Reviewer’s report

Title: Comparative satisfaction of receiving medical abortion service from nurses and auxiliary nurse-midwives or doctors in Nepal: Results of a randomized trial

Version: 0 Date: 26 Sep 2016

Reviewer: Tamara Fetters

Reviewer's report:

September 20, 2016

Thank you for the opportunity to review your paper. I think it is an excellent paper on a rigorous study and will be a great contribution to our field. The intention to treat analysis, the best fit model and the low level of lost-to-follow-up are all strong indicators of the strength of this paper. I have only a few suggestions that I think will help clarify things for your readers.

In your background section, it would be nice to know a little more about the differences in training/skills/education between nurses and auxiliary nurse midwives. You have this information in procedures but I found myself wondering about this distinction earlier.

P. 6 - it seemed odd to me that women are monitored for 3 hours after misoprostol insertion. Was this a part of the study or national protocol? I'm not sure it is evidence-based practice.

p. 6 - I'm wondering if you monitored or controlled waiting time on the days of mife, miso and follow-up visits? Could this have impacted satisfaction in any way?

I think it would be better to be clearer earlier the definition of "complications" or adverse events resulting from the procedure and your definition of side effects. You have a nice description of side effects just before the Discussion section but it might be better defined earlier.

p. 9, just under the placeholder for Table 3, it is not clear if your measurement of appropriate counseling was to include the signs of complications or the expected symptoms of the medication, or both. It would be nice to hear more in the text about the components of satisfactory counseling since this is a point of debate in our field. I wonder if this might be better described as the quality and content of the provider-client interaction (counseling) rather than "quality of services"? Related to this point, I don't believe that the first or last variables in Table 4 are truly quality/provider interaction measures. I think that the first variable (and the extraordinarily high level of acceptance) on availability could merely be described in the text. The last variable is quite important but I don't think it belongs with these other "quality" variables.
p. 9 - could it be that the correlation between higher gestation and higher satisfaction could be related to relief at the termination of the unwanted pregnancy rather than actual satisfaction with the procedure?

Discussion - I think it is worth mentioning that a part of your measurement is really about how well providers counseling meets a woman's expectations of what she believes her abortion process will be like. This shows comprehension by women themselves and is a key part of the interaction.

p. 10 - I think that the first line of your second paragraph of your Discussion should be cited. I'm not sure this paragraph is even important. There is a big difference between an "acceptable level of privacy", which is important and privacy being "less than expected".

p.11 - I'm not sure the term "emergency procedure" is correct. Abortion is certainly highly stigmatized and is a personal decision but it is not necessarily for an emergency. Difficult? Personal? I can't think of a great term but I found this odd. Earlier in this paragraph, it would be good to mention that these are "elective" abortion services.

I also had a question about Table 1. Is it true that you did not ask about previous experience with MA? Was this, by chance, exclusion criteria? The number of women who had a previous abortion was not small. These women may know more about what to expect and their previous experiences may have affected their levels of satisfaction. Depending on how you dealt with this, I think this could be a limitation.

Table 5 - I found the label "Management of symptoms by women" to be unclear.

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