Implementation Process and Comparative Analysis

Classroom and Facility-based Post-Abortion Care Service Delivery On-the-Job Training for Health Workers in Six States in Nigeria

Ipas Partners for Reproductive Justice
NIGERIA HEALTH FOUNDATION

Implementation Process and Comparative Analysis of Classroom and Facility-based Post Abortion Care Service Delivery on the Job Training for Health workers in Six States in Nigeria

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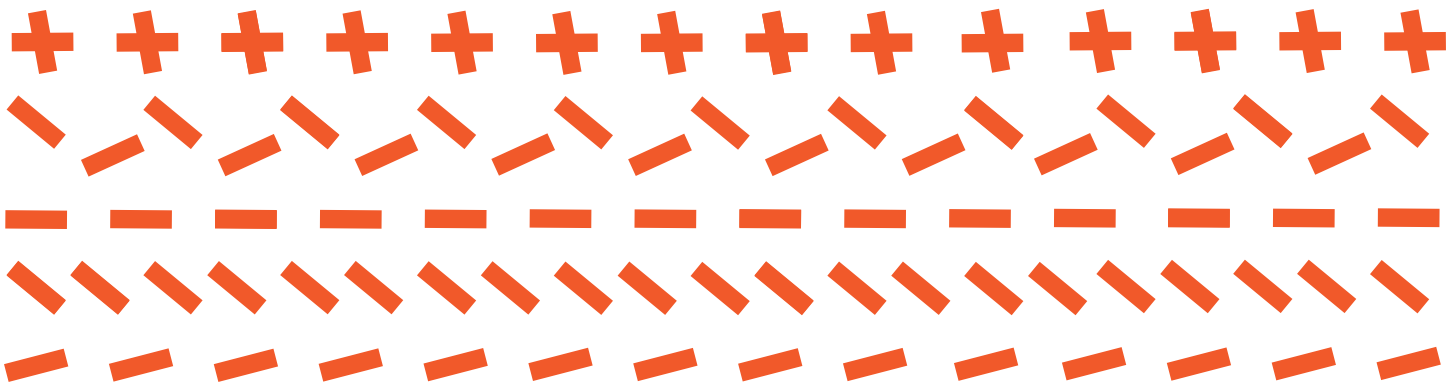


List of Abbreviation

CAC	Comprehensive Abortion Care
FMoH	Federal Ministry of Health
OJT	On-the-Job Training
PAC	Post Abortion Care
TOT	Training of Trainers
FP	Family Planning
MVA	Manual Vacuum Aspirator

Executive summary

Globally, about 25 million unsafe abortions occur annually, while about 7 million women are treated for complications arising from unsafe abortions. Unsafe abortion is one of the leading causes of maternal mortality and morbidity globally. In Nigeria alone, not less than 1.25 million abortions occur every year. Post Abortion care (PAC) becomes very important in reducing the mortality and morbidity associated with unsafe, incomplete, and spontaneous abortions. To provide safe and effect PAC services, health workers would require specific capacity building in PAC knowledge and competency. In Nigeria, Ipas supported the Federal Ministry of Health (FMoH) in developing and publish a training manual for Post Abortion Care and train over 1,000 healthcare workers of different cadres on the provision of PAC services in several states. More recently, Ipas conducted an On-the-Job Training on PAC service delivery for health workers in six states in Nigeria using the classroom and facility-based training approaches and commissioned a study to document the training implementation process and determine the effectiveness of the facility-based training approach compared to the classroom training approach.

The training implementation included stakeholder meetings at the national and sub-national levels to sensitize stakeholders, identify participants, and develop the training plan. In addition, training of trainers and refresher training were conducted at national and subnational levels to get the facilitations ready for the training. Pre and post-training assessments were administered to participants on PAC knowledge and competency to measure the impact of the training. Furthermore, training monitoring and follow-up interviews were conducted with trainers and trainees to elicit information on their training experience, while client-provider interaction and client exit interviews were conducted to get feedback from clients on their opinions of the PAC service received.

A total of 119 participants from the classroom training cohort completed the PAC knowledge pre-test and post-test assessment. The average pre-test performance across all participants was 64.5%, while the post-test was 76.6%, resulting in an 18.8% improvement in PAC knowledge after exposure to training. The difference in performance in pre and post-training assessment is statistically significant ($t=7.8673$, $p<0.001$). Participants from Ondo State recorded the highest average post-test performance in PAC Knowledge with 80%. The average pretest performance in the Family planning counseling competency assessment was 86.5%, while the post-test was 79%, resulting in an 8.7% decline

in Family planning counseling competency. The difference in performance in pre and post-training assessment is statistically significant (t = -2.6315, p<0.01). Of the six states trained, Kwara State recorded higher average performance in Family planning counseling competency at post-test compared to pretest scores. Similarly, the average pretest performance Misoprostol competency was 76.8%, while the post-test was 68%, resulting in an 11.5% decline in Misoprostol competency after the training. The difference in performance in pre and post-training assessment is statistically significant (t = -2.7349, p < 0.01). Furthermore, the average pretest performance in the Manual Vacuum Aspirator competency assessment was 83.3%, while the post-test was 83.5%, resulting in a 0.2% decline in MVA competency after the training. The difference in performance in pre and post-training assessment is not statistically significant (t = - 0.8439, p = 0.4005).

A total of 112 participants from the facility-based training cohort completed the PAC knowledge pre-test and post-test assessment. The average pre-test performance across all participants was 62.3%, while the post-test was 83.2%, resulting in a 33.6% improvement in PAC knowledge after exposure to training. The difference in performance at pre and post-test is statistically significant (t=12.1183, p<0.001). Participants from Ebonyi State recorded the highest average posttest performance in PAC Knowledge with 86%. The average pre-test performance in Family planning counseling competency assessment was 87.5%, while the post-test was 81%, resulting in a 7.4% decline in Family planning counseling competency among participants after the training. The difference in performance at pre and post-test is statistically significant (t= -3.8889, p<0.001). Of the six states trained, only Kwara State recorded higher average performance in Family planning counseling competency at posttest compared to pretest scores. Similarly, the average pretest performance in Misoprostol competency was 88%, while the post-test was 83.1%, resulting in a 5.6% decline in Misoprostol competency among participants after the training. The difference in performance at pre and post-test is statistically significant (t= -3.4139, p<0.001). Furthermore, the average pretest performance in the Manual Vacuum Aspirator competency assessment was 89.3%, while the post-test was 83.5%, resulting in a 6.5% decline in MVA competency among participants after the training. The difference in performance at pre and post-test is not statistically significant (t= -1.6635, p=0.0991).

Comparing performance in PAC knowledge and competency assessments between classroom and facility-based training participants, average post-test performance on PAC knowledge assessment among facility-based participants (81.5%) was higher than classroom participants (73.2%). The difference in performance in PAC knowledge post-test assessment between facility-based and classroom training participants is statistically significant (t=-5.1164, p<0.001). Average performance in PAC knowledge after the

training was higher among facility-based training participants than classroom training participants in all the States except in Cross River state. Performance in post-abortion family planning counseling competency assessment was comparable between classroom (77%) and facility-based (74.9%) training participants across States. The difference in performance in the Post-Abortion Family Planning Counselling Competency assessment between facility-based and classroom training participants is not statistically significant (t=0.7895, p=0.4254). Similarly, performance in post-abortion Misoprostol Competency assessment was comparable between classroom (70.3%) and facility-based (71.7%) training participants across States. The difference in performance in Post-Abortion Misoprostol Competency assessment between facility-based and classroom training participants is not statistically significant (t=-0.4663, p=0.6415). Performance in post-abortion Manual Vacuum Aspirator competency assessment was comparable between classroom (80.7%) and facility-based (77.5%) training participants across the States. The difference in performance in Post-Abortion Manual Vacuum Aspirator Competency assessment between facility-based and classroom training participants is not statistically significant (t=1.4603, p=0.1456)

A total of 101 participants were interviewed after completion of the training. Almost all of them considered their personal experience from the training as good, very good or excellent, while all of them agreed the training was relevant. Similarly, participants believed that the facilitators were excellent (55%), very good (37%), and good (8%). However, about 33% did not consider the training as convenient, while 24% did not consider the duration of the training as adequate. Participants requested that the training manual should be made available to all and should include a more pictural description of the processes. Also, facility-based participants would like to be refreshment included in future trainings. Participants rated the training as Excellent (65%), very good (24%) and good (11%). Facilitators also shared similar positive opinions about the training. All the trainers followed the necessary PAC service delivery steps during the client-provider interaction observation and clients reported general satisfaction with the PAC services they received.

This study has shown that the facility-based training method is a viable training method and outperforms the classroom training method for PAC service delivery training. Some of the issues that could have affected the performance in the PAC competency assessment include the convenience and timing of the post-assessments, the availability of the classroom participants, access to the training materials, and exposure to practice in between the assessments. These are areas to improve in future training. The lessons from this study would guide future PAC service delivery training.

1.0 Introduction

Globally, about 25 million unsafe abortions occur annually. According to Arshad et al., (2023), about 50 million induced abortions occur annually in developing countries. Meanwhile, about 7 million women are treated for complications arising from unsafe abortions. In Nigeria alone, not less than 1.25 million abortions occur every year. Unsafe abortion is one of the leading causes of maternal mortality and morbidity globally. While abortion is illegal in most cases, the only way abortion is permitted by law in Nigeria and some other countries is in the case of severe fetal anomalies and to prevent significant harm or save the life of the one carrying the pregnancy.

Awoyemi and Novignon (2014) established the fact that induced abortion is still prevalent in Nigeria despite the illegality and social unacceptability attributed to it. It is however sad that women still seek induced abortion from local and unqualified personnel, which may eventually result in complications or death. This development may not be unconnected with the stigma associated with carrying unintended pregnancy, legal restrictions on abortion, lack of access to standard medical facilities, and several others. Hence, the need to educate health workers, women, and stakeholders not only on the prevention of abortion but also on its management and care.

Post-abortion care (PAC) becomes very important in reducing the mortality and morbidity associated with unsafe, incomplete, and spontaneous abortions. PAC is an integrated service delivery that includes treatment, counseling, contraceptive and family planning services, reproductive and other health services, and community and service provider partnerships. According to Stephens et al., (2019) and Juma et al., (2022), this initiative is a set of maternal health and family planning interventions that are both curative and preventive.

In recent years, Nigeria's health sector has been seriously hit with attrition of skilled workers. This is due to the huge number of nurses, doctors, and health workers seeking greener pastures in developed countries, and the inability to replace them. With this, it is obvious that using the classroom approach might seem to deprive the already burdened health system of the workforce for 5 to 6 full days. Hence, the consideration of On-the-Job training (OJT). The OJT approach is not new in terms of capacity development of the

health workforce. It is an approach that creates a platform for health workers to learn at the service delivery point, ensuring knowledge and skills transfer and attitudinal changes necessary to deliver quality healthcare services.

Kramer et al., (2023) in a research conducted in the United States discussed some factors likely to influence PAC training and PAC service delivery. For instance, gender, religion, culture, and environment can affect intention rates of performing PAC. Their research assessed the intention of training participants (Obstetrics and Gynaecology residents) after their residency. It was found that training participants from a religious background are least likely to provide abortions. This finding is also similar to other studies in the literature that identified that Catholics, Evangelicals, and Physicians with high religious beliefs are less likely to provide abortion or provide a referral. Religiosity in this case was measured using three different metrics (the religion of the resident, the parent's degree of religiosity-being regular attendant or not.

In 2017, Ipas Nigeria supported the Federal Ministry of Health (FMoH) in developing and publishing a training manual for Post Abortion Care in Nigeria. Following approval of the manual for use, Ipas Nigeria has since 2017 deployed the manual to train over 1,200 healthcare workers of different cadres on the provision of PAC services in several states. In 2021, as part of Ipas Nigeria's support to 2 states (Gombe and Jigawa), the PAC/CAC OJT approach was piloted in 7 health facilities (Tertiary, Secondary, and Primary) for 22 healthcare providers. Simultaneously, 40 Healthcare providers were trained through the classroom approach for comparison. The pilot process was for 4 months. In addition, there were a series of planning meetings with State actors across different line ministries and agencies, design of the approach, implementation, and data gathering. With lessons learned from this and given the background already stated above, in 2023, Ipas Nigeria supported the FMoH to conduct a national pilot of the National Guideline for On-the-Job training for PAC services in Nigeria, using two training approaches: classroom and facility-based.

The National pilot involved implementation research which included the following components; clinical review and comparative evaluation of knowledge, skill, and competence, Operations Research and documentation of the process, and Cost Efficiency Analysis providing information on the cost vs benefit of the approach. The pilot was conducted in 6 states; Adamawa, Cross-River, Ebonyi, Kano, Kwara, and Ondo states. Working with the FMoH and the relevant States' MoH and parastatal, the 2 training approaches were conducted on 2 sets of health worker cadres to include Nurses, Midwives, and CHEWs across Secondary and Primary health facilities in the 6 states. Cluster sampling was used to select facilities based on geographical divisions e.g. LGAs and Senatorial Zones.

Further random sampling was used to assign healthcare workers to the classroom vs facility-based training categories. A knowledge assessment and clinical skill evaluation tool were administered to both sets of trainees before and after the training and a competency assessment was conducted at the end of the process to evaluate skill retention and practice among both sets of trainees. Client perspectives on aspects of quality of care were collated through client exit interviews across all participating facilities. Findings from the training evaluation and highlights of the implementation process are provided in this report.

1.1 Aim and objectives

This operation research aims to evaluate the conduct of a national pilot of the National Guideline for On-the-job Training for Post-abortion care services in Nigeria. To achieve this aim, the following objectives were considered.

1. Determine the effectiveness of On-the-job training (OJT) of health workers on post-abortion care (PAC) service delivery in Nigeria.

2. To compare two training methods: classroom and facility-based training and the effectiveness of one over the other.

3. To review and document the perception of trainers and participants about the training implementation process and their possible effects on training outcomes.

2.0

Training implementation process

2.1 National OJT pilot stakeholder's planning & orientation meeting

The Federal Ministry of Health (FMoH), with Ipas Nigeria, developed and published the National Manual on Postabortion Care (PAC) in 2017 which was deployed to service points across the country. The PAC manual was used to train various cadres of service providers on PAC services. Since then, there have been new developments in the field of abortion care, which necessitated the need to review the current document to incorporate these developments to make the manual up-to-date, and relevant to contemporary issues in the reproductive health space. Equally important is the fact that the trained service providers are 'lost' to staff attrition (retirement, immigration, death, etc), and job rotation among other reasons.

Consequently, the FMoH and Ipas Nigeria saw the need to review the PAC manual and develop an On-the-Job Training manual for the country that will address some of the challenges of skilled manpower in reproductive healthcare. Ipas in conjunction with the Federal Ministry of Health reviewed and developed a new guideline on the PAC manual, and the On-the-Job Training manual in Lagos in October 2022, which required to be field-tested in 6 pilot states.

In 2021, Ipas Nigeria worked in Jigawa with the Gombe State Ministry of Health to address the issue. Together, they developed and piloted the first On-the-Job Training (OJT) Guideline for Comprehensive Abortion Care (CAC) in seven facilities, with 22 health workers in each state. State health officials, clinical trainers, and health workers co-developed the draft guideline used to facilitate CAC skill transfer across pilot sites. The benefits of this approach have proved to not only increase the availability of skilled health workers but to provide a more cost-effective training approach that improves the clinical competency of trained providers when compared to historic classroom-based models. This is in part due to the standardized structure that the tool provides, which ensures that critical components of comprehensive abortion care, like counseling, are not overlooked.

Therefore, a one-day stakeholders meeting was held in Abuja and had the following objectives:

1. Provide orientation to participants on the PAC OJT approach.
2. Provide updates on key successes and learnings from PAC OJT implementation in other states.
3. Develop a comprehensive PAC OJT pilot plan along with stakeholders from the pilot states: Adamawa, Cross-River, Ebonyi, Kano, Kwara and Ondo States

In attendance were representatives from Ipas, Datametrics Associates, FMoH, Adamawa, Cross River, Ebonyi, Kano, Kwara, and Ondo States Ministries of Health. The agreed next steps from the meeting were that the State representative to select the local government for the pilot, the health facilities, and the healthcare trainers to train the different healthcare workers (Doctors, nurses, midwives, community health officers, and community health extension workers) with matching cadre for both the classroom OJT trainees as well as the facility OJT trainees for each state.

2.2 Four-day master trainers refresher training

Ipas in collaboration with the FMoH Organized a four-day Training of trainers (TOT) workshop for obstetricians and gynecologists who will serve as master trainers in the selected states during the implementation of the OJT approach. The training had in attendance representatives of the FMoH and 18 clinicians, mainly Obstetricians and Gynaecologists. The training was held at Ibeto Hotels, Abuja from Monday 13th to Thursday 16th March,2023. The training consisted of 4 days of theory and practical demonstration sessions for the participants who had opportunities to make presentations during the group work and teach-back sessions. All the sessions were participatory and conducted as scheduled. Presentations were conducted using a PowerPoint projector, charts, videos, and worksheets.

Training Evaluation was conducted using a post-test assessment, oral evaluations by the participants, and completion of an online questionnaire that assessed participants' satisfaction and perceptions regarding several aspects of the training. The results of the post-test showed that there was an appreciable improvement in the knowledge of all the participants at the end of the training. Participants also evaluated if the course fulfilled its goal and objectives; the course was well organized; the trainers were responsive to participants' needs; the trainers used effective training methods and the training mod-

ules were effective. They all attested to the training fulfilling its goal and objectives and were happy with all aspects of the training.

At the end of the training, participants expressed their joy and enthusiasm to put into immediate practice all aspects of the training on return to the facilities in the States where they were pulled from.

Recommendations from the Master trainers include:

1. Although the participants attested to having gained significant knowledge and skills, the teams from Ebonyi, Cross River, and Ondo may require in-person support by a master trainer during their state-level training.

2. There is a need to provide Job Aids and manuals to be used during the step-down training. This will be useful since the next level of trainees will be visiting the facilities to conduct the OJTs.

2.3 State-level stakeholder meetings

A one-day stakeholder meeting and orientation on the PAC OJT pilot program was carried out in 6 States across the six geo-political zones of Nigeria based on different timelines and dates that were selected by Ipas program monitors and state(s) representatives, (Cross River, Ebonyi, Kano, Kwara, Ondo and Yola). In attendance were representatives from the State Ministry of Health, FMoH, Ipas, and Datametrics Associates.

The objectives of the meeting were to:

1. Provide orientation on the OJT process to relevant stakeholders from the state and LGA Health authorities, facility managers, and trainers.

2. Galvanize stakeholders' support and ownership of the pilot activities.

The stakeholders' roles and responsibilities were explained and clarifications were provided on support needed, materials required, work plan, expectations, and timeliness. Further discussions were conducted on the OJT approach, a teaching methodology that enhances the transfer of skills, attitudes, and knowledge required to make healthcare providers competent, and confident to offer quality healthcare services including family

planning services in the States. Commodities and training materials were distributed to trainers.

2.4 Three-day state-level trainers refresher training

The State-level refresher training was conducted in the 6 selected States. The training was targeted at identified facility providers selected as trainers to train their peers through the OJT approach. The facility trainers were provided refresher training on the provision of PAC and orientation on the PAC OJT manual and its delivery.

2.5 Training

The training started with the 4- 6 weeks facility OJT category immediately after the refreshers training across all selected facilities within the pilot States. The first day of training started with a pre-test session where trainees' knowledge could be assessed before and after training. The Datametrics Research Assistants conducted the pretest for all trainees using the knowledge assessment checklist for the PAC OJT program.

Training then started with 2 hours per session on the PAC curriculum document for PAC training. Research Assistants, state supervisors, and master trainers followed up with each facility's trainers and trainees via visits, phone calls, and daily reports on the State WhatsApp group on how lectures were received on each module across the facilities, Deliverables like attendance, training pictures, practical pictures were also shared regularly and archived by Datametrics Research team. The last day of training ended with a post-test session by the Datametrics Research Assistants who conducted the post-test for all trainees using the knowledge assessment checklist for PAC OJT program.

The 5-day classroom OJT category also commenced 2 weeks after the facility OJT started. Master trainers who were the facilitators for this training category conducted a 5-day residential On-the-Job training for 25 participants at an accommodation provided by the Ipas team. All sessions of the PAC curriculum were covered as sessions during the 5-day training. The first day of training started with a pre-test session for all trainees where trainees' knowledge could be assessed before and after training. The Datametrics Research Assistants conducted the pretest using the knowledge assessment checklist for PAC OJT program. Similar to the facility OJT training, the last day of the 5-day classroom training ended with a post-test session by the Datametrics Research Assistants who conducted the post-test for all trainees using the knowledge assessment checklist for the PAC OJT program.

2.6 Post-training assessments and monitoring visit

Trainees especially the facility OJT category received a lot of supervision during the training. The Attendance/Logbook by all trainees and trainers were reviewed regularly by Research Assistants from Datametrics Associates and the SMoH team on the OJT program, to know how many hours and days each module was taken and if it aligns with the allocated time per module. A post-training assessment was administered to trainers and trainees which included:

1. Post-test on knowledge gained on the PAC OJT training
2. Pre-test on competency gained on the PAC OJT training
3. Trainees post-training experience
4. Observation and Client-Exit Interviews
5. Facilitators post-training experience

2.6.1 Post-test on knowledge and pretest on competency assessment

The post-training post-test was conducted by Datametrics research team immediately after the last class and the module was taken on the PAC OJT training. A team of fieldwork monitors including Datametrics State team and Datametrics team from the National (Abuja) were in attendance to observe the post-test exercise and also observe as the State gynecologist team on the OJT program administer the competency assessment test to all trainees. Assessment scripts were marked by the State team and scores/scripts were given to the Datametrics team for collection and data entry.

2.6.2 Fieldwork monitoring

A thorough review of all the facility OJT processes was further conducted by the monitoring team comprising representatives from Datametrics, SMoH, FMoH, and Ipas program monitors. Consultants were selected from a particular state to follow up on other state trainees to know and see if the trainees have improved on PAC services provisions and see if they have true knowledge of what has been taught and if they can practicalize those training they have received so far.

During this exercise, Client exit interviews for patients who happen to come for PAC

service at the health facility and observations by Datametrics research assistant as trainees provide PAC service to clients in need of this service took place. This happened only to patients who gave consent to be a part of the client-exit interview and have their procedure observed by the research team. Trainer and trainees' experience with the training was also assessed and documented using a structured questionnaire. Consent was sought and obtained before any interview was conducted. Finally, a one-month post-training competency assessment test was conducted on all trainees by the Ipas Consultants selected from another state to follow up on different states to deliver the post-test on competency for all trainees on PAC services and access level competency gained over the last month when the first competency assessment was done.

Questionnaires utilized for the post-training exercise were developed by Datametrics Associates in collaboration with the Ipas team. All Ras were trained on the proper use of this tool in a one-day virtual training before they were administered to PAC clients in each facility. The questionnaires were designed to know the Knowledge of client-provider exit on post-abortion care, and also to know the Client satisfaction with the visit and their overall thoughts on the visit. Most of the research assistants were not allowed into the Theatre for client-provider interaction observation due to privacy policy. The observation interview was done in the theater while the client exit interviews were done after the patient is out of the surgery room.

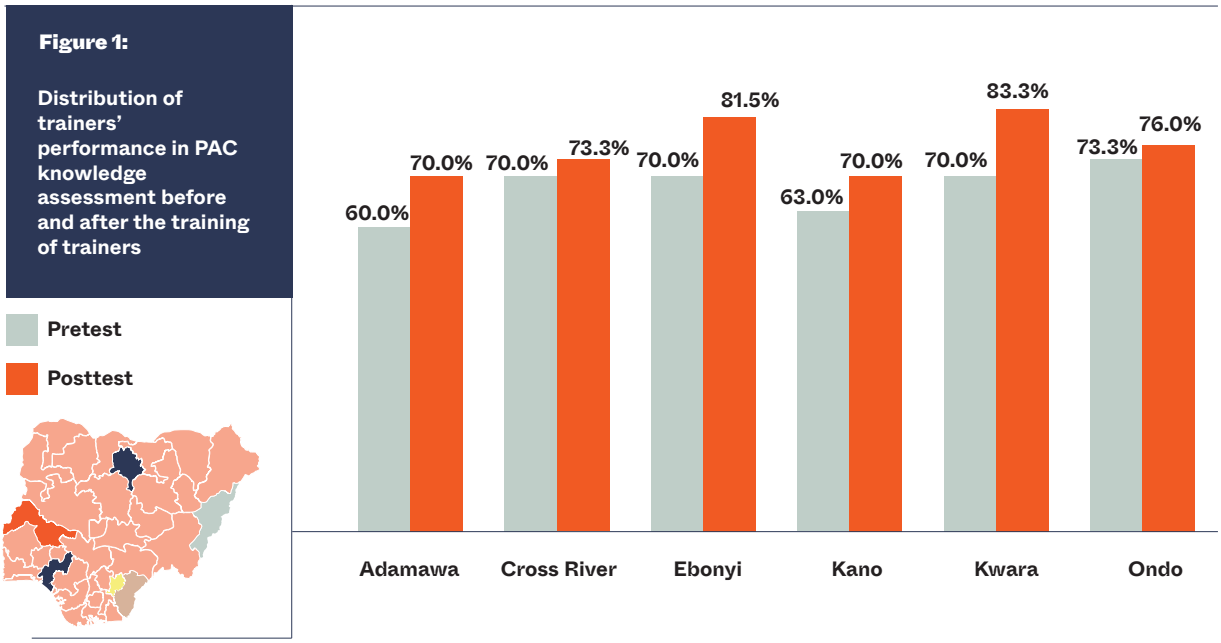
3.0 Outcome of training and monitoring activities

3.1 Trainer's knowledge assessment

Overall, 54 health workers were trained as trainers for the PAC OJT training. The average pretest performance across all the trainers was 70%, while the post-test was 74.7%, resulting in a 13.8% improvement in PAC knowledge after exposure to training. Performance differs across States. Average post-test performance in PAC Knowledge was 70% and above in all six States. Kwara State recorded the highest average post-test performance in PAC Knowledge with 83.3%, followed by Ebonyi State with 81.5% while Adamawa and Kano States recorded 70% each. Similarly, PAC knowledge among trainers in Kwara State improved by 19% at the post-test, compared to the pre-test score. Figure 1 presents the distribution of average performance in PAC Knowledge pre-test and post-test across the six States among trainers.

Figure 1:

Distribution of trainers' performance in PAC knowledge assessment before and after the training of trainers



3.2 Outcome of classroom training

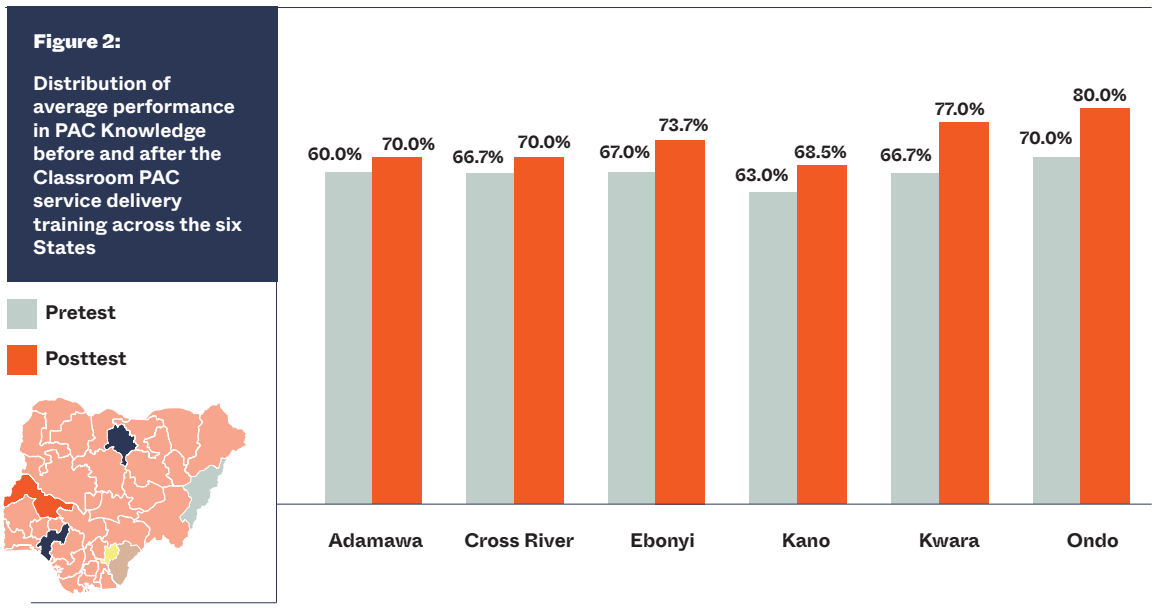
A total number of 112 participants were considered in the classroom training. Of the number of participants, 10 were Male and 102 Female. The result showed that more than half (53.6%) of the participants were 41 years old and above. The majority (83%) of the participants were married. More than half (58%) of the participants had more than eleven years of practice, followed by those that had between five to ten years of practice (28.6%), and those with less than five years experience (15.4%).

3.2.1 Knowledge assessment in classroom training

A total of 119 participants completed the PAC knowledge pre-test and post-test assessment. Average performance in the pretest was 64.5%, while the post-test was 76.6%, resulting in an 18.8% improvement in PAC knowledge among participants after the training. The difference in performance in pre and post-training assessment is statistically significant ($t=7.8673$, $p<0.001$). Participants from Ondo State recorded the highest average performance in PAC Knowledge posttest with 80%, followed by Kwara State with 77% while Adamawa and Cross River States recorded 70% each. Similarly, PAC knowledge among participants in Ondo State improved by 20.6% in the post-test, compared to the pre-test score. All the participants in the six States except Cross River State scored above 80% in the PAC knowledge assessment at the post-test. Only 10% of participants from Cross River State scored more than 80% in PAC knowledge assessment in the post-test. Figure 2 presents the distribution of average performance in PAC Knowledge at the pre-test and post-test among classroom training participants across the six States.

Figure 2:

Distribution of average performance in PAC Knowledge before and after the Classroom PAC service delivery training across the six States

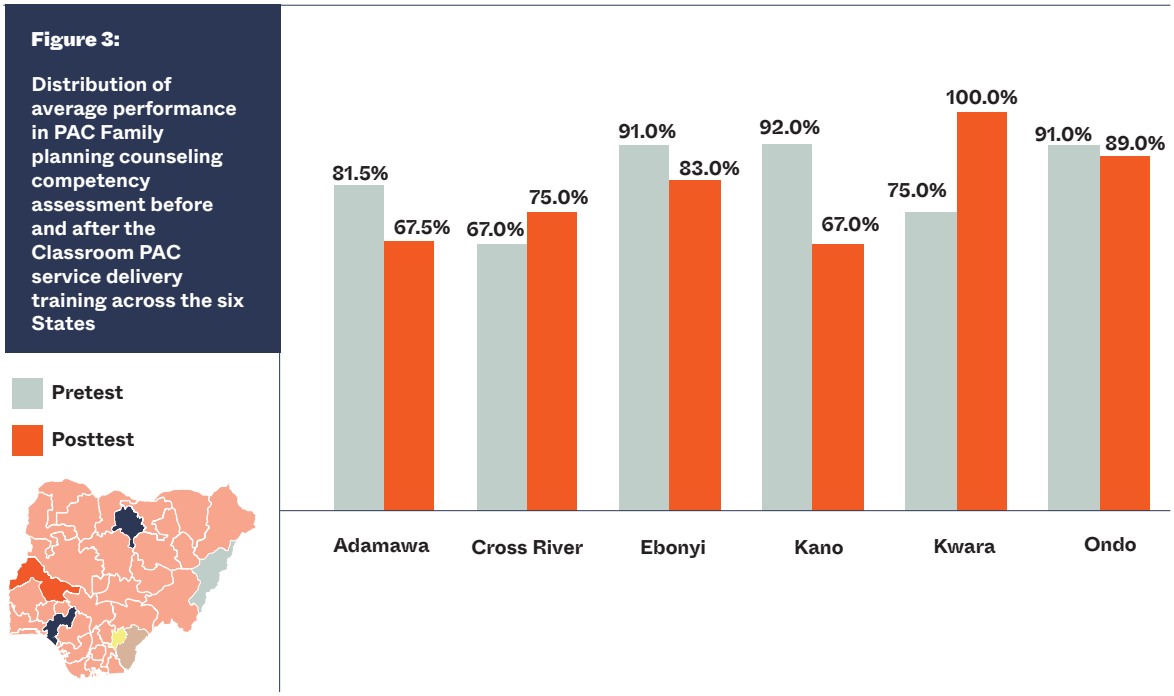


3.2.2 Family planning counseling competency assessment in classroom training

A total of 115 participants completed the Family planning counseling competency assessment pretest and posttest. The average pretest performance was 86.5%, while the post-test was 79%, resulting in an 8.7% decline in Family planning counseling competency among participants after the training. The difference in performance in pre and post-training assessment is statistically significant ($t = -2.6315$, $p<0.01$). Participants from Kwara State recorded the highest average performance in Family planning counseling competency assessment at the post-test scoring 100%, followed by participants from Ondo State with 89%, while participants from Kano State had the lowest average post-test score of 67%. All the States except Kwara State recorded lower performance in Family planning counseling competency assessment at the post-test compared to the pre-test. Kwara State recorded a 20.5% improvement in Family planning counseling competency after the training. However, more than one-third of participants from all the States except Adamawa State scored above 80% in the Family planning counseling competency assessment after the training. Only 10% of participants from Adamawa State scored above 80%. Figure 3 presents the distribution of average performance in Classroom PAC Family planning counseling competency assessment across the six States.

Figure 3:

Distribution of average performance in PAC Family planning counseling competency assessment before and after the Classroom PAC service delivery training across the six States

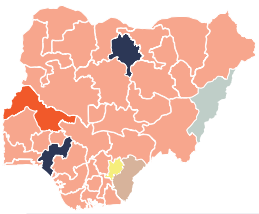


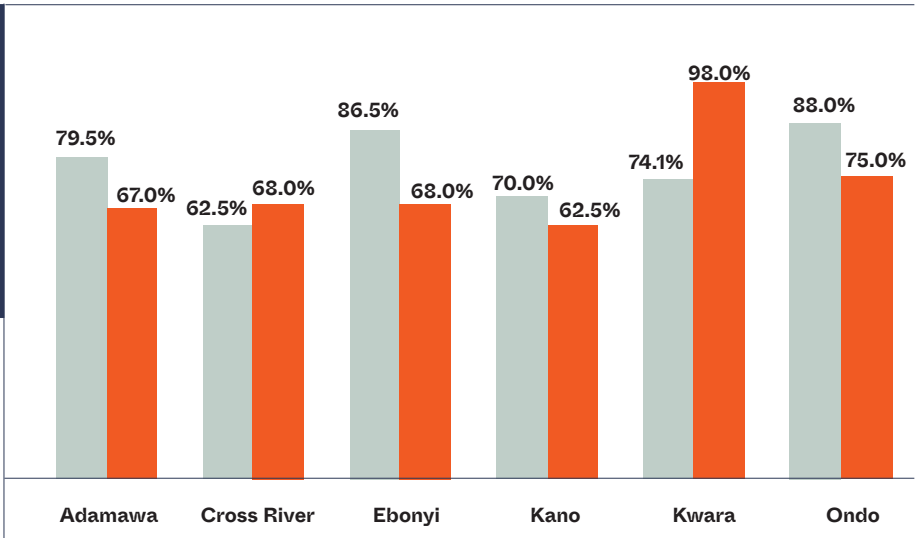
3.2.3 Misoprostol competency assessment in classroom training

A total of 115 classroom training participants completed the Misoprostol competency assessment pretest and posttest. The average pretest performance across all participants was 76.8%, while the post-test was 68%, resulting in an 11.5% decline in Misoprostol competency. The difference in performance in pre and post-training assessment is statistically significant ($t = -2.7349$, $p < 0.01$). Participants from Kwara State recorded the highest average posttest performance in the Misoprostol competency assessment scoring 98%, followed by participants from Ondo State with 88%, while participants from Kano State had the lowest average posttest score of 62%. All the States except Kwara State recorded lower performance in Misoprostol competency assessment at the post-test compared to the pre-test. Kwara State recorded a 22.8% improvement in Misoprostol competency after the training. However, more than one-third of participants from all the States except Kano State scored above 80% in the Misoprostol competency assessment after the training. Figure 4 presents the distribution of average performance in Classroom PAC Misoprostol competency assessment across the six States.

Figure 4:

Distribution of average performance in Misoprostol competency assessment before and after the Classroom PAC service delivery training across the six States



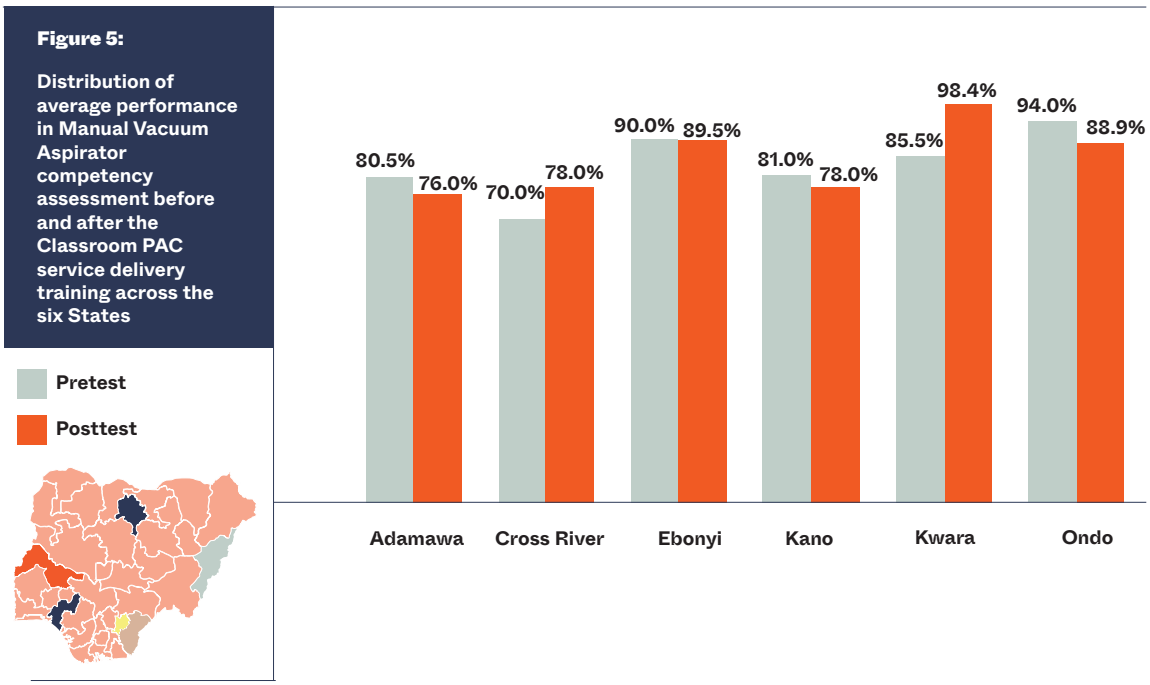


3.2.4 Manual vacuum aspirator competency assessment in classroom training

A total of 115 classroom training participants completed the Manual Vacuum Aspirator competency assessment pre-test and post-test. The average pretest performance across all participants was 83.3%, while the post-test was 83.5%, resulting in a 0.2% decline in Manual Vacuum Aspirator competency. The difference in performance in pre and post-training assessment is not statistically significant (t = - 0.8439, p = 0.4005). Participants from Kwara State recorded the highest average posttest performance in the Manual Vacuum Aspirator competency assessment scoring 98%, followed by participants from Ebonyi State with 89.5%, while participants from Adamawa State had the lowest average posttest score of 76%. All the States except Kwara and Cross River States recorded lower performance in Manual Vacuum Aspirator competency assessment at posttest compared to pretest. Kwara and Cross River States recorded 12.8% and 3.8% improvement respectively in Manual Vacuum Aspirator competency after the training. However, more than one-third of participants from all the States scored above 80% in the Manual Vacuum Aspirator competency assessment after the training. Figure 5 presents the distribution of average performance in Classroom PAC Manual Vacuum Aspirator competency assessment across the six States.

Figure 5:

Distribution of average performance in Manual Vacuum Aspirator competency assessment before and after the Classroom PAC service delivery training across the six States



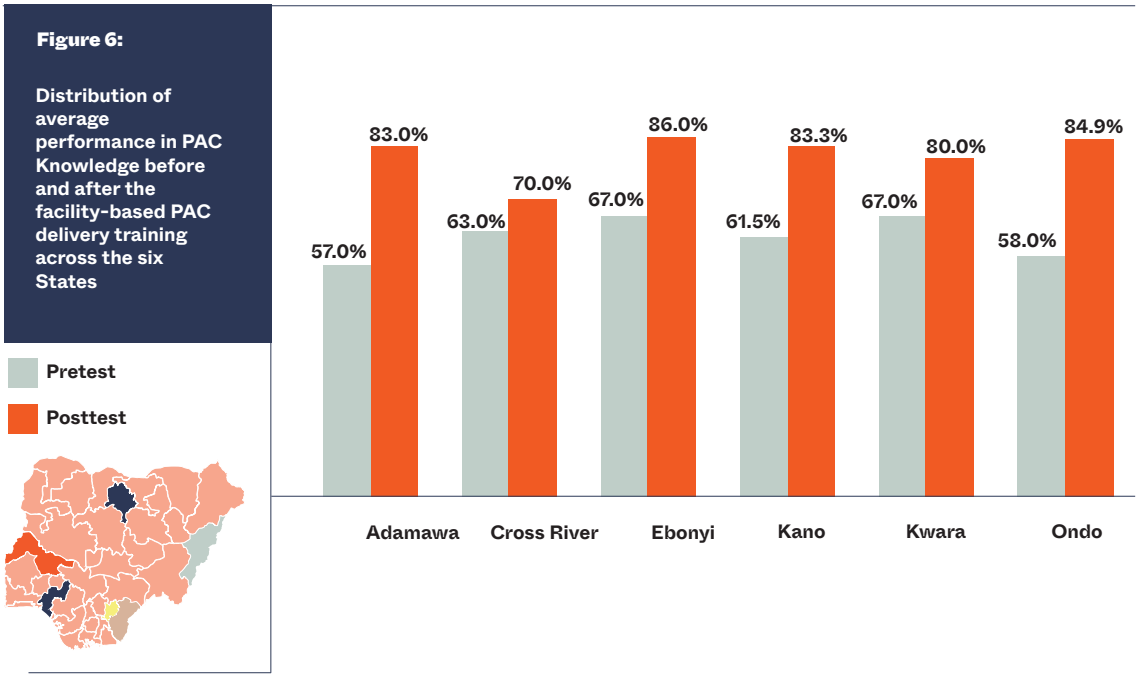
3.3 Trainer's knowledge assessment

3.3.1 PAC knowledge assessment in facility-based training

Overall, 112 participants received facility-based PAC training across the six States and completed the PAC knowledge assessment pre-test and post-test. The average pretest performance across all participants was 62.3%, while the post-test was 83.2%, resulting in a 33.6% improvement in PAC knowledge. The difference in performance at pre and post-test is statistically significant ($t=12.1183$, $p<0.001$). Performance differs across States. Ebonyi State recorded the highest average posttest performance in PAC Knowledge with 86%, followed by Ondo State with 84.9% while Cross River State recorded 70%. Similarly, PAC knowledge among facility-based participants in Ondo State improved by 52.7% at post-test, compared to pre-test score. Average performance in PAC knowledge assessment at posttest was higher than 80% in all States except Cross River State. Figure 6 presents the distribution of average performance in PAC Knowledge among facility-based training participants across the six States.

Figure 6:

Distribution of average performance in PAC Knowledge before and after the facility-based PAC delivery training across the six States

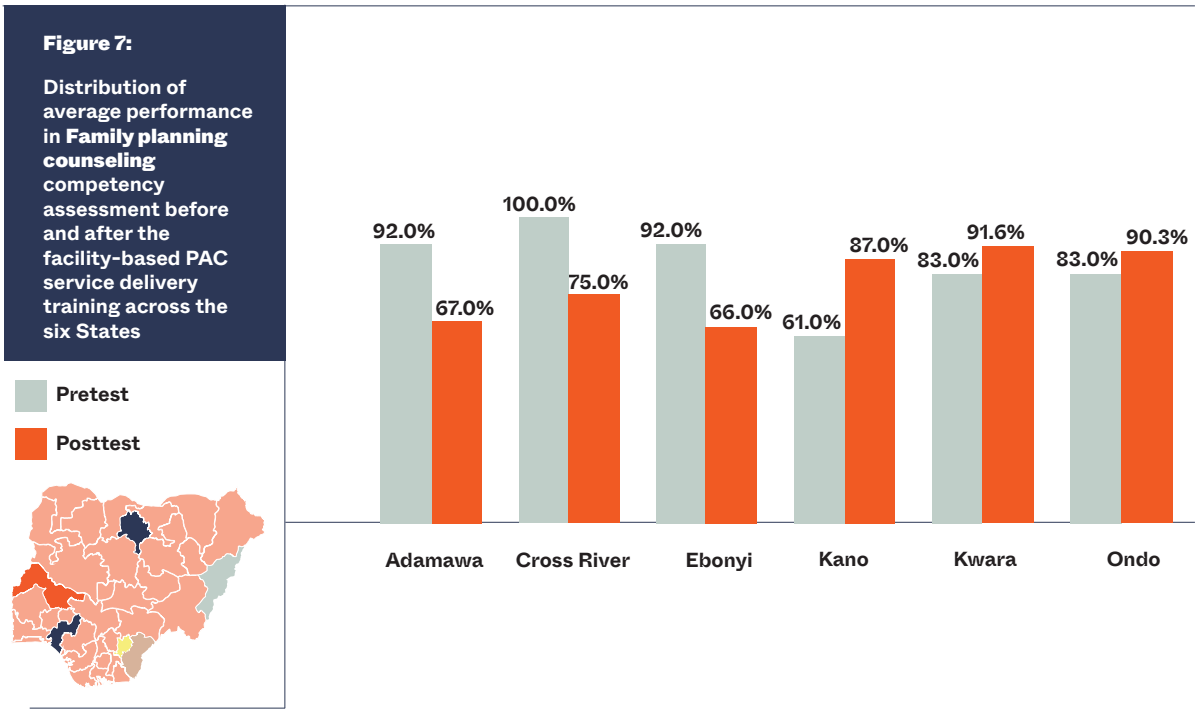


3.3.2 Family planning counseling competency assessment in facility-based training

Overall, 109 participants completed the Family planning counseling competency assessment pre-test and post-test. The average pretest performance across all participants was 87.5%, while the post-test was 81%, resulting in a 7.4% decline in Family planning counseling competency. The difference in performance at pre and post-test is statistically significant (t= -3.8889, p<0.001). Participants from Kwara State recorded the highest average post-test performance in Family planning counseling competency assessment scoring 91.6%, followed by participants from Ondo State with 90.3%, while participants from Ebonyi State had the lowest average post-test score of 66%. Adamawa, Cross River, and Ebonyi States recorded lower performance in Family planning counseling competency assessment at the post-test compared to the pre-test. Kano, Kwara, and Ondo States recorded 46.6%, 10.4%, and 3.6% average improvement in Family planning counseling competency after the training. However, more than one-third of participants from all the States except Adamawa State scored above 80% in the Family planning counseling competency assessment after the training. Only 15.8% of participants from Adamawa State scored above 80%. Figure 7 presents the distribution of average performance in facility-based PAC Family planning counseling competency assessment across the six States.

Figure 7:

Distribution of average performance in Family planning counseling competency assessment before and after the facility-based PAC service delivery training across the six States

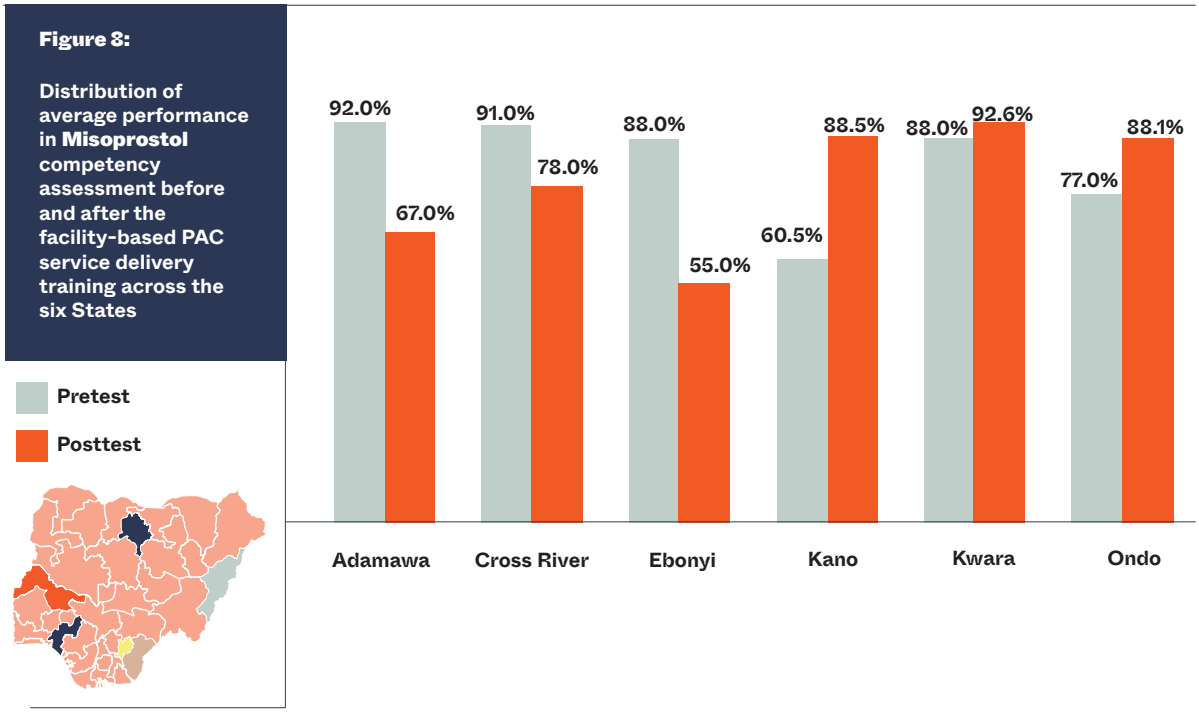


3.3.4 Misoprostol competency assessment in facility-based training

A total of 109 participants completed the Misoprostol competency assessment pretest and post-test. The average pretest performance across all participants was 88%, while the the post-test was 83.1%, resulting in a 5.6% decline in Misoprostol competency. The difference in performance at pre and post-test is statistically significant ($t= -3.4139$, $p<0.001$). Participants from Kwara State recorded the highest average post-test performance in the Misoprostol competency assessment scoring 92.6%, followed by participants from Kano State with 88.5%, while participants from Ebonyi State had the lowest average post-test score of 55%. Adamawa, Cross River, and Ebonyi States recorded lower performance in the Misoprostol competency assessment at the post-test compared to the pre-test. Kano, Ondo, and Kwara States recorded 44.8%, 15%, and 7.5% improvement in Misoprostol competency respectively, after the training. However, more than one-third of participants from all the States except Adamawa and Ebonyi States scored above 80% in the Misoprostol competency assessment after the training. Figure 8 presents the distribution of average performance in facility-based PAC Misoprostol competency assessment across the six States

Figure 8:

Distribution of average performance in Misoprostol competency assessment before and after the facility-based PAC service delivery training across the six States

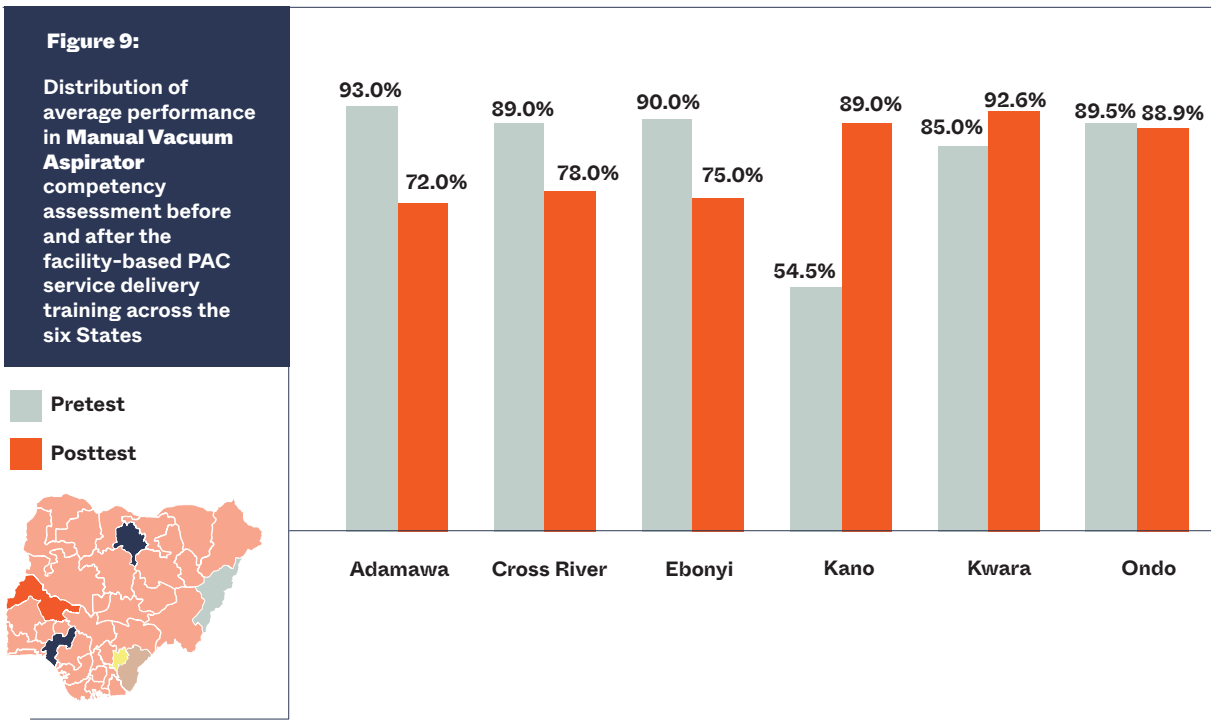


3.3.5 Manual vacuum aspirator competency assessment in facility-based training

A total of 102 participants completed the Manual Vacuum Aspirator competency assessment pre-test and post-test. The average pretest performance across all participants was 89.3%, while the post-test was 83.5%, resulting in a 6.5% decline in Manual Vacuum Aspirator competency. The difference in performance at pre and post-test is not statistically significant (t= -1.6635, p=0.0991). Participants from Kwara State recorded the highest average post-test performance in the Manual Vacuum Aspirator competency assessment scoring 92.6%, followed by participants from Kano and Ondo States with 89% each, while participants from Adamawa State had the lowest average post-test score of 72%. All the States except Kano and Kwara States recorded lower performance in Manual Vacuum Aspirator competency assessment at the post-test compared to the pre-test. Kano and Kwara States recorded 64.2% and 6.2% improvement respectively in Manual Vacuum Aspirator competency after the training. However, more than one-third of participants from all the States scored above 80% in the Manual Vacuum Aspirator competency assessment after the training. Figure 9 presents the distribution of average performance in PAC Manual Vacuum Aspirator competency assessment across the six States.

Figure 9:

Distribution of average performance in Manual Vacuum Aspirator competency assessment before and after the facility-based PAC service delivery training across the six States



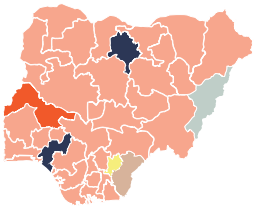
3.4 Comparison of classroom and facility-based training

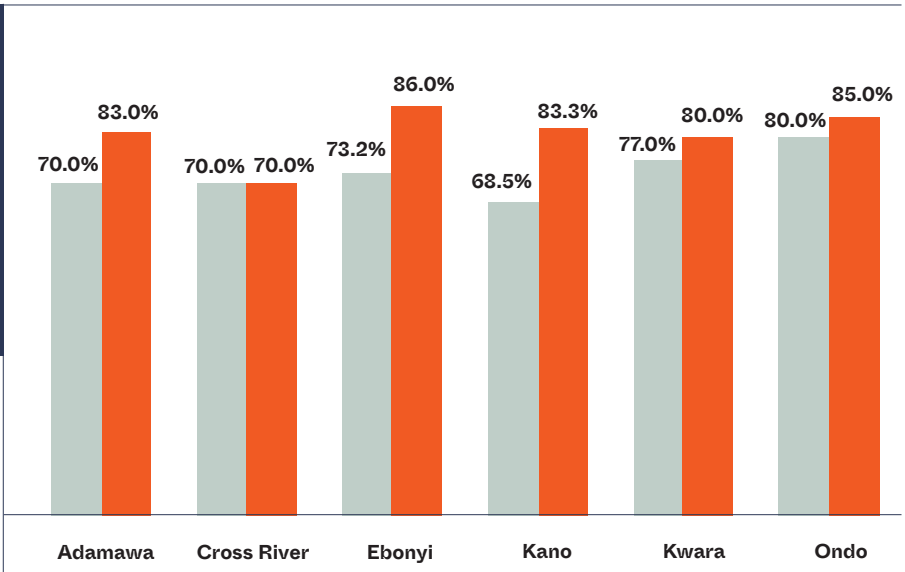
3.4.1 PAC knowledge assessment

Overall, the average posttest performance on PAC knowledge assessment among facility-based participants (81.5%) was higher than classroom participants (73.2%). The difference in performance in PAC knowledge posttest assessment between facility-based and classroom training participants is statistically significant (t=-5.1164, p<0.001). Average performance on PAC knowledge was higher among facility-based training participants in all the States except in Cross River state with equal performance. Similarly, the average improvement in PAC knowledge after the training was higher among facility-based training participants compared to classroom training participants. Figure 10 presents the distribution of average performance in PAC knowledge assessment between classroom and facility-based training participants.

Figure 10:

Distribution of average performance in PAC knowledge assessment between classroom and facility-based training participants across the six States





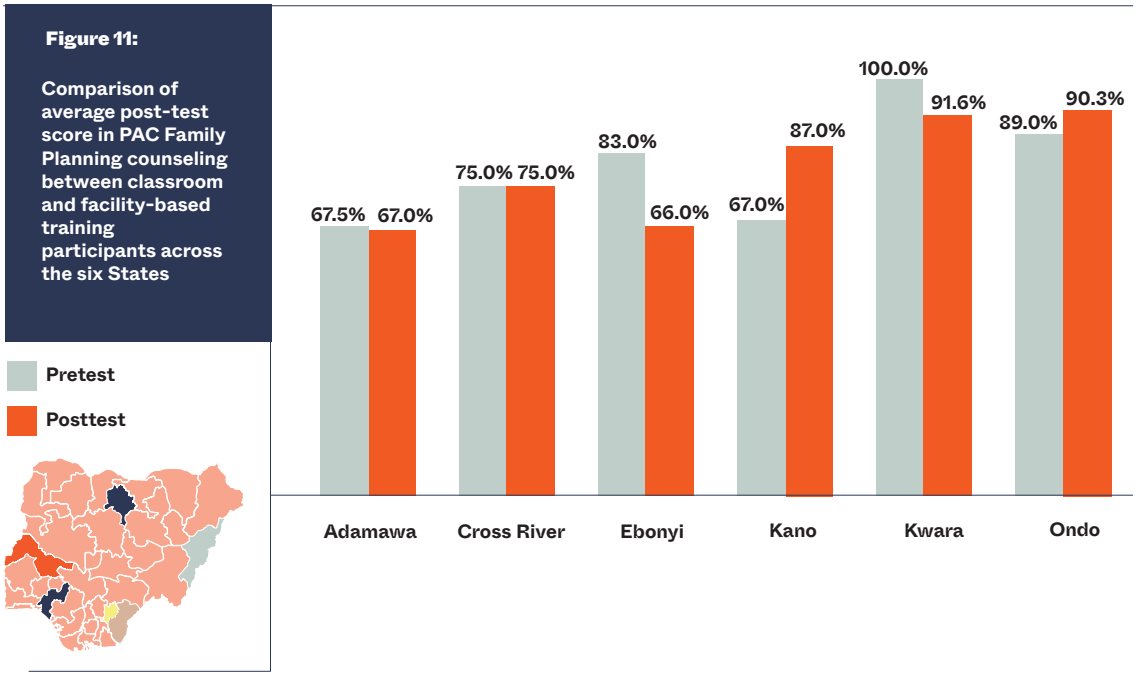
3.4.2 Post-abortion family planning counselling competency

Performance in post-abortion family planning counseling competency assessment was comparable between classroom (77%) and facility-based (74.9%) training participants across States. The difference in performance in the Post-Abortion Family Planning

Counselling Competency assessment between facility-based and classroom training participants is not statistically significant (t=0.7895, p=0.4254). In Ondo and Kano States, the average performance of facility-based training participants in post-abortion family planning counseling competency assessment was higher than classroom training participants. Classroom and facility-based training participants in Adamawa and Cross River States had a similar average performance in post-abortion family planning, while the average performance in post-abortion family planning classroom training by participants in Ebonyi and Kwara State was higher than facility-based training participants. In addition, a higher proportion of participants from Classroom training in Cross River, Ebonyi, and Kwara States scored more than 80% in Family Planning Counselling, compared to participants from facility-based training. However, a higher proportion of participants from Classroom training in Kano, Ondo, and Adamawa States scored more than 80% in Family Planning Counselling, compared to participants from facility-based training. Figure 11 presents the comparison of average post-test scores in PAC Family Planning counseling between classroom and facility-based training participants across the six

Figure 11:

Comparison of average post-test score in PAC Family Planning counseling between classroom and facility-based training participants across the six States



States

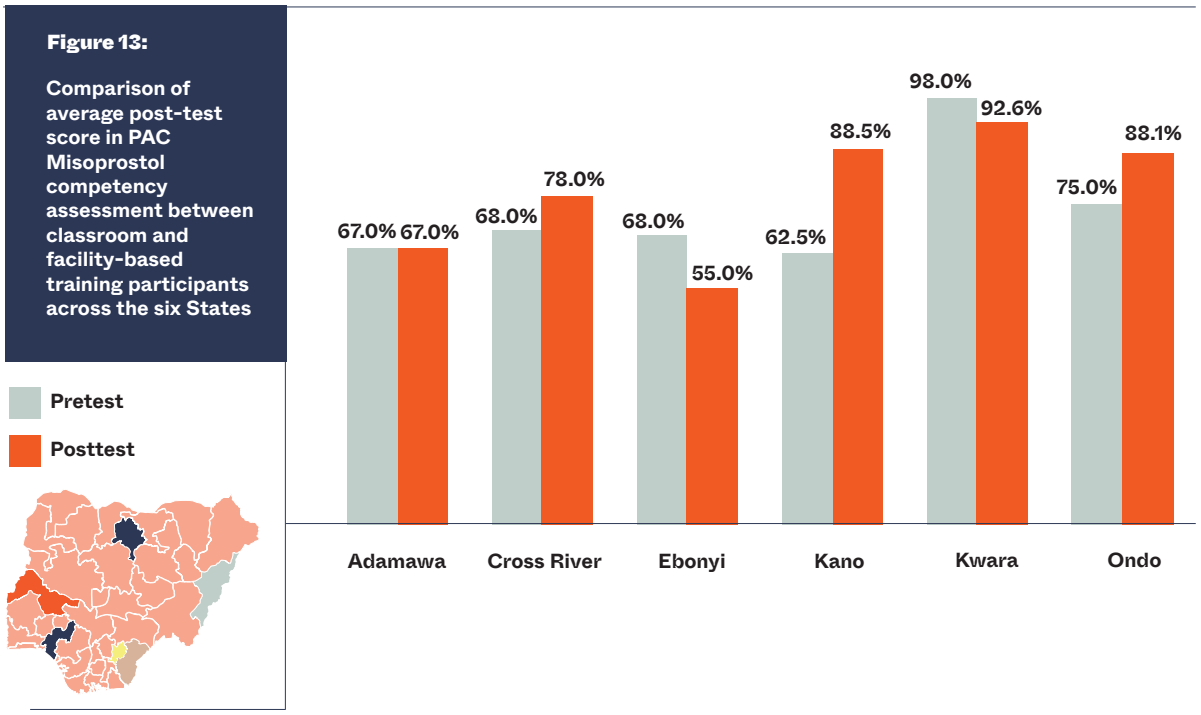
3.4.3 Post-abortion misoprostol competency

Performance in post-abortion Misoprostol Competency assessment was comparable between classroom (70.3%) and facility-based (71.7%) training participants across States. The difference in performance in Post-Abortion Misoprostol Competency assessment between facility-based and classroom training participants is not statistically significant

(t= -0.4663, p=0.6415). In Cross River, Kano, and Ondo States, the average performance of facility-based training participants in post-abortion Misoprostol competency assessment was higher than classroom training participants, while the average performance in post-abortion Misoprostol competency by classroom training participants in Ebonyi and Kwara State was higher than facility-based training participants. In addition, a higher proportion of participants from facility-based training in Cross River, Kano, Ondo, and Adamawa States scored more than 80% in the Misoprostol competency assessment, compared to participants from facility-based training. However, a higher proportion of participants from Classroom training in Ebonyi and Kwara States scored more than 80% in the Misoprostol Competency assessment, compared to participants from facility-based training. Figure 12 presents the comparison of average post-test scores in PAC Misoprostol Competency between classroom and facility-based training participants

Figure 13:

Comparison of average post-test score in PAC Misoprostol competency assessment between classroom and facility-based training participants across the six States



across the six States.

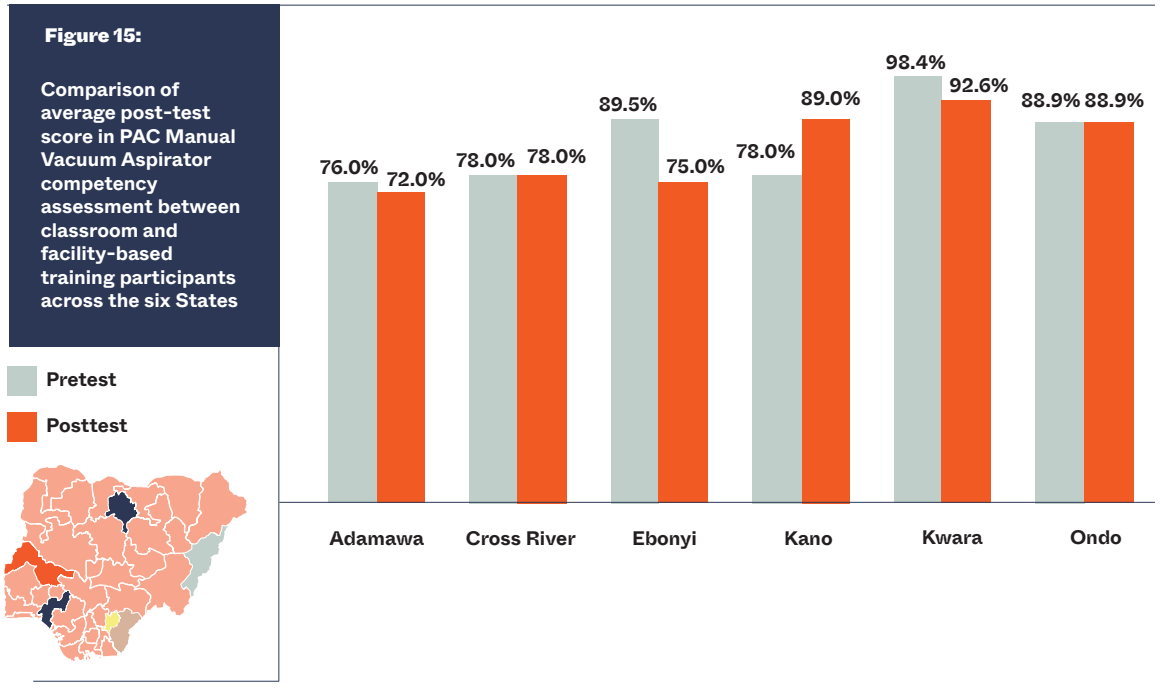
3.4.4 Post-abortion manual vacuum aspirator competency

Performance in post-abortion Manual Vacuum Aspirator competency assessment was comparable between classroom (80.7%) and facility-based (77.5%) training participants across States. The difference in performance in the Post-Abortion Manual Vacuum Aspirator Competency assessment between facility-based and classroom training participants is not statistically significant (t= 1.4603, p=0.1456). In Cross River and Ondo States, the average performance of classroom and facility-based training participants

in the post-abortion Manual Vacuum Aspirator competency assessment was equal. In Adamawa, Ebonyi, and Kwara States, the average performance of classroom training participants in post-abortion Manual Vacuum Aspirator competency assessment was higher than facility-based training participants. Only in Kaduna State was the average performance of facility-based training participants in post-abortion Manual Vacuum Aspirator competency assessment higher than classroom training participants. In addition, a higher proportion of participants from Classroom training in Ebonyi and Kwara States scored more than 80% in the Manual Vacuum Aspirator competency assessment, compared to participants from facility-based training. However, a higher proportion of participants from facility-based training in Cross River, Kano, Ondo, and Adamawa States scored more than 80% in the Manual Vacuum Aspirator competency assessment, compared to participants from facility-based training. Figure 14 presents the comparison of average post-test scores in PAC Manual Vacuum Aspirator competency assessment

Figure 15:

Comparison of average post-test score in PAC Manual Vacuum Aspirator competency assessment between classroom and facility-based training participants across the six States



between classroom and facility-based training participants across the six States.

3.5 Findings from training follow-up activities

3.5.1 Findings from the qualitative interview with participants (trainee)

A total of 101 participants were interviewed after completion of the training. Summary findings from the post-training interview is presented in this section

3.5.1.1 Personal experience from the training

Most of the participants gave positive personal experiences about the PAC service delivery training while some found it not so easy due to interference with their duty.

> The experience was fine because before now I didn't know. When I see MVA I think it is only Doctors that can handle it but now I know nurses can use it. I was able to know that MVA is better than curettage"
> **Participant from Cross River State**

> So, far the training went well and the person who taught us is superb. Before I use to hear MVA but never performed it but I can boast of being able to use it now.
> **Participant from Ebonyi State**

> The training was very educating and impressive, the time was worth it and now I'm able to render PAC to client. It was a wonderful and skillful experience.
> **Participant from Ondo State**

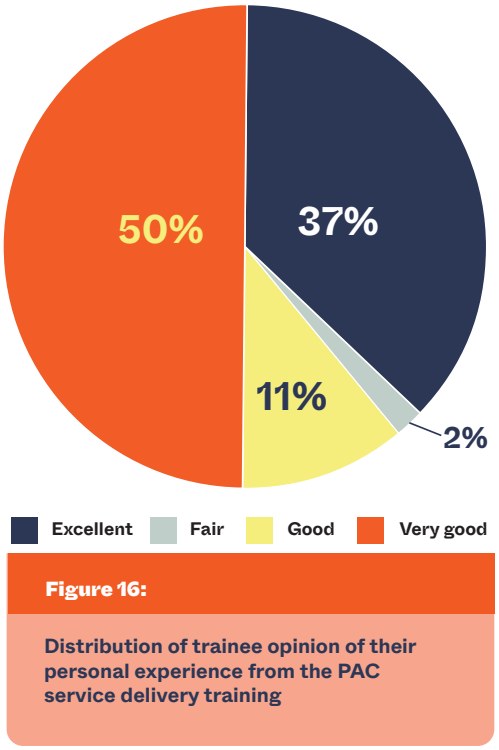


Figure 16:

Distribution of trainee opinion of their personal experience from the PAC service delivery training

> Undertaking the training is not very easy though it was interesting. The short staffing in the facility does not give one enough time for the training.
> ***Participants from Ondo State***

Excerpts from the participants are provided below;

3.5.1.2 Relevance of the training

Many participants believed the PAC training was very relevant to them and their work. Nurses and midwives mentioned that before the training, they would need to find a medical doctor to attend to patients in need of PAC but the training has provided the

needed knowledge and skills to provide PAC services. For some, the usual practice of sending patients in need of PAC services has ended due to the training. The training has provided an opportunity for them to expand their services within their respective health facilities. Overall, 77% of training participants believed the training was very relevant.

> I am a family planning provider. Before now there was no clear role so now, we can now conduct PAC alongside providing family planning"
> **Participant from Cross River State**

> Ah! It will help me to grow in the side of my profession because as a chew, when I see this type of case I can manage it using the module as a guide.
> **Participant from Ebonyi State**

> Its relevant to me because am working in maternity section am dealing with pregnant women.
> **Participant from Kano State**

> It has helped me as a midwife to know more about post-abortion care and it opened my mind to those things, I think are not important before.
> **Participant from Kwara State**

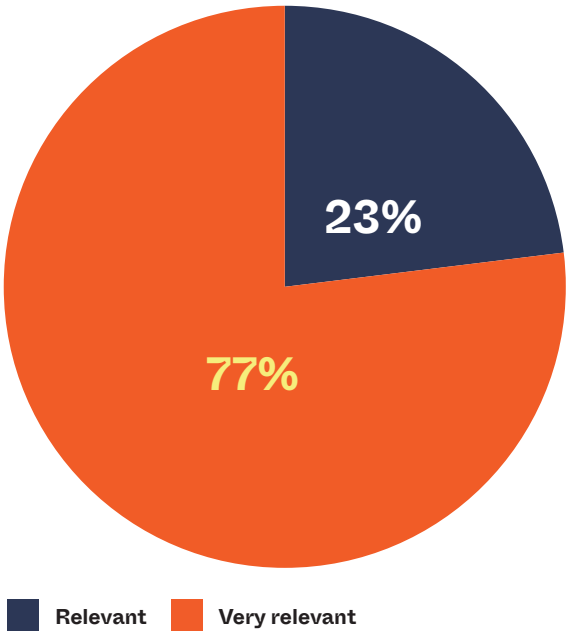


Figure 17:

Distribution of trainee opinion on relevance of the PAC service delivery training

> It is very relevant because client walk into the unit most times with bleeding and after taking of history and ultrasound, incomplete abortion is revealed and we have to be looking for doctor to come and perform MVA but with the help of the training I'll be able to assist the patient. ***Participant from Ondo State***

Excerpts from the interviews are provided below;

3.5.1.3 Convenience of the training

Participants expressed diverse opinions on the convenience of the training. While a larger proportion believed the training was convenient or very convenient, 33% considered the training as not so convenient. Some participants believed training inside the facility

would suffer from work distraction, others reported that their supervisors gave them time for the training. However, some facilities were short-staffed and relied on the available hands thereby making the training not convenient. Some participants were happy to create time despite their busy schedules due to the relevance they accrue to the training.

> Even if it is not convenient, we have to create time. But it was not really convenient but we created time in the evening for the training."
> **Participant from Cross River State**

> It's convenient because we have to agreed and create a special time when it the training will be convenient for everybody.
> **Participant from Kwara State**

> Because of the present shortage of staffs in my facility, it was not convenient.
> **Participant from Kwara State**

> It was not convenient because a times I will be on duty and I had to manage it with the training I felt very uncomfortable.
> **Participant from Ebonyi State**

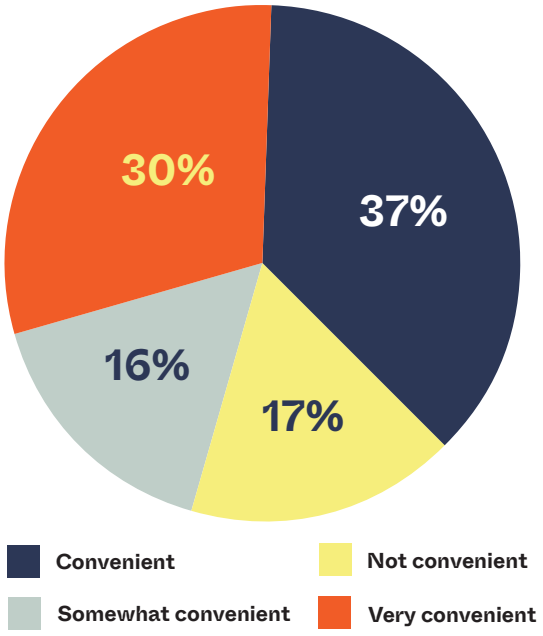


Figure 18:

Distribution of trainee opinion on convenience of the PAC service delivery training

> That one is another thing. Initially it was not convenient. It came in a period when I was supposed to go for my leave but I had to forgo my leave because of the relevance. ***Participant from Kwara State***

Excerpts from the interviews are provided below;

3.5.1.4 Duration of training

Many of the participants believed the duration of training was sufficient. They believed the time allocated for each module was sufficient as they covered the module and

understood the training. Some felt the duration of the training was not sufficient to cover each module. Some participants suggested that the training should be delivered for about 2 to 3 months which will provide the opportunity for more practical sessions

> As for me it was a very good time. There are some people that it takes a very long time to understand but for me it was ok.
> **Participant from Cross River State**

> "It is alright because the time allocated made me to be able to ask questions and know many things that were not clear to me."
> **Participant from Kwara State**

> It is alright because the time allocated made me to be able to ask questions and know many things that were not clear to me.
> **Participant from Kwara State**

> The time allocated is good and it makes the training to be delivered effectively.
> **Participant from Ondo State**

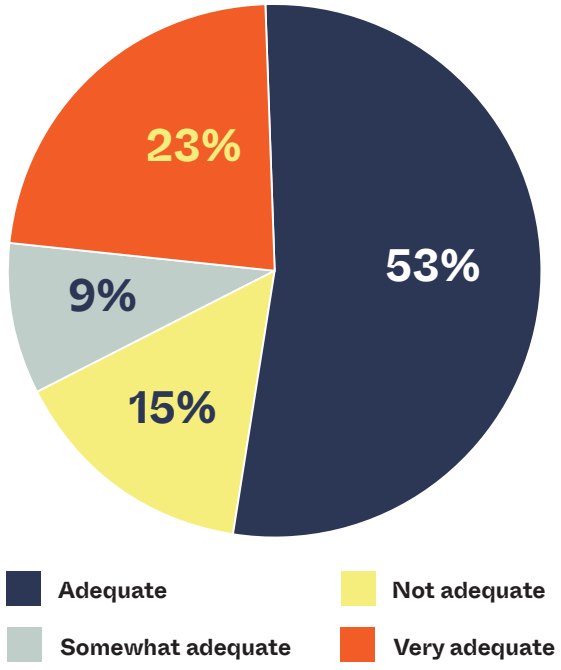


Figure 19:

Distribution of trainee opinion on duration of the PAC service delivery training

> The time allocated was ok because my attention span is very short, so if it takes longer time, I won't pay attention. ***Participant from Cross River State***

with live patients. Excerpts from the interviews are provided below;

3.5.1.5 Facilitator

All the participants judged their facilitator as good, very good or excellent. They believed the facilitators were very knowledgeable in the topics taught, provided detailed explanations to enhance learning, and kept to time. Excerpts from the interviews are provided below;

Very very knowledgeable. I like her tunes. She is not fast. She is not slow. She speaks in the language everyone understands and she explains every bit".
Participant from Cross River State

"My facilitator did good about this training; she is knowledgeable well educated about the topic."
Participant from Kano State

"Yes, she really has the knowledge because she explained to us in a way we can easily understand".
Participant from Kwara State

"Yes, very knowledgeable and ready to explain all what is not clear and answer all questions ask"
Participant from Ondo State

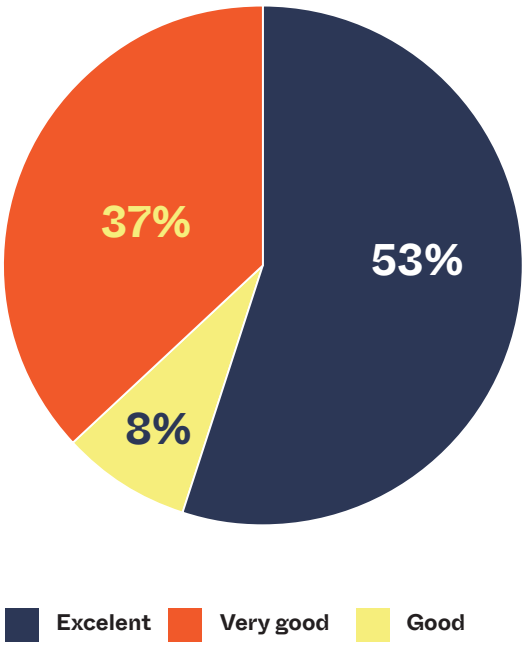


Figure 20:

Distribution of trainee opinion on facilitator of the PAC service delivery training

The time allocated was ok because my attention span is very short, so if it takes longer time, I won't pay attention. ***Participant from Cross River State***

3.5.1.6 Facilitation

The facilitation was generally adjudged as good, very good, or excellent. Facilitators deployed relevant facilitation skills such as demonstration, explanation, discussion, recap, and question and answer to pass the knowledge to participants. The facilitation was aided by the training manual. Participants attended to the fact that facilitators provided opportunities for questions and provided responses to their satisfaction. Some of the participants believed that the facilitation can be further improved by allocating more time for practice and introducing more practical sessions, use of markers and flipcharts, ensuring hard copies of the manual is available in the facility, use of presentation slides,

and practice with real patients. The provision of refreshments and other incentives were proposed for future training. Excerpts from the interviews are provided below;

My opinion is that sometimes we don't understand the explanation with her mouth but with the way she demonstrates we are able to understand.".
Participant from Cross River State

"The method is very good because when we come next day, she will first make us recap."
Participant from Ebonyi State

"The method is okay because we were able to follow up and he gives room for questions and answer".
Participant from Kwara State

"It would have been better if the trainees also have the handbook so that we can all be in the same page."
Participant from Ondo State

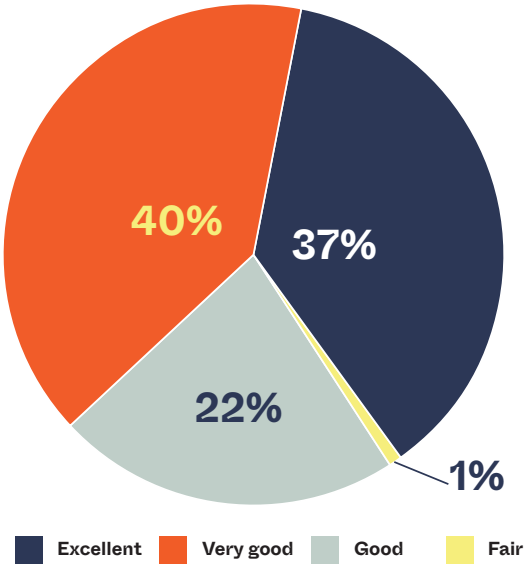


Figure xx:

Distribution of trainee opinion on facilitation of the PAC service delivery training

The time allocated was ok because my attention span is very short, so if it takes longer time, I won't pay attention. ***Participant from Cross River State***

3.5.1.7 Training manual

Some of the participants did not receive a hardcopy training manual and believed it would have enhanced their learning experience. However, most of them believed the manual is useful and helpful as a guide for continuous learning and a reminder about the details of the training. Overall, most of the participants mentioned that the manual can be further improved with a more pictural description of the PAC procedure and concept and adding other areas of maternal health like Antenatal. Excerpts from the interviews are provided below;

3.5.1.8 Success stories

All the participants mentioned that they would recommend the training to other health workers without reservations. Some of the success stories shared by participants are provided in the excerpt below.

> The manual should be made available to all trainees and reviewed every three years" Participant from Adamawa State

> "The manual can be improved by having a lot of diagram and pictures on PAC. There should be detailed information about each topic."
> **Participant from Cross River State**

> "To improve the manual, the step-by-step procedures should be identified with pictures."
> **Participant from Ondo State**

> "They should simplify it the more because of some people that don't understand the big English."
> **Participant from Ebonyi State**

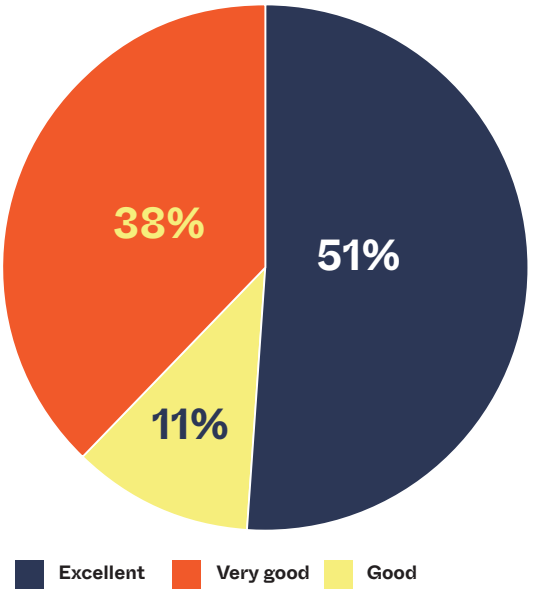


Figure 21:

Distribution of trainee opinion on training manual of the PAC service delivery training

> When next they're producing the manual, they should include pictures in the manual so as to serve as a guide in our facility so that immediately we see the pictures it will guide us to understand much better. ***Participant from Kwara State***

3.5.1.9 Overall rating of the training

Participants rated the training as excellent, very good, and good as presented in Figure 22.

Before the training, if a case comes, I used to rush the client to theater but the training helped me to first stabilize the client, explain the procedure, give pain relief, examine product and other procedure I learned that I did not do before.
Participant from Cross River State

"Before we thought that is only doctors that can handle such case but we now know nurses can handle it well".
Participant from Ebonyi State

"The success I have during this training is the way I see me doing MVA on a live patient, I did it myself during one of the clinics visit of a patient".
Participant from Kano State

"Before i don't know anything about MVA but now i am able to do it and practicalize everything and the use of misoprostol and other drugs and also i am able to educate my people about the criminal abortion so that if they have any problem they'll come to the clinic and explain themselves and we'll be able to assist them".
Participant from Kwara State

Before i don't know how to do the MVA by myself but during the training in our facility, our facilitator use to train us with the Sister-U practically and anytime we have a life patient she'll call us to come and observe and practice by ourselves and now i have been able to do one MVA successfully with the guide and supervision of my facilitator.
Participant from Kwara State

The training was very educating, impressive and not time-consuming, It was performed at the health centre while at work, I can now do the Post Abortion Care for client.
Participant from Ondo State

3.5.2 Findings from qualitative interview with facilitators (trainers)

A total of 48 facilitators were interviewed after completion of the training. Summary findings from the post-training interview are presented in this section

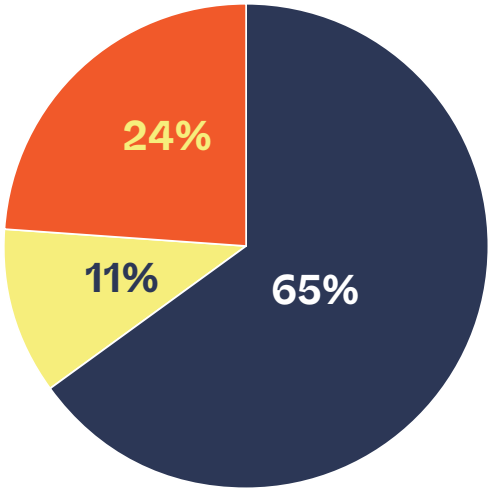


Figure 22:

Distribution of trainee overall rating of the PAC service delivery training

3.5.2.1 Personal experience from the training

The majority of the facilitators gave an excellent personal experience about the PAC service delivery training with some emphasis on how it helped them to acquire more knowledge. Some found it not so easy due to interference with their duty. Excerpts from the interview are provided below;

> The experience I had was wonderful, educative and at the same time very stressful. I had to combine my work schedule and the training most times and it wasn't really easy. In general, it was an awesome experience."
> **Facilitator from Cross River State**

> "It was an interesting and wonderful experience. During the training, we were able to acquire new knowledge on how to provide PAC services using MVA. We also gained knowledge on medical abortion process".
> **Facilitator from Ebonyi State**

> "My experience during the training it gave me more confidence, also increased my knowledge and my participants were ready to learn".
> **Facilitator from Kano State**

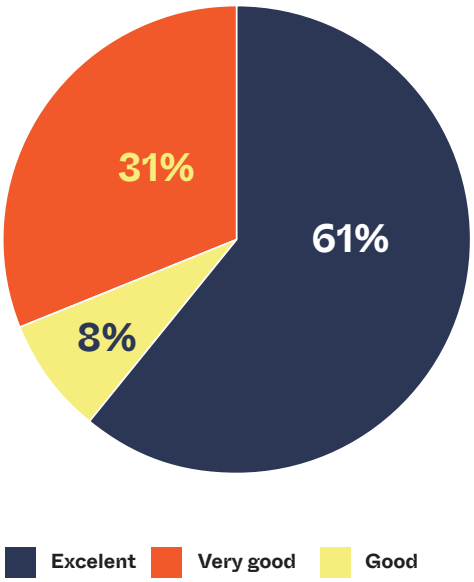


Figure 22:

Distribution of facilitator opinion of their personal experience from the PAC service delivery training

"It has been interesting considering the eagerness of the trainees to learn, they were able to learn and gain more knowledge on post abortion care". ***Facilitator from Ondo State***

3.5.2.2 Relevance of the training

Many facilitators believed the PAC training was very relevant to them and their work. Some of the facilitators mentioned that the training has now equipped health workers with more skills and will also reduce maternal mortality rate as a result of abortion. Overall, almost 90% of the facilitators believed the training is very relevant. Excerpts from the interviews are provided below;

> Very relevant as PAC services will help reduce mortality rate and reduce complications arising from pregnancy as the training equipped health workers with the knowledge needed"
> **Facilitator from Cross River State**

> The training is relevant as it will help to reduce maternal mortality rate and also equip health workers with the required skills needed to manage post abortion cases.
> **Facilitator from Ebonyi State**

> It is very relevant because it is applicable to my work because I work where MVA is been carried out.
> **Facilitator from Kano State**

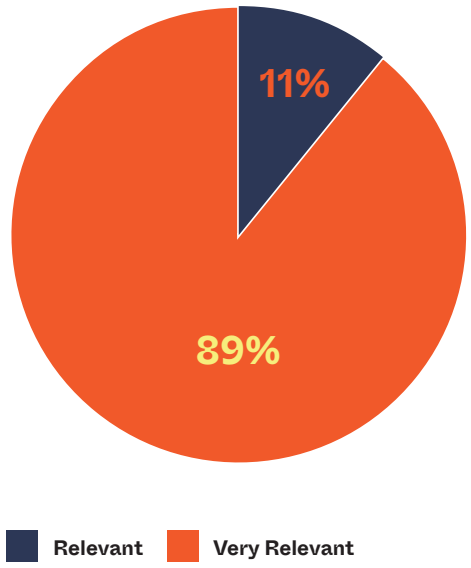


Figure 24:

Distribution of facilitator opinion on relevance of the PAC service delivery training

> It is quite relevant especially in our community to prevent death as a result of abortion complications. *Facilitator from Ondo State*

3.5.2.3 Convenience of the training

Facilitators expressed diverse opinions on the convenience of the training. While a larger proportion believed the training was convenient or very convenient, 12% considered the training as not so convenient. Some of the facilitators who found it convenient mentioned that it was a result of flexibility in time adjustment that suits their trainee's availability.

However, some of those that found the training not so convenient mentioned the stress of workload and lack of staff at the facility. Excerpts from the interviews are provided below;

Yeah, it was convenient for me and my partners as we agreed and chose training days on days that will be less busy for us in the facility.
Facilitator from Cross River State

"It wasn't really convenient for me and my trainees because of shifts and day offs in our work schedule but we all made out time to complete the modules and training".
Facilitator from Cross River State

"It was convenient for me and my participants, we had to reschedule our duty roaster to accommodate the training and suit everyone".
Facilitator from Ebonyi State

"The training was not convenient because I was not on permanent morning duty so I had to rescheduled time but for participants it was convenient because it was during their duty, we did the training"
Participant from Kano State

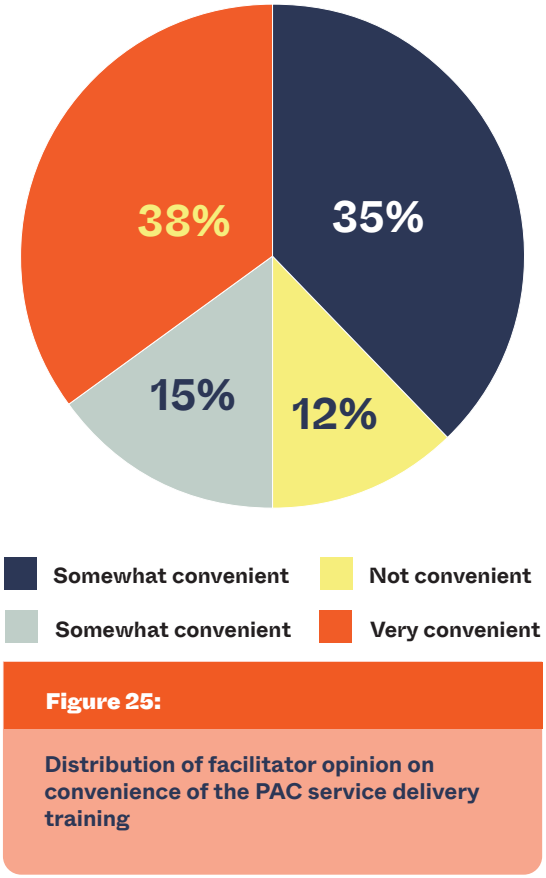


Figure 25:

Distribution of facilitator opinion on convenience of the PAC service delivery training

"Sincerely, it wasn't convenient for us due to the workload and shortage of staffs in our facility" *Facilitator from Kwara State*

3.5.2.4 Duration of training

Many of the facilitators believed the duration of training was sufficient. They believed the time allocated for each module was sufficient as they covered the module. While some facilitators suggested that between 4 to 6 weeks would be more appropriate to deliver the training, others mentioned that the current duration is appropriate. Excerpts from the interviews are provided below;

The time allocation for each module was enough".
Facilitator from Cross River State

"The time was adequate and sufficient."
Facilitator from Kano State

"In my opinion about the time allocated for each module it is very adequate"..
Facilitator from Kwara State

"The time allocated is okay but just that the participant are not readily available due to workload"
Facilitator from Ondo State

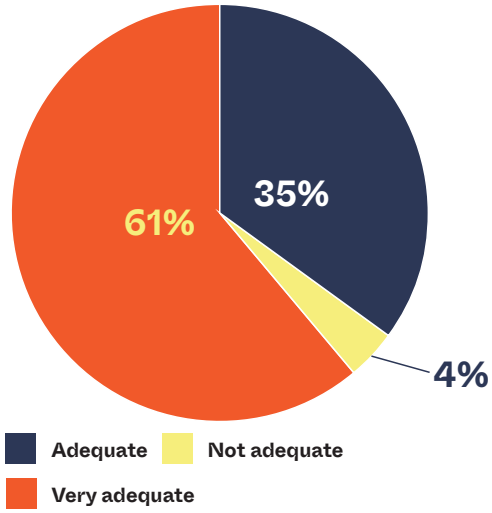


Figure 26:
Distribution of facilitator opinion on duration of the PAC service delivery training

3.5.2.5 Participant

All the facilitators judged their participants as good, very good, or excellent. They expressed that participants showed great interest in learning and are willing to acquire more skills in PAC. Excerpts from the interviews are provided below;

"The participants showed great interest to learn and acquire the practical skill of MVA procedures and other PAC knowledge".
Facilitator from Cross River State

"Yes o, judging from the sacrifices they made coming to the facility even on their day off and their participation during the training portrayed that they really had interest to learn."
Facilitator from Ebonyi State

"Yes, they did. Most times I even see them glancing through the manual even when it wasn't training period. They really showed great interest."
Facilitator from Ebonyi State

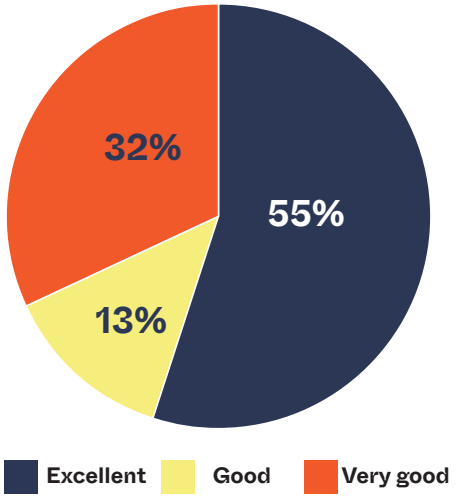


Figure 27:
Distribution of facilitator opinion on trainee of the PAC service delivery training

Yes, they were interested because they stayed back to do the training over the week end even if they cannot stay for the week end to have the training, we reschedule time for them, ***Facilitator from Kano State***

3.5.2.6 Facilitation

The facilitation was generally adjudged as good, very good, or excellent. Facilitators deployed relevant facilitation skills such as demonstration, explanation, discussion, recap, practical, illustration, role play, and question and answer to pass the knowledge to participants. The facilitation was aided by the training manual. Some of the facilitators believed that the facilitation could be further improved by providing incentives or refreshments during training for the trainees, a more confined environment for the training, supervision, and making copies of the training manual available for the trainees. Excerpts from the interviews are provided below;

> The trainees complained of hunger during training, I think providing food for the trainees will facilitate the training.".
> **Facilitator from Cross River State**

> "Incentives and allowances should be provided for both trainers and trainees. This will go a long way spurring their interest."
> **Facilitator from Ebonyi State**

> "The training should be done in the conference room not in the ward because there are a lot of distraction in the ward".
> **Facilitator from Kano State**

> "By giving out each copy of the handouts to the participants and repeating the training whenever we are less busy.."
> **Facilitator from Kwara State**

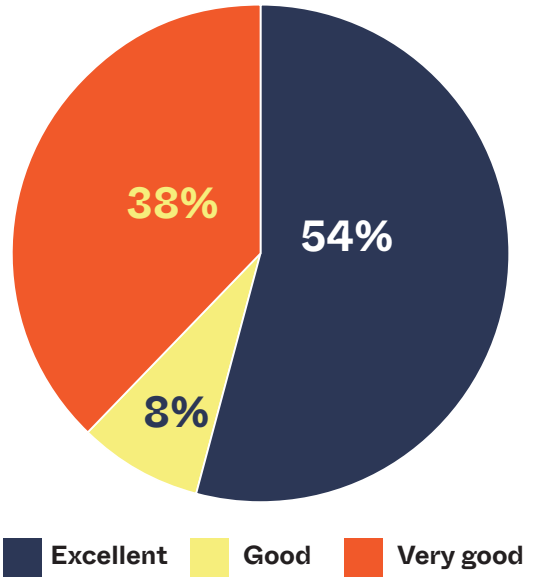


Figure 28:

Distribution of facilitator opinion on trainee of the PAC service delivery training

By distributing a copy of the manual to the trainees so they can easily follow up. Facilitator from Ondo State

3.5.2.7 Training manual

The training manual was generally adjudged by facilitators as being good, very good, and excellent. All facilitators believed that providing a manual for trainees would be useful and helpful as resource material. Some of the facilitators believed that the manual could be improved by summarizing it into a smaller version with more pictures to demonstrate practical aspects. Overall, most of the facilitators mentioned that the manual is adequate. Excerpts from the interviews are provided below;

> the manual can be improved by compressing it to make it smaller in a summary form."
> **Facilitator from Ebonyi State**

> "The manual should have more picture to demonstrate the practical aspect of MVA."
> **Facilitator from Kano State**

> "They should please include diagrams on the manual to make illustrations in the modules more easier to understand."
> **Facilitator from Kwara State**

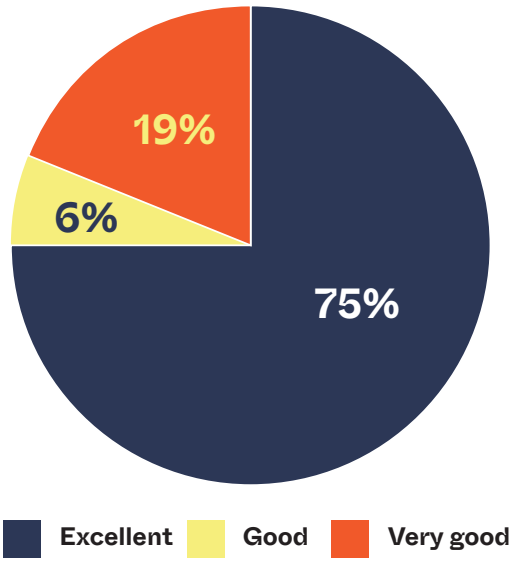


Figure 29:
Distribution of facilitator opinion on training manual of the PAC service delivery training

They can include more diagrams to make some illustrations but to me, I feel that It's not for doctors or nurses maybe for some of the CHEWs and CHOs. They might need some illustrations. ***Facilitator from Ondo State***

3.5.2.8 Training of trainers

The concept of training the trainers was generally adjudged by facilitators as being good, very good, and excellent. Some of the facilitators mentioned that they like the concept of training the trainers because it helps refresh their memories and broadens their knowledge of PAC services. Some of the facilitators believed that PAC training could be further improved by regular visits and monitoring of training, more personnel for the training, providing incentives or refreshments during training for the trainees, equipment

for practical sessions and making copies of training manual available for the trainees. Excerpts from the interviews are provided below;

> TOT can be improved by provision of equipment to use for practical, they should provide all the equipment for the procedure"
> **Facilitator from Kano State**

> "Allow each facility work based on their schedule and give prior notification of activities."
> **Facilitator from Kwara State**

> "There should a good quality supervision."
> **Facilitator from Ondo State**

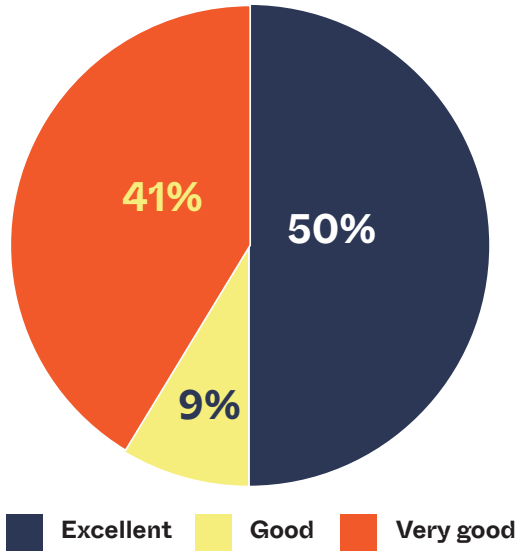


Figure 30:
Distribution of trainee opinion on training manual of the PAC service delivery training

They should ensure that all they were supposed to do at the stepdown level should be mentioned at the level of TOT, we should not assume, there are some parts of the topics that have been left without being treated so they should make sure they cover all the topics. better. ***Facilitator from Kwara State***

3.5.2.9 Overall rating of the training

Facilitators rated the training as excellent, very good, and good as presented in Figure 31.

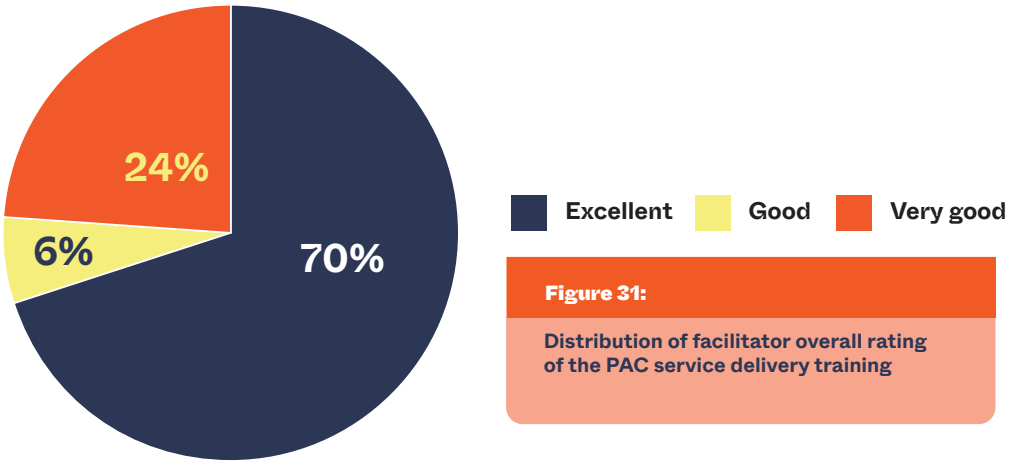


Figure 31:
Distribution of facilitator overall rating of the PAC service delivery training

3.5.3 Findings from client trainee interaction observation

Only three clients who received post-abortion care services agreed for research assistants to observe the service provision process. The symptoms presented by the three clients were bleeding as a result of missed abortion, pain and heavy bleeding, and abdominal cramping and bleeding respectively. The first client observed required PAC services as a result of a failed family planning method which was previously provided by the facility. The second client was newly married, wanted to get pregnant, and would not require family planning services. Two of the three clients were attended to by a medical doctor and a nurse, while the third client was attended to by a nurse and Community Health Extension Worker (CHEW). For all the three clients, the providers ensured auditory privacy, assured them orally of confidentiality, treated them respectfully and kindly, assessed them for pelvic inflammation or complications, documented a full medical history, performed limited physical and pelvic examination to confirm the incomplete abortion status, ensured an open cervical Os and a uterine size less than 12 weeks of gestation, used ultrasound as an additional diagnostic tool to confirm incomplete abortion status, provided them with information about their condition and what to expect, explained the PAC process to them, listened to them and responded attentively to their questions and concerns, provided continual emotional support and reassurance, discussed their needs, concerns, and fears and guided them to choose an appropriate method and informed them of the course of treatment and follow up visit. For all three clients, the PAC service surgical method was performed. Only two of the three clients were provided with information about family planning choices available, including their benefits and limitations, and advised to receive family planning counseling before discharge or during the follow-up visit.

3.5.4 Findings from client exit interview

Six clients who received post-abortion care services were interviewed. All of them believed the right of women to choose when, if, and with whom to engage in sexual activity and whether or when to have children is a basic human right of them know that. Five of them know that unsafe abortion is a procedure performed either by persons lacking in necessary skills or done in an environment lacking in medical standards. Four of them have previous knowledge of Post Abortion care. Four of them have previously used at least one of the post-abortion care services before the current visit. All of them found the advice or information received from the healthcare providers about PAC services during the visit very useful. Five of them were very confident about the PAC service

they received from the providers. The concern all of them had before the visit was fear and pain and all of them mentioned that the concerns were adequately discussed and resolved by the providers. All of them were very satisfied with the PAC services received in the facility.

Conclusion

This study has shown that the facility-based training method is a viable training method and comparable with the classroom training method for PAC service delivery training. However, the lower performance of participants in the PAC competency assessment after the training compared to their performance before the training is concerning. This will require further study, starting with a review of the assessment scripts and mode of administration. Also, training reports, observations of facilitators during the training, and daily evaluations of the training could provide additional insight and should be explored. The lessons from this study would guide future PAC service delivery training.

Appendix

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