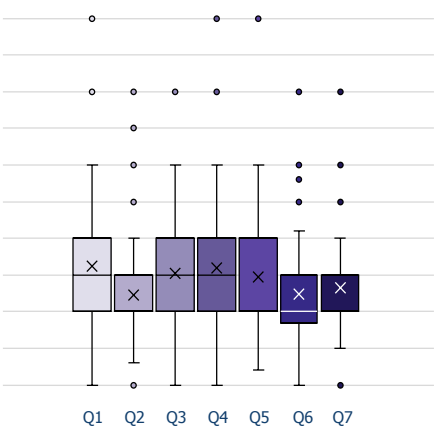
Middle East and North Africa (n=33)



South Asia (n=28)



Sub-Saharan Africa (n=96)



ANNEX

Implementation Research Priorities for Sexual and Reproductive Health and Rights (SRHR) in Humanitarian Crises

Supplementary document 1: Final long list of research questions on SRHR in humanitarian settings by domain with original number referencing and with examples of interventions provided by experts.

SRHR Domain 8: Comprehensive Abortion Care

1. Policies: What are effective strategies for ensuring implementation of comprehensive abortion care policies in humanitarian settings, including restrictive legal environments, to increase access to, and use of, abortion care services?

- *Focus areas:* Understanding how laws and policies facilitate or hinder Safe Abortion Care / Self-Managed Abortion / Post-Abortion Care access, and using this to inform the strengthening of policy frameworks, legal protections for service providers, advocacy strategies, access to misoprostol/medication abortion, provider or client criminalization, capturing morbidity and near miss-related morbidity due to abortion complications in humanitarian health response.
- *Examples of interventions:* Opposition/political change/regression monitoring and overcoming resistance from policymakers and service providers and community members through participatory Stakeholder dialogue. Advocacy strategies increasing awareness among high-level political leaders and social media influencers about the circumstances under which abortion is legal; operationalising legal and regulatory frameworks that secure safe abortion access. Cross-border referral mechanisms.

2. Financing and cost barriers: What are the direct, indirect and opportunity costs of providing comprehensive abortion care in humanitarian settings, and what financial arrangements improve access?

- *Focus areas*: Cost-effectiveness, financing models, impact of cash transfers, community-based health insurance, universal health coverage, health disparities between citizens and refugees
- *Examples of interventions:* Conditional/unconditional cash transfers (CCTs), community-based health insurance for SAC/PAC, integration into broader cash-based assistance, community-based health insurance models; alternative modes of financing.

3. User acceptability, quality and person-centred abortion care: What is the impact of less medicalised abortion care on women's abortion experience, clinical outcomes and post-abortion contraceptive uptake (ie, care led by midwives, nurses or trained community providers)?

- *Focus areas:* Implementation research-effectiveness, Feasibility, safety, acceptability, impact of the model of the care, financial impacts of cost-shifting, quality of care
- *Examples of interventions:* Midwife-led SAC/PAC, training and supervision models for non-physician providers, task-shifting.

4. Improving women's experience and access to abortion care: How effective are different models of self-managed medication abortion (SMA) (ie, digital support SMA, pharmacist-led, telemedicine, midwife-led or community-based approaches) for improving women's ability to choose and access SAC/PAC in conflict-affected and remote settings?

- *Focus areas*: Women's needs/preferences on SAC/PAC in humanitarian settings. Different model's ability to deliver SAC/PAC in humanitarian settings - surgical Vs medication abortion.
- *Examples of interventions:* Testing different models to see how well interventions effectively meet women's needs and influence acceptability and decision-making: Telemedicine for SAC/PAC, CHW task-sharing for MA guidance, digital tools for abortion access, CHW and midwife-led MA, self-use MA with digital support, and pharmacist-led care. Gender and agency-based frameworks for improving abortion services.

5. Service delivery innovations for comprehensive abortion care: How effective are telemedicine platforms and digital support tools in delivering comprehensive abortion care among displaced populations and conflict-affected areas?

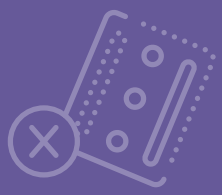
- *Focus areas:* Safety, privacy, acceptability, hybrid telemedicine/in-person models, MA (including screening for eligibility). Combining digital consultations with human accompaniment models, helping people to women (and their families when relevant, i.e. they are needed to support the woman to get to care for her to reach care) to identify complications using different telemedicine and digital support tools, increasing access to post-abortion care.
- *Examples of interventions:* Telemedicine models for SAC/PAC, digital decision support tools, hybrid models combining telemedicine with in-person referrals. Virtual abortion accompaniment models, remote counselling. Connecting with just the woman vs. including family members to see what is more effective at increasing women's access to SAC/PAC.

6. Addressing barriers to reproductive autonomy and ability to choose: What are the effective interventions that contribute to changing social and gender norms around abortion stigma, which harm women's ability to exercise their ability to access SAC?

- *Focus areas:* Understanding how gender norms, stigma, and social agency affect SAC/PAC access and use of those services in different delivery models.
- *Examples of interventions to explore:* Approaches which are effective at increasing access to/ use of services, community-based interventions addressing abortion stigma, person-centred care models for SAC/PAC, building individual agency and autonomy to exercise reproductive choices across the spectrum (from fully self-managed to clinical management by a health provider).

7. Provider support, wellbeing and training: What approaches most effectively improve healthcare workers' willingness and wellbeing to provide abortion care services in humanitarian settings?

- *Focus areas:* Addressing stigma / attitudinal barriers among healthcare providers; addressing mental health of providers and other types of support; values clarification training; incentives; Provider confidence in different methods; Protecting abortion care providers from prosecution in restrictive settings. Prevalence of conscientious objection with the health facility. Structural barriers faced by healthcare providers. Providers' preferences for different methods of abortion and post-abortion contraceptive provision for different clients.
- *Examples of interventions to explore:* Training and sensitisation for midwives and CHWs, incentive models, values clarification workshops.



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