Author’s response to reviews

Title: Why do they take the risk? A systematic review of the qualitative literature on informal sector abortions in settings where abortion is legal

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Author’s response to reviews:

Reviewer 1 (Rachel Jones)

1. This study has the potential to make a contribution to the literature but it needs some work before it is ready for publication. First, I think the framework needs to be reconfigured. The authors seem to equate informal sector abortions with unsafe abortions, but increasingly that is not the case. Use of misoprostol and even mifepristone accessed via the internet mean that many ISAs are safe, or at least not unsafe.

THE FRAMEWORK HAS NOW BEEN CHANGED FOLLOWING REV1 AND REV2’S ADVICE (FIG.1). WE HAVE NOW MADE THIS DISTINCTION BETWEEN ISA AND UNSAFE ABORTION (INTRODUCTION, PAR.3). HOWEVER, OUR POSITION IS THAT THE EVIDENCE SHOWS THAT UNSAFE ABORTION IS MORE LIKELY WHEN PROCEDURES ARE CLANDESTINE AND LEGAL PROVISION IS RESTRICTIVE (GRIMES ET AL. 2006). REV1 IS RIGHT TO POINT OUT THAT NEW (AFFORDABLE AND EASY TO COME BY) TECHNOLOGY HAS REDUCED THE RISK IN HIGHER-INCOME COUNTRIES, BUT DISEMPOWERED WOMEN WITHOUT ACCESS TO INFORMATION IN LOW-INCOME SETTINGS WILL ALWAYS BE EXPOSED TO THE WHIMS OF INFORMAL PROVIDERS. WE HAVE NOW QUALIFIED OUR STATEMENT IN THE INTRODUCTION.

2. The introduction devotes too much text to unsafe abortion in highly restricted settings. Instead you should provide background information about the (limited) provision of abortion care in countries where many folks may not be aware it is legal: Kenya, Ethiopia, South Africa, etc.

EXTRA INFORMATION HAS NOW BEEN ADDED ON THE SITUATION IN KENYA, ETHIOPIA AND INDIA (INTRODUCTION, PAR.3).

3. The information on lines 32-40 (page 3) belong in the intro/background and are not part of the methods section.

THE INFORMATION ON LINES 32-40 WAS MEANT TO INTRODUCE OUR CONCEPTUAL FRAMEWORK ON WOMEN’S TRAJECTORIES TO INFORMAL ABORTIONS. WE HAVE NOW CLARIFIED AND EXPANDED THE DESCRIPTION OF FIG.1.
4. Why did the authors not include the search terms "self-abortion" "self-induced abortion" or "self-managed abortion"? Similarly, I was surprised that none of Abigail Aiken's research made the cut. WE DID NOT THINK OF THE TERMS 'SELF-ABORTION' IN OUR ORIGINAL STRATEGY. AIKEN’S QUALITATIVE RESEARCH SEEMS TO BE MOSTLY FROM COUNTRIES WHERE ABORTION IS RESTRICTED (AS IN IRELAND AND LATIN AMERICA) (AIKEN, JOHNSON, ET AL. 2018). HOWEVER, WE HAVE NOW INCLUDED IN OUR REVIEW A VERY RECENT PAPER FROM HER ON UK WOMEN (AIKEN, GUTHRIE, ET AL. 2018). MANY THANKS FOR THE SUGGESTION.

5. What does snowball sampling mean in this context? (line 40, page 6) BY SNOWBALLING, WE MEANT TRACKING AND CHASING DOWN REFERENCES IN FOOTNOTES AND BIBLIOGRAPHIES OF THE ORIGINAL ARTICLES AND OTHER RESEARCH DOCUMENTS. WE HAVE NOW SPELLED IT OUT IN RESULTS, PAR.1.

6. Table 2 needs to be revised to include country and sample size/n of interviews, perhaps year of publication and journal. Having 8 categories of reasons for 13 studies is too much information for readers to process and can be described in the text. Alternately, you could have another tables that lists the reasons and the N of studies where it was found to be a motivating factor. WE HAVE NOW EXPANDED THE DATA EXTRACTION TABLE TO INCLUDE LOCATION OF THE STUDY, JOURNAL, SAMPLE SIZE AS WELL AS DURATION OF THE STUDY WHERE IT WAS STATED (SEE NEW TABLE APPENDIX 2).

7. The US and Hong Kong are "outliers" in this context insofar as they are relatively wealthy and have more advanced health care systems. Seeking ISAs in this context has a very different meaning than in the other countries and the authors should relate when these two countries are relevant. (Did women in the US indicate all 8 reasons or just cost and knowledge?) FOR THE US, COSTS (OR RATHER, LACK OF INSURANCE COVERAGE) WAS THE MAIN REASON QUOTED IN THE INTERVIEWS (PAG.9, PAR.2). IN HONG KONG, LAWS THAT PUNISHED MEN WHO HAD SEX WITH MINORS DETERRED YOUNG GIRLS BELOW THE AGES OF SIXTEEN TO SEEK LEGAL ABORTION FOR FEAR THAT THEIR PARTNERS WOULD BE PROSECUTED (PAG.10, PAR.2).

8. The Discussion largely repeats the findings. It would be more useful to synthesize them: ISA occurs in less developed and more developed countries, and for a variety of reasons. What are the similarities and differences across studies? What are the implications for ISA given that it is increasingly safer do to mifeprostol and the availability of mife on the internet? WE HAVE NOW SYNTHESISED AND CONTRASTED THE FINDINGS AT THE BEGINNING OF THE DISCUSSION (PAR.1).

9. Similarly, the first paragraph of Conclusions is just repeating the findings and the Discussion and needs to be deleted. REPETITIONS OF FINDINGS HAVE NOW BEEN DELETED, AND THE CONCLUSION HAS BEEN SHORTENED (PAR.1).

10. More niggling issues. Abstract: last sentence of methods and first sentence of findings are redundant. REPETITIONS HAVE NOW BEEN DELETED IN THE ABSTRACT.
11. Intro: many of the citations are dated and the authors do not seem aware of more recent research and statements. For example, Singh et al. (Lancet Global Health, 2018) estimated that 75% of abortions in India were medication abortions performed outside of a health care facility, a lower percentage than citation [2].

THIS MORE RECENT REFERENCE HAS NOW BEEN ADDED (INTRODUCTION, PAR.1).

Reviewer 2 (Tamara Fetters)

Dear Authors, I found this manuscript very interesting and very helpful. Even though the number of articles was small, it is an important question to review. I have very minimal comments and suggestions. I look forward to seeing it in print.

1. I believe that the current proportion of maternal deaths due to unsafe abortion is 8% (Sedgh G et al., Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends, Lancet, 2016, 388(10041):258-267).

THIS PROPORTION HAS NOW BEEN CORRECTED AND THE LANCET PAPER CITED (INTRODUCTION, PAR.1). FOLLOWING REV1 AND REV 2 SUGGESTIONS, WE HAVE IDENTIFIED AND ADDED FOUR MORE STUDIES. 3 BY AIKEN (GREAT BRITAIN, NORTHERN IRELAND AND THE US) ONE BASED IN CAMBODIA BY HEGDE.

2. I think that somewhere in this discussion you should mention that there are not just two outcomes for an abortion, but that morbidity can be lengthy and can lead to delays which increases risks if a lay or formal woman or a provider needs to complete that abortion.

POST ABORTION COMPLICATIONS HAVE NOW BEEN MENTIONED, AND A REFERENCE ADDED ABOUT THIS ISSUE (MELESE ET AL. 2017).

3. Also, taking ineffective medication or even effective medication that is in the wrong dosage, may not cause morbidity but can be ineffective and lead to further delays and expense. I think that this is an important article to reference in your discussion: 1.Developing a forward-looking agenda and methodologies for research of self-use of medical abortion; Kapp, Nathalie et al.; Contraception , Volume 97 , Issue 2 , 184 - 188.

THIS HAS NOW BEEN ADDED TO THE INTRODUCTION (PAR.1), AND THE SUGGESTED REFERENCE INCLUDED (SEE REFERENCES N.6).

4. On page 3, in the section on The Adopted Methodology, I think it would be good to mention here that even self-induction and unsafe abortions outside of facilities can have legal consequences for women and providers.

THIS IS AN IMPORTANT POINT, AND WE PREFERRED TO ADD A SENTENCE AND A REFERENCE IN THE INTRODUCTION (PAR.3), RATHER THAN IN THE METHODS SECTION (BERER 2017).

5. Also, in this section, it would be good to be clearer that these two options presented as "two trajectories" are often intrinsically intertwined. Many, if not most, women trying to have an induced abortion outside of a health facility end up trying multiple times to have a complete abortion.

THIS IS A GOOD POINT. DRAWING FROM COAST ET AL (2018) PAPER, WE HAVE NOW
CHANGED OUR CONCEPTUAL FRAMEWORK TO REFLECT THIS POSSIBLE INTERTWINED TRAJECTORY IN SEEKING ABORTION PROCEDURES (FIG.1).

6. Can you mention why you did not include Spanish in the paper? I wonder if you may have found significantly more articles? THE LEAD AUTHOR FOR THIS PAPER DOES NOT SPEAK SPANISH (SEE LIMITATIONS IN THE DISCUSSION, PAG.12); HOWEVER, A FEW BASIC SEARCHES WERE RUN ON SEARCH WORDS LIKE ABORTO INFORMAL AND ILEGAL, AND INSEGURIDAD AND EMBARAZO. NO ADDITIONAL PUBLICATION WAS IDENTIFIED IN SPANISH. WE COULD NOT FIND ANY RELEVANT ARTICLES FOR LATIN AMERICA. ONE STUDY IN BOLIVIA CAME CLOSE BUT IT DID NOT FOCUS ON REASONS.

7. In Table 2, I would love to see you add a column for the size of these samples in the included studies. I think that there may be articles on unsafe/clandestine abortion from Cambodia which would meet your criteria. Can you check that one more time? WE HAVE NOW EXPANDED TABLE 2 TO INCLUDE EXTRA INFORMATION ABOUT THE STUDIES REVIEWED (PAG.8-9). WE IDENTIFIED AN EXTRA STUDY FROM CAMBODIA (HEGDE, HOBAN, AND NEVILL 2012) – MANY THANKS FOR THE SUGGESTION.

8. On page 9, in the section on lack of knowledge, please consider that a lack of knowledge might be different from an inability or confusion about how to navigate the health system. Did any of the articles discuss this? It seems an important distinction. THIS IS AN IMPORTANT DISTINCTION, AND HAVE NOW INTRODUCED A REFERENCE TO THIS IN OUR RESULTS (SEE RESULTS, KNOWLEDGE OF ABORTION LAWS SECTION, PAG.9). HOWEVER, WE WERE NOT ABLE TO FIND ANY SPECIFIC EVIDENCE FROM THE STUDIES REVIEWED.

9. Women's social networks. I know that at least one of these studies refers to knowing a health worker as a determinant for accessing a safe abortion. This might be useful to mention, especially if there are others, or even if not. This does imply that SES might be a factor as these networks are more common among families of professionals. THIS IS A VALID POINT, AND WE HAVE REFERRED NOW A PAPER FROM KENYA ON THIS IN THE SOCIAL NETWORKS SECTION OF THE RESULTS (PAG.10) (MARLOW ET AL. 2014).

10. I think that you might like to reference this article in your discussion: Trajectories of women's abortion-related care: A conceptual framework. Coast E, et al. Social science & medicine (2018), ISSN: 1873-5347, Vol: 200, Page: 199-210 THIS IS A VERY GOOD PAPER AND WE USED IT TO RE-STRUCTURE OUR CONCEPTUAL FRAMEWORK (FIG.1) AND HAVE NOW ALSO QUOTED IT IN THE DISCUSSION. MANY THANKS FOR THE USEFUL SUGGESTION.

11. On page 11, you mention, "ISA is seen as the normal trajectory". Is there another descriptor perhaps? Most common? one of the challenges of a review like this is capturing articles with odd names, did you consider this article as possibly meeting your inclusion criteria? Meselu Taye Kebede, Per Kristian Hilden & Anne-Lise Middelthon (2012) The tale of the hearts: deciding on abortion in Ethiopia, Culture, Health & Sexuality, 14:4, 393-405, DOI: 10.1080/13691058.2011.649495 THE WORD ‘NORMAL’ HAS NOW BEEN SUBSTITUTED BY ‘MOST COMMON’. WE HAVE CONSIDERED THE ARTICLE BY KEBEDE ET AL 2012 "THE TALE OF HEARTS", BUT WE DON’T THINK IT MEETS THE INCLUSION CRITERIA BECAUSE IT FOCUSES ON
12. Just a couple of comments in the Discussion section. Did any of these articles mention that women thought unsafe abortion was dangerous? Did they think all abortion was dangerous? Were they fearful? Are there programmatic implications for your findings and for abortion services, in general? Could you give this a little more thought?

We did not find evidence of this in our review, but we have now highlighted the point in the future areas of research section in the discussion (last paragraph).

13. You present findings on cost of services as a deterrent but in fact some of these articles found that ISA cost more than in-facility abortions. It would be good to present these as perceived costs and also mention this finding.

This is correct, and we have now qualified this perception of costs (see Discussion, Par.4).

14. I am not sure that a first mention of misoprostol for harm reduction on page 13 is appropriate. If it was a finding, it should be in the Results, if not, this should be removed.

Women’s preference for use of misoprostol and mifepristone is mentioned in the privacy section of results (Page 9).

15. In terms of your reference [41] there are actually many many organizations, networks and digital sources for this now. It would be good to round that out. Perhaps the Kapp article will help? In the last paragraph before the conclusion, you comment on regulations. These regulations should in fact not be burdensome impediments, the role of these policies should be to facilitate safe abortion care, no? I don't think it is only about anonymity. Also, regulations are to be written by ministries and medical professionals and not lawyers, they might work better!

We have now added a comment and the reference to the discussion on this respect (last but one paragraph) and added the reference to the suggested paper (Kapp et al. 2018).

16. I have one of the articles you are looking for by Rosemary Likwa from Zambia. I have attached it as a reviewer attachment.

Many thanks for this. Unfortunately, it looks like the paper does not meet the inclusion criteria, being based on a quantitative study.

17. I think your conceptual framework is maybe too simple. Please review the ones in the Coast studies. I think that an outcome can also be short and long-term morbidity or death. I think that these trajectories often cross. In our research a significant proportion of women who sought legal services had already tried trajectory 1 and there is a premise that many of the women in trajectory 1 are really just trying to get to PAC services (I am not sure I believe that but it should be mentioned). I am not sure how to show this visually but this feels too black and white.

This is a very good point, and we have now reviewed out framework to allow for these intertwined trajectories (see Fig.1 and Section 3.3 attribute of illegal abortion, Par.2).
References for these responses


