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Women's experiences of post-abortion care services at health facilities in Somaliland – A qualitative study among women with incomplete abortion

Umulkhayr Mohamed Ismail [a,b], Fatumo Osman [c], Marie Klingberg-Allvin [d,c], Jama Ali Egal [a,e,*]

[a] Faculty of Nursing and Midwifery, University of Hargeisa, College of Medicine and Health Sciences, Somaliland
[b] Research Center, Hargeisa Group Hospital, Somaliland
[c] School of Health and Welfare, Dalarna University, Falun, Sweden
[d] Department of Women and Children's Health, Karolinska Institutet, Solna, Sweden
[e] Midwifery Department, Birmingham City University, Birmingham, United Kingdom

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ABSTRACT

Objective: Somaliland faces one of the highest maternal mortality and morbidity rates globally. Access to high-quality post-abortion care is essential for managing complications arising from incomplete abortions, including those following miscarriages. This study aimed to explore women's experiences of incomplete abortion and their encounters with Post abortion care (PAC) services in public healthcare facilities.

Methodology: An inductive qualitative design was employed. In-depth interviews were conducted with women who had experienced incomplete abortions and received PAC. Data were analysed using thematic analysis guided by an inductive approach.

Results: Two key themes emerged from the analysis:(i) Women's understanding of incomplete abortion and barriers to accessing PAC – This theme explores women's care seeking and perceptions of causes of miscarriage, the challenges faced in accessing PAC, and the enabling factors that supported their care-seeking behaviour. (ii) Perceptions of care quality and suggestions for improvement – This theme captures women's experiences with the quality and accessibility of PAC services and their recommendations for improving service delivery.

Conclusions: The study highlights the vital role of family and friend in encouraging women to seek care. However, it reveals significant gaps, particularly in counselling, community awareness, and emergency care. Many women reported continued pain and bleeding after discharge, indicating the need for service improvement. Further quantitative research is needed to assess the capacity of health facilities to deliver comprehensive PAC. The Health authority and policy maker should support further research and increase investment in midwifery training and continuous professional development to improve access to and quality of PAC.

Introduction

Globally, an estimated 230 million women become pregnant each year, and approximately 31 million of these pregnancies end in spontaneous abortion [1]. Between 2015 and 2019, around 73.3 million induced abortions occurred annually worldwide, with approximately 8 million taking place in sub-Saharan Africa. Alarmingly, 45.1 % of global abortions are classified as unsafe, and the African region accounts for the highest proportion, with 75.6 % considered unsafe [2]. Incomplete abortion—where not all products of conception are expelled from the uterus—is often marked by an open cervical os and vaginal bleeding. It may result from both spontaneous and induced abortions and is typically managed either medically, using misoprostol, or surgically, through manual vacuum aspiration (MVA) or, in some settings, dilatation and curettage (D&C) [3].

Abortion is one of the leading contributors to the high maternal mortality rates (MMRs) in sub-Saharan Africa. Unsafe abortions, often driven by social barriers such as stigma, negative attitudes of healthcare providers, and conscientious objection, are a major concernAdde et al. [4]. Studies indicate that 97 % of abortions in sub-Saharan Africa are unsafe, contributing to 9 % of all maternal deaths in the region. An estimated 1.6 million women are hospitalized each year due to

* Corresponding author at: Faculty of Nursing and Midwifery, University of Hargeisa, College of Medicine and Health Sciences, Somaliland
E-mail addresses: fos@du.se (F. Osman), marie.klingberg-allvin@ki.se (M. Klingberg-Allvin), jama.egal@bcu.ac.uk (J.A. Egal).

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complications from unsafe abortions. A study in Uganda found that the need for confidentiality, privacy, and the lack of financial resources often leads women to delay care and resort to unsafe methods of abortion[5]. To prevent maternal deaths, improving access to life-saving interventions—such as post-abortion care (PAC), family planning, and reproductive health services—is critical.

Post-abortion care (PAC) is a comprehensive service model designed to manage complications arising from both spontaneous and induced abortions. According to the United States Agency for International Development (USAID), PAC includes three core components: (1) emergency treatment of abortion-related complications such as haemorrhage, shock, sepsis, and uterine injury; (2) family planning counselling and the provision of reproductive health services, including HIV/STI management; and (3) community engagement through awareness and mobilization activities aimed at empowering women and their communities (Carolyn et al., 2007).

Several African countries have made strides in integrating PAC into their health systems. For instance, Ghana introduced a national PAC policy in 2003 to reduce abortion-related maternal mortality and morbidity. Despite this, abortion remains a key contributor to maternal deaths in the country. Similarly, Ethiopia implemented technical and procedural guidelines in 2006 to enhance safe abortion access and maternal health outcomes. As a result, approximately 96 % of abortions were carried out under safe conditions, with an emphasis on expanding services through mid-level provider training. While service quality and access have improved significantly, challenges persist in ensuring comprehensive abortion care in certain regions.

In contrast, Somaliland—a self-declared republic that gained de facto independence from Somalia in 1991—faces considerable barriers to PAC access. With an estimated population of 4.2 million in 2020, Somaliland continues to record some of the highest maternal mortality ratios in the world, at approximately 732 deaths per 100,000 live births (WHO, 2014). Obstetric haemorrhage accounts for 32 % of maternal deaths in the country [6]. Despite ongoing efforts by the government to rebuild and strengthen the healthcare system post-civil war, major challenges remain. These include limited infrastructure, a shortage of skilled health professionals, financial constraints, and a fragmented health system.

In Somaliland, induced abortion is strictly prohibited by law, with exceptions made only to save the life of the mother. Furthermore, consent from the husband or a male guardian is often required for emergency interventions. Pregnancies outside of legal marriage are criminalized, and women may face social consequences such as rejection, discrimination, or forced marriage [7]. These cultural and legal restrictions make access to PAC—especially for rural women—exceptionally difficult, often leading to life-threatening complications following incomplete abortions.

Given this context, the current study aimed to explore women's experiences of incomplete abortion and their encounters with PAC services in public healthcare facilities in urban areas of Somaliland. It further investigates the sequence of events surrounding their pregnancies, the barriers they faced in accessing care, and their perspectives on how PAC services can be improved.

Materials and methods

This study employed an inductive qualitative research design using in-depth interviews (IDIs) to explore women's experiences of miscarriage and their encounters with post-abortion care (PAC) services. The research was conducted in Hargeisa, the capital city of Somaliland, and focused on urban healthcare facilities that provide maternal health services, including PAC.

Participants were recruited from Hargeisa Group Hospital, the national referral and teaching hospital in Somaliland, which houses emergency obstetrics and gynecology wards offering PAC services. Purposive sampling was used to select participants who had received PAC at this facility [8]. Inclusion criteria were as follows: (1) women admitted for incomplete abortion within the past six months, (2) women of reproductive age, and (3) women who had received PAC. Eligible participants were approached, provided with both oral and written information about the study, and asked to sign informed consent forms. Interviews were arranged at a mutually convenient time and location. Twenty participants were initially identified from hospital medical records based on the inclusion criteria, and 14 women ultimately agreed to participate in the study. Data collection took place from January to March 2022 and was conducted by the first author. A semi-structured interview guide with open-ended questions were developed and reviewed by the Authors, subsequently two pilot interviews were conducted to refine the tool and no revisions were considered necessary. The participants selected the interview locations based on their convenience, either at home or in the hospital. Fourteen interviews were conducted in Somali, with eleven held in person and three conducted via telephone due to participants' remote locations. Interviews lasted between 30 min and 1 h and 16 min. All interviews were audio-recorded, transcribed verbatim by the first author, and subsequently translated into English (Creswell, 2013). The audio-recorded interviews were transcribed word by word by first and last author and were analysed manually using an inductive thematic analysis approach [9]. The analysis began concurrently with transcription. Transcripts were read multiple times for immersion and initial familiarity by the research team four times to ensure the research team felt the themes addressed and represented the data accurately. Text relevant to the study aim was extracted, condensed, and coded. The codes were then translated into English, grouped into sub-themes based on content similarity, and further organized into overarching themes. A main theme and related sub-themes were identified. The methods, analysis process and findings were rechecked by all the authors to ensure credibility and consistency. Participant quotes were included the findings to support the emerge themes. Presented in Table 2.

Results

Socio-demographic background and reproductive history of the respondents

Six participants were in their 20 s, while eight were between the ages of 31 and 40. In terms of education, three participants had tertiary-level education, one attended Quranic school, one received vocational training, and nine were illiterate. All participants were married, though two were separated from their spouses at the time of the study. Ten women had undergone type-3 female genital mutilation (FGM), while four had experienced type-2 FGM. Regarding obstetric history, ten participants had experienced one miscarriage, two had two miscarriages, and two had experienced three or more (Table 1).

Themes and subthemes identified

Two main themes emerged from the data analysis: (i) Women's perspectives on understanding incomplete abortion and the barriers to accessing PAC services – This theme explores women's care seeking after miscarriage, women's perception of the causes of miscarriage, primary and secondary barriers of PAC the experience of incomplete abortion. It also highlights the enabling factors that supported their care-seeking journeys. (ii) Perceptions of the quality of care received and suggestions for improving PAC – This theme captures women's experiences with the quality and accessibility of PAC services and includes their recommendations for enhancing service delivery. These themes, along with their corresponding sub-themes, are presented in more detail in Table 2.

Table 1
Socio-demographic background and reproductive history of the respondents (n = 14).

Respondents	Number ($N = 14$)
Age (years)	
a. 20–30	6
b. 31–40	8
c. 41–51	0
Marital status	
a. Married	12
b. Separated	2
c. Widowed	0
Education	
a. Primary	0
b. Secondary	0
c. University	3
d. Illiterate	9
e. Vocational training	1
f. Quran school	1
Occupation	
a. Formal employment	3
b. Informal employment	3
c. Housewife	8
Current resident	
a. Rural	3
b. Urban	11
Parity	
a. 0	1
b. 1	0
c. 2 or more	13
Number of abortions	
a. 1	10
b. 2	2
c. 3 or more	2
Gestational age of current pregnancy (weeks)	
a. 1st trimester	14
b. 2nd trimester	0
c. 3rd trimester	0
Incomplete abortion treatment	
a. Medication	4
b. Surgical	6
c. Both	2
e. No intervention	2
Female genital mutilation type	
a. Type 1 (Sunni without stitches)	0
b. Type 2 (Sunni with stiches)	4
c. Type 3 (infibulation)	10

Table 2
Themes and subthemes emerged from the results.

Women's Experiences of Post-abortion Care Services in Somaliland	Women's Perspective on Seeking PAC	Women's care seeking after miscarriage Women's perception of the causes of miscarriage Primary and secondary barriers of PAC Enabling factors to seek care
	Women's perception of quality of care	Women's experiences of quality and access to care Women's recommendations for improving post-abortion care

Women's perspectives on understanding incomplete abortion and barriers to accessing PAC services

This theme encompasses four related sub-themes: women's care seeking after miscarriage, women's perception of the causes of miscarriage, p*rimary and secondary barriers to post-abortion care (PAC)*, and *Enabling factors that support women in seeking PAC.*

Women's care seeking after miscarriage

Participants described various reasons that prompted them to seek care following symptoms indicative of a miscarriage. Most women reported seeking medical attention only when symptoms became severe. A common understanding among participants was that vaginal bleeding is a sign of miscarriage, prompting concern for their pregnancy and motivating them to seek care.

"The reason I came to the hospital was heavy bleeding and pain, which felt like labour pains."

(PAC client, 36 years old).

Another participant added:

"When the bleeding didn't stop, and became heavier, I started feeling dizziness and decided to go the hospital." *(PAC client, 30 years old)*.

Women's perception of the causes of miscarriage

All participants had experienced miscarriages and attributed them to various causes. Many believed that strenuous physical activity, such as household chores and heavy lifting, contributed to the miscarriage.

"As we all know, every mother works at home and lifts heavy things. In this pregnancy, I lifted a 20-litre jerrycan of water, and shortly after, the bleeding started… In my previous miscarriages, it also happened after I lifted water I had fetched." *(PAC client, 33 years old)*.

Some participants also believed that breastfeeding during early pregnancy could result in miscarriage:

"I had a miscarriage before my sixth child. I was 16 weeks pregnant and breastfeeding my other child. Some people say that being pregnant and breastfeeding at the same time can cause a miscarriage." *(PAC client, 39 years old)*.

Primary and secondary barriers to PAC

Participants identified multiple barriers to accessing PAC, which were categorized as primary barriers—faced before reaching a health facility—and secondary barriers—encountered within the facility.

Primary barriers included financial hardship, reliance on herbal remedies, and consulting traditional birth attendants (TBAs). Several women mentioned that the lack of financial support prevented them from seeking timely medical care.

"I didn't go to the hospital when I was bleeding because I had no money. My husband doesn't help with expenses. I make money by selling food on the street to support the family. I couldn't afford to go." *(PAC client, 29 years old)*.

Some participants shared insights into cultural practices used to manage bleeding before seeking professional healthcare. These included ingesting traditional herbs believed to expel the contents of the uterus without medical assistance. Commonly mentioned substances included sheep fat (*badhi*), fenugreek seeds (*xulbad*), honey, papaya, myrrh, and *tiiro*.

"I never tried it, but in the community, they say you can use sheep fat and fenugreek seeds to clear the uterus." *(PAC client, 30 years old)*.

Traditional methods were particularly common in cases of pregnancies outside marriage, which are considered illegal. In such situations, women face significant social stigma and sometimes resort to unsafe practices:

"One of my neighbours had an illegal pregnancy. Her mother knew, and they tried many methods—like *badhi* and *tiiro*—to induce an abortion, which eventually ended the pregnancy."

(PAC client, 39 years old)

Some women also reported unsafe abortion practices performed by TBAs, particularly in cases of illegal pregnancies. These methods sometimes led to serious health complications and delayed access to formal healthcare.

"Once, while I was working at a private hospital, a 17-year-old girl came in with heavy bleeding. She had gone to a TBA who inserted a metal object to open her cervix. She had lacerations and an infection in her cervix and vagina, and the TBA didn't even manage to terminate the pregnancy." *(PAC client, 26 years old)*.

To collaborate the above quote, another participant state

"Some women visited went to the TBA's to induce their pregnancy (illegal

pregnancy) at home. When the complication arises, they usually taken to the hospitals, but they never disclosed what methods the TBA used." (PAC client, 27yrs).

Secondary barriers were experienced within health facilities and contributed to further delays in receiving PAC. Decision-making authority often lay with male relatives, particularly husbands, which limited women's autonomy in seeking care.

"At first, they tried to call my husband, but he didn't answer. Then they sent his uncle to inform him. He came around 3 p.m. and signed the consent form. Only then did they admit me to the induction room." *(PAC client, 39 years old)*.

Some women described being denied treatment until their husband's consent was obtained:

"The doctor told me they couldn't do anything without my husband's consent." *(PAC client, 27 years old)*.

Participants also highlighted the lack of supportive care in the hospital. Many described navigating the facility alone—completing admissions, visiting the lab, and returning to the ward—despite experiencing pain and emotional distress.

"I had no support from my family. My husband came to sign the consent form and left. I went to the lab for blood tests and returned to the ward on my own. There was no one to help me."

(PAC client, 36 years old).

Enabling factors to seek post-abortion care

Despite the barriers, women identified several enabling factors that supported their access to care. Family members, particularly husbands, as well as friends and neighbours, played a key role in encouraging care-seeking and providing emotional and logistical support.

"It was my husband's decision to go to the hospital when I was bleeding. I told him I didn't need to because I thought the fetus had already been expelled, but he insisted." *(PAC client, 30 years old)*.

Participants also emphasized the importance of social support from female peers and community members:

"I only told my neighbour about what happened. I trusted her because she's a woman, and we can share these things." *(PAC client, 33 years old)*.

Another participant added:

"I confided in a woman who was my neighbour because I felt that, as women, we could share these experiences with one another, and she encourage me to go the hospital." *(PAC client, 30 years old)*.

Perceptions of the quality of care received and suggestions for improving post abortion care

This theme explores women's perceptions of the quality of post-abortion care (PAC) based on their direct experiences. Two subthemes emerged: (i) *Women's experiences of the quality of PAC,* and (ii) *Women's recommendations for improving PAC*.Each is presented below with supporting quotations from participants.

Women's experiences of the quality of post-abortion Care

Many participants felt that the care they received was ineffective and incomplete, as they continued to experience bleeding even after discharge. Several women also highlighted key factors that influenced the quality of care they received.

"From the day I was discharged until now, I've been bleeding. Although it's not heavy, it has continued for a week and has a foul smell. I'm still taking the medication they prescribed."

(PAC client, 30 years old).

Another participant added:

"They gave me medication (misoprostol) for three days, but I saw no improvement—the fetus was still in the sac. Whenever the bleeding stopped, it would start again. The doctors couldn't explain the cause, nor did they offer any alternative advice or solutions."

(PAC client, 29 years old).

Women also spoke about inequities in the quality of care they received, which they believed were tied to their socio-economic status. Education and income were described as major determinants of how they were treated by healthcare professionals.

"I'm an educated person and I can afford to pay for services. I asked a lot of questions and received detailed information, so I got good care. But an uneducated mother who lacks money won't get the same level of care. Whether it's a public or private facility—if you're educated and have money, they treat you better." *(PAC client, 38 years old)*.

Many participants reported a lack of respectful maternity care, which includes being informed about their diagnosis and treatment options, being asked for consent before procedures, receiving pain relief, and getting appropriate follow-up care.

"During my third miscarriage, they performed a D&C without giving me any pain relief. I felt every part of the procedure. Even now, as I talk about it, I can still hear the sound of the instruments in my head—it was traumatizing."

(PAC client, 38 years old).

Women also noted that family planning counselling and other critical components of PAC were often absent, affecting both their recovery and mental wellbeing.

"I believe women get the first phase of care—emergency treatment. But the rest, like counselling, managing underlying conditions, and giving supplements, is missing. There's a long way to go. I think this is because staff are not adequately trained and don't have time to offer proper counselling." *(PAC client, 26 years old)*.

Women's recommendations for improving post-abortion care

Participants shared several suggestions to improve the availability, accessibility, and quality of PAC, especially for women living in rural areas and those from low-income or low-education backgrounds. They recommended that health authorities:

One participant summarized these recommendations

"I would suggest building places that offer emergency care like dilatation and curettage (D&C), deliveries, and postpartum haemorrhage management. These centers should also train MCH staff in managing abortion cases and provide services free of charge—or supported by the government or NGOs—for women who can't afford to pay. Healthcare providers should also offer advice to mothers, because they know more than we do." *(PAC client, 33 years old)*.

Discussion

The main finding from the study is that women in Somaliland face significant structural, cultural, and systemic barriers to accessing and receiving quality post-abortion care (PAC), which limits their understanding and delays their care seeking. Primary and secondary barriers to care seeking were identified and despite these challenges, social support—especially from family and community members—acts as an enabling factor for care-seeking. Women also report inequities in care based on socio-economic status, and they recommend comprehensive improvements to PAC services, including respectful care, better infrastructure, trained staff, and free or subsidized services for vulnerable groups. The core insights are discussed below.

The findings reveal that women faced primary barriers that caused a delay in their care seeking which consist of financial hardship, reliance on TBAs and traditional medicines due to fear of stigma. Many women seek care only after symptoms worsen as they are fearing the loss of their baby. Many participants had misconceptions about causes of miscarriage attributed miscarriages to strenuous physical activity, excessive household chores, or breastfeeding during pregnancy. These findings align with previous research indicating that physical strain and exclusive breastfeeding during pregnancy are perceived or potential risk factors for miscarriage. This highlights the need to incorporate education on miscarriage causes and early warning signs into antenatal care (ANC) services in Somaliland.

Despite the importance of skilled obstetric care, the majority of women in Somaliland still give birth at home with the assistance of traditional birth attendants (TBAs). Over 70 % of women avoid health facilities due to fears of mistreatment, discomfort, and poor quality of care (Egal et al., 2022). TBAs, although accessible and culturally accepted, may contribute to delays in care-seeking through the use of ineffective or harmful traditional remedies. This study found that women often turn to herbal treatments such as sheep fat and *tiiro*, which can delay critical interventions. In some cases, TBAs performed dangerous procedures that resulted in complications. A related study noted that myrrh is sometimes used to stimulate the uterus and treat incomplete abortion, yet its safety and efficacy remain questionable. The use of such remedies reflects the broader issue of unsafe abortion practices in a context where induced abortion is illegal and highly culturally stigmatized, especially around pregnancies outside of marriage which leads some women to use unsafe abortion methods.

Consistent with findings from other countries such as South Africa, women in Somaliland may seek traditional or herbal methods to induce abortion in order to avoid social stigma, maintain privacy, or protect themselves from mistreatment in health facilities [10]. Additionally, poverty was identified as a significant barrier to accessing PAC. Financial constraints pushed women to delay seeking care or resort to cheaper, potentially harmful alternatives. This is supported by findings from Uganda, where lack of financial resources hindered timely access to PAC services [11].

A particularly concerning finding from this study was that women were often denied care unless accompanied by a husband or male relative who could provide consent. This finding was identified as a secondary barrier facing women while in the health facilities where they faced lack of autonomy, poor support from the facility where they were left to navigate the system alone while in pain. This aligns with studies from Somaliland and Afghanistan, where emergency procedures like caesarean sections were delayed due to the absence of male authorization Kiruja et al., 2022; [12]. These findings highlight how patriarchal norms and legal structures limit women's autonomy and delay access to life-saving care. Efforts to improve PAC must therefore include community education targeting men, who often hold decision-making power in such contexts.

Despite these challenges, women in this study also identified enabling factors. Support from partners, female relatives, and neighbours encouraged women to seek care, particularly through shared experiences of miscarriage. These findings echo those of Adde et al. [4], which found that emotional and informational support from family members facilitated care-seeking after miscarriage. Strengthening community-level awareness and providing counselling prior to discharge could help build networks of support and improve early access to PAC.

While PAC is a recognized component of essential maternal health care, access to high-quality services remains inequitable and women highlighted poor quality of care. Women in this study reported incomplete care, continued bleeding and lack of clear communication and follow up, which are two of the five core components of PAC. In addition, lack of respectful maternity care including absence of pain management, informed consent and counselling services. Notably, several participants reported undergoing dilation and curettage (D&C) procedures without any form of pain relief. This reflects findings from a multi-country study in Africa, where 62 % of women experienced at least one negative aspect of PAC and 13 % received no pain management. Developing and enforcing pain management protocols is essential for ensuring respectful and humane care during PAC procedures.

Another significant gap identified in this study was the lack of counselling, particularly around family planning and post-procedure care. This is consistent with research by Baynes et al. [13], where women described poor counselling and inadequate information following abortion care. Without adequate counselling, women are left uninformed about risks, follow-up, and contraceptive options, limiting the preventive potential of PAC services.

Socioeconomic inequalities shape the quality of care received, where educated and wealthier women report experiencing better treatment. Similar findings have been reported in the United States, where resource-constrained individuals were more likely to face obstacles to accessing abortion care[14]. Some women in this study reported persistent bleeding even after being discharged, suggesting incomplete treatment—often attributed to understaffed facilities, lack of trained personnel, and overreliance on physicians for PAC provision.

Women's recommendations for PAC improvement includes expanding the scope of practice to include midwives, who are often more accessible and capable of managing PAC, more facilities especially in rural areas which are free or low cost for the women. Evidence shows that trained midwives are equally competent as physicians in diagnosing and treating incomplete abortion using misoprostol in both the first and second trimesters. Involving midwives through structured pre-service and in-service training and providing them with better equipment could improve service availability and reduce provider workload while maintaining quality.

Furthermore, there is a need to strengthen both primary and tertiary care facilities to ensure essential PAC services are available and accessible. Owolabi et al. [15] identified significant gaps between service availability and system capacity across sub-Saharan Africa. Although PAC is considered a basic midwifery competency, limitations in Somaliland's legal and regulatory frameworks, coupled with cultural and gender-related barriers, restrict midwives from fully exercising their roles [16,17].

To improve PAC services in Somaliland, policy makers need to develop clear scope of practice for PAC providers, address gender-based professional limitations. Reinforcing respectful maternity care (RMC) principles within midwifery and broader healthcare provider training is essential for improving women's experiences and health outcomes. Also, a stronger focus on patient-centred care, the inclusion of family planning counselling and the establishment of an emergency phone line would improve PAC in Somaliland.

Strength and limitation

Credibility: This study involves women with incomplete abortions following miscarriage which a fundamental strength of this study. Asking women to share personal abortion experiences was challenging as they were asked to recall a difficult experience in their lives. Therefore, it was vital to ensure the interviews were conducted post-discharge to minimize distress. *Transferability:* the study findings align with those similar researches in the field, reinforcing dependability through consistent results. *Confirmability:* The data were collected but not analysed solely by the main author to reduce bias, henceforth the results were checked multiple times by research team before analysis was completed.

Conclusions

This study highlights the crucial role that family members, friends, and neighbours play in supporting and encouraging women to seek post-abortion care (PAC) in Somaliland. However, it also reveals significant gaps in the quality of care provided. Essential components of PAC, such as counselling and community awareness, are largely absent, and emergency treatment remains inadequate—often resulting in continued pain and bleeding after discharge. To enhance women's experiences and outcomes, further quantitative research is needed to evaluate the capacity of health facilities to deliver comprehensive PAC services. The health authority and policy maker should support further research and increase investment in PAC providers to improve access to and quality of PAC. Additionally, empowering midwives to lead the provision of PAC at both primary and referral health facilities is critical to ensuring accessible, high-quality care for all women in Somaliland.

Ethical approval

Ethical clearance was obtained from the institutional (University of Hargeisa) with the following reference number DRCS/66/05/2021 and national levels in Somaliland (Ministry of Health Development) with the following reference number MOHD/DG:2/84/2020. All participants included in this study, as informants, were given oral and written information about the study, and they were aware that they were able to withdraw from the study at any time, without any consequences.

CRediT authorship contribution statement

Umulkhayr Mohamed Ismail: Writing – review & editing. **Fatumo Osman:** Writing – review & editing. **Marie Klingberg-Allvin:** Writing – review & editing. **Jama Ali Egal:** Writing – review & editing, Supervision, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Data availability

Data will be made available on request.

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