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Clients' reports on postabortion family planning services provided in Mexico City's public sector legal abortion program

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Abstract

Objective—First trimester abortion was decriminalized in Mexico City in 2007. We studied client views of family planning services provided during abortion care at public facilities and acceptance of postabortion contraception.

Methods—We surveyed 402 clients seeking first trimester abortion care in Mexico City. We used logistic regression to test whether postabortion contraception varied by abortion visit characteristics or client sociodemographics.

Results—Most participants (81.6%) reported being offered contraception at their visit and 89.5% selected a contraceptive method postabortion, with 58.9% selecting the IUD. Surgical abortion clients were more likely to report being offered contraception than medical abortion clients ($p<.001$), as were clients attended by a female physician ($p<.05$). Clients at the general hospital were less likely to report being offered contraception ($p<.001$).

Conclusion—Public sector facilities in Mexico City are providing a generally high level of postabortion family planning care and uptake of postabortion contraception is high.

Keywords

postabortion family planning services; Mexico City; postabortion contraception; IUD; abortion services

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Introduction

In 2007, in a groundbreaking decision, the Mexico City legislature, voted to decriminalize abortion in the first 12 weeks of pregnancy. The law that was passed stipulated that abortion care be provided in hospitals and health centers of the Mexico City Ministry of Health (MOH) free of charge for Mexico City residents and for sliding fees for women from other states [1, 2]. As of July 31, 2012, 84,159 abortions have been performed at public sector facilities in Mexico City [3]. While some research has been conducted to evaluate the quality of care in Mexico City's public sector abortion program [4–6], limited research has focused specifically on family planning services. Postabortion family planning services are a recognized element of high quality abortion care [7, 8].

In this study, we evaluate the postabortion family planning services women are provided at public sector facilities in Mexico City. We test whether services vary by sociodemographic or abortion visit factors such as the type of abortion procedure, type of site, or gestational age. We also describe client acceptance of postabortion contraception including reported reasons for not selecting any method.

Materials and methods

Between September and December 2009, we surveyed a convenience sample of women seeking abortion care at three public sector MOH facilities in Mexico City: a general hospital, a maternity hospital and a primary health care center. These sites were selected because they reflect the three types of public sector facilities where abortion services are offered. Together, the sites accounted for 61% of all abortions performed at public sector facilities in 2009, with 43% of the total performed at the primary health center [9].

Women aged 18 years old or older, and a client for a first trimester medical or surgical abortion, were eligible to participate. The survey was conducted after women's appointment, in a private space at the facility. All participants provided verbal informed consent to participate. The surveys were conducted by three female interviewers. The interviewers attended the sites nearly all days that abortions were offered, and recruited as many participants as possible. Surgical abortion patients were recruited the day of their abortion. Medical abortion patients were recruited the day of their follow-up visit, which is generally two weeks after the appointment when they receive misoprostol. Participants received a gift card worth approximately US$10 upon completing their survey. We estimated the sample size for the study so we could detect an expected difference of 15 percentage points in women's overall rating of care, the primary study end point, for those seen at the primary health center versus at either of the hospitals, with 80% power. For a detailed description of methods, see Becker et al. 2011[4]. The study protocol was approved by the University of California, San Francisco Committee of Human Research and by the Mexico City MOH.

Survey questions assessed whether the staff had discussed family planning methods at any of the appointments, and if so, whether the information provided had been easy to understand and whether the client felt it had been sufficient. Women were also asked whether the staff had offered any contraceptive methods at their appointment(s), and if so,

which methods. Additionally, women were asked whether they had felt any pressure from the staff to accept a particular type of contraceptive and if so, which method. Women were also asked whether they selected any contraception postabortion, and if so, which method(s). Those who had not selected any method were asked in an open-ended question why they had not selected any method. The survey also included questions asking whether the staff had discussed emergency contraception or sexually transmitted infections, and if the staff had informed the woman when she could resume sexual activity. Social and demographic characteristics assessed included age, education, marital status, parity and state of residence. Abortion type (medical or surgical), women's gestational age, and physician gender were also measured. Survey questions were adapted from a previous study assessing patient perspectives on abortion care [10]. The questionnaire was developed in English and translated into Spanish by a native Spanish speaker. We pilot tested the survey with 12 women to assess question clarity and modified wording as needed.

Data were analyzed using Stata, version 11.2. We presented frequencies and means of variables. We estimated bivariate and multiple logistic regression models for two outcomes: whether the staff offered the client contraception and whether the woman selected a postabortion contraceptive method. Independent variables in the logistic regression analyses were: age, parity, education, state of residence, marital status, site, type of abortion procedure, gestational age, and physician gender. Variables significant at the $p<.10$ level in bivariate analysis were included in multiple logistic regression models. We consider p-values less than 0.05 as statistically significant.

Results

A total of 597 women were informed about the study, and 402 participated, for a participation rate of 67.3%. The mean age of participants was 25.5 years. Over half had a high school education or higher (Table 1). Most women were residents of Mexico City, but 29.1% were from other states of Mexico, most commonly, from the neighboring state of Mexico. Over half were single. Forty-three percent were nulliparous, while 32.4% had two or more children. The sample was nearly evenly split between women who received medical and surgical abortions. The mean gestational age was 8.4 weeks. Slightly less than half (47.8%) of the participants were attended by a female physician. The percentage attended by a female physician varied by site, with 97.1% of clients at the maternity hospital seen by a female physician, compared with 32.1% at the primary health center, and 14.2% at the general hospital ($p<.001$).

When asked about previous use of contraception, 87.0% reported ever having used a contraceptive method. Nineteen percent of women reported they had not been using any method at the time of conception, 32.6% said they were using condoms, 15.7% said they were using oral contraceptive pills, and 14.7% said they were using the IUD. This finding is surprising, given the high level of effectiveness of the IUD. We speculate that many of these participants had been taking a break or rest from the IUD at the time they conceived and were reporting on the method they had used most recently, but additional research is needed to better understand how and why these women became pregnant. The remaining

participants reported other methods including injectables, rhythm method, and emergency contraception.

The majority of participants (87.8%) reported that a staff member had discussed family planning methods during the appointment (Table 2). Of those who received this information, over 90% reported that the information was clear and sufficient. However, only 25.6% of participants reported that the staff discussed emergency contraception, and 37.8% reported that the staff discussed sexually transmitted infections. Slightly over two-thirds (68.4%) were informed when they could resume sexual activity.

Most participants (81.6%) reported being offered contraception at the visit. The percentage offered specific methods was as follows: the IUD (72.9%), oral contraceptive pills (46.0%), injectables (33.6%), and condoms (21.6%). Other methods mentioned less frequently included sterilization, the patch and the implant. When asked whether they had felt any pressure from the staff to select a particular contraceptive, the majority (88.3%) indicated they had not. Of participants who did feel pressure (n=47), the majority (n=41) indicated they had felt pressure to select the IUD. The other methods mentioned included: oral contraceptives (n=1), injectables (n=1), patch (n=1) and sterilization (n=1).

Clients attended by female physicians were more likely to report being offered contraception compared to clients attended by male physicians (95.3 vs. 69.1%, respectively, $p<.001$). Additionally, when asked whether specific contraceptive methods had been offered, participants attended by female physicians were more likely than those attended by male physicians to report being offered the IUD (91.2% vs. 56.2%, $p<.001$), oral contraceptive pills (57.3% vs. 35.7%, $p<.001$) or injectables (46.9% vs. 21.3%, $p<.001$).

In multivariable analysis, women seen at the general hospital had a lower odds of reporting they were offered contraception at the visit compared to women seen at the primary health center or maternity hospital (OR=.13, $p<0.001$ and OR=0.04, $p<0.001$, respectively) (Table 3). Women attended by a female physician compared to a male physician had a higher odds of reporting they were offered contraception (OR=2.99, $p=0.028$), as did those who had received surgical abortions compared to medical abortions (OR=5.44, $p<0.001$).

Nearly all women (89.5%) selected a postabortion contraceptive method (Table 4). Overall, 58.9% selected the IUD, 12.2% oral contraceptive pills, 8.0% injectables, and 5.0% condoms. Other methods selected less frequently included the implant (3.0%), sterilization (2.2%), and the patch (1.5%). One respondent selected abstinence. In multivariable analysis, the only factor significantly associated with uptake of postabortion contraception was physician gender. Participants attended by a female physician had an increased odds of selecting contraception postabortion compared with those attended by a male physician (OR=6.32, $p=0.013$).

The most frequently reported reason for not selecting any contraception postabortion was because the woman needed more personalized information to decide on a method (n=19). One participant explained she had not selected any contraception at the visit because she felt uninformed about contraceptives and needed more information to decide on a method that suited her needs. The next most frequently mentioned reason was a low perceived risk of

pregnancy due to infrequent sexual activity or not having a partner (n=10). Other reasons included plans for sterilization or hysterectomy (n=3), wanting to resolve an existing health issue first (n=2), preferred method unavailable at the site (n=2), staff requesting that the woman return for a follow-up visit to get family planning (n=2), wanting to consult one's partner first (n=1), having to pay out-of-pocket for contraception because not qualified for free services (n=1), being focused on the abortion experience itself and unable to make any decisions about family planning (n=1), and not having thought about family planning (n=1).

Discussion

In this research, we evaluated the postabortion family planning services provided in Mexico City's public sector legal abortion program. We found that the vast majority of participants were counseled about family planning during their visit and offered contraception. Furthermore, nearly all respondents considered the counseling they received as clear and the information provided as sufficient. These findings suggest that women are receiving high quality postabortion family planning care. Our results are consistent with other studies of public sector abortion clients in Mexico City which have also found high rates of contraceptive counseling and provision of contraception [5, 6].

Nevertheless, our findings do point to areas where improvements could be made. While family planning methods in general were discussed frequently, emergency contraceptive pills were rarely mentioned. Although knowledge of emergency contraception has been increasing in Mexico, a high percentage of reproductive-aged women are still unaware of this method [11]. It is important to include postcoital contraception in counseling in the event that other methods fail or are not used. Important related topics, including sexually transmitted infections and when participants could resume sexual activity, were also discussed less frequently. Studies of prenatal clients in Mexico City have found chlamydia to be prevalent in between 3.6% and 10% of women [12, 13], and gonorrhea to be prevalent in 4.5% [12].

We identified significant differences in the provision of family planning services by type of abortion procedure, and site of care. Results revealed that clients receiving surgical abortions were more likely to report being offered contraception than clients receiving medical abortions. Surgical abortion clients spend more time at the facility and are offered IUD insertions at the time of their abortion, not just at follow-up. Improving contraceptive service delivery for medical abortion clients is a priority, particularly given the trend of an increasing percent of all abortions in Mexico City MOH facilities performed medically [5]. Women seen at the general hospital were less likely to report being offered contraceptives at their visit than women at the other sites. What leads to this difference requires further investigation, but we speculate that there may be barriers at the general hospital related to staffing or client load that make the provision of contraceptive services more difficult. Since our study was fielded, the Mexico City MOH has begun to shift the majority of abortion services to designated primary level health centers which are specialized in providing abortion care [3].

We found the vast majority of clients (89.5%) selected a method of contraception postabortion, with 58.9% selecting an IUD. The high acceptance of IUDs may be due to providers' placing emphasis on the IUD in contraceptive counseling over other contraceptive methods, likely because they perceive the IUD as offering clients' the best protection from future repeat unintended pregnancies and abortions. Our results on contraceptive uptake are comparable to what has been reported in other research in public sector hospitals in Mexico City [5, 6]. In one study with over 20,000 patients at public sector hospitals, researchers found 82.3% adopted a method of contraception postabortion, with 41.6% selecting an IUD [5]. Given that postabortion acceptance of the IUD has been linked to a reduced risk of repeat abortion [14, 15], the high acceptance of IUDs may be a contributing factor to the rate of repeat abortions. Service statistics indicate that the percent of clients seeking repeat abortions at public sector sites is 0.6% [3].

We found acceptance of postabortion contraception was higher among clients attended by female physicians, which we speculate may be related to differences in contraceptive counseling practices by female physicians compared to male physicians. Clients attended by female physicians were more likely than clients attended by male physicians to report being offered any contraception, and were more likely to report being offered specific effective methods such as the IUD, oral contraceptive pills and injectables. Other studies should continue to investigate how physician gender shapes postabortion contraceptive care.

The most frequently reported reason women gave for not selecting any contraceptive was the need for more personalized counseling before deciding on a method. Clients' preference to receive personalized family planning counseling has been reported in other studies of postabortion care [16–18]. Although we found high acceptance of postabortion contraception in this study, a greater emphasis on personalized counseling could result in an even higher uptake. Furthermore, it could aid women in selecting methods that are the best suited to their needs and preferences, which could lead to higher method satisfaction. Staff might consider incorporating a screening question into counseling to identify women who would like assistance in choosing contraception.

Infrequent sexual activity was another frequently mentioned reason for not selecting any post-abortion contraception. Staff might help women to reevaluate their level of risk for pregnancy by emphasizing that even one episode of unprotected sex may result in a pregnancy. These women may also find barrier methods backed up by emergency contraception to be a more acceptable option than ongoing hormonal methods.

The generalizability of our study is limited because our recruitment was conducted at just three public sector sites delivering abortion care. At the time of our study, abortion services were offered at 13 public sector sites [9]. A comparison of our sample with the overall population of women receiving public sector abortions in Mexico City indicates that our sample is similar to the client population overall in terms of education, marital status, and state of residence, but includes a higher percentage of nulliparous women and young women under age 24 [3]. Additionally, our recruitment approach surveyed women who had received medical abortions at their follow-up visits, so medical abortion clients who failed to return for their follow-up appointment were excluded from the sample. An estimated 75 to 80% of

women who receive medical abortions return for the follow-up appointment [5]. Our sample also did not include any minors. Approximately 5% of clients seeking public sector abortions are minors [3]. At the time of our study, the Ministry of Health instituted a policy focusing abortion service provision for minors at specialized “youth-friendly” sites. Because minors were not being offered services across all of the sites in our sample, we excluded them. Our results may also have been affected by social desirability bias. Although we conducted the surveys in private and participation was anonymous, some participants may have been reluctant to be critical of the services while still at the site. Future studies using client surveys should consider conducting some of the surveys off-site as a comparison, in order to measure the magnitude of social desirability bias. Finally, our measures of contraceptive care were limited. Multi-dimensional measures are necessary to obtain a more complete view of the services.

Despite these limitations, our results contribute new evidence about the quality of post-abortion family planning services in Mexico City's public sector legal abortion program. A strength of this study is that we investigated the quality of family planning services from the perspective of clients, whose views are understudied, but of great importance since it is their behavior that is being targeted for change. The overall picture from this research is that Mexico City's public sector legal abortion services are successfully incorporating family planning services into abortion care. Although there are areas for improvements, these services are resulting in a high post-abortion contraceptive method uptake, including a high uptake of the IUD.

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Synopsis

Mexico City's public sector legal abortion services are incorporating family planning into abortion care. Postabortion contraceptive method uptake is high, with 58.9% selecting IUDs.

Table 1

Study sample characteristics and abortion visit information (N=402)

	n	% or mean
Mean age, years (SD)	402	25.5 (6.0)
Current residence		
Mexico City	285	70.9
Outside of Mexico City	117	29.1
Highest completed education		
Less than high school	160	40.0
High school	152	38.0
More than high school	88	22.0
Parity		
0	173	43.0
1	99	24.6
2	73	18.2
3+	57	14.2
Marital status		
Single	211	52.5
Married or in civil union	168	41.8
Separated, divorced or widowed	23	5.7
Reported ever use of contraception		
Yes	348	87.0
No	52	13.0
Contraceptive method client reported using at the time of conception		
No method	78	19.4
Condoms	131	32.6
Oral contraceptives	63	15.7
IUD	59	14.7
Injectable	29	7.2
Rhythm method	13	3.2
Emergency contraception	11	2.7
Other method (patch, vaginal ring, implant)	10	2.5
Site of care		
General hospital	134	33.3
Maternity hospital	134	33.3
Primary health center	134	33.3
Type of abortion procedure		
Surgical	210	52.2
Medication	192	47.8
Mean gestational age, weeks (SD)	402	8.4 (2.1)
Sex of doctor attending patient		
Male	210	52.2

	n	% or mean
Female	192	47.8

Data are % unless otherwise specified.

Table 2

Women's reports about staff provision of family planning information and services during their abortion care (N=402)

	n	%
Staff member discussed family planning methods at the appointment(s)		
Yes	353	87.8
No	49	12.2
Information provided on family planning methods was clear and easy to understand[a]		
Yes	341	97.4
No	9	2.6
Information provided on family planning methods was sufficient[a]		
Yes	328	92.9
No	25	7.1
Staff member discussed sexually transmitted infections at the appointment		
Yes	152	37.8
No	250	62.2
Staff member discussed emergency contraception at the appointment		
Yes	102	25.6
No	296	74.4
Staff member discussed when client could resume sexual activity		
Yes	127	68.4
No	275	31.6
Staff member offered client contraceptive method(s) at the appointment		
Yes	328	81.6
No	74	18.4
Contraceptive methods clients reported being offered[b]		
IUD	293	72.9
Oral contraceptive pills	185	46.0
Injectables	135	33.6
Condoms	87	21.6
Sterilization	17	4.2
Patch	12	3.0
Implant	8	2.0
Emergency contraception	1	<1
Abstinence	1	<1
Client reported feeling staff pressure to choose a particular method type		
Yes	47	11.7
No	354	88.3

[a] Among those who reported a staff discussion of family planning methods at the visit.

[b] More than one method could have been reported.

Table 3

Factors associated with client reports of being offered contraception and selecting postabortion contraception (N=400)

	Staff offered client a contraceptive method during the abortion care		Client selected a postabortion contraceptive method	
	Adjusted odds ratio	**p-value**	**Adjusted odds ratio**	**p-value**
Marital status				
Married or in civil union	1.36	0.392	1.74	0.198
Unmarried	Ref		Ref	
Parity				
Nulliparous	1.09	0.812	0.65	0.268
Parous	Ref		Ref	
Place of residence				
Mexico City	1.29	0.519	1.15	0.748
A state of Mexico	Ref		Ref	
Site of care				
General hospital	0.13	<0.001	0.45	0.057
Maternity hospital	3.16	0.099	1.27	0.784
Primary health center	Ref		Ref	
Type of abortion procedure				
Surgical	5.44	<0.001	1.63	0.255
Medication	Ref		Ref	
Sex of doctor attending patient				
Female	2.99	0.028	6.32	0.013
Male	Ref		Ref	
Gestational age (in weeks)	1.17	0.114	1.05	0.635

Table 4

Percentage of clients reporting uptake of postabortion contraception and contraceptive methods selected (N=401)

Client selected a method of contraception for use postabortion	*n*	%
Yes	359	89.5
No	42	10.5
Contraceptive method selected[a]		
IUD	236	58.9
Oral contraceptive pills	49	12.2
Injectables	32	8.0
Condoms	20	5.0
Implant	12	3.0
Sterilization	9	2.2
Patch	6	1.5
Abstinence	1	<1%

[a]Responses do not sum to 100 because respondents could list multiple methods.