


Manual aspiration abortion experience

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Expanding legislation to include a health exemption could increase access to safe abortion; however, the ambiguity surrounding the law, including conflicts in the 2010 Constitution, which permits abortion in some cases, and the Criminal Code, which criminalizes abortion, leads to inconsistent implementation. The result of this legal and enforcement uncertainty is that doctors are afraid to perform abortions and patients are stigmatized. In this context, while access to safe abortions exists, the quality of abortion care remains a persistent problem. In addition to clinical problems, the experience of caring for abortion recipients is often particularly complex. The World Health Organization emphasizes the experience of care and care in various equally important areas of abortion quality. In practice, however, the empirical quality of the patient is largely absent or over-enhanced as satisfaction in much of the literature. This is problematic both because patient experience is important from a human rights perspective, and because women's experiences can influence outcomes, adherence to post-abortion guidelines, and future decisions by patients and health-seeking women who hear about their experiences. A systematic review found that human-centred abortion care remains a worldwide problem, potentially due to deep-seated social stigma, institutional rules and legal constraints. The issues of quality of care related to dignity, autonomy, confidentiality, social support, communication, support and the environment of the health facility are evident in different contexts and conditions. However, while there was recognition, analysis of women's experiences was constrained by a lack of consensus on definitions of human-centred abortion care, as well as the lack of standardized indicators of the quality of abortion, more generally. In Kenya, data are particularly rare: most patient-centered studies are qualitative. While qualitative data can reveal gaps in women's experiences, care, quantitative data are needed to understand the scale of problems in the quality of care, establish basic quality of care, track tracking over time, compare the quality of care in different geographic regions and institutions and inform efforts to improve quality. The combination of abortion methods provides a better understanding of this aspect of quality, especially in Kenya. Little is known about how the female experience differs between medical abortion (MA) and manual vacuum aspirations (MVA), two very different procedures. MA refers to the use of a drug or combination of drugs for abortion (i.e. mifepristone followed with or without misoprostol), while MVAs are a type of surgical abortion. Several studies that evaluated the patient's experience through two methods found mixed and sometimes contradictory results related to the experience of care with MA vs. MVA. For example, one quantitative study reported levels of satisfaction with response options, including those who were very satisfied, satisfied and dissatisfied, and found that overall satisfaction for both MA and surgical abortions was high. The study also reported that MA clients reported higher levels of satisfaction compared to surgical abortions; however, few women who reported dissatisfaction in the sample were higher among MA customers against surgical clients. This may be due to MA customers reporting higher levels of side effects such as nausea, seizures, and bleeding compared to surgical abortion clients. Other quantitative studies also find mixed results when asked about the experience through questions related to satisfaction, whether they will recommend it to others, or whether they will choose the same method again. These findings are limited if past measures have not adequately addressed women's experiences with specific aspects of abortion care. The aim of the study is to study women's experiences in surgical (i.e. MVA) and medical abortion in the official health sector in Nairobi, Kenya. We surveyed women and used a proven human-centred abortion care measure, with two under domains, including Respectful and Supportive Treatment and Communication and Autonomy. First, this study assesses whether the type of abortion is related to a person-centered care assessment. Second, this study compares human-centred abortion determinants. This is a cross-sectional study of abortion clients recruited from six family planning clinics located throughout Nairobi County, Kenya's Marie Stopes Kenya (MSK) facilities. Nairobi County is a metropolitan area densely populated, including slums or market centers. Six clinics were selected based on the volume of clients (i.e. ranged from about 50 to 220 reproductive health clients, including abortion clients), a diverse population, and interest and willingness to participate in a human-centered abortion survey. The method of abortion is determined by the age and preferences of the customer in consultation with the supplier. In MSK, approximately 70% have medical abortions and 30% MVA. On the day of employment, women are entitled to participate if they receive MBA or medical abortion services at the clinic; 2) were at least 18 years old; 3) spoke English or Swahili; and 4) owned a mobile phone and it was convenient to contact the study staff by phone. We have received written informed consent in person at the clinic from interested and suitable women prior to the start of educational procedures. After obtaining consent, the women were examined by a qualified researcher through an electronic tablet survey, which took about 40 minutes to complete, in a private space located in the clinic. All recruitment, consent and baseline surveys were conducted on the same day after receiving abortion services. We experimentally checked these issues with women before starting a full survey to assess whether the duration of the survey and survey questions were appropriate. All the women who agreed and completed the survey received an airtime mobile phone equivalent to approximately \$1.50 for their participation in the study. The University of California, San Francisco (UCSF), Marie Stopes Kenya (MSK) and Innovations to Fight Poverty (IPA) conducted a randomized follow-up study (RCT) on post-abortion intervention in Nairobi, Kenya, in 2017. This manuscript provides the basic data of a broader study of intervention on social support after abortion, with initial plans to collect a sample of 1,000 participants in three weapons studies (330 at hand of the study). The intervention included training a peer counsellor and post-abortion nurse, including providing emotional and informational support to women after an abortion. All women were recruited into the post-abortion study, and therefore the intervention did not affect the type of abortion that women choose. The sample size was calculated using Stata 15MP and involved the discovery of five-dimensional differences between the intervention and control group with a capacity of at least 0.90, taking into account repeated measurements (basic and two subsequent surveys). Only 371 women were eventually recruited to the study at a basic level because of unexpected stoppages in the provision of services related to government bans on abortion services in Kenya during the study. However, calculating power using two samples means the test and sample sizes for MVA vs. MA offer sufficient sampling to estimate differences in the two abortion methods with a capacity of 0.76 (subject to a standard deviation of 10.24 and 10.79 from the analysis). The full study protocol and all training materials have been reviewed and approved UCLA, San Francisco and Kenya Research Institute. The result was an assessment from the Proven Human-Oriented Abortion Scale (PCAC) (available in Table S1), which was adapted from two other human-oriented reproductive health scales (16.17). The scale was developed using standard psychometric procedures, including literature review, cognitive interviews with abortion clients, to determine the validity of the person (i.e. how they understand the issue and how important this item was to them in terms of their experience with caution), expert reviews and factor analysis to determine the number of factors, including 15. The scale includes 24 names for women receiving MVA (Alpha Cronbach) and 23 names for medical abortion Cronbach's alpha and 0.82. One paragraph relating to the provision of painkillers does not apply to women receiving medical abortions. Given that most women receive abortion pills at the facility (at the time of the examination), but usually do not take the pills until they are at home, women do not feel pain until they have taken the pills at home when the abortion has begun. The full scale consists of two sub-scales. Subscale Respectful and Supportive Treatment includes questions such as: Do doctors, nurses or other staff treat you with respect?, Do you think your medical information will be kept secret at this facility? and do you think there were enough medical staff in the facility to take care of you? Subscale Communication and Autonomy includes questions such as: Doctors, nurses or other health care providers call you by name? and did you feel like doctors, nurses or other staff at the facility involved you in making decisions about your abortion? Response options for each item ranged from 0 (Never) to 3 (All Times) and were on a total of 23 counts, which are the same for both surgical and medical abortions of clients (i.e. except for the issue of painkillers) to get a total score ranging from 0 to 69. Higher scores point to a better PCAC. A variable was then created, classifying overall PCAC scores as low, medium or high, with scores in the lower 25 percentile defined as low and scores in the top 75th percentile defined as high. The same procedure was used to calculate and re-register points for each PCAC subscale. Sensitivity analysis was also launched, which included a PCAC assessment as a continuous and binary result. Since the main conclusions have not changed significantly and for the simplicity of interpretation, we present the results from the categorical result. We highlight the results of the sensitivity analysis in the Discussion section below. Independent variables of interest are the type of abortion procedure (MVA compared to medical abortion), characteristics, self-assessment of health status, as well as beliefs and feelings regarding abortion. Demographic characteristics include women's age, marital status, level of education, employment status, religion and number of pregnancies (including current pregnancies), live births and live births. The current self-esteem of women's health was assessed by the question: How do you assess your health now, will you say that it is excellent, very good, good, fair, poor or very bad? then a binary variable was created to document whether a woman rated her current health as excellent, very good, or good compared to the poor or very poor (1 - excellent, very good, or good, 0 - poor or very poor). The ability to pay for an abortion procedure was appreciated by asking: How easy is it for you to get money to buy what you need for your procedure and pay for the service at this MSK clinic? Would you say it's very easy, easy, hard, or very difficult? The ability to pay for transportation to an abortion clinic has been evaluated by asking: How easy is it for you to pay for transportation to this MSK clinic? Would you say it's very easy, easy, hard, or very difficult? Of these items, two binary variables were created to capture whether it was easy for a woman to get money for an abortion procedure and pay for transportation to a clinic for an abortion procedure, respectively (1 - Yes, 0 - No). In addition, women were asked whether abortion was legal in Kenya; Options for the answer included yes, no and I don't know. The stigma associated with abortion was assessed using three points from the judgmental concern scale of the Individual Abortion Stigma (ILAS). In these paragraphs, women were asked to describe how concerned they were: other people had learned about their abortion; disappointing someone they love; or people gossip about them. Each item had response options ranging from not bothered to extremely concerned, and then was recoded as a dichotomous variable capture to whether women reported feeling worried about that appropriate scenario (1 - Yes, 0 - No). All analyses were conducted using StataSE 15.1 using narrative, bivariate and multivariate statistics. Since the missing data accounted for less than 1 per cent of the responses, they were recoded into the most common category of responses; only questions about marital status, religion, the ability to obtain money to pay for abortion, the legal status of abortion in Kenya and the stigma of abortion are not data - available. We conducted a sensitivity analysis, which resulted in the re-analysis after excluding all the missing data, and no conclusions were different. We used Pearson's chi-square tests to study differences in the distribution of demographics, health conditions, as well as beliefs and feelings around abortion by type of abortion procedure (MVA against medical abortion). Pearson's chi-square chi-square were also used to study differences in the distribution of PCAC scores by type of abortion procedure. We ran bivariate and multivariate ordered logistical regressions to study the relationship between the type of abortion procedure, demographic characteristics, self-assessment of health status, as well as beliefs and feelings around abortion and general PCAC evaluation. In multivariate analyses we have included variables, significant in bivariate analyses (p-value<0.05); multivariate analysis is also controlled by age, marital status, education and employment status, regardless of the significance of the bivariate analysis. All regression analyses took into account the potential intragroup correlation at the clinic level (i.e. that observations are independent in clinics but cannot be independent in clinics) using appropriate reliable standard procedures for errors. A total of 383 women were applied to the study; two of them were not eligible to participate in the study, and seven were denied consent to participate in the study. Of those who agreed, only three had not completed the survey and a total of 371 had completed the examination. Of these, 353 (95%) women have reliable data on all PCAC articles, including 157 people who received ANVA and 196 who received medical abortions. Demographic characteristics, self-assessment of health status, as well as beliefs and feelings about abortion, stratified by type of abortion procedure received, are presented in Table 1. P-values corresponding to chi-square tests are also included. A higher proportion of women in the MVA sample were aged 35 and over compared to the medical abortion sample (18% vs. 7%, respectively; p 0.001), while the higher proportion in the sample of medical abortion compared to the MVA sample was less than 20 years old (13% vs. 4%, respectively; p 0.001). Most women, both among MVA and medical abortion samples, respectively, were not married, partners or cohabitation (73% and 81%), had at least secondary education (87% and 93%), are currently employed for pay (62% and 55%) And identified as Christians (95% and 96%); statistically significant differences in these characteristics in different samples were found .0066), although the difference is only approaching statistical significance. There were no statistically significant differences in the items relating to the beliefs and feelings associated with abortion in MVA and medical abortion samples. Most women are of both reported that it was easy to pay for transportation to the clinic (77% and 83%, respectively); however, the majority said it was difficult to get money to pay for the procedure itself (66% and 57%, 57%. Nearly half of the women in both samples reported that abortion was illegal in Kenya; about a fifth reported that they did not know whether abortion was legal. About 38% of women in both samples reported feeling concerned that people might learn about their abortion, while 33% of women in the MVA sample and 41% of women in the medical abortion sample reported feeling disturbed by loved ones. A lower proportion of women in both MVA and medical abortion samples reported that they were concerned that people would gossip about them (26% and 21% respectively). None of these characteristics were statistically significantly different in the type of abortion procedure. The distribution of PCAC scores (low, medium or high) for the full scale and each subscale of the abortion procedure type, including the p-value corresponding to Pearson's tests, is included in Table 2. A significantly higher proportion of women in the MVA sample had PCAC scores classified as high compared to those in the medical abortion sample (36% vs. 23%, respectively; p 0.005). Although no significant differences in the distribution of sub-scale rates of respectful and supportive care were found, a significantly higher proportion of women in the MVA sample were categorized as high in the subscale Of Communication and Autonomy than in the abortion sample (24% vs. 11%, respectively; p<0.001). Distributions of sub-scale points Respectful and supportive care and Communication and Autonomy, stratified by type of abortion, are included in the S2 and S3 tables, respectively. The results of two-variant customized logistical regressions, which explore factors related to the PCAC assessment (after accounting for potential intragroup correlation at the clinic level), are presented in Table 3 under the column marked Unadjusted Coeff. The type of abortion procedure was significantly related to the PCAC assessment. Without taking into account other factors, the odds of having high or average PCAC scores were 95% higher among MVA customers than MA customers. It has also been found that employment status, current health status and worry about disappointing loved ones, which is largely due to the evaluation of PCAC. Specifically, the odds of a high or average PCAC score were 62% higher among women who reported working for a fee than those who did not. Those who rated their current health as excellent, very good, or good had a chance of a high or average PCAC score, which was about 100% higher than those who did not. Compared to women who weren't worried about disappointing loved ones, those who worried had a chance of a high or average PCAC score, which was 37% lower. No other significant differences in the PCAC assessment were found in terms of age, marital status, education, parity, beliefs regarding the legality of abortion in Kenya, paying for an abortion or being transported to a clinic, and worrying about people learning about their abortions or that people would gossip about them. The results of a multivariate analysis of the logistical regression of orders exploring factors related to the PCAC assessment (after accounting for potential intragroup correlation at the clinic level) are also presented in Table 3. The type of abortion procedure remained significant in multivariate analyses after adjustment to other factors. For all the equal terms, MVA customers had a chance of being high compared to the low or average PCAC score, which was 92% higher than that of MA customers. In addition, women who rated their current health as either excellent, very good, or good, had a chance of a high or average PCAC score, which was 80% higher than those who did not. Employment status and worries about the frustration of loved ones were marginally significant at a p-value of less than 0.10; After controlling other factors, the odds of a high-compared to low or medium pAc score were 55% higher among women who reported working for a fee than those who did not (p 0.06) and 29% lower among women who worried about disappointing loved ones compared to those who were not (p 0.07), respectively. Other demographic characteristics (age, marital status and level of education) remained statistically insignificant in multivariate analyses. The number of births and worrying about the frustration of loved ones lost statistical significance in multivariate analysis after controlling other factors. Human-centred care is an essential aspect of the quality of care; this is important from a human rights perspective and has an impact on long-term health outcomes, and this is best assessed by the woman herself. Because of the highly stigmatized nature of abortion, little is known about the quality of abortion care outside the security. To our knowledge, this study is the first to examine a person's abortion care center services using a proven scale. Our overall findings are positive: in both methods, most women felt they were treated with respect, the staff of the agency took care of them, their information was confidential, they were given attention, there were enough staff and they could trust the staff that was there. This is in line with other studies: a study in Mexico found that women reported consistently high satisfaction after receiving abortions in public clinics. Another study found that over 98% of women reported being satisfied with their chosen method, with medication clients more likely to choose this method again compared to surgical clients (94% vs. 78%, respectively). In the U.S., similarly high satisfaction rates were found abortions; close satisfaction matching for all types of outpatient surgical care for women. Problems with the quality of abortions in however, remain, especially with regard to communication and autonomy. According to our data, only 61% of MVA customers and 57% of drug customers reported that providers called them by name all the time. Only 77% and 74% respectively, women said they agreed to care, and only 60% of MVA customers and about 41% of drug customers indicated that suppliers talked to them about how they felt. S2 and S3 tables. These are all areas of care and treatment that women have identified as important markers of quality and human-centered care. Bivariate and multivariate analyses show that the type of abortion predicts a female child-centered care score. MVA customers are more likely to report being treated in a friendly manner, called by name, asked how they feel and how much pain they are in pain. There are several possible explanations for these findings. First, MVA customers have more opportunities to interact with suppliers: more time, more communication, and potentially present while pain is observed in the clinic. As a result, providers can actively engage to ask women how much pain they have been in and how they have felt. Secondly, in Kenya, MBA training involves a vocal local method that involves talking to a woman throughout the procedure. This method is personalized, and providers are trained to call a woman by her first name, an important component of PCAC. Furthermore, it is likely that expectations of care and previous experience with health systems may explain the difference in human-centred care, given that these factors may play a role in deciding whether to seek reproductive health services. In both bivariate and multivariate regressions, other factors associated with higher levels of human-centred care include work and a message of higher self-esteem of health; on the other hand, worrying about the frustration of loved ones, a measure of abortion stigma, has been associated with a lower level of the person in the care center. These findings are not surprising; employment status, for example, is associated with women's empowerment and higher status; it was therefore likely that working women would be more likely to be able to defend their interests and demand better care, while health care providers might also be treated with greater respect. Given their social status. In addition, women who report better health may have less anxiety about their overall health, and as such may report better experiences. We know, for example, that health self-assessment has a strong association with other factors such as mortality and social resources. Reports of higher levels of stigma, on the other hand, were associated with care This is an important finding, given that abortion in Kenya continues to be highly stigmatized, with community communities abortions involve promiscuity or involvement in sex work or prostitution. Thus, women who report higher levels of stigma may be more likely to report lower levels of human-centred care because they tend to perceive low support, even from proxies such as health care workers or family members. In addition, women with higher levels of stigma may also interact and interact with service providers in different ways, influencing a sense of self-reaffirmation to demand or expect better care. In addition, stigma is associated with psychological consequences, including anxiety, depression and advanced physiological disorder. Thus, combined with self-assessment of health conditions, stigma may be linked to other health-related anxieties that will encourage women to report worse experiences. This study has a number of limitations. First, the women were interviewed in a medical facility. Past studies of the quality of care show that interviewing women in an institution, immediately after their medical procedure, is associated with higher levels of satisfaction with care and the intended quality of care. Thus, it can offset our results positively and underestimate the mistreatment. Second, this study includes individuals who took their first pills at a medical facility, as well as women who return to their second pill for medical abortion. There may be differences in the type of care and interaction that women getting their first versus second pill will have. However, most pains are experienced after the second MA pill and therefore these differences may be minimal. This study is also limited to a small sample size. Although this study works to detect differences between the two tools, it may have lower power to detect differences between queries and the result of interest. In addition, a small sample size limits our ability to subanalyse with a subregion of human-centred care. Future studies should include a larger sample size in order to model the results differently for ease of interpretation. We conducted a human-centered abortion sensitivity analysis as a continuous, categorical and binary result. We decided to use a categorical result due to the simplicity of interpretation and the main results for the categorical result in accordance with the findings for bivariate results for continuous result and bivariate and multivariate results for binary result. Additional covariates were comparable in different human-centered designs Abortion. A categorical outcome may be more intuitive for health professionals interested in improving women's experience in care compared to the continuous outcome, where it may be less clear that a one-on-one point increase in human-centric care can lead to clinical practice; on the other hand, the categorical result retains thinner compared to the binary result. Another limitation is that only women from Nairobi County, which includes urban populations living in both formal and informal settings, participated in the study. The results may thus be not entirely common for rural communities, as the level of social support, experience and socio-economic status of women in rural areas may be quite different. In this study, women who access drug abortions from less formal institutions (i.e. private informal service providers) may have very different experiences than women. In various institutions, including public and private institutions, as well as in higher and lower-level institutions, women seek safe abortion services. Given the perception that private facilities are often of higher quality, it is possible that this sample represents a higher socio-economic status group than those to be used for lower-level public institutions. Future studies should examine human-centred care in different health facilities and in different contexts. Our findings highlight the need for closer attention to patient experiences, patient and service providers' interactions, and assessments among abortion providers about how cost, stigma, and choice method can interact to influence the experiences of women seeking abortion services. Human-centred care requires aligning the agenda of patients and doctors through attention to communication, power and patient autonomy. There are a number of important changes that need to be made. Service providers should make the abortion experience personal for women by ensuring the use of the names of both customers and service providers. Such an approach would further destigmatize abortions among women. Our findings demonstrate the value of introducing providers' training for medical abortion, which is equivalent to the vocal local training given to surgical abortions and emphasizing greater personalized care. Lower PCAC scores among women who have obtained medical abortion have broader political implications because of the global trend in middle-income countries not culling from surgeries; the trend is accelerating in many countries due to the growth of non-revised sales in pharmacies. Where this happens, this is likely to lead to a further reduction in human-centred care for women, as their interactions with suppliers are reduced to engaging focused on pharmaceutical procurement. Responding to this will need to include a combination of both policies and programmes, increasing non-traditional ways of significant interaction with women outside of clinical settings. Internet-based support networks and hotlines, outreach workers and trainings for a wide range of clinical, pharmaceutical and social support providers are likely to play a role. Experts in this area have only recently been cooperating on more measures. Further efforts are needed continue to improve the quality of women's abortion care around the world, especially in relation to women's experience in care. We thank the research team, including Sun Cotter, Beth Phillips, Avery Seefeld, Edvard Ikiugu, Ginger Golub, James Ovuta, Nancy Onditi and Maureen Odongo, for their efforts. 1. Mohamed SF, Izugbara C, Moore AM, Mutua M, Kimani-Muraj EW, Siraba AK, et al. Estimated frequency of induced abortions in Kenya: cross-study. BMC Pregnancy Of Childbirth. 2015;15:185. PMID:26294220 2. 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