Abortion Care in Humanitarian Conflict-Affected Settings:

A Scoping Review

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March 1, 2020

Abstract

This major research paper seeks to examine the literature on safe abortion care within humanitarian conflict settings. In the last decade, there has been a growing discussion within the humanitarian community recognizing the importance of providing safe abortion care. Unsafe abortion is one of the leading causes of maternal mortality, a risk that is particularly heightened for pregnant women in humanitarian conflict settings. In such challenging contexts, access to reproductive health services is often limited. This, in addition to the increasingly protracted nature of humanitarian conflicts, means that many girls often reach reproductive age without key reproductive health services, such as contraception, during a situation of conflict and/or displacement. With the systematic use of rape and sexual violence as weapons of war, girls in humanitarian conflicts are more exposed to unintended pregnancy outcomes, which increases the risk of self-aborting through unsafe methods. Through a scoping review methodology, this major research paper seeks to provide a preliminary mapping of the key issues identified in the literature on abortion care within humanitarian conflicts. This paper examines the global discussions to make safe abortion care a priority within humanitarian settings; outlines the numerous challenges – legal, operational, cultural, and political – that humanitarian organizations face in providing this health service; and ultimately provides a way forward for future studies that seek to delve deeper into this topic.

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Introduction

Safe abortion care remains one of the most critical gaps in the provision of sexual and reproductive health services within humanitarian settings. For pregnant women in such contexts, there is often very little access to reproductive health care, increasing the risk of unsafe abortion. Furthermore, humanitarian organizations face nearly insurmountable barriers to providing abortion care. In the last decade, there has been a growing discussion within the humanitarian community recognizing the harmful risks of unsafe abortion. Humanitarian actors are becoming more and more aware of the importance of providing safe abortion care within conflict-related humanitarian settings. The systematic use of rape and sexual violence as weapons of war, terror, and genocide has only further intensified this discussion.

Through a scoping review methodology, this major research paper seeks to provide a comprehensive overview of the existing literature on abortion care within humanitarian conflict settings and outline the points of consensus and contention. In doing so, this paper aims to provide a foundation that other studies can use as a starting point for a more in-depth study on this topic.

This paper is divided into four main sections. It begins with a background section, which sets the stage and establishes my overarching research question. This is followed by a section on the methodology used in this paper – a scoping review. The next section describes the results of this scoping review, outlining the key points of consensus within the literature and the main barriers to providing abortion services in humanitarian conflict settings. Following the results section, the last section highlights the main weakness of the literature on abortion services in humanitarian conflict settings.

Background

Unsafe abortion is one of the leading causes of maternal mortality. Globally, nearly 10% of all maternal deaths can be annually attributed to unsafe abortion practices (Inter-Agency Working Group [IAWG], 2018, p. 145). According to the World Health Organization (WHO), between 2010 and 2014, approximately 25 million unsafe abortions occurred each year (WHO, 2019). Of these, about 8 million were performed under the most precarious conditions by untrained professionals using the most dangerous and invasive methods (WHO, 2019). While almost all unsafe abortions take place in the developing world, mortality due to unsafe abortion disproportionately affects women in Africa. The continent suffers from a 62% rate of unsafe abortion-related deaths (WHO, 2019).

The risk of unsafe abortion is particularly heightened for women and girls in humanitarian conflict settings. The United Nations High Commissioner for Refugees (UNHCR) reported that 70.8 million people – 41.3 million internally displaced and 25.9 million refugees – remain forcibly displaced due to conflict and persecution at the end of 2018. Women account for about half of the world's refugee and internally displaced populations and are often at greater risk than men (The Brookings Institution, 2014). In comparison to men, refugee and internally displaced women tend to have less access to assistance, adequate education, healthcare, and livelihoods; are often excluded from decision-making processes; and face an increased risk of rape as well as sexual and gender-based violence, which is pervasive in conflict settings (The Brookings Institution, 2014). Furthermore, within humanitarian contexts, access to reproductive health services, including contraception, is severely limited (IAWG, 2018, p. 146). This lack of access to key reproductive health services is compounded by the increasingly protracted nature of humanitarian crises, which on average now last for seven years or more (United Nations

Office for the Coordination of Humanitarian Affairs [OCHA], 2019). As such, many girls reach reproductive age without access to key reproductive health services, such as contraception, during displacement (IAWG, 2018, p. 146). The lack of access to such services means that girls in humanitarian conflicts are more exposed to unintended pregnancy outcomes, which increases the risk of self-aborting through unsafe methods.

The risks of unsafe abortion for women and girls within humanitarian settings have gained global prominence in the last decade. Following the 1994 International Conference on Population and Development in Cairo, which mainstreamed reproductive health in humanitarian health responses, a coalition of United Nations Agencies, national and international non-governmental organizations, government agencies, donors, and academic institutions established the Inter-Agency Working Group on Reproductive Health in Crises (IAWG), an international network dedicated to improving the reproductive health of communities affected by conflict and natural disaster (Chynoweth, 2015, p. 1).

Over the past years, the IAWG has made large strides in raising awareness of the risks of unsafe abortion and the importance of safe abortion care for people affected by conflicts and natural disasters. In 2010, the IAWG included a chapter on comprehensive abortion care within the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (IAFM)*, an internationally accepted field manual that explicitly recognizes the fundamental importance of sexual and reproductive health and rights and needs of women and girls in crisis-affected settings (Foster et al., 2017, p. 19). More recently, in the 2018 edition of the manual, safe abortion care was added as a "note" to the *Minimum Initial Service Package for Reproductive Health (MISP)*, a set of priority reproductive health interventions outlined in the manual that is recommended to be implemented at the outset of a humanitarian crisis (Foster et al., 2017, p. 19).

Within the global political arena, a number of states have come out explicitly in favour of the provision of legal safe abortion care in humanitarian settings. For instance, the United Kingdom Department for International Development and the Dutch Ministry of Foreign Affairs both explicitly affirm their support of safe abortion care, where permitted by law, in order to reduce maternal mortality (McGinn and Casey, 2016, p. 3). In 2017, Canada explicitly endorsed the provision of safe and legal abortion, as well as post-abortion care, in humanitarian settings through its *Feminist International Assistance Policy* (Global Affairs Canada, 2019).

Despite the rising awareness of the risks of unsafe abortion and the need for safe abortion care within the humanitarian community, the academic literature on this topic has not kept pace. There are very few studies that comprehensively analyze sexual and reproductive health care in crisis settings, and even less that focus on unsafe abortion. Safe abortion care receives less reported institutional and academic coverage than any other reproductive health interventions outlined in the MISP (Tran et al., 2015, p. 13). Furthermore, several systematic reviews on reproductive and sexual health in humanitarian conflicts found that studies on safe abortion care are often missing from the evidence base (Singh et al., May 2018; Hartmann et al., 2016; Tanabe et al., 2015).

Purpose of this Major Research Paper

Given the dearth of research available on abortion services within humanitarian settings, this major research paper seeks to respond to this critical gap within the literature. As such, this paper aims to answer the following research question: *What does the academic literature tell us about abortion care services for women, including those displaced and identified as refugees, within humanitarian conflict-affected crises?*

This paper is primarily exploratory in scope, seeking to generate substantive knowledge on the topic of abortion in humanitarian settings. This is reflected by the broad nature of the research question, which is intended to capture as many studies as possible on this topic. To respond to this research question, this paper provides a scoping review of the existing literature on abortion in humanitarian conflict settings. In doing so, this paper provides a more comprehensive overview of the literature and maps the key points of consensus and contention. Furthermore, this paper provides a critique of the gaps in the literature and a basis for future studies that seek a more in-depth understanding of the abortion care provided in humanitarian contexts.

Definitions

In order to achieve the aim of this paper, it is first important to establish the definitions of the key concepts within the research question. There are three key concepts to note. The first is the phrase "humanitarian conflict-affected crises". Generally speaking, a humanitarian crisis constitutes a situation where "local and national resources are insufficient to meet the needs of the affected population", thus requiring varying degrees of assistance from an interconnected network of institutional and operational entities (ALNAP, 2015). There are various types of crises, necessitating different responses, but they can be broadly subsumed into two main categories: major sudden-onset disasters and complex emergencies. The latter is defined as a crisis "where this is a total or considerable breakdown of authority resulting from civil conflict and/or foreign aggression" (Inter-Agency Standing Committee, 1994).

When referring to humanitarian settings, this research paper concentrates solely on complex emergencies. The purpose of excluding natural disasters is to limit the scope of this research paper to the developing world, as natural disasters occur in both developed and

developing nations, as well as to populations affected by armed conflict, including refugees and internally displaced persons. While women's reproductive health needs are also important to address within the context of natural disasters, the risk of unsafe abortion for women and girls is heightened in the developing world, and in particular, within protracted humanitarian conflicts.

The second key concept is unsafe abortion. According to the WHO, unsafe abortion occurs "when a pregnancy is terminated either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both" (WHO, 2019). There are two types of abortion procedures, each requiring different skills and medical standards. The first is medical abortion, which requires the use of drugs, and the second is surgical abortion, which is performed using a manual or electric aspirator, a tool that uses suction to remove foreign tissue from the body (WHO, 2019). Abortion procedures are unsafe when performed using outdated methods; if it involves the ingestion of caustic substances; or the insertion of foreign, non-medically recommended objects into one's body (WHO, 2019).

Related to the concept of unsafe abortion, the third key concept is safe abortion care. Abortions are considered to be safe if performed using a method recommended by the WHO that corresponds to the appropriate pregnancy duration as well as if the person performing the procedure is trained (WHO, 2019). Abortions can be conducted using oral medication or through an outpatient procedure, which can be performed without going to a hospital (WHO, 2019). Examples of safe abortion procedures include the ingestion of oral tablets such as misoprostol and/or mifepristone, or outpatient procedures such as manual or electric vacuum aspiration (WHO, 2019). Outpatient procedures can only be performed in the first trimester of a pregnancy (up to 12 weeks). Abortions induced in the second trimester of a pregnancy should be performed in a hospital with trained providers and the relevant supplies (IAWG, 2018, p. 153).

Within the humanitarian community, there are three types of abortion care. The first is safe abortion care, which refers to procedures that safely terminate the pregnancy. The second is post-abortion care, which refers to "the global strategy to reduce death and suffering from the complications of unsafe and spontaneous abortion" (IAWG, 2018, p.146). Post-abortion care essentially treats the consequences of incomplete and unsafe abortion procedures, as well as any related complications that may potentially be life-threatening (IAWG, 2018, p. 146). This includes the evacuation of the uterus in the first trimester of the pregnancy through vacuum aspiration or the ingestion of misoprostol (IAWG, 2018, p. 154). In addition to the treatment of unsafe abortion complications, post-abortion care also includes counselling for women and girls; contraceptive services; reproductive and other health services provided on-site or through referrals; and community partnerships to further prevent unintended pregnancies (IAWG, 2018, p. 146). The third type of abortion care refers to comprehensive abortion care, which combines all the elements of post-abortion care with the provision of safe induced abortion procedures (IAWG, 2018, p. 146).

Methodology

To respond to the research question above, I performed a scoping review of the literature on abortion care services within humanitarian conflict settings. My review was designed drawing on Arksey and Malley's five-stage methodological framework. In general, scoping reviews are typically used for bodies of literature that have not yet been comprehensively reviewed or exhibit such a heterogeneous nature that a systematic review would not be possible (Peters et al., 2015, p. 141). A scoping review allowed me to identify, map, and synthesize key concepts within this topic, without assessing the quality of the included literature (as would be the case had I attempted a systematic review). As there is currently a dearth of research on abortion care within humanitarian conflict-settings, as well as given the broad and exploratory scope of the research question, a scoping review was therefore the most appropriate methodology to use for this paper.

It is important to clarify that the scoping review methodology used in this research paper is different than undertaking a systematic review. Traditional systematic reviews provide an in-depth analysis of high-level, usually quantitative, studies with the objective of answering a very precise, clearly defined research question (Peterson et al., 2016, p. 13). Conversely, scoping reviews have less analytical depth, but a broader conceptual range of the available literature. Scoping reviews are also more flexible than traditional systematic reviews in that they can account for a diversity of relevant literature and methodologies (Peterson et al., 2016, p. 13). Given the heterogeneity of the literature related to abortion care within humanitarian conflict settings, a scoping review aligned better with the objective of this paper.

Arksey and Malley's methodological framework included the following five-major steps when undertaking a scoping review (Arksey and O'Malley, 2005, p. 22):

1. Identify the research question.

2. Identify the relevant studies.
3. Study selection.
4. Charting the data.
5. Summarizing and reporting the results.

Identifying the Research Question

As mentioned above, the research question for this scoping review is the following: *What does the academic literature tell us about abortion care services for women, including those displaced and identified as refugees, within humanitarian conflict-affected crises?* This research question consists of two elements, each of which are defined above: (1) abortion care services and (2) humanitarian conflict-affected crises. The target population of this research question is women, including those who are displaced from conflict or identify as refugees.

Literature Search Strategy

To conduct the scoping review of studies reporting on abortion care services within humanitarian conflict settings, a literature search for relevant articles published between January 1, 2008 and July 1, 2019 was carried out for the following electronic databases:

- PubMed;
- EMBASE;
- AMED;
- EBM Reviews – Cochrane Central Register of Controlled Trials;
- CINAHL;
- ProQuest Politics Collection;
- Worldwide Political Science Abstracts;
- International Political Science Abstracts;

- GenderWatch; and
- Scopus.

These electronic databases were initially chosen to capture the different analytical dimensions on this topic. Abortion in humanitarian conflicts is not just a global health issue. It is also mired in political sensitivities, with the United States and other conservative states opposing the funding of such services. Further, abortion also affects and is affected by the gender dynamics of the specific context where the service is being provided. As such, I thought it important to expand the list of electronic databases beyond those that focused on global health in order to capture these political and gender implications. In consultation with the University of Ottawa Library Services, the above databases were suggested to contain the studies most relevant to the research question.

The selection of articles was limited to those published in English and found in peer-reviewed scholarly journals, dissertations, and books. To review the literature, I used the key search terms outlined in Table 1 below. The search terms were used alone as well as part of combinations using the Boolean operators “AND”, “OR”, and “NEAR”. To search the peer-reviewed literature, I typed the key search terms into the advanced search engine of each database. Upon receiving the initial results, I then organized the search by “publication date” and noted down how many articles were included. Afterwards, I quickly scanned the abstract of each article to see if it fit the inclusion criteria. I stopped scanning the abstracts once the date of the articles went below January 2008. If there was a particular article that seemed to fit the inclusion criteria, I opened the full article and searched the word “abortion”. If it appeared on multiple pages of the article, I included the article within the final synthesis for this scoping review.

Table 1: Key Search Terms	
Abortion	Misoprostol
Abort*	Crisis
Pregnancy Termination	Humanitarian
Induced Abortion	Conflict
Induce*	Armed Conflict
Safe Abortion	Refugee
Unsafe abortion	Displaced
Mifepristone	Asylum
Mexico City Policy	Global Gag Rule

**Please note that the "*" was used as a tool to capture all variations of the word within the literature.*

Inclusion and Exclusion Criteria

To respect the constraints of the research question, inclusion and exclusion criteria for this scoping review were established and implemented. The inclusion criteria consisted of the following:

- Primary and secondary source research studies, including systematic reviews, published in English, between January 2008 and 2019;
- All studies (qualitative, quantitative, and mixed methods) that provided an analysis of abortion services within a humanitarian conflict;
- All systematic reviews that analyzed maternal health or sexual and reproductive health, in its entirety, within humanitarian conflict settings;
- All studies that provided an analysis of sexual and reproductive health in humanitarian conflict settings, provided that abortion was one of the main topics;
- All studies pertaining to the Minimum Initial Service Package.

The exclusion criteria for this scoping review were editorials, summaries of academic scientific conferences, the grey literature, congressional announcements, wire feeds, newspapers, blogs, podcasts, trade journals, and masters' theses.

Study Selection

This search strategy initially identified a total of 6,661 articles. No articles using the key search terms were found within the AMED and EBM Reviews – Cochrane Central Register of Controlled Trials databases. After applying the inclusion/exclusion criteria to the abstracts of each article, a total of 194 articles were selected for further screening. Following a full-text reading, an additional 128 articles were found to not meet the inclusion criteria. This resulted in a total of 65 articles for inclusion in the final synthesis of this scoping review. Please see **Appendix A** for a bibliography of the final studies included in this scoping review.

Charting the Data

To track the articles included in this scoping review, a combination of an excel spreadsheet and the reference management software *Zotero* were used to collect general citation information, study type, methodology, study approach, and key findings on abortion services within humanitarian conflict settings.

Results

In total, after removing any duplicate studies and applying the inclusion criteria, 65 articles were included in the final list of analysis for this scoping review. Of these 65 articles, 57 originated from the medical, global health databases and 8 from the political science and gender studies databases. The final synthesis consisted of 6 quantitative articles, 48 qualitative studies, 2 mixed methods studies, and 9 systematic reviews. Among these studies, only 17 focused their analysis solely on abortion care services within humanitarian conflict settings. The remaining 48 articles provided a broad analysis of maternal health or sexual and reproductive health services within humanitarian settings, with abortion included as one of many interventions under discussion. Almost half of the articles (28 studies) included in this scoping review were case studies on specific geographic regions including the Thailand-Burma border, the Democratic Republic of the Congo, Burkina Faso, South Sudan, Syrian Refugees in Lebanon and Jordan, Burundi, Northern Uganda, Somalia, Northern Ethiopia, and Northeast Nigeria. Of these case studies, nearly half concentrated on the impacts of the humanitarian conflict on the Thailand-Burma border (7 studies) and the Democratic Republic of the Congo (8 studies).

To provide an overall synthesis of the studies included in this scoping review, this section of this major research paper is grouped under three main themes: (1) the status of abortion services within the literature; (2) the operational realities of providing abortion care within humanitarian conflict settings; and (3) an exploration of the case studies in which abortion care was successfully provided in humanitarian conflict contexts.

The Status of Abortion Services in and within the Literature

In general, within the literature included in this scoping review, there were several key points that garnered strong consensus. First, there is an overwhelming agreement within the

literature that maternal mortality remains a significant problem in low-income countries, in particular those affected by humanitarian conflicts. For instance, Baraté and Temmerman (2010) emphasize that 86% of all maternal deaths occur in Sub-Saharan Africa and in South Asia, with more than 60% of maternal morbidity cases relating to pregnancy complications (p. 22). More recently, Gebrecherkos et al. (2018) arrive at a similar conclusion. They analyze that women in crises, whether humanitarian or economic, continue to be vulnerable to an increased risk of unwanted pregnancy and maternal complications (Gebrecherkos et al., 2018). Gebrecherkos et al. (2018) highlight that pregnancy-related complications are the leading causes of maternal mortality, and that this risk is even higher for refugee women in conflict settings.

Second, several studies in the literature emphasize that unsafe abortion is one of the leading causes of maternal mortality in conflict-affected, low-income settings. Baraté and Temmerman (2010), Adler et al. (2012), Casey et al. (2015), Ganatra and Faundes (2016), Gebrecherkos et al. (2018), Onyango and Heidari (2017), among others, all operate under the premise that unsafe abortion results in severe health consequences and significantly impacts women, families, and health systems. These studies estimate that unsafe abortion accounts for a high proportion of maternal mortality, though the exact percentage varies greatly within the literature between 25% to 78%. The literature further emphasizes that abortion services are even more highly relevant in humanitarian settings, particularly as conflict and displacement increase the vulnerabilities of women to sexual violence, decrease access to contraception, and reduce the functionality of existing health systems (Onyango and Heidari, 2017; Ganatra and Faundes, 2016).

Recognizing that maternal mortality is particularly acute in humanitarian conflict settings, the literature documents an increased global awareness and policy advancement in

addressing the sexual and reproductive health needs of women in humanitarian conflicts (Tran et al., 2015; Foster et al., 2017). The literature follows the growth of the IAWG in mainstreaming reproductive health into international humanitarian standards. The literature highlights the development of the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, and more specifically, the interventions outlined in the *Minimum Initial Service* Package (MISP), a set of priority reproductive health interventions that members of the IAWG strongly recommend to be implemented at the beginning of a humanitarian crisis.

The key objectives of the MISP include the prevention and management of the consequences of sexual violence; the reduction of HIV transmission; the prevention of excess maternal and newborn morbidity and mortality; as well as the provision of comprehensive reproductive health services (Onyango et al., 2013). The MISP also outlines the supplies that standard reproductive health kits should contain during humanitarian crisis situations.

With respect to unsafe abortion, the literature outlines a growing awareness of the need to provide abortion services in humanitarian settings. This is most aptly demonstrated in the recent changes to the MISP (Foster et al., 2017). In 2010, the MISP did not explicitly recognize the consequences of unintended pregnancies in women's health and lives, nor were any references to abortion care included (Foster et al., 2017). This changed in 2018, when an explicit reference to the provision of safe abortion care was included as a standalone "other priority activity" within the MISP (Foster et al., 2017).

Related to the global policy recognition of the importance of sexual and reproductive health in humanitarian settings, and on safe abortion care in particular, several studies also tracked the organizational capacity of humanitarian actors to provide these reproductive services in the field. Through a questionnaire, Tran et al. (2015) demonstrate that the overall institutional

capacity for humanitarian actors to provide sexual and reproductive health services continues to grow. Over a period of ten years, Tran et al. (2015) found that about 68% of the 82 humanitarian organizations interviewed had developed institutional policies regarding sexual and reproductive health and had expanded their provision of the number of services outlined in the MISP.

Despite this overall increased capacity in providing sexual and reproductive health services in humanitarian settings, Tran et al. (2015) demonstrates that this capacity is not equally distributed among all the services outlined in the MISP. The authors argue that humanitarian actors focus more on basic family planning, HIV, and youth programs. Conversely, such actors largely ignore the provision of post-abortion care and comprehensive abortion care services (Tran et al., 2015). This finding is further reinforced by several other studies. Austin et al. (2008) argued that reproductive health services were not equally available in refugee camps, highlighting that care for survivors of gender-based violence and the management of sexually transmitted infections were rarely offered. More recently, Casey et al. (2015) and Scott, R. et al. (2018) both assert that the provision of abortion services is still missing or largely ignored by humanitarian health actors. Case-studies in Mali, Lebanon, Burkina Faso, the Democratic Republic of the Congo, and South Sudan all highlight the unavailability of abortion services and poor pregnancy outcomes experienced by displaced women and women affected by crisis (Reese Masterson et al., 2014; Tunçalp et al., 2015; Casey et al., 2015).

These studies, as well as others included in this final synthesis, all point to one overwhelming conclusion within the literature: the provision of abortion services are and still remain an alarming gap within humanitarian conflict settings. When referring to abortion as a gap, this scoping review reveals an implicit double meaning. The studies aforementioned highlight that there is a gap in terms of the provision and availability of safe abortion care to

conflict-affected women; in other words, health programming gaps in the field. However, an analysis of the studies included in this review also demonstrate that there is a gap *within* the academic literature itself with respect to abortion services.

As part of this scoping review, 9 systematic reviews were analyzed and included in the final synthesis. Of these systematic reviews, 6 provided an analysis on a specific element of sexual and reproductive health care provided in humanitarian settings. Beek et al. (2017) analyze the factors that affect the ability of health aid workers to transfer their knowledge of sexual and reproductive health from theory to practice. Casey (2015), Warren et al. (2015), and Singh et al. (May 2018) attempt to ascertain the effectiveness of delivering sexual and reproductive health interventions in humanitarian crises. Tanabe et al. (2015) aimed to provide an in-depth analysis of funding for reproductive health activities in humanitarian settings. Hartmann et al. (2016) aimed to uncover the current research gaps on sexual and reproductive health programmes.

In each of these systematic reviews, there is an overwhelming consensus that there is a dearth of studies on abortion services within the literature. Warren et al. (2015) is cited as having conducted one of the only systematic reviews to comprehensively assess the effectiveness of sexual and reproductive health interventions in humanitarian settings, yet this review does not include any study focusing on abortion services (Singh et al., May 2018). Hartmann et al. (2016) notes that humanitarian conflict-affected countries were often missing from the evidence base on sexual and reproductive programmes, and even in studies when such contexts were included, the effectiveness of the sexual and reproductive health interventions used in country were often found to be unclear. Tanabe et al. (2015) explicitly notes the limited references to abortion-related services in their systematic analysis. Two more recent systematic reviews on this topic did attempt to include abortion services within their search strategies yet could ultimately find no

relevant documentation. In fact, the authors explicitly refer to the lack of documentation on comprehensive abortion care and safe abortion care as a gap in the literature on sexual and reproductive health services in humanitarian conflict settings (Beek et al., 2017; Casey, 2015). A more recent systematic review conducted by Singh et al. (May 2018) included the word "abortion" within their search terms, yet still found no studies that specifically evaluated post-abortion care or safe abortion services in crisis-affected contexts. The findings of these systematic reviews are consistent with the recommendation in several studies that advocate for more research on the provision of quality abortion care in humanitarian conflict situations (Ganatra et al., 2016; Scott, R. et al., 2018; Loyer et al., 2014; Onyango and Heidari, 2017; Tanabe et al., 2015).

The Operational Realities of Providing Abortion Services in Humanitarian Settings

The systematic reviews above highlight the dearth of studies that focus on abortion interventions within humanitarian conflict settings. However, unlike systematic reviews, this scoping review encompassed a wide range of primary and secondary sources in its final synthesis, with broader inclusion criteria. As such, rather than being limited to the 17 articles that solely focused on abortion services in humanitarian conflict contexts, this scoping review also included those studies that provided an overall analysis of maternal health or sexual and reproductive health interventions in humanitarian settings, including as a sub-set, comprehensive abortion care, post-abortion care, and safe abortion care services. While these articles varied in the analytical attention towards abortion services, they did provide fragmented analyses of the challenges to providing abortion in conflict-affected settings. Through the scoping review methodology, this paper was thus able to draw on these analytical fragments and paint an overall

picture of the different barriers to providing abortion services in humanitarian conflict settings. From the existing literature, these barriers can be categorized into four groups.

Legal Barriers to the Provision of Abortion Services in Humanitarian Conflict Settings.

The first group consists of the legal barriers to providing abortion services in humanitarian contexts. To comprehensively understand the legal challenges pertaining to the provision of abortion care, it is necessary to consider the international and national laws related to this issue. The legal barriers to providing abortion care are not always a direct result of a restrictive legal framework (i.e., "abortion is illegal"). Rather, these barriers arise from the ambiguity, lack of clarity, and low awareness of how to apply the laws on abortion services in practice.

From an international perspective, there are numerous instruments of international human rights that support improved access to safe abortion care. The 1994 Programme of Action of the International Conference on Population and Development, signed by 179 countries, as well as the 1995 Beijing Platform for Action commit to supporting the rights of women to sexual and reproductive health services, including safe abortion care, and reaffirmed signatories' commitments to review punitive abortion laws (McGinn and Casey, 2016). In Africa, Article 14 of the 2003 Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol) explicitly endorses access to safe abortion "in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the foetus (McGinn and Casey, 2016, p. 4)". This protocol has been ratified by 37 out of 54 African Union Member States. Furthermore, the denial of abortion services as gender-based

discrimination is internationally recognized by the Human Rights Council and violates the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention against Torture, and the International Covenant on Civil and Political Rights (Radhkrishnan et al., 2017, p. 42).

Radhkrishnan et al. (2017) further assert that the denial of abortion services within humanitarian contexts is a violation of international humanitarian law. This is a body of law, also known as the "laws of war", that ultimately regulates what is considered acceptable in situations of armed conflict and non-armed conflict as well as guarantees the rights of victims in such conflict (Radhkrishnan et al., 2017, p. 41). International humanitarian law encompasses the 1949 Geneva Conventions and their Additional Protocols. Under international humanitarian law, it is required that "persons wounded and sick be collected and cared for and receive comprehensive, non-discriminatory medical treatment (Radhkrishnan et al., 2017, p. 41)". Radhkrishnan et al. (2017) thus argue that pregnant women and girls in conflict situations are a protected class under the category of "wounded and sick" (p. 42). As such, they are entitled to the medical care required for their condition, including safe abortion services (Radhkrishnan et al., 2017, p. 42). The denial of such services is gender-discriminatory, counter to international humanitarian law, and results in intensified physical and psychological suffering especially in cases where the pregnancy is a result of rape and sexual violence (Radhkrishnan et al., 2017, p. 42).

While it is clear that the United States and a few other very conservative countries oppose the provision of abortion care, and by extension, funding for abortion services in humanitarian conflict settings, Radhkrishnan et al.'s argument demonstrates that there is

support nonetheless within international humanitarian law for the provision of abortion services in humanitarian settings. As international legal instruments appear to be in support of abortion care, many humanitarian actors assume that national laws are inherently more restrictive (McGinn and Casey, 2016). However, the literature demonstrates that this is not entirely the case.

While the legal status of abortion varies, in almost all countries, abortion is legal to save a woman's life (Bouvier, 2014). Only within seven states is abortion illegal under any circumstances: Malta, Dominican Republic, El Salvador, Chile, Nicaragua, South Sudan (World Population Review, 2019). According to the Global Abortion Policies Database, as of 2018, approximately 82% of countries allow or permit abortion to save a woman's life; 64% of countries to preserve her physical and/or mental health; 51% on the basis of a fetal condition; 46% in cases where the pregnancy is the result of rape; and 10% specify an economic or social justification (Lavelanet et al., 2018, p. 1).

Therefore, national laws on abortion are not inherently opposed to the global legal framework. Rather, the discrepancy between the gap in abortion services within humanitarian settings and the international and national frameworks that seemingly support such services arise from a lack of clear interpretation on how to apply these national laws on abortion in practice. In many countries, national policy guidelines on sexual and reproductive health tend to be silent, or at best vague, on the application of the law pertaining to accessing abortion services or the legal options for survivors of sexual violence who become pregnant (Thompson et al., 2018). In such cases where there is no clear guidance on the legality of abortion services, the legal application tends to be interpreted narrowly to avoid being in contravention of the law (Thompson et al., 2018).

For instance, in the cases of Kenya and Zambia, the policy guidance on the legality of abortion with respect to sexual violence is unclear. As such, in practice, abortion is not generally offered to sexual violence survivors and is considered by most to be a criminal offense, even if the law legally permits abortion to protect the life and health of the mother (Thompson et al., 2018).

The lack of guidance on the practical application of the legal provisions on abortion often make it difficult for women and girls to determine how they can access such services. For women and girls in need of abortion services, legal procedures are often riddled with hurdles (Schulte-Hillen et al, 2016). To overcome these barriers, the law often requires women and girls to expose themselves and their situation in a public manner. For instance, if abortion services can be provided for pregnancies that are a result of rape, this requires the legal establishment that the rape had in fact occurred requiring an often brutal and expensive court process for the woman in question.

This lack of guidance on how to apply national abortion laws in practice impacts the guidelines that govern humanitarian actors. The international humanitarian guidance on safe abortion place more emphasis on the legal directive, rather than the needs of women, when referring to the provision of safe abortion care (Duroch and Schulte-Hillen, 2014). This is evident in the *Clinical Management of Rape Survivors Guide*, drafted by the World Health Organization in 2001, which states that in contexts where safe abortion services are not available, it is recommended that women with unwanted pregnancies be referred to such services (Duroch and Schulte-Hillen, 2014). This emphasis on the legality of abortion is also most recently evident in the MISP, which notes that safe abortion care should be available, “to the full extent of the law” (Foster et al., 2017, p.

21). However, if there is no clear guidance on how to apply national abortion laws, then these humanitarian guidelines continue to be rather impractical statements.

Furthermore, the lack of clear policy guidance on applying national abortion laws in certain country contexts, particularly in countries affected by humanitarian crises, also contributes to the dissemination of misinformation and low levels of awareness of abortion services among both beneficiaries of humanitarian assistance as well as aid workers themselves. Humanitarian program managers are often unsure of what is permitted by laws and policy (McGinn and Casey, 2016). Erring on the side of caution, this makes it easier to dismiss services such as safe abortion which are perceived to be controversial.

In addition to the ambiguity around applying national abortion laws in practice, the gap in the provision of abortion services in humanitarian settings is at times also affected by a direct tension between the international and national abortion legal frameworks. A prominent example of this conflict are national health policies. In the Democratic Republic of the Congo (DRC), the omission of newer, safer, and easier to use drugs and procedures from their reproductive health policies has affected the availability of abortion services (Casey et al., 2009). Misoprostol and minimum vacuum aspiration are two tools that humanitarian actors can use to provide abortion services. However, neither misoprostol nor minimum vacuum aspiration appear in the DRC's national reproductive health norms or policy documents, making it more difficult to procure and provide abortion services (Casey et al., 2009).

Operational Barriers to the Provision of Abortion Services in Humanitarian Conflict Settings.

The second group consists of the operational barriers to providing abortion services in humanitarian contexts. A few of the defining characteristics of a humanitarian conflict are social disruption, widespread population displacement, and the partial or near-total collapse of the public health infrastructure (Casey et al., 2009). Such challenging contexts create barriers to providing health care services in general. Ongoing conflict and insecurity can severely restrict the mobility of humanitarian health workers in reaching its populations of concern, as well as limit the availability of hospitals and other places in providing health services.

Focusing particularly on reproductive health, Onyango et al. (2013) outline four main barriers to the provision of sexual and reproductive health activities within humanitarian contexts. These include: (1) a lack of awareness of the necessity and types of sexual and reproductive health interventions required during a crisis by many government agencies and humanitarian health organizations; (2) a lack of human resources in providing sexual and reproductive health services in the field, particularly the need for female staff; (3) poor logistics in terms of stocking reproductive health supplies; and (4) poor coordination leading to overlaps and gaps in reproductive health services.

Though Onyango et al. (2013) do not specifically refer to abortion services, the barriers outlined above can also be applied to the provision of abortion care in humanitarian conflicts. More specifically, the operational barriers to the provision of

abortion services in humanitarian settings can be categorized into two groups: information and human resource challenges.

While Onyango et al. (2013) narrowly defines the lack of awareness from the perspectives of the service providers, the literature on abortion services within conflict settings notes that information challenges apply equally to the beneficiaries of humanitarian assistance as well as the aid workers themselves. Both the service providers as well as the beneficiaries experience information challenges which hinder their ability to provide or access abortion services within humanitarian settings.

For instance, as noted in the previous section, humanitarian actors are often not well informed of the policies on abortion services within the country contexts they work in as well as the restrictions placed by donors (McGinn and Casey, 2016). As a result, many humanitarian organizations put aside or dismiss abortion services, leading to a lack of provision (McGinn and Casey, 2016). Likewise, when abortion services are available, the beneficiaries face information challenges in terms of the quality of the service, the restrictions they face, and even where to find these services. For example, Krause et al. (2015) document the provision of post-abortion care and comprehensive abortion care services for Syrian refugees. However, the study found that the target population of these services were often unaware of the locations for abortion services. As such, many women would try to self-abort through lifting heavy objects if they had an unwanted pregnancy (Krause et al., 2015).

More than the lack of appropriate information, perhaps the largest operational barrier to the provision of abortion services in humanitarian contexts within the literature relates to human resource challenges. This is manifested in the literature in several ways.

First, several studies point to a dearth of trained staff as one of the main reasons for not providing abortion services (Casey et al., 2009; Casey et al., 2015; Loyer et al., 2014). In their study on the availability of reproductive health services in Burkina Faso, the DRC and South Sudan, Casey et al. (2015) found that health facilities reported few trained staff as well as scarce supplies as the major barriers to providing abortion services.

Second, the literature documents a clear lack of trust and confidence in reproductive health service professionals. In their study on reproductive health in Somalia, Gure et al. (2015) found that women rarely interacted with reproductive health care providers, choosing instead to seek care from women in their communities. Abortion is only legally permissible to save a woman's life in Somalia and, as such, more women trusted in a number of informal, traditional practices to terminate a pregnancy to reduce the risk of being discovered by the authorities or members of the community (Gure et al., 2015). This finding has been reiterated in several other case studies. In the DRC, some studies found that women who became pregnant as a result of sexual violence rarely disclosed their desire to terminate to health care providers (Onyango et al., 2016; Burkhardt et al., 2016; Rouhani et al., 2016). Their perception that disclosure to a health care provider risked a negative reaction, breach of confidentiality, stigma, and rejection, so most women who terminated their pregnancies did so outside of the formal health care system (Onyango et al., 2016).

Third, and related to the second point, are the attitudes and perceptions of the humanitarian health care workers towards providing abortion services. Several studies depicted a reluctance or resistance among reproductive health care workers to providing abortion services (Schulte-Hillen et al., 2016; Burkhardt et al., 2016; Casey et al., 2009;

Onyango and Heidari, 2017). In their analysis of *Médecins Sans Frontières'* experience in implementing safe abortion care, Schulte-Hillen et al. (2016) note that the main challenge was actually internal resistance amongst staff. National staff, in particular, felt particularly exposed to potential repercussions in their home country and community (Schulte-Hillen et al., 2016). Loi et al. (2015) reiterates this finding through a systematic literature review of the conservative attitudes in sub-Saharan Africa and Southeast Asia towards abortion services. While not focusing specifically on humanitarian conflicts, Loi et al. (2015) found that many providers possessed moral, social, and gender-based reservations regarding the provision of abortion, impacting their attitudes towards the women seeking abortion care.

In addition to the three human resource challenges above, a few studies in the literature also document other additional operational barriers to providing abortion care within humanitarian contexts. These include financial barriers and uneven availability of services. Gure et al. (2015) note that costs are seen as a major barrier to accessing abortion care in Mogadishu, Somalia. While local and international nongovernmental organizations at times offered free care, they were typically reserved for women in internally displaced persons settlements or survivors of rape (Gure et al., 2015). This finding was reiterated in a more recent study of Syrian Refugee women in Lebanon (Cherri et al., 2017). Related to costs, through a case-study in the DRC, Chae et al. (2016) noted that more post-abortion care services were provided in private health centres rather than hospitals. Moreover, post-abortion care was more readily accessible within the capital city of Kinshasa than in other parts of the country (Chae et al., 2016).

Cultural Barriers to the Provision of Abortion Care in Humanitarian Conflict Settings.

The third group of barriers to providing abortion care in humanitarian contexts relates to the cultural sensitivities and social norms surrounding this issue. In many societies, even those with largely unrestricted policy environments, abortion remains a controversial topic. The negative stereotype of abortion is widely acknowledged, resulting in a degree of reluctance or resistance to discussing this sensitive issue (Hakansson et al, 2018). In more restrictive abortion policy environments, the fear of inviting controversy, discrimination, and social exclusion stifles discussion, leading health care providers to dismiss or act under the assumption that it is illegal in all cases even if it is not.

With respect to providing abortion in humanitarian settings, this fear of controversy is further intensified. Of all the barriers outlined in the literature, the cultural stigma around abortion is documented to be one of the strongest factors against providing this service. Several case-studies within conflict-affected settings note that induced abortion is widely regarded as "sinful", conflicting with religious beliefs, and highly politicized (Palmer and Storeng, 2016; Casey et al., 2015; Chynoweth, 2015; Cherri et al., 2017). Palmer and Storeng (2016) argue that in South Sudan, the stigma and suspicion associated with abortion is due to the perception that it is western in origin – "imported by returnees and foreigners" (p. 13).

Even if legal, these negative cultural attitudes towards abortion intimidate women with a desire to terminate their pregnancies from seeking such services (Burkhardt et al., 2016, p. 7). In order to avoid the stigma of being associated with having had an abortion,

women instead attempt to self-abort through more traditional methods that mimic spontaneous causes, such as “ingesting bitter roots or herbs, an overdose of malaria medicines, laundry detergent, battery acid or petrol; inserting objects into the cervix; or self-harm” (Palmer and Storeng, 2016, p. 9). The cultural stigma of abortion is also likely to lead to under-reporting of unsafe abortion methods (Kisindja et al., 2017).

In order to overcome the cultural stigma of abortion, the literature calls for increased efforts to address these culturally sensitive attitudes as well as more culturally contextual engagement with the community (Chukwumalu et al., 2017; Burkhardt et al., 2016). Chukwumalu et al. (2017) notably argue that sustained engagement with religious and community leaders is vital to clarifying misconceptions on abortion and improving service utilisation, given that religion is often cited as one of the main factors behind this cultural stigma.

The cultural stigma on abortion not only impacts the beneficiaries in seeking such services, but also the humanitarian organizations that provide it. The undeniably strong negative social norms related to abortion can create internal resistance within humanitarian organizations in providing such services. For instance, Schulte-Hillen et al. (2016) document the struggles of *Médecins Sans Frontières* to change the attitudes towards the provision of abortion within the organization. The unwillingness and personal reluctance to engage with such a controversial topic lead staff at different levels to justify the organization’s non-action regarding safe-abortion care, citing reasons such as “there is no need” or “it is too complicated” (Schulte-Hillen et al., 2016, p. 3). *Médecins Sans Frontières* argue that to overcome interorganizational cultural stigma on abortion, there is a need to actively create a safe environment in which all staff feel the

freedom to express their fears and convictions on abortion, while understanding their professional responsibilities (Schulte-Hillen et al., 2016).

The negative cultural attitudes towards abortion services becomes further complicated with respect to pregnancies resulting from sexual violence or rape in contexts of armed conflict. Not only are women in such scenarios burdened with the cultural stigma of abortion, but they are also forced to endure the stigma of rape and sexual violence. Studies suggest that survivors of armed conflict face a high risk of unwanted pregnancy due to exposure to frequent, forced, and unprotected sex, with a lack of access to contraception (Oladeji et al., 2018). Nearly half of women who become pregnant from sexual violence seek or undergo termination of their pregnancy, often using medications or herbs obtained outside the formal healthcare sector (Rouhani et al., 2016).

The double stigma of sexual violence and undergoing abortion services is documented within a few case studies in the literature. In Northeast Nigeria, Oladeji et al. (2018) note that approximately half of women in internally displaced camps, who had become pregnant as a result of sexual violence, leave to terminate their pregnancies. Community-based surveys show that nearly half of these terminations are performed clandestinely, in unsafe conditions, placing the lives of these women at risk (Oladeji et al., 2018). Not only do these women leave the camps to seek termination of their pregnancies, but also to escape the stigmatization of their community of having been a survivor of sexual violence – often these women are labelled the “Boko Haram wives” (Oladeji et al., 2018, p. 9).

This dual stigma is also documented in the DRC. In their study on the psychosocial outcomes among women with sexual violence related pregnancies, Scott et al. (2017) find that social stigmatization and rejection were commonly cited reasons among women to terminate their pregnancies, though it is unclear if this was referring to the stigma from the sexual violence, stigma from being pregnant as a result of the sexual violence, or the stigma around pregnancy termination. Furthermore, Scott, J. et al. (2018) also note that the negative perception associated with children born from sexual violence was also considered to be a factor in pregnancy termination.

Given the willingness of women with sexual violence-related pregnancies to terminate through unsafe methods in order to avoid stigma, the literature calls for the importance of access to safe abortion care and comprehensive post-abortion care for survivors of sexual violence (Rouhani et al., 2016). Furthermore, when providing this care, the literature also emphasizes the need for confidentiality. Survivors of sexual violence who want to terminate their pregnancy disclose their situation to a select few, only those they trust, in order to avoid the dual stigma of sexual violence and wanting to undergo an abortion (Onyango et al., 2016). As such, ensuring confidentiality is key and must be considered (Schulte-Hillen et al., 2016).

Political Barriers to the Provision of Abortion Care in Humanitarian Conflict Settings.

The fourth and last group of barriers to providing abortion services in humanitarian contexts relates to the political constraints of donor funding. McGinn and Casey (2016) argue that one of the most commonly cited reasons that humanitarian organizations use to justify the lack of safe abortion care is the restrictions on donor funding. More specifically, McGinn and Casey (2016) refer to the restrictions on funding from the United States.

The United States is the single largest donor of humanitarian assistance in the world. In 2018, the United States provided about US $6.646 billion, accounting for 29% of all public funding for humanitarian assistance (Development Initiatives, Global Humanitarian Assistance Report 2019). As such, their foreign assistance policies, specifically any funding restrictions, have a tremendous impact on the international humanitarian system.

As a major donor of humanitarian assistance, the United States' funding is heavily restricted with respect to abortion care. Indeed, the United States does not fund abortion services. Since 1973, under the *Foreign Assistance Act*, the United States has had a standing policy which prohibits foreign assistance funds to be used for "the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions" (McGinn and Casey, 2016, p. 3; Singh and Karim, 2017, p. 387). Also known as the Helms Amendment, this policy prohibits U.S. non-governmental organizations (NGOs) from providing abortion care themselves but does allow them to provide information or counselling on legal abortion services (McGinn and Casey, 2016).

While the Helms Amendment restricted American funding in particular from funding abortion services, previously NGOs and foreign recipients of U.S. family planning assistance funding could use their own resources to fund abortion-related activities were legal, though they needed to maintain separate accounts for the U.S. funding to demonstrate compliance with the abortion restrictions (Blanchfield, 2018). However, this all changed when President Reagan enacted the Mexico City Policy in 1984. Formally known as the *Protecting Life in Global Health Assistance* Act and informally as the *Global Gag Rule*, the Mexico City Policy is arguably the most contentious abortion policy to date. This policy restricts U.S. family planning assistance to foreign NGOs engaged in voluntary abortion services, even if such activities do not use American funding (Blanchfield, 2018). In other words, the Mexico City Policy bars any foreign organization that receives U.S family planning funding from using its own resources to perform abortions; advocate for abortion policies; or provide information, referrals, or counsel to women on abortion procedures (Sippel, 2008).

The Mexico City Policy exemplifies the epitome of political football, in that it is overturned by every Democratic President and reinstated under every Republican President (Hawkes and Buse, 2017). However, the re-establishment of the Mexico City Policy under the Trump Administration drastically expanded the policy's scope. Prior to President Trump, the Mexico City Policy only applied to the US$600 M spent by the U.S. Agency for International Development (USAID) on family planning (Greer and Rominski, 2017). However, the Trump administration expanded the Mexico City Policy to all "global health assistance furnished by all departments and agencies" (Blanchfield, 2018, p. 12). Essentially, this restriction now applies to US $8.8 billion in funding for

international health programs by the Department of State, USAID, and the Department of Defense (Blanchfield, 2018, p. 12). However, this policy is exempted for USAID disaster and humanitarian-relief activities, as well as post-abortion care (Blanchfield, 2018, p. 12).

Despite the exemption for humanitarian activities and post-abortion care, organizations providing sexual and reproductive health services in humanitarian conflict contexts are nevertheless still affected by the far-reaching implications of the Mexico City Policy. While at the macro-level of the global health system, organizations understand how best to comply with this policy, policy compliance becomes more and more confusing at the sub-macro level and in the field (Mavodza et al., 2019). When multiple levels of the global health system interact with the Mexico City Policy, opportunities abound for miscommunication, confusion, and chilling effects (Mavodza et al., 2019).

Gezinski (2012) argues that the Mexico City Policy creates a bureaucratic mess for NGOs receiving USAID funding by forcing them to monitor sub-grantees to ensure that money is not being utilized for abortion-related activities. For organizations that receive both humanitarian and development funding, the multiplicity of rules makes it difficult to determine which and when the restrictions apply (McGinn and Casey, 2016). As such, organizations that provide sexual and reproductive health services in conflict settings find that the least confusing and often "safest" course is to prohibit all abortion-related activities (McGinn and Casey, 2016). This "chilling" effect instills fear within humanitarian organizations of losing their funding, leading to self-censorship and a fear of advocacy (Cousins, 2018). For instance, when debating on how safe abortion care should be referred to in the MISP, the United Nations Population Fund and the United

Nations High Commissioner for Refugees were opposed to a greater focus on abortion care in humanitarian settings due to political sensitivities (Edwards, 2017).

The implications of the Mexico City Policy and the strong opposing stance towards abortion by the Trump Administration has even affected the language found within the annual United Nations humanitarian resolutions. Every June, state representatives flew to Geneva during the week of the Economic and Social Council, a body of the UN General Assembly, to negotiate the annual UN Resolution on "Strengthening of the Coordination of Emergency Assistance of the United Nations". This is essentially a routine UN resolution that re-confirms the life-saving mandate of humanitarian work and the need to address humanitarian needs (Parker, 2019). However, this year, the United States actively sought to include within this resolution language that explicitly excludes abortion, justifying that abortion is not a human right and should not be promoted in either humanitarian or development work (Parker, 2019). While the United States failed in its attempt to successfully insert this language, it nevertheless underscores the far-reaching implications of the Mexico City Policy on the international humanitarian system.

Successful Case Studies

The literature so far outlines the legal, operational, cultural, and political barriers to providing abortion care in humanitarian settings. Given the numerous barriers to overcome, it is understandable that humanitarian organizations would argue that it is "too complicated" to provide abortion services in conflict-affected settings (McGinn and Casey, 2016, p. 2). However, within the literature, a few successful case-studies have been documented, challenging the argument that abortion care cannot be provided in humanitarian conflict settings. However, these

case-studies are limited geographically. Within this scoping review, there are six case studies specifically evaluating abortion care provided in a humanitarian conflict context. Five of these studies evaluate safe abortion referral programs and community distribution misoprostol programs along the Thailand-Burma border. Only one case study analyzes the provision of post-abortion care in Somalia.

In eastern Burma, decades of civil conflict between the military junta and the ethnic minority groups, ongoing human rights violations, and the lack of socio-economic development, has resulted in more than 1.5 million people relocating to the Thailand-Burma border in refugee camps (Foster et al., October 2017). In conflict-affected Eastern Burma, the maternal mortality ratio is estimated to be 1000 deaths per 100,000 live births (Arnott et al., 2017). Refugee and displaced women in this region are at high risk of sexual violence, and unintended pregnancy and unsafe abortion are rather common occurrences (Tousaw et al., 2017). In Burma, abortion laws are highly restrictive and only permissible to save a woman's life (Tousaw et al., 2017). Abortion laws are more relaxed in Thailand, which permit abortion services under a broader set of circumstances. However, despite the broader availability of abortion in Thailand, women in Eastern Burma and refugee Burmese women in Thailand face significant obstacles in obtaining affordable and timely abortion care (Tousaw et al., 2018).

To help refugee and displaced women in Thailand, as well as women residing in Eastern Burma, access safe abortion care, the literature documents the successful implementation of several programs. These include a Mobile Obstetric Maternal Health Workers (MOM) Project; the Safe Abortion Referral Program; and a community-based misoprostol program for Burmese refugees (Arnott et al., 2017; Foster et al., October 2017; Tousaw et al., 2017; Tousaw et al., 2018; Mullany et al., 2008). The MOM Project involved creating a collaborative network of

community-based reproductive health workers to provide a limited subset of reproductive health interventions (Mullany et al., 2008). The Project succeeded in providing community training on post-abortion care to traditional birth attendants, who were then able to provide this service to the community (Mullany et al., 2008).

The Safe Abortion Referral Program was designed to help refugee women along the Thailand-Burma border access safe abortion care in Thailand (Arnott et al., 2017; Tousaw et al., 2017). The literature documents the success of this program. Women who participated in the project indicated positive results and said that it had helped reduce significant challenges (Arnott et al., 2017; Tousaw et al., 2017). Approximately 64% of women in this program were successfully referred to a Thai hospital or private clinic for safe abortion care, while 21% were denied a referral (Tousaw et al., 2017). While further research is necessary to determine why women were deemed ineligible for a legal referral, the findings from this program indicate the possibility of establishing a formal abortion referral program within a humanitarian context (Arnott et al., 2017; Tousaw et al., 2017).

Similar positive findings were also associated with the community-based misoprostol program for Burmese refugees. This program, first launched in 2011, established two community networks, through which Burmese women seeking an abortion would be able to obtain information about misoprostol and free medication (Foster et al., October 2017). These networks eventually grew to serve cross-border, refugee, and migrant populations throughout northern Thailand (Foster et al., October 2017). Both Foster et al. (October 2017) and Tousaw et al. (2018) documented the success of this program. The program boasts a relatively high success rate, with over 96% of women successfully terminating their pregnancies (Foster et al., 2017). Tousaw et al. (2018) identify that one of the factors contributing to the success of this program is

its community roots. This appeared to have increased the credibility and trustworthiness of the overall initiative (Tousaw et al., 2018).

While a majority of the limited case studies available in the literature focus on the refugee population on the Thailand-Burma border, there was one case study that outlined the successful implementation of post-abortion care in a different humanitarian context: Somalia. Similar to Burma, Somali law is severely restrictive with its abortion laws; the only exemption being to save a woman's life (Chukwumalu et al., 2017). Despite the legal, cultural, and social barriers, Save the Children International was able to successfully implement post-abortion care services within this humanitarian context (Chukwumalu et al., 2017). From the program's inception to December 2015, the project was able to provide post-abortion care services to approximately 1111 women (Chukwumalu et al., 2017). The main factors contributing to the success of this program were the availability of competent staff in all facilities 24/7, adequate equipment and supplies, as well as sustained engagement with all segments of the communities, including religious and community leaders (Chukwumalu et al., 2017).

While these nascent success stories do indeed challenge the view that providing abortion care in humanitarian settings is impossible, the number of successful case studies available in the literature is still limited. The successes of each of the case studies above are also dependent on the specific cultural context in which they arose. As such, further field research is required to fully determine the feasibility and success of implementing abortion care in humanitarian conflict contexts.

The Relationship between Contraception and Abortion in Humanitarian Conflict Settings

In addition to exploring the many barriers to providing abortion care services within humanitarian settings, the literature also broadly documents the impact of contraception on abortion. Several studies outline an inverse relationship between these two services, arguing that providing more contraception would reduce the need for the provision of safe abortion care. For instance, Miller and Valente (2016) find that the relationship between contraceptive use and abortion is best described as substitution. As contraceptive use increases, abortion rates decline (Miller and Valente, 2016). As such, the authors recommend that policies aiming to reduce unsafe abortion be accompanied by the provision of contraception (Miller and Valente, 2016).

While this study did not concentrate on a humanitarian context, this recommendation is further reiterated in other studies that do focus on conflict-affected contexts. In a study on refugee adolescent girls, Ivanova et al. (2018) finds that a lack of knowledge on contraception leaves girls with unwanted pregnancies, which increases the risk of unsafe abortion (p. 8). This need for more education and awareness on contraception is reiterated by Gedeon et al. (2015) and Kisindja et al. (2017), both of whom believe that it would decrease the harm from unsafe abortion methods.

Discussion

This scoping review attempted to provide a more comprehensive overview of the existing literature on abortion care for women, including those displaced and who identify as refugees, within humanitarian contexts. Overall, this scoping review confirms the danger of unsafe abortion as one of the primary causes of maternal mortality in low-income, conflict-affected settings. Furthermore, this review underscores the growing awareness of the need to reduce the harm of unsafe abortion practices, as well as the global discussions to make safe abortion care a priority within humanitarian interventions. However, this scoping review also emphasizes and maps the numerous challenges – legal, operational, cultural, and political – that humanitarian organizations face in providing this health service.

Ultimately, this scoping review provides a preliminary mapping of the different topics in the literature related to abortion care within humanitarian conflict settings. In doing so, this review confirms the dearth of research available on this topic. The current state of the literature is incomplete. In order to more comprehensively understand the nuances of this issue, the information gap within the literature must be reduced. In this discussion section, I advance several recommendations to enhance the existing literature on abortion care in humanitarian contexts.

Invest in More Comprehensive Analyses of Abortion Services within Humanitarian Settings

The first recommendation is to increase the number of comprehensive analyses that focus solely on the provision of and access to abortion care within humanitarian conflict contexts. To date, the current literature on this topic is extremely fragmented. Of the 65 studies that met the inclusion criteria in this scoping review, only 17 concentrated solely on abortion care within a

conflict-affected setting. The majority of the studies in this review included abortion services within a broader analysis of sexual and reproductive health in humanitarian settings or expanded their scope to look at abortion services within both humanitarian and low-income development settings. Furthermore, among the 17 studies that specifically focused on abortion care within a humanitarian context, a large majority primarily targeted the termination of pregnancies related to sexual violence and rape. As such, it is unclear where the literature stands on the termination of pregnancies in conflict settings for reasons unrelated to sexual violence.

The lack of comprehensive analyses on this topic is best exemplified by the systematic reviews included in this scoping review. Within the literature, the number of systematic reviews that analyze sexual and reproductive health services within humanitarian settings is quite small. Furthermore, of the systematic reviews that do exist, none could actually find peer-reviewed studies related to abortion services. This not only highlights the need for a more robust evidence base for sexual and reproductive health, but also the need for studies to delve more in-depth on the different types of sexual and reproductive health interventions. After all, this is an umbrella term capturing numerous types of care such as contraception and safe abortion.

While safe abortion should not be studied in isolation from other types of care, given the inextricable links to contraception, analyzing sexual and reproductive health interventions as a group implies that all types of care under this umbrella term have been treated with equal progress. This is not the case. For instance, more studies can be found on the use of contraception than abortion (Singh et al., May 2018). This leads to contraception being treated as more of a priority activity than safe abortion (Foster et al., November 2017). The lack of specification in the literature on the different sexual and reproductive health interventions obscures these differences. That being said, it is also possible that the literature intentionally uses

umbrella terms in order to denote more sensitive and specific services, so that they can be provided discreetly (Tanabe et al., 2015). As such, it is possible that more safe abortion care is being provided within humanitarian contexts but cannot be accurately captured within the literature due to political sensitivities.

Further Integration between the Legal, Operational, Cultural and Political Barriers

There is the possibility that the political sensitivities of providing safe abortion impact the way this intervention is discussed in academic research. This points to a second recommendation arising from this scoping review. Academic researchers need to more comprehensively integrate the different types of barriers to providing abortion care within humanitarian settings. The studies included in this review touch on the legal, operational, and cultural restrictions barring the success of abortion interventions, but do not investigate the interlinkages between these barriers. For example, McGinn and Casey (2016) outline the legal and operational reasons to explain why humanitarian organizations rarely provide safe abortion services but neglect to mention the importance of overcoming the cultural stigma of abortion. Alternatively, while a number of studies investigate the social stigmatization of terminating pregnancies resulting from sexual violence, they do not take the step of analyzing how their findings can be used by humanitarian practitioners in the field (Scott et al., 2017; Scott, J., et al., 2018; Rouhani et al., 2016). At most, these case studies reiterate the need for access to safe abortion services for survivors of sexual violence. While it is important to continue highlighting the immense need for such interventions in the field, more research is required pertaining to the implementation of, in terms of demand for and opportunities to provide, abortion care in humanitarian conflict situations (Scott, J. et al., 2018).

Furthermore, of the nascent successful case-studies within the literature, those pertaining to referral programmes or misoprostol community-based distribution programmes along the Thailand-Burma border do not explicitly mention the impacts of the stigmatization of abortion (Foster et al., November 2017; Tousaw et al., 2018; Tousaw et al., 2017). These studies acknowledge the conservative cultural context pertaining to abortion in Thailand, and even more so in Burma, but it is unclear how these contexts impacted the care that women received. The case study in Somalia by Chukwumalu et al. (2017) was the only example within this scoping review that provided detail on how it managed the sensitive cultural context of providing post-abortion care. Even then, the study acknowledges that its messaging did not go far enough to diversify community awareness and mobilize all members, including men and youth (Chukwumalu et al., 2017).

As such, there is a clear need to more comprehensively explore the impacts of reticent and conservative cultural norms on the provision of abortion care, as well as how these norms interact with the legal and operational barriers. The linkages appear to be implicit. Severe legal restrictions on abortion contribute to the conservative cultural stigmatization, which can also be reflected in the reluctance and attitudes of national humanitarian health care aid workers in providing abortion services. However, a more explicit analysis is required to confirm and delve deeper into these linkages.

The clearest gap within the studies included in this scoping review relates to the political barriers. Several studies hint at the political constraints surrounding the provision of abortion. Tanabe et al. (2015), Tousaw et al. (2017), Chukwumalu et al. (2017) all briefly touch on working within humanitarian contexts that are politically sensitive to abortion interventions. With respect to the global political constraints, McGinn and Casey (2016) and Scott, R. et al.

(2018) hint at the hostile policy environment created by the Mexico City Policy. However, the literature lacks a more in-depth and nuanced analysis of the political barriers to providing abortion services. Shockingly, there were very few studies in the literature that explicitly mentioned the impact of the Mexico City Policy on the work of humanitarian organizations. Only two of the studies that met the inclusion criteria did so (McGinn and Casey, 2016; Scott, R. et al., 2018). Extra research, outside of the scope of this review's methodology, was done to find more information on the impacts of the abortion restrictions of the United States on humanitarian organizations. Even then, the studies found broadly described the impacts of the Mexico City Policy on foreign aid in general, briefly mentioning organizations that engage in humanitarian work.

It is possible that the dearth of studies focusing on the impacts of American foreign policy on the provision of abortion care in humanitarian settings expose the limitations of the search strategies used in this scoping review. However, even when the search terms were refined to explicitly include the Mexico City Policy, few studies were found. This absence of analysis on the effects of the Mexico City Policy on humanitarian settings within the literature highlights the interplay between the political and operational barriers. Many of the studies that passed the inclusion criteria held a more operational perspective of providing abortion services in the field. In other words, the academic literature on abortion services in humanitarian settings is dominated by program evaluations – focusing solely on the best way to deliver a program of action, allocate funding, or implement a policy. The "elephant in the room", so to speak, were the global political policies on abortion which were briefly, but rarely, mentioned. For instance, none of the studies included in this scoping review spoke to the effects of Canada's *Feminist International Assistance Policy*, which explicitly endorses the provision of safe and legal abortion and post-

abortion care (Global Affairs Canada, 2019). Rather, perhaps due to the political constraints set by the Mexico City Policy that have defined the provision of abortion services, the literature focuses more on the operational aspects of these interventions. Furthermore, it is also possible that the lack of research generally on abortion care in humanitarian settings is partly defined by the political constraints on this topic, which discourages further research. However, by ignoring the global policy context on abortion and focusing solely on program evaluations, the literature downplays the larger political forces that shape the ability of actors to provide abortion services.

Recognize the Power Dynamics in Providing Abortion Care in Humanitarian Conflict Settings

The third recommendation to enhance the existing literature on abortion care within humanitarian settings is to provide a more explicit understanding of the power dynamics that exist when providing such interventions. By dynamics of power, this review refers to the impact of patriarchal gender norms within certain contexts as well as the differing perspectives between international aid workers and the beneficiaries of humanitarian assistance.

Few studies within this scoping review hint at the pervading gender norms that surround the provision of abortion care in humanitarian conflict settings. Cherri et al. (2017) speak to the patriarchal norms that allow husbands and parents to have the final decision on whether Syrian refugee women can access family planning services. Likewise, Hartmann et al. (2016) recognize that while abortion has clear gender equality and human rights associations, these are rarely covered in the literature. However a more fulsome understanding of the gender norms surrounding abortion care is key to the implementation of this intervention in humanitarian conflict contexts. Many of the qualitative studies included in this scoping review only provide the women's perspective. This is very important given that women are the central persons of

concern with respect to abortion care. However, in order for such interventions to be successfully implemented, men and boys also need to be included in the conversation, especially if patriarchal gender norms provide them with more power and control over women's lives. The lack of men and boys' perspectives is recognized as an implementation weakness by Chukwumalu et al. (2017) in their case study on post-abortion care in Somalia. As such, understanding the gender power dynamics within specific contexts can enhance the implementation of abortion care services by highlighting which sections of the population in question need to be engaged.

In addition to providing a more comprehensive understanding of the gender norms in humanitarian contexts, the literature should also include a more thorough analysis of the power dynamics between international aid workers and recipients of abortion care services. In more culturally conservative conflict-affected settings, especially where reluctance to abortion is quite strong, it is easy to construe the provision of modern abortion methods as a western imposition. This is recognized by Palmer and Storeng (2016) in their analysis of abortion in South Sudan, where it was considered to be "cultural pollution imported by returnees and foreigners" (p. 13). Multiple studies recognize that women have more trust in their own communities and in their traditional practices of terminating pregnancies rather than in formal healthcare providers (Onyango et al., 2016; Scott et al., 2017; Scott, J. et al., 2018). As such, the literature hints at competing discourses between "modern" abortion services, associated with western medicine, and "traditional" practices. In order to reduce the harm of unsafe abortion, more research is required to expand on these discourses. International humanitarian assistance workers are in a position of power over beneficiaries by having the privilege and the resources to decide what kind of aid can be provided. To effectively use this power and overcome the cultural stigma of abortion, aid workers need the buy-in of the communities they want to help. This can be done by

using their power to respectfully engage with the communities in question without belittling their traditions.

Increase the Diversity of Perspectives

The fourth recommendation to further enhance the literature on abortion care in humanitarian settings is to include a more diverse set of perspectives. Within the studies included in this scoping review, there was a strong consensus that abortion care services *should* be provided in areas affected by conflict in order to reduce maternal mortality and the harm caused by unsafe abortion practices. While the fragmented literature indeed outlines the barriers to the provision of abortion care in such complex contexts, it is buoyed by a sense of optimism that these can be and *should* be overcome, especially given that modern abortion methods can be performed by mid-level health workers rather than specialists (Chukwumalu et al., 2017). The implication is that, if specialists are not required, safe abortion services requires less training and are therefore easier to provide. This optimism is best exemplified by McGinn and Casey (2016) whose key premise is that humanitarian NGOs should be providing safe abortion to women with unwanted pregnancies during humanitarian conflicts.

We cannot disregard the harm of unsafe abortion nor the increases in maternal mortality when safe abortion care is not provided, especially during humanitarian conflicts. However, given the political and cultural sensitivities around abortion, there is a distinct lack of alternative views within the current literature that challenge the premise that this service *should* be provided. Of the studies included in this scoping review, only one in particular notably provides a more nuanced perspective and considers the political and cultural sensitivities. Tran and Schulte-Hillen (2018) caution against openly focusing on safe abortion care within humanitarian contexts as it "may put field staff, patients, and operations at risk" (p. 4). Their fear is that openly supporting

such a politically and culturally sensitive topic could possibly affect the working relationship that humanitarian organizations have with donor and refugee-hosting governments (Tran and Schulte-Hillen, 2018, p. 4). Governments, especially those within more conservative contexts, may not be open to working with humanitarian organizations that support safe abortion, which could affect the implementation of other important humanitarian services such as the provision of food, shelter, and water.

The political sensitivities surrounding safe abortion care indeed calls into question the compatibility of this intervention with the core principles that define humanitarian assistance. All humanitarian assistance is guided by four main principles, formally enshrined in two UN General Assembly resolutions (OCHA, 2012). These principles are humanity, neutrality, impartiality, and independence. In this case, the primary principle in doubt is that of impartiality which declares that humanitarian action must be "carried out on the basis of need alone, giving priority to the most urgent cases of distress and making no distinctions on the basis of…political opinions" (OCHA, 2012). Tran and Schulte-Hillen (2018) argue that the provision of abortion care could run the risk of violating the principle of impartiality by placing humanitarian organizations in a position of advocacy in favour for a politically sensitive issue. This could run the risk of jeopardizing the relationship that humanitarian organizations have with local actors on the ground, especially if these local actors are not in favour of providing abortion services.

In this fourth recommendation, I hint at a potential conflict between those who argue that abortion services should be provided as a matter of course and those who argue that openly advocating for abortion care in contexts that are opposed to this service could result in negative ripple effects for other humanitarian services. However, the current state of the literature does little more than hint at this conflict. It is therefore imperative that the academic literature

undertake further research to bring this normative conflict to the fore. This can start with presenting more perspectives that challenge the view that, or at least acknowledge the political and cultural consequences of, providing abortion services in humanitarian settings. To reiterate, unsafe abortion practices carry very real and harmful risks, especially for women and girls in humanitarian settings. My recommendation does not disregard this fact. Rather, the objective of my recommendation is to foster a better understanding of the consequences of advocating for or implementing abortion services, a politically and culturally sensitive topic, rather than be blinded by a sense of moral optimism on what humanitarian organizations *should* do.

Clarify the Objectives of Providing Abortion Care in Humanitarian Conflict Settings

The impact of the political sensitives surrounding abortion care leads to the fifth and final recommendation arising from this scoping review. The literature reveals that humanitarian actors need to come a shared understanding of the objective of providing abortion care in humanitarian settings. The provision of abortion care encompasses several slightly different activities. Abortion services can refer to comprehensive abortion care, safe abortion care, or post-abortion care. As defined in the background section of this review, these terms correspond to the type of care provided. To briefly reiterate, post-abortion care refers to the treatment of incomplete and unsafe abortion and complications that are potentially life-threatening, including counselling, contraception, and referral services (IAWG, 2018, p.146). Safe abortion care refers to procedures to terminate pregnancies through a method that is recommended by the World Health Organization and with a trained professional (WHO, 2019). Comprehensive abortion care includes the services of post-abortion care as well as safe induced abortion methods (IAWG, 2018, p. 146).

According to the Minimum Initial Service Package (MISP), comprehensive abortion care is considered to be a life-saving intervention (IAWG, 2018, p. 147). However, this idea is quite contentious within the IAWG. Political opposition to providing comprehensive abortion care, and more specifically safe induced abortion methods, has created friction within the IAWG as well as casted doubts on the feasibility of the MISP by several international humanitarian organizations. For instance, the United Nations Population Fund and *Medécins Sans Frontières* both expressed concern that the political opposition to abortion can derail the "lifesaving focus" of the MISP (Edwards, 2017).

The idea of "lifesaving" is of particular importance within the humanitarian sector. Regardless of the crisis, the priority in any humanitarian response is to "save lives and reduce suffering through meeting humanitarian needs" (Humanitarian Coalition, 2019). This is reiterated among NGOs, UN Agencies, and even among donors. For instance, Canada's ultimate aim for its humanitarian assistance is to "save lives, alleviate suffering, and support the dignity of those affected by crises" (Global Affairs Canada, 2019). This is related to the humanitarian principles, which explicitly states that the purpose of humanitarian action is to "protect life and health" and should be carried out "on the basis of need alone" (OCHA, 2012).

The opposition to providing comprehensive abortion care thus stems from the lack of a clear objective. Storeng and Ouattara (2014) argue that the objectives of post-abortion care differ from that of safe or comprehensive abortion care. Post-abortion care tackles the consequences of unsafe abortion through a focus on harm reduction (Storeng and Ouattara, 2014). It is framed as a "lifesaving" service and does not imply any legal, cultural, or social reform. Post-abortion care allows humanitarian organizations to bypass the social, legal, and cultural barriers associated with the provision of abortion and retain their "lifesaving" mandate (Storeng and Ouattra, 2014,

p. 949). In comparison, comprehensive abortion care requires not only the implementation of safe abortion methods, but also greater awareness raising, advocacy, and engagement with the beneficiaries of humanitarian assistance on the importance of abortion to preventing maternal mortality (IAWG, 2018, p. 160).

Humanitarian actors need to come to a shared understanding and consensus of what is needed during a crisis with respect to abortion. Should humanitarian organizations safeguard their life-saving focus, or should they be engaging in advocacy and preventing further maternal mortality during a humanitarian conflict? While comprehensive abortion care may be included in the MISP, the literature documents a gap between the provision of comprehensive abortion care and post-abortion care. Chynoweth (2015) finds that there has been slightly more progress in the provision of post-abortion care than of comprehensive abortion care in humanitarian settings. This only serves to further highlight the need for a clear objective on the provision of abortion and also the role of humanitarian organizations – whether that be to focus on saving lives and reducing the harm of unsafe abortion or to go even further and engage with the legal, cultural, and political barriers to providing abortion services.

Conclusion

The provision of safe abortion care continues to be one of the major gaps of sexual and reproductive health services in humanitarian settings. Unsafe abortion is one of the leading causes of maternal mortality. For pregnant women and girls in humanitarian conflict and crisis situations, there is often very little access to reproductive health care, increasing the risk of turning to unsafe abortion practices. While the risks of unsafe abortion for women and girls in humanitarian contexts has gained global prominence among the humanitarian community in the last decade, the academic literature has not kept pace. Safe abortion care receives less academic coverage than other reproductive health interventions and only a small number of studies actually focus on the provision of abortion services in humanitarian settings.

Through a scoping review of the academic literature, the purpose of my major research paper was to generate more substantive knowledge on abortion services in humanitarian settings and foster a better understanding of the current state of the existing literature on this topic. In this regard, I succeeded. Within the literature, there was a strong consensus that the provision and availability of abortion care services are and still remain an alarming gap in humanitarian contexts, despite the growing awareness of the risks of unsafe abortion practices and the overall increased capacity among humanitarian health actors in providing sexual and reproductive health services.

To provide an explanation for this gap, I outlined four different types of barriers to the provision of abortion care services in humanitarian settings – legal, operational, cultural, and political. Legal barriers arise when there is ambiguity and a lack of clear policy guidance on how to apply international and national abortion laws in practice. Operational barriers to providing abortion care can include a lack of information for both beneficiaries as well as humanitarian

actors and even a lack of human resources such as trained staff in providing abortion services. Cultural barriers can relate to the stigma around abortion, which impacts both the beneficiaries and the humanitarian organizations that provide the service. Political barriers relate to the global policy context around the issue of providing abortion care services, more specifically the impact of the Mexico City Policy, its reinstatement and expansion under the Trump Administration on the capacity of humanitarian health actors to provide abortion care.

While I succeeded in providing a preliminary mapping of the current literature on abortion care in humanitarian settings, my scoping review methodology also confirmed the dearth of available research on this topic. The current state of the literature is fragmented and incomplete. This is best exemplified through the systematic reviews included in my scoping review. In the literature, the number of systematic reviews that analyze sexual and reproductive health in humanitarian settings is small. However, of these reviews that exist, none could actually identify peer-reviewed studies related to abortion services. This points to an overwhelming information gap in the literature and highlights the need for a more robust evidence base for safe abortion care services in humanitarian settings.

In order to more comprehensively understand the nuances of this topic, I proposed five recommendations to enhance the existing literature on abortion services in humanitarian contexts. First, I recommend increasing the number of comprehensive analyses that focus solely on the provision of and access to abortion care in humanitarian settings, rather than include abortion within a broader analysis of sexual and reproductive health. Second, I suggest that academic researchers need to better integrate the impacts of the different types of barriers – legal, operational, cultural, and political – in their analyses. The studies included my scoping review tend to focus on one barrier and neglect the others. Most importantly, academic researchers need

to include a more in-depth analysis of the impacts of the political context of providing abortion services. The literature is overwhelmingly dominated by program operational evaluations. There were very few studies that explicitly mentioned the impact of the Mexico City Policy on the work of humanitarian organizations. The lack of research and literature on the political context could possibly be a result of the political constraints set by the Mexico City Policy, which discourages further contentious research on this topic. By concentrating on the operational aspect of providing abortion services, researchers may perhaps feel that the topic becomes less sensitive and they can avoid naming and shaming powerful government donors. However, by ignoring the political barriers to providing abortion care services, the literature ultimately downplays the larger political factors that shape the ability of humanitarian actors to provide abortion services. This is a vital, albeit currently missing, element in understanding why abortion services remain an alarming gap in humanitarian settings.

Third, I recommend that the existing literature include studies that specifically focus on the impact of patriarchal gender norms on the provision of abortion care services as well as the ways in which the perspectives of international aid workers and the beneficiaries of humanitarian assistance differ. In doing so, the literature needs to recognize and analyze the dynamics of power that exist in these humanitarian contexts, especially with respect to the provision of abortion care services. This relates to my fourth recommendation which is to increase the diversity of perspectives within the literature. This includes challenging the overwhelming narrative in the literature advocating that humanitarian organizations *should* provide abortion care without understanding the political or cultural consequences of advocating for or implementing abortion services. My fifth and final recommendation is for humanitarian actors to come to a shared and clearer understanding of the objective of providing abortion care services.

Should they be focusing solely on reducing the harm of unsafe abortion practices or engaging in more preventative methods?

Through a scoping review, my paper ultimately reveals that more comprehensive nuanced research, with an increased diversity of perspectives, is required to overcome the fragmentation of the current state of the literature on abortion care services in humanitarian settings. Academic researchers need to start asking broader policy questions and extend the scope of their analysis beyond program orientations. As the humanitarian health community becomes more aware of the need to provide safe abortion care and as donor governments such as Canada throw their support behind the implementation of such health interventions, the academic literature needs to keep pace. While it may be one of many factors, more robust and comprehensive research on this topic may very well be the first step to reducing the gap in providing abortion care services in humanitarian settings.

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Appendix A

Final List of Studies Included in the Scoping Review

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