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**Systematic Review**

# Barriers to quality post-abortion care in low and middle-income countries: a systematic review

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## ABSTRACT

Post-abortion care (PAC) is a vital component of reproductive healthcare and essential for reducing abortion-related morbidity and mortality. Despite improvements in service availability, barriers affecting the quality and utilization of PAC services remain common across low-and middle-income countries (LMICs). The review was conducted using PubMed, Scopus, Google scholar and Open search database by following Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) statement (PROSPERO registration: CRD420261425414). The peer-reviewed studies published between 2010 and 2026 were screened according to inclusion criteria. Study selection was performed using Rayyan Software, and methodological quality was assessed using Joanna Briggs Institute (JBI) critical appraisal tools. Five major categories of barriers were identified; Knowledge and awareness barriers; Socio-cultural, financial, and geographic barriers; provider-related and quality -of-care barriers; health-system and facility-level barriers; and policy and legal barriers. The common challenges included abortion-related stigma, limited awareness of services, financial hardship, inadequate counselling, shortage of trained providers, weak referral systems, and insufficient infrastructure. Barriers to quality post -abortion care are multidimensional, and addressing these barriers through coordinated interventions may improve access, quality and utilization of post-abortion care services and help bridge the persistent access-quality gap in LMICs.

**Keywords:** Post-abortion care, Quality of care, Barriers and facilitators, Reproductive health, Health system

## INTRODUCTION

Abortion is a common reproductive health event and an integral component of sexual and reproductive healthcare. The World Health organization (WHO) estimates that approximately 73 million abortions occur worldwide each year, with unsafe abortion continuing to contribute substantially to maternal morbidity and mortality, particularly in low-and middle-income countries (LMICs).[1,2] Ensuring access to safe abortion and appropriate post-abortion care (PAC) is therefore essential for protecting women's health, reducing abortion-related complications, and supporting reproductive rights.[1,3] Recognizing its importance, the WHO Abortion Care Guideline (2022) identifies post-abortion care as a fundamental component of comprehensive abortion care and recommends timely management of complications, contraceptive counselling, emotional support, and referral for additional reproductive health services when required.[1]

Although access to post-abortion care has improved in many settings, the quality of care received by women remains inconsistent. The concept of quality post-abortion care extends beyond clinical management and includes

care that is safe, effective, accessible, equitable, respectful and responsive to women's needs.[3] Despite these standards, women continue to encounter numerous challenges while seeking and receiving care. Studies included in this review have documented barriers such as abortion-related stigma, financial hardship, long travel distances, inadequate counselling, shortage of trained providers, weak referral mechanisms, and deficiencies in health-system capacity. In addition, provider related factors including moral conflicts, negative attitudes, discriminatory behavior, and inadequate pain management have been reported to adversely affect women's experiences of care.[4-6]

The challenges surrounding post-abortion care are shaped by factors operating both within and beyond healthcare facilities. Social norms, gender expectations, legal environments, economic circumstances and health-system constraints frequently interact to influence when, where, and whether women seek care.[7-10] Previous research indicates that women often face multiple barriers even when services are available, suggesting that improving access alone may not be sufficient to ensure high-quality post abortion care.[5,7,9,11]

These observations suggest that improving access alone may be insufficient unless the broader determinants affecting the quality of care are also addressed. Although individual studies have explored barriers to post-abortion care in different countries and contexts, their findings remain dispersed across diverse populations, settings and healthcare systems. A synthesis of the available evidence is therefore needed to identify recurring barriers and inform strategies to strengthen post-abortion care services.

Therefore, this systematic review was undertaken to identify and synthesize barriers affecting the quality of post-abortion care services in low-and middle-income countries. The review further sought to categorize these barriers into individual and community-level, provider-level, health-system and policy related domains and to identify important gaps influencing the accessibility, utilization and quality of post-abortion care.

## METHODS

### *Search strategy and data sources*

A systematic search was conducted across four electronic databases: PubMed, Scopus, Google Scholar and Open Search. This search was limited to studies published between 2010 and 2026 to capture contemporary evidence related to barriers affecting the quality of post-abortion care services.

A combination of Boolean operators (AND/OR) with specific keywords such as "post-abortion care", "Comprehensive abortion care", "Abortion care Barriers", "Quality abortion care", "Respectful care". Additional manual screening of reference lists was undertaken to identify potentially relevant studies. The final search was conducted on 28 May 2026.

### *Inclusion and exclusion criteria*

Studies were selected based on predefined inclusion and exclusion criteria to ensure relevance to the review objective. Eligible studies included qualitative, quantitative and mixed-method research examining barriers, challenges, facilitators or quality-related aspects of post-abortion care services among women, healthcare providers, health systems, or communities. Only peer-reviewed articles published in English between 2010 and 2026 were included. Studies were excluded if they were systematic reviews, literature reviews, editorials, commentaries, conference abstract, case reports, policy briefs, or if they did not specifically address post-abortion care, quality of care or factors influencing service utilization. Articles with inaccessible full texts were also excluded from the review. This systematic review was registered with International Prospective Register of Systematic Review (PROSPERO; CRD420261425414).

### *Data extraction and quality assessment*

A total of 176 records were identified through database searching (PubMed n=41, Scopus n=37, Google Scholar n=15, Open Search n=83). After the removal of 65 duplicate records and 15 excluded for other reasons, 96 studies were screened by title and abstract using Rayyan software by two independent reviewers, of which 11 were excluded.

The remaining 85 reports were sought for retrieval; 50 could not be retrieved. The remaining 35 full-text articles were assessed for eligibility, of which 13 were excluded (no full text available, n=8; not assessing quality, n=2; broad abortion care discussion only, n=3). Finally, 22 studies met the inclusion criteria and were included in the review. Two reviewers independently screened titles, abstracts and full texts. Any disagreements were resolved consensus of third reviewer.

Data extraction was performed independently and in duplicate by two reviewers; discrepancies were resolved through discussion, with a third reviewer consulted where consensus could not be reached. The methodological quality of the included studies was assessed using the Joanna Briggs institute (JBI) critical appraisal tools appropriate to each study design. Overall, the included studies demonstrated moderate to high methodological quality. Most studies reported clearly defined objectives, appropriate study designs, and adequate data collection and analysis procedures. Out of the 22 included studies, the majority were rated as high quality, while a smaller number were rated as moderate to moderately–high quality. No study was excluded based on methodological quality. The detailed quality appraisal ratings are presented in Table 1.

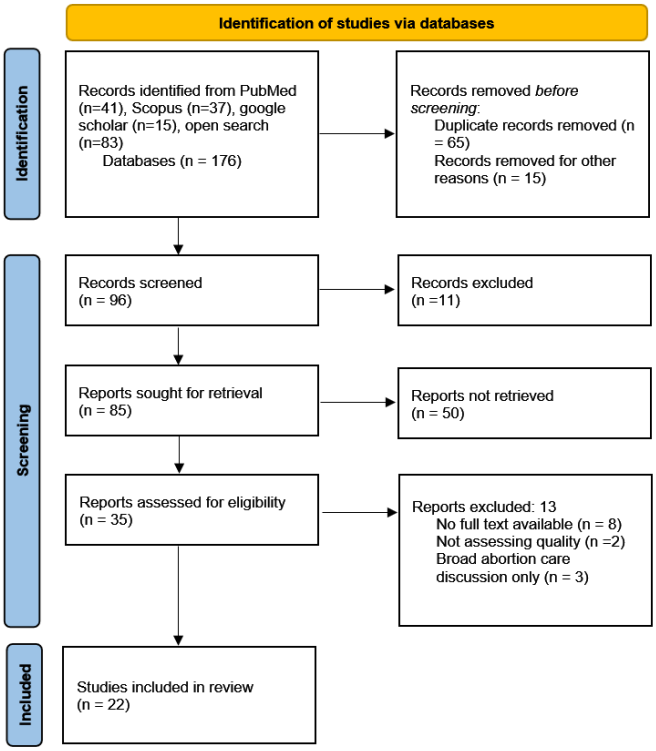



**Figure 1: PRISMA 2020 flow diagram for new systematic reviews which included searches of databases.**

**Table 1: Quality appraisal of included studies.**

| Author (year) | Study design | JBI tool used | Quality rating |
|---|---|---|---|
| **Mbehero et al (2022)[12]** | Qualitative | Adapted JBI (Qualitative Domain) | Moderate-High |
| **Mutua et al (2018)[7]** | Qualitative | Adapted JBI (Qualitative Domain) | Moderate-High |
| **Chukwumalu et al (2017)[13]** | Cross-sectional | Adapted JBI (Cross-sectional domains) | Moderate |
| **Adejugbe et al (2026)[14]** | Cross-sectional | Adapted JBI (Cross-sectional domains) | Moderate-High |
| **Ishoso et al (2021)[15]** | Quasi- experimental | Adapted JBI (Quasi-experimental domains) | High |
| **Koko et al (2025)[16]** | Cross-sectional Facility survey | Adapted JBI (Cross-sectional domains) | Moderate-High |
| **Belizan et al (2020)[17]** | Qualitative | Adapted JBI (Qualitative Domain) | Moderate |
| **Perera et al (2021)[8]** | Qualitative | Adapted JBI (Qualitative Domain) | High |
| **Cleeve et al (2019)[4]** | Qualitative | Adapted JBI (Qualitative Domain) | High |
| **Muga et al (2024)[18]** | Cross-sectional | Adapted JBI (Cross-sectional domains) | High |
| **Riley et al (2020)[19]** | Cross-sectional | Adapted JBI (Cross-sectional domains) | High |
| **Melkamu et al (2010)[20]** | Cross-sectional | Adapted JBI (Cross-sectional domains) | Moderate |
| **Azmat et al (2012)[21]** | Mixed methods | Adapted JBI (Mixed domains) | High |
| **Obure et al (2024)[9]** | Qualitative | Adapted JBI (Qualitative Domain) | High |
| **Paul et al (2014)[22]** | Qualitative | Adapted JBI (Qualitative Domain) | High |
| **Sengupta and Ghosh (2025)[23]** | Observational | Adapted JBI (Cross-sectional domains) | Moderate |
| **Roemer et al (2025)[24]** | Cross-sectional | Adapted JBI (Cross-sectional domains) | High |
| **Ouedraogo et al (2023)[6]** | Qualitative | Adapted JBI (Qualitative Domain) | High |
| **Bright et al (2026)[10]** | Qualitative | Adapted JBI (Qualitative Domain) | High |
| **Ismail et al (2025)[25]** | Qualitative | Adapted JBI (Qualitative Domain) | High |
| **Lubeya et al (2024)[5]** | Qualitative | Adapted JBI (Qualitative Domain) | High |
| **Baynes et al (2021)[26]** | Cross-sectional | Adapted JBI (Cross-sectional domains) | High |

### *Data synthesis and thematic analysis*

A thematic synthesis approach was employed to analyze findings across the 22 included studies. Data were categorized into five major themes: knowledge and awareness barriers, sociocultural, financial and geographic barriers, providers-related and quality-of-care barriers, health system and facility-level barriers, and Policy and legal barriers. Studies were further grouped according to the nature of the barriers identified and the strategies proposed to improve post-abortion care. This synthesis enabled a comprehensive understanding of the multifaceted factors influencing the quality, accessibility and utilization of post-abortion care services in low and middle-income countries.

Given the heterogeneity of study designs and outcome measures across included studies, no quantitative pooling or meta-analysis were undertaken; findings were synthesized narratively using a thematic approach. Given the predominance of qualitative and mixed-method designs among included studies, a formal statistical assessment of publication bias (e.g. funnel plots) was not applicable. The possibility of selective reporting and publication bias favoring studies documenting significant barriers cannot be excluded and is noted as a limitation.

## RESULTS

### *Characteristics of included studies*

Our review included 22 studies published between year 2010 to 2026 and conducted across multiple low-and middle-income countries including Kenya, Uganda, Nigeria, Somalia, Afghanistan, Pakistan, Ethiopia, Zambia, Liberia, Sierra Leone, Zimbabwe, the Democratic Republic of Congo, Somali land, Honduras and India. These studies employed diverse methodological approaches comprising eleven qualitative studies, eight cross-sectional studies, one quasi-experimental studies, one mixed method study and one observational. A detailed summary of the characteristics of the included studies is presented in Table 2.

**Table 2: Characteristics of included studies.**

| Author (year) | Title | Study design | Settings and population | Key findings and barriers identified |
|---|---|---|---|---|
| **Mbehero et al (2022)[12]** | Facilitating Uptake of Post-abortion Contraception for Young People in Kenya | Qualitative/ programmatic study | South West Kenya; young women and post-abortion care clients attending 80 public and private health facilities | Barriers: limited awareness of post-abortion contraception, provider stigma, shortage of trained providers, restrictive abortion environment, and inadequate youth-friendly services hindering utilization of PAC and contraceptive services.<br>Facilitators: Provider training and mentorship, youth-friendly counselling, community health volunteers, peer referrals, expanded service hours and integration of post-abortion family planning improved contraceptive uptake and access to quality care. |
| **Mutua et al (2018)[7]** | Policy, law and post-abortion care services in Kenya | Qualitative Cross-sectional study | Kenya, post-abortion care service providers and women receiving PAC in public and private healthcare facilities | Barriers: Policy restriction, stigma, and inadequate facilities preparedness compromised the quality and timeliness of post –abortion care<br>Facilitators: Strengthened policies, provider training and integrated reproductive health services supported improved care delivery. |
| **Chukwumalu et al (2017)[13]** | Uptake of post-abortion care services and Acceptance of Post-abortion Contraception in Puntland, Somalia | Programmatic Descriptive Study | Puntland, Somalia; Women receiving post-abortion care at four sci-supported health facilities | Barriers: restrictive laws, abortion stigma, limited trained personnel, inadequate infrastructure and poor access to reproductive health services.<br>Key findings: A comprehensive PAC programme involving provider training, community engagement, and integration of family planning services was associated with increased PAC utilization and post-abortion contraceptive uptake. |

Continued.

| Author (year) | Title | Study design | Settings and population | Key findings and barriers identified |
|---|---|---|---|---|
| **Adejugbe et al (2026)[14]** | Availability and readiness of post-abortion care in public and private healthcare facilities in Ile-Ife, Osun State, Nigeria | Cross-sectional mixed-method study | Ile-Ife, Osun State, Nigeria, officer-in-charge from 25 public and private health facilities | Key Findings: PAC service availability was higher in private facilities (75%) while in public only 40%. Barriers: Inadequate facility resources, shortage of trained staff, negative provider attitudes towards abortion and service-costs limited the provision of quality PAC services. |
| **Ishoso et al (2021)[15]** | Effect of Implementing a Post-abortion Care strategy in Kinshasa Referral Hospitals, Democratic Republic of the Congo | Quasi-experimental | Kinshasa, Democratic Republic of the Congo; 334 Women admitted with complications of induced abortions in 20 referral hospitals | Key Findings: Implementation of the PAC strategy increased the use of WHO-recommended manual vacuum aspiration by 29.3% and reduced hospitalization by one day. Barriers: Limited uptake of post-abortion contraception, financial constraints, lack of dedicated PAC units, and insufficient quality –improvement mechanisms continued to affect service delivery. |
| **Koko et al (2025)[16]** | Assessing facility capacity to provide safe abortion and post-abortion care in Liberia: a 2021 signal function survey across 48 public health facilities | Cross-sectional facility survey | Liberia, 43 public health facilities (clinics, health centers, and hospitals) providing abortion-related care | Key Findings: Only 65% of facilities could provide basic PAC, while 28% could provide comprehensive PAC services. Referral capacity (77%), blood transfusion (53%), and surgical/laparotomy capability (41%) were the weakest PAC components. Barriers: Lack of equipment and supplies, restrictive facility policies, inadequate referral systems, and limited capacity for blood transfusion and surgical care constrained quality PAC provision. |
| **Belizan et al (2020)[17]** | Contraception and post abortion services: qualitative analysis of users' perspectives and experiences following Zika epidemic in Honduras | Qualitative (Interviews & Focus groups) | Tegucigalpa, Honduras; 136 (Women receiving PAC and contraceptive services, male partners and service users) | Key Findings: Participants reported poor counselling, inadequate privacy, and mistreatment during PAC services. Barriers: Long waiting times, financial costs, geographic access challenges, and poor quality of care limited-service utilization |
| **Perera et al (2021)[18]** | Barriers to seeking post-abortion care in Paktika Province, Afghanistan: a qualitative study of clients and community members | Qualitative study | Paktika Province, Afghanistan; women receiving PAC and community members | Key Findings: Cost, distance to health facilities, need for male accompaniment, and abortion-related stigma delayed care-seeking for PAC. Community members generally supported women receiving lifesaving PAC despite negative attitudes toward abortion. |
| **Cleeve et al (2019)[4]** | Morality versus duty - A qualitative study exploring midwives' perspectives on post-abortion care in Uganda | Qualitative study | Kampala, Uganda; 22 midwives providing PAC in public hospital. | Key Findings: Midwives were committed to providing PAC but experienced conflicts between personal beliefs and professional responsibilities. Barriers: Abortion stigma, negative provider attitudes, shortage of supplies and equipment, high patient load, and poor working conditions affected the quality of care. |

Continued.

| Author (year) | Title | Study design | Settings and population | Key findings and barriers identified |
|---|---|---|---|---|
| **Muga et al (2024([18]** | Barriers to post-abortion care service provision: A cross-sectional analysis in Burkina Faso, Kenya and Nigeria | Cross-sectional | Burkina Faso, Kenya, and Nigeria; health facilities, PAC clients, healthcare providers, and policymakers | Key Findings: PAC readiness was low across the three countries, with fewer than half of facilities reporting trained PAC providers. Only 16.6% of facilities in Kenya and 20.3% in Burkina Faso had functional MVA rooms. Barriers: Limited provider training, inadequate infrastructure, poor referral capacity, and suboptimal patient-provider interactions hindered quality PAC provision. |
| **Riley et al (2020)[19]** | Evaluating the quality and coverage of post-abortion care in Zimbabwe: a cross-sectional study with a census of health facilities | Cross-sectional | Zimbabwe; health facilities providing PAC and women receiving PAC services | Key Findings: Only 21% of facilities had basic PAC capability, 10% had comprehensive PAC capability, and 25% of PAC patients received recommended treatment. Barriers: Inadequate PAC service coverage, limited facility readiness, shortages of essential supplies, and poor compliance with evidence-based care standards. |
| **Melkamu et al (2010)[20]** | Utilization of post-abortion care services in three regionals states of Ethiopia | Cross-sectional | Ethiopia (Amhara, Oromia, and SNNPR); 1,492 women of reproductive age, service providers, and key informants | Key Findings: Most women preferred public health facilities for PAC because of better perceived quality and accessibility. Barriers: Lack of community support (36.8%), high service costs (16.2%), transportation challenges (11.1%), distance to facilities (10.5%), and poor provider attitudes limited-service utilization. |
| **Azmat et al (2012)[21]** | Delivering post-abortion care through a community based reproductive health volunteer programme in Pakistan | Mixed Methods | Pakistan (Sindh and Punjab);76 PAC clients and 15 reproductive health volunteers. | Key findings: Medical treatment was preferred by 84% of women in Punjab and 82 % in Sindh because it was perceived as less painful and easier to use. Barriers: Financial constraints, opposition from husbands and in-laws, restrictions on women's mobility, lack of transport, and abortion –related stigma limited access to PAC services. |
| **Obure et al (2024)[9]** | "Sometimes you have knowledge but lack the equipment to save a life": perspectives on health system barriers to post-abortion care in Liberia and Sierra Leone | Qualitative Study | Liberia and Sierra Leone;33 healthcare providers and 13 policy actors | Barriers: Weak health-system capacity, inadequate infrastructure, limited policy awareness, stigma and religious beliefs affected the provision of quality PAC. Facilitators: Provider training, functional referral systems, adequate PAC supplies, and dissemination of PAC guidelines were identified as key measures to improve service quality. |
| **Paul et al (2014)[22]** | Barriers and facilitators in the provision of post-abortion care at district level in central Uganda– a qualitative study focusing on task sharing between physicians and midwives | Qualitative Study | Central Uganda;27 healthcare providers (10 doctors and 17 midwives) from seven health facilities | Barriers: Inadequate training, resource shortages, high workload, and weak counselling support limited quality PAC provision. Facilitators: Task sharing, provider capacity building, and expanded use of MVA and misoprostol were identified as key strategies to improve PAC services. |

Continued.

| Author (year) | Title | Study design | Settings and population | Key findings and barriers identified |
|---|---|---|---|---|
| **Sengupta and Ghosh (2025)[23]** | A study on abortion care services in different tiers of rural health care in Malda district of West Bengal, India | Mixed Methods (Observational) | Rural West Bengal, India;133 ANMs, 48 staff nurses, women seeking CAC, doctors, and administrators | Key Findings: Only 31% of ANMs had received CAC training, and only 40% of women seeking abortion were accompanied to health facilities. Barriers: knowledge deficits, inadequate refresher training, stigma, poor confidentiality, weak service support, and administrative gaps contributed to suboptimal CAC utilization |
| **Roemer et al (2025)[24]** | Inequities in Safe Abortion: Women's Care Trajectories in Abuja and Lagos, Nigeria | Cross-sectional survey | Abuja and Lagos, Nigeria; 197 women with a history of induced abortion in the previous 5 years. | Key Findings: Nealy half (44.7%) of abortions were classified as most unsafe, 71.6% involved non-clinical sources and 10.7% of women reported complications. Barriers: Poverty, rural residence, limited access to preferred providers, and restrictive abortion environments contributed to unsafe abortion experiences. |
| **Ouedraogo et al (2023)[6]** | "I will never wish this pain to even my worst enemy": Lived experiences of pain associated with manual vacuum aspiration during post-abortion care in Kenya | Ethnographic qualitative study | Kilifi County, Kenya; 21 girls and young women receiving PAC and 12 healthcare providers | Key findings: Women reported severe pain during MVA procedures, often describing it as worse than childbirth. Barriers: Lack of pain medication, inadequate provider training, faulty equipment, abortion stigma and discriminatory provider attitude compromised the quality of post-abortion care. |
| **Bright et al (2026)[10]** | 'Making abortion safe': abortion and post- abortion care providers' experiences of stigma in Rwanda, Zimbabwe, Sierra Leone and Nigeria | Qualitative Study | Rwanda, Zimbabwe, Sierra Leone and Nigeria; 44 abortion and PAC providers (doctors, nurses and midwives) | Key Findings: Provider demonstrated resilience and commitment to delivering abortion and PAC service despite stigma. Barriers: Restrictive legal frameworks, abortion stigma, negative workplace attitudes and religious and cultural beliefs adversely affected providers and care quality. |
| **Ismail et al (2025)[25]** | Women's experiences of post-abortion care services at health facilities in Somaliland – A qualitative study among women with incomplete abortion | Qualitative Study | Somaliland;14 women who received PAC following incomplete abortion | Key Findings: Family and community support facilitated care –seeking, while women reported inadequate counselling and poor continuity of care after discharge. Barriers: Financial constraints, traditional practices, male consent requirements, lack of respectful care , inadequate pain management, and limited counselling compromised quality PAC services. |
| **Lubeya et al (2024)[5]** | Post-abortion care services in Zambian health facilities: a qualitative study of users' experiences and perceptions | Qualitative case study | Zambia (Lusaka and Copperbelt Provinces); 15 women receiving PAC | Barriers: Abortion stigma, negative provider attitude, poor awareness of legal services, financial costs, and shortages of essential supplies limited access to quality PAC. Facilitator: Increased community awareness regarding abortion legality and availability of free PAC services was suggested to improve timely care–seeking and service utilization. |

Continued.

| Author (year) | Title | Study design | Settings and population | Key findings and barriers identified |
|---|---|---|---|---|
| **Baynes et al (2021)[26]** | Women's Perceptions of the quality of post-abortion care in Public-sector facilities in Senegal | Cross-sectional study | Dakar, Senegal; 729 women receiving post-abortion care from eight public health facilities. | Key Findings: Effective counselling, privacy, adequate pain management, facility readiness, and family planning services enhanced perceived quality of care.<br>Barriers: Poor counselling, inadequate privacy and pain management and shortage of medicines and supplies. |

**Table 3: Frequency of barriers categories reported across included studies.**

| Barrier category | Numbers of studies |
|---|---|
| **Provider-related and quality -of-care barriers** | 14 |
| **Socio-cultural barriers** | 13 |
| **Health system and facility level barriers** | 12 |
| **Knowledge and awareness barriers** | 9 |
| **Financial barriers** | 8 |
| **Policy and legal barriers** | 8 |
| **Geographical barriers** | 5 |

To provide an overview of the relative prominence of barriers identified across the included studies, the frequency of each barrier category was summarized. Provider-related and quality -of-care barriers were the most commonly reported challenges (14 studies), followed by socio-cultural barriers (13 studies) and health-system and facility-level barriers (12 studies). Knowledge and awareness barriers (9 studies), financial barriers (8 studies), policy and legal barriers (8 studies), and geographical barriers (5 studies) were also reported. (Table 3).

***Barriers to quality post-abortion care***

The synthesis of the included studies demonstrated that barriers to quality post-abortion care are interconnected and operate at multiple levels. These barriers arise from knowledge deficits, socio-cultural challenges, provider-related factors, health–system limitations and policy related constraints that collectively influence access to and provision of post-abortion care services. Five major themes emerged from the analysis and are presented below.

*Knowledge and awareness barriers*

One of the most commonly reported barriers to quality post-abortion care was limited knowledge and awareness regarding post–abortion care health needs and available services. Across the included studies, women frequently demonstrated inadequate understanding of post-abortion complications, contraceptive options, and the importance of timely healthcare seeking following abortion related events.[5,8,12,13,17,20,21,25] Misinformation and inadequate counselling often delayed care-seeking and reduced service utilization.[8,12,13,20,21,25]

*Sociocultural, financial and geographical barriers*

Sociocultural and economic circumstances play a significant role in influencing women's access to post-abortion care services. Providers highlighted that stigma surrounding abortion, restrictive genders norms, family opposition and fear of social judgement discouraged women from seeking timely care and, in some cases, prevented them from accessing formal healthcare services altogether.[8,12,13,21,24,25] Financial constraints, including treatment cost, transportation expenses, and loss of income, further limited access to care, particularly among economically disadvantaged populations.[8,13,17] Geographic barriers including long travel distances, poor transportation network and limited-service availability in rural areas, delayed access to care and contributed to persistent inequities in post-abortion care services.[8,20,21,23]

*Provider-related and quality-of-care barriers*

Providers related factors shape women's experiences and the overall quality of post-abortion care services. Evidence reported that abortion-related stigma, moral and religious conflicts, inadequate communication, and insufficient counseling negatively influenced the provision of care.[4,5,6,9,22,25] Healthcare providers reported stigma, social disapproval, and moral conflicts associated with abortion related services, while women described poor communication, inadequate privacy and pain management, limited emotional support, long waiting times, and insufficient counseling during care provision.[4,10,5,25,26]

*Health system and facility-level barriers*

The availability of adequate resources and services readiness are essential for delivering quality post-abortion

care. Across different settings, healthcare facilities frequently lacked trained personnel, essential medicines, equipment, and infrastructure required for comprehensive post-abortion care services.[9,14-19,22,23,26] Deficiencies in emergency preparedness, referral mechanisms, and workforce capacity were particularly evident in rural and resource constrained settings, limiting the ability of facilities to manage abortion-related complications effectively.[14,16,19,23] Variations in service availability across healthcare facilities contributed to inequitable access, and delayed receipt of appropriate post-abortion care services.[18,19,23]

*Policy and legal barriers*

Apart from individual and provider-related challenges, broader policy and health system factors substantially influenced the provision of post-abortion care services. Several studies reported that restrictive abortion laws, policy ambiguity, and inadequate implementation of reproductive health policies created uncertainty among both healthcare providers and service users.[7,22,24] Studies examining health system performance further highlighted fragmented referral pathways, inequitable service coverage, and insufficient institutional support as barriers to effective post-abortion care delivery.[9,18,19,24] In some setting, policy gaps affecting task-sharing and integration of post-abortion care within reproductive health programme further restricted services availability. These systemic challenges often limited continuity of care and hindered equitable access to quality post-abortion care services.

***Facilitators and improvement strategies***

The included studies identified several strategies for improving the quality and utilization of post-abortion care services. Provider training, supportive supervision, and institutional support enhanced provider's competence and ability to deliver respectful, evidence-based care.[4,9,15,18,22,26] Integration of family planning within post-abortion care improved contraceptive uptake and continuity of reproductive healthcare services.[12,13,15] Community-based interventions, including health volunteers and referral networks, facilitated awareness and timely access to care.[12,21] In addition, task-sharing approaches, strengthened referral systems, improved infrastructure, and the availability of essential medicines and equipment were reported to enhance service readiness and quality of care, particularly in resource-constrained settings.[9,18,22,26]

## DISCUSSION

***Principal findings: the access-quality gap***

The review of 22 included studies identified the persistent "access-quality gap" in post-abortion care across low and middle –income countries. While many countries have expanded the availability of post-abortion care services, the findings suggest that service availability alone does not guarantee equitable access to high-quality care. Rather, women frequently encounter multiple and overlapping barriers that delay care-seeking, restrict service utilization and compromise care experiences.[4,8,9,12,18,24-26] These findings suggest that expanding service availability alone is insufficient to ensure equitable access to quality care. The predominance of provider-related, sociocultural, and health-system barriers across the included studies indicates that improvements in service availability must be accompanied by efforts to strengthen provider competency, reduce abortion-related stigma, and enhance health-system readiness.

***Individuals and community-level determinants***

Women's utilization of post-abortion care is influenced by knowledge, socio-cultural norms, financial circumstances, and geographic accessibility.[8,12,13,20,21,23-26] Similar findings have been reported in reproductive health literature and are reflected in WHO and national abortion care guidelines, which emphasize the importance of accurate information, supportive environments, and timely access to care.[1] Collectively these address the need for a broader public health approach to improving post-abortion care utilization.

***Health system and provider level challenge***

The quality of post-abortion care largely depends on the ability of healthcare providers and health systems to deliver timely, respectful and evidence–based services. Providers level challenges, like attitude, inadequate counseling, workforce shortage, limited infrastructure and weak referral mechanisms indicates the availability does not guarantee quality care.[4-6,9,10,18,22,25,26]

Similar concerns have been highlighted in the WHO abortion care guidelines, FIGO best practice advice on abortion care, and the Government of India's comprehensive abortion care guidelines, all of which emphasize trained providers, person-centered care, and functional referral system as essential components of quality abortion care.[1,27,28] The evidence underscores the importance of strengthening provider competency and health system readiness to improve the quality and continuity of post-abortion care services.

***Implication for policy and practice***

Ultimately, addressing barriers alone cannot serve the quality, it demands effective implementation of policies and practice. Efforts to improve reproductive health literacy, reduce abortion-related stigma, and increase community awareness may facilitate timely care-seeking and service utilization.[8,12,13,20,21,24,25] At the health system level, provider training, task-sharing, supportive supervision, and functional referral systems remain essential for ensuring quality and continuity of

care.[9,15,18,22,26] These priorities are consistent with recommendation by different organization.[1] Strengthening policy implementation and ensuring equitable access to care, particularly in underserved settings, may substantially improve women's reproductive health outcomes.

### *Strengths*

The principal strength of this systematic review lies in its comprehensive synthesis of evidence from 22 studies conducted across diverse setting of low-and-middle-income countries. Adhering by the PRISMA framework, the review systematically identified and analyzed barriers and facilitators influencing the quality of post-abortion care.

### *Limitations*

Several limitations should be considered. Only English-language studies were included, potentially excluding relevant evidence published in other languages. Publication bias could not be formally assessed. The include studies were heterogenous in design and setting, which may limit direct comparability of findings. In addition, most evidence was derived from qualitative and observational studies. Additionally, 50 of the 85 reports sought for full text retrieval could not be obtained, which may have introduced retrieval bias and excluded potentially relevant evidence from the synthesis.

## CONCLUSION

There is lack of awareness and inadequate knowledge This review of 22 studies highlights that the challenges affecting post-abortion care extend beyond the mere availability of services and reflect a persistent "access-quality gap" across low and middle–income countries. Women continue to encounter multiple and interconnected barriers, including limited knowledge, socio-cultural stigma, financial and geographic constraints, provider-related challenges, and health-system weaknesses, all of which influence access to timely and quality care. This evidence suggests that improving post-abortion care requires more than expanding service provision; it demands strengthening reproductive health literacy, reducing stigma, improving provider competency, and enhancing health-system capacity. Ultimately, bridging the access-quality gap in post abortion care requires coordinated efforts that ensure women can access timely, equitable and high-quality care.

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