Research Article

Between Compassion and Controversy: Providers and Patients Navigating the Post-Abortion Care Labyrinth in Nongr-Massom Health District, Burkina Faso

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Unsafe abortion remains a major contributor to maternal mortality, particularly in low-resource settings. In Burkina Faso, post-abortion care (PAC) was integrated into national health policy between 1997 and 1998, yet service uptake remains low. This qualitative study explores perceptions of PAC quality among healthcare providers and clients in the Nongr-Massom health district.

We conducted 21 in-depth interviews—11 with providers and 10 with PAC recipients—and analyzed transcripts using thematic analysis. Most clients were aged 20–29, with half lacking formal education; providers were aged 40–49 and held higher education credentials.

Providers described PAC delivery as structured and protocol-driven but acknowledged systemic limitations and the need for improvement. Clients reported mixed experiences, ranging from poor reception and confidentiality concerns to compassionate care and emotional support. Although some initially expressed dissatisfaction, many later emphasized provider empathy and encouragement during treatment.

Findings reveal persistent barriers to high-quality PAC despite governmental efforts. While providers recognize their critical role, gaps in service delivery and client trust remain. Addressing these challenges is essential to improving maternal health outcomes and reducing unintended pregnancies.

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 doi.org/10.32388/URT7Co

Introduction

Maternal mortality remains a major global public health issue, affecting hundreds of thousands of women annually. According to the World Health Organization (WHO), an estimated 287,000 women died from maternal causes in 2020, equating to approximately 800 deaths per day[1]. The Sustainable Development Goals (SDG 3.1) aim to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030[2]. However, in 2020, the global maternal mortality ratio stood at 223 per 100,000 live births, with approximately 70% of these deaths occurring in sub-Saharan Africa[1].

Unsafe abortion is among the leading causes of maternal mortality. WHO estimates that between 4.7% and 13% of maternal deaths globally are attributable to unsafe abortion, with mortality rates reaching up to 220 per 100,000 unsafe abortions in low-and-middle-income countries[2]. In sub-Saharan Africa, nearly 75% of abortions are unsafe, and almost half occur under the least safe conditions—performed by untrained individuals using dangerous methods[1].

Restrictive abortion laws in many developing nations have done little to reduce the prevalence of unsafe abortions. Approximately 97% of unsafe abortions occur in countries with highly restrictive abortion policies[3]. These legal constraints, combined with weak health systems, contribute to poor management of abortion-related complications. Moreover, abortion stigma remains pervasive, limiting women's access to psychological support and post-abortion counseling, which could help prevent repeat abortions[4].

Post-abortion care (PAC) is a critical intervention for reducing maternal mortality and includes both curative and preventive components. According to WHO's Abortion Care Guideline, PAC encompasses five essential components: emergency treatment of abortion complications, family planning services, counseling, reproductive health and related services, and partnerships with community service providers[5]. Healthcare providers play a pivotal role in delivering these services at both facility and community levels.

Despite global efforts, multiple barriers continue to hinder the provision of quality PAC. It is well-documented that providers' personal beliefs and attitudes toward abortion can influence the level of care and support they offer to clients. Studies from several African countries—including Nigeria, Rwanda, Sierra Leone, and Zimbabwe—have shown that fear of judgment, lack of trust, and limited access to comprehensive sexual health education deter women from seeking timely care[4][6][7].

In Burkina Faso, the maternal mortality ratio remains high, with 320 deaths per 100,000 live births as of 2022. Abortion accounts for approximately 10% of maternal deaths in the country[8]. The Burkinabe Penal Code classifies abortion as a criminal act, permitting it only in cases where the mother's life is at risk, fetal malformation is diagnosed, or the pregnancy results from rape or incest. Consequently, many women resort to clandestine abortions performed under unsafe conditions by unqualified personnel, increasing the risk of severe complications and mortality[9]. In response, Burkina Faso introduced PAC in public health facilities between 1997 and 1998, while maintaining strict abortion laws. However, access to PAC remains limited due to socio-cultural barriers, religious beliefs, and structural deficiencies within the healthcare system[10].

This study aims to assess the quality and accessibility of PAC in Burkina Faso by analyzing the perceptions and experiences of healthcare providers and clients in the Nongr-Massom health district.

Materials and Methods

Study Design

A qualitative, single-case, holistic approach was employed to explore the lived experiences of healthcare providers and clients. This method allows for an in-depth understanding of how individuals experience PAC and the meaning they assign to their interactions with the healthcare system[11]. The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist guided data collection and reporting[12].

Study Setting

The study was conducted in the Nongr-Massom health district, specifically at the medical center of Kossodo. Nongr-Massom is one of five health districts in Burkina Faso's Centre region and was chosen due to its provision of reproductive health services.

Study Participants

The target population consisted of healthcare providers directly involved in PAC and women who had received such care. Eligibility criteria for providers included being a midwife, general practitioner, or gynecologist with at least one year of experience in PAC at the CMA maternity hospital in Kossodo. Clients were eligible if they had received PAC in the same facility.

Sampling

Purposive sampling was used to recruit participants progressively until data saturation was reached, meaning no new themes emerged from the interviews. The final sample included 11 healthcare providers and 10 PAC clients.

Data Collection Methods and Tools

A semi-structured individual interview guide was developed to explore the different aspects of PAC. The interview guide was structured around five themes: care administration procedures, providers' perceptions of PAC, client experiences, satisfaction levels, and structural barriers to quality care. Interviews were conducted in French and local languages, audio-recorded with participant consent, and transcribed verbatim.

Data Analysis

Thematic analysis was performed using Braun & Clarke's[13] six-step framework: 1) familiarization with the data, 2) generation of initial codes, 3) identification of themes, 4) review of themes, 5) definition and naming of themes, and 6) synthesis and reporting of findings[13]. NVIVO software version 12 was used for data coding and management. Findings are presented as a narrative synthesis with direct excerpts from participants.

Ethical Considerations

The study was approved by the Burkina Faso Health Research Ethics Committee (approval number: 2022-06-136). All participants provided informed consent after receiving detailed information about the study's objectives and procedures. Confidentiality and anonymity were ensured throughout data collection and analysis.

Results

Sociodemographic Characteristics

The study included 21 participants: 11 healthcare providers and 10 PAC beneficiaries. Providers were predominantly female (72.7%) and aged between 40–49 years (72.7%), with all holding higher education qualifications. In contrast, beneficiaries were exclusively female, mostly aged 20–29 years (90%), and half

had no formal education. These demographic differences highlight potential disparities in communication, understanding, and expectations between providers and clients, which may influence perceptions of care quality and service delivery.

Post-Abortion Care Administration Process

Healthcare providers described a structured and protocol-driven approach to post-abortion care (PAC). Upon arrival, women are received by staff, assessed for clinical severity, and—when indicated—undergo ultrasound examinations. Treatment is then administered based on the diagnosis, typically involving manual vacuum aspiration (MVA) or medication. While this process reflects clinical rigor, gaps in communication and patient engagement were evident.

One provider emphasized the importance of timely assessment and tailored intervention:

> "When a woman arrives, we first assess her situation and determine the best course of treatment. If there is excessive bleeding, we act quickly. Otherwise, we explain the options to her before proceeding." (Provider 1)

However, this ideal was not consistently reflected in client experiences. Several beneficiaries reported limited involvement in their care and a lack of clear information regarding procedures and medications. One client recalled feeling confused and excluded from the process:

> "I was not told much. They just gave me some pills and said, 'Take this.' I had no idea what they were for." (Client 4)

Another client expressed distress over inadequate preparation for post-treatment effects:

> "They explained the procedure but did not prepare me for how much pain I would feel afterward." (Client 7)

These accounts underscore the need for improved provider-client communication and more patient-centered care practices within PAC services.

Providers' Perceptions of Post-Abortion Care

Healthcare providers generally regarded post-abortion care (PAC) as a critical component of maternal health services. Many emphasized their ethical responsibility to deliver compassionate, non-judgmental

care, recognizing that respectful treatment fosters trust and encourages women to seek timely medical attention.

One provider articulated this commitment clearly:

> "We are here to care for these women, not to judge them. Our duty is to make sure they leave the facility in good health." (Provider 6)

This perspective reflects a broader understanding of PAC as both a clinical and moral obligation, aimed at safeguarding women's health regardless of the circumstances surrounding their abortion.

However, divergent views emerged among some providers, revealing underlying tensions in the implementation of PAC policy. A few expressed concerns that the availability of free PAC services might inadvertently normalize induced abortion or reduce its perceived consequences:

> "The fact that PAC is free worries me because it might make some women think they can terminate pregnancies without consequence." (Provider 4)

These contrasting viewpoints highlight the complex interplay between professional duty, personal beliefs, and public health policy. They underscore the need for ongoing dialogue and training to ensure that PAC is delivered consistently, ethically, and without stigma.

Patients' Experiences with Post-Abortion Care

Client experiences with post-abortion care (PAC) varied considerably, revealing a complex interplay between clinical treatment and emotional support. While some women described receiving compassionate and affirming care, others reported feeling neglected, judged, or dismissed during a vulnerable time.

Several clients emphasized the emotional significance of provider empathy. One woman recalled the reassurance she received:

> "The midwife was very kind. She told me not to blame myself and reassured me that I could try again for a baby when I was ready." (Client 6)

Such interactions were deeply valued, helping to mitigate the psychological distress often associated with abortion and PAC. However, not all clients encountered this level of support. Others described feeling stigmatized or emotionally unsupported:

> "The staff seemed annoyed with me like I had done something wrong. I was already feeling bad enough—I didn't need their judgment." (Client 3)

Pain management emerged as another critical concern. While some women received appropriate relief, others felt their suffering was minimized or ignored:

> "I was in a lot of pain, but they just told me to bear it. No one gave me anything to ease the pain." (Client 2)

These accounts underscore the need for more consistent, patient-centered care that addresses both physical and emotional dimensions of PAC.

Client Satisfaction with Post-Abortion Care

Client satisfaction with post-abortion care (PAC) was shaped by multiple intersecting factors, including waiting time, provider communication, emotional support, and the physical environment of care. While some women expressed appreciation for the accessibility and affordability of services, others encountered logistical and interpersonal challenges that negatively impacted their experience.

For many, the cost-free nature of PAC was a source of relief:

> "At least the care was free. I was grateful that I didn't have to worry about how to pay for the treatment." (Client 8)

However, prolonged waiting times and administrative inefficiencies were frequently cited as sources of frustration and fatigue:

> "I waited for nearly three hours before I was seen. It was exhausting." (Client 5)

Concerns about confidentiality also emerged, particularly in facilities where spatial arrangements compromised privacy. Several clients felt exposed during consultations, which heightened their emotional discomfort:

> "I was uncomfortable. The consultation rooms were not private, and I felt like other patients could hear everything." (Client 9)

These findings underscore the importance of not only clinical competence but also organizational responsiveness and respectful care environments in shaping client perceptions of PAC quality.

Barriers to Ensuring Quality of Care

Despite the integration of post-abortion care (PAC) into national health policy, several structural and operational barriers continue to hinder the delivery of high-quality services. Providers identified critical limitations, including inadequate infrastructure, insufficient staffing, and a lack of essential resources. These constraints not only compromise clinical effectiveness but also diminish the overall care experience for clients.

One provider emphasized the absence of dedicated facilities for PAC, which undermines patient privacy and dignity:

> "We don't have a dedicated space for PAC. Women have to be treated in general maternity wards, which makes privacy impossible." (Provider 7)

Concerns about hygiene and equipment shortages were also prevalent among providers:

> "The conditions are not ideal. We need more equipment, clean spaces, and better materials for procedures." (Provider 3)

Clients echoed these frustrations, expressing anxiety over the cleanliness and safety of the care environment:

> "The place wasn't clean. The sheets looked old, and I worried about infections." (Client 10)

These findings highlight systemic deficiencies that impede the delivery of respectful, safe, and effective PAC. Addressing infrastructure gaps and resource constraints is essential to improving service quality and fostering trust among beneficiaries.

Characteristic	Healthcare Providers		PAC Beneficiaries	
	N	%	N	%
Age				
20–29 years	0	0.0	9	90.0
30–39 years	1	9.1	1	10.0
40–49 years	8	72.7	0	0.0
≥ 50 years	2	18.2	0	0.0
Gender				
Male	3	27.3	0	0.0
Female	8	72.7	10	100.0
Level of Instruction				
No formal education	0	0.0	5	50.0
Primary	0	0.0	1	10.0
Secondary	0	0.0	2	20.0
Higher education	11	100.0	2	20.0

Table 1. Sociodemographic Characteristics of Participants

Discussion

This qualitative study explored the perceptions and experiences of healthcare providers and clients regarding the quality of post-abortion care (PAC) in the Nongr-Massom health district of Burkina Faso. In a context where abortion is socially stigmatized and often associated with shame, the emotional vulnerability of women seeking PAC underscores the importance of respectful, empathetic, and well-communicated care. Our findings reveal a multifaceted landscape shaped by clinical procedures, provider attitudes, patient experiences, and systemic constraints.

The study identified five key domains influencing PAC quality: the care administration process, provider-client communication, emotional and physical experiences of care, patient satisfaction, and structural barriers. Providers described a protocol-driven approach involving assessment, treatment (typically manual vacuum aspiration or medication), and post-treatment counseling. However, clients frequently reported poor communication, limited explanation of procedures, and inadequate contraceptive counseling. While some praised providers for their empathy, others felt judged or neglected. Pain management and privacy were inconsistent, and structural barriers—such as inadequate infrastructure and resource shortages—further compromised care delivery.

Our findings align with several studies across sub-Saharan Africa. In Senegal, Baynes et al. found that while PAC services were generally available, clients reported low satisfaction with counseling and information provision, particularly regarding post-abortion fertility and contraception[14]. Similarly, a study in Nigeria and the Central African Republic using the WHO Quality of Care Framework revealed that only 15% of women felt able to ask questions during treatment, and less than half reported satisfaction with privacy during care[15].

Provider attitudes toward abortion care are shaped by moral, religious, and social beliefs. A systematic review by Loi et al. highlighted that healthcare providers in sub-Saharan Africa often hold ambivalent or negative views toward induced abortion, which can influence their willingness to provide non-judgmental care[7]. In South Africa, Jim et al. found that higher levels of abortion stigma among health facility staff were significantly associated with obstruction of abortion care, underscoring the impact of provider bias on service delivery[16].

Client satisfaction is a critical indicator of care quality. A meta-analysis in Ethiopia reported that only 56% of women were satisfied with abortion care, with satisfaction strongly linked to provider communication, pain management, and privacy[17]. In Dakar, Senegal, women rated provider interaction highly but gave low scores to counseling and information provision, reinforcing the need for comprehensive, client-centered communication strategies[18].

Improving PAC quality requires a multi-pronged strategy. First, provider training should emphasize person-centered care, including effective communication, emotional support, and non-judgmental attitudes[19]. Values clarification workshops, as recommended by Loi et al., may help address moral reservations and reduce stigma[7].

Second, health system reforms must address staffing shortages, infrastructure deficits, and resource limitations. Investments in dedicated PAC spaces, clean and private consultation rooms, and adequate pain management supplies are essential to enhancing patient comfort and safety[20].

Third, contraceptive counseling must be integrated into PAC services as a standard component. Ensuring that women receive clear, accurate, and culturally sensitive information about family planning options can help prevent unintended pregnancies and reduce repeat abortions[21].

To strengthen the delivery of post-abortion care (PAC), future research should prioritize scalable interventions that address both clinical and social dimensions of service provision. Task-shifting models —where mid-level providers such as nurses and midwives are trained to deliver PAC—have shown comparable effectiveness to physician-led care and can expand access in resource-limited settings[22]. Mobile health (mHealth) tools also offer promising avenues for improving counseling and follow-up. In Kenya, mobile phone-based support from nurses and peer counselors significantly reduced perceived stigma and improved mental health outcomes among PAC clients[6]. Community-based education programs, particularly those that engage local leaders and peer networks, can further enhance awareness and uptake of PAC services[23].

Longitudinal studies are needed to evaluate the sustained impact of provider training, infrastructure improvements, and patient-centered care models on clinical outcomes and client satisfaction[24]. Expanding research beyond a single district will help assess the generalizability of findings and inform national reproductive health strategies.

Moreover, deeper investigation into the sociocultural dimensions of abortion stigma is essential. Evidence from South Africa and Nigeria shows that provider stigma can lead to obstruction of care and discriminatory practices[16][25]. Understanding how stigma influences provider behavior and patient decision-making will be critical for designing effective stigma-reduction interventions and promoting inclusive, rights-based reproductive healthcare[4].

Strengths and Limitations of the Study

This study offers several strengths. By capturing the perspectives of both healthcare providers and PAC beneficiaries, it provides a nuanced understanding of service delivery and patient experience within a real-world clinical setting. The findings contribute valuable insights that can inform reproductive health policy and guide strategic improvements in post-abortion care (PAC) in Burkina Faso. Specifically, the

study highlights critical gaps in communication, infrastructure, and provider attitudes that warrant targeted interventions.

However, several limitations must be acknowledged. First, the potential for social desirability bias exists, as interviews were conducted within the same facility where care was received. Although efforts were made to mitigate this—such as conducting interviews in private settings and ensuring confidentiality—responses may still have been influenced by participants' desire to provide socially acceptable answers. Second, the study was conducted in a single health district, limiting the generalizability of findings to other regions of Burkina Faso or similar contexts. As with all qualitative research, the results are context-specific and intended to be transferable rather than statistically representative. Finally, researcher subjectivity may have influenced data interpretation. While reflexivity and neutrality were maintained throughout the analysis, the interpretive nature of qualitative inquiry inherently involves researcher perspectives.

Conclusion

This study explored provider and client perceptions of post-abortion care (PAC) in Burkina Faso. While providers described a structured care process and acknowledged their duty to deliver PAC, gaps in communication, emotional support, and contraceptive counseling were evident. Clients reported mixed experiences, with some receiving compassionate care and others facing stigma, poor reception, and limited privacy. Despite government efforts, systemic barriers continue to hinder the delivery of high-quality PAC. Strengthening provider training, improving infrastructure, and ensuring patient-centered care are essential to advancing reproductive health outcomes.

Statements and Declarations

Conflicts of Interest

The authors declare no competing interests.

Acknowledgements

The authors express their sincere gratitude to all study participants for their time and openness during the interviews. Appreciation is also extended to the staff of the CMA maternity hospital in Kossodo for their logistical support and collaboration during data collection.

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Declarations

Funding: No specific funding was received for this work.

Potential competing interests: No potential competing interests to declare.