Expanding Access to Comprehensive Abortion Care in Humanitarian Contexts: Case Study from the Rohingya Refugee Camps in Bangladesh

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The need for comprehensive sexual and reproductive health (SRH) care can be especially acute during humanitarian crises, as women and girls are at increased vulnerability of experiencing sexual violence, unintended pregnancy and pregnancy-related complications.[1] However, in such settings, the chaos of displacement and basic survival may supplant the importance of SRH care,[2] and individuals may also have diminished access to safe services. Abortion and abortion-related care may be particularly limited in humanitarian contexts because of a number of barriers beyond the lack of infrastructure, supplies and trained staff: For example, abortion care practitioners in emergency settings may perceive or face legal complications or loss of funding due to their provision of abortion services, insititutions and governments may lack timely data on and underestimate the true volume of abortion demand among refugees, and providers may hold a perception that providing abortion care in crisis settings may be too difficult to attempt.[3,4]

Given the myriad barriers to SRH and safe abortion care for women and girls in crisis settings, as well as the competing survival priorities that a displaced person may be experiencing, many women in such situations are delayed from seeking abortion until later in pregnancy. Although induced abortion is extremely safe when conducted by trained providers, abortions at later gestational ages (namely at or after 13 weeks' gestation) carry a higher risk of complications when performed clandestinely.[5] Unsafe abortion in the second trimester increases women's risk of morbidity and mortality: Nearly half of all abortion-related deaths and two-thirds of all complications occur after 13 weeks' gestation–the majority of them in countries where access to safe abortion is restricted.[6]

Limitations in access to safe abortion care are further exacerbated for women seeking services at or after 13 weeks' gestation. Even in settings with legal indications for abortion, policies governing abortion after the first trimester are typically more restrictive.[7] In a number of countries where abortion in the first trimester is available on request or with few limitations, second-trimester abortion may be restricted only to cases involving rape or risk to the woman's life; access may be further complicated by additional requirements such as agreement of multiple approved practitioners for the procedure or consent from families or spouses.[8] Beyond legal indications, women may face additional challenges to accessing safe abortion services at or after 13 weeks because of limited knowledge of service availability and legal indications, fewer facilities with providers trained in second-trimester abortion and increased transportation costs or lost wages for reaching these services.[9] Together, these barriers make it more difficult for women to access a safe and legal abortion in later gestational ages, thus increasing their likelihood of relying on an unsafe procedure.

Safe and accessible abortion care at or after 13 weeks' gestation is essential in any setting, but all the more so in humanitarian crisis contexts, where women face substantial obstacles in seeking timely and appropriate care.[4] This report summarizes the work of Ipas–an international nongovernmental SRH organization–to expand access to abortion-related care after the first trimester in the context of the Rohingya refugee camps in Cox's Bazar, Bangladesh. The initiative is the first documented comprehensive abortion service program implemented during the acute emergency phase of a humanitarian crisis, and was designed to improve access to and availability of high-quality, trauma-informed, comprehensive abortion services. The lessons learned from Ipas's experiences in terms of advocacy, implementation and follow-up support can inform comprehensive SRH initiatives in other humanitarian settings.

The Rohingya Crisis and Cox's Bazar

The Rohingya are a Muslim ethnic minority group–originally based in the western Rakhine State of Myanmar–who have been subject to decades of systematic discrimination and statelessness. In August 2017, organized attacks by militants on Rohingyas escalated, resulting in one of the largest humanitarian crises in modern times.[10,11] As a result of the violence, nearly one million Rohingya have been displaced over the border into the Cox's Bazar district of Bangladesh; of these, an estimated 325,000 are women of reproductive age (15–49).[12]

By far the largest and most densely populated refugee settlement in the world, the Kutupalong refugee camp in Cox's Bazar is managed by the government of Bangladesh with the support of the United Nations (UN) High Commissioner for Refugees, the International Organisation for Migration and the UN Resident Coordinator in Bangladesh.[13] The influx of refugees since 2017 has resulted in a number of adjoining or nearby expansion sites that cover a geographic area of 3,000 acres and are comprised of flimsy shelters in flood-prone areas. Within the wider subdistrict of Cox's Bazar, there are 10 secondary, 33 primary and 170 basic health units, which are managed by more than 100 agencies.[14] Activities conducted by these agencies are coordinated by the UN Office for the Coordination of

Humanitarian Affairs using the "cluster approach," an international humanitarian coordination system established by the UN in 1991.* The health "cluster" is under the purview of the World Health Organization (WHO) and is further subdivided into specialty areas, each headed by a lead organization, and in the context of Cox's Bazar, UNFPA leads subcluster activities related to SRH.

The Rohingya population in Cox's Bazar† is highly vulnerable to unintended pregnancy and other SRH risks—having fled conflict and enduring extremely difficult conditions within refugee camps with limited access to contraceptives.[12] A 2018 independent UN fact-finding mission reported that scores of Rohingya women and girls endure targeted acts of sexual violence, including rape, prior to and during their migration journeys.[13] Once settled in Cox's Bazar, they are further exposed to gender-based and sexual violence at the hands of security forces and other men in the camps—increasing the risk of unintended pregnancy and unsafe abortion.[15,16] Furthermore, according to initial Ipas assessments, only short-acting contraceptive methods (i.e., condoms and the pill) were available in Cox's Bazar before 2018; long-acting reversible methods were introduced in a small number of facilities in 2018, but availability of a full range of contraceptive methods was an ongoing issue. The combination of sexual violence and lack of proper SRH care exacerbate the need for abortion services.

Abortion in Bangladesh

Women in Cox's Bazar should theoretically have access to the same abortion services available elsewhere in Bangladesh; however, the legality of abortion care in the country is somewhat unclear and, thus, service availability and provision on the ground may be inconsistent. Abortion law in Bangladesh is based on the highly restrictive British Penal Code of 1860, which criminalizes provision of abortion in all cases, except those where the life of the mother is at risk. However, in 1979, the Government of Bangladesh legalized menstrual regulation (MR) as an "interim method" of establishing nonpregnancy in women at risk of becoming pregnant—whether or not they are actually pregnant—up to 10 weeks' gestation.[17] The procedure, updated by the Directorate General of Family Planning in 2014, allows use of manual vacuum aspiration (MVA) or medication abortion (mifepristone and misoprostol) to "regulate the menstrual cycle when menstruation is absent" for up to 12 weeks and use of MR with medication up to nine weeks since a woman's last menstrual period.[18] According to the Bangladesh Ministry of Health and Family Welfare (MOHFW) Population Control and Family Planning Division, MR services can be provided by specially trained and registered medical practitioners, who have traditionally been limited to obstetric physicans. Although illegal, self-management of abortion with off-label use of medication is common in Bangladesh, where misoprostol and combination medication abortion drugs are sold over the counter.[19] Postabortion care (PAC) is legal in Bangladesh to treat abortion-related complications (from miscarriage, MR, or clandestine or self-managed abortion), and is performed by MVA, medication or sharp curettage (an obsolete method).[20]

Abortion at or after 13 weeks' gestation is only legal in Bangladesh to save the life of the woman and, even so, is available in only a few high-level facilities, mostly in Dhaka.[20] MOHFW guidance does not explicitly state that PAC at or after 13 weeks can be provided, but it is implied as a life-saving measure and signal function of emergency obstetric and newborn care; this is also the case for induced abortion for maternal and fetal indications presenting at or after 13 weeks.

Although abortion care may technically be legal, providers may eschew participating in abortion-related services, especially at or after 13 weeks' gestation, because of lack of knowledge or misconceptions of the law.[4] In addition, despite the availability of MR services at public, private and nongovernmental organization facilities across Bangladesh, women report barriers to all types of abortion care (including MR, PAC and second-trimester abortion), such as stigma, exorbitant fees and providers' imposition of legally baseless policies (e.g., requiring husband's or guardian's permission).[19] As such, even in the first trimester, women in Bangladesh may seek alternative or unsafe options for MR.

Unsafe abortion is a leading cause of maternal mortality and morbidity around the world, and incidence is concentrated in fragile or poorly-resourced contexts, such as Bangladesh.[21,22] More than one million induced abortions are performed in Bangladesh each year, many of them in unsafe conditions or by unskilled providers.[15] In 2014, an estimated 384,000 women in Bangladesh experienced complications from unsafe or clandestine abortions. In 2016, the maternal mortality ratio was 196 deaths per 100,000 live births, and an estimated 7% of maternal deaths were abortion related.[20] Furthermore, there was a notable increase in the proportion of PAC clients experiencing hemorrhage from 27% in 2010 to 48% in 2014, believed to be the result of increases in improper use of misoprostol.[15] In both the public and private sectors, clients typically present for PAC and indicated abortion care at or after 13 weeks' gestation because of fetal or maternal health issues, incomplete abortion (attempted with over-the-counter drugs or by an untrained provider) or delayed care-seeking due to the trauma of having experienced sexual violence.[19,23]

* The cluster approach was developed by the UN General Assembly to improve system-wide preparedness and technical assistance in humanitarian responses. The clusters are responsible for coordination of all activities in each of nine focus key areas: health, logistics, nutrition, protection, shelter, water/sanitation/hygiene, camp management, early recovery, education, emergency telecommunications and food security.

† Cox's Bazar is the district within which the Rohingya camps are located; however, as the local refugee population expands, facilities used by the refugees may be within the camp or elsewhere in the district. Thus, in this report, "Cox's Bazar" is often used to refer to the geographic location in which Rohingya women are accessing abortion care.

Ipas's Approach and Initial Project Interventions

Since 2011, Ipas Bangladesh has worked with the MOHFW to foster improved access to quality SRH services, including abortion care. The organization's support includes working with the government to advocate for safe legal abortion and conducting clinical training of abortion care providers (i.e., physicians, nurses, midwives, family welfare visitors, paramedics). Ipas uses a sustainable approach to capacity-building whereby abortion trainers are based at local university medical centers and engage in cascading training through a trainer-of-trainers model. Training typically entails six days of both didactic and practical instruction in induced abortion and PAC, with time for hands-on clinical practice and supervision, usually at a specified training facility or learning hospital. Ipas training can take place where obstetric services are available, and covers using medication for either induced abortion or PAC, leveraging existing procedures and technologies for MR and PAC for cases before 13 weeks' gestation. Interventions also include training in noncoercive contraceptive counseling for providers and community-based behavior change programming to connect women to services.[24]

In October 2017, Ipas Bangladesh responded to UNFPA's request to establish quality MR and PAC services in strategically located facilities in Cox's Bazar, given the lack of availability of safe abortion care, and anecdotal evidence of high rates of rape-related pregnancies and unsafe abortions. In partnership with UN agencies, several local and international organizations in Bangladesh, and in cooperation with relevant government stakeholders, Ipas began working to address the unmet SRH needs of Rohingya refugee women and girls living in and around the camps. Eight strategically located public-sector facilities (six located within the camps and two nearby in the district) were selected on the basis of partner presence in or accessibility to the sites; eventually services were expanded to 40 sites. Ipas conducted site readiness activities and workforce capacity assessments of each facility to gauge the current number of providers from different types of cadres available, and their level of experience in and desire to provide abortion care either before 13 weeks' gestation or at or after 13 weeks; existing methodologies available for MR and PAC; contraceptive commodity availability; infection prevention practices; pain management provision; and the availability of antibiotics.

Although many of the facilities in and around the refugee camps in Cox's Bazar should offer SRH services in line with the Minimum Initial Services Package (MISP),‡[25] Ipas baseline reports in late 2017 indicated low levels of uptake of both abortion and family planning services among Rohingya women and girls due to issues of access to facilities. MR was theoretically available in Cox's Bazar, as in the rest of Bangladesh; however, Ipas site assessments showed that very few facilities in the camps or surrounding district were equipped with adequate supplies or trained staff to provide MR. Shortages in contraceptive supply and low-quality PAC (e.g., inadequate site set-up, newly trained midwives unfamiliar with clinical and infection prevention protocols) were also common among facilities. In addition, a review of 2018 Ipas Bangladesh data showed that much of PAC care in this context was performed by sharp curettage, an obsolete and unsafe technology. Furthermore, referral systems for more complicated cases did not exist in local facilities at the start of this program.

Training activities began at the eight selected sites in 2018, and initially targeted provision of first-trimester comprehensive abortion services (MR, PAC and postabortion contraception), as is legally provided for in Bangladesh. However, from the very first day of training, health providers found that a high proportion of women were presenting for PAC at or after 13 weeks' gestation. Providers commonly noted physical scarring or soft-tissue trauma among clients, resulting from unsafe attempts at abortion. The master trainers, although knowledgeable about and experienced in first-trimester MR and PAC protocols, were unprepared for provision of services at or after 13 weeks, and thus reached out to Ipas headquarters for additional training and programmatic support.

Advocating for Expanded Abortion Services

Since government guidance regarding the legality of abortion care at or after 13 weeks' gestation is unclear, stakeholders at the national, district and camp levels had some initial apprehension to engage in PAC provision after the first trimester. Therefore, the Ipas team advocated through the SRH subcluster with donors, partners and government stakeholders (including those associated with UNFPA, Packard, WHO and the MOHFW) to adjust the planned MR trainings to include PAC and indicated abortion care to save a woman's life. The team attended weekly SRH subcluster meetings and oriented stakeholders on the need to expand availability of abortion care at or after 13 weeks by presenting statistics on abortion need and data related to unsafe abortion. They also integrated MR and PAC data into the subcluster SRH data system, to improve tracking and measurement of abortion services for both service- and policy-related reasons.

As a result of these technical advocacy and representation efforts over the course of six months, stakeholders were persuaded that abortion services after the first trimester should be integrated into training materials, and clinical guidance and protocols. Ipas developed a clinical protocol for abortion at or after 13 weeks' gestation that was disseminated widely throughout the subcluster and with national level stakeholders, such as the Obstetric and Gynecology Society of Bangladesh (OGSB). In addition, UNFPA agreed to incorporate MR and PAC into their data

‡ The MISP is a set of priority SRH activities developed by the Inter-Agency Working Group on Reproductive Health in Crises to be implemented at the onset of every humanitarian emergency to prevent sexual violence, HIV transmission, and maternal and newborn morbidity and mortality.

system, and to enable reporting of data for the first time within the cluster system.

District-level providers, as well as government stakeholders, were eager to receive this training and support, as they were providing basic medical management of women presenting for PAC at or after 13 weeks' gestation but without proper protocols and quality standards. Furthermore, Ipas sensitized stakeholders—particularly obstetricians and gynecologists—to the program, and expressed support by acknowledging the high volume of PAC cases and high-risk pregnancies at or after 13 weeks. Sensitization entailed review of global data on and examples of other rapid-response programming for abortion in development contexts, guidance on abortion service delivery outlined in the MISP and the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (IAFM),§ presentation of needs on the ground identified from key informant interviews with providers in Cox's Bazar and feedback from Rohingya women. Additional sensitization and exposure were needed for some local government department heads to ensure their backing; this was provided in the form of national- and district-level stakeholder meetings, evidence reviews for service provision at or after 13 weeks, and values clarification and attitude transformation (VCAT) workshops that address abortion stigma by encouraging stakeholders to reflect on their attitudes and assumptions toward abortion and women who seek it.[26]

Given the technical intensiveness of dilatation and evacuation (D&E), a surgical method used for second-trimester abortion, stakeholders decided instead to focus on medical management (mifepristone and misoprostol) and use of MVA, which are equally effective methods for abortion care at or after 13 weeks' gestation.[27] Since this intervention was a rapid response program, and in alignment with the IAFM and MISP, Ipas opted to begin with medical management and expansion of MVA up to 16 weeks, where feasible.[28] This route was also chosen, in part, because of supply chain issues in obtaining D&E equipment in an emergency response setting where resources are scarce and services are time-sensitive.

Training in Abortion Care at or After 13 Weeks

Once buy-in and support from the appropriate government and local stakeholders was obtained, Ipas began introducing training and posttraining support for PAC at or after 13 weeks' gestation through the use of medications in February 2018. Ipas enlisted master trainers in abortion care at or after 13 weeks from nearby Nepal to support the training. These trainers are members of Ipas's global trainers' network, are familiar with the Ipas second-trimester training protocols and could be immediately deployed to the emergency situation in Cox's Bazar. Bangladeshi providers trained in quality PAC or abortion care beyond 12 weeks are concentrated in large hospitals in Dhaka and were not available in areas like Cox's Bazar at the time of training.

Capacity building was tailored to meet the unique needs on the ground: For example, off-site trainings would not be feasible for providers who were the only one at their facility responsible for maternal and reproductive health services. Thus, Ipas developed bespoke training strategies to cause minimal disruption to service provision, which included either on-the-job trainings or on-site trainings at health facilities. Training was adjusted from six days to five days of theoretical and practical instruction to accommodate the availability of providers. In addition, training was focused on PAC, rather than induced abortion, and prioritized practicum sessions on pelvic models and women seeking care to ensure adequate uptake of skills and to increase provider confidence in their ability to perform procedures.

Under the supervision of a trainer, providers were divided into small groups and assigned to treat clients and to provide follow-up to complete the full expulsion. For such sessions, providers were taken to a local district-level referral hospital with high case loads for clinical practice. This adjustment was made for the circumstances, as trainees are typically sent to Dhaka for instruction. Keeping the training local to Cox's Bazar not only reduced the time and logistical effort for training, but also enabled networking between local providers and referral facilities. Furthermore, by training on PAC provision within their daily surroundings, providers had a greater opportunity to understand the local needs for abortion care, to visualize providing abortion care in their given context and to grapple directly with abortion-related stigma within their own communities. The primary disadvantage to training locally rather than in Dhaka, however, was a lower case load of abortion clients for hands-on practical instruction.

After initially training only obstetric providers, Ipas advocated for adjusting training activities to be applicable to providers with no prior abortion care experience. This was deemed necessary to accommodate the rapid response needed in this context and—for the first time in Bangladesh—to allow for some task-shifting of abortion provision to midlevel cadres (e.g., midwives and paramedics), which has been shown to be safe and effective.[29] Training a mixture of physicians and midlevel providers was a novel approach for Ipas, necessitated by local human resource constraints, and the fact that midwives and paramedics are often the first line of defense in treating women presenting at lower level facilities with abortion complications. By reframing the concept of PAC at or after 13 weeks as being in line with emergency obstetric and newborn care, Ipas was able to gain stakeholder approval to train lower level cadres to provide the first dose of medication per medical management PAC protocols, as well as to refer clients to

§ The IAFM—issued by the Inter-Agency Working Group on Reproductive Health in Crises, in collaboration with hundreds of representatives from nongovernmental and UN agencies around the world—is the definitive guide on SRH care in crisis settings. It includes technical guidance on applying global SRH and human rights standards in humanitarian settings.

referral facilities in case of hemmorhage, infection, shock, or other signs of instability or nonresponsiveness.

Training of midlevel providers was conducted at select facilities using standard Ipas training modalities, complemented by on-the-job instruction by trained obstetricians. Five skilled midlevel service providers were trained in PAC and MR up to 12 weeks' gestation, initial medical management for abortion beyond 12 weeks, and instruction on referral pathways for PAC or abortion case management and uterine evacuation. They were then dispatched to a public health post** for three months to provide service provision, transfer skills and build competency among posted government providers at each of the sites. The recruited midlevel service providers used the MR, PAC and MR with medication protocols to facilitate skill-transfer.

Both the formal and on-the-job training used a rights-based approach rooted in promotion of equality and upholding of international human rights standards, and addressed stigma and attitudes about MR through VCAT exercises.[24] Ipas staff also introduced providers to patient data recording systems—first log sheets, and later a single patient register for all uterine evacuation cases—and oriented them on how to properly complete forms for accurate service provision monitoring. In addition, follow-up support was provided by clinical trainers and project staff, usually two weeks after the initial training sessions or on demand as needed.

Many clients presenting for care at or after 13 weeks' gestation displayed symptoms of physical, emotional or sexual trauma due to rape or violence. Although these clients were receptive to care, local providers were not adequately equipped to treat cases that included trauma. Ipas developed a trauma-informed pelvic care module for abortion and family planning services that trained providers on how to counsel a client who had experienced trauma, and on how to conduct a pelvic exam to ensure the client's ease and comfort. Given how common the experience of rape or violence was among clients, project staff integrated this trauma-informed pelvic care into all clinical training to ensure emotional support, as well as referrals to health and protection services for women dealing with physical, sexual and psychological trauma.

Furthermore, to establish a referral mechanism for complicated cases and those beyond 12 weeks' gestation, Ipas sensitized facility managers and service providers of Cox's Bazar Medical College Hospital (Sadar Hospital) on the management of referral cases for this project. Two health centers were oriented to serve as referral points and service sites because of their proximity to several camp and union-level sites, making it easier for Rohingya women to access services. Project staff also trained more than 250 community health workers on signs of MR and PAC complications, and the location of service delivery points, so they could identify and refer potential clients. Finally, Ipas provided logistics and equipment according to the need of each facility. Each facility received an appropriate amount of MVA equipment and MR drugs (mifepristone and misoprostol) to be able to provide first- and second-trimester abortion and postabortion care to clients. In some facilities, Ipas made small renovations—such as building barriers for auditory and visual privacy, and improving toilets and exam rooms—to ensure that facilities met minimum site quality standards set for the project. A record keeping system for abortion care at or after 13 weeks' gestation was not available in the Bangladesh public health system at the onset of activities; Ipas introduced separate logbooks for documenting cases of abortion after 12 weeks.

** This is the lowest level facility in the public health care system in Bangladesh.

Project Impact in Cox's Bazar and Beyond

By the end of 2017, 49 midlevel providers (three midwives and 46 paramedics) had been trained in PAC and MR up to 12 weeks' gestation, initial medical management for abortion beyond 12 weeks' gestation and referral pathways; these providers were from the eight Ipas-supported sites and from sites run by other SRH cluster partners offering service provision in Cox's Bazar. In February and December of 2018, the project trained 24 physician providers in clinical PAC at or after 13 weeks, 16 of whom went on to complete a training-of-trainers curriculum and became local trainers themselves.

From January 2018 through December 2019, the project provided more than 22,000 abortion clients with SRH care. MR or PAC services were provided to 2,799 women with a pregnancy up to 12 weeks' gestation and to 563 women with a pregnancy at or after 13 weeks' gestation; MR with medication was the most utilized uterine evacuation technology (75%), followed by MVA (24%) and D&C (1%). In addition, the project provided contraceptive counseling and methods, and referrals to gender-based violence (GBV) and other services within the humanitarian coordination system. Of women of reproductive age accessing care, 13% were aged 19 or younger and 30% were aged 20–24. Through the SRH subcluster, all partners in Cox's Bazar were made aware of sites offering services at or after 13 weeks' gestation, improving referral of cases to appropriate facilities. The SRH subcluster also made a concerted effort to ensure that facilities designated as SRH access points were ready and able with trained providers and commodities to offer SRH services.

Furthermore, Ipas's activities regarding abortion care at or after 13 weeks' gestation in Cox's Bazar opened the door to advocacy for similar abortion services in the broader Bangladesh health system. Following the initial training and service delivery pilot in Cox's Bazar, Ipas held a one-day, awareness-raising meeting with government and partner stakeholders to advocate for expansion of PAC training at or after 13 weeks across Bangladesh. During the workshop, held in February of 2018, Ipas met with representatives of the MOHFW and the OGSB (the training and accrediting body for obstetric and gynecologic care in the country) to discuss scale-up of abortion training and provision for care beyond 12 weeks. After reviewing the results

of the project in Cox's Bazar, stakeholders understood the enormity of the dangers of unsafe abortion in Bangladesh, and the positive impact that providing abortion training and services at or after 13 weeks could have on women and girls across the country. Stakeholders expressed their support for integrating abortion services at or after 13 weeks into hospitals at subdistrict and higher levels, as well as for training "teams" of abortion care providers, rather than focusing solely on obstetricians and gynecologists. Ipas was able to assist in developing plans to expand abortion services after government partners realized that provision of PAC after the first trimester is far less politically controversial than they initially assumed and that such services are safer than routine obstetric care.

MOHFW guidance already provided for activities related to PAC at or after 13 weeks' gestation, but stigma and lack of understanding limited its application in Bangladesh. Following the onset of activities in Cox's Bazar, MOHFW partners asked Ipas to integrate training in abortion at or after 13 weeks into government guidelines and clinical protocols; these materials are currently pending ratification. Furthermore, Ipas is presently conducting a training and service delivery program in and around Dhaka to see how these services could be delivered and scaled in a non-humanitarian setting within Bangladesh. To prepare for country-level expansion and roll-out of abortion services at or after 13 weeks, Ipas conducted a training of trainers, and integrated skills into training-of-trainer guides and plans.

Lessons Learned

The project in Cox's Bazar created a successful precedent for advocacy and service delivery of abortion at or after 13 weeks' gestation in a humanitarian context. The approach yielded a number of lessons that may be applicable to abortion service delivery in other humanitarian crises.

• *Responding to the call.* Implementation of Ipas training was quickly adapted to better respond to needs seen on the ground. Implementers mobilized around the demand for PAC at or after 13 weeks' gestation that emerged within the first moments of the intervention. This was done not only through a rapid response shift in training focus (which expanded capability to include providers with no previous abortion experience), but also through concerted advocacy and partnership with local government stakeholders to ensure acceptability and feasibility of services. PAC services at or after 13 weeks were only made possible by the foundation of support that Ipas Bangladesh created for overall SRH, MR and abortion services up to 12 weeks' gestation in Cox's Bazar. This included closely collaborating with donors and government stakeholders at the central and local levels; coordinating NGO and UN agency stakeholders to train their providers on MR, MR with medication and PAC; and participating in coordinated efforts by the Office of the Refugee Relief and Repatriation Commissioner, the Cox's Bazar Health Cluster and the SRH subcluster.

By both working within and challenging the local systems to stretch to meet women's needs, formal training and services for abortion at or after 13 weeks were made available for the first time anywhere in Bangladesh. Furthermore, this intervention shows that providing innovative services in a humanitarian context can lead to adoption of improved practices or guidelines at a broader level.

• *Recognizing provider cadre strengths and needs.* In Bangladesh, MR and PAC have been the purview of obstetric providers. To maximize access to safe abortion care at or after 13 weeks' gestation, this program included training midlevel providers on abortion care up to 12 weeks, and initial medical management of and referral pathways for abortion care at or after 13 weeks. Midlevel providers—such as midwives and paramedics—are the most prevalent cadre in Cox's Bazar, and are often the first to treat women who seek care from lower level facilities for abortion complications. In line with WHO task-shifting guidance on safe abortion care, future programming in humanitarian settings should be inclusive of multiple cadres to ensure the highest availability of services.[30] Furthermore, recognizing the enormous burden of work on this cadre, we recommend tailoring training and supervision modules to be minimally disruptive to ongoing services. This approach is particularly critical in refugee camps, where issues of staff shortages and heavy workload are exacerbated.

• *Embedding referral services.* While Ipas Bangladesh began its humanitarian response focusing on eight facilities and expanding it to 40, the intervention also focused on establishing six facilities for abortion care at or after 13 weeks' gestation within Cox's Bazar, selected on the basis of key staffing and facility criteria. However, the reach and effectiveness of these services was expanded by enhancing referral systems both between clinics (i.e., clinics without services could refer patients to others providing abortion care before 12 weeks and at or after 13 weeks) and from clinics to referral hospitals for emergency cases. At the onset of activities, no such referral systems existed for abortion care at or after 13 weeks; however, sensitization of providers in these clinics and onboarding of two nearby hospitals as referral sites increased access to services for Rohingya women. It should be noted, that transportation barriers for Rohingya women did limit access to these secondary sites, and there is more to be done to ensure smooth transfer of emergency referral cases such as additional ambulance or transportation services. Furthermore, trained provider turnover in some of the referral hospitals resulted in lack of service availability in at least one hospital and reduced service hours in a second location.

• *Data collection and program monitoring.* Though Ipas introduced a data collection system to monitor abortion cases after 12 weeks, the program faced challenges in completion of records as providers did not have the capacity to keep logbooks or records up to date. Moreover, due to budget cutbacks and a lack of human resources on the program side, Ipas staff were unable to maintain adequate program support and monitoring throughout the duration of the project. This resulted in reduced staff visits and program support for targeted facilities where need

was greatest, and lack of sufficient follow-up and training for sites that experienced provider turnover. In the future, additional support for data collection and record-keeping, such as simplified data collection forms or use of digital technologies, may assist in improved data gathering and use for documentation and program adaptations.

• *Addressing attitudes and stigma against abortion.* A key component of the training was VCAT to address provider stigma against abortion provision and abortion clients. VCAT is especially important in refugee settings, where women seeking services may be from different cultural backgrounds than providers and subject to further discrimination. In addition, negative attitudes of policy makers and stakeholders toward abortion at or after 13 weeks' gestation was a barrier to change. Ipas experience showed that by holding awareness-raising consultative meetings and VCAT with goverment stakeholders, and by focusing those efforts on the implications for maternal safety, programs can help assuage ongoing reticence to providing abortion care at or after 13 weeks among policymakers.

• *Contraception, gender-based violence and a rights-based approach.* In humanitarian contexts, women and girls are at elevated risk of unwanted pregnancies due to rape, unsafe abortion and unmet need for contraception.[16] As outlined in the MISP and IAFM, access to quality comprehensive abortion care is both a public health and rights-based issue. The Rohingya women and girls in Cox's Bazar were exposed to an inordinate amount of GBV, and lacked access to accurate contraceptive information and services; in particular, obstacles to accessing long-acting reversible contraceptives were reported.[17] In line with the MISP recommendations, the program ensured prevention and treatment for GBV were readily available.[25] While this project provided comprehensive abortion care, including postabortion contraceptive services using a noncoercive rights-based approach, more could have been done to meet the refugee population's considerable demand for contraceptives, such as providing all short- and long-acting methods in all facilities and holding additional community mobilization activities.[31] The widespread experience of violence among Rohingya women and girls demonstrated the need for SRH frontline providers—who had little to no GBV experience—to receive an orientation on trauma-informed pelvic care; counseling; and the importance of referring clients to appropriate health, protection and psychosocial counseling and services. This multidimensional approach to programming in humanitarian settings not only improves health outcomes for women and girls seeking SRH care, it also minimizes delays in accessing services in humanitarian settings.

• *Institutional learning to address turnover.* In humanitarian crises, turnover of health services staff is high and can put delivery of new services at risk of diminishing as staff are transferred out of facilities. In this project, providers that were previously trained passed on their knowledge to new providers through informal means before their departure, and a number of physicians were trained as trainers to maintain local capacity; however, there was no formal system for on-site training or handover of abortion services. In some cases, when a trained provider left a facility, there would be no one to immediately replace her or him, creating gaps in services until such a time as a new provider could be onboarded. Future programs could address this issue by embedding training on abortion at or after 13 weeks' gestation into institutional learning processes and providing a package of training to all relevant cadres of providers as part of their standard medical training.

CONCLUSIONS

Ipas's experience of introducing abortion care at or after 13 weeks' gestation in a humanitarian crisis setting in Bangladesh serves as a roadmap for expanding lifesaving access to abortion care across gestational ages, defying common misconceptions of the difficulty of bringing abortion services to refugee camps. It also challenges assertions in the humanitarian and SRH fields, that abortion provision in humanitarian settings is too technically and politically complex to deliver effectively.[31]

Sexual and reproductive rights—including access to safe comprehensive abortion care across gestational ages—are human rights imperatives. This is particularly true in humanitarian settings where women and girls are at elevated risk of unintended pregnancy due to sexual violence, displacement, lack of contraception and other challenges. Furthermore, PAC is a signal function for basic and comprehensive emergency obstetric and newborn care, and should be included in all maternal and reproductive health service delivery packages. PAC training and provision can serve as an entry point for abortion care, particularly in contexts like Bangladesh, where self-use of medication abortion is high and legal indications for induced abortion are limited.

It is incumbent upon the humanitarian and SRH communities to provide safe abortion care in line with the MISP and IAFM for all refugee women and girls. Ipas's experience in the Rohingya crisis shows that it can be done.

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