Reviewer’s report

Title: "Confidence comes with frequent practice": Health professionals' perceptions of using manual vacuum aspiration after a training program

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Reviewer: Laura Castleman

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Title: "Confidence comes with frequent practice": Health professionals' perceptions of using manual vacuum aspiration after a training program.

Overall comments:

The authors administered a survey before and carried out focus group discussions one year after an MVA training in Malawi. The topic is of interest because of the high rate of unsafe abortion and curettage use in Malawi. The paper would be strengthened by 1) cutting out some of the specific details on the training, and 2) comparing participant perceptions from the discussion group with those found at baseline and emphasizing results related to MVA implementation—factors enabling versus blocking its uptake.

Abstract

Under Results, line 40, states "Major obstacles identified to MVA use were broken equipment and lack of staff." What period? —baseline, a year out from training, or both?

Plain English Summary

The first sentence states the paper examines the MVA skills of health personnel. The methods used do not enable skills assessment—rather the survey looks at knowledge, attitudes, and self-reports of practice. The last sentence of the background section, page 5 line 118, states that the study aim is "to explore health workers perceptions about the use of MVA…" That is different from skills.

Background

Line 84: definition of unsafe abortion. Include the most recent WHO article on this—Ganatra Lancet vol 390 no 10110, 2017.
Line 96 mentions misoprostol as the treatment of choice for incomplete abortion/postabortion care. Vacuum aspiration (VA) should be included as well; many references support VA for PAC, for example FIGO Faundes IJGO 2012.

Page 5 line 103 uses a reference from 2001. Suggest using the more recent reference on the same topic (Cochrane Review, Surgical procedures for evacuating incomplete miscarriage, published Sept 8, 2010).

It would be helpful to know the legality of MVA provision for postabortion care for the various cadres of providers in the study (clinical officers, nurses, and interns).

Methods

Page 7. Consider shortening the sections on study participants and the training intervention. For example, removing details such as "At the referral hospital the training took place during regular teaching session," and "The session started with 45 minutes of background information…" as these details do not contribute substantively to the study's aim.

Page 7: Ipas is the organization name (Not International Pregnancy Advisory Services).

Line 168: In general the MVA cannula is referred to like that—cannula (not Karman cannula).

Line 171: these steps are all probably more detailed than is warranted for the study aim. Consider deleting this step by step list, break schedule, etc. If the authors want to keep these details, then the reference to forceps needs to be clarified. Typically, in PAC before 13 weeks treated with MVA, a forceps is not used. Perhaps the authors mean a tenaculum? On page 8, line 177, the authors talk about cleaning the vagina (in addition to the cervix). Cleaning the vagina is not part of the MVA procedure. Regardless, such details should probably be deleted as they are beyond the study's scope.

Results

Page 11, Table 1. From context, it sounds like Table 1 refers to incomplete abortion but the questions are about abortion, listed as "symptoms of abortion," and "complications after an abortion." Readers in different countries may be confused (that abortion really means incomplete abortion). It's surprising that misoprostol is not listed as an option under "recommended treatment for incomplete abortion."

The authors weave participant quotes throughout the results section. This is a strength of the paper. Consider shortening the feedback shared on the training itself as that is not directly relevant to the paper's aims, and instead bringing in more data on MVA's implementation one year out—perceived supporting factors and obstacles.
Page 19: The paper states repeatedly that participants thought MVA is more time consuming than sharp curettage; for example, page 19 line 385. I didn't see that assumption addressed in the paper and am curious as to why it's a theme in the focused discussion groups. According to the 2010 Cochrane review of sharp curettage versus VA for postabortion care, MVA is significantly faster.

Discussion

Several of the statements in the discussion would benefit from clarifying if they are findings from the study, results from other studies (therefore needing a citation), or the author's opinions. For example, see the first few sentences under "Community Level" on page 23.

The authors should include the potential conflict of trainers asking directly for feedback on the training. Participants may have avoided sharing negative perceptions. Currently the discussion—and much of the paper—sounds like a course evaluation. Suggest re-focusing to perceptions of MVA usage one year after the course.

Many readers will not be familiar with the socioecological model reference on the top of page 21. If the authors want to use this model to frame much of the last half of the paper, the model should be introduced in the background, including the rationale for using here.

Page 21 line 426 notes that the study found personnel who had not previously performed MVA were enabled to do so in the training. Where is that in the results—that the training led to MVA implementation in individuals who had not previously done MVA? After re-reading the results, I don't see that data explicitly.

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