Author's response to reviews

Title: Health care providers' perceptions of and attitudes towards induced abortion in sub-Saharan Africa and Southeast Asia: a systematic literature review of qualitative and quantitative data

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Author's response to reviews: see over
Dear Editor-in-Chief,

We were pleased to read your positive response regarding our manuscript entitled “Health care providers' perceptions of and attitudes towards induced abortion in sub-Saharan Africa and Southeast Asia: a systematic literature review of qualitative and quantitative data” and we would like to thank you for the useful comments. We have made revision in line with your suggestions. Furthermore, a complete, updated literature search was conducted in four databases due to prolonged review process. Please find attached a detailed description of our changes of the manuscript, according to the reviewers’ comments. Hereby we resubmit the manuscript for publication.

We confirm that this manuscript has not been published elsewhere and is not under consideration by another journal. All authors have approved the manuscript and agree with its submission to BMC Public Health.

Yours sincerely,

Ulrika Rehnstrom Loi, RNM, MSc, PhD Student
Reviewer #1 Rajib Acharya

1) The authors state that the aim of the study was “to identify, congregate and synthesize available research addressing health care providers’ perceptions of and attitudes towards induced abortion in sub-Saharan Africa and Southeast Asia”. I think the aim should not be just “identify, congregate and synthesize”, but also to present findings in such a way that it gives readers an idea of the extent and pattern of these perceptions and attitudes in the given geographical boundaries. The authors tried to do this in the paper but it is missing from the aim. The aim should be rewritten to reflect this.

Authors’ comment: Thank you for your observation. We have thoroughly discussed the aim but consider the current formulation is focused, stringent and reflect the perceptions and patterns that emerged in relation to the subject.

2) I am not convinced about the argument that authors make to restrict their work only to sub-Saharan Africa and Southeast Asia. In fact, I am baffled by the fact they had decided to leave South Asia and Latin America from their study. As far as I am aware there are published literatures from South Asia on providers’ perspectives on abortion, the issue of morality of abortion and the obstacles they face in delivering abortion services. Some of the countries, eg. India, has fairly broad and open legal framework for abortion services and such services are available at both government and private facilities. Even in Latin America, similar issues exist. It appeared to me from the beginning of the article that the authors are aware of this. This review work, which is a very important piece of work, would have been much more enriched and useful, had they covered these two regions as well. I urge the authors to consider this seriously.

Authors’ comment: We agree with you that a thorough global analysis of health care providers’ attitudes towards abortion in all settings is certainly important but would make the paper much longer since the large differences in cultures and legal situations would then need to be elaborated. We have thus limited our focus here to sub-Saharan African and Southeast Asian countries, where the burden of maternal mortality due to unsafe abortion is high.

3) While the authors bring in nice comparisons and references between the regions and make their arguments, I failed to understand the reason why they did not quote range of actual numbers to give the readers an idea of the levels of the indicators. For example it would be desirable to say “while XX%-YY% of providers from Southeast Asia termed abortion immoral, ZZ%-AA% of providers from sub-Saharan Africa thought so”. In a meta analysis framework, such statements are made to make readers aware of the levels of indicators they are talking about. I am aware that some of the studies are qualitative in nature and do not provide numbers. Even such studies can be interestingly used to make the point. In fact, it would be nice if they did include some comparable (or even contrasting) quotes from the qualitative studies. These quotes are real data and can make the article read more interesting. I strongly feel that the authors should give range of estimates and quotes to improve the paper.
Authors’ comment: We agree that in a meta-analysis this kind of comparisons are required but this is not such a literature review and for qualitative research it is not possible to give this information. Our aim was not to conduct a meta-analysis because the scientific literature on this matter is more of a qualitative nature. The size of the paper would be rather long to include both a meta-analysis and findings from a qualitative literature review.

Reviewer #2 Janie Benson

1) [DISCRETIONARY] Background: Please see just-released article by Kassebaum et al in the Lancet on cause-specific maternal mortality. Also recent WHO report on maternal mortality.

Authors’ comment: Thank you, we agree and both the article and the WHO report on Unsafe abortion is now included in the manuscript.

2) [MINOR ESSENTIAL] Background: Not clear on meaning of “…structured access to safe abortion…”

Authors’ comment: Structured access to safe abortion has been substituted by legal access to safe abortion.

3) [MAJOR COMPULSORY] Background: Important to acknowledge that while abortion laws are restrictive in much of sub-Saharan Africa and Southeast Asia, in the last decade significant changes have occurred in legal reform and implementation of safe abortion. For example, Ethiopia approved significant liberalization of their abortion law in 2005 (Gebreselassie et al, Caring for women with abortion complications in Ethiopia: National estimates and future implications, , 2010). Ghana has a fairly liberal abortion law that was not well-implemented until the last 5 years. Zambia’s abortion law from the 1970s is fairly liberal but not implemented, but in recent years, safe, legal abortion services have been initiated.

Authors’ comment: We completely agree with you and have incorporated above-mentioned information at page 5, paragraph 1.

4) [MINOR ESSENTIAL] Methods, section of studies: Clarify that inclusion criteria = checklist of quality criteria mentioned later.

Authors’ comment: This info has been incorporated in the paper at page 6, paragraph 4 under 2.3 Selection of studies.

5) [DISCRETIONARY] Results, Human Rights and Quality of Life: awkward phrasing: “…the right of the fetus”

Authors’ comment: This was the phrasing used in the original paper but we have now made changes in line with your recommendations and it now reads: “…the foetus should also have a right…” at page 9 paragraph 4.

6) [MAJOR COMPULSORY] Discussion, Limitations. Other limitations include and
should be acknowledged in the paper: a). Sample selection of respondents varied by study; and b). Time period of the studies spanned 35 years (1977-2012). Much about abortion and abortion attitudes has changed in the two regions during this time frame, including reformed abortion laws and updated policies, and expanded safe abortion service delivery access and methods of abortion, and larger societal changes such as urbanization and women’s status. All of these would have influenced and been influenced by providers’ attitudes toward abortion.

Authors’ comment: We agree and have included the above-mentioned limitations at page 14, paragraph 1.

7) [MAJOR COMPULSORY] Interpretations. While the authors acknowledge that training and values clarification can have a positive impact on health care workers’ attitudes, please also see: Mitchell et al, Building alliances from ambivalence: Evaluation of abortion values clarification workshops with stakeholders in South Africa, 2005.

The predominance of South Africa in the studies included in the review is a dimension that should be highlighted, given that conscientious objection has emerged as a barrier to positive provider attitudes since liberalization of the abortion law occurred in the mid-1990s. Please see: Trueman and Magwentshu, Abortion in a progressive legal environment: The need for vigilance in protecting and promoting access to safe abortion services in South Africa, 2013.

Furthermore, conscientious objection around abortion provision should be noted as often abused and harmful to women’s rights and health. Please see:
--- Fiala and Arthur, Dishonorable disobedience: Why refusal to treat in reproductive health care is not conscientious objection, !"2014.
---Dickens, Conscientious commitment, #$2008

Authors’ comment: Thank you for pointing out these valuable comments - Mitchell et al, Building alliances from ambivalence: Evaluation of abortion values clarification workshops with stakeholders in South Africa, 2005, is now included in our manuscript.

Trueman and Magwentshu, Abortion in a progressive legal environment: The need for vigilance in protecting and promoting access to safe abortion services in South Africa, 2013, a very interesting article and now included in our manuscript.

Fiala and Arthur, Dishonourable Disobedience: Why Refusal to Treat In Reproductive Healthcare Is Not Conscientious Objection, also very interesting and now included in the manuscript.

8) [MAJOR COMPULSORY]: The following statement should be changed, as it is not borne out by the evidence: “This review emphasizes that midwives and nurses in sub-Saharan Africa and Southeast Asia are not yet technically and emotionally prepared to step in and share abortion care tasks together with the physicians.” There is more and
more evidence about the role of midwives and other mid-level practitioners as successful providers of abortion care, and WHO is currently preparing a guidance document on this topic. For example, while negative attitudes toward abortion among midwives in South Africa exist, safe abortion services continue to be offered by this cadre of provider. Please see:


Many of the providers’ attitudes in the studies in this review were negative toward abortion. But positive attitudes were also reported. The picture of abortion in these regions is changing, and next steps should involve building on existing positive attitudes and addressing remaining attitudinal barriers.

Authors’ comment: We agree and have made corrections accordingly at page 15, paragraph 3. In addition some of the suggested articles are now included in the manuscript.

9) [MINOR ESSENTIAL] References: Please note that the footnote numbering in the reference list is not consistent with footnotes listed in Table 2.

Authors’ comment: Thank you for observing this, it has been corrected.

Reviewer #3 Jane Harries

1) I would strongly suggest that the paper is reviewed by an editor as there are numerous language and grammatical errors and incorrect use of words. There are also numerous typos throughout this paper.

Authors’ comment: The manuscript has now undergone a thorough review regarding language, spelling and grammar.

2) References - there are numerous formatting inconsistencies and would need a careful reviewing. Apart from language issues there are some conceptual and lack of depth in terms of a systematic review on the subject matter. The themes are confusing and some concepts have been conflated. I noted some gaps in the literature as it relates to Southern Africa and have included some literature that has been overlooked and would suggest that they are included. (please see attached document)

Authors’ comment: Reviewer #2 has also suggested that more refs should be included.
We have thus carefully looked at all suggested literature and included several of them in the manuscript.

3) I would suggest that the authors, if they haven’t already, review Lipp’s 2008 study on health care professionals’ attitudes towards abortion. Studies included were mainly in the US, UK and Canada and Scandinavia but would still be most useful for framing some of the themes and has resonance for the situation in SE Asia and Sub Saharan Africa. (see reference below)
Authors’ comment: The authors are aware of this study and have actually had it in mind during the analysis although we have not directly copied the themes from Lipp’s study.

4) Abstract Please substitute another word for congregate. Need to illustrate or explain how negative attitudes impede/influence access to safe abortion services.
Authors’ comment: The word congregate has been substituted by summarize. As the Journal has a word limit for abstract, we have only included the main results in the abstract. How the conservative attitudes might impede/influence abortion service is included in the discussion section of the manuscript.

5) Abstract : Background - consider replacing word exaggerate by exacerbate
Authors’ comment: The word exaggerated has been substituted by exacerbate.

6) Methods - missing words
Authors’ comment: Has been reviewed accordingly.

7) Results 9 themes - unclear how personal trauma/value are considered one theme
Authors’ comment: We have changed this theme and it now reads ambivalence.

8) Background : what is meant by structured access to safe abortion - is this legal access?
Authors’ comment: Yes, structured access to safe abortion has been substituted by legal access to safe abortion.

9) "In many societies abortion is a taboo". This section is unclear - would suggest need to discuss the contested nature of abortion - stigmatised and why so contested - i.e. issues around the sanctity of life etc.
Authors’ comment: We agree and have now discussed stigmatization of abortion in more detail at page 5, paragraph 3.

10) Results It would be useful to identity different cadres of health care providers as attitudes are different for the differing providers often linked to their differing roles to the abortion process. The visceral and physical responses to an aborted fetus and also to the gestational age of the pregnancy as the pregnancy and hence fetus advances.
Authors’ comment: We completely agree with you, this would be very interesting but with the literature included in the review it is not possible as the different cadres of health
personnel are often lumped together. Furthermore, the definitions of midwife, nurse and physician are not the same in the different papers.

11) Please note study no. 41 is not a mixed methods study.
Authors’ comment: As mixed methods are used differently we have rephrased the paragraph and it now reads: “... nine studies ... had used more than one data collection method such as surveys, observations, focus group discussions and in-depth-interviews.” at page 8, paragraph 4.

12) Human rights and quality of life Replace severe public health problem with significant public health problem. “Only one study explored nurses’ attitudes towards abortion among women living with HIV/AIDs (31) There are other peer reviewed publications exploring HIV and abortion in South Africa - please see Orner Phyllis 2010 & 2011.
Authors’ comment: Severe public health problem has been replaced with significant public health problem. The references you have mentioned are interesting and we have read them however, they did not meet the inclusion criteria for the review. An updated literature search was done to include latest studies in line with the inclusion and quality criteria.

13) Gender, stigma and victimisation What is meant by terminating motherhood? What is meant by the majority of studies visualised gender inequalities)—these are some examples of incorrect or inappropriate word usage. Health care providers perceived themselves as murderers. This is not the correct interpretation of some of these studies – rather providers were perceived of by other colleagues (those opposed to abortion) as murderers or baby killers – providers providing abortions did not see themselves as murderers.
Authors’ comment: We have carefully looked at this and made some changes. We have, however, decided to keep some of these wordings (although they might seem wrong) since they come directly from the articles included in the literature review.

14) Religion The transition from religion to pre-marital sex is unclear. Access and quality of care Here the type of abortion procedure i.e. medical versus surgical and gestational age – i.e. first trimester versus second trimester needs to be expanded on.
Authors’ comment: We agree with you. Changes have been made accordingly.

15) Limitations Point g) several of the included studies had a qualitative approach and it is thus not possible to quantify the results; would fundamentally disagree with this statement as one is not able to quantify perceptions and attitudes – qualitative in depth research is precisely required for these types of studies and questions – so do not agree with the limitations presented. Furthermore, how would one measure practice and how would this contribute to complex issues around attitudes, beliefs and perceptions around abortion?
Authors’ comment: We agree with you. Changes have been made accordingly.
16) WHO and task shifting – while an important observation and comment – it must be noted that in South Africa (SA) most abortions (in the first trimester) are undertaken by nurses and midwives and it is physicians that are more opposed to abortion especially second trimester abortions – so the issue is not merely that midwives and nurses are not emotionally and technically prepared to step in and share abortion tasks with physicians – it applies in the SA setting at least to physicians as well. In discussion please refer to studies that have explored task shifting in relation to abortion care in SA, Vietnam and Nepal (Warriner I et al).

Authors’ comment: We have carefully discussed this and made changes accordingly.