Nigerian Journal of Social Psychology

Published by
Nigerian Association of Social Psychologists
www.nigerianjsp.com

NIGERIAN JOURNAL OF SOCIAL PSYCHOLOGY

Volume 3, Issue 1

Online ISSN: 2682-6151
Print ISSN: 2682-6143

2020

Women's experience and perceptions of quality of post-abortion care (PAC) at public health facilities in Nigeria

Nkechi Emma-Echiegu[1]
Chibuogwu Izugbara[1, 2]
Ogbonnia Eze
Philip Ekene Mbam
[1]*Department of Psychology and Sociological Studies, Ebonyi state university, Abakaliki*
[2]*corresponding Author (cizugbara@yahoo.com)*

Abstract

Abortion is restricted by law in Nigeria except to save a woman's life and most abortion procedures are performed under unsafe, clandestine conditions. In Nigeria, abortion related complications contribute a significant percentage of maternal mortality. Using data from exit interviews and in-depth interviews with Post-abortion care (PAC) clients following their discharge from care, we assessed PAC clients' experience with provision of post-abortion care as well as their perceptions of the quality of the quality of PAC at public health hospitals in Nigeria. Post-abortion care (PAC) was introduced in public health systems as a way to reduce maternal mortality and morbidity in settings where abortion laws are restrictive. Our findings show that waiting time for treatment at the public institutions across the country was relatively short. PAC clients were satisfied with the prompt attention they received at the facilities. Our findings further revealed that PAC clients were generally satisfied with post-abortion care they received at the health institutions mainly because of the positive and humane attitudes exhibited towards them by the health professionals. However, few of the PAC clients expressed dissatisfaction with PAC services at the public health institutions due to the provocative nature of some health professionals.

Keywords: Post Abortion Care, Quality, Public Health Facilities, Women's Experiences, Perception.

INTRODUCTION

Unsafe abortions are a serious public health problem. Defined as a procedure for terminating an unintended pregnancy performed by persons lacking the necessary skills, in an environment that does not conform to minimal medical standards, or both (Murray & Frenk, 1999; Arambepola, et al. 2014). Unsafe abortion is one of the three leading causes of maternal mortality globally, along with hemorrhage and sepsis from childbirth (Arambepola, et al. 2014).

Globally, an estimated 25 million unsafe abortions occur each year with about 70,000 women of childbearing age dying yearly from the complications of unsafe abortion (Brawley, 2000; Arambepola, et al. 2014). According to WHO, over 69,000 of these mortalities occur in developing countries while 23,000 occur in sub-Saharan African countries alone, representing an estimated 680 deaths per 100,000 abortion procedures in Africa (Melkamu et al, 2005, Murray & Frenk, 1999; Arambepola, et al. 2014)).

Currently, about 90% of women of childbearing age in Africa live in contexts with restrictive abortion laws (Isaac, 2005; Jackson, 2011). The majority of women needing abortion in these contexts resort to unsafe methods and procedures resulting in fatalities, severe disabilities or complications (Brawley, 2000), which require treatment, hospital stays, intensive care, and attendance by highly skilled, yet scarce, health providers (Brawley, 2000).Consequently, unsafe-abortion-related mortalities and morbidities persist (Jackson, 2011; Brawley, 2000).

In Nigeria abortion is restricted by law except to save a woman's life. Nigeria has one of the highest maternal mortality ratios in the world (608/100,000 live births) (Adinma, et al, 2010; Arambepola et. al. 2014), and abortion-related complications contribute a significant percentage to the general burden of maternal mortality (Arambepola et. al. 2014). The incidence of abortion in Nigeria is high and most procedures are performed under unsafe, clandestine conditions. For instance, in 1996, an estimated 610,000 abortions occurred (25 per 1,000 women of childbearing age), of which 142,000 resulted in complications severe enough to require hospitalization. The number of abortions is estimated to have risen to 760,000 in 2006. According to conservative estimates, more than 3,000 women die annually in Nigeria as a result of unsafe abortion (Bankole et. al. 2015). The consequences of these losses and sufferings to individuals, families and communities are manifold (Arambepola et. al. 2014; Bankole et. al. 2015).

Post-abortion care (PAC) was introduced in public health systems around the world since the 1994 International Conference on Population and Development (ICPD). PAC was developed as a way to reduce maternal mortality and morbidity in settings where abortion laws are restrictive (Murray and Frenk, 1999 and, Arambepola,C, et al. 2014).

The PAC Consortium updated the definition of PAC to include five elements namely, prompt treatment of complications from unsafe (or spontaneous) abortion that are potentially life-threatening, using manual vacuum aspiration (MVA) or other preferred methods; (8-10) Offering contraceptive counselling and methods to help women achieve their reproductive intentions and avoid repeat abortions; (Melkamu, et al, 2005; Murray & Frenk, 1999; Arambepola, et al. 2014) Offering on-site, or through referral, other reproductive health services needed by women

experiencing abortion complications (Melkamu et al, 2005; Murray & Frenk, 1999; Arambepola et al. 2014)).

The World Health Organization recommends assessing clients' perspectives as part of routine monitoring and evaluation of post-abortion services, including post-abortion family planning (Melkamu, et al, 2005; Murray & Frenk, 1999; Arambepola, et al. 2014)

Using data from exit interviews and in-depth interviews with PAC clients following their discharge from care, we assessed PAC clients' experience with provision of post-abortion care as well as their perceptions of the quality of the quality of PAC at public health hospitals in Nigeria.

MATERIAL AND METHODS

Study Design

An inductive study approach was adopted utilising the qualitative method of in-depth interviews (IDI). Thematic analysis was utilised to structure the data

Study Setting

The data collection was conducted at 227 public health facilities providing PAC in six states and Federal Capital Territory. Focus was on public health facilities on account of the fact that government investments in service improvements are principally directed to public health facilities and majority of PAC cases are managed or treated in public health facilities though initiation of induced abortions usually start in private facilities (World Health Organization 2010). Again, specialist facilities that do not offer PAC often and lower level facilities such as dispensaries are not likely to provide PAC.

Inclusion Criteria

For each selected facility, women who have been treated for PAC were included in the study.

Exclusion Criteria

Participants who declined to participate or were unable to provide informed consent or assent were excluded. Patients who are not yet physically or psychologically stable following treatment and could not provide informed consent were ultimately excluded from the study.

Data Collection

The IDI were collected from November 2018 - January, 2019. We used data from exit interviews and in-depth interviews with PAC clients following their discharge from care, we assessed their experiences and perceptions of the quality of care they received. At all the study sites, PAC providers were used as gatekeepers, facilitating the identification of eligible study subjects. Prior to deployment, 20 data collectors with clinical and social science backgrounds, including experience conducting qualitative interviews with women on related topics, received a 10-day training on the ethical, technical, and logistical aspects of data collection. All participants signed a written consent prior to the IDI and the interviews took place in convenient places where privacy

and confidentiality of the participants were maintained. In all, a total of 153 in-depth interviews (IDIs) were carried out with women who had sought treatment for post-abortion complications (tables 1)

In-Depth Interviews				
State	**Policy Makers**	**Providers**	**Women**	**Total Per state IDIs**
Anambra	3	15	8	26
Bauchi	4	8	10	22
Cross River	2	8	9	19
Edo	3	8	15	26
FCT	3	9	8	20
Kano	1	8	9	18
Kogi	2	9	11	22
Total	**18**	**65**	**70**	**153**

Table 1 In-depth Interview

The interview guidelines, consent/assent forms, and scripts were pre-tested, resulting in a revision to impart a better in-depth character to the questions. The final guide was semi-structured, open-ended and utilized probes. The in-depth interviews were performed in English, Hausa and Igbo languages and lasted between 30-60 minutes and were tape-recorded. The data collected were transcribed and analyzed using Dedoose web- application.

Data Analysis

The recorded data were transcribed verbatim, read through several times and carefully coded manually. Data was analysed thematically through the Dedoose web-application. Furthermore, a thick description to reflect the content of the data was employed. The interpretation of the data was continuously discussed and re-evaluated by all researchers in the team. Additionally, the data were reviewed to categorize extracts for clarification of the themes.

Ethical Considerations and Confidentiality

Ethical approval to conduct this study was obtained from National Health Research Ethics Committee, Nigeria. Other relevant approvals were sought from the different states and hospitals where sampled facilities were located. The study was identified as a minimal risk study. A written consent form stated the rights of the participants, and confidentiality and the anonymity of the participants were guaranteed. The data and informed consent forms were stored safely under lock and key were used only by the researchers involved in the study.

Results

Tables 2- presents socio-demographic characteristics of participants by state level. At the state level, a total of 165 PAC clients were interviewed in Anambra, 164 in Bauchi, Cross River 164, 169 in Edo, 164 in FCT, 256 in Kano and 165 in Kogi. Persons aged 35 years and above were the majority in Anambra (39.39%) and Kogi (24.85), while those aged 25-29 years formed the majority for Bauchi (33.54), Cross River (26.83), Edo (, 26.63) and Kano (27.34).

With regard to region of residence, the highest proportion of the total participants (54.45%) lived in urban areas while 45.55% lived in the rural areas. For educational attainment, the highest

Characteristic	Anambra N=165 n(%)	Bauchi N=164 n(%)	Cross River N=164 n(%)	Edo N=169 n(%)	FCT N=164 n(%)	Kano N=256 n(%)	Kogi N=165 n(%)	Overall N=1247 n(%)
Age of respondent (years) age group								
14-19	10 (6.06)	14 (8.54)	19 (11.59)	18 (10.65)	26 (15.85)	19 (7.42)	19 (11.52)	125 (10.02)
20-24	20 (12.12)	30 (18.29)	37 (22.56)	24 (14.2)	46 (28.05)	47 (18.36)	37 (22.42)	241 (19.33)
25-29	39 (23.64)	55 (33.54)	44 (26.83)	45 (26.63)	37 (22.56)	70 (27.34)	39 (23.64)	329 (26.38)
30-34	31 (18.79)	36 (21.95)	38 (23.17)	41 (24.26)	32 (19.51)	52 (20.31)	29 (17.58)	259 (20.77)
At least 35	65 (39.39)	29 (17.68)	26 (15.85)	41 (24.26)	23 (14.02)	68 (26.56)	41 (24.85)	293 (23.5)
Area of residence								
Rural	86 (52.12)	82 (50)	62 (37.8)	92 (54.44)	37 (22.56)	147 (57.42)	62 (37.58)	568 (45.55)
Urban	79 (47.88)	82 (50)	102 (62.2)	77 (45.56)	127 (77.44)	109 (42.58)	103 (62.42)	679 (54.45)
Ever attended school (yes)	162 (98.18)	100 (60.98)	155 (94.51)	163 (96.45)	152 (92.68)	203 (79.3)	117 (70.91)	1052 (84.36)
Never attended school	3 (1.82)	64 (39.02)	9 (5.49)	6 (3.55)	12 (7.32)	53 (20.7)	48 (29.09)	195 (15.64)
Highest level of education								
Primary	13 (8.02)	25 (25)	17 (10.97)	22 (13.5)	22 (14.47)	47 (23.15)	14 (11.97)	160 (15.21)
Secondary	84 (51.85)	47 (47)	65 (41.94)	89 (54.6)	41 (26.97)	100 (49.26)	56 (47.86)	482 (45.82)
Tertiary	65 (40.12)	27 (27)	73 (47.1)	52 (31.9)	89 (58.55)	27 (13.3)	47 (40.17)	380 (36.12)
Arabic/Qu'ranic curriculum	0 (0)	1 (1)	0 (0)	0 (0)	0 (0)	29 (14.29)	0 (0)	30 (2.85)
Main activity								
Working (employed/self-employed)	108 (65.45)	57 (34.76)	81 (49.39)	91 (53.85)	54 (32.93)	81 (31.64)	59 (35.76)	531 (42.58)
Unemployed	57 (34.55)	107 (65.24)	83 (50.61)	78 (46.15)	110 (67.07)	175 (68.36)	106 (64.24)	716 (57.42)
Monthly income (working group, N=531)								
≤NGN 5,000	3 (2.83)	14 (25.45)	4 (5.33)	2 (2.25)	1 (1.85)	24 (30)	1 (1.69)	49 (9.46)
NGN 5,000-10,000	15 (14.15)	12 (21.82)	10 (13.33)	12 (13.48)	5 (9.26)	17 (21.25)	3 (5.08)	74 (14.29)
NGN 10,001-15,000	14 (13.21)	3 (5.45)	8 (10.67)	7 (7.87)	2 (3.7)	4 (5)	7 (11.86)	45 (8.69)
>NGN 15,000	74 (69.81)	26 (47.27)	53 (70.67)	68 (76.4)	46 (85.19)	35 (43.75)	48 (81.36)	350 (67.57)
Religion								
Catholic	79 (47.88)	6 (3.66)	61 (37.2)	22 (13.02)	30 (18.29)	1 (0.39)	24 (14.55)	223 (17.88)
Protestant	41 (24.85)	12 (7.32)	20 (12.2)	17 (10.06)	27 (16.46)	1 (0.39)	19 (11.52)	137 (10.99)

Other Christian	42 (25.45)	4 (2.44)	83 (50.61)	100 (59.17)	39 (23.78)	4 (1.56)	46 (27.88)	318 (25.5)
Islam	2 (1.21)	142 (86.59)	0 (0)	29 (17.16)	66 (40.24)	250 (97.66)	74 (44.85)	563 (45.15)
No religious affiliation	1 (0.61)	0 (0)	0 (0)	1 (0.59)	2 (1.22)	0 (0)	2 (1.21)	6 (0.48)
Marital status								
Married/cohabiting	133 (80.61)	160 (97.56)	99 (60.37)	121 (71.6)	102 (62.2)	253 (98.83)	128 (77.58)	996 (79.87)
Separated/divorced /widowed	5 (3.03)	2 (1.22)	2 (1.22)	5 (2.96)	6 (3.66)	3 (1.17)	3 (1.82)	26 (2.09)
Single	27 (16.36)	2 (1.22)	63 (38.41)	43 (25.44)	56 (34.15)	0 (0)	34 (20.61)	225 (18.04)

Table 2Socio-demographic characteristics of participants by state

proportion of the total participants (45.82) had secondary education, 36.12% had tertiary, 15.21% had only primary education while 2.85% said they had only Arabic/Qu'ranic curriculum.

Regarding employment status, the highest proportion (57.42%) of the participants were unemployment, only 42.58% noted that they were employed at the time of the study.79.87% of the participants were married or cohabiting while 18.04% noted that they were single.

Experiences and perceptions of the quality of post-abortion of PAC clients

Attitude of Health Professionals

The attitude of health professionals towards patients is an essential part of post-abortion care. This study revealed that the participants were generally happy about the attitude of PAC providers and praised them for being caring and friendly. A 28-year-old trader who expressed satisfaction with the attitude of the PAC providers said the following:

> *Like what I told you before, they attended to me with empathy; they were very caring, even the doctor that did it was the same doctor that did the evacuation in 2015. He does not know me but I know him, I remembered that time when he was doing it, I was shouting "Jesus, the holy spirit" he said "Keep shup! What are you talking" but this time he is more friendly, when I entered, he said "Madam don't shout, Yoruba's (a tribe) don't use to shout". While he was injecting into the drip, some poured on my body, he was telling me sorry, when he finished, he said "madam, I am done". He attended to me better than the previous one (trader, 28yrs, married, FCT).*

Another participant indicated the following:

> *The nurses attended to me very well especially during the blood transfusion, I was tired, 5 hours and I was lying on my back all through. When I wanted to help myself, I shifted and it affected the floor. I had to call her, she came, anytime I called her even in the mid night while she was sleeping, she will come and attend to me. But the one on duty on Sunday morning was not friendly initially but she later responded, she came to my side I was not looking at the second transfusion so I didn't even know that the things has finish. It was a patient that called my attention to it that the thing has finish. I called the nurse to inform her. She said was I not there just now, don't I know that it has finished. I was surprise and was asking myself why is this nurse talking to me like this? I kept quiet. At a time she decided on her own to come and remove it. Even when I started coughing my husband said he went to meet her because he know that I was reacting, I asked my husband why he did not tell me, he said that he did not want to frighten me. My husband went to meet her but her response to him was not encouraging, he said that when he met her, he said "let the doctor come now…." But later, she became friendly. All of them did very well (civil servant, 33 yrs, married, Kogi state).*

Corroborating the positive attitude of the health professionals, another participant noted the following:

The first nurse on afternoon-night duty, I love her promptness in attending to patients, she does not drag her foot on the ground though at a time in the night she did not answer me very well. I believe it was because of sleep, I was shouting "nurse" she did not answer but after sometimes she came and after attending to me she did not sleep again(student, 23yrs, married, Cross River state)

Another respondent affirmed:

I did not really receive any encouragement though I receive a little encouragement, like when my husband was insisting that we don't want blood transfusion, a doctor came and was telling him the importance and why it is necessary. But the nurse really tried, anytime she came in the morning, she usually go round the beds to ask people how they are doing (house wife, 36 yrs, married,, Kano state).

Similarly,

No! I did not waste time, as soon as I came in, they commenced treatment on me and everything began to go, they took proper care of me, I will be directing people to this hospital, this people know what they are doing(teacher, 30 yrs, married, Bauchi state).

Yet another respondent noted:

All of them attended to me with soft mind, it is only on the process of trying to bring out the baby, they were encouraging me to be strong, I told them that I am tired, they said that I should take it easy that everything will be fine(Housewife, 36 yrs, married, FCT)

Similarly,

Their attitudes were nice, the only and little challenge we had was when my people were insisting that they want to come in to see me, they refused to allow them in. another challenge was when they said that I have shortage of blood, one of my sisters said that I should not allow them to transfer someone's blood to me, I should do my best to feed very well(trader, 29 yrs, married, Anambra).

Another respondent noted:

Yes, I like the way I was being treated because I don't know any of them and they did not shout at me, they did not look down on me, am ok with the way they treated me because I don't even know the doctor, all the nurses I don't know them either, they were treating me because of what happened to me and they even had pity on me. As I was telling them about the flow of blood, everybody were concerned about me ((civil servant, 37 yrs married, Kogi state)

Dignity and Respect:

The participants have a common perception that they were treated with almost dignity and respect which for them was quality in the context of PAC. These women generally viewed their being

treated in private areas without compromising their womanhood as an indication of quality of post abortion care service they received from their service providers in the facilities they were being treated for abortion complications. We found vignettes like;

":….*so my body was well covered and nobody was looking or piping, it was only the two of us in the room and that was very good care*" (house wife, 27 yrs, married, Bauchi state)

Participants saw the respect for their dignity as good care just as these individuals have come from very strict cultural communities where dignity of women is highly observed. If the service providers have done otherwise, it would be considered not just a bad care in PAC services but an offense with strict cultural sanctions. Other extracts that resonates the perception of quality PAC services through respect for their dignity are such responses as;

".....honestly, before they treat us, they tell all the people who accompanied us to leave the ward. It will now be us and the doctors and we are respected by the nurses and doctors who will start treating us" (trader, 30 yrs, married , kano state)

Yet another stated,

" *…this hospital is different and I thank Almighty Allah and I'm extremely happy* ***[Cleared throat]*** *that I came to this hospital for treatment. And firstly, this is my third miscarriage, I've been having it spontaneously and every miscarriage I had, when I get here, I get the best treatment because they always respect our woman body when treating us, like they will cover everywhere and treat us alone"* " (Business woman, 37 yrs, married , FCT)

Autonomy regarding decision making during treatment:

The participants saw their ability to contribute to decision making during treatment for abortion complications as a good practice. As we saw in their responses, they perceived to have received quality care if they are asked by the doctors to be part of decision making regarding their treatment. Placing value on being allowed to decide what they want, the participants commended efforts to get them take part in what concerns them as seen below.

"... I enjoyed this hospital because I thought they are going to operate on me. ...before I came, I was even crying that I'm not going I don't want them to operate me. But when I come, the doctor ask me what l want and l said l don't want operation and God did His best and they cared for me, yea". " (tailor, 32 yrs, married , Anambra state)

And another said:

"... the doctor told me what he wanted to do when l came, I said the doctor I met told me that the fetus had stop growing that they may have to do an MVA for me and they may have to admit me. So I was happy he told me and l said go ahead all I want is to be ok after all I cannot help myself" " (civil servant, 32 yrs, married , FCT)

What constitute quality PAC as perceived by the participants in this study as seen in their interview responses also involves allowing them to hear and know the procedure that they have to undergo. Their views is that they may not really have objections to what the doctors and nurses feel is best

for them but their concern is to know what they are undergoing as they feel that they are vulnerable people.

Privacy and confidentiality:

The participants had a common theme that in as much as they know that sometimes they are always brought into the hospital unconscious or in a terrible condition, it was their view that quality post abortion care should ensure that their privacy and issues concerning them are kept confidential. This as they echoed is to avoid stigma associated with a person who had an abortion. This can be seen in some their narrative vignettes below.

"*….i was brought in the hospital unconscious but I am happy the way the doctors handled me and not allow people gather to see my condition. When I got myself l asked the doctor about how l came and he explained very well everything to me. It is the thing I like most because nobody else know about my problem until they bring me to the ward to see other people like me"* " (Business woman, 37 yrs, married , cross river state)

The above extract which is similar to the rest, showed the importance the PAC women attached to both their privacy and the confidentiality of information about them. The level of stigma when induced abortion is mentioned in Nigeria is high and women who have abortion problems do everything to hide it from the society. Their notion of quality post abortion care also connotes protecting their information and ensuring that the outside world does not know about their ordeal. This is further buttressed in the extract below.

"*….the doctors here are giving us good care, when they treat me, its just me and her nobody else. Even everything we discussed, nobody heard what we were talking because it just me and the doctor inside the room*" " (student, 21 yrs, single , Edo state)

Communication with service providers:

The quality care in the context of post abortion care as evidenced from the interviews of the participants in this study has shown, consists of a peaceful flow of information between the care receivers and the care givers. The themes of effective communication as what constitutes quality post abortion care weaved the entire interview response. This is seen in the extracts below.

"…the doctor is a nice person, he will tell me l want to do this and I want to do that and I really like it. For example when they come around they are always asking of my health and if I have any complain. The doctor came requesting for my medication but I told him that the other drugs has not yet arrived. So he said until the drug is complete before I can start taking it so they always talk with me about everything" " (Trader, 29 yrs, married , FCT)

"….this hospital is good. They are taking good care of us like the one I liked was when she asked me how many kids I had before this miscarriage and how did the miscarriage happened? I told her the number of kids I have and also I told her that I accidently took some tablets unknowing that I was pregnant. " (Housewife, 31 yrs, married , Kogi)

As seen in the above extracts which is synonymous in all of them, there is a sense of fulfillment the patients had when they found out that the caregivers were empathic about their conditions and communicated adequately with them. They echoed that it was quality care as care providers were able to talk to them in a manner they really liked.

Social support and Supportive care from service providers:

The participants reckoned in their interview responses that quality in the context of PAC where they are clients can also be assessed based on how the PAC providers are able to support their clients to overcome their challenges. Evidence of this is seen in the extracts from the interview responses below.

"… I tell you that the doctors are good to us. We don't have any problem with them and they are helpful. They are the best because you see, even during the MVA, she told me to be patient that I will be fine. And after the MVA when she disposed off the things she brought out from my body, she told me not to worry that the mouth of the uterus will seal up itself. That is all l need to know who is good in this job because we are already in a bad state after losing pregnancy" " (Business woman, 27 yrs, married, Anambra state)

As the above has evidenced, participants in the study have a feeling that they should be supported by their care providers since they already know that they were undergoing excruciating moments both physically and psychologically and all they needed was that support. For a participant who did not get this support, she also felt that there was no quality in the post abortion treatment she got from the health facility she was admitted into and this is shown in her response below.

"…: you see in this hospital they differ you know they are differs, section by section. But morning section they are fair and they provide good support to us. Afternoon section they are fair and give us good support. Evening section they are fair but night section, they are stupid. Because four days now, I didn't sleep, even I shout now from next tomorrow, nobody will come. go outside and talk to them a'a! Wetin! Wetin! for where. Like this old woman wey come day before yesterday, she call, cry, her daughter went to call doctor around 2'oclock in the night they didn't attend to her before they came the woman ***[Hisses]*** *na her life they front. And which is not fair*" (Trader, 30 yrs, married , Edo)*"*

The above extract from a participant that did not get supportive care from a particular night shift category of care providers saw her experience as not of quality but one of lack of quality in the kind of care provided for a post abortion patient. Thus, where the PAC women were supported by their care providers, they perceived it as quality PAC services and when they were not supported they saw it from a point of one lacking quality. Supportive care therefore was an index they used to make sense of quality post abortion care.

Action to overcome anxiety:

Where PAC service providers provided counseling services that helped the participants overcome their anxiety, they participants perceived it as quality in PAC services they received. We observed

in the study that participants reeled our blessings to doctors and nurses who talked to them in manners that they were able to overcome the shock and anxiety of losing their pregnancies with complications. This is seen throughout the interview responses of participants who received good care from their care givers as seen below.

"…: Yes I got a very good care and I know what quality care is. The way the doctor console me on my losing pregnancy make me like this hospital. There was a time I heard on the radio that this facility is bad news. That the health workers are nasty and they humiliate people when they come visiting. But when I arrived here the story wasn't as it is. Here I got the best care and I'm happy with the treatment and God will bless them" " (Housewife, 33 yrs, married, FCT)

"…the doctors gave me good care because she was always telling me that I should endure a bit it will soon be over and made me get better quick. When I came to the hospital, I was in a pool of blood but nobody was irritated rather I was comforted. So you see, no treatment can be better than this" " (Student, 24 yrs, married, Cross River state)

"…It was because of lack of rest of mind in my husband's house that made me had the miscarriage. But I feel better now because of the way one nurse talk to me. Honestly, like the first nurse that received me she comes around to ask, "=Faridah= how are you doing" with smiles and kind words. She made me forget so many things that happen to me" " (Housewife, 26 yrs, married, Kano state)

The extracts above show how the participants used the kind of actions their care providers gave them to make sense of quality in post abortion care. Such care did make them get better and changed a lot of things in their lives. The participants used different languages to suggest that being comforted through counseling and providing an atmosphere that will enable PAC patients to recover mentally and biologically was a way of determining quality in post abortion care services.

Perceptions of the quality of post-abortion care

> *I see it as when you are satisfied with the way they take care of you without being hostile to you, you do not have any complain, you are just okay. I see it as good care from the care givers (trader, 27yrs, married, Cross River state).*

Another respondent noted:

> *My idea of quality care starts with the personnel, the personnel should be friendly. I watched one foreign movie sometime ago about personnel, one thing that happened in UNTH, the doctor was shouting "We don't eat corpse, come and carry you corpse". I was surprised. I said this man will be a corpse someday. The thing start from the personnel, that is the care givers, they should know that some people lack understanding, they should be able to explain things to them, tell them why they want to do anything for their patients. Another thing is on the facility, facility should be more convenient, when all these things are in place, the patient will be well on time, like the cleaner I complained about her cleaning but she is very*

friendly, they usually call her one beautiful name, she is very friendly ((teacher, 37 yrs, married, Kano state).

Another respondent noted:

Honestly, I have seen people complain about some hospital, how they humiliate them, how insensitive they are. But when I came here I didn't witness any of that (Business woman, 28 yrs, married, Kogi state).

Yet another respondent stated:

Well, bad care is wrong directions, bad prescription of drugs, lack of attention and lack of care. For example, I told her to get me some drugs, some shops didn't have. But she had to check every store before she got the one I wanted. If it was someone else he won't put that effort she put and that's a good care (House wife, 34 yrs, married, Bauchi state).

Discussion

In this study, we assessed PAC clients' experience with provision of post-abortion and how they view quality of care and the factors that contribute to their overall evaluation of the service. Our findings show that waiting time for treatment at the public institutions across the country was relatively short. PAC clients were satisfied with the prompt attention they received at the facilities. This finding is in contrast to (14) who observed that the waiting time from arrival to treatment is usually very long.

Our findings further revealed that PAC clients were generally satisfied with post-abortion care they received at the health institutions mainly because of the positive and humane attitudes exhibited towards them by the health professionals. This finding is in agreement with (13) who reported that health professionals are usually caring and polities to patients who sought PAC services. However, few of the PAC clients expressed dissatisfaction with PAC services at the public health institutions due to the provocative nature of some health professionals. Similar finding is also recorded in Sri Lanka

The study findings show that treating PAC clients with care and respect by PAC providers gives them the needed satisfaction with PAC. From the narratives, PAC providers were applauded by the clients for the attitude towards them. The study findings further revealed that the inability of some hospital to perform post-abortion care services resulted in the referral of some participants to the hospital, while some other indicated that they chose the facility for the services based on their past experiences at the hospital which they considered satisfactory. This finding also agrees with (22) who argued that patients seek post-abortion care at particular hospitals as a result of the satisfaction or experience with the services at the facility

Conclusion and recommendation

Our findings established that PAC providers were responsive to post-abortion care at the public health institutions across the country. PAC clients were also found to be generally satisfied with post-abortion care services they received at the public health facilities.

Post-abortion care is appreciated by clients and advances access to information and shed lights on misconstructions about PAC. PAC should prioritize ways to reduce incidental costs for repeat facility visits; it should also include steps to fellow-up and support women who have been discharged after PAC.

FUNDING

We acknowledge our funders Hewlett Packard supported by APHRC Kenya in partnership with Ebonyi state university Abakaliki

References

Adinma, J.I., Ikeako, L., Adinma, E.D., Ezeama, C.O., & Ugboaja, J.O. (2010). Awareness and practice of post abortion care services among health care professionals in southeastern Nigeria. *Southeast Asian J Trop Med Public Health, 41*, 696-704.

Arambepola, C., Rajapaksa, C.L., Galwaduge, C. (2014). Usual hospital care versus post-abortion care for women with unsafe abortion: a case control study from Sri Lanka. *BMC Health Services Research, 14***,** 470

Bankole, A., Adewole, I.F., Hussain R., Awolude ,O., Singh .S., & Akinyemi J.O. (2015). The incidence of abortion in Nigeria. *International perspectives on sexual and reproductive health, 41*(4), 170-181

Brawley, M. (2000). The client perspective: What is quality health care service? A literature review

Isaac, K.(2005). Abortion legislation in Eritrea: an overview of law and practice. *Med Law, 24*(1),137-61.

Jackson, E., Johnson, B.R.,Gebreselassie, H., kangaude, G.D., & Mhango, C. (2011). A strategic assessment of unsafe abortion in Malawi. Reprod Health Matters, *19*(37), 133-43.

Melkamu, F., Enquselassie, A., Ali, H., & L. Yusuf, (2005). Assessment of quality of post abortion care in government hospitals in Addis Ababa, Ethiopia. *Ethiopian Medical Journal, 43*(3), 137–149.

Murray & Frenk, J. (1999). A WHO framework for health system performance assessment, Evidence and Information for Policy, World Health Organization,.

Sedgh, G., Singh,S., Shan, I. H., Ahman, E., Henshaw, S.K., & Bankole, A. (2016). Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends. *The Lancet, 388*(10041), 258-267.

World Health Organization,(2010) *Nine steps for developing a scaling-up strategy.*