Reviewer's report

Title: Contraceptive use in the six months following an abortion in a restrictive abortion law country: results from a Brazilian longitudinal study

Version: 1 Date: 31 March 2015

Reviewer: Deborah Billings

Reviewer's report:

• Major Compulsory Revisions

1. The term “postabortion care” is used throughout the manuscript. It is not clear if this refers to a general use of the term, in reference to any period after an abortion or if the authors are using the PAC concept developed over many years throughout the world. It seems like the term is used in a more general way and not referring to PAC. If it does refer to PAC, then references to the extensive literature on PAC, and in particular to the literature referring to contraceptive provision and use postabortion, need to be included in the article. PAC itself has referred to women seeking care for complications of unsafe abortion. Again, the authors need to clarify whether these are the women included in the study or is it also the few women who access legal abortion services?

2. Terms are used throughout the abstract that are not clear: Results section: what is meant by “time” (which is associated with contraceptive use); what is meant by “maternity discharge”. Conclusions section: what are “standard guidelines” (standard according to whom or in relation to what?); what is meant by “simple counseling”

3. Abstract: Conclusions section: It states “Medical consultation, in the absence of contraceptive provision, makes no difference.” However, in the results section medical consultation and contraceptive counseling are stated as making an impact on contraceptive use. Is provision or counseling the key variable?

4. Background, paragraph 3: what is meant by “proper postabortion family planning”? What does that look like? What is “proper”? Overall, this paragraph mixes statements generally about abortion stigma and the quality of postabortion care with specific statements about the Brazilian reality. The authors should finish a more general discussion, citing literature that demonstrates a link between stigma and poor postabortion care and then transition to a more specific discussion of Brazil. They note that only one study (#15) was found in evaluating the quality of postabortion care in Brazil, but numerous studies around the world have looked at this issue. Authors should cite that broader literature before narrowing the discussion to Brazil only. This same paragraph then ends by defining the study aims. The aims should be pulled out to stand alone in a paragraph, rather than embedded in a paragraph that discusses many different issues.

5. The authors need to provide the reader with more clarity about the Brazilian
context. The aims highlight that postabortion contraception is offered through “a prescription” and “self-initiated use”. Are all women in Brazil left to find a way to fill a prescription and then self-initiate use? Are there no hospitals offering methods before women leave the hospital after being treated for abortion complications?

5a. Methods, paragraph two: hormonal methods and the copper IUD require a prescription. Does this mean that the study only included women leaving with a prescription for hormonal methods or the copper IUD?

Overall, the text in this paragraph does not belong in the methods section. It describes the system in the SUS, not the methods used for the study.

6. Methods, paragraph one: explain in more detail how the SUS is based on principles of health as a right and state’s duty. Show specifically how this is relevant in the study (and how it relates to the methods used).

7. Methods, paragraph three: the sample included women hospitalized following an abortion—this makes it sound like the abortion was conducted in the same hospital. I don’t think this is the case. Please clarify this in the article.

8. Methods overall: it would be very helpful to the reader if the authors could create a flow diagram of inclusion as well as the numbers of women participating in follow-up over the six month period of the study.

9. Methods overall: there is no discussion of how women’s safety and confidentiality were protected, especially when monthly phone calls were being made in relation to an illegal activity (abortion). What did the social researchers say when calls were made? How did they ensure that they were talking to the woman herself and not a family member or friend who could have answered the phone?

10. Methods: what is meant by the term “medical consultation”? Does this refer only to provision of prescription? If so, it seems like the prescription should have been given before women leave the hospital. Or is the study also interested in women who receive a prescription for an IUD or hormonal methods at some later point postabortion? This is not clear. At the same time, what was the basic definition used for “contraceptive counseling” that then was counted in the study? Did the researchers define this term for respondents or did they merely ask, “did you receive contraceptive counseling” and then let every woman interpret this in her own way before responding? If the latter, this seems problematic since women may interpret this in many different ways.

11. Please explain in better detail why Generalized Estimating Equations were used and to what means. What additional insights did using GEE provide to this study?

12. Results: why are “traditional methods” reported as contraceptive use? Which methods did this include?

13. Results, paragraph four: “On average, women who reported receipt of both medical consultation and contraceptive counseling…” It is not clear when this occurred and if that made an impact on use. Could women report this separately for different months; was it reporting of receipt at any time during the six months;
14. Discussion: the study does not show (as claimed) that national guidelines are not being followed. The national guidelines are never described in the paper so the reader does not know what they contain. The authors claim that the study shows that “primary health services were not prepared to deliver family planning postabortion care (that term itself does not make sense, since FP is part of PAC). Nowhere in the study was an analysis of the capacities of primary health services made, so this particular claim can not be asserted. Last paragraph: The study also does not show (as claimed by the authors) that “quality family planning services can contribute to contraceptive use” six months postabortion. The study does not include an examination of the quality of care provided.

• Minor Essential Revisions

The author can be trusted to make these. For example, missing labels on figures, the wrong use of a term, spelling mistakes.

1. Background, first paragraph- make it clear to the reader with MDG5 is.

2. Background, second paragraph- clarify how guidelines for abortion care (2011) include women who “seek postabortion care”. The reader needs to understand the ways in which postabortion care are included in abortion care guidelines, especially in a context where abortion is legally restricted.

3. Methods- add the term “women” before “high-risk pregnancies”. Women themselves are offered services, not “high risk pregnancies”.

4. Discussion: postabortion care is important for preventing repeat unintended pregnancy, not “preventing repeated use of the procedure”, as stated by the authors. Please also define what is meant by “More qualified counseling techniques.”

Level of interest: An article of importance in its field

Quality of written English: Acceptable

Statistical review: Yes, but I do not feel adequately qualified to assess the statistics.

Declaration of competing interests:

I declare that I have no competing interests