

GUIDANCE

Implementing comprehensive abortion care in emergencies: guidance, tools and field-based examples

February 2026



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Acronyms

BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CACiE	comprehensive abortion care in emergencies
GBV	gender-based violence
IAFM	Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings
IASC	Inter-Agency Standing Committee
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
IPPF	International Planned Parenthood Federation
IRC	International Rescue Committee
MA	medical abortion
MVA	manual vacuum aspiration
MHPSS	mental health and psychosocial support
MISP	Minimum Initial Service Package
NGO	non-governmental organization
PAC	post-abortion care
PPFN	Planned Parenthood Federation of Nigeria
SAC	safe abortion care
SMA	self-managed abortion
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
SRH-TT	SRH-Task Team
TAG	Technical Advisory Group
VCAT	Values Clarification and Attitude Transformation
WHO	World Health Organization

I. Introduction

The World Health Organization (WHO) defines **comprehensive abortion care (CAC)** as the provision of information, abortion management (including induced abortion and care related to pregnancy loss) and post-abortion care (WHO, 2022a). **Post-abortion care (PAC)** is defined as the provision of services after an abortion, such as contraceptive services and linkages to other needed services in the community or beyond. It can also include management of complications after an abortion (WHO, 2022a). **Safe abortion care (SAC)** refers to abortions that are carried out using one of the WHO-recommended methods, appropriate to the gestational age and by someone with the necessary skills.

Both PAC and SAC are core components of the *Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crises* as defined by the Inter-Agency Working Group on Reproductive Health in Crises (IAWG).

MISP Objective 4: Prevent excess maternal and newborn morbidity and mortality includes PAC as an integral function of emergency obstetric and newborn care, which should be provided without delays, denial of service or breach of patient confidentiality.

MISP Objective 2: Respond to the needs of sexual violence survivors calls for provision of SAC or referrals for all pregnancy options to the full extent of the law for survivors of sexual violence (IAFM, 2018).

The **“Other MISP Priority”** calls for the provision of SAC to the full extent of the law.

Chapter 8 of the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (IAFM)* goes into more detail about establishing CAC programmes, improving the quality of care and engaging with communities on their rights and policymaker duties. The *Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response* recognizes PAC as a life-saving intervention and endorses SAC access or referrals to the full extent of the law without discrimination (Sphere, 2018).

Sexual and reproductive health (SRH) coordinators, programme managers and front-line service providers should ensure that CAC in emergencies (CACiE) is available in all humanitarian contexts. PAC should be made available at the onset of a crisis, with no exceptions or delays. When capacity already exists, SAC should be made available to the full extent of the law from the earliest days of a crisis. In contexts where capacity is not already in place, SAC should be made available to the full extent of the law once implementation of the MISP is under way, ideally within the first three months after the onset of an emergency.

Why CACiE matters

The need for CAC in humanitarian settings is urgent and undeniable. The humanitarian imperative to reduce preventable mortality and uphold the rights and dignity of crisis-affected populations demands that CAC be integrated into emergency response.

Maternal mortality is significantly higher in conflict-affected areas (504 deaths per 100,000 live births), compared with fragile settings (368 per 100,000) and non-conflict or non-fragile settings (99 per 100,000).

In 2023, 37 countries were classified as being in conflict or institutional or social fragility (World Bank, 2023), accounting for 61 per cent of global maternal deaths (WHO, 2025). Complications from unsafe abortion account for an estimated 8 per cent of global maternal mortality (Cresswell, 2025) and in certain conflict-affected countries such as the Central African Republic, abortion-related complications are estimated to be responsible for 31 per cent of the country's direct causes of maternal deaths (MSF AMOCO French, 2023; CAR Ministère de la Santé, 2010).

Women and adolescent girls in crisis contexts are at risk for unintended pregnancies due to increased exposure to sexual violence and challenges accessing essential SRH information and services, including contraception. Other factors, such as school closure, loss of livelihoods and child marriage specifically affect adolescents and increase their risks of unintended pregnancy. The risks associated with unsafe abortion are magnified by a breakdown in access to emergency obstetric care and limited access to safe abortion services, even though in most countries, national law permits SAC for at least one indication (Ipas, 2023). For instance, near-miss abortion complications were 1.6 times more frequent and severe life-threatening complications were seven times more frequent in African hospitals in two humanitarian settings compared with African hospitals in stable settings (Pasquier, 2023).

Access to SAC is increasingly recognized as a human right. Regional and international bodies – including the United Nations Human Rights Committee, the African Commission on Human and Peoples' Rights and the Inter-American Court of Human Rights – have affirmed access to abortion as integral to the right to life, health and freedom from torture and discrimination (Amon, 2024).

Objective, intended audience and involved stakeholders

The objective of this guidance is to provide front-line SRH and gender-based violence (GBV) service providers, programme managers and coordinators working in humanitarian settings with information and tools to support the provision of high-quality CACiE services. The document summarizes key elements of existing CAC guidelines with the aim of overcoming the “know-do gap” and supporting humanitarian actors to address morbidity and mortality due to complications of unsafe abortion and lack of access to SAC services.

This document was developed by the SRH-Task Team (SRH-TT) of the Global Health Cluster and informed by consultations with SRH and GBV actors at the global, regional and national levels. Some specific information and sources are anonymous at the request of the key informants due to the sensitive nature of this topic.

Although PAC has always been a core component of the MISP, the recognition of SAC as a life-saving humanitarian SRH intervention was only established in the 2018 IAFM. The following sections summarize the key issues related to PAC and strategies to ensure that PAC services are fully implemented in emergencies. This is followed by a deeper dive into SAC, including principles, emergent strategies and examples of SAC implementation in humanitarian settings across a range of legal contexts.

II. Ensuring access to PAC in humanitarian settings

PAC is legal in all contexts as a standard element of both Basic and Comprehensive Emergency Obstetric and Newborn Care (BEmONC/CEmONC). It is essential, therefore, that health workers in EmONC and CEmONC facilities are trained and equipped to provide high-quality PAC services (IAWG, 2018), including management of incomplete abortion using either medication (misoprostol) or manual vacuum aspiration (MVA) (WHO, 2022a). High-quality PAC goes beyond clinical treatment to include a non-judgmental approach to care, ensuring that patients are also offered comprehensive contraceptive information, counselling and methods to prevent future unintended pregnancies (IAWG, 2018; WHO, 2022a).

A rights-based, gender-sensitive and trauma-informed approach to PAC is crucial for improving its quality and accessibility in humanitarian settings (IAWG, 2020). PAC is more than just treating a complication; it is a holistic, patient-centred service that must be delivered without judgment and with respect for privacy (WHO, 2022a). Key actions to improve quality include ensuring services are available, accessible, acceptable and of good quality (WHO, 2022a). These principles are the foundation for overcoming common issues such as delays in treatment, a lack of pain medication and the refusal of care (Ipas, 2024; Médecins Sans Frontières and others, n.d.).

Key measures to improve PAC access

- Strengthen legal understanding and confidentiality:** Confusion among staff about local laws and national policies can lead to self-censorship and fear (IAWG, 2020). All staff must be educated on the legal framework related to PAC to clarify their professional obligations. Confidentiality is a guiding principle that must be protected, especially for survivors of sexual violence, to build trust and encourage care-seeking behaviour (WHO, 2022a).
- Strengthen clinical skills:** Competency-based clinical training is essential to ensure providers have the necessary skills and confidence to deliver safe and effective PAC (WHO, 2022a). This includes training on uterine evacuation using both misoprostol and MVA, managing complications (IAWG Training Partnership Initiative, 2023), providing post-abortion contraception and adolescent-friendly services. Ongoing supportive supervision, coaching and mentorship are also critical for maintaining high standards of care (IAWG, 2020).
- Conduct Values Clarification and Attitude Transformation (VCAT):** Even with legal clarity and clinical skills, a provider's personal attitudes and fears can pose a significant barrier to providing quality care (IAWG, 2020; Ipas, 2021). VCAT workshops are a proven tool for addressing these internal biases, helping providers align their personal values with their professional commitment to patient care. VCAT is often a necessary first step before technical training.
- Ensure access to pain medication:** Pain management is a fundamental component of quality PAC (WHO, 2022a). A lack of pain medication can be a significant barrier to women seeking or completing care (Médecins Sans Frontières and others, n.d.). As part of clinical training and service provision, providers must ensure that pain medication is consistently available and offered to all patients without judgment (WHO, 2022).

- **Ensure access to contraceptives after PAC:** Post-abortion family planning is a core element of comprehensive PAC that significantly reduces the risk of future unintended pregnancies and repeat unsafe abortions (IAWG, 2020; Ipas, 2021). It is essential to ensure that a wide range of contraceptive methods is available and that all patients receive contraceptive counselling if they choose. If patients opt for contraception after PAC, they should receive the method of their choice immediately following PAC (WHO, 2022a). This is a proven strategy for improving both maternal and reproductive health outcomes (Ipas, 2021).

III. Ensuring access to SAC in humanitarian settings

Safe abortion guiding principles

The IAWG Safe Abortion Sub-Working Group developed the following set of guiding principles for SAC that are foundational to improving SRH care and outcomes (IAWG, 2025b):

1. **Access to safe abortion for all women and adolescent girls in crisis is a human right.** The right to access safe and legal abortion services is grounded in the realization of other core human rights, including the right to life, health, equality, privacy, self-determination, bodily integrity and freedom from inhuman or degrading treatment and discrimination, as well as the right to benefit from scientific progress. Numerous international and regional human rights instruments have upheld a woman's right to safe and legal abortion.
2. **SAC is an evidence-based health intervention that prevents maternal mortality and morbidity.** For every woman or adolescent girl who dies from unsafe abortion, many more are left with serious injuries or permanent disabilities, including infertility. These deaths, injuries and disabilities can be almost entirely prevented by ensuring access to SAC services. Access to SAC is considered part of a comprehensive package of sexual, reproductive and maternal health interventions by key health agencies and organizations, including WHO and other United Nations agencies.
3. **Access to high-quality SAC for all women and adolescent girls contributes to gender equality and social justice.** Enabling women and adolescent girls to make decisions about their own bodies and lives, including exercising their sexual and reproductive rights, is linked to their improvements in social status, economic opportunity and gender equity.
4. **A core package of evidence-based safe abortion services should be made available to women and adolescent girls in all crisis situations.** Safe abortion services must be accessible, adequate and available at any time, of good quality and delivered without discrimination, violence or coercion. Health workers in crisis settings should be trained to provide high-quality, rights-based safe abortion services. Context-relevant and evidence-based equipment and medication should be made available in crises and crisis-affected populations should be made aware of the types of available abortion services and the conditions under which these services can be provided.

10 Steps for safe abortion action

Building on these principles, the IAWG Safe Abortion Sub-Working Group developed a core set of actions to improve access to and the quality of SAC in humanitarian settings. The actions are presented as sequential steps but can be reordered to meet local needs. For additional details on each step and links to additional guidance see: [Safe Abortion Care: 10 Steps for Starting/Expanding Programming](#).

1. Have frank discussions

Starting a conversation about SAC can be challenging due to stigma and personal beliefs. It is important to discuss how SAC aligns with your organization's mission and professional values. These discussions should create a confidential space for all staff to talk openly and explore their role in providing care.

2. Develop and disseminate an internal policy

An explicit policy on SAC can overcome confusion and fear among staff who are unsure about the organization's position. A strong policy should explain why the organization supports SAC, align with organizational values and include a plan to support staff who may face risks. This policy must be actively shared and discussed with all staff, not just stored away.

3. Create a plan to implement the policy

Once there is organizational support, develop a plan that outlines how to build knowledge, improve attitudes and raise funds for SAC programmes. This plan should include activities such as training providers, conducting values clarification workshops and involving key teams such operations and security from the start. Having dedicated staff and resources is crucial for success.

4. Develop standardized messages

Prepare clear, standardized messages to explain your SAC work to different audiences, both inside and outside your organization. These messages should describe why SAC is important to your organization's mission and provide honest answers to tough questions, such as those about legality, reputation or staff opinions. This helps staff feel comfortable and confident in discussing their work.

5. Analyse relevant laws and identify entry points

Begin by analysing national laws and a wide range of policies to identify and understand the full extent of legal grounds for providing SAC. Also consider international and humanitarian laws that can support your work. Organizations can then ensure access to services in circumstances that are not prohibited by law, rather than using "illegality" as a blanket excuse to avoid providing care.

6. Discuss the legal context

Engage in discussions with local authorities and staff to clarify legal ambiguities and promote task-shifting where possible. Use international humanitarian law, global and regional protocols, such as the Maputo Protocol, to advocate for protections for providers and patients. Ipas and the Center for Reproductive Rights have developed a process to help organizations manage legal risks by training legal professionals and engaging with law enforcement.

7. Conduct values clarification activities with staff at all levels

VCAT activities help staff at all levels explore their beliefs and fears in a safe space. VCAT can be done before technical training to build a more supportive environment and increase willingness to provide services. The [Abortion Attitude Transformation: A values clarification toolkit for humanitarian audiences](#) can be a helpful resource. These workshops provide an opportunity for potential gatekeepers to explore their values, attitudes and knowledge related to abortion, with the goal of making abortion-related care available in humanitarian settings.

8. Consider opportunities to incorporate SAC into existing programmes

Look for ways to integrate SAC into existing SRH programmes, especially if you already provide PAC. This can be done without major new funding, as it may only require a simple budget realignment. Integrating SAC into existing programmes is a practical way to ensure abortion services are not overlooked.

9. Identify local SAC champions and potential partners

Identify and support champions – leaders and advocates for abortion care – within your organization and at the national and subnational levels. Champions are crucial for driving change, reducing stigma and providing protection for providers and peers. You can help build a community of champions by creating opportunities for people to become leaders and use advocacy resources.

10. Build SAC clinical and management capacity

SAC with MVA or medication is a safe and relatively simple procedure that can be provided by a variety of health providers, including nurses and midwives. It is essential to provide competency-based training and supportive supervision to ensure providers have the skills and confidence to deliver high-quality care. Use existing training materials from organizations such as IAWG and Ipas to build this capacity.

Building commitment and capacity

There is a wealth of guidance and tools that humanitarian SRH and GBV programme staff can use or adapt for their contexts. The foundational guidance documents for knowing what to do and how to do it include the [WHO abortion care guideline, Second edition](#) and the [Inter-Agency Field Manual on reproductive health in humanitarian settings](#), chapters 3 and 8.

Often, a key first step to establishing CACiE access is gaining clarity about why SAC is an essential, life-saving service. As suggested in the 10 Steps, this involves personal reflection, organizational commitment and stakeholder dialogue. Key informants interviewed for the development of this document recommend VCAT workshops with health workers, policymakers, non-governmental organization (NGO) staff and community stakeholders. The motivation for making SAC more accessible can vary. Common reasons include the desire to reduce morbidity and mortality from unsafe abortion and recognizing that legal indications for abortion care for one or more reasons exist in almost all countries. It is useful to develop a community engagement plan for SAC programming and engage religious, judicial, law enforcement and community leaders in awareness-raising. For more guidance, see the International Planned Parenthood Federation's training modules on [stigma-free abortion messaging](#) (IPPF, 2023) and the Ipas [guide on partnering with police](#) (Ipas, 2016).

Training and mentoring are key components of provider capacity-building for abortion service provision. Key informants indicated that in addition to knowing the legal framework, addressing stigma and learning clinical skills, it is helpful to have an experienced provider demonstrate CACiE provision in crisis situations and accompany new providers as they begin to provide services. Below are some resources that support SAC training and mentoring for health workers.

- For broad training materials on SAC and comprehensive PAC, see the Ipas (2014) [Woman-Centered, Comprehensive Abortion Care Trainer's Manual](#) and other Ipas curricula, available at: [Ipas – Resources](#)
- IAWG Training Partnership Initiative (2023): [Uterine evacuation in crisis settings using medications and manual vacuum aspiration](#) (combination training curriculum for instruction by qualified trainer)
- Online courses for medical abortion (MA) providers, self-managed abortion (SMA), and MA in humanitarian settings: [Abortion Education - Online Course for Individuals](#)

For additional CACiE tools and training materials, see Annex 1.

Emergent strategies to increase SAC access in humanitarian settings

In addition to the 10 Steps recommended by IAWG, front-line SRH and GBV service providers and programme managers continue to innovate with new approaches to improve access, quality and equity of abortion care in humanitarian settings. WHO recommends a multi-pronged approach, including self-management, clinical care, task-sharing, human rights and an enabling legal environment to deliver high-quality SAC and PAC services (WHO, 2022a).

Integration of CAC into SRH and GBV programming: Integrating PAC and SAC within broader SRH and GBV services ensures a holistic response (IAWG, 2018). This approach leverages existing entry points, such as clinical management of rape, EmONC and other SRH services or referrals for CAC services from GBV or mental health and psychosocial support (MHPSS) services (WHO, 2024). When referral pathways are functional and care is survivor- or patient-centred, such an integrated approach may reduce stigma and re-traumatization, while ensuring seamless access to vital care. Integration efforts must be accompanied by capacity-building and ongoing supervision of front-line providers, and should involve outreach workers and local organizations that can develop and disseminate appropriate, context-specific messages about the availability of both PAC and SAC as part of the package of SRH services. Ultimately, integrating CAC in existing SRH, GBV and MHPSS services promotes dignity and reduces re-traumatization by addressing interconnected health and protection needs simultaneously.

Trauma-informed or survivor-centred abortion care: This is an approach to providing CACiE services that explicitly recognizes how past or current trauma – such as sexual violence, intimate partner violence, and other forms of violence and trauma experienced in humanitarian contexts – can affect an individual's health, decision-making and experience of care. Providing trauma-informed abortion care involves prioritizing safety, trust, peer support, collaboration, empowerment and cultural sensitivity throughout service delivery (Ipas, 2022). This approach acknowledges the profound impact of trauma in humanitarian settings, especially for survivors of sexual violence, by creating a supportive environment that fosters psychological safety and reduces re-traumatization. Focusing on a patient's experience enhances comfort, encourages engagement and improves access to and uptake of essential CAC services.

Self-managed abortion care: SMA increases access to SAC by empowering individuals to manage all or part of their abortions outside formal clinical settings, guided by clear information and remote support, with PAC at a facility as a backup if needed (WHO, 2022b). Approaches to SMA represent a continuum of increasing support ranging from harm reduction models, abortion accompaniment networks, hotlines and community distribution programmes to telemedicine. These approaches are particularly promising in humanitarian contexts, where formal health infrastructure is disrupted or access is limited by distance, insecurity or legal restrictions necessitating discreet options for accessing medications and self-managing abortions (Jayaweera, 2021). SMA expands reach, reduces barriers such as travel and cost, and can be supported through digital tools that help estimate gestation and provide MA regimens (WHO, 2023; Population Services International (2023), [MIA.com.co](https://www.mia.com.co), accessed August 2025) and accompaniment by community-based networks (Ipas, 2021; IPPF, 2021).

Task-shifting/task-sharing: Task-shifting or sharing empowers a wider range of trained health providers, including nurses, midwives, community health workers, pharmacists and drug sellers to deliver components of CAC, particularly MA and PAC (WHO, 2022a; IAWG Training Partnership Initiative, n.d.). This strategy significantly increases service availability in humanitarian settings where specialized personnel are scarce, optimizing the use of existing human resources (WHO, 2022a).

Private-sector engagement: The private sector offers important opportunities for improving access to abortion care, particularly for SMA in restrictive settings where the public sector may be disrupted, less reliable or less accessible to underserved populations (Erin Wheeler, International Rescue Committee (IRC), personal communication, September 2025). For example, at the local level, pharmacists and other drug sellers may be an important access point for misoprostol and mifepristone and women-led businesses (such as hairdressers and dressmakers) can be safe and confidential places to access information about abortion. At the national or regional levels, pharmaceutical or medical supply chain companies may be able to offer abortion commodities that are not available through the public sector and may have stronger distribution capabilities for reaching the last mile. It is important to note that the private sector may be disrupted or weakened in humanitarian settings, so suppliers should be vetted in advance with careful attention to and monitoring of the quality, accessibility, equity and affordability of commodities. As with any partner, it is important to set expectations and agreements in advance with private-sector partners, including around rights-based practices, prices and data-sharing.

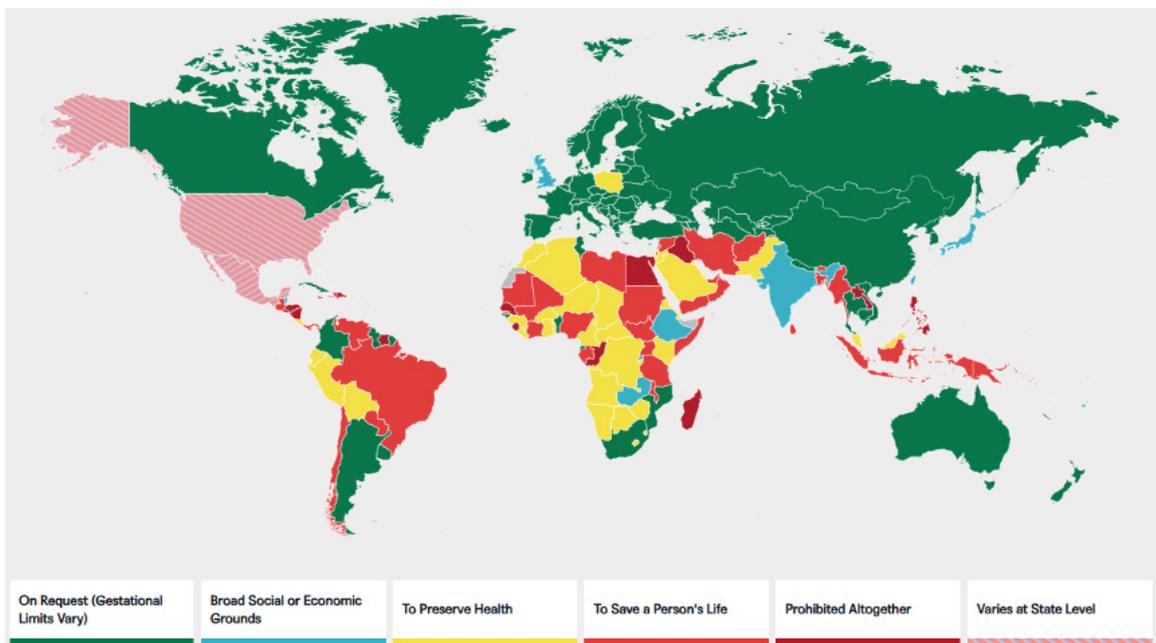
CAC preparedness planning: Integrating CAC into emergency preparedness plans ensures that essential services are not only provided reactively but proactively planned for before crises escalate (WHO Health Cluster, 2024). This includes pre-positioning supplies (e.g. Inter-Agency Reproductive Health Kits), training personnel, establishing referral pathways, conducting legal and policy reviews, and assessing CAC preparedness as part of MISP Readiness Assessments (UNFPA, 2023). Proactive planning builds resilience, minimizes service disruption and ensures rapid, effective provision of life-saving CAC from the onset of an emergency (Ipas, 2023).

Inter-agency coordination

Effective coordination at the national and subnational levels is crucial for ensuring CAC is available in humanitarian settings. In countries where the Inter-Agency Standing Committee (IASC) cluster system is activated, different clusters and working groups should work closely together; cross-sectoral coordination should also be ensured in countries where the cluster system has not been activated. A baseline assessment conducted by the SRH-TT found that only half of activated health clusters have a fully established SRH

working group (SRH-TT, 2024). Health cluster and SRH coordinators serving as key informants suggested formalizing collaboration between SRH and GBV coordination (including coordinating with MHPSS Technical Working Groups), which creates a forum for systematically addressing CAC as a health and protection priority across all phases of a humanitarian response. Multisectoral collaboration involving the health cluster, SRH working group, protection cluster (including GBV coordination), government officials and other humanitarian organizations strengthens advocacy efforts by aligning integrated messaging and strategies. In Sudan, joint working groups fostered trust among actors and created a forum for emphasizing the importance of data collection on key indicators (Kahn interview, 2025). Inter-agency coordination is critical for meeting quality standards for SAC (Rosmini interview, 2025). Joint advocacy can address critical supply chain issues for essential reproductive health commodities in emergency-prone areas (IRC, 2025). By fostering a coordinated, evidence-based approach, these efforts can overcome internal and external barriers, ensuring that life-saving CAC services are a component of emergency response from the outset. For a list of specific actions, see the CACiE Checklist for SRH Coordinators in Annex 2.

IV. Where is SAC being implemented? Three case studies



Documenting new approaches and the lessons learned is critical to inspiring front-line health workers to implement CACiE and advance our knowledge of what works in humanitarian settings. The following case studies illustrate successful approaches to providing SAC to the full extent allowable under the law in a variety of legal contexts. The case studies are informed by the document review, Technical Advisory Group (TAG) recommendations, and key informant interviews with TAG members and front-line health workers. References are provided for additional details on the approaches and results. [The World's Abortion Laws - Center for Reproductive Rights](#) is referenced to define the legal context in each of the case study settings.

The case studies are presented in order from limited to broadly allowable legal indications for providing SAC. As indicated earlier, PAC is an integral part of emergency obstetric care and should be universally available.

Abortion allowed to save a woman's life: Nigeria

Background and context: North-east Nigeria has faced more than a decade of conflict, resulting in massive displacement, GBV and breakdown of basic health services (UNHCR, UN Women and UNFPA, 2018). SRH services in camps for internally displaced persons are limited. This context leads to a significant need for SAC, often due to unintended pregnancies from sexual violence and lack of, or low uptake of, contraception. The abortion law in Nigeria is highly restrictive, where SAC is only permitted to save a woman's life and complications from unsafe abortion are common. Studies show abortion complications are often more severe due to delays in accessing care and low access to SAC (Pasquier, 2023). The facility-based near-miss ratio in conflict-affected Jigawa State is at least 2.5 times higher in referral facilities than in 42 Nigerian tertiary hospitals in a recent study (Pasquier, 2023; Adanikin, 2019).

Barriers and challenges: According to local staff at Planned Parenthood Federation of Nigeria (PPFN), low awareness of the national guideline for safe termination of pregnancy to save a woman's life, restrictive abortion law, and cultural and religious practices create significant barriers (PPFN interview, 2025). Stigma and fear among providers also hinder service provision according to an anonymous NGO working in humanitarian contexts in Nigeria. Patients receiving harm reduction¹ services may have expectations of receiving full abortion care services, which can lead to frustration when only counselling is provided (anonymous NGO, 2020). Security issues limited supervision and supply deliveries (anonymous NGO, 2020).

Entry points/access facilitators: Inclusion of PAC as part of the MISP for SRH is a critical entry point (IAWG, 2018). Strong collaboration with government facilities ensures continuity of services and resource sharing (PPFN interview, 2025). VCAT training significantly increases healthcare workers' willingness to provide abortion-related services within the legal framework, improving provider attitudes from 40 per cent willing to 90 per cent willing after training (PPFN, 2025). Community engagement, including educating traditional leaders and women's groups, helps mobilize patients and build acceptance (PPFN, 2025). Leveraging digital tools such as e-health apps and WhatsApp lines for anonymous consultations and referrals also improves access (PPFN, 2025).

Intervention: Humanitarian organizations such as PPFN and the other NGO interviewed, provide CAC services within the legal framework in Nigeria, focusing on PAC, referrals and harm reduction approaches.

PPFN offers MA for PAC and refers surgical cases to government facilities (PPFN, 2025). The other NGO implemented a harm reduction pilot in Borno State, providing counselling on safe abortion using misoprostol and referral pathways, but did not provide the misoprostol itself. They also established a referral partnership with another organization in an insecure rural town for direct service provision.

1 Harm reduction is a clinical service model in which women are supported with pre-abortion information, are told where to find the medicines and how to use them, and can return for post-abortion support if needed, but are not actually provided with the medicines to terminate the pregnancy (WHO, 2022a). Studies show that most recipients of harm reduction counselling use misoprostol for abortion, have low complication rates and are satisfied with the intervention (Stephani, 2022).

Outcomes:

- Targeted outreach, including for people with disabilities, resulted in higher turnout and patient satisfaction (PPFN, 2025).
- 384 women received counselling through the harm reduction pilot in one urban and one rural town between September 2019 and November 2020. Thirteen per cent (49 women) returned for PAC services (including both those requiring uterine evacuation and those requiring other services, such as PAC family planning) (anonymous NGO, 2020).
- In one insecure rural town, 58 women followed referrals to another organization for SAC services between January and November 2020 (anonymous NGO, 2020).

Quotes:

“Personally, I was sceptical about how to discuss [abortion] in communities. But gradually, with the help of activities and VCAT, we let them know about services.” – Community mobilizer (anonymous NGO, 2020).

Strategies for success:

- Build provider capacity, including VCAT and clinical training, to address attitudes, clinical competency and legal understanding.
- Advocate for domestication of national guidelines at the state level to promote broader access to safe termination of pregnancy.
- Explore scaling up harm reduction, integration in Ministry of Health facilities and strengthening inter-agency collaboration for referrals.
- Ensure sustainable funding for these vital services beyond pilot phases.

Abortion allowed for multiple indications but significant barriers to access: the Democratic Republic of the Congo

Background and context: Over a decade of conflict in the north-east of the Democratic Republic of the Congo (DRC) has caused massive displacement and disruption of health services (IRC DRC case study, 2020). Unsafe abortion contributes significantly to high maternal mortality rates, with over 50 per cent of abortions estimated to be unsafe nationally (PMA, 2024). The DRC ratified the African Union’s Maputo Protocol in 2008, a pan-African treaty recognizing the right to safe abortion under specific conditions including rape, incest and when the pregnancy endangers the mental and physical health or the life of the woman or the fetus (African Commission, 2003). Despite its publication in the Official Gazette in 2018, which gave it precedence over conflicting national laws, a restrictive penal code, a limiting public health law, and strong religious and cultural opposition continue to create legal confusion and significant barriers to access to abortion care (Hefez, 2024; Glover, 2023; IRC, 2020; IRC, 2025).

Barriers and challenges: Persistent legal confusion and enforcement of outdated laws remain significant barriers, leading to providers fearing arrest (IRC, 2020; IRC, 2025). Community stigma, provider resistance and misinformation are widespread. Health system readiness to provide CAC is low, with many providers lacking training and relying on outdated practices, including dilation and curettage (IRC, 2025; Lunganga, 2017). Access is hampered by direct costs for patients and stringent consent requirements such as proof of rape documentation or adult accompaniment for minors (IRC, 2025). One study found that patients under 18 years old were significantly less likely (90 per cent) to receive SAC compared with women aged 18 and over (96 per cent) (Kumar and others, 2022). Humanitarian operations also face severe staffing shortages due to providers fleeing conflict and supply chain disruptions (e.g. destruction and looting of health facilities and supply warehouses) due to conflict, bank and airport closures, and tariffs, leading to commodity stockouts (Spilotros, 2025). The provision of abortion care in the internally displaced persons camps in Nord-Kivu revealed the lack of preparedness within the humanitarian community to support such an initiative (Ipas, 2023). Despite the engagement of the Ministry of Health, and laws and policies supporting the provision of abortion care, Ipas faced strong opposition from humanitarian actors. It was only after VCAT training that buy-in started to be evidenced by increasing referrals of patients to mobile clinics (Ipas, 2024).

Entry points/access facilitators: The domestication of the Maputo Protocol and subsequent national guidelines are key enablers to SAC access (APHRC, n.d.; Ipas, 2023). In the context of constant political leadership change, continuous advocacy initiatives using locally generated data are instrumental to maintaining stakeholder momentum (Kumar and others, 2022). Strong civil society advocacy coalitions and government champions have been crucial in driving policy change (APHRC, n.d.). VCAT workshops for healthcare providers, Ministry of Health staff, humanitarian actors and communities have significantly improved attitudes and legal understanding, overcoming internal barriers to care provision (IRC, 2020; Kumar and others, 2022). The availability of training tools, a national pool of trainers, data-collection tools and health management information system indicators on CAC have fuelled evidence-based programming (Kumar and others, 2022). The integration of SAC within existing SRH and GBV services leverages established entry points, critical in the context of widespread sexual violence (IRC, 2020). Digital tools such as the Ipas “Nurse Nisa” chatbot provide private SRH information and referrals (Ipas, 2023; IRC, 2025). Adolescent access barriers are addressed through the Mashujaa referral network, a community-based youth movement that contributes to transforming youth’s attitudes and gender norms and improves accessibility to SRH services (Celestine Buyibuyi (Ipas), email correspondence, August 2025).

Intervention: Organizations implement multifaceted approaches to expand SAC access. The IRC piloted a dual-pronged harm reduction model in conflict-affected areas (between January 2019 and December 2020), offering direct SAC at facilities for those meeting Maputo criteria (IRC, 2020). For other patients, counselling for SMA with misoprostol or mifepristone/misoprostol combi-packs was provided, with referrals to partner pharmacies for purchasing medication (IRC, 2020). From 2021 to date, Ipas has worked with the humanitarian community to diversify the pathways to abortion care in humanitarian settings of Nord- and Sud-Kivu, Ituri, Tshopo and Tanganyika. The programme is organized around strengthening the existing health system while using pharmacies, Mashujaa (young sexual and reproductive health and rights (SRHR) activists with a medical background), community health workers, hotlines and telehealth as access points for abortion information and care (Ipas, 2025b). In Goma, Ipas implemented a community-based SMA intervention, training local pharmacists to provide information, misoprostol and follow-up care (IRC, 2025). Broader efforts include the development of comprehensive national CAC guidelines, which clarify legal conditions, standardize MA protocols and permit task-shifting to non-physician cadres (Ipas, 2023; IRC, 2025; DRC CAC Standards and Guidelines 2021; SRH-COVID Standards and Guidelines 2020).

Outcomes:

- National Standards and Guidelines for Comprehensive Woman-Centred Abortion Care in DRC drafted in alignment with the Maputo Protocol, revised with stakeholder inputs, validated in 2020 and published in 2021.
- The IRC SAC programme (January 2019 to November 2020) reached 4,388 women; 69 per cent were referred for self-management and 78 per cent of these patients were successfully followed up for family planning services, a higher rate than for other, similar pilots (IRC, 2020).
- Ipas' SMA intervention (2021–2025) reached a total of 11,242 people in the provinces of South Kivu, Tanganyika, Tshopo and Ituri. Of these, 1,101 were reached in Goma via pharmacists, with 99 per cent self-reporting successful outcomes and 849 (77 per cent) receiving post-abortion contraception (Ipas project data, 2025).
- Access to information through the "Nurse Nisa" chatbot, as well as community health workers associated with the strengthened referral mechanism between health facilities and community SMA access points, have streamlined the management of adverse events and supported women seeking care.

Quote:

- "As a health professional, it's important to have skills that enable me to protect women's rights to choose, but above all to contribute to reducing the maternal mortality ratio" – Aimée Olenga, Midwife, Kintambo Maternity Hospital (Ipas, 2023).

Strategies for success:

- Strengthen legal protection for providers by aligning national guidelines and laws with Maputo Protocol provisions through sustained advocacy (IRC, 2025).
- Scale up evidence-based approaches such as SMA through the private sector (e.g. pharmacies), ensuring quality assurance and robust referral systems (IRC, 2025).
- Conduct provider capacity-building, including comprehensive VCAT, task-shifting and clinical training (IRC, 2025; Kumar and others, 2022).
- Implement CAC preparedness planning for recurrent crises by establishing buffer stocks and exploring alternative routes for commodity supply chains (Spilotros, 2025).
- Prioritize data collection and analysis to inform data-driven advocacy by key institutional and community stakeholders and equitable service delivery, particularly for vulnerable populations such as adolescents (IRC, 2025; Kumar and others, 2022).
- Build health system resilience, particularly by supporting innovative abortion service delivery approaches that place communities at the centre of their well-being.

Abortion available on request: Colombia

Background and context: Colombia hosts nearly three million Venezuelan refugees and migrants, many of whom reside in informal settlements with limited access to healthcare services. In 2006, Constitutional Court Ruling C-355 decriminalized abortion in cases of risk to a woman's life or health, fetal anomalies incompatible with life, or pregnancy resulting from rape or incest. In 2022, Court Ruling C-055 further liberalized the law by decriminalizing abortion on request up to 24 weeks. This ruling recognized SAC as a reproductive right and emphasized equal access for all women, including migrants (UNHCR, 2024; Corte, 2006; Corte, 2022). While abortion law in Colombia is one of the most liberal in the region, many migrant women remain unaware of their rights or how to access services. Factors such as displacement, stigma and fear of legal consequences can delay or prevent care. Humanitarian and SRH actors have responded by integrating free CACiE services into multisectoral support for Venezuelan migrants (Profamilia, 2022).

Barriers:

- Lack of awareness among migrants about their legal rights to free CAC services.
- Misinformation and stigma surrounding SAC services.
- Logistical issues (transport and documentation) for reaching clinics.
- Clinics and hospitals lack resources for abortion commodities and provider training.

Entry points:

- The national ruling in 2022 explicitly affirms migrant rights to abortion care.
- Profamilia's social franchise model brings CACiE to underserved and mobile populations.
- Sexual violence used as a rationale for the SRH sub-cluster to address migrant SAC needs.
- Integration with GBV response, social protection programmes and migrant support services.

Intervention: Profamilia has trained health workers to provide non-judgmental, rights-based care, provided community-centred information campaigns and ensured services did not require identity documents. Services include MA, PAC, counselling and legal navigation. Health teams offer migrant-sensitive outreach, explain legal options in plain language and referrals to safe abortion facilities without requiring official papers. Profamilia's teams also collaborate with shelters, border checkpoints and mobile brigades to meet women where they are. Staff are trained in values clarification, legal standards and respectful communication. Lastly, Profamilia has developed *Mi cuerpo, Mi autonomía-MIA* (My Body, My Autonomy), a telemedicine, first trimester MA programme.

Outcomes:

- Since 2020, SAC for migrants has increased steadily, rising from 1,598 to 2,394 cases, representing a 50 per cent increase.
- Migrant women report increased knowledge of their rights and greater willingness to seek care.

- Health workers report greater confidence in applying SAC and PAC protocols and supporting complex cases.
- Community outreach materials are now routinely adapted for migrant audiences and shared in shelters, clinics and peer groups.

Quote:

- “We successfully integrated abortion services into the MISP by linking it to the prevalence of violence, sexual abuse and exploitation at border crossings, which resonated more readily with other organizations than maternal mortality alone.” – Marta Royo, Executive Director (Profamilia Colombia, 2025).

Strategies for success:

- Expand mobile PAC and SAC services at migrant entry points and in underserved areas.
- Include abortion access messaging in humanitarian welcome kits, hotlines and community briefings.
- Support continued training, supervision and legal clarification for health workers.
- Prioritize partnerships that focus on dignity, rights and access for displaced and stateless women.

V. Core CACiE indicators and measurements

The indicators below aim to help front-line humanitarian SRH staff and programme managers track CACiE preparedness and service delivery. These measures, built on MISP indicators from the [Inter-Agency Field Manual](#), are practical and useful for busy staff working under challenging conditions. As a crisis stabilizes, teams may want to add more indicators to measure the quality of abortion care, perhaps utilizing more comprehensive indicators developed in the [ACQ \(Abortion Care Quality\) Tools and Toolkit](#).

Type of indicator	Indicator	Relevant MISP objective
Preparedness	Facility has trained staff, equipment and supplies to provide PAC services [Yes – No]	MISP Objective 4
Preparedness	Facility provides SAC services to the full extent of the law [Yes – No]	Other MISP priority

Type of indicator	Indicator	Relevant MISP objective
Preparedness	Facility does not provide SAC but refers clients elsewhere [Yes – No] If yes, where? _____	Other MISP priority
Service delivery	Number / percentage of pregnant survivors of sexual assault receiving SAC (as permissible by law)	MISP Objective 2
Service delivery	Number of women and girls receiving PAC	MISP Objective 4
Service delivery	Number of women and girls receiving SAC to the full extent of the law	Other MISP priority
Geographic coverage	Coverage of PAC (number of health facilities where PAC is available/number of health facilities that offer BEmONC/CEmONC) x 100 per cent	MISP Objective 4
Geographic coverage	Coverage of SAC (number of health facilities where SAC is available/number of health facilities that offer BEmONC/CEmONC) x 100 per cent	Other MISP priority

VI. Summary of key findings and next steps

This document summarizes examples and guidance on how to implement CACiE. The methods, examples and tools described here outline the main actions for starting and expanding CACiE programmes. These actions include exploring values and attitudes about abortion; conducting local stakeholder meetings to address myths, misinformation and fears; clinical training on abortion methods and post-abortion contraception; supporting and mentoring service providers; integrating CAC in existing SRH, GBV and MHPSS services and ensuring functional referral pathways; preparedness and response planning; and gathering data to track results. These steps can and should be implemented as soon as possible as part of MISP implementation.

In addition to using these tools, humanitarian actors should continue to innovate and find new ways to address the need for CACiE. New CACiE tools and guidance documents can be found on the following websites:

- [IAWG Safe Abortion Sub-Working Group](#)
- [Ipas Resource Library](#)

- WHO [Abortion care guideline, Second edition, WHO Academy](#) and related links
- Elrha's policy brief [Her Health, Our Future: The Case for Evidence-Based Abortion Care in Humanitarian Policy and Funding](#) complements this guidance note

VII. Acknowledgements

The United Nations Population Fund (UNFPA) would like to thank the Directorate-General for European Civil Protection and Humanitarian Aid Operations (DG-ECHO) for its generous funding to develop this CACiE guidance.

UNFPA and the SRH-TT of the Global Health Cluster gratefully acknowledge the experts, organizations and agencies who contributed to the planning, development and review of this CACiE guidance. This document was developed by Sub-group E of the SRH-TT with technical guidance from the CACiE TAG led by Kathleen Mitchell (UNFPA), Tamara Feters and Bill Powell (Ipas); and members Sarah Ashraf (Save the Children International); Melissa Cockroft (IPPF); Kidist Lemma Gizachew and Caron Rahn Kim (WHO); and Nathaly Spilotros (IRC). The document was drafted by Lorelei Goodyear (consultant).

The support of the following additional reviewers and contributors is greatly appreciated: Columbia University: Sara Casey; FP2030: Laura Raney; International Medical Corps (IMC): Zipporah Bochaberi; IPPF: Nathalie Kapp and Diana Pulido; IRC: Erin Wheeler; Ipas: Celestine Buyibuyi and Mike Mpoyi; PPFN: John Chawa, Abubakar Okai Haruna, Elizabeth Joe, Olayinka Morufu Muili, Tiamiyu Sunmonu and Paul Odigbo Tochukwu; Profamilia Colombia: Marta Elena Royo Ruiz and Ivan Molano Pulido; Joint United Nations Programme on HIV/AIDS (UNAIDS): Lise-Marie Le Quere; UNFPA: Suhaila Aboud, Christine Apio, Karen Hobday, Baraa Mahgoob, Alice Rosmini, Catrin Schulte-Hillen and E.M. Sreejit; WHO: Maria Caterina Ciampi, Jenny Cresswell and Henry Ilunga; Sudan Health Cluster: Fawad Khan; Global Health Cluster: Andrea King.

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Annex 1: CACiE tools and resources

	Description
Policy and advocacy	
Abortion language guide: how to use your voice for choice - MSI Reproductive Choices (MSI, accessed August 2025)	Recommendations and guidance on decreasing stigma and the power of advocacy
How to talk about abortion guide: stigma-free messaging. (IPPF)	IPPF’s training modules on abortion messaging
SRH coordination	
Annex 2: CACiE Checklist for SRH Coordinators	Identifies key coordination actions to support CACiE initiation and inter-agency coordination
Training and mentoring	
VCAT training: Abortion Attitude Transformation: A values clarification toolkit for humanitarian audiences. Ipas (2018).	VCAT training workshops help participants explore their values, attitudes and knowledge related to abortion
Woman-Centered, Comprehensive Abortion Care Trainer’s Manual (Ipas, 2014) and other Ipas curricula, available at: Ipas – Resources	Broad training materials on SAC and comprehensive PAC
Uterine evaluation in crisis settings using medications and manual vacuum aspiration IAWG Training Partnership Initiative (2023)	Combination training curriculum for instruction by qualified trainers
Abortion Education - Online Course for Individuals	Online courses for MA providers, SMA and MA in humanitarian settings
Clinical practice	
WHO Comprehensive Abortion Care Tool Available on Apple and Google Play	A “digital decision support tool” or app to support caregivers in the decision-making process and using the WHO Abortion care guideline , to provide CAC
WHO Pocket Guide on Medical Management of Abortion (WHO, 2014, updated 2022)	Clinical guidance for estimating gestational age, MA regimens, and timing of post-abortion contraception
Steps for performing manual vacuum aspiration. (Ipas)	This illustrated wallchart presents a clear, easy-to-read, 10-step guide to performing uterine evacuation using the Ipas MVA Plus® and Ipas EasyGrip® cannulae

Tips for using the Ipas MVA Plus (Ipas)	Quick tips on disassembly, reassembly, processing and solving technical problems
Paracervical block technique (Ipas)	This job aid provides clinicians with step-by-step instructions for performing a paracervical block
Prophylactic antibiotics in safe abortion care (Ipas, updated 2021)	Dosing recommendations for use of prophylactic antibiotics in SAC
Clinical practice handbook for quality abortion care (WHO, 2023)	Facilitates the practical application of the clinical recommendations from WHO’s 2022 Abortion care guideline . Not a training manual
Ipas Trauma-Informed Abortion Care (Ipas, 2022)	See the Confidential Consent for Release of Information and Referral Form on pages 29 to 32. Can be used to track the types of referrals made
Patient-focused tools	
Mia.com the virtual abortion care service (Profamilia)	Pregnancy date calculator and virtual counsellor with question and answer ability in Spanish (English version available in Chrome)
Safe Abortion Options Information Worldwide (safe2choose)	Pregnancy date calculator and virtual counselling on abortion options in nine languages

Annex 2: CACiE checklist for SRH coordinators

This checklist outlines higher-level activities for SRH coordinators to ensure CAC is effectively introduced and supported to the full extent of the law through coordination mechanisms in humanitarian settings. It is designed to be a practical tool for monitoring progress and identifying gaps.

Phases and checklist items	Yes	Limited	No	Notes and follow-up actions
Acute emergency response				
Review and analyse the legal context for abortion, including national laws and the applicability of international and regional human rights instruments such as the Maputo Protocol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Conduct stakeholder mapping to identify and engage with national and subnational government champions, influential partners (e.g. local NGOs) and legal actors who can support CAC and mitigate legal risks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Develop a coordination plan with other clusters (e.g. protection, GBV coordination, MHPSS) to ensure a harmonized and integrated approach to CAC to the full extent of the law	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Assess pre-positioned CACiE supplies and redistribute as needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disseminate standardized messages about the legal context for abortion and the organization's position on CAC to all stakeholders, including front-line health workers and local authorities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ensure that all partners providing health services are aware of and adhere to the MISP, including the provision of PAC and SAC to the full extent of the law	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
As time and conditions permit, arrange rapid training, on-the-job training or provider secondment to rapidly implement SAC and build a provider pool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Phases and checklist items	Yes	Limited	No	Notes and follow-up actions
Establish and strengthen referral pathways between humanitarian services, government facilities, and NGO and private-sector providers to ensure clients have a functional, confidential route to care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Protracted/post-acute crisis phase				
Monitor service availability by mapping which agencies and organizations are providing PAC and SAC, and identify any gaps in service delivery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Monitor service readiness by tracking the availability of trained providers, medical commodities and functioning facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Monitor the effectiveness of the referral pathways between different service providers (e.g. between GBV and SRH services) to ensure that women experiencing unintended pregnancy receive timely, confidential care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Implement VCAT workshops for providers and other humanitarian actors to overcome internal barriers and stigma related to CAC, which is a key barrier to implementation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Liaise with government health authorities to advocate for task-sharing and the development of national guidelines that align with international standards for patient-centred, high-quality CAC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Track key CAC indicators to generate evidence that can be used for data-driven advocacy, policy discussions and programmatic decision-making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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