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Barriers to safe abortion care in internally displaced persons camps in Ethiopia: a qualitative study

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Abstract

This qualitative study examines barriers to safe abortion care among women in Internally Displaced Persons (IDP) camps in Ethiopia using the Social Ecological Model (SEM). Data were collected through in-depth and key informant interviews with displaced women, healthcare providers, community leaders, NGO representatives, and policymakers. The findings reveal multi-level challenges, including personal and structural barriers, where cultural and religious beliefs, financial constraints, and limited education prevent women from access to safe abortion care. Social networks and healthcare providers play a critical role, with unsupportive partners and providers' moral objections worsening the situation. Community stigma and social norms perpetuate misinformation and isolation, while societal barriers such as inadequate healthcare infrastructure and policy gaps further limit access. Urgent, coordinated action is critical. The Ministry of Health, humanitarian organizations, and local leaders must expand healthcare access, ensure legal protections, combat Sexual and Gender Based violence, and dismantle stigma. Without urgent intervention, displaced women will continue facing life-threatening risks. *(Afr J Reprod Health 2025; 29 [9s]: 121-131)*

Keywords: Abortion, Induced, Reproductive Health Services, Health Services Accessibility, Refugees, Qualitative Research, Ethiopia

Résumé

Cette étude qualitative examine les obstacles à l'avortement médicalisé chez les femmes vivant dans des camps de personnes déplacées à l'intérieur du pays (PDI) en Éthiopie, à l'aide du Modèle Écologique Social (MES). Les données ont été recueillies lors d'entretiens approfondis avec des informateurs clés auprès de femmes déplacées, de prestataires de soins de santé, de dirigeants communautaires, de représentants d'ONG et de décideurs politiques. Les résultats révèlent des difficultés à plusieurs niveaux, notamment des obstacles personnels et structurels, où les croyances culturelles et religieuses, les contraintes financières et le manque d'éducation empêchent les femmes d'accéder à un avortement médicalisé. Les réseaux sociaux et les prestataires de soins de santé jouent un rôle crucial, le manque de soutien des partenaires et les objections morales des prestataires aggravant la situation. La stigmatisation communautaire et les normes sociales perpétuent la désinformation et l'isolement, tandis que les obstacles sociétaux, tels que l'insuffisance des infrastructures de santé et les lacunes politiques, limitent encore davantage l'accès. Une action urgente et coordonnée est essentielle. Le ministère de la Santé, les organisations humanitaires et les dirigeants locaux doivent élargir l'accès aux soins de santé, garantir une protection juridique, lutter contre les violences sexuelles et sexistes et mettre fin à la stigmatisation. Sans une intervention urgente, les femmes déplacées continueront d'être exposées à des risques mortels. *(Afr J Reprod Health 2025; 29 [9s]: 121-131).*

Mots-clés: Avortement provoqué, Services de santé reproductive, Accessibilité aux services de santé, Réfugiés, Recherche qualitative, Éthiopie

Introduction

At the end of 2023, 75.9 million people were internally displaced globally, marking the highest number ever recorded. Ethiopia ranked among the top five most affected countries, with 2.85 million internally displaced due to conflict and an additional 881,000 displaced by disasters.[1] Although Ethiopia's 2005 Penal Code reform expanded the legal grounds for abortion, access to safe abortion services remains severely constrained, particularly in rural and conflict-affected areas.[2] These challenges are

further intensified within Internally Displaced Persons (IDP) camps, where limited infrastructure, inadequate social support systems, and poor awareness of reproductive health services hinder access to safe abortion care.[3]

The situation is compounded by restrictive social norms, cultural and religious taboos, and prevailing legal ambiguities that continue to stigmatize abortion, creating additional barriers for women in IDP settings.[4] Although abortion is legally permitted under specific conditions such as in cases of rape, incest, or threats to a woman's health its availability is often compromised by a lack of healthcare personnel, insufficient medical supplies, and minimal integration of sexual and reproductive health services into humanitarian responses.[5]

Access to safe and legal abortion is a fundamental reproductive health right that should be upheld irrespective of an individual's geographic location or socio-economic status. Yet, in humanitarian contexts like IDP camps, the intersection of structural, cultural, and institutional barriers compounded by the collapse of health systems and the DE prioritization of reproductive health by aid agencies makes accessing safe abortion care particularly difficult[6].

To address these complex barriers, this study adopts the Social Ecological Model (SEM), which provides a comprehensive framework for analyzing the interplay of factors at multiple levels: individual, interpersonal, community, institutional, and societal. By applying SEM, the research aims to generate a nuanced understanding of the multifaceted challenges women face in seeking safe abortion care in IDP camps across Ethiopia.

Methods

Study area

The study was conducted in four purposively selected IDP sites in Amhara Northshoa Zone at Debrebrhan and Oromia special zone at Kemese between April and July 2024. Based on a recent report from the Ethiopian Public Health Institute (EPHI) in July 2023, in two IDP sites in North Shoa Zone of Amhara region, China Camp IDP site and Woinshet Camp IDP site there were 30,600 IDPs from which 5809 women were in the reproductive age group where as in Oromia special Zone in North Shoa, 41,061IDPs are there with 7795 women in the reproductive age group.

Study design

This qualitative study used in-depth interviews (IDI) and key informant interviews (KII) to explore the barriers to safe abortion care in IDP camps. A purposive sampling technique was employed to select participants who had experience with abortion care in these settings. The sample included displaced women who had undergone both safe and unsafe abortions, healthcare providers, community leaders, NGO representatives, and policymakers involved in reproductive health. (Table 1)

Data collection

Data were collected between April and July 2024. In-depth interviews were conducted with 16 displaced women and eight community leaders. Key informant interviews were conducted among eight healthcare providers, four NGO representatives, and four policymakers. Interviews were semi-structured, an interview guide was developed to explore in-depth experiences, perceptions, and perspectives regarding safe abortion care and its barriers in IDP camps.

Interview guide content

We developed five semi-structured interview guides tailored for (1) women of reproductive age with abortion experience, (2) community leaders, (3) healthcare providers, (4) NGO and stakeholder representatives, and (5) policy makers. Each guide began with an introduction (study purpose, consent, and background questions) and then proceeded through topic-specific sections aligned with the Social Ecological Model:

Women of Reproductive Age (IDI): Questions explored individual-level knowledge, attitudes, and economic constraints around abortion; interpersonal influences (partner and family support); community norms (stigma, religious beliefs); institutional factors (facility access, provider attitudes); and legal/policy awareness. Probes encouraged detailed

Table 1: Sociodemographic characteristics of study participants by type of qualitative study

S. No.	Type of Qualitative Study	Participant Group	N	Sex (F / M)	Age Range (years)
1	In-depth Interviews (IDI)	Women of reproductive age in IDP camps	16	16 / 0	15 – 49
		Community leaders from IDP camps	8	2 / 6	30 – 60
		Total IDI Participants	24		
2	Key Informant Interviews (KII)	Healthcare providers (nurses, midwives, MDs)	8	3 / 5	28 – 55
		Representatives from local NGOs	4	2 / 2	30 – 50
		Policy makers (regional/district level)	4	1 / 3	35 – 60
		Total KII Participants	16		

recounting of prior safe or unsafe abortion experiences, coping strategies, and suggestions for improvement.

Community Leaders (IDI): Items focused on prevailing community attitudes toward abortion, the leader's role in shaping norms or education campaigns, interactions with health providers, and opportunities for community-based interventions. Questions also examined misconceptions, cultural practices, and collaboration with NGOs or clinics.

Healthcare Providers (KII): This guide covered service availability (staffing, supplies, facility infrastructure), training or resource needs, typical patient concerns or misconceptions, counseling practices, collaboration with community leaders, and the influence of national or local abortion policies on service delivery. Providers were asked for concrete examples of barriers (e.g., refusal to perform abortions on moral grounds) and recommendations for strengthening care.

NGO/Stakeholder Representatives (KII): Interview topics included organizational roles in reproductive health, programmatic challenges (funding, staffing, legal restrictions), collaboration with clinics and community actors, advocacy efforts, and policy-level recommendations. Probes elicited descriptions of past campaigns, referral pathways, and successful strategies to improve safe abortion access.

Policy Makers (KII): Questions targeted the current policy framework governing abortion in IDP camps, perceived gaps in implementation, coordination with NGOs and health providers, resource allocation, and advocacy efforts. Participants were asked to identify policy barriers (e.g., restrictive regulations) and suggest legislative or operational reforms.

Interview conduct

A team of six trained data collectors- healthcare professionals holding at least a BSc and primarily instructors from Debrebrhan and Wollo Universities carried out all interviews. Prior to data collection, this team completed a five-day intensive training covering ethical considerations (informed consent, confidentiality, and voluntary participation), in-depth qualitative interviewing techniques (including open-ended questioning, active listening, and probing), and data confidentiality protocols. Participants were purposively sampled through camp coordinators, clinic managers, and NGO contacts to ensure representation across age, sex, and role. Interviews were scheduled one day in advance and conducted in private settings either a reserved room at the camp clinic or a shaded tent selected to maximize confidentiality and participant comfort.

At the outset of each session, the interviewer introduced themselves, explained the study's objectives, and obtained written informed consent (or a thumbprint for participants with low literacy). Basic demographic information (age, sex, education, role, and years in the camp) was recorded. All interviews were conducted in the participant's preferred language (Amharic or Afaan Oromo) by interviewers fluent in those languages. With each participant's permission, sessions were audio-recorded, which were immediately expanded into near-verbatim transcripts after the interview. Field notes captured contextual observations such as body

language, emotional responses, and environmental conditions to enrich the audio recordings. Within 48 hours, each recording was transcribed verbatim in its original language by the same interviewer, and a second researcher reviewed 10 percent of transcripts for accuracy. Transcripts were then translated into English by bilingual team members, with cultural idioms and locally specific terms preserved and explained via footnotes when necessary. Weekly debriefing meetings allowed the team to discuss emerging themes, clarify ambiguities, and ensure consistent probing across interviewers. All digital recordings, written transcripts, and consent forms were stored on a password-protected server, and participants were assigned unique codes to maintain anonymity. Ethical approval was granted by St. Paul's hospital millennium medical college institutional review board and regional health bureau ethical review boards and participants received a modest incentive (in the form of a bar of soap, detergents, and sanitary napkins) in line with local norms, ensuring gratitude without exerting undue influence.

Data analysis

In this study, we employed a rigorous qualitative data analysis plan to explore the complexities of women's experiences and perceptions related to safe abortion care within Internally Displaced Persons (IDP) camps in Ethiopia. Our qualitative analysis was guided by a systematic process to ensure the depth, richness, and validity of the findings. Qualitative data analysis software NVivo was used to assist with data management and organization.

Digital data were transcribed and translated into English before being uploaded to the qualitative analysis software NVivo. Data were coded using both emerging and predetermined codes, leading to the identification of six main themes with several subthemes. The first theme, Personal and Structural Barriers to Safe Abortion Care, highlights how cultural and religious stigma, financial constraints, and lack of education prevent women from seeking safe abortion services. Misinformation and legal unawareness further restrict their options. The second theme, Influence of Social Networks and Healthcare Providers, reveals that unsupportive partners and families, as well as healthcare providers' moral objections, exacerbate barriers. Many women receive little to no counseling on safe abortion options. The third theme, Community Stigma and Social Norms, underscores how societal silence, misinformation, and fear of judgment discourage women from openly discussing or accessing reproductive healthcare.

The fourth theme, Impact of Sexual and Gender-Based Violence (SGBV), demonstrates how experiences of violence increase the risk of unwanted pregnancies and psychological trauma, further shaping reproductive decisions. The fifth theme, Healthcare Infrastructure and Policy Gaps, highlights the limited availability of safe abortion services, a shortage of trained providers, and the misinterpretation of abortion laws among healthcare workers, all of which hinder access to care. Lastly, the Role of NGOs and Stakeholders in Supporting Displaced Women emerged as a key theme, emphasizing ongoing efforts to provide reproductive health information, advocate for long-term contraceptive use, and facilitate access to safe abortion services.

Ethical considerations

Ethical approval was granted by St. Paul's hospital millennium medical college institutional review board with reference number Pm23/347 dated on 11/12/23 and regional health bureau ethical review boards reference no 423/2016 dated on 16/5/2016 on Ethiopian Calendar. Informed consent was obtained from all participants. Anonymity and confidentiality of the participants' personal information was strictly maintained during interviews, analysis, and reporting. For those study participants who are under the age of consent, informed written assent was obtained from their parents.

Results

In-depth interviews (IDIs)

We conducted 24 in-depth interviews (IDIs) with women of reproductive age (15–49 years) residing in IDP camps (n = 16) and community leaders (n = 8). Four overarching themes emerged from these interviews.

Personal and structural barriers to safe abortion care

Many women described deep-rooted cultural and religious stigma. One participant mentioned that *"Any woman who decides to terminate a pregnancy is seen as impure in the eyes of God and is condemned to spend eternity in Hell."* Another woman explained that *"If a woman has an abortion, people see it as a huge sin, almost like she's committed murder."* A third participant reflected on her own faith: *"Even if the service is available, my faith doesn't allow me to consider abortion."* Financial constraints were also a major obstacle. A woman in her late 20s noted that *"I needed 3,500 ETB for the procedure but couldn't afford it. I had to borrow money even though I had no way to pay it back."* When formal services were out of reach, several women resorted to unsafe traditional methods; one explained, *"Many women end up using traditional methods or dangerous herbs because there's no support or awareness about safe abortion options."* Limited education and widespread misinformation compounded these challenges. One woman admitted, *"Most of us don't know where to go for help or what our rights are,"* and a healthcare provider confirmed, *"Most of the women seeking help do not fully understand their rights or the available options."* A few participants noted that basic literacy empowered them: *"Being able to read and write helped me grasp the situation and seek professional help,"* but younger and unmarried women faced intensified isolation and judgment.

Influence of social networks

Most women reported unsupportive partners and family members. One participant said, *"My husband told me to handle it on my own. He didn't want to be involved."* Another added, *"When I first told my husband I was pregnant, he wasn't happy and stopped talking to me. I ended up handling everything on my own."* The fear of judgment led many to hide their pregnancies or abortion plans entirely; as one woman described, *"I couldn't tell anyone about my situation. I was terrified they would judge me and make everything worse."* A minority did experience peer support—one recalled, *"My friend encouraged me to seek care and even helped with transportation,"*—but the predominant lack of empathy and open dialogue within social networks amplified feelings of isolation and helplessness.

Community stigma and social norms

Community leaders often reinforced the taboo around abortion. A religious leader stated, *"Abortion is a sin in our religion, and it is a topic that should not be discussed publicly. Our duty is to guide women to make better choices, but we must respect cultural and religious views."* Another leader remarked, *"We keep reminding them that sustenance is in God's hands, and they should just accept it."* Some leaders acknowledged the harm caused by silence and misinformation; one explained, *"The silence around this issue is harming women. We need to break the taboo and start educating the community about safe reproductive health options."* Nonetheless, entrenched norms continued to restrict open dialogue.

Impact of sexual and gender-based violence (SGBV)

Several women described how SGBV contributed to unintended pregnancies and compounded barriers to care. One survivor shared, *"I was raped, but I can't even identify who did it because the living situation is that bad. My heart is shattered, and there was nothing I could do about it."* Others noted that shame drove peers to disappear rather than seek help; as one woman recounted, *"Three girls disappeared after unplanned pregnancies. They were too embarrassed and didn't know where to turn."* These accounts highlight how SGBV interacts with stigma and lack of support to create additional barriers to safe abortion care.

Key informant interviews (KIIs)

We conducted 16 KIIs with healthcare providers (n = 8; ages 28–55 years, 3 F/5 M), NGO/stakeholder representatives (n = 4; ages 30–50 years, 2 F/2 M), and policy makers (n = 4; ages 35–60 years, 1 F/3 M). Three themes emerged from these interviews.

Influence of healthcare providers

Several providers admitted that personal beliefs prevented them from offering abortion services. One provider explained, *"Some trained professionals have opted out, saying they repented and no longer want to perform abortions."* A minority, however, still tried to guide women despite moral objections; as one noted, *"A minority of providers actively tried to guide women despite prevailing moral objections."* Counseling gaps and workarounds were common: many women fabricated benign complaints in order to access services. As a provider described, *"To see a health professional here, we often tell the receptionist we have a headache, just to get through the door."* Some providers confessed that they attended abortion trainings primarily for incentives, rather than genuine commitment: *"I attended the training sessions mainly for the incentives rather than to actively participate in delivering the service,"* and *"There are abortion trainings organized by NGOs that run for 12 days, but many of them choose not to provide these services, citing personal beliefs that it is a sin."* Provider refusal or judgment often drove women toward unsafe methods; one participant noted, *"Three girls disappeared after unplanned pregnancies. They were too embarrassed and didn't know where to turn."* Even when services existed, fear of discrimination deterred some women: *"Safe abortion services just aren't available in the IDP camps, so we end up referring patients to health centers."*

Healthcare infrastructure and policy gaps

Providers described inadequate facilities and severe workforce shortages. One stated, *"There is no clinic nearby that offers these services,"* and another added, *"We currently have only two professionals available. The reproductive-age population in the camp is notably high, yet we lack sufficient professionals to meet the demand."* Emergency response gaps included lack of 24-hour services and ambulance shortages: *"A mother sadly died at 4:00 AM due to severe bleeding because the health services close down at night,"* and *"I was bleeding heavily and had to plead for an ambulance to take me to the hospital, which delayed my care."* Policy and legal misinterpretation were also widespread. A provider confessed, *"Even we as healthcare providers are not fully aware of the existing policies regarding abortion services in camps,"* and a policy maker acknowledged, *"We are not trained to provide these services effectively due to the restrictive policies mainly to do surgical abortion."*

Role of NGOs and stakeholders

NGO representatives described ongoing efforts despite resource shortages. One lamented, *"The place is not clean; we have materials and supplies shortage, and we cannot say it is safe abortion."* NGOs conducted community-based awareness programs for example, integrating SRHR discussions into tea or coffee gatherings but tension existed when some NGOs discouraged advertising abortion services for fear of negatively impacting family planning use. A town-level SRHR coordinator noted policy misinterpretation among both community members and providers: *"The community assumes it is abortion for any reason, and even health professionals lack awareness of the policies,"* and she recommended clearer policy interpretation, stronger community engagement, and integration of SRHR services within IDP camps. Policy makers confirmed the absence of supportive guidelines for abortion care in IDP settings: *"There is no dedicated budget line for reproductive health programs in IDP camps,"* and *"In practice, ambiguous regulations lead to hesitancy among providers and NGOs to offer abortion services."* Some policy makers pointed to successful expansions of medical abortion in other regions and suggested that similar approaches could be piloted in IDP camps.

Discussion

This qualitative study revealed several key themes that highlight significant challenges at the individual, interpersonal, community, and societal levels. Personal and structural barriers to safe abortion care emerged as a major challenge, with deep-rooted cultural and religious beliefs stigmatizing abortion, leading to fear, shame, and

moral judgment. Financial constraints further restrict access, as many women cannot afford safe abortion services. Additionally, a lack of education and legal awareness leaves many women uninformed about their rights under Ethiopian law, often forcing them to resort to unsafe alternatives.

The influence of social networks and healthcare providers also plays a critical role. Many women face unsupportive partners and families, exacerbating their isolation and limiting their ability to make autonomous reproductive health decisions. Furthermore, moral objections from healthcare providers create an additional barrier, as some refuse to offer abortion services, leading to inconsistent care. Limited counseling and support on reproductive health further prevent women from making informed choices.

At the community level, stigma and social norms continue to reinforce barriers. Misinformation and silence surrounding abortion discourage open discussions, leading to widespread myths and misconceptions. Fear of judgment prevents women from seeking necessary care, making abortion a highly secretive and stigmatized procedure. This stigma is particularly harmful to survivors of sexual and gender-based violence (SGBV), who often face unwanted pregnancies but lack access to safe abortion services. Psychological trauma, compounded by societal shame and limited survivor-centered care, further restricts their ability to seek help.

At the societal level, healthcare infrastructure and policy gaps remain significant obstacles. Many health facilities lack trained providers, limiting access to safe abortion care. Additionally, misinterpretation of legal provisions prevents healthcare workers from confidently offering services within the law. The absence of well-equipped healthcare facilities in IDP camps further restricts women's options, leaving them vulnerable to unsafe abortion practices.

Despite efforts from NGOs and other stakeholders, resource shortages, policy misinterpretations, and restrictive social norms continue to hinder access to safe abortion services. Addressing these challenges requires targeted interventions at multiple levels, including legal reform, community engagement, and strengthening the healthcare system to ensure that displaced women have access to safe, legal, and compassionate reproductive healthcare.

IDP perspectives

Displaced women face profound personal and structural obstacles to accessing safe abortion care. As one participant expressed, *"I felt ashamed even to ask, because abortion is seen as a sin in my community."* Deeply rooted cultural and religious beliefs create an environment of shame, moral judgment, and secrecy, deterring women from seeking care. Consistent with earlier studies[7,8], such stigma is compounded by misinformation and lack of education. Many women are unaware that abortion is legal under specific conditions in Ethiopia, which leaves them vulnerable to unsafe alternatives. One respondent said, *"We don't know what the law allows; we just hear people say abortion is illegal."*

Financial constraints also emerged as a dominant theme. Displaced women often lack the resources to pay for safe services or the cost of transportation to reach better-equipped facilities outside the camp. This financial burden is especially heightened by the need for diagnostic tests *"We were told to go outside for ultrasound and lab, but we don't have the money,"* a woman explained. These findings mirror prior research in sub-Saharan African humanitarian settings, where financial hardship pushed women toward unsafe abortion options.[9,10]

At the interpersonal level, the role of male partners and family members significantly influenced decision-making. Many women reported experiencing pressure, abandonment, or outright opposition from partners or family. *"He told me it's my problem, not his,"* shared one participant, underscoring the isolation many women face. The lack of support creates an environment where women's reproductive autonomy is severely constrained, reinforcing evidence from previous studies that social relationships can either enable or block access to care. [11,12]

Survivors of sexual and gender-based violence (SGBV), a subgroup among displaced women, face even greater challenges. Psychological trauma, stigma, and limited survivor-centered care

exacerbate the difficulty in accessing abortion services. One participant shared, *"I was raped, but I couldn't tell anyone, and I didn't know where to go."* This aligns with existing literature showing that SGBV survivors in crisis settings often seek abortion care in secrecy due to trauma and social stigma.[13,14]

Policymaker and provider perspectives

From the perspective of healthcare providers and policymakers, structural and institutional limitations also contribute to the poor access to safe abortion services. Many facilities within IDP camps are under-resourced and lack trained personnel. A provider noted, *"We are not trained to provide these services, and we don't have the equipment."* This was a recurring issue key informants revealed that many IDP health centers lack ultrasound, laboratory, and other diagnostic capabilities, forcing referrals outside the camps and further increasing costs for women. This gap aligns with reports from WHO and humanitarian agencies stressing the need for improved infrastructure in crisis contexts.[15]

Moreover, providers often hesitate to deliver abortion services due to legal ambiguity or moral objections. One provider explained, *"I don't want to risk my job by doing something that might be considered illegal."* Misinterpretation of Ethiopia's abortion law creates confusion and inaction, a finding consistent with previous research showing that legal allowances often fail to translate into actual service delivery.[16] In some cases, providers' personal beliefs further restrict access *"Abortion is against my religion,"* stated a provider, reflecting how conscientious objection continues to limit care.[17,18]

Policy actors interviewed also highlighted the challenge of weak coordination among humanitarian organizations. *"There are many NGOs here, but we don't have a clear system for who does what,"* one official said. Without streamlined coordination, institutional conflicts and service duplication undermine the goal of comprehensive reproductive healthcare. This supports earlier findings that fragmentation in service delivery is a persistent issue in humanitarian settings.[15]

Strengths and limitations

A key strength of this study is the use of both in-depth interviews (IDIs) and key informant interviews (KIIs) with multiple stakeholder groups, which allowed us to capture diverse perspectives on barriers to safe abortion care in IDP camps. Conducting 24 IDIs with women and community leaders provided rich, firsthand accounts of cultural, interpersonal, and trauma-related influences. The 16 KIIs with healthcare providers, NGO representatives, and policy makers enabled triangulation of user experiences with system-level constraints, increasing the credibility and depth of our thematic analysis. All interviews were conducted in participants' preferred language (Amharic & Afaan Oromo) by trained professionals who underwent five days of rigorous instruction in qualitative methods, ethics, and confidentiality; this likely enhanced rapport, reduced misunderstandings, and improved data quality. Field notes documenting nonverbal cues and contextual observations further enriched our interpretation. Finally, applying the Social Ecological Model as an analytical framework allowed us to systematically examine multilevel interactions from personal stigma and financial constraints to policy misinterpretation and resource shortages—thereby offering a comprehensive understanding that can inform targeted interventions.

Despite these strengths, several limitations should be acknowledged. First, purposive sampling through camp coordinators and NGO contacts may have introduced selection bias; women or community leaders who declined participation or were less connected to service providers may have held different opinions or experiences. Second, social desirability bias could have influenced participants' responses especially on sensitive topics like abortion resulting in underreporting of stigmatizing attitudes or unsafe practices. Third, this study focused on selected IDP camps in Ethiopia and may not fully capture barriers in other regions or countries; therefore, findings may not be generalizable beyond similar humanitarian settings. Finally, because interviews were at a point in time,

we cannot assess how attitudes or access barriers may shift over time as camp conditions or policies evolve.

Implications for policy and practice

The findings of this study underscore critical policy and practice gaps in the provision of safe abortion care for women in internally displaced persons (IDP) camps in Ethiopia. Legal and policy reforms must be prioritized to clarify the conditions under which abortion is permitted and to ensure that both healthcare providers and community members are informed. Displaced women should be given clear, accessible information about their legal rights, including the circumstances under which abortion is legally allowed. Health workers and women's groups can play a vital role by offering accurate information, advocating for long-term contraceptive use, and facilitating access to services—ultimately reducing stigma, misinformation, and barriers to care.

Strengthening healthcare infrastructure is essential. IDP camps must be equipped with 24-hour reproductive health facilities staffed by trained personnel capable of providing safe abortion care. The current practice of referring women outside camps for essential diagnostic services, such as ultrasound and laboratory tests, reflects serious infrastructural deficits. Targeted investments by the Ministry of Health, in collaboration with NGOs and humanitarian organizations, are urgently needed to close these gaps.

Addressing sexual and gender-based violence (SGBV) must also be a policy and programmatic priority. Survivors require access to safe spaces, comprehensive post-SGBV care, and systems of accountability for perpetrators. A multi-sectoral approach involving legal, medical, and psychosocial services is necessary to provide holistic, survivor-centered care.

Community-driven interventions are crucial for reducing the pervasive social stigma surrounding abortion. Engaging religious and community leaders in educational initiatives can help reshape harmful narratives and encourage acceptance of reproductive rights. Integrating abortion services into broader maternal health programs may further reduce stigma and increase service uptake.

Increased coordination among NGOs, humanitarian agencies, and government stakeholders is needed to ensure that reproductive health services—including abortion—are recognized as essential components of emergency response. Policymakers should issue camp-specific guidelines that clarify the legal grounds for abortion and ensure all healthcare providers are properly trained. Addressing provider confusion through legal orientation and continuous professional development is foundational.

Training programs must go beyond clinical skills to promote nonjudgmental, trauma-informed care. Incentivizing compassionate service delivery—such as offering continuing professional development credits—can motivate providers to adopt respectful practices. Additionally, involving community leaders in disseminating accurate information can counteract misinformation and build trust in available services.

Ultimately, reproductive health must be elevated as a central priority in humanitarian response frameworks. No woman should be left behind due to displacement, stigma, or lack of access to safe, legal, and compassionate care.

Conclusion

Women in IDP camps in Ethiopia face multiple intersecting barriers to accessing safe abortion care. Deep-rooted cultural and religious beliefs, combined with severe financial constraints and low levels of education, create significant personal challenges that discourage women from seeking formal healthcare services. These individual barriers are compounded by unsupportive interpersonal relationships, ranging from partner abandonment to healthcare providers' moral objections, which further isolate women and force many to resort to unsafe traditional methods. Community stigma and silence, fueled by rigid social norms and conflicting messages from local leaders, exacerbate these issues, while the pervasive impact of SGBV not only inflicts trauma but also influences reproductive decisions. Systemic barriers, including inadequate healthcare infrastructure, policy gaps, and limited legal awareness among both providers and communities,

hinder access to safe abortion care. Although NGOs and SRHR coordinators are actively working to mitigate these challenges, resource shortages and policy misinterpretations persist. Urgent multi-sectoral interventions are needed to expand healthcare services, enhance legal awareness, and foster supportive community environments. Addressing these issues is crucial not only for improving access to safe abortion care but also for reducing maternal mortality and morbidity, contributing to the broader effort of safeguarding women's health and rights in conflict-affected areas.

Recommendation

Women in Ethiopian IDP camps face multiple intersecting barriers that restrict access to safe abortion care. Cultural and religious stigma, financial constraints, SGBV, and inadequate healthcare services collectively contribute to the challenges experienced by displaced women. While NGOs and healthcare providers attempt to mitigate some of these barriers, systemic issues such as policy misinterpretation, lack of trained professionals, and restrictive social norms continue to pose significant obstacles. Urgent, multi-sectoral interventions led by the Ministry of Health, humanitarian organizations, and local community leaders are needed to ensure displaced women receive safe, legal, and compassionate reproductive healthcare. Expanding healthcare infrastructure, addressing SGBV, reducing stigma, and improving legal awareness are critical steps in advancing the reproductive rights and health of women in IDP camps.

Contribution of authors

Samrawit S. Ethiopia conceived and designed the study, secured funding, provided data collectors training, supervised data collection and quality checks, led the analysis, and drafted the manuscript. Andamlak G. Alamdo participated in study design, provided data collectors training, conducted supervision and quality checks, contributed to data analysis, and reviewed the manuscript. Fanna A. Debele Provided data collectors training, supported data collection, conducted data quality check, and assisted in manuscript preparation. Ferid A. Abubeker contributed to study design, tool preparation and validation, provided data collectors training, data interpretation and reviewed the manuscript for intellectual content. Mitikie M. Sisay provided methodological guidance, supervised the analysis, and contributed to manuscript revision.

All authors read and approved the final version of the manuscript.

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