Reviewer’s report

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

Version: 0 Date: 24 Oct 2018

Reviewer: Tamara Fetters

Reviewer's report:

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.

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).

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. 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.

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. 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. Can you mention why you did not include Spanish in the paper? I wonder if you may have found significantly more articles?

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?
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.

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.


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

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?

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.

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.

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!

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

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.
Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

Yes

Does the work include the necessary controls?
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