

Perceptions and Barriers to Provision of Post-abortion Services Among Healthcare Workers in Osogbo, Nigeria: A Qualitative Study

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Abstract

Background

Healthcare workers' perceptions and experiences significantly influence the provision and quality of post-abortion care (PAC). This qualitative study explored the perceptions, experiences, and barriers to providing post-abortion services among healthcare workers in Osogbo Local Government Area (LGA), Osun State, Nigeria.

Methods

Key informant interviews (KIIs) were conducted with 12 healthcare workers (nurses, Community Health Extension Workers (CHEWs), and other cadres) from selected primary healthcare facilities in Osogbo LGA from June to November 2024. Participants were purposively selected until data saturation was achieved. Interviews were audio-recorded, transcribed verbatim, and analyzed using thematic analysis following Braun and Clarke's six-phase framework.

Results

The thematic analysis revealed two major themes; (1) Perception of healthcare workers, with three sub-themes such moral and religious conflict, level of convenience in providing PAC and perceived impact of PAC availability in the community, and (2) Barriers to PAC. Despite the barriers, most participants acknowledged the life-saving nature of PAC and expressed willingness to provide services with adequate support while providing recommendations for the improvement of PAC services.

Conclusions

Healthcare workers in Osogbo face complex moral, legal, and institutional barriers to providing PAC. Addressing these barriers requires comprehensive training, clear legal guidelines, institutional support, and interventions to reduce stigma. Policy efforts should focus on creating an enabling environment for PAC provision.

Categories: Obstetrics/Gynecology, Public Health, Epidemiology/Public Health

Keywords: nigeria, perception levels, post-abortion care, primary healthcare worker, qualitative approach, barriers

Introduction

The World Health Organization (WHO) estimates that around 73 million induced abortions occur worldwide each year, approximately 45% of which are unsafe. Unsafe abortion remains a leading cause of maternal mortality, with an estimated 39,000 deaths annually [1]. This is disproportionately seen in low- and middle-income countries, especially in sub-Saharan Africa, where inadequate legal frameworks and access to good reproductive health services contribute to this situation [2]. Nigeria's maternal mortality ratio remains among the highest globally, estimated at 993 per 100,000 live births [3]. Unsafe abortion is estimated to account for approximately 13% of maternal deaths in Nigeria [4]. About 20,000 women in Nigeria die every year due to complications of unsafe abortions, and tens of thousands of women develop serious complications such as haemorrhage, sepsis and uterine perforation [5].

Post-abortion care (PAC) is a life-saving intervention comprising emergency treatment of abortion complications, contraceptive counselling, and referral to reproductive health services [6,7]. The legal

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distinction between PAC and elective abortion care is clinically and ethically significant because PAC is universally accepted as an integral part of emergency obstetric care and is legally permissible under Nigerian law to save a woman's life [8]. Under Nigerian law, abortion is permitted only to save a woman's life, according to the Penal Code, with a slightly broader provision in the Criminal Code for physical and mental health. This legal ambiguity creates significant uncertainty for providers, who may face prosecution or professional sanctions even when providing legitimate, life-saving PAC [9]. The criminalisation of abortion has been recognised as a structural driver of unsafe abortion, pushing women toward clandestine procedures and discouraging providers from offering essential services [10]. Consequently, many women present late to health facilities with complications, and the quality of PAC they receive is often compromised by systemic and interpersonal barriers [7].

Healthcare providers play a key role in providing quality PAC, and their attitudes, beliefs, and experiences have a profound impact on the availability and accessibility of services. Substantial evidence has been documented that providers often suffer moral distress, stigma, and fear of legal consequences for providing abortion and PAC [11,12]. Qualitative work in Nigeria has identified stigma faced by providers, including societal judgment, labelling, and even fear for personal safety, with societies perceiving stigma towards abortion and PAC providers differently; the former are perceived by society as 'killers' and the latter as 'lifesavers' [9]. These results underscored the multifaceted socio-emotional and work-based landscape faced by the providers.

There are some gaps in the existing qualitative research in Nigeria, which has started to investigate these issues. The majority of the available evidence is on the experience of doctors and tertiary healthcare providers in urban areas with little attention to the experience of nurses and Community Health Extension Workers (CHEWs), who represent the frontline providers in primary health centres [13]. In addition, there have been few studies that focus specifically on the views, experiences and obstacles of providers of PAC in Southwest Nigeria and none that focus on Osogbo Local Government Area (LGA). Awareness of the ways providers in this particular context manage the conflict between professional obligations, values, and beliefs, legal uncertainty and ambiguity, and institutional constraints are critical to designing effective interventions to enhance PAC quality and access. This study therefore explored healthcare workers' perceptions, experiences, and barriers to providing post-abortion services in Osogbo LGA, Osun State, Nigeria using qualitative method. This research seeks to provide evidence that will guide specific trainings, clarification of policies, and institutional support to improve PAC provision in Osogbo LGA and similar contexts in Nigeria in order to answer the questions raised above. The primary objective of this study was to explore, qualitatively, healthcare workers' perceptions of PAC, their experiences of providing it, and the barriers they encounter in Osogbo LGA, Osun State, Nigeria. The primary outcomes were the themes and sub-themes derived from key informant interviews, organised under two domains: perceptions of healthcare workers and barriers to PAC provision.

The socio-ecological model was used to guide this study, which suggests that healthcare workers' practices are influenced by the interaction of factors at various levels, including the intrapersonal level (knowledge, attitudes, beliefs), interpersonal level (relationships between healthcare workers and patients), institutional level (facility resources, policies, training), community level (cultural norms, stigma), and policy level (laws, regulations) [14]. This framework offers a broad framework for analysing the multi-level obstacles and enablers to PAC provision, taking a more systems approach than focusing on the individual level.

Materials And Methods

Study design

This was a qualitative study, carried out from June to November 2024, in selected primary healthcare facilities in Osogbo LGA, Osun State, Nigeria. Key informant interviews were used to obtain an in-depth understanding of providers' experiences and perceptions about post-abortion services.

Study setting

Osun State capital, Osogbo LGA, has 15 political wards. It has a combination of public and private primary healthcare centres, with some 45 registered facilities, including 28 public and 17 mission-based or private ones. These facilities offer reproductive health services, including family planning, antenatal care, and PAC, with PAC quality varying by facility.

Sampling Techniques

The wards, facilities, and participants were purposefully selected using a multi-stage purposive sampling process. A purposive sampling method was used since the study aimed to obtain rich and context-specific information from healthcare workers who directly interacted with post abortion care. The sampling process was conducted in three phases: first, wards were selected in Osogbo LGA; second, primary health centres were selected within the selected wards; third, participants were selected within the selected primary healthcare centres.

Stage One: Selection of Wards

Osogbo LGA was deliberately chosen as it is the administrative capital of Osun State, and there is a variety of both private and public primary healthcare centres in the area. For this study, seven of the 15 wards were purposively selected because each contained at least one facility offering PAC services, the wards were spread across the LGA; there was a mix of both public and private facilities; and the wards were accessible to data collection. The selected wards are Oke-Baale, Atelewo, Enikanoyun, Oja-Oba, Alekuwodo, Isale-Osun and Oke-Fia, which contains 18 primary healthcare centres (11 public and seven private).

Stage Two: Selection of Primary Healthcare Centres

Seven primary healthcare centres were purposively selected from a total of 18 facilities in the selected wards. The facilities included were those that offered post-abortion services as part of their routine healthcare, PAC, management of incomplete abortion, manual vacuum aspiration, and post-abortion contraceptive counselling, as documented in their services records, confirmed by the officer-in-charge, and confirmed by initial visits by the research team. The facilities also had to have at least two of their healthcare staff be qualified with at least two years of experience and who directly worked with post-abortion patients. In addition to public facilities, participation in private facilities was also included, and permission to participate had to be granted by the heads of the facilities. Two private facilities refused to participate due to "sensitivity of the subject". Participants were interviewed in each facility, adding facilities until data saturation occurred, and finally seven facilities were included, six of which were public primary healthcare centres, and one was a private healthcare centre.

Stage Three: Participant Selection

Individuals within the selected facility were purposively selected based on their roles as either a nurse, CHEW, Community Health Officer or other cadres within the health system who interact directly with clients who received PAC. Participants needed to have two years or more of experience in their current position, to have provided PAC in the last six months, have consented in writing and be able to share their experiences in the English or Yoruba language. Medical doctors were excluded as they were not part of the regular staff of the primary healthcare centres. Participants were identified with the assistance of the facility's officer-in-charge, approached individually by the research team, and invited to participate. Sampling was continued until data saturation was reached at 12th interview.

Rationale for Sampling Technique

Purposive sampling was used to ensure information rich as the participants were directly involved in PAC practices, and they could give a detailed account of their experiences. It also ensured some diversity in this regard, including different cadres, different kinds of facilities, and years of experience, so that the study could reflect a variety of views. The facilities chosen were known to deliver post-abortion services thus making the findings contextually relevant and having greater credibility and transferability. The purposive sampling method was used in an iterative manner to ensure full coverage and continuous addition of themes until no new ones were found, thus allowing the research team to proceed until the phenomenon being studied was covered.

Data collection

Key informant interviews were done with a semi-structured interview guide developed from the literature and piloted in two healthcare workers from a healthcare centre not involved in the study. The guide discussed experiences in identifying and addressing PAC needs, attitudes toward provision of PAC, attitudes of colleagues, comfort in provision of PAC, reasons for concern, religion, culture, law and policy, balancing duty and personal feelings, challenges in providing the care, impact of having PAC services in the community, and recommendations for strengthening services. Interviews were conducted in English or Yoruba and lasted a duration of 45 to 60 minutes, were audio-recorded with participants consent and translated into English or Yoruba for transcription. Data collection was continued until the 12th interview to reach thematic saturation of data and non-verbal cues and contextual observations were noted in field notes.

Data analysis

We analysed the interviews using Braun and Clarke's six-phase approach to thematic analysis [15]. The team began by reading and re-reading the transcripts and field notes to become familiar with the data. Two researchers then coded the transcripts independently. Coding was inductive, so the codes came from what participants said rather than from a pre-set coding frame. Codes were attached to meaningful sections of text, and a working codebook was kept and updated with code labels, definitions and example quotations.

The two coders then compared codes and grouped related ones into candidate themes and sub-themes. For example, comments about religious or cultural disapproval and professional duty were grouped under "Moral

and Religious Conflict”; discomfort, professional obligation, policy backing and unwillingness were grouped under “Level of Convenience in Providing PAC”; and legal fear, judgmental attitudes and patient concealment were grouped under “Barriers to Post-Abortion Care.” We checked these candidate themes against the coded extracts and the full dataset, splitting, merging or dropping themes where they did not fit well. Each final theme and sub-theme was then defined and named. The final structure had two major categories; perception of healthcare workers and barriers to PAC plus a separate category for recommendations on improving PAC services. Findings were reported narratively along with illustrative quotations.

Theme development was iterative. The coders moved back and forth between transcripts, codes and candidate themes until the final themes reflected the range and depth of participants’ accounts. Data collection continued to the 12th interview, when thematic saturation was reached. Themes were not chosen simply because they appeared often; they captured patterned meanings relevant to the research question, including contradictions such as providers offering PAC despite moral discomfort.

When the two coders disagreed, they compared their coding of each transcript and identified differences in code labels, code boundaries or theme placement. They resolved these differences by returning to the transcript extracts and codebook definitions, discussing the reasoning behind their interpretations, and reaching consensus through discussion. An audit trail documented coding decisions and changes to the codebook, and all discrepancies were resolved by consensus.

We integrated the inductive analysis with the socio-ecological model (SEM) sequentially rather than using the SEM as an a priori coding template. The interview guide and the overall study were informed by the SEM, which made the team alert to possible influences at intrapersonal, interpersonal, institutional, community and policy levels. However, coding and theme development remained inductive and data-driven. Once the themes were developed, we used the SEM as an interpretive and synthesizing lens in the discussion. Themes were mapped into SEM levels: intrapersonal (moral and religious conflict, personal disapproval, discomfort, attitudes toward patients); interpersonal (provider-patient judgment, patient concealment, professional duty versus personal beliefs, colleague attitudes); institutional (training gaps, equipment and supplies, institutional support, policy guidelines); community (cultural norms, stigma, community trust in facilities, perceived positive impact of PAC availability); and policy (legal ambiguity, fear of arrest or prosecution, Osun State policy backing, calls for legal reform). This mapping helped explain how perceptions and barriers interact across levels, for example, how policy-level legal ambiguity combines with intrapersonal moral distress and community or interpersonal stigma to shape PAC provision. The SEM therefore served as an organising and interpretive framework in the discussion and synthesis, while the themes themselves remained grounded in the inductive coding of participants’ accounts.

Ethical considerations

This study was approved by the Osun State University Health Research Ethics Committee (approval no. UNIOSUNHREC/2024/PBH/153). All participants gave informed consent and were informed of their right to withdraw at any time without penalty. Confidentiality and anonymity was maintained by using pseudonyms and secure storage of data.

During data collection, the interviews were conducted in a private setting, at a time and place convenient to the participant, and no facility staff or clients were present. Written informed consent was obtained separately from any contact details. Audio recordings and transcripts were labelled with study codes only, not participants’ names or exact facility names. Names and other identifying details were removed during translation and transcription, and field notes used codes rather than names. Audio files and transcripts were stored securely in password-protected, restricted-access files, with consent forms and the code-linkage log stored separately. Participants were reminded that they could decline any question or withdraw at any time without penalty.

During reporting, the participants were not identified by personal name or exact facility name. Quotations were attributed by cadre and ward-level label (for example, “Nurse, Oke-Baale”) rather than by name. We avoided reporting exact ages, dates, facility names, or rare personal details that could identify an individual, and member checking used summaries of findings rather than raw transcripts.

Results

Socio-demographic characteristics of the participants

A total of 12 healthcare workers participated. All twelve (100.0%) were women. Nurses were the largest cadre (n=7, 58.3%), followed by community health officers (n=3, 25.0%) and CHEWs (n=2, 16.7%). Seven participants (58.3%) were Christian and five (41.7%) were Muslim, broadly reflecting the religious composition of Osun State. Participants were drawn from all seven participating primary healthcare centres - six public and one private - and each had provided PAC within the six months preceding data collection. Seven participants (58.3%) had between two and nine years of professional experience and five (41.7%) had 10-20 years; the minimum eligibility criterion was two years in the current position.

Qualitative findings

The qualitative analysis yielded two major overarching categories: (1) Perception of healthcare workers, and (2) Barriers to PAC. Under each major heading, relevant themes and sub-themes are presented with illustrative verbatim quotations in tables.

Perception of Healthcare Workers

This major category covers the perception, feelings and thoughts of healthcare workers regarding PAC, such as their beliefs, comfort, and attitudes about the effect of providing PAC.

Theme 1: Moral and religious conflict: There was a great deal of conflict between the professionals' responsibility to care for the sick and their personal religious/cultural convictions. Some respondents indicated that their faith and cultural backgrounds did not support abortion and that this moral dilemma led to moral distress when providing PAC. However, for some employees, the ability to reconcile their values with their duty to care hinged on the provision of lifesaving care (Table 1).

Sub-theme	Quotation
Personal and cultural disapproval	"Culture also doesn't support it." (Nurse)
	"Whether legal, cultural, or personal, none supports it." (CHEW)
	"I do not like it." (Nurse)
	"It's as if one has done something wrong." (CHEW)
Reconciliation with professional duty	"We will save the life...I will not look at the fact that my religion, Christianity, my doctrine, does permit it." (Nurse)

TABLE 1: Quotes illustrating moral and religious conflict

In the tables presenting qualitative findings, each quotation is attributed to the participant's cadre and facility; CHEW, Community Health Extension Worker.

Theme 2: Level of convenience in providing PAC: Although the majority of respondents offered PAC services, they did not feel comfortable to do it. Reasons for offering care ranged from the prevention of patients from seeking care from an unqualified source to the obligation of the professional oath. Facilitators of PAC provision identified were institutional support and clear policy guidelines. Some healthcare workers were encouraged by the policies of the Osun State government that explicitly provided for PAC. Others showed no interest or reluctance (Table 2).

Sub-theme	Quotation
Motivations for providing care	"Not that I'm comfortable, I'm happy doing it." (CHEW,)
	"I like to care for them. Because if I don't care for them, if they go to non-experienced people, they can..." (Nurse)
	"Because if I don't take care of them, they would go to another place, which could be a quack." (Nurse)
	"So, I would say it is a legal something to help people with...post-abortion...complications... There is a policy backing it up that we should be doing it." (Nurse)
	"...so the policy is backing us, I have the backing of Osun State government." (CHEW)
Indifference or unwillingness	"If, for instance, abortion, the person intentionally did it, there is no need to care for the person." (Nurse)
	"Well, I just think that when we treat them, they may do it again..." (CHEW)
	"...when they come, we don't feel comfortable managing post abortion care, but we don't have a choice." (CHEW)
	"Someone who has had an abortion, I can't even take care of the person." (Nurse)

TABLE 2: Quotes illustrating level of convenience in providing post-abortion care

In the tables presenting qualitative findings, each quotation is attributed to the participant's cadre and facility; CHEW, Community Health Extension Worker.

Theme 3: Perceived impact of PAC availability in the community: All respondents collectively agreed that the availability of PAC services has been a positive addition to the community. They mentioned that it has helped to save the lives of residents in need of PAC, mainly due to the ease of access and assurance of safety from this care (Table 3).

Quotation
"Positively, you know, because they know if they abort, the health facility in the community is where they will go for treatment." (Nurse)
"It affects them in a good way, they receive good care, and they are out of unforeseen problems." (CHEW)
"I think it's perfect because one thing about community people is they feel free to come to a health centre..." (Nurse)

TABLE 3: Quotes illustrating perceived impact of post-abortion care availability in the community

In the tables presenting qualitative findings, each quotation is attributed to the participant's cadre and facility; CHEW, Community Health Extension Worker.

Barriers to PAC

This broad category refers to barriers for healthcare providers in providing PAC, such as legal concerns, lack of resources, stigma and systemic problems.

Uncertainty about Nigeria's abortion law and fear of arrest deterred some healthcare workers from providing PAC. Participants expressed concern that providing abortion-related care could result in legal consequences, particularly if complications arose. Stigma surrounding abortion led many patients to conceal their abortion history, presenting instead with symptoms such as heavy bleeding or abdominal pain. Healthcare workers also reported that patients often did not disclose the true cause of their symptoms and some healthcare workers also expressed judgmental attitudes towards patients, particularly young or unmarried women (Table 4).

Sub-theme	Quotation
Fear of arrest and legal consequences	"It will be more of legal because if anything bad happens, one will be arrested." (Nurse)
	"There might have been some damage that we do not know of. If we start working on it and there's an issue..." (Nurse)
	"Some might have used drugs that have damaged their intestines, while others might have complications from incomplete procedures." (Nurse)
Judgmental attitudes of providers	"...they tend to blame clients sometimes, even if they will still render the care." (Nurse)
Patient concealment	"Most of them will not say the truth, what they will tell you is that they are menstruating." (CHEW)
	"...we discovered she had an infection, she said she had abdominal pain." (CHEW)

TABLE 4: Quotes illustrating barriers to post-abortion care

In the tables presenting qualitative findings, each quotation is attributed to the participant's cadre and facility; CHEW, Community Health Extension Worker.

Recommendations for improving PAC services

Participants recommended training for all cadres of healthcare workers, provision of equipment, drugs, and consumables, financial support for patients, increased awareness of PAC availability, youth-friendly services, elimination of bureaucratic barriers, and enhanced family planning awareness (Table 5).

Quotation
"Possibility to train all skilled...other cadre can be trained." (CHEW)
"If there can be financial support to the health workers, so that they can render to the patient..." (Nurse)
"The first thing is to look for means of preventing unwanted pregnancy...counseling upon counseling on family planning to the youth." (CHEW)
"So, I will want them to make law, policy good one that will legalize post-abortion care that will remove the bottleneck being in fear of providing the care." (CHEW)
"Creating awareness and being youth-friendly." (Nurse)
"And also, a kind of awareness on...availability of family planning..." (Nurse)

TABLE 5: Quotes illustrating recommendations for improving post-abortion care services

In the tables presenting qualitative findings, each quotation is attributed to the participant's cadre and facility; CHEW, Community Health Extension Worker.

Discussion

This was a qualitative study that examined the perceptions of healthcare workers and barriers to them in offering PAC in Osogbo LGA of Nigeria. Analysis resulted in two broad categories: perceptions of healthcare workers and barriers to PAC. The three themes found under perceptions were: moral conflict and religious conflict, convenience of provision of PAC, and the perceived impacts of PAC provision in the community. Themes under barriers encompassed concerns regarding legal ramifications, stigma and patient concealment, and suggestions for the enhancement of PAC services. The results show a nuanced picture in which the healthcare worker is faced with various personal, professional, legal and institutional demands and pressures which are all competing for his or her attention whilst trying to deliver life-saving care.

Perception of healthcare workers

Moral and Religious Conflict

A central finding was the tension that arose between the professional duty to provide care and the personal religious and cultural beliefs. A significant number of healthcare workers reported a conflict between their

religious and cultural values and abortion, which led to moral distress when considering providing PAC. This is similar to findings from Ethiopia, where healthcare providers found themselves in a "moral dilemma" of managing the tension between competing moral norms and demands of their profession and were engaged in continuous negotiation among such competing norms throughout their service [16]. The notion of moral residue - after experiencing stress when acting against their strong moral convictions - may account for the distress some providers reported [17]. This is significant to the health and retention of providers. Healthcare workers can suffer from chronic moral distress, which can contribute to the development of burnout, compassion fatigue or avoidant behaviours that can impact the quality of their care provision and/or prompt them to exit the PAC provision [11]. Institutions need to therefore be aware of and respond to the psychological impact of moral distress, including through provision of supportive supervision, ethical debriefings and mental health support.

However, for certain workers, the mix of faith and work was manageable, and the primary concern was to save lives. This is in line with the ethical principle of beneficence and a professional duty to render emergency care in spite of beliefs. Similar responses are reported with healthcare providers in other restrictive contexts, where providers portray PAC as a life-saving emergency service as opposed to abortion [18]. This mental shift seems to be one of the strategies that helps providers to provide services while being uncomfortable with the moral issues. Learning about how some providers managed to navigate this tension successfully, compared to other providers who did not, could inform targeted interventions to support those providers who have a moral conflict.

Motivation and Reluctance in Providing PAC

Findings showed that many healthcare providers were uncomfortable yet provided PAC, which demonstrates a complex understanding of provider motivation. Reasons for providing care were to avoid patients seeking care from unqualified providers, and to adhere to professional codes of conduct. This is consistent with the Nigerian findings that PAC providers are not perceived to be stigmatised like abortion providers but are regarded as "lifesavers" [9]. The separation of abortion care from PAC seems to allow PAC providers to balance their moral concerns with their work duties. Providers' readiness to offer PAC despite discomfort indicates that they understand the life-saving nature of PAC and are driven by the welfare of patients.

It is important to note that institutional support and clear policy guidelines were found to facilitate PAC provision. Some healthcare workers expressed confidence in the policies of the Osun State government which explicitly endorsed PAC [19]. This discovery shows how policy efforts at the state and facility level can address legal concerns and enhance PAC access. Consistent results have been reported in other contexts where providers were able to provide services without fear because clear guidelines and institutional support were available [20]. However, the finding that others showed no interest or reluctance suggests that policy support alone is insufficient to address deeply held moral objections. Legally robust guidelines, distributed openly and clearly to set out the legal boundaries of PAC provision, are vital to minimise the uncertainty surrounding provision, but should go alongside efforts to tackle the moral and cultural barriers at the heart of provider attitudes.

The distaste shown by some providers such as the feeling that women who chose to have an abortion do not deserve to be treated or that treatment may make future abortions more likely, does indicate the persistence of judgmental attitudes which may discourage women from seeking timely treatment. This is in line with the study that found negative attitudes of the providers to be a critical barrier to PAC access [11]. The presence of such attitudes highlights the importance of interventions that tackle more than knowledge and skills, but also the moral judgements that influence provider behaviour.

Perceived Impact of PAC Availability in the Community

All respondents stated that the PAC services have been a positive attribute to the community and that they have saved lives and made care more accessible. This is a positive attitude that is encouraging and indicates that the healthcare workers are aware of the importance of PAC in the public health. It also shows that people from the community are comfortable using services at their local health centre, a key factor in minimising delays in seeking treatment. The result is consistent with the result of the study conducted in Nigeria which concluded that the establishment of PAC services in facilities is one of the ways of reducing maternal morbidity and mortality because women can easily access them close to their residence [8]. The good image of PAC availability could be used as a basis for development of PAC services and quality improvement because PAC providers are already convinced of the value of their services. The finding also implies that community awareness campaigns and engagement with the community can leverage current trust in health facilities to further enhance access to PAC.

Barriers to PAC

Fear of Legal Implications

Lack of awareness of potential legal consequences was one major impediment to PAC provision. The

abortion law in Nigeria makes it unclear and unconfident for providers, because they can only provide abortions to save the life of the woman [8]. The assurance of some providers to the effect that they were feeling good about policies by the Osun State government underlines the need for clear and explicit policy statements to ensure that providers feel protected if they provide PAC in good faith. If this is not done, fears of prosecution will persist, and providers will resist providing necessary services. The fact that some providers were concerned about possible issues - including damage they may not know about - further highlights the concerns that come with providing PAC in a legally limiting environment. This help needs not only policy clarity but legal protections and institutional support of the providers as well to combat these fears.

The legal position is more permissive than participants assumed. The Federal Ministry of Health's National Guidelines on Safe Termination of Pregnancy for Legal Indications (2018) confirm that abortion may lawfully be performed to save a woman's life and set out the medical indications [19]. The same guidelines note that "health providers are unaware that there are medical indications that allow therapeutic abortions to be performed to save a woman's life," which anticipates the perception gap documented here [21]. The Nigeria Best Practice Paper on Post-Abortion Care sets out the essential elements for evidence-based PAC and is explicitly adapted from WHO guidance [22]. At the international level, the WHO Abortion Care Guideline states that "regardless of whether abortion is legal, States are required to ensure access to post-abortion care where it is needed," and that such care must be available "without the threat of criminal prosecution or punitive measures" [22]. PAC is therefore best understood not as a legally tolerated exception to the abortion prohibition but as a separate, lawful and clinically mandated component of emergency obstetric care. Their uncertainty was therefore interpretive rather than textual, a reasonable response to an unclear policy environment rather than a misreading of a clear statute.

The Osun State policy picture is similarly more supportive than participants' accounts suggest. The state government unveiled a policy document on safe termination of pregnancy and its legal indications in December 2023, explicitly intended to "build the capacity of medical professionals to identify pregnancies for which the law is intended so that ethical and safe management can be instituted" [19]. Participants who cited Osun State policy as protective were therefore closer to the formal position than those who feared arrest, which reinforces the interpretation that the difference lies in awareness and communication rather than in the law itself.

Stigma and Patient Concealment

Many patients hid their abortion, and their symptoms were vague, like abdominal pain or heavy bleeding, due to the stigma associated with abortion. This is similar to the findings from Nigeria and other contexts where stigma pushes women towards receiving care from unqualified providers or to postpone care until complications are severe [9,18]. The concealment of abortion history likely has important clinical implications, because it can result in misdiagnosis, delayed treatment, and poor outcomes. Judgmental attitudes of healthcare workers towards patients, especially young or unmarried women, can also act as a barrier to seeking care and perpetuate the cycle of concealment and delayed presentation. Some providers' responses of pointing fingers at their clients in the midst of care delivery services points to the possible presence of interpersonal stigma and that it can happen even among people delivering services [12]. Stigma is multi-level, from intrapersonal to interpersonal, institutional, community, to policy, and interventions should target all these levels [18]. Interpersonally, provider education needs to involve stigma reduction methods. There should be privacy and confidentiality at the institutional level. Community-level awareness-raising campaigns may be used to normalise PAC as a lifesaving intervention.

Recommendations made by participants for improving PAC services

It was recommended that all cadres of healthcare workers be trained, provision of equipment, drugs and consumables, financial support for patients, increased awareness of the availability of PAC, provision of youth-friendly services, removal of bureaucratic barriers and enhancement of awareness of family planning. The following recommendations are consistent with WHO recommendations for comprehensive PAC [22] and are consistent with the multi-level barriers identified in this study. It is strongly recommended that all cadres should be trained, which was highlighted by this study as many healthcare workers were not formally trained in PAC. Recommendation for financial support for patients reflects the fact that many patients were not able to cover costs, similar to a recent study in Osun State which reported high service cost as one of the barriers to quality PAC [23]. Reduction of financial barriers by providing health insurance coverage or affordable services is necessary to have equitable access to services. The call for "youth-friendly services" is designed to respond to the unique stigmas and barriers to seeking PAC that youth experience. The elimination of bureaucratic barriers and legalisation of PAC, as recommended, was due to the fact that providers were frightened of legal consequences. Improved family planning services (as suggested by participants) can help to prevent unintended pregnancies and abortion, which is the underlying cause of many PAC needs.

Synthesis: where perceptions and barriers collide

Results indicate a complex relationship between the perception of healthcare workers and barriers.

Providers' willingness to provide care is influenced by moral and religious conflict, and fear of legal consequences contributes to structural barriers to providers' ability to provide care. Stigma has multiple dimensions and is felt by both providers and patients, while encouraging to mask and to delay treatment. This positive perception of PAC availability in the community can serve as a basis for growing the services but this will only be realised if the identified barriers in this study are overcome. The socio-ecological model offers a framework for understanding these intersections, by emphasising the interactions among intrapersonal, interpersonal, institutional, community, and policy factors in shaping PAC provision. It is therefore important to intervene on more than one level at the same time and not one level at a time. The recommendations made by participants - training, resources, financial support, awareness, youth-friendly services, legal reform, and family planning - are multi-level in nature, and provide a blueprint for action.

Implications for policy and practice

The findings have the following specific implications for policy and practice in Nigeria that can be acted upon. First, comprehensive PAC training needs to be incorporated into pre-service and in-service curricula for all health cadres. Second, clear legal rules and frameworks need to be established and communicated to all healthcare workers regarding the provision of PAC, defining the situations in which it is allowed and the safeguards for providers that act in good faith. The Osun State government should make specific policy declarations that explicitly allow for PAC, and that providers will not be prosecuted for providing life-saving care. Thirdly, stigma reduction interventions should be done at multiple levels: provider trainings, community awareness building, and policy advocacy to decriminalise abortion.

Strengths and limitations

There are numerous strengths in this study. The qualitative design facilitated the in-depth exploration of healthcare workers' experience and perceptions, which may have been overlooked by quantitative approaches. Key informant interviews allowed for the provision of rich, contextualised data where participants were able to voice their experiences in their own words. Different cadres (nurses, CHEWs, and Community Health Officers) represented a range of views and experiences. This was an iterative sampling procedure which was continued until data saturation was reached, thus making for comprehensive coverage of the phenomenon studied. To increase the trustworthiness, member checking, peer de-briefing, and independent coding by two researchers were applied.

The study had some limitations. The study was done in one LGA; therefore, it may not be generalisable to other LGAs in Nigeria that have different cultural, religious, and health system settings. There is also possibility of social desirability bias due to the sensitive nature of abortion. To reduce this bias: interviews were conducted privately, confidentiality and the use of pseudonyms were explained before consent, participants were assured that neither individuals nor facilities would be identified, and probes asked about discomfort and difficulty as well as about willingness.

Conclusions

This qualitative study aimed to examine the perceptions and barriers of healthcare workers in providing PAC in Osogbo community, Nigeria. Providers are faced with moral dilemmas, legal issues, lack of training, and stigma, although many do not walk away from providing life-saving care. There is a nexus between perceptions and barriers: moral and religious conflicts affect willingness to provide care, while legal constraints and resource limitations create structural barriers.

Solving these challenges will take a multi-faceted strategy, including general training, well-defined legislation, institutional assistance, reducing stigma, and policy changes. Existing community acceptance of access to PAC sets the stage for further expansion of services, if barriers, where identified, are tackled in a systematic way.

All stakeholders, including policymakers, facility managers, training institutions, and researchers, have important responsibilities to establish an enabling environment for the provision of PAC that respects women's rights to life-saving care as well as the providers' conscience objections. Further research should include medical doctors and other health cadres. In addition, there is a need to explore the experiences of women who seek PAC and evaluate the effectiveness of multi-level interventions to enhance access and quality of PAC in Nigeria.

Additional Information

Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the

work.

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Disclosures

Human subjects: Informed consent for treatment and open access publication was obtained or waived by all participants in this study. Osun State University Health Research Ethics Committee issued approval UNIOSUNHREC/2024/PBH/153. **Animal subjects:** All authors have confirmed that this study did not involve animal subjects or tissue. **Conflicts of interest:** In compliance with the ICMJE uniform disclosure form, all authors declare the following: **Payment/services info:** All authors have declared that no financial support was received from any organization for the submitted work. **Financial relationships:** All authors have declared that they have no financial relationships at present or within the previous three years with any organizations that might have an interest in the submitted work. **Other relationships:** All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

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