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Efficacy, acceptability and safety of medication abortion in low-income, urban Latina women

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Abstract

Background: Health care providers may be reluctant to offer medication abortion to low-income, non-English-speaking populations. Concerns include lack of patient interest, incorrect use of misoprostol at home, missing mandatory follow-up visits and inappropriate use of emergency services. We describe the appeal, acceptability, safety and follow-up rates of medication abortion in a low-income Latina population in New York City.

Study Design: Nested analysis of 270 subjects up to 63 days' gestation enrolled in a multicenter trial of medication abortion comparing different mifepristone–misoprostol intervals. After receiving mifepristone, subjects were instructed on home use of misoprostol, what to do in an emergency and when to return.

Results: This population was predominantly Spanish-speaking, unmarried, poor and publicly insured. Ninety-six percent took the misoprostol at home correctly, 90% returned as scheduled without reminders and 2% were lost to follow-up. Ninety-six percent described the experience as positive or neutral and 94% would recommend medication abortion to a friend. Three serious adverse events occurred and women accessed emergency services appropriately.

Conclusion: Medication abortion can be a very appealing, safe and effective option in low-income, non-English-speaking populations.

Keywords: Medication abortion; Latina; Underserved; Acceptability

1. Introduction

Mifepristone is a synthetic antiprogestin currently used in combination with the prostaglandin analogue misoprostol in medication abortions as a safe alternative to surgical abortion. Women and providers find the method efficacious and acceptable [1]. Women report advantages of medication abortion include the lack of surgery, the lack of injections, that it is less frightening, simpler, faster, less painful, more "natural and feminine" and easier emotionally than surgical abortion [1]. Physicians find other advantages to medication abortion including increased privacy for patients, lack of need for specialized equipment and fewer requirements in the clinical setting for administration [2]. Most importantly, medication abortion has been demonstrated to be safe and effective [3].

Despite these advantages, many abortion providers may not consider low income, non-English-speaking populations such as Latina immigrants as candidates for medication abortion. Anecdotally, many large-volume providers are often reluctant to offer medication abortion to this population due to the predominantly unsupervised nature of the procedure (personal communication). Concerns include potential lack of patient interest, incorrect use of misoprostol at home, inappropriate use of emergency services and loss to follow-up. Supporting this impression, Latina women are often not included in studies of medication abortion despite the fact that the National Institutes of Health has identified the Hispanic population as a priority area [4]. In reviewing the literature prior to our study, we found a total of 8835 subjects involved in US studies of medication abortion. Only 591 (7%) were Latina [5–11], who otherwise comprise 20% of

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US abortion patients [12]. This review excluded pilot studies involving fewer than 100 subjects, which may have been less likely to recruit from the general eligible population.

Many of the specific concerns regarding the appropriateness of medication abortion for low-income, low-educational-attainment patients have been addressed in studies of medication abortion in developing countries. There is ample evidence demonstrating that medication abortion is efficacious, acceptable and safe in resource-poor settings [13–16] and that a large number of women with limited resources will opt to have a medication abortion when given the choice [1].

Given the many advantages of medication over surgical abortion, our goal was to assess the appeal, safety, efficacy and acceptability of medication abortion in a low-income, urban Hispanic population.

2. Methods

Two hundred seventy participants were enrolled from one site of a larger multicenter trial comparing two regimens of mifepristone and misoprostol for medication abortion. The methodological details of this multicenter study have been described elsewhere [17]. Women at up to 63 days' gestation and desiring pregnancy termination were offered either the standard care at our University-based clinic at the time (manual vacuum aspiration) or participation in the medication abortion trial. At that time, medication abortion was not available at this clinic outside the trial. Information comparing surgical to medication abortion was provided at the time of scheduling the abortion appointment and/or on the day of the appointment. If the patient was considering participation, the same bilingual research assistant discussed the study protocol with her by phone or in person, in English or Spanish.

At the enrollment visit, each woman had her gestational age confirmed by ultrasound examination. Criteria for inclusion were patient in a state of general good health, 18 years of age or older, requested an elective termination of pregnancy, had a singleton intrauterine pregnancy ≤63 days' gestation confirmed by endovaginal ultrasound, willing and able to sign informed consent in English or Spanish, willing to comply with the study protocol and visit schedule, willing to have a surgical abortion/dilation and currettage if indicated, easy and ready access to a telephone, no contraindications to mifepristone or misoprostol and a hemoglobin >10 g/dL.

All study procedures were reviewed and approved by the institutional review board, and all subjects provided written informed consent before participating in the study. All subjects had third-party payer funding for their abortions, and there was no financial incentive to choose a medication abortion or participate in this study. If patients desired medication abortion outside the study protocol, they were referred to a different clinic. Statistical analyses were performed using SPSS 12.0. Means were compared using *t* tests, and proportions were compared using the chi-square test or Fisher's Exact test if cell sizes were less than 5. Statistical significance was achieved if $p<.05$.

3. Results

Detailed demographic data of the study population are presented in Table 1. The subjects were predominantly Latina with 88% identifying themselves as such. Thirty-eight percent (n=104) reported that they spoke no English [Spanish-speaking only (SSO)]. The remainder were classified as English-speaking (ES). Of note, 82% of the ES subjects reported Spanish as their language of preference/language spoken at home.

Participants ranged in age from 18 to 44 (mean±S.D.=25.5±5.5) years. Approximately 73% of participants lived in households with earnings less than $20,000.

Table 1
Sociodemographic characteristics (N=270)

Self-identified as Hispanic	88.5%
Self-described race	
Black	6.6%
White	4.1%
Asian	1.1%
American Indian or Alaska Native	0.4%
None of these	87.8%
Language preference	
Speaks English	61.7%
Prefers Spanish	82.0%
Speaks Spanish only	38.1%
Age; mean±S.D. (years)	25.5±5.5
18–24	50.4%
25–31	33.7%
32–38	14.4%
39+	1.5%
Household income	
≤$10,000	36.7%
$10–20,000	36.3%
$20–30,000	17.4%
>$30,000	9.6%
Employment status	
Unemployed/homemaker	43.5%
Part-time or full-time	34.9%
Student	21.6%
Years of education completed	
≤12 years	60.6%
Some college	39.0%
College graduate	0.4%
Relationship status	
Single	75.6%
Married	15.6%
Divorced, widowed, separated	8.8%
Parity (mean±S.D.)	1.3±1.2
0	27.0%
1	36.3%
2	22.6%
≥3	14.1%
Prior TABs	1.0±1.2
0	43.7%
≥1	56.3%