

Abortion in conflict zones: moral responsibilities of humanitarian agencies in providing safe abortion care

ANOKWURU, Collins Chibueze, EKWEBENE, Onyeka Chukwudalu, NWUZOH, Moses Ifeatu, EDEH, Gabriel Chidera, NWALIEJI, Chioma Adaora, UDOKANG, Ephraim Ikpongifono, OBI, Chidera Gabriel and ENEH, Stanley

Available from Sheffield Hallam University Research Archive (SHURA) at:

<https://shura.shu.ac.uk/37292/>

This document is the Published Version [VoR]

Citation:

ANOKWURU, Collins Chibueze, EKWEBENE, Onyeka Chukwudalu, NWUZOH, Moses Ifeatu, EDEH, Gabriel Chidera, NWALIEJI, Chioma Adaora, UDOKANG, Ephraim Ikpongifono, OBI, Chidera Gabriel and ENEH, Stanley (2026). Abortion in conflict zones: moral responsibilities of humanitarian agencies in providing safe abortion care. *Frontiers in Reproductive Health*, 8: 1767552. [Article]

Copyright and re-use policy

See <http://shura.shu.ac.uk/information.html>



OPEN ACCESS

EDITED BY
Zhaohui Su,
Southeast University, China

REVIEWED BY
Efa Nugroho,
State University of Semarang, Indonesia
Imane Boujguenna,
Université Ibn Zohr, Morocco
Hanane Houmaid,
Cadi Ayyad University, Morocco

*CORRESPONDENCE
Collins Chibueze Anokwuru
✉ collinschibueze179@gmail.com

RECEIVED 14 December 2025
REVISED 10 February 2026
ACCEPTED 12 March 2026
PUBLISHED 01 April 2026

CITATION

Anokwuru CC, Ekwebene OC,
Nwuzoh MI, Edeh GC, Nwalieji CA,
Udokang EI, Obi CG and Eneh S (2026)
Abortion in conflict zones: moral
responsibilities of humanitarian agencies
in providing safe abortion care.
Front. Reprod. Health 8:1767552.
doi: 10.3389/frph.2026.1767552

COPYRIGHT

© 2026 Anokwuru, Ekwebene, Nwuzoh,
Edeh, Nwalieji, Udokang, Obi and Eneh.
This is an open-access article distributed
under the terms of the [Creative
Commons Attribution License \(CC BY\)](#).
The use, distribution or reproduction in
other forums is permitted, provided the
original author(s) and the copyright
owner(s) are credited and that the
original publication in this journal is
cited, in accordance with accepted
academic practice. No use, distribution
or reproduction is permitted which does
not comply with these terms.

Abortion in conflict zones: moral responsibilities of humanitarian agencies in providing safe abortion care

Collins Chibueze Anokwuru^{1,2,3*},
Onyeka Chukwudalu Ekwebene^{4,3}, Moses Ifeatu Nwuzoh^{5,3},
Gabriel Chidera Edeh^{6,3}, Chioma Adaora Nwalieji^{7,3},
Ephraim Ikpongifono Udokang^{8,3}, Chidera Gabriel Obi^{9,3} and
Stanley Eneh^{10,11,3}

¹Department of Public Health, Federal University of Technology Owerri, Owerri, Nigeria, ²Corona Management Systems, Abuja, Nigeria, ³Youth in Research Hub, Enugu, Nigeria, ⁴Department of Pediatrics, Ryan White Center for Pediatric Infectious Disease and Global Health, Indiana University School of Medicine, Indianapolis, IN, United States, ⁵Institute of Social Sciences, Sheffield Hallam University, Sheffield, United Kingdom, ⁶Department of Haematology/Blood Transfusion, Babcock University Teaching Hospital, Ilishan-Remo, Ogun State, Nigeria, ⁷Faculty of Clinical Sciences, University of Nigeria Teaching Hospital Enugu State, Enugu, Nigeria, ⁸Faculty of Pharmacy, University of Uyo, Uyo, Akwa Ibom State, Nigeria, ⁹Department of Parasitology and Entomology, Nnamdi Azikiwe University Awka, Awka, Nigeria, ¹⁰Department of Community Health, Obafemi Awolowo University, Ile-Ife, Osun, Nigeria, ¹¹Interdisciplinary Health Sciences, The University of Texas at El Paso, El Paso, TX, United States

Unsafe abortion remains a leading cause of maternal mortality globally, disproportionately affecting women in conflict zones where health systems are fractured, legal protections are weakened, and access to reproductive care is severely limited. Armed conflict increases the incidence of unwanted pregnancy through sexual violence, displacement, and disruption of contraceptive services, while also heightening barriers to timely, comprehensive abortion care. Despite growing international recognition of abortion as a life-saving intervention, humanitarian agencies often face legal, cultural, and operational barriers that hinder service provision. From an ethical standpoint, obligations grounded in humanity, beneficence, respect for autonomy, impartiality, and the right to health support the inclusion of safe abortion as an essential, reproductive health service. International practice shows that agencies can deliver services through adaptable modalities such as mobile clinics, trained local providers, telemedicine guidance, and integration of the minimum initial service package at onset of crises; but legal variability and criminalization complicate implementation and expose both patients and providers to risk. Operational challenges include disrupted supply chains for medical abortion drugs and equipment, workforce shortages and ethical tensions among staff, monitoring and accountability constraints, and community resistance shaped by cultural and religious norms. The analysis highlights pragmatic strategies that preserve rights while navigating constraints: prioritizing clinical training and values-based preparation for personnel, ensuring availability of evidence-based supplies, embedding timely abortion care within emergency service packages, engaging communities to reduce stigma, and strengthening monitoring systems to protect patients and providers. Safe abortion services in humanitarian settings are not optional adjuncts but moral imperatives. Humanitarian agencies must move beyond rhetorical support to operationalize rights-centred, evidence-based abortion care despite legal and logistical

challenges. Upholding reproductive dignity and preventing avoidable harm in conflict zones requires decisive action: sustained commitment to service delivery, workforce capacity, supply security, community engagement, and accountability mechanisms that together translate ethical obligation into lifesaving practice.

KEYWORDS

abortion services, conflict zones, health, human right, moral ethics, war

Introduction

Unsafe abortion continues to be a serious public health concern on a global scale, accounting for an estimated 13% of all maternal deaths, or around 39,000 deaths per year, the majority of which take place in areas with limited resources or that are impacted by war (1). Unsafe abortion is defined by the WHO as a pregnancy termination procedure carried out by someone who is not qualified to do so or in a setting that does not meet basic medical requirements (2). In conflict zones settings, where infrastructure is damaged, health systems are frequently fractured, sexual violence and unintended pregnancy intersect, and legal protections are either halted or unclear, the situation is grimmer.

WHO estimates that around 68,000 women die annually due to unsafe abortion, largely from haemorrhage, infection, or organ damage (3). In countries affected by conflict, maternal mortality ratios can be up to five times higher than in stable regions (4). Reports from Sudhakaran et al. estimate that maternal mortality attributed to abortion may reach 25%–50% in refugee and displacement situations where abortion care is absent or limited (5, 6). Similarly, UNFPA analyses suggest that between 25% and 50% of maternal deaths in some refugee settings are linked to unsafe abortion complications (7). However, estimates of abortion related mortality in conflict and displacement settings vary by data source and methodology and should be interpreted with caution due to underreporting, attribution challenges, and measurement constraints in insecure environments. Despite this uncertainty, abortion related services have historically been neglected in humanitarian responses, reflecting compounded health system disruption during conflict, reduced access to emergency obstetric care, and persistent misconceptions among providers and communities about the restrictiveness of national law (8, 9).

These factors not only constrain access to essential reproductive health care but also contribute to higher levels of unintended pregnancy by increasing exposure to sexual violence, disrupting contraceptive supply chains, and weakening social and legal safeguards (10). In response to these pressures, humanitarian organizations have progressively expanded their sexual and reproductive health mandates to include emergency abortion treatment and post abortion care alongside maternal health and contraception services. The Inter Agency Working Group (IAWG) positions abortion care as a vital and life saving intervention in emergency contexts in the Inter Agency Field Manual on Reproductive Health in Humanitarian Settings (11). However, in practice, safe abortion services remain inconsistently implemented and are sometimes restricted or excluded by humanitarian actors, often due to donor

constraints, legal uncertainty, or perceived ethical dilemmas (12). Thus, this paper explores the health infrastructure, legal, and social consequences of restricted abortion access in emergency settings and analyses these challenges in relation to the core humanitarian principles of humanity, neutrality, impartiality, and independence.

Conflict zones and health infrastructure

Armed conflict systematically destroys health infrastructure and disrupts supply chains. For example, the wars in Syria and the Democratic Republic of the Congo respectively, has left medical supply chains disrupted, clinics and pharmacies looted, and health workers fleeing, so that essential services are collapsing (13, 14). South Sudan's decades of war likewise left its weak health system in ruins, such that only about 25%–30% of the population had any access to care by 2015 (15). In summary, conflict turns hospitals and clinics into ruins, forcing survivors to go without care or seek assistance in makeshift tents and mobile units (13–15).

Conflict also triggers massive social and economic upheaval that harms women's health. Millions are uprooted, as observed in Syria, where more than seven (14) million internally displaced persons live in overcrowded camps or informal sites (13). Displacement brings food shortages, unsanitary conditions, and disease outbreaks, as noted by WHO (13). Physical barriers, including destroyed roads, checkpoints, and the risk of violence, deter travel to clinics, especially in rural or conflict-heavy areas. Economic collapse makes care unaffordable as impoverished families cannot pay for transport or medicines. Social factors such as stigma and restrictive norms may also worsen, which can discourage women from seeking reproductive care, especially abortion or family planning in conservative communities under strain. These combined disruptions leave pregnant women at extreme risk, lacking both food and healthcare, and drive many towards unsafe solutions.

Humanitarian agencies have increasingly stepped in to fill these gaps, expanding their mandate to include sexual and reproductive health (SRH). International guidance now explicitly treats abortion as an essential component of emergency care. For instance, the 2018 Inter-Agency Field Manual (IAFM) for SRH in crisis calls for integrating safe abortion care (SAC) as part of the Minimum Initial Service Package (16, 17). MSF (Doctors Without Borders), since a 2004 policy resolution, has worked to incorporate safe abortion into its services (17). By 2023 MSF teams delivered over 54,600 safe abortions across 37

countries, even as they continue to treat the tens of thousands of complications from unsafe procedures (18). WHO's latest Abortion Care Guideline similarly reaffirms abortion as an essential, evidence-based health intervention with a strong human-rights foundation (19, 20). The United Nations Population Fund (UNFPA) also urges treating abortion as an essential service in emergencies (21). In this way, humanitarian policy has shifted, such that safe abortion care is now seen not as an optional extra, but as integral to preserving women's health and rights in crisis.

In practice, agencies use flexible delivery models to reach women. Mobile clinics and outreach teams are widely used, as reported by UNFPA where 28 mobile gynaecological teams were dispatched across Ukraine, providing SRH services to 111,000 women (22). Telemedicine is another innovation, as demonstrated by MSF, which piloted a hotline in the Middle East, remotely guiding 22 women through medical abortions at home (23). Other approaches include training midwives in manual vacuum aspiration and using the WHO Information, Education, and Communication (IEC) kits for post-abortion care. These programmatic adaptations help circumvent clinic shortages and legal barriers, making SRH care available even in insecure areas.

Agencies generally work through health clusters or agreements with ministries of health to ensure legality and scale. For example, in Bangladesh's Rohingya camps, UNFPA and Ipas collaborated with the government's health system to rapidly set up menstrual regulation (safe abortion) services, which within one month of the 2017 influx, eight health facilities were offering abortions, and by mid-2019 over 300 providers across 37 clinics had been trained (24). In Ukraine, UNFPA partnered with local NGOs (e.g., the Ukrainian Women's Foundation and family-planning charities) to establish 123 "barrier-free" SRH clinics for displaced women (22). In summary, successful programs align with ministries for oversight, train and support local health workers and NGOs, and involve community leaders in outreach, ensuring that even in conflict settings, comprehensive reproductive services, including safe abortion, reach women in need.

Legal and social landscape of abortion in conflict zones

Conflict zones are known for fragility and displacement, which can put women and children at high risk of unwanted pregnancy, sexually transmitted infections, and other risks of sexual violence and exploitation (25). This fragility and displacement may lead to the violation of international guidelines governing humanitarian health practice, hence raising profound ethical questions for humanitarian actors. This tension necessitates a closer examination of the ethical principles that govern reproductive health interventions in conflict settings, as discussed below.

Ethical framework and principles

Health interventions in conflict settings are commonly framed as being guided by beneficence and duty of care, requiring action

that promotes wellbeing and prevents avoidable harm among affected populations. However, in practice, these principles are not value neutral and often come into tension with legal restrictions, security risks, and institutional caution (26, 27). Respect for autonomy further requires recognition of girls' and women's reproductive decision making, yet autonomy is frequently constrained in humanitarian contexts by coercion, sexual violence, displacement, and service inaccessibility (28). In such settings, appeals to neutrality or legal compliance can function less as ethical safeguards and more as practical justifications for limiting reproductive choice.

Given the well documented association between armed conflict, sexual violence, and unintended pregnancy, restricting access to comprehensive reproductive health services, including safe abortion, raises serious ethical concerns about preventable harm and discriminatory exclusion (28, 29). Normative guidance increasingly reflects this position. The WHO Abortion Care Guideline grounds abortion access within beneficence, non-maleficence, autonomy, and equity, and calls on health systems and humanitarian actors to remove legal, policy, and operational barriers that impede timely care, including in emergencies (19). Similarly, International Federation of Gynecology and Obstetrics (FIGO) situates abortion care within medical ethics, reproductive justice, and gender equality, and argues that conscientious objection must not translate into effective denial of services, placing responsibility on institutions to ensure access through referral or task sharing arrangements (25).

Taken together, these frameworks shift the ethical debate from whether obligations exist to how they should be operationalized under constraint. The central ethical challenge for humanitarian actors is therefore not only to acknowledge duties in principle, but to justify and design implementation choices when legal, political, and security pressures make rights consistent service delivery difficult.

International human right reproductive right frameworks

Several international human rights guidelines and instruments recognise reproductive health, including safe abortion, as a major component of the right to health, which may be violated in conflict zones. The Geneva Conventions require the treatment of wounded and sick civilians, which is not limited to reproductive health services for survivors of sexual violence (30). Other guidelines, such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and FIGO not only support access to healthcare but also uphold the right to reproductive health autonomy, including access to safe abortion in conflict zones (25, 31, 32).

Variation in legal restrictions

The legal landscape governing abortion in conflict zones varies considerably across national context. In some countries, abortion remains criminalised except to save the pregnant woman's life, while others have no exceptions (33). This not only increases

the risk of unsafe abortion but also poses a challenge to healthcare workers in those settings as to whether to respect local laws or uphold international human rights norms (34, 35). However, humanitarian organisations working in conflict zones should maintain a balance by respecting local laws while offering safe abortion care in accordance with what the law permits (35).

Social, cultural and religious dimensions

In many societies, the acceptability and accessibility of abortion services are influenced by social stigma, religious doctrine, cultural beliefs, and practices, which may deter women and girls living in such societies from seeking or receiving services, even when these are legally permitted by local law in that conflict zone (36–38). For instance, Palestinian women may prefer to follow Palestinian law due to religious beliefs over the more abortion-permissive Israeli law (39). These social, cultural, and religious influences may trigger backlash against humanitarian service providers in conflict zones, thereby hindering service provision (40).

Moral responsibilities of humanitarian agencies in providing safe abortion services

Synthesis of moral imperatives vs. operational realities

The provision of safe abortion services is a complex issue that involves balancing moral imperatives with operational realities. The International Federation of Gynecology and Obstetrics asserts that the right to safe abortion is an integral part of sexual and reproductive health and rights, gender equality, reproductive justice, and universal health care, particularly in cases where pregnancy poses a risk to the life or health of women (41). Nonetheless, abortion care, operation, and prompt provision of non-judgmental services are preemptory, indeed in emergencies. Despite the evidence suggesting the need for safe abortion services and consensus in the humanitarian community about the importance of providing comprehensive abortion care, operational realities such as legal restrictions, social stigma, fear of death from unsafe abortion procedures, and lack of access to healthcare services can limit the availability of safe abortion services (42).

Balancing neutrality with advocacy for reproductive rights

Healthcare providers must balance their professional obligation to remain neutral with their moral obligation to advocate for reproductive rights. This can be particularly challenging in settings where abortion is heavily stigmatized or restricted (43, 44). However, advocacy for reproductive rights is essential to ensuring that women have access to safe and comprehensive reproductive healthcare services (45). Advocacy is core to the provision of sexual and reproductive health, and it

can take many forms, including supporting policy changes that promote reproductive rights, providing accurate information about abortion services, and engaging in public discourse about the importance of reproductive autonomy. By advocating for reproductive rights, healthcare providers can help to promote a culture of respect for women's dignity, their right to personal reproductive autonomy, and collective gender equality (46).

Implications for humanitarian ethics and global health policy

In humanitarian settings, there is often limited access to safe abortion services, and women may be forced to undergo unsafe abortions and seek care from unqualified providers, resulting in significant mortality and morbidity, mostly in settings where healthcare systems are already overstretched. Therefore, as a critical component of comprehensive reproductive healthcare, Global health policy should prioritize the provision of safe abortion services. This requires an obligation to ensure that abortion services are affordable, accessible, and safe, especially in low-income countries (47). This can help to promote the health and well-being of women and girls, particularly in humanitarian settings.

Challenges and dilemmas

Legal and security constraints

Eliminating unsafe abortion is a global priority from an international, public health, reproductive rights, and human rights perspective. Achieving this requires removing social and legal barriers to voluntary termination of pregnancy, while also ensuring that accessible reproductive health services, including safe abortion care, are available. Both governmental and non-governmental humanitarian organizations frequently encounter legal and security constraints that impede their capacity to respond effectively to crises. Abortion is a highly safe procedure when conducted by qualified personnel adhering to current medical protocols; however, it remains legally restricted in numerous countries (48), which can make it worse in war zones. Such restrictions necessitate that abortion be performed illegally, in a clandestine manner, and under unsafe conditions. The imposition of restrictive laws and regulations by governments can inhibit their ability to operate in particular areas or to provide specific services. Furthermore, security threats, including kidnapping, violence, or arrest, can restrict humanitarian workers' access to the affected populations (49, 50).

Resource limitations and supply chains

A crucial component of abortion care relies on a functional supply chain to ensure the availability of supplies and abortion drugs such as misoprostol or mifepristone, manual vacuum aspiration (MVA) kits, or other key medicines such as analgesics and antibiotics within the health system. Disruptions in the supply of medical abortion drugs delay the provision of abortion

services and can increase the risks to the health of women. Furthermore, inefficiencies such as poor funding for procurement and distribution, weak management systems, lack of trained staff, and governmental policies that limit procurement or distribution of supplies create substantial bottlenecks in the supply chain (51).

Ethical tensions among staff

Healthcare organizations face ethical tensions among workers, particularly in complex and high-pressure environments. A variety of factors undercut the ability of healthcare workers to fulfill their responsibilities, such as cultural differences that can lead to differing values and perspectives on service response, while moral dilemmas such as prioritizing aid to certain groups over others can create ethical tensions. Other issues affecting healthcare worker rights and the roles they ultimately play in health systems include facilities and communities' challenges to their rights, roles, and responsibilities, such as conflicting policies laws, and guidelines; pressure to achieve coverage and quality; violations of the rights and professionalism of healthcare workers, undercutting their ability and motivation to fulfill their responsibilities; inadequate stewardship of the private sector; competing paradigms for decision-making such as religious beliefs, that are inconsistent with professional responsibilities; donor conditionalities and fragmentation; and, the persistence of embedded practical norms that are at odds with healthcare worker rights and responsibilities. The tensions lead to a host of undesirable outcomes, ranging from professional frustration to the provision of a narrower range of services or poor-quality services (52).

Community resistance and stigma

There is substantial evidence that at the community level, Community Health Workers can deliver a wide range of services, that they can increase access to essential healthcare services, and that scaling up community-level interventions can lead to large improvements in reproductive, maternal, and child health (53). However, the challenges to implement community health services in a humanitarian setting can be daunting, and these include acute and protracted crises, such as prolonged periods of conflict and insecurity and during population displacement, reduced access to services when travel was limited, security threats and psychological trauma because of their work (54).

Monitoring, evaluation, and accountability

Collecting and analyzing data is crucial to understanding the impact of programs and making informed decisions. In addition, establishing accountability mechanisms ensures transparency and accountability to affected populations. Challenges in monitoring, evaluating, and ensuring accountability in programs are being faced by healthcare organizations. Such challenges include criminalization of abortion practices, poor quality of care, and reduced access to safe abortion. However, these challenges must

be navigated to provide effective and efficient aid to those in need. Recognizing these challenges does not negate ethical responsibility; rather, it underscores the need for deliberate, evidence-informed strategies that can reconcile moral obligations with operational realities that can better address the needs of affected populations (55).

Strategic recommendations

In order to protect their rights, humanitarian agencies and systems must ensure that women, girls, and professionals are not criminalized for either seeking or providing timely and necessary abortion treatment and services (25). This can be achieved through (Table 1).

1. **Advocacy for Policy Reform on Abortion Access:** Humanitarian agencies must intensify efforts to advocate for the decriminalization and legalization of abortion, particularly in conflict-affected countries. Strategic policy engagement with United Nation (UN) bodies, government authorities, ministries of women affairs and human right organizations is necessary to **eliminate the legal, security and social constraints to voluntary termination of pregnancy**, and enable safe, timely, and equitable abortion services in humanitarian settings.
2. **Skilling up the Healthcare Workforce:** Health care providers who work in emergency situations ought to receive training on how to deliver safe, high-quality abortion services that respect patients' rights. Almost always required, workshops that cover attitudes, values, and beliefs are best conducted prior to technical training and service delivery. Long before a crisis, UN agencies, governments, and international and national NGOs, among others, must support the capacity of local Ministries of Health and Disaster Management, national and community-based organizations, health workers, and communities themselves to strengthen health systems with an emphasis on comprehensive reproductive health, accessibility, and resilience-building within a rights-based framework. Operational readiness, training, and supportive supervision enable abortion service delivery even in complex emergency environments.
3. **Timely Access Medical Equipment and Medications:** Time-sensitive critical health care is a fundamental human right. This right to health and scientific advancement should not be denied because of a person's circumstances; even in an emergency, refugees, asylum seekers, and displaced individuals should have access to safe abortion (56). In crisis setting, affected populations should be informed about the abortion services that are accessible and the circumstances in which they can be rendered, as well as the availability of context-relevant and evidence-based equipment and drugs. Moreover, Casey et al. (59) and Krause et al.'s (60) studies highlight the urgent need to strengthen commodity management processes to prevent stock-outs and provide consistent access to care.
4. **Integration of Minimum Initial Service Package (MISP):** The MISP is an emergency response that should be put into

TABLE 1 Linking evidence to strategic recommendations for safe abortion care in humanitarian settings.

Recommendation	Supporting evidence/examples	Implementation preconditions (Who, what, How)	Key risks	Mitigation strategies	Suggested indicators
Advocacy for Policy Reform on Abortion Access	Restrictive abortion laws in conflict settings force clandestine, unsafe procedures, increasing maternal morbidity and mortality. (46, 48–50)	Who: Humanitarian agencies, UN bodies, ministries of health, human rights organizations What: Policy dialogue, legal reviews, protection clauses for providers and patients. How: Strategic advocacy, engagement with ministries of women affairs, legal aid partnership.	Political backlash or suspension of humanitarian access	Frame advocacy within human rights, lifesaving care, public health and humanitarian law. Use incremental reforms and coalition advocacy	Humanitarian permits for abortion care; Policy inclusion; legal clarifications; Reduction in reported providers arrest or service disruption
Skilled Training for Healthcare Providers	Prepared and supported providers can deliver care even in restrictive environments (52).	Who: Ministries of Health, NGOs, professional associations. What: Values clarification, clinical abortion training, supportive supervision. How: Pre-crisis capacity building; in-service training; mentorship models embedded in emergency preparedness plans; referral pathways	Conscientious objection; staff resistance; burnout due to moral conflict	Values clarification; Ongoing ethical support; peer mentoring; non-punitive work environments; task-sharing	Provider coverage, Provider confidence and attitude scores, and referral completion.
Ensure Timely Access to Medical Equipment and Medications	Commodity management failures (51, 56)	Pre-positioning supplies, emergency procurement waivers, integrated logistics management systems of essential abortion drugs and equipment	Stock-outs; border restrictions; Confiscation of supplies.	Clear labeling as essential medicines, diversified supply routes, donor alignment with humanitarian standards	Stock-out frequency; Average time to replenish supplies; Proportion of facilities with full abortion commodity kits
Integration of the Minimum Initial Service Package (MISP)	The MISP is an evidence-based framework proven to reduce preventable maternal morbidity and mortality in emergencies when implemented early (57)	Who: Humanitarian coordinators, health cluster leads, Ministries of Health. What: Full MISP implementation including abortion-related components. How: Immediate activation at crisis onset, standardized protocols, coordination through health clusters.	Delayed activation or partial implementation.	Pre-crisis planning, accountability within health clusters, routine MISP audits.	Time from crisis onset to MISP activation; Inclusion of abortion care in MISP plans; Facility-level MISP compliance
Community Engagement and Stigma Reduction	Engagement with community leaders and CHWs improves acceptability and service uptake (53, 54, 58).	Dialogue forums, CHW training, culturally sensitive messaging.	Community backlash or targeting of providers/clients.	Anonymized reporting; Confidential service models, trusted intermediaries, gradual norm-shifting approaches	Complication rates; Service uptake trends;

place as soon as a humanitarian crisis occurs. Its purpose is to provide women and girls with the minimal sexual and reproductive health (SRH) interventions required to prevent mortality and morbidity (57). Pre-crisis planning and routing MISP audits can mitigate the occurrence of delayed or partial implementation.

5. **Community Engagement and Stigma Reduction:** To establish a supportive environment for women seeking abortion services in conflict areas, government and non-governmental organizations should enter a memorandum of understanding (MOU) with community leaders, survivors, medical professionals, law enforcement, and

other stakeholders (58). Additionally, community members ought to be informed and trained against stigmatizing those who obtain abortion services. Leaders in the community should incorporate anti-stigmatization customs to help women who deserve abortion services feel less afraid.

Limitations of the study

First, as a Policy and Practice perspective review, it does not provide the exhaustive coverage of a evidence synthesis or empirical findings. Most of the evidence is context-specific, shaped by national legal frameworks, security conditions, displacement patterns, and baseline health system capacity, limiting generalizability across conflict typologies. Second, epidemiological data on abortion-related outcomes in conflict settings remain limited due to underreporting, stigma, and challenges in attributing maternal deaths. Finally, key evidence gaps remain, including comparative effectiveness of service delivery models, legal risk mitigation strategies, standardized monitoring indicators, and long-term outcomes of stigma-reduction interventions. Addressing these gaps should be a priority for future humanitarian research.

Conclusion

It is evidently clear that unsafe abortion remains a leading cause of preventable maternal mortality in crisis settings, exacerbated by fractured health systems, legal ambiguity, and sociocultural stigma. Yet, safe abortion is a medically simple, cost-effective, and essential component of emergency health response. This review has demonstrated that humanitarian agencies bear a moral and professional responsibility to ensure a safe abortion services, grounded in international human rights law, medical ethics, and the core humanitarian principles of humanity, impartiality, neutrality, and independence. Ultimately, the provision of safe abortion in conflict zones is not merely a clinical obligation; it is a moral imperative. Evidence from humanitarian responses indicate that when appropriately integrated into emergency reproductive health programming, safe abortion services can be delivered in ways that are context-sensitive, right-informed and operationally feasible. Humanitarian actors may benefit from moving beyond rhetorical support and operational hesitancy to embrace abortion care as a key component of comprehensive emergency health response for women. Aligning ethical commitments with practical implementation has the potential to support reproductive justice, protect vulnerable populations, and fulfill their ethical mandate to do no harm.

Author contributions

CA: Conceptualization, Data curation, Methodology, Project administration, Supervision, Writing – original draft, Writing –

review & editing. OE: Formal analysis, Investigation, Methodology, Validation, Visualization, Writing – original draft. MN: Conceptualization, Data curation, Investigation, Methodology, Writing – original draft, Writing – review & editing. GE: Formal analysis, Investigation, Methodology, Project administration, Writing – review & editing. CN: Conceptualization, Formal analysis, Resources, Validation, Visualization, Writing – original draft. EU: Formal analysis, Project administration, Resources, Writing – original draft. CO: Formal analysis, Investigation, Methodology, Writing – review & editing. SE: Project administration, Supervision, Visualization, Writing – review & editing.

Funding

The author(s) declared that financial support was not received for this work and/or its publication.

Acknowledgments

The authors gratefully acknowledge the support and mentorship provided through the Youth in Research Hub. This manuscript is a product of collaborative engagement and capacity-building efforts led by the Hub to foster research leadership among early-career African scholars.

Conflict of interest

The author(s) declared that this work was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Generative AI statement

The author(s) declared that generative AI was not used in the creation of this manuscript.

Any alternative text (alt text) provided alongside figures in this article has been generated by Frontiers with the support of artificial intelligence and reasonable efforts have been made to ensure accuracy, including review by the authors wherever possible. If you identify any issues, please contact us.

Publisher's note

All claims expressed in this article are solely those of the authors and do not necessarily represent those of their affiliated organizations, or those of the publisher, the editors and the reviewers. Any product that may be evaluated in this article, or claim that may be made by its manufacturer, is not guaranteed or endorsed by the publisher.

References

- Say L, Chou D, Gemmill A, Tunçalp Ö, Moller AB, Daniels J, et al. Global causes of maternal death: a WHO systematic analysis. *Lancet Glob Health*. (2014) 2(6):e323–33. doi: 10.1016/S2214-109X(14)70227-X
- WHO. Preventing unsafe abortion (2021). Available online at: <https://www.who.int/news-room/fact-sheets/detail/abortion> (Accessed June 9, 2025).
- Saludeverywhere. Abortion in humanitarian and conflict settings (2025). Available online at: <https://saludeverywhere.com/en/health-in-humanitarian-crises/abortion-in-humanitarian-and-conflict-settings/> (Accessed January 13, 2026).
- World Health Organization. Maternal mortality (2025). Available online at: <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality> (Accessed January 13, 2026).
- Erhardt-Ohren B, Paul D, Mahmud A, Tarannum A, Weidert K, Hossain A, et al. Maternal mortality due to abortion complications in forcibly displaced populations: a study protocol for a community-facility capture-recapture (CFRC) study. *PLoS one*. (2025) 20(2):e0315182. doi: 10.1371/journal.pone.0315182
- ELRHA. Her Health, Our Future: The Case for Evidence-Based Abortion Care in Humanitarian Policy and Funding (2025). Available online at: <https://www.elrha.org/resource/her-health-our-future-evidence-based-abortion-care-in-humanitarian-policy-and-funding> (Accessed January 13, 2026).
- United Nations Population Fund (UNFPA). State of World Population 1999: Six Billion – A Time for Choices. (1999). Available online at: <https://reliefweb.int/attachments/d44b0578-406d-39b0-b206-e2dc9b2ef97/43028854B9E8B966C1256DBB002FB644-fpa-swp-1999.pdf> (Accessed June 9, 2025).
- Lehmann A. Safe abortion: a right for refugees? *Reprod Health Matters*. (2002) 10(19):151–5. doi: 10.1016/S0968-8080(02)00026-5
- McGinn T. Reducing death and disability from unsafe abortion. In: Parker R, Sommer M, editors. *Routledge Handbook of Global Public Health*. New York: Routledge (2010). p. 23–30.
- Tanabe M, Schaus K, Rastogi S. Ensuring sexual and reproductive health for women affected by conflict: findings from an evidence review. *Confl Health*. (2021) 15(1):38. doi: 10.1186/s13031-021-00365-4
- Inter-Agency Working Group on Reproductive Health in Crises (IAWG). *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. New York: IAWG (2018).
- Foster AM, Evans DP, Garcia M, Knaster S, Krause S. The 2018 revision of the inter-agency field manual on reproductive health in humanitarian settings: process and lessons learned. *Reprod Health Matters*. (2019) 27(53):1846114. doi: 10.1080/09688080.2019.1846114
- World Health Organization. *Syria Crisis*. Geneva: WHO (2024). Available online at: <https://www.who.int/emergencies/situations/syria-crisis> (Accessed May 29, 2025).
- United Nations Development Programme. *Crisis in the DR Congo* (2025). Available online at: <https://www.undp.org/stories/crisis-dr-congo> (Accessed May 29, 2025).
- Sami S, Mayai A, Sheehy G, Lightman N, Boerma T, Wild H, et al. Maternal and child health service delivery in conflict-affected settings: a case study from South Sudan. *Confl Health*. (2020) 14:34. doi: 10.1186/s13031-020-00272-2
- Inter-Agency Working Group on Reproductive Health in Crises. *Safe Abortion Care in the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Humanitarian Settings*. New York: IAWG (2019). Available online at: <https://iawg.net/resources/safe-abortion-care-in-the-minimum-initial-service-packag-e-misp-for-sexual-and-reproductive-health-in-humanitarian-settings> (Accessed November 6, 2025).
- Okeke SR, Okeke-Obayemi DO, Njoroge MR, Yaya S. Collateral damage: the overlooked reproductive health crisis in conflict zones. *Reprod Health*. (2024) 21:198. doi: 10.1186/s12978-024-01941-8
- Medecins Sans Frontieres. *Safe Abortion Care*. Available online at: <https://www.msf.org/safe-abortion-care-depth> (Accessed June 8, 2025).
- World Health Organization. Abortion care guideline: executive summary. Available online at: <https://www.who.int/publications/i/item/9789240045163#:~:text=The%20objective%20of%20this%20guideline,respect%20to%20quality%20abortion%20care> (Accessed June 9, 2025).
- Center for Reproductive Rights. *Using the law to Protect Reproductive Rights Worldwide*. New York: Center for Reproductive Rights (2016). Available online at: <https://reproductiverights.org> (Accessed November 6, 2025).
- Center for Reproductive Rights. *Human Rights Standards on Comprehensive Abortion Care: Key Questions for Monitoring Health System Compliance*. New York: Center for Reproductive Rights (2022). Available online at: unfpa.org (Accessed June 10, 2025).
- United Nations Population Fund, Ukraine. *Sexual and Reproductive Health*. Ukraine: UNFPA (2025). Available online at: <https://ukraine.unfpa.org/en/topics/sexual-and-reproductive-health-10#:~:text=28%C2%A0mobile%20gynaecological%20teams%20and%20one,Sumy%2C%20Chernihiv%2C%20Donetsk%2C%20Kherson%2C%20A0and%20Odesa> (Accessed June 9, 2025).
- Lasserre L, Staderini N, Hasan M, Rossi V. Self-managed abortion as a humanitarian revolution: accounts of a telehealth pilot in the Middle East. *Confl Health*. (2025) 19(1):8. doi: 10.1186/s13031-024-00641-1
- Feetters T, Rubayet S, Sultana S, Nahar S, Tofigh S, Jones L, et al. Navigating the crisis landscape: engaging the ministry of health and united nations agencies to make abortion care available to rohingya refugees. *Confl Health*. (2020) 14:50. doi: 10.1186/s13031-020-00298-6
- International Federation of Gynecology and Obstetrics. Supporting access to safe abortion in conflict and humanitarian settings (2023). Available online at: <https://www.ifo.org/resources/ifo-statements/supporting-access-safe-abortion-conflict-and-humanitarian-settings> (Accessed May 28, 2025).
- Broussard G, Rubenstein LS, Robinson C, Maziak W, Gilbert SZ, DeCamp M. Challenges to ethical obligations and humanitarian principles in conflict settings: a systematic review. *J Int Humanit Action*. (2019) 4:15. doi: 10.1186/s41018-019-0063-x
- Rubenstein L, Haar R. What does ethics demand of health care practice in conflict zones? *AMA J Ethics*. (2022) 24(6):E535–41. doi: 10.1001/amajethics.2022.535
- Singh S, Remez L, Sedgh G, Kwok L, Onda T. *Abortion Worldwide 2017: Uneven Progress and Unequal Access*. New York: Guttmacher Institute (2018). Available online at: <https://www.guttmacher.org/report/abortion-worldwide-2017> (Accessed May 28, 2025).
- United Nations Population Fund. *State of World Population 2015: Shelter from the Storm—a Transformative Agenda for Women and Girls in a Crisis-prone world*. New York: UNFPA (2015). Available online at: https://www.unfpa.org/sites/default/files/pub-pdf/State_of_World_Population_2015_EN.pdf (Accessed May 28, 2025).
- International Committee of the Red Cross. *Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies*. Geneva: International Committee of the Red Cross (2013). Available online at: <https://www.icrc.org/en/document/ethical-principles-health-care-conflict-and-emergencies> (Accessed May 28, 2025).
- United Nations. *International Covenant on Economic, Social and Cultural Rights*. New York City: United Nations Publications (1966). Available online at: <https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights> (Accessed May 28, 2025).
- United Nations. *Convention on the Elimination of All Forms of Discrimination Against Women*. New York City: United Nations Publications (1979). Available online at: <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women> (Accessed May 28, 2025).
- United Nations Department of Economic and Social Affairs, Population Division. *World Abortion Policies 2013*. New York City: United Nations Publications (2013). Available online at: <https://www.un.org/en/development/desa/population/publications/policy/world-abortionpolicies-2013.shtml> (Accessed May 28, 2025).
- Ganatra B, Gerds C, Rossier C, Johnson BR, Tunçalp Ö, Assifi A, et al. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. *Lancet*. (2017) 390(10110):2372–81. doi: 10.1016/S0140-6736(17)31794-4
- McGinn T, Casey SE. Why don't humanitarian organizations provide safe abortion services? *Confl Health*. (2016) 10(1):8. doi: 10.1186/s13031-016-0075-8
- Adamczyk A, Cuvilier F, Chen FY, Tseng CC, Lin YA. The effect of personal religiosity on attitudes toward abortion, divorce, and gender equality: does cultural context make a difference? Available online at: https://www.researchgate.net/publication/331453113_The_Effect_of_Personal_Religiosity_on_Attitudes_toward_Abortion_Divorce_and_Gender_Equality-Does_Cultural_Context_Make_a_Difference (Accessed July 22, 2025).
- Shahawy S, Diamond MB. Perspectives on induced abortion among Palestinian women: religion, culture and access in the occupied Palestinian territories. *Cult Health Sex*. (2018) 20(3):289–305. doi: 10.1080/13691058.2017.1344301
- Chandrasekaran S, Key K, Ow A, Lindsey A, Chin J, Goode B, et al. The role of community and culture in abortion perceptions, decisions, and experiences among Asian Americans. *Front Public Health*. (2023) 10:982215. doi: 10.3389/fpubh.2022.982215
- Shahawy S. The unique landscape of abortion law and access in the occupied Palestinian territories. *Health Hum Rights*. (2019) 21(2):47–56.
- Tazinya RM, El-Mowafi IM, Hajjar JM, Yaya S. Sexual and reproductive health and rights in humanitarian settings: a matter of life and death. *Reprod Health*. (2023) 20(1):42. doi: 10.1186/s12978-023-01594-z
- FIGO. *The Global Voice for Women's Health* (2023). Available online at: <https://www.ifo.org/resources/ifo-statements/supporting-access-safe-abortion-conflict-and-humanitarian-settings> (Accessed May 29, 2025).
- Jayaweera R, Powell B, Gerds C, Kakesa J, Ouedraogo R, Ramazani U, et al. The potential of self-managed abortion to expand abortion access in humanitarian contexts. *Front Glob Womens Health*. (2021) 2:681039. doi: 10.3389/fghw.2021.681039
- Amnesty International. *El Salvador's Total ban on Abortion: The Facts*. London: Amnesty International (2015). Available online at: <https://www.amnesty.org/en/latest/press-release/2015/11/el-salvador-total-abortion-ban/> (Accessed November 13, 2025).

44. Lilly AG, Newman IP, Bjork-James S. Our hands are tied: abortion bans and hesitant medicine. *Soc Sci Med.* (2024) 350:116912. doi: 10.1016/j.socscimed.2024.116912
45. de Vries I, van Keizerswaard LJ, Tolboom B, Bulthuis S, van der Kwaak A, Tank J, et al. Advocating safe abortion: outcomes of a multi-country needs assessment on the potential role of national societies of obstetrics and gynecology. *Int J Gynaecol Obstet.* (2020) 148(3):282–9. doi: 10.1002/ijgo.13092
46. Carroll S, Joshi D, Espey E. Physicians and healthcare professionals as advocates for abortion care and reproductive choice. *Curr Opin Obstet Gynecol.* (2022) 34(6):367–72. doi: 10.1097/GCO.0000000000000833
47. Adekola PO, Adedini SA. Sexual violence, disclosure pattern, and abortion and post-abortion care services in displaced people's camps in Africa: a scoping review. *Int J Environ Res Public Health.* (2024) 21:1001. doi: 10.3390/ijerph21081001
48. Ambast S, Atay H, Lavelanet A. A global review of penalties for abortion-related offences in 182 countries. *BMJ Glob Health.* (2023) 8:e010405. doi: 10.1136/bmjgh-2022-010405
49. Dias Amaral B, Sakellariou D. Maternal health in crisis: a scoping review of barriers and facilitators to safe abortion care in humanitarian crises. *Front Glob Womens Health.* (2021) 2:699121. doi: 10.3389/fgwh.2021.699121
50. Sridhar A, Koch MR, Kasliwal A, Morris JL, Gil L, Purandare N, et al. Beyond borders: the global impact of violating reproductive human rights. *Int J Gynaecol Obstet.* (2024) 167(3):877–82. doi: 10.1002/ijgo.15945
51. Samandari G, Kapp N, Hamon C, Campbell A. Challenges in the abortion supply chain: a call to action for evaluation research. *Reprod Health.* (2021) 18:14. doi: 10.1186/s12978-020-01060-0
52. Schaaf M, Lavelanet A, Codjia L, Nihlén Å, Rehnstrom Loi U. A narrative review of challenges related to healthcare worker rights, roles and responsibilities in the provision of sexual and reproductive services in health facilities. *BMJ Glob Health.* (2023) 8(Suppl 4):e012421. doi: 10.1136/bmjgh-2023-012421
53. Le Roux KW, Almirol E, Rezvan PH, Le Roux IM, Mbewu N, Dippenaar E, et al. Community health workers impact on maternal and child health outcomes in rural South Africa—a non-randomized two-group comparison study. *BMC Public Health.* (2020) 20:1404. doi: 10.1186/s12889-020-09468-w
54. Miller NP, Ardestani FB, Dini HS, Shafique F, Zunong N. Community health workers in humanitarian settings: scoping review. *J Glob Health.* (2020) 10(2):020602. doi: 10.7189/jogh.10.020602
55. de Londras F, Cleeve A, Rodriguez M I, Farrell A, Furgalska M, Lavelanet A. The impact of criminalisation on abortion-related outcomes: a synthesis of legal and health evidence. *BMJ Glob Health.* (2022) 7:e010409. doi: 10.1136/bmjgh-2022-010409
56. FIGO. FIGO Statement: FIGO endorses the permanent adoption of telemedicine abortion services. Available online at: www.figo.org/FIGO-endorses-telemedicine-abortion-services (Accessed June 6, 2025).
57. Nabulsi D, Abou Saad M, Ismail H, Doumit MA, El-Jamil F, Kobeissi L, et al. Minimum initial service package (MISP) for sexual and reproductive health for women in a displacement setting: a narrative review on the Syrian refugee crisis in Lebanon. *Reprod Health.* (2021) 18:58. doi: 10.1186/s12978-021-01108-9
58. Amplify change. Building community approaches to address conflict-related sexual violence in Cameroon. Available online at: <https://amplifychange.org/grantee-stories/building-community-approaches-to-address-conflict-related-sexual-violence-in-cameroon/> (Accessed June 6, 2025).
59. Casey SE, Chynoweth SK, Cornier N, Gallagher M, Wheeler EE. Progress and gaps in reproductive health services in three humanitarian settings: mixed-methods case studies. *Confl Health.* (2015) 9(Suppl 1):S3. doi: 10.1186/1752-1505-9-S1-S3
60. Krause SK, Williams H, Onyango MA, Sami S, Doedens W, Giga N, et al. Reproductive health services for Syrian refugees in zaatri camp and irbid city, hashemite kingdom of Jordan: an evaluation of the Minimum initial services package. *Confl Health.* (2015) 9(Suppl 1):S4. doi: 10.1186/1752-1505-9-S1-S4