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Patients' experiences of first-trimester abortion services in two public facilities in Mexico City three years after decriminalization

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B.A., Emory University, 2006

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An abstract of

A thesis submitted to the Faculty of the

Rollins School of Public Health of Emory University

in partial fulfillment of the requirements for the degree of

Master of Public Health

in Global Health

2011

Abstract

Patients' experiences of first-trimester abortion services in two public facilities in Mexico City three years after decriminalization

By Roula F. AbiSamra

Background: In 2007, Mexico City decriminalized abortion in the first twelve weeks of pregnancy. This work describes experiences of patients obtaining legal first-trimester abortion care through Mexico City's Ministry of Health (MOH). Aims included comparing satisfaction of medical and surgical abortion patients; deriving recommendations for program improvement; and measuring pre- and post-abortion contraceptive use.
Methods: Mixed-methods, secondary data analysis of responses from patients at two main MOH abortion facilities: surveys of 350 patients and in-depth interviews with a subset of 20 patients. Survey data were analyzed with tests for bivariate association and multivariate logistic regression. Interview data were used in qualitative thematic-content analysis using principles of grounded theory.
Results: Most components of the MOH abortion care protocol were followed. Of 16 appointment components reviewed, 13 were completed for at least four-fifths of patients. Patients overwhelmingly reported satisfaction with care overall (97.1%), with no significant differences between medical and surgical abortion patients. However, qualitative data revealed a need for more sympathetic staff, reduced wait times, better information on surgical abortion, patient choice of abortion methods, and counseling that addresses psychosocial issues. Both medical and surgical abortion methods were acceptable, but few patients were given the opportunity to choose. Contraceptive uptake was high, especially for IUDs (63% of respondents, up from 14% who used one in the preceding 12 months); however, few contraceptive methods were discussed or available.
Discussion: Mexico City's newly-created legal abortion program is successfully addressing most of the basic goals of quality clinical care. Yet quality of care has non-clinical aspects as well, and our results reveal opportunities for the legal abortion program to make care excellent and become a model for other providers in the country. Mixed-methods research on experiences of abortion care can provide insight that might be overlooked by a purely quantitative study.

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Acknowledgments

Roger Rochat has been not only my thesis adviser but also a mentor, role model, and dear friend. I owe him a debt of gratitude for his confidence in my abilities and for his never-flagging ingenuity in addressing the concerns that motivate this thesis. Without them, this endeavor, as well as those that shaped it and those that it has shaped in turn, would not have been possible.

The researchers and managers in Mexico who originated the study of MOH services, and who were willing later to share their data with me for this thesis, also became important sources of moral and practical support. Thanks to Claudia Diaz-Olavarrieta and Sandy Garcia for sharing the data and giving critical guidance and feedback; to Vanessa Cravioto and Olimpia Gomez for fastidious data collection, invaluable cultural interpretation, and real friendship; to Aremis Villalobos for analysis help in a pinch; and to Laura Carrillo for making all these cross-continent relationships feasible behind the scenes.

I had the good fortune to meet and partner with these colleagues while in Mexico for travel and research supported by the Global Elimination of Maternal Mortality from Abortion (GEMMA) Fund and the Emory Global Health Initiative.

Thanks to Richard Barfield and Josh Van Otterloo for last-minute counsel that greatly improved the clarity of my analytic methods.

Ruth Dawson, Taylor Rose Ellsworth and Aimee Leidich were constant, generous friends throughout the challenging months of juggling research and all the other parts of life. I will always be grateful.

In the last stages of this work, Elizabeth Johnston and Tamer Middleton were beyond understanding of my need to take days off from work to write, Laura Anderson and Naquia Harris helped me hang on to my sanity, and Chris Huber and Lauren Job helped me stay awake. Sharia Ahmed, Kristine Dennis, Gaelle Gourmelon and Josh Van Otterloo kept me well fed.

Finally, I owe much to the love, encouragement and near-inexhaustible patience of my parents, Freddy Abi-Samra and Randa Habib, whose excellent standards and hard work I hope to emulate; my sisters Lamia, Rima and Freddy-May, whose opinions of me I hope to someday be equal to and who never let me think I have failed; my partner of “way too many” years, Joshua, who has to live with me; and my good friend Patrick, who also has to live with me.

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Introduction

In April 2007, the legislature of the Mexico City Federal District (Distrito Federal, or DF) reformed the District's penal code to decriminalize abortion in the first 12 weeks of pregnancy. This was achieved by redefining "abortion" as a procedure occurring only after 12 weeks, and renaming procedures before this point as "legal termination of pregnancy" (abbreviated as ILE in Spanish). In addition, the Ministry of Health of Mexico City (MOH) designated particular health facilities as public providers of abortion, where care can be obtained for free by Mexico City residents and on a sliding scale by other Mexican residents and foreign nationals.

Since decriminalization, local public opinion supporting the right to abortion has increased steadily, from 38% in 2007 to 63% in 2008 and 73% in 2009.[1] In that time more than 50,000 patients obtained legal abortion care in the MOH's designated public facilities, with the volume of patients growing each year. (Private facilities have also been providing legal abortion in these years; the exact number is unknown, but thought to be smaller.)[2] To meet the need for services, providers have made both misoprostol-only medication abortion (or medical abortion, or MA) and surgical abortion (usually done by manual vacuum aspiration) a routine part of their practice.[3] The effectiveness of misoprostol decreases beyond 9 weeks (or 63 days) from the last menstrual period, as confirmed by ultrasound; therefore, after that point vacuum aspiration abortion is recommended by the clinical guidelines of several organizations, including of

the World Health Organization, the National Abortion Federation, and the Mexico City Ministry of Health.[4-6]

Mexico is comprised of 31 states and the capital city (Mexico City, commonly called DF) and abortion law is determined at the state level. Currently Mexico City is the only jurisdiction in the country with a legal elective abortion program. In a backlash against the decriminalization of abortion in the capital city, legislatures in 18 states around the country have passed amendments to their respective state constitutions declaring "*the sanctity of life from conception,*" effectively outlawing abortion there even in the rare instances when it was previously allowed.[7] As a result of the shrinking legality of abortion outside of the capital and of growing awareness of its availability within, Mexico City's public abortion care program is likely to see greater patient volume in coming years if latent demand is to be met. Expansion of the program should be informed by comprehensive evaluation of its initial successes and shortcomings.

Besides the likely need for future expansion of the program, the maintenance and improvement of services should be a goal in its own right. Unsafe abortion is among the top three causes of global maternal mortality and morbidity (estimates vary, but its toll is around 47,000- 68,000 deaths annually and another 5 million women who survive with temporary or permanent disability).[8,9] Additionally, the death and disability of women is often followed by health burdens (e.g. increased mortality risk, decreased nutrition) on other family members, usually their children.[10] The vast majority (95-97%) of unsafe

abortions occur in the developing world, and proportionally more occur in Latin America than in other regions (32 unsafe abortions per 100 live births, or 29 unsafe abortions per 1000 women; the absolute number, however, is much higher in Asia due to greater overall population).[11] Yet both in the region and in the world, abortion-related death and disability are quite rare where governments and societies have expanded the legality of abortion and supported access to abortion care.[11,12] Mexico City's legal and public health institutions have begun implementing these changes, and the new MOH abortion services have proved effective and safe. The remaining task is to ensure *excellent quality* of abortion care, such that women who need to end their pregnancies will trust the public health system to provide them with safe and supportive treatment, thereby reducing their risk of turning to previously-common unsafe methods rather than an unfamiliar new service.[12]

In the present research, I describe the experiences of patients obtaining public abortion services in the Mexico City MOH, particularly their satisfaction with the care they received, and their use of contraception before and after abortion. Specific aims were to (1) compare the experiences of medical abortion patients with those of surgical abortion patients; (2) identify protocol elements and patient needs that the MOH abortion program does and does not meet, in order to derive overall recommendations for improving the program.

Materials and Methods

All data were collected, de-identified and stored (by research staff of the National Institute of Public Health and the Population Council) before the beginning of the study presented in this thesis. Therefore, this study constituted secondary data analysis of a de-identified database, rather than human subjects research. In addition, the main goal of the current study was not generalizability of findings, but the identification of ways to improve the patient experience within a particular health program. (However, the original study's protocol for data collection was approved by the IRB of the Mexico City Ministry of Health.)

Methods for the collection of data are described in the original study's protocol, as follows. Between February and June 2010, research staff enrolled 350 consenting patients of the MOH abortion program who had already completed their abortion. Participants were drawn from two Mexico City MOH facilities which provide most of the city's publicly-provided abortions. Besides their patient volume, the facilities were chosen because they reflect two different approaches to the incorporation of abortion care into MOH service provision. One is a large, older hospital serving maternal and child health needs, where a small area has been retrofitted for an abortion "wing." The other facility is a community health center built after 2007 which included a dedicated space for abortion care from the start.

The original study protocol proposed a target sample size of 350 in order to allow detection of differences by procedure type. This was based on a sample

size calculation and power calculation to detect differences in satisfaction between medical and surgical abortions (assuming a 70% overall acceptability of medical abortion services and a 15% difference in satisfaction between the two procedure types) [13-20]. To detect significant differences between the two groups with 85% power, the sample included 170 patients who followed the misoprostol-only medication regimen (approached at their follow-up visit) and 180 surgical aspiration patients (approached on the day of their abortion, after the procedure and recovery time were complete).

To reach the needed sample size, 358 patients were approached and asked to participate in a survey, with 350 consenting to study participation for a response rate of 97.5%. According to the original study protocol, project members were present five days a week outside the medical facilities in order to recruit women and administer the survey. Before recruiting a patient, a member of the study team explained the nature of the study and that her consent or refusal would not affect the care she received.

A second component included in-depth interviews (IDI) lasting 90-120 minutes; 20 women (10 medical and 10 surgical abortion patients) were asked to participate, and all consented. The IDI interviewer was present on-site once a week to schedule qualitative interviews. The interviewer assessed if the woman met the eligibility criteria for an IDI: any woman who had just completed her follow-up appointment (if a medical abortion patient) and had read the study flyer that she received from the medical personnel. Surgical patients were not

approached during a follow-up visit but a few hours after the procedure was completed, while they were waiting to be discharged from the facility. If the woman was eligible and agreed to participate, the interviewer then followed standard informed-consent procedures and asked her to participate in a survey and an IDI.

Women who agreed to participate signed an informed-consent form and all participants in the survey and the IDI were reimbursed for their time to cover food and transportation. During the same study period, an additional 20 interviews were conducted among the facilities' abortion care providers (see *Diaz and Cravioto*, forthcoming).

The full survey, a list of interview themes, and an interview guide may be found in the Appendix. Survey respondents answered a survey of 65 items including questions about their demographic background, their opinions on abortion legality, and their familiarity with misoprostol and self-induced abortion. They were also asked whether they experienced specific aspects of MOH care protocol, namely a review of medical history, gestational dating ultrasound, counseling, education about abortion methods and their side effects, informed consent, the choice between surgical or medical abortion when possible, appropriate recommendations of procedure type when indicated (surgical abortion for patients beyond the ninth week of pregnancy and those living far from the facility), and contraceptive provision.

The primary outcome measure, patient satisfaction, was measured with several survey questions. The first concerned the program as a whole: "*Are you satisfied with the legal abortion services of the Mexico City Ministry of Health?*" Respondents were also asked whether or not they were satisfied with specific components of the experience: the general physical environment of the facility, their treatment by staff, counseling about contraceptive methods, and counseling overall. Responses to these five measures were recorded dichotomously, as Yes or No. Finally, patients were asked the open-ended question, "*In your opinion, what actions would improve the services you received*?"

Interview participants were asked to describe their path from first seeking abortion information to finally undergoing the procedure. They also discussed as their personal experiences with the abortion process, opinions about abortion's legal status, and attitudes about abortion in general.

The original research team shared the de-identified, stored data with the author of this thesis project for the purposes of secondary data analysis (in November 2010). Quantitative survey data were stored in Microsoft Excel 2003 and SPSS (PASW). SPSS and Stata were used to perform statistical analysis through frequency and distribution calculations, t-tests for differences in means or z-tests for differences in proportions, tests of bivariate association (Pearson's χ^2, or Fisher's exact p-value when 20% or more cells have an expected count less than 5), and multivariate logistic regression at the 95% confidence level. For multivariate regression, terms found to have a significant bivariate association

with the outcome were included in a full model using stepwise selection, but only those remaining significant were retained in the reduced multivariate model.

Because quantitative analysis involved multiple independent variables and multiple outcomes of interest, a correction for multiple comparisons was considered, but ultimately not used for two reasons. First, the independent variables included in analysis were selected because they potentially had plausible relationships with the outcomes of interest, based both on previous literature and on the researcher's professional experiences with abortion patients. Multiple-comparisons corrections are typically appropriate in studies testing for associations without a preliminary rationale for the particular relationships to be tested ("data mining"). The second reason was decided *a posteriori*: this particular study's main findings suggested there was insufficient evidence to reject the null hypothesis; thus, using a more-conservative significance threshold would actually make this conclusion appear even stronger. Counter to expectations, then, it would be most prudent to omit Bonferroni correction or Tukey values from the quantitative analysis methods.

Qualitative interview data were stored in Word 2007 and MAXQDA and analyzed using thematic analysis and principles of grounded theory. For this study, the interview data were used to further explore *a priori* themes of interest that were only partially answered by quantitative results, as well as to probe questions raised by quantitative findings during the analytic process.

Patients gave their free and informed consent to participate in this study, and alpha-numeric patient identifiers were used to ensure confidentiality of data. The study was approved by the institutional review boards of the Mexico City Ministry of Health and the National Institute of Public Health of Mexico.

Results

Participant Demographics

Patients surveyed were mostly residents of the capital city (74.0%) or nearby Mexico State (20.1%), with only 5.4% residing in other states; no respondents were residents of other countries (Table 1). About half were married or living with a partner (43.7%) and half had completed high school or higher (54.6%). The mean age was 25.4 years old. Most patients were Catholic (75.7%), and most had had at least one child (60.6%) and no prior induced abortions (92.0%). Patients' income varied widely. Excluding three implausible values (6,000 pesos per week or more), weekly incomes ranged from 0 to 3,750 pesos. The average weekly income was 393.6 pesos (std.dev 621.1 pesos), with 210 respondents reporting incomes of zero[1]. Just over half (181) of patients had their abortion procedure before the end of 9 weeks' gestation, whereas 169 patients had their abortion after 9 weeks.

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[1]Equivalent to about $33 in US currency (2010 exchange rate).

Medical vs. Surgical Abortion

The only significant difference in demographic characteristics between MA patients and surgical abortion patients was in residency: compared to surgical abortion patients, MA patients had 8.76 times the odds of residing within DF (95% confidence interval [1.99, 38.52], p=0.004).

Procedure type was also significantly associated with gestational age: compared to patients who had their procedures before the end of nine weeks, those who had their procedure after nine weeks' gestation had 36 times the odds of undergoing the surgical abortion procedure (OR=36.05, 95% CI [19.66,66.09], p<0.001). However, 20 (14.2%) of the MA patients said they had their abortion after the recommended 63-day (9.0 week) gestational limit for misoprostol-only abortion. Conversely, only 31 (17.3%) respondents who were in the under-64-day timeframe had a surgical abortion. Although 87.4% of patients reported that staff had discussed both procedures with them, only 57.5% felt they had received enough information to decide between the two. Among the 181 respondents who had their abortion at or below the 63-day limit, insufficient information to decide was less common but still reported by 67 (31.7%) respondents. Further, only 33 (17.6%) of the under-limit respondents said that they played a part in deciding which procedure they would undergo (possible answers included the doctor, a counselor, a nurse, a partner, a family member, etc. and were not mutually exclusive). Of the 181 respondents who had their abortion before 64 days of pregnancy, 55 (30.4%) did not answer the question "do you feel you were given a

choice between the two methods?" Of the remaining 126 who did respond, 36 (28.6%) answered in the affirmative, while 90 (71.4%) did *not* feel they had been given a choice of procedures. Both medical and surgical abortion patients reported that the reason they were given for the selection of their respective procedure type was their gestational age (as recounted by 96.5% of MA patients and 92.8% of surgical patients).

Despite this, in general, women felt that the type of procedure they underwent was one they would choose again if needed in the future. Although 105 (30%) responded that they did not know which procedure type they would choose if they sought another abortion in the future, the responses of the remaining 245 were closely associated with the procedure type they had just undergone (Pearson's χ^2=66.673, $p<0.001$). Of the 170 who underwent MA, 95 (55.9%) would choose MA again in the future, 11 (6.5%) would choose surgical abortion, and 64 (37.6%) were not sure. Of the 180 who underwent surgical abortion, 86 (47.8%) would choose it again in the future, 53 (29.4%) would choose MA, and 41 (22.8%) were not sure. The proportion of those who would choose their own method again in the future was not significantly different between the two groups; however, significantly more patients in the surgical group than in the medical group said that they would choose the other method in the future ($p<0.001$). In addition, significantly more patients in the MA group said they did not know which method they would choose in the future ($p=0.003$).

Services and satisfaction

A full list of items in the survey pertaining to the various goals and stages of the abortion appointment process, along with the proportion of cases in which patients say these goals were met, can be found in Table 2. In a majority of cases, most of the recommended steps of the abortion care process were completed. However, 36% respondents reported not receiving an ultrasound to estimate the length of the pregnancy, and 37% reported being given appointments that were more than a week away from the day they contacted the facility.

Respondents overwhelmingly reported that they were "satisfied with the ILE services of the Ministry of Health" (97.1%), with "the general physical environment" of the facility (95.7%), the treatment on the part of staff (94.0%), counseling in general (94.9%), and counseling about methods of contraception (94.6%). Of all the demographic, pregnancy- and procedure-related factors tested, few were found to have significant bivariate association with the various measures of satisfaction (see Table 4) and even fewer had significant association with the outcomes in multivariate logistic regression (see Table 5).

Overall satisfaction with the ILE services of the MOH was only associated with two factors: not living with a partner (Fisher's exact p=0.022) and having received information about the process of follow-up care (Fisher's exact p=0.002). In multivariate logistic regression including both significant terms, only the latter remained a significant predictor: compared to those who did not recall receiving follow-up care information, those receiving such information had

17.73 times the odds of being satisfied overall (95% confidence interval [3.86,81.36], $p<0.001$). In open-ended answers about how services could be improved, 104 (29.7%) of the 350 respondents said “nothing,” or stated that everything about the program was fine.

In a reduced model derived from multivariate logistic regression, patients who reported receiving follow-up care information also had 7.11 times the odds of feeling *satisfied with the facility’s physical environment* (95% CI [1.31,38.62], $p=0.023$). No other factors were significantly associated with satisfaction with the facility’s physical environment.

In the reduced multivariate model for patients’ *satisfaction with the treatment received from staff*, several factors remained significantly associated with satisfaction. Patients had greater odds of being satisfied with their treatment by staff if they had not completed secondary school (those who did finish had an adjusted odds ratio of satisfaction = 0.26 [0.09, 0.76], $p=0.013$); if they had waited less than a week for their first appointment (compared to being made to wait a week or more, aOR=4.29 [1.31,38.62], $p=0.005$); if staff asked them if they were sure about their decision to have an abortion (compared to not asking, aOR=3.08 [1.04,9.12], $p=0.042$); and if staff had discussed both the surgical and medical methods of abortion (aOR=3.84 [1.30,11.32], $p=0.015$).

In addition, in multivariate regression modeling of *satisfaction with contraceptive counseling*, patients who had finished secondary school had 81% lower odds of satisfaction than those who had not (adjusted OR=0.19 [0.05,0.75],

p=0.018). There were three other significant predictors in the model, all related to other components of abortion counseling: staff explaining what to expect from a typical procedure with both procedure types (compared to giving this information about one method or no methods, aOR=7.23 [1.12,46.58], p=0.037); receiving enough information to decide between the two procedure types (compared to not receiving information sufficient for this purpose, aOR=3.83 [1.08,13.55], p=0.037); and receiving follow-up care information (compared to not receiving it, aOR=16.45 [2.93,92.34], p=0.002).

Patients' *satisfaction with counseling overall* was associated with actually receiving counseling (compared to not receiving any, aOR=7.07 [1.15, 43.43], p=0.035); receiving "*enough information*" in counseling (compared to insufficient or no information, aOR=10.66 [3.41,33.33], p<0.001); and receiving enough information to decide between the two procedure types (again, compared to information insufficient for this purpose, aOR=3.72 [1.14,12.13], p=0.029).

Although quantitative analysis suggests nearly universal satisfaction, patients expressed more varied feelings in open-ended answers and interviews. The most frequently-suggested improvement in open-ended answers, cited by 52 (14.9%) of the 350 respondents, was to reduce waiting times before, during, and between appointments. Some of these elaborated, e.g. that long waits at the facility were difficult to bear when experiencing pregnancy symptoms, or that they missed the opportunity to use MA because there were no appointments available the week they called. Many of these 52 respondents specifically

suggested that the MOH organize or increase staff, and that facilities stagger appointment times (as opposed to beginning all appointments at the same time).

For the most part, the education and information provided by medical staff was thorough and helpful, according to both survey respondents, 87.4% of whom stated that providers discussed both the medical and surgical abortion methods, and interviewee participants. Yet according to most interviewees' descriptions of the information imparted, providers focused more heavily on explaining details about the MA process, and were not specific about what the surgical abortion experience would entail. Interviews described counseling as a group session with all the day's patients, in which a provider explained how the abortion would proceed. One interviewee, who had a surgical abortion at 12 weeks at the hospital facility, said that "They sent us all in together, 17 of us, they saw us all in the same room" and that after the counselor described the MA process and side effects at length,

> *…one girl who was here for aspiration asked her how the procedure would be done, and she said 'Oh! You're doing aspiration? Who else is doing aspiration?' And we raised our hands, four of us, and she told her that with the aspiration it's different, she says 'You all will take some pills too, but only one dose [for dilation]…and you will have those side effects too,' but she didn't really explain what [the abortion] was or what was going to happen to us….* (INO155)

On the other hand, some patients did recall clear and detailed explanations of both procedures. These conflicting accounts were present at both facilities.

Some patients also expressed that the services and staff could do more to make patients feel comfortable and accepted. In open-ended answers about how the services could be improved, 42 (12.0%) of the respondents mentioned difficult or judgmental attitudes on the part of staff, particularly guards, receptionists and doctors. This was supported by interview participants' observations of guards being rude to patient companions or scolding patients who sat on the floor for lack of seating spaces, and of receptionists acting "condescending" or "unsympathetic." On the other hand, although a few open-ended survey responses referred to "tyrannical" behavior by a doctor, in interviews most participants either did not mention the doctor's attitude or expressed appreciation for the doctor's willingness to address questions and concerns.

In addition, interviewees said that counseling mostly focused on education about the procedure and on informed consent. Some said it was lacking a focus on feelings about the pregnancy, the alternative of carrying to term, or the decision itself; some specifically wished it did more to support patients in their decision or to counter the negative messages they received from anti-abortion groups outside the facility. Nevertheless, participants often did experience supportive interactions with staff, sometimes independently of the counseling session or other clinical care. A 37-year-old married mother of three, who had obtained MA at the hospital facility, recalled that after their counseling session, a nurse told her group:

> *…that some people might tell us that we would be punished by God but no, God sees us all and cares for us all, if we felt that now is not the time to be mothers then everyone here would respect us, no one was going to expose or speak ill of us, that all our information was confidential, that this is legal and women have a lot of support and help just as long as we made the decision, even if we had a partner…. And from there we went to do the whole thing, everything was legal, everything was within the law, we weren't doing anything wrong, and that she wished us lots of luck.* (INO151)

However, at the same time as they wished for more affirmation of their agency and their ability to remain good people, interviewees also said that counseling should address decision-making more seriously and ensure that patients are not making their decision (to have an abortion) lightly. Although comparatively few women in our survey reported having had a prior abortion, interviewees frequently said they were concerned about women being able to have multiple abortions unchecked, citing presumed ill effects on physical health, mental health, or morality. This 20-year-old university student, who sought MA services at the health-center facility, echoed the concerns of several other participants:

> *…I mean, maybe you can't just say, 'OK, you can only have an abortion two times, or three times,' but maybe try to see what is it that's going on, if it's just because of irresponsibility, like 'I get pregnant, I abort it, I get pregnant, I abort it'… The doctor or the social worker [should] see what is going on, tell her the consequences that this could have…like guiding them, to prevent them from going on doing this indiscriminately, I mean, to get pregnant and abort however many times they want…I think that it's not healthy for them, maybe in the long-term it will cause them some emotional or physical issue…. When I went to that place where the pro-life people took us, they told us that you could have breast cancer, uterine cancer, you could end up infertile, all that.* (BVV083)

A 25-year-old patient of the hospital facility, who was a substance abuser with an infant son and an unstable partner, needed to undergo aspiration at 64 days after her medical abortion was incomplete. Though she frequently referred to her belief that God could understand one's reasons for choosing abortion, she also said that such an experience:

> *…should just be the one time, I mean if someone has done this before, they should use birth control, because you can't just keep coming back all the time…there are a lot of girls who come again and again and again, over and over.* (BVV084)

Overall, patients felt that counseling should include some attention to psychosocial issues, but revealed some contradictions in how they wanted this to be implemented.

Contraception

Respondents were asked about their choice of contraceptive methods before and after the abortion; Table 6 compares these results by type of abortion procedure. Half (50.6%) of all respondents said that they were using male condoms when they became pregnant. The next most common methods used at the time of conception were pills (10.9%), IUDs (7.1%), and withdrawal and rhythm (6.6% combined). A quarter (24.3%, or 85 respondents) were using no method at all; more than half of these (44 respondents) said this was due to personal preference, while another 27 said it was due to personal and partner preference. Respondents were also asked what contraceptive methods they had used in the previous year. Again, the most common methods were male condoms

(55.7%), pills (16.9%), IUDs (14.0%), and withdrawal and rhythm (9.4%). Another 15.1% of respondents said they had used no methods in the preceding year.

In contrast, for post-abortion contraception, the most commonly chosen method by far was the IUD (chosen by 62.6% of respondents). The proportion of medical abortion patients choosing IUD for post-abortion contraception (54.1%) was significantly smaller than the proportion of surgical abortion patients who chose this (70.6%) (Pearson's χ^2=6.507, $p<0.011$). The next most common methods of post-abortion contraception were injectibles (17.1%) and oral pills (12.6%). Just two respondents said they planned to use withdrawal or the rhythm method. Only 10 (2.9%) said that they had not chosen any method, and half of these said they were not given any information about contraception to take home.

In their survey responses, nearly all (94.6%) of the 350 respondents reported being satisfied with the contraceptive counseling they received. However, when given the chance to elaborate in in-depth interviews, participants revealed that contraceptive counseling tended to focus on a small number of methods that were preferred by the provider – most often the IUD – and that choices were further limited by what was actually available in the facility on a given day. Provider preference was noted by several patients, such as this 23-year-old single mother of two from Mexico City, who had a surgical abortion at 12 weeks in the hospital facility:

> Participant: *They told us there were various ones, but the one they mentioned most was the Mirena, that's the one they taught us about the most, and they said it had a little bit of hormones but a minimal amount, well they also were talking about the IUD, which is the Copper T, right? Well some ladies were saying that it didn't work, or that it came out all the time, and the doctor told them that people could get carried away with the opinion of just one person…Anyway, I think they just mentioned those two.*
>
> Interviewer: *Pills, injections, did they mention anything about those?*
>
> P: *They only told us that it was more convenient to have the Mirena because that way you don't have be worrying about 'the pill, the pill' and then you forget it and so on, or the injections that you have to go get each month, that it was better like this, more simple.*
>
> I: *OK, and what contraceptive method did you choose?*
>
> P: *The Mirena.*
>
> (INO155)

In other cases, rather than strongly encouraging a particular method, providers gave only cursory contraceptive counseling:

> *I mean, if you asked, if you told the doctor that you wanted some method he explained it to you…but other than that no, no one explained anything about contraceptive methods. The doctor just asked me "Are you going to use a method of contraception" and I said yes, I said [I would go back to using the patch] and he wrote that on his piece of paper and that was it.* (BVV083)

Discussion

Demographic findings from our study (on residency, marital status, education and age) are similar to figures from the entire registry of the Mexico City legal abortion program's patients since 2007.[3]

However, as with all self-report information on stigmatized behaviors, our findings about patients' reported prior abortions are subject to desirability bias, due to stigma against abortion, stigma against being a "*repeat aborter*" (*repetidora*), and stigma against activity that may have been illegal at the time.

Although nearly all survey respondents report satisfaction with all five aspects of care named by the questionnaire, the integration of quantitative and qualitative data reveals room for improvement in the MOH program. Training should ensure that all staff be nonjudgmental and respectful. Staff and workflow should be organized to minimize delays in care. Patients should be given the opportunity to choose between medical and surgical methods when possible, including education about both methods for all patients under 64 days of pregnancy. Counseling is generally very attentive to education and informed consent, but should address psychosocial issues as well. Finally, efforts must be made at multiple levels (e.g. counseling, pharmacy and inventory) to ensure patients have knowledge and supply of a full range of methods for post-abortion contraception.

These needs might not have been uncovered in a quantitative-only study such as a satisfaction survey, especially if measures focus on pre-established items considered important by providers or program managers without input from patients. Judith Bruce's 1990 framework for measuring quality of care from the client perspective has been applied extensively in global health program design and evaluation. Bruce identifies six essential elements in quality of care: free and informed choice of methods; information provided to clients; technical competence of providers; interpersonal relations between clients and staff; follow-up and continuation mechanisms; and appropriate constellation of services. Bruce asserts that among these, choice of method is the first and fundamental element in assuring quality of service from the patients' perspective.[21,22] Studies of family planning services concur that clients are more likely to stop seeking care if they do not receive information or supply of the contraceptive method of their choice.[23-31] There may very well be a similar relationship between choice of *abortion* methods and patients' likelihood of returning to a given facility (or recommending it to someone else) if services are needed in the future. In addition, decisions to seek or return for family planning services are further affected by perceptions of facility quality, the provision of accurate and complete information, the duration of waiting times and the convenience of service hours, all of which were discussed by subjects in the current study.[23-31]

For various reasons, in an exit survey of satisfaction some patients may not voice complaints directly, and thus report satisfaction in spite of concerns

they may have. For some aspects of care, younger and less-educated survey respondents were more likely than others to report satisfaction. These patients may have lower expectations for satisfactory care or feel uncomfortable expressing dissatisfaction (it is unlikely that their care was actually of higher quality than others', especially in light of recent findings that among the MOH program's patients, those without high-school education were more likely to report difficulty securing appointments and making arrangements to get to their appointments[32]). Overall, integration of detailed appointment data, open-ended patient suggestions, and in-depth interviews shed more light on patient perspectives of care quality, suggesting that "satisfaction" surveys alone may be a limited measure of abortion-care quality and unduly lead program evaluators to overlook opportunities for improvement.

It appears that providers are appropriately considering patients who have traveled from outside of Mexico City as strong candidates for the surgical abortion method. This is the MOH-recommended practice when possible[4], to avoid requiring the patient to make another journey for a follow-up appointment, and to avoid the (rare) possibility of having a complication arise while the patient is far from the facility. Although recent and ongoing research has found that providers can safely offer MA without routine follow-up (by instructing patients on symptoms requiring additional care)[33,34], in the year 2007 the Mexico City abortion program was initiated with the more conservative approach of recommending follow-up for all MA patients.

Surgical abortion patients also included most of those beyond nine weeks of pregnancy, again in accordance with recommendations since MA is less effective beyond 63 days. According to the Mexico City MOH guidelines of the legal abortion program[4], the physician must assess the gestational age of the pregnancy using an ultrasound, and misoprostol is recommended preferably for abortion up to 9 weeks or 63 days from the last menstrual period as confirmed by ultrasound. However, 14% of MA patients stated they were over 9 weeks when they had their abortion, with no clear explanation for the choice. Either providers were not following the MOH guidelines in these cases, or these respondents inaccurately reported their gestational age to study interviewers. Conversely, very few patients who were under 64 days underwent the surgical procedure, although both methods were medically appropriate for them. Abortion patients should be given the choice between the two methods when possible, yet most respondents said they were not given the option to decide. On the other hand, many patients said that if they needed an abortion in the future, they would probably choose the same procedure type as the one they had just undergone. The misoprostol-only regimen and the surgical aspiration method appear to be widely acceptable, corroborating studies which demonstrate the acceptability of both abortion methods, even when randomly assigned[13-20].

Excluding patients who were not sure which method they would choose in the future, a majority in each procedure group stated that in the future they would probably choose the same method they had just undergone. This suggests that both procedure types were generally acceptable to respondents. (There is

some risk for bias here, since patients who had very negative experiences might avoid their follow-up visit and thus not be available for recruitment.) However, significantly more surgical patients than MA patients thought they would switch methods in the future, and significantly more MA patients than surgical patients did not know which method they would choose. Taken together, these differences suggest further support for our qualitative findings that regardless of which method they actually underwent, patients received more detailed information about MA than about surgical abortion, which therefore remained an unknown entity for some MA patients.

Counseling is largely attentive to giving information about the abortion process and to obtaining informed consent, but overlooks patients' perceived psychosocial needs. Patients would prefer explicit rebuttals of stigmatizing anti-abortion messages, and to some extent have misconceptions about psychological sequelae of abortion. They appreciate when staff validate their agency in making the abortion decision, yet they have a double standard: they simultaneously say counseling should make sure women are not seeking abortion lightly, irresponsibly, or too many times. This finding appears to contrast with a recent study of US abortion patients, who do *not* want to discuss their feelings or decision-making in counseling, and often do not want to go through counseling at all; on the other hand, that study found that US women say counseling should still be provided, for the sake of "other women" who might need it[35]. This concern for the decisions of other women, evidenced in our study as well, may be a way to lay claim to one's own responsible nature or agency, while conceding to

anti-abortion messages that “most” women who have abortions are either careless or under duress. (This may also be commingled with social desirability bias, if participants are drawing a distinction between themselves and hypothetical less-responsible women for the sake of the interviewer’s opinion.)

Many of the open-ended answers and interview responses cited the drawn-out process as a major area for improvement, echoing the survey findings that a third of patients waited over a week for the first available appointment, and three-quarters waited over an hour in the facility for their first contact with a provider. Long wait times to obtain an appointment may have caused some patients to miss the 9-week limit for having a choice of methods. Although official MOH guidelines [36] state that “the administrative procedures necessary for the procedure of legal abortion must be performed […] in a maximum of forty-eight hours […],” this is not often the case and some women face longer wait times. The Mexico City abortion program is the country’s only public resource for abortion services, and at the time data was collected for this survey, the MOH faced abortion provider scarcity due to conscientious objection (decreasingly prevalent with medical abortion). Based on their observations of the work-flow while they waited, many patients specifically suggested that the MOH organize or increase staff and stagger appointment times to reduce delays, steps which could help reduce all three kinds of delay (before appointments, during care, and between the various required visits). Because the sample only included patients who had completed their abortion, it is not possible to know whether any would-be

patients faced wait times that would have violated the 12-week gestational limit of the abortion law.

Compared to before the pregnancy, respondents' contraceptive mix changed dramatically. The male condom, which half of respondents were using at the time of conception, fell out of favor in patients' responses about their chosen contraceptive method going forward. Conversely, whereas only 14% of respondents had used an IUD in the preceding year, after the abortion nearly two-thirds had chosen the IUD as their new method of contraception. Likewise, 8% of patients had used injectibles in the past year, compared to 17% choosing it after the abortion. The significant difference observed between surgical and medical abortion patients' post-abortion uptake of IUD (70% and 54% respectively) may be due to the comparative ease of inserting an IUD immediately post-aspiration, when the cervix is already dilated, whereas MA users desiring an IUD must return after the abortion for dilation and insertion.

Contraceptive counseling may have been extremely successful in informing patients about the most highly-effective forms of birth control, with patients preferring methods that are relatively long-term. However, interviewed patients often reported that they were informed of only one or a few methods, and that many methods were not available at the facility during their visit. Bruce suggests that choice of method is the fundamental aspect of quality of care and meaningfully affects clients' use or non-use of family planning services. Contraceptive counseling must respect the patient's ability to choose the best

method for herself when fully informed, and must be backed up by an effective supply chain.

Limitations

The findings from this study have certain limitations, beginning with subject recruitment. First, as random sampling from all patients was not possible within the constraints of facility flow and interviewer availability, the data reflect a convenience sample which limits the generalizability of the findings. Secondly, the timing of recruitment may have an impact on findings. Medical abortion patients were recruited at their follow-up appointment (typically two weeks after beginning the abortion process), and may have had more time to form opinions on their experience compared to surgical patients who were recruited a few hours after their procedure. Third, it is possible that medical abortion patients who were dissatisfied with their care did not return to the facility for their follow-up appointment, causing risk for bias in favor of higher satisfaction scores.

As well, by design, this study is limited in scope, and its findings are intended to apply to the population frame initially described: patients who obtained legal, first-trimester abortion services in Mexico City's public facilities. Therefore, results may not be generalizable to women seeking abortion services from an illegal provider or a private provider.[37] Finally, the sample size was selected based on power calculations to identify differences based on type of abortion procedure (medical vs. surgical). Other characteristics that did not

reveal significant differences might still figure importantly in future studies with greater sample size.

Recommendations

Below I summarize six areas in which the Mexico City Ministry of Health and its facilities could apply focused efforts and achieve meaningful improvements in patients' experiences within the legal abortion care program.

(1) Patients should be given the opportunity to choose between medical and surgical methods, including education about both methods, gestational age and medical history permitting. The misoprostol-only regimen and the surgical aspiration method appear to be widely acceptable, corroborating studies which demonstrate the acceptability of both abortion methods, even when randomly assigned[6-13]. Nevertheless, abortion patients should be given the choice between the two methods when possible, something which many of this study's respondents did not experience.

(2) Counseling should be revised to address psychosocial issues and model non-judgmental attitudes for patients. Counselors are attentive to giving information about the abortion process and to obtaining informed consent, but do not delve into patients' perceived psychosocial needs. Patients would benefit from explicit rebuttals of stigmatizing anti-abortion messages, and to some extent have ill-founded worries about psychological sequelae of abortion. They appreciate when staff validate their agency in making the abortion decision, but simultaneously believe some stereotypes about "women who have abortions."

(3) The Ministry of Health should offer facilities assistance in organizing staff and workflow to minimize delays in care, due to the time-sensitive nature of medical abortion and of Mexico City's abortion law in general. Interviewees and survey respondents described a drawn-out process to obtain care, before, during and between appointments, exceeding the 48-hour maximum delay advised by MOH guidelines[18]. Future research should investigate whether this is due to high daily volume of patients, work-flow inefficiencies, provider shortage or something else. In addition, research is needed on the current use of conscientious-objection guidelines and their effect on timely service availability.

(4) Training should ensure that all staff be nonjudgmental and respectful. Most patients experienced helpful and compassionate care on the part of counselors, nurses, and doctors. However, some of the most difficult interactions they reported were with support staff such as security guards and receptionists. As the first people encountered at the facility, these staff members are an important part of a patient's abortion experience; they can make her feel welcome in seeking care or afraid to continue.

(5) The program should provide knowledge and supply of a full range of methods for post-abortion contraception, requiring efforts at multiple levels of the health system (e.g. counseling, pharmacy and supply chain). Compared to before the pregnancy, respondents' contraceptive mix changed dramatically, with contraceptive use replacing non-use and more-effective methods replacing less-effective methods. However, contraceptive counseling must respect the patient's

ability to choose the best method for herself when fully informed, and must be backed up by an effective supply chain.

(6) The MOH may choose to review its policy of routine follow-up visits two weeks after medical abortion, and of recommending surgical abortion for patients who live far from the facility. Medical abortion patients were satisfied with services, reported very few complications after home insertion of misoprostol, and felt burdened by the number of appointments required. Recent and ongoing research in other countries has found that providers can safely offer MA without routine follow-up (by instructing patients on symptoms requiring additional medical attention).

Conclusions

Mexico City's newly-created legal abortion program is successfully addressing most of the basic goals of quality clinical care, especially considering it is a free public service in a developing country. However, quality of care has non-clinical aspects as well, and the present findings indicate these are areas to improve in the MOH legal abortion program. These can best be seen as opportunities for the program to make care excellent, and to emerge as a model for private services operating in the country, and perhaps for other governments considering a change in abortion policy.

Increasing women's positive experiences of seeking abortion care, and decreasing their negative experiences, is a public health goal in and of itself. Beyond that, doing so would also dismantle anti-abortion groups' frightening

narratives of abortion, and mitigate their impact on current and prospective patients and their social networks. In Mexico, where such groups have begun to misinform and misdirect women outside the public health facilities that provide abortion services, proactively dealing with these issues would help maintain abortion's role as a personal, and not a political, experience.

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Tables

Table 1. Characteristics of patients obtaining abortion care (n=350) by procedure type (medical=170, surgical=180)				
		Procedure		
		Medical	**Surgical**	**Total**
	(column %)	***n (row %)***	***n (row %)***	***n***
Age (mean=25 years)	<15 (0.3)	1 (100.0)	0 (0.0)	1
	15-19 (19.1)	29 (43.3)	38 (56.7)	67
	20-24 (32.6)	50 (43.9)	64 (56.1)	114
	25-29 (21.7)	41 (53.9)	35 (46.1)	76
	30-34 (14.0)	28 (57.1)	21 (42.9)	49
	35-39 (10.6)	17 (45.9)	20 (54.1)	37
	40-44 (1.4)	3 (60.0)	2 (40.0)	5
	45+ (0.3)	1 (100.0)	0 (0.0)	1
Current residence	Mexico City (73.7)	136 (52.7)	122 (47.3)	258
	*other (26.3)	34 (37.0)	58 (63.0)	92
Last level of completed schooling	no education (0.6)	0 (0.0)	2 (100.0)	2
	primary (10.6)	13 (35.1)	24 (64.9)	37
	secondary (34.0)	51 (42.9)	68 (57.1)	119
	high school (37.7)	66 (50.0)	66 (50.0)	132
	technical school (7.1)	14 (56.0)	11 (44.0)	25
	university (9.4)	25 (75.8)	8 (24.2)	33
	postgraduate (0.3)	1 (100.0)	0 (0.0)	1
marital status	married (16.6)	36 (62.1)	22 (37.9)	58
	cohabiting (27.1)	48 (50.5)	47 (49.5)	95
	single (52.9)	81 (43.8)	104 (56.2)	185
	divorced (22.9)	4 (50.0)	4 (50.0)	8
	widowed (0.0)	0 (0.0)	0 (0.0)	0
	separated (1.1)	1 (25.0)	3 (75.0)	4
number of children	0 (39.4)	68 (49.3)	70 (50.7)	138
	1 (25.7)	42 (46.7)	48 (53.3)	90
	2 (22.9)	41 (51.3)	39 (48.8)	80
	3 (6.8)	13 (54.2)	11 (45.8)	24
	*4 or more (5.0)	6 (33.3)	12 (66.7)	18
previous induced abortions	0 (92.0)	157 (44.9)	165 (47.1)	322
	1 (6.6)	9 (39.1)	14 (60.9)	23
	2 (1.1)	3 (75.0)	1 (25.0)	4
	3 (0.3)	1 (100.0)	0 (0.0)	1
		Medical ***n(%)***	**Surgical** ***n(%)***	**Total** ***n***

**significant difference between medical and surgical procedure types at $p<0.05$, Pearson's χ^2*

Table 2. Goals of abortion appointment process met	Yes %	No %	Total *n*
Patient waited a week or less for first appointment	62.9%	37.1%	348
Patient waited an hour or less for first provider after checking in	27.7%	72.3%	350
A staff person…			
Obtained informed consent from patient	99.4%	0.6%	348
Provided counseling	96.9%	3.1%	350
Explained process for follow-up care	96.8%	3.2%	349
Reviewed medical history	96.0%	4.0%	349
Explained what to do in an emergency	95.8%	4.2%	239
Gave sufficient information in counseling	90.2%	9.8%	348
Discussed pros and cons of medical method (MA)	88.8%	11.2%	349
(MA only) Explained what patient would see/feel during process	88.6%	11.4%	167
Asked if patient was sure of her decision	88.5%	11.5%	349
Discussed both abortion methods	87.4%	12.6%	349
Discussed pros and cons of surgical method	86.0%	14.0%	349
Explained normal process for both methods	83.1%	16.9%	349
Explained complications and warning signs for both methods	83.0%	17.0%	348
Explained side effects for both methods	81.7%	18.3%	349
Performed gestational dating ultrasound	63.6%	36.4%	349
Gave sufficient information to decide between the two methods	57.5%	42.5%	348
MA: Was it easy to tell when the abortion completed?	56.3%	43.7%	167
MA: Were you given the choice between methods?	27.1%	72.9%	133
Surgical: Were you given the choice between methods?	24.1%	75.9%	174
MA: Did you avoid side effects requiring emergency care?	97.6%	2.4%	168
Surgical: Did you avoid side effects requiring emergency care?	99.4%	0.6%	178
Did you choose a post-abortion contraceptive method?	97.1%	2.9%	350
Would you return to the MOH services?	94.8%	5.2%	349
Are you satisfied with the general physical environment of the facility?	95.7%	4.3%	350
Are you satisfied with your treatment by staff?	94.0%	6.0%	350
Are you satisfied with the counseling overall?	94.9%	5.1%	350
Are you satisfied with the contraceptive counseling?	94.6%	5.4%	350
Are you satisfied with the ILE services of the DF MOH?	97.1%	2.9%	350

Table 3. Significant bivariate associations with satisfaction measures
(p-values from Pearson's χ^2 or Fisher's exact, as appropriate, α=0.05)

	Satisfied with…				
	MOH ILE services	Physical environment	Treatment by staff	Counseling in general	Contraceptive counseling
Demographic characteristics					
Has children					0.030
Under 25 years old				0.025	
Did not complete high school			0.025		0.005
Single	0.022				
Waited a week or less for first appointment			0.004		
A staff person…					
Provided counseling				0.015	
Asked if patient was sure of her decision			0.005	0.043	0.014
Discussed both abortion methods			0.009		
Explained what to expect in typical process for both methods					0.001
Explained possible side effects for both methods					0.012
Explained complications & warning signs for both methods					0.007
Explained process for follow-up care	0.002	0.009	0.023	0.015	0.002
Gave sufficient information in counseling		0.038	0.043	<0.001	
Gave sufficient information to decide on procedure type				0.033	0.005

Table 4. Significant multivariate associations with satisfaction measures
(adjusted odds ratios, confidence intervals and p-values from logistic regression, α=0.05)

	Satisfied with…				
	MOH ILE services	Physical environment	Treatment by staff	Counseling in general	Contraceptive counseling
Demographic characteristics					
Has children					
Under 25 years old					
Did not complete high school			0.27, p=0.160		0.19, p=0.018
Not living with a partner					
Waited a week or less for first appointment					
A staff person…					
Provided counseling				7.07, p=0.035	
Asked if patient was sure of her decision					
Discussed both abortion methods					
Explained what to expect in typical process for both methods					7.23, p=0.037
Explained possible side effects for both methods					
Explained complications & warning signs for both methods					
Explained process for follow-up care	17.73, p<0.001	7.11, p=0.023			16.45, p=0.002
Gave sufficient information in counseling				10.66, p<0.001	
Gave sufficient information to decide on procedure type				3.72, p=0.029	3.83, p=0.037

Table 5. Contraceptive use before and after abortion, by procedure type (medical=170, surgical=180)

		Procedure		
		Medical	**Surgical**	**Total**
	(column %)	***n (cell %)***	***n (cell %)***	***n***
Method(s) used at the time of conception	Pill (10.9)	23(13.5)	15(8.3)	38
	Patch (1.1)	2(1.2)	2(1.1)	4
	Vaginal ring (0.3)	1(0.6)	0(0)	1
	Withdrawal (4.6)	11(6.5)	5(2.8)	16
	*IUD (7.1)	6(3.5)	19(10.6)	25
	Female condom (0.3)	0(0)	1(0.6)	1
	Injectible (3.1)	3(1.8)	8(4.4)	11
	Male condom (50.6)	87(51.2)	90(50.0)	177
	None (24.3)	46(27.1)	39(21.7)	85
	Other (9.4)	20(11.8)	13(7.2)	33
If "None": Reason for using no method	Personal preference (43.8)	20(47.6)	15(39.5)	35
	Partner's preference (2.5)	2(4.8)	0(0)	0
	Preference of patient & partner (27.5)	9(21.4)	13(34.2)	22
	Other (26.3)	11(26.2)	10(26.3)	21
Methods used in year prior to conception	Pill (16.9)	35(20.6)	24(13.3)	59
	Patch (2.3)	5(2.9)	3(1.7)	8
	Vaginal ring (0.3)	0(0)	1(0.6)	1
	Withdrawal (4.3)	10(5.9)	5(2.8)	15
	IUD (14.0)	18(10.6)	31(17.2)	49
	Female condom (0.3)	1(0.6)	0(0)	1
	Injectible (8.0)	15(8.8)	13(7.2)	28
	Male condom (55.7)	98(57.6)	97(53.9)	195
	None (15.1)	29(17.1)	24(13.3)	53
	Other (9.4)	14(8.2)	19(10.6)	33
Method chosen for post-abortion use	Pill (12.6)	27(15.9)	17(9.4)	44
	Patch (2.0)	3(1.8)	4(2.2)	7
	Vaginal ring (0.6)	1(0.6)	1(0.6)	2
	Withdrawal (0.3)	1(0.6)	0(0)	1
	*IUD (62.6)	92(54.1)	127(70.6)	219
	*Injectible (17.1)	36(21.2)	24(13.3)	60
	Male condom (2.6)	6(3.5)	3(1.7)	9
	None (3.1)	5(2.9)	6(3.3)	11
	*Other (2.9)	8(4.7)	2(1.1)	10
If "None": Received birth control information to take home?	Yes (45.5)	1(20)	4(66.7)	5
	No (54.4)	4(80)	2(33.3)	6
If "None": Reason for choosing no method	Unsure which one to choose (27.3)	3(60)	0(0)	3
	Want to obtain it elsewhere (27.3)	0(0)	3(50)	3
	Desired method was unavailable (9.1)	1(20)	0(0)	1
	Other (45.5)	2(40)	3(50)	5
		Medical	**Surgical**	**Total**
		n(%)	***n(%)***	***n***

**significant difference between medical and surgical procedure types at $p<0.05$, Pearson's χ^2*

Appendix: Data collection instruments from original study

Part A. Full survey

Part B. Major themes guiding in-depth interviews

Part C. Interview guide

CUESTIONARIO MUJERES OMS

FOLIO:

EXPERIENCIAS DE MUJERES Y PROVEEDORES: PROGRAMA ILE-SS-GDF

CUESTIONARIO PARA MUJERES

Versión Enero 25, 2010

PROCEDIMIENTO MÉDICO___
Fecha de la primera
toma de la pastilla: ____/____/_______

PROCEDIMIENTO QUIRÚRGICO___
Fecha del procedimiento:
____/____/_______

INFORMACIÓN SOCIODEMOGRÁFICA

1. ¿Cuántos años cumplidos tiene usted?
________años

2. ¿Cuál es su peso aproximado?______kg.

3. ¿Cuánto mide usted, aproximadamente?
________mts.

4. ¿Dónde vive actualmente?
1___DF
2___otro (especificar cuál País o Estado):
____

5. ¿Cuál es su estado civil?
1___casada
2___unión libre
3___soltera
4___divorciada
5___viuda

6. ¿Cuántos hijos tiene?
______hijos

7. ¿Cuántos embarazos ha tenido antes de este?
______embarazos

8. ¿Cuántos abortos voluntarios/inducidos ha tenido antes de este? __________abortos

9. ¿Cuántos abortos espontáneos ha tenido?
______abortos espontáneos

10. En general, ¿cuánto dinero recibe usted por su trabajo a la semana?
$____________

11. ¿Cuál es su religión? (especificar)
____

12. ¿En cuál de las siguientes Instituciones o Programas de salud está usted asegurada?
1___SSA
2___ISSSTE
3___IMSS
4___Oportunidades
5___ninguno
6___otro (especificar)____________________

13. ¿Cuál fue el último nivel de estudios que cursó?
1___primaria
2___secundaria
3___preparatoria
4___escuela técnica
5___universidad
6___otro (especificar)____________________

PROCESO ANTERIOR AL PROCEDIMIENTO

Conocimiento y opinión sobre el aborto

14. ¿Por qué decidió usted interrumpir el embarazo?
1___por falta de recursos de manutención
2___no desea tener un hijo en este momento
3___su pareja no desea tener un hijo ahora
4___por falta de tiempo
5___porque no lo tiene planeado
6___ni su pareja ni usted desean hijos ahora
7___porque actualmente no tiene pareja
8___otra (especificar)_____________________

15. ¿De quién fue la decisión final de solicitar el servicio de ILE?
1___suya 2___de su pareja 3__de un familiar
4___de una amistad 5___suya y de su pareja
6___del médico 7___del(la) consejero(a)

16. ¿Ha escuchado acerca de una ley en el DF que permite a las mujeres interrumpir un embarazo dentro de las primeras 12 semanas de gestación? 1___sí 2___no

17. ¿Qué método(s) anticonceptivo(s) estaba utilizando al momento del embarazo?

a___pastillas b___parches
c___anillo vaginal d___diafragma
e___coito interrumpido f___DIU
g___condón femenino h___inyección
i___condón masculino j___ninguno
k___otro (especificar)____________________

(En caso de "ninguno")

17.1 ¿Por qué no estaba utilizando un método?
1___estaba tratando de quedar embarazada
2___preferencia personal
3___preferencia de la pareja
4___preferencia personal y de la pareja
5___otra (especificar)
____

18. ¿Qué método(s) anticonceptivo(s) ha utilizado durante el último año?

a___pastillas b___parches
c___anillo vaginal d___diafragma
e___coito interrumpido f___DIU
g___condón femenino h___inyección
i___condón masculino j___ninguno
k___otro (especificar)____________________

(En caso de "ninguno")

18.1 ¿Por qué no estaba utilizando un método?
1___estaba tratando de quedar embarazada
2___preferencia personal
3___preferencia de la pareja
4___preferencia personal y de la pareja
5___otra (especificar)
____

19. Antes de acudir a solicitar el servicio, ¿había usted escuchado acerca del aborto con medicamentos o de unas pastillas llamadas "Cytotec"?

1___sí 2___no

(En caso afirmativo)

19.1 ¿Qué escuchó acerca del aborto con medicamentos o sobre las pastillas?
____
____

20. ¿Qué tan de acuerdo o en desacuerdo está usted con esta nueva ley que legaliza el aborto dentro de las primeras 12 semanas de gestación?

1___totalmente de acuerdo
2___algo de acuerdo
3___ni de acuerdo ni en desacuerdo
4___algo en desacuerdo
5___totalmente en desacuerdo

21. Antes de que esta ley fuera aprobada, el aborto en el DF era legal bajo algunas circunstancias, ¿qué tan de acuerdo o en desacuerdo está usted con que el aborto sea legal bajo circunstancias como:

21a Cuando el embarazo pone en riesgo la vida de la mujer?
1___totalmente de acuerdo
2___algo de acuerdo
3___ni de acuerdo ni en desacuerdo
4___algo en desacuerdo
5___totalmente en desacuerdo

21b Cuando el embarazo pone en riesgo la salud de la mujer?
1___totalmente de acuerdo
2___algo de acuerdo
3___ni de acuerdo ni en desacuerdo
4___algo en desacuerdo
5___totalmente en desacuerdo

21c Cuando el embarazo es producto de una violación?
1___totalmente de acuerdo
2___algo de acuerdo
3___ni de acuerdo ni en desacuerdo
4___algo en desacuerdo
5___totalmente en desacuerdo

21d Cuando el producto presenta malformaciones congénitas severas?
1___totalmente de acuerdo
2___algo de acuerdo
3___ni de acuerdo ni en desacuerdo
4___algo en desacuerdo
5___totalmente en desacuerdo

21e Cuando la mujer así lo decide?
1___totalmente de acuerdo
2___algo de acuerdo
3___ni de acuerdo ni en desacuerdo
4___algo en desacuerdo
5___totalmente en desacuerdo

Conocimiento sobre el Programa Prioritario de ILE-SS-GDF

22. ¿Cómo se enteró usted sobre el Programa de ILE de la SS-GDF?
1___internet 2___amistad 3___radio
4___periódico 5___familiar 6___folletos
7___clínica/hospital/centro de salud
8___otro (especificar)_____________________

23. ¿Por qué decidió acudir a la SS-GDF? en lugar de acudir a otra Institución (pública o privada)?
1___porque es el sitio más cercano para ud.
2___porque le tiene más confianza a la Institución del Gobierno
3___porque donde vive no se ha aprobado la ley
4___porque se lo recomendaron (quién)
____
5___porque no tenía los recursos para una clínica privada
6___porque por ley le corresponde
7___otra (especificar)_____________________

Experiencia del proceso anterior al procedimiento

24. Antes de acudir a la clínica/hospital, ¿usted misma intentó interrumpir el embarazo? 1___sí 2___no

(En caso afirmativo)

24.1 ¿Cómo lo intentó?
1___consumiendo alguna hierba (cuál)_______________
2___con pastillas (cuáles)
____
3___con golpes
4___cargando objetos pesados
5___introduciendo algún objeto en la vagina

24.2 ¿Por qué falló ese intento?
1___no lo sabe
2___porque no lo hizo bien
3___porque lo que hizo no servía para abortar
4___porque no terminó el procedimiento
5___otra (especificar)
____

25. ¿Cuántas semanas de gestación tenía cuando acudió a solicitar el servicio de ILE?
1___menos de 9 semanas
2___más de 9 semanas

(En caso de más de 9 semanas)

25.1 ¿Por qué le llevó más de 9 semanas solicitar el servicio?
1___porque no estaba segura de la decisión
2___porque no sabía que estaba embarazada
3___porque le tomó tiempo convencer a su pareja
4___porque le tomó tiempo convencer a su familia
5___porque no contaba con los recursos para el traslado/ procedimiento
6___otra (especificar)
____

26. Aproximadamente, ¿cuánto tiempo transcurrió desde que hizo la 1a cita hasta que la atendieron?
1___menos de una semana
2___dos semanas
3___tres semanas

27. Una vez que llegó a la clínica para su 1a cita, aproximadamente, ¿cuánto tiempo transcurrió hasta que la atendieron?
1___15 min. 2___30 min. 3___45 min.
4___1 hr. 5___más de una hora

28. Por favor, dígame si recibió o no los siguientes servicios en la clínica/hospital:

28.1 ¿Le dieron consejería antes del aborto?
1___sí 2___no

28.1.a Ofrecida por:
1___médico 2___enfermera
3___trabajadora social
4___otro (especificar)
____

28.2 ¿Le preguntaron si estaba segura de su decisión? 1___sí 2___no

28.3 ¿Revisaron su historia clínica y los antecedentes de su embarazo?
1___sí 2___no

28.4 ¿Discutieron las opciones de aborto con medicamentos y aborto quirúrgico?
1___sí 2___no

28.5 ¿Discutieron las ventajas y desventajas del aborto quirúrgico? 1___sí 2___no

28.6 ¿Discutieron las ventajas y desventajas del aborto con medicamentos?
1___sí 2___no

28.7 ¿Le explicaron qué esperar de un caso normal, sin complicaciones, para ambos procedimientos? 1___sí 2___no

28.8 ¿Le explicaron los posibles efectos secundarios, de ambos procedimientos?
1___sí 2___no

28.9 ¿Le explicaron las posibles complicaciones que pudieran surgir y los signos de alarma para ambos procedimientos?
1___sí 2___no

28.10 ¿Le explicaron qué hacer en caso de presentar una urgencia médica?
1___sí 2___no

28.11 ¿Le explicaron el proceso de seguimiento? 1___sí 2___no

28.12 ¿Usted dio consentimiento informado? 1___sí 2___no

28.13 ¿Se llevó a cabo un ultrasonido para determinar la edad gestacional?
1___sí 2___no

29. ¿Usted siente que recibió suficiente información durante la consejería antes del aborto para saber qué esperar del procedimiento? 1___sí 2___no

30. ¿Usted siente que recibió suficiente información para decidir qué procedimiento elegir (quirúrgico vs medicamentos)?
1___sí 2___no

PROCEDIMIENTO

PROCEDIMIENTO CON MEDICAMENTOS

31. ¿Quién tomó la decisión final de solicitar un procedimiento con medicamentos vs uno quirúrgico?
1___el médico que la atendió
2___la decisión fue personal
3___la consejera o consejero
4___su pareja
5___tanto su pareja como usted
6___un familiar (quién)___________________
7___otra (especificar)___________________

32. ¿Qué le explicaron acerca de los efectos secundarios de tomar los medicamentos?
(especificar)____________________________
____

33. ¿Cuáles fueron las señales de alarma a las que le sugirieron estar atenta?
1___cólico intenso
2___malestar general intenso
3___dolor de cabeza intenso
4___vómito y náusea incapacitantes
5___sangrado intenso permanente
6___otra (especificar)_____________________

34. Además del personal de salud, ¿quién más estuvo presente en la primera toma de la pastilla? 1___nadie más 2___su pareja
3___un familiar (quién)___________________
4___otra (especificar)____________________

35. ¿Qué efectos secundarios experimentó después de tomar la primera dosis?
1___náusea 2___diarrea 3___vómito
4___escalofríos 5___sangrado abundante
6___cólicos intensos 7___náusea/vómito
8___otro (especificar)_____________________

36. ¿Dónde tomó usted la segunda dosis?
1___casa 2___clínica/hospital
3___otro (especificar)_____________________

37. Además del personal de salud, ¿quién más estuvo presente en la segunda toma de la pastilla? 1___nadie más 2___su pareja
3___un familiar (quién)___________________
4___otra (especificar)____________________

38. ¿Qué efectos secundarios experimentó después de tomar la segunda dosis?
1___náusea 2___diarrea 3___vómito
4___escalofríos 5___sangrado abundante
6___cólicos intensos 7___náusea/vómito
8___ninguno 9___otro (especificar)_________

39. ¿Cuántas pastillas tomó antes de completar el procedimiento?_____pastillas

40. ¿A usted le pareció "obvio" o fácil determinar el momento en que sucedió el aborto? 1___sí 2___no

41. ¿Le explicaron lo que usted vería o sentiría cuando ocurriera el aborto?
1___sí, que vería la evidencia, los restos
2___sí, que sentiría la evidencia
3___no lo explicaron
4___otra (especificar)______________________

42. ¿Cuál fue la explicación que recibió acerca de someterse a un procedimiento con medicamentos vs uno quirúrgico?
1___la edad gestacional: menor o igual a 9 semanas
2___la presencia de una contraindicación para un aborto quirúrgico (eg. Trastorno de coagulación)
3___no había servicios de aborto quirúrgico disponibles en ese momento
4___otra (especificar)______________________

43. En general, ¿cuáles considera usted que son las principales ventajas del aborto con medicamentos comparado con el aborto quirúrgico?
1___no tiene ventajas, son lo mismo
2___evitar la anestesia
3___poder saber y ver qué está pasando
4___evitar un trauma físico
5___evitar una cirugía
6___tener mayor control sobre la situación
7___realizar un procedimiento más seguro
8___poder tener un aborto en casa/lejos de la clínica u hospital
9___el costo

44. ¿Usted sintió que se le había dado la opción de elegir entre un procedimiento con medicamentos y uno quirúrgico?
1___sí 2___no

PROCEDIMIENTO QUIRÚRGICO

45. ¿Quién tomó la decisión final de solicitar un procedimiento quirúrgico en lugar de uno con medicamentos?
1___el médico que la atendió
2___la decisión fue personal
3___la consejera o consejero
4___su pareja
5___tanto su pareja como usted
6___un familiar (quién)____________________
7___otra (especificar)____________________

46. ¿Qué le explicaron acerca de los efectos secundarios de someterse al procedimiento? (especificar)_____________________________

47. ¿Cuáles fueron las señales de alarma a las que le sugirieron estar atenta?
1___cólico ienso
2___malestar general intenso
3___dolor de cabeza intenso
4___vómito y náusea incapacitantes
5___sangrado intenso permanente
6___otra (especificar)______________________

48. ¿Qué efectos secundarios experimentó después de someterse al procedimiento?
___cólicos ___malestar general
___diarrea ___dolor de cabeza ___mareo
___escalofríos ___sangrado abundante
___otro (especificar)______________________

49. ¿Cuál fue la explicación que recibió acerca de someterse a un procedimiento quirúrgico en lugar de uno con medicamentos?
1___la edad gestacional: mayor a 9 semanas
2___la existencia de una contraindicación para un aborto con medicamentos (eg. Alergia)
3___no había servicios de aborto con medicamentos disponibles en ese momento
4___otra (especificar)______________________

50. ¿Quién fue la primera persona que le comunicó si el procedimiento se había completado exitosamente?
1___médico 2___enfermera
3___trabajadora social
4___usted lo supuso una vez terminado el procedimiento 5___otra (especificar)
____

51. En general, ¿cuáles considera usted que son las principales ventajas del aborto quirúrgico comparado con el aborto con medicamentos?
1___no tiene ventajas, son lo mismo
2___estar anestesiada en el procedimiento
3___estar en compañía de enfermeras y médicos durante el procedimiento
4___el procedimiento está en manos de gente con experiencia 5___el costo
6___evitar los efectos secundarios de los medicamentos
7___no hay fallo en el procedimiento
8___reducir riesgos durante el procedimiento
9___otra (especificar)______________________

52. ¿Usted sintió que se le había dado la opción de elegir entre un procedimiento quirúrgico y uno con medicamentos?
1___sí 2___no

PROCESO POSTERIOR AL PROCEDIMIENTO

Opinión sobre el procedimiento

53. ¿Qué medicamentos tomó para aliviar los síntomas de los efectos secundarios?
1___recetados por el médico
2___recomendados por un familiar
3___recomendados por una amistad
4___auto-recetados
5___ninguno

(En caso de medicamentos auto-recetados)

53.1 ¿Qué medicamentos tomó?
1___aspirina
2___tylenol (paracetamol)
3___advil (naproxeno)
4___antiespasmódicos (buscapina y syncol)
5___antieméticos (bonadoxina)

54. ¿Los efectos secundarios ameritaron que usted fuera a una sala de urgencia de algún hospital o clínica?
1___sí 2___no

55. La cantidad del sangrado a causa del procedimiento fue:
1___mayor de la esperada
2___menor de la esperada
3___igual a la esperada

56. La cantidad del cólico a causa del procedimiento fue:
1___mayor de la esperada
2___menor de la esperada
3___igual a la esperada

Experiencia del proceso posterior al procedimiento

57. ¿Cuál fue el método anticonceptivo que eligió después de haberse completado el procedimiento?
1___pastillas 2___parches
3___anillo vaginal 4___diafragma
5___coito interrumpido 6___DIU
7___condón femenino 8___inyección
9___condón masculino 10___ninguno
11___otro (especificar)____________________

(En caso de "ninguno")

57.1 ¿Le dieron información anticonceptiva que usted pudiera consultar en casa?
1___sí 2___no

57.2 ¿Por qué no eligió un método anticonceptivo?
1___no sabía cuál método elegir 2___quería obtener un método de otro proveedor
3___el método que quería no estaba disponible (cuál) _____________
4___otro motivo (especificar) ___________________________

58. Si en el futuro usted se viera en la necesidad de interrumpir un embarazo, ¿qué procedimiento elegiría?
1___procedimiento con medicamentos
2___procedimiento quirúrgico
3___no lo sabe

59. Si en el futuro, neceistara interrumpir un embarazo, ¿regresaría a los servicios de la SS del GDF? 1___sí 2___no

60. En su opinión, ¿qué acciones mejorarían los servicios a los que usted acudió?
____
____
____

61. Por favor, dígame si se encuentra satisfecha o insatisfecha con los siguientes servicios de la clínica.
61a Ambiente físico en general 1___S 2___I
61b Trato por parte del personal 1___S 2___I
61c Consejería en general 1___S 2___I
61d Consejería sobre métodos anticonceptivos 1___S 2___I
61e Servicios de ILE de la SS-GDF 1___S 2___I

FIN DEL CUESTIONARIO

Part B: Major themes guiding in-depth interviews

Entrevistas a profundidad con pacientes: Temas generales

1. Razones de la usuaria para acudir a este hospital para interrumpir su embarazo.

2. Intervención (apoyo, obstaculización) por parte de la pareja o familiares en hacer la decisión, solicitar servicio ILE, seguir el tratamiento etc.

3. Acciones que la paciente habría tomado en caso de no existir el servicio de ILE en D.F.

4. Atentos y razones de inducir un aborto antes de acudir al servicio de ILE.

5. Razones por las cuales le tomó más de 9 semanas solicitar el servicio (si aplica).

6. Ruta de acceso a la ILE en el hospital y/o centro de salud.

7. Percepción del trato proporcionado por el personal administrativo, paramédico, de enfermería y médico del hospital y/o centro de salud.

8. Experiencia con personas de Provida fuera del hospital y/o centro de salud.

9. Consejería previa al procedimiento.

10. Proceso de Consentimiento Informado.

11. Estudios de laboratorio.

12a. ILE con Misoprostol, y/o 12b. Procedimiento quirúrgico.

13. Consejería post-aborto.

14. Calidad de la atención.

15. Emociones sobre su experiencia: antes del procedimiento, durante, después.

16. Opiniones del aborto inducido en general, de la ley ILE, de otras mujeres quienes abortan; conocimientos (o rumores) sobre otros métodos de inducir el aborto.

Part C: Interview guide for patients undergoing medical abortion

(surgical abortion patients received corresponding version for questions 11-17)

Guía entrevistas a profundidad
Mujeres, misoprostol
Experiencias de mujeres y proveedores: Aborto con medicamentos en el sistema de salud del Distrito Federal
(*Versión actualizada, Marzo 2009*)

Introducción

1. ¿Por qué decidió acudir a este centro de salud/clínica el día de hoy para obtener un aborto?

2. En caso de que el aborto dentro de las primeras 12 semanas de gestación no fuera legal en el DF, ¿Qué hubiera usted hecho para solicitar una interrupción del embarazo?

Información acerca del Programa de Interrupción Legal del Embarazo (ILE)*

*ILE es término normativo que se utiliza para describir el aborto legal en México y específicamente en la Secretaría de Salud del Distrito Federal

3. ¿Cuántas semanas tenía de embarazo?
    - Si >9 semanas - ¿Porque demoró en buscar la ILE?

4. ¿Me puede describir su "ruta" por el hospital, empezando por el sitio donde le dieron la primera información, y terminando con la última vez que acudió al centro de salud para la ILE?

5. ¿La pudieron recibir el mismo día que usted llegó? En caso contrario, ¿Cuántos días tuvo que esperar para que le dieran su primera cita?

6. ¿Cómo percibió el trato por cada prestador de servicios? (Respetuosa? Neutra? Discriminatoria? Otro?)

- Por el policía a la entrada
- En el módulo de atención/la recepción
- Por la trabajadora social/la enfermera
- Por los médicos

7. Favor de describir el tipo de consejería que recibió

Acerca de su decisión de interrumpir el embarazo

¿Discutieron con usted otras opciones (continuar con el embarazo, adopción, etc.)
¿Qué tipo de consejería le dieron en estos temas?
¿Le dieron información acerca del procedimiento de ILE?
¿Le dieron información acerca de métodos de ILE disponibles?
¿Le explicaron de modo que usted entendiera la forma en la que se tenía que tomar las pastillas de misoprostol?
¿Le explicaron acerca de los signos de alarma asociados a la ingesta de estas pastillas? ¿Qué tipo de consejería recibió?
Le explicaron acerca de otros métodos de planificación familiar?

8. ¿Qué opinión tiene sobre la consejería que le brindaron?
    - El respeto a su decisión
    - La calidez de atención
    - El contenido de la información

9. ¿Comprendió la información que le brindaron?

10. ¿En que momento firmó el consentimiento informado?
    - ¿Le dieron información acerca del procedimiento de ILE?
    - ¿Sabe para que sirve el consentimiento informado?
    - ¿El consentimiento informado fue fácil de comprender y estaba escrito en lenguaje que usted entendió?

    ¿Le hicieron un ultrasonido antes del procedimiento?
    Porque si/no?
    ¿Le hicieron pruebas de laboratorio antes del procedimiento?
    Porque si/no?

ILE con misoprostol:

11. ¿Que le explicaron sobre como tomarse las pastillas de misoprostol (dosis, intervalo, vía de administración)?

- ¿Quien le dio esa información?
- ¿La información era entendible para usted?
- ¿Se quedó con alguna duda?

12. ¿Tomó la primera dosis de misoprostol en el centro de salud o en su casa? ¿Porque?

13. ¿Que le explicó el personal de salud sobre los signos de alarma que se pueden presentar cuando usted toma misoprostol?
    - ¿La información fue sencilla de entender?
    - ¿Se quedó con alguna duda?

14. Le dieron hojas informativas sobre la toma de las pastillas y los signos de alarma?

15. ¿Cómo se sintió después de que tomó el misoprostol?
    - ¿Tuvo que acudir al hospital a causa de alguna complicación? ¿Cómo la atendió el personal de salud? ¿Cómo se resolvió?

16. ¿El procedimiento de aborto con medicamentos funcionó? ¿Se logró interrumpir el embarazo?

En caso afirmativo, ¿En cuántos días se completó el proceso?
¿Cómo supo que se había completado el proceso? ¿Alguien se lo confirmó?
En caso de que el procedimiento no haya sido exitoso, ¿regresó usted al centro de salud/clínica para un procedimiento de aborto quirúrgico?

17. Si el procedimiento de aborto con medicamentos no funcionó y fue necesario que usted acudiera a un procedimiento quirúrgico de seguimiento, favor de describir:
    ¿Cómo se sintió después de haber tenido un aborto de seguimiento
    ¿Cómo la trató el personal de salud (médicos y enfermeras)?
    En general, ¿Cómo describiría la calidad del servicio de seguimiento?

Consejería post-aborto

18. ¿Cómo supo que el aborto con medicamentos había sido exitoso?

19. Después del procedimiento, ¿le dieron algún tipo de consejería?
    - ¿Que le dijeron?
    - ¿Que le pareció esa información?

20. ¿En algún momento le dieron información sobre regreso de la menstruación y la fertilidad?

21. ¿Que le explicaron sobre métodos anticonceptivos?
    - ¿Que métodos mencionaron?
    - ¿Que le pareció esa información?

22. ¿Sintió algún tipo de presión para utilizar algún método anticonceptivo?

23. ¿Usted eligió algún método anticonceptivo en ese momento?
    - En caso afirmativo, ¿cuál eligió?
    - En caso de no elegir un método, ¿Por qué no lo hizo?

24. ¿Actualmente usted está utilizando algún método anticonceptivo?
    - ¿Cual?
    - ¿Opinión?
    - Si no: ¿porque no?

Calidad de la atención

En general, ¿que le pareció el servicio de este programa de ILE en este centro de salud/clínica?

- ¿Que le gustó, que no le gustó?
- Tiempos de espera, trato por parte del personal de salud, ambiente en la clínica/centro de salud, etc.
- ¿Porque?

25. En su opinión, ¿en que se podrían mejorar los servicios de ILE en la SS-GDF?

26. ¿Siente que al personal de salud le hace falta capacitación? ¿En que?

27. ¿Usted recomendaría este servicio a alguna amiga que quisiera una ILE?
    - ¿Por qué si/no?

28. ¿Usted recomendaría este servicio de ILE en la SS-GDF a alguna amiga que quisiera interrumpir un embarazo?
    - ¿Por qué si/no?

Sugerencias y comentarios

29. ¿Tiene alguna otra sugerencia o comentario, además de todo lo que ya platicamos?

Muchas gracias por su participación !