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Research Article

Patients' Satisfaction of a Newly Implemented Medication Abortion Option vs. Surgical Abortion in Barbados

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Abstract

Objectives: We sought to compare and assess the characteristics and satisfaction of patients who opted for surgery vs. a newly implemented medication alternative for abortion.

Methods: A previously applied and field tested patient satisfaction survey on abortion experience was administered to 91 patients. All data was recorded without identifiers and entered into Excel and the Statistical Package for the Social Sciences (SPSS) for further analysis. Categorical variables were compared using chi-square and continuous variables with a t-test.

Results: Of total subjects, 68.5% reported complete satisfaction with their abortion experience. Patients chose their method based on perceptions of safety, pain severity, invasiveness, and success rate. When split at the median age, younger women (≤26 yo) were significantly more likely to choose medication, while older women (≥27 yo) were more likely to choose surgery (p =0 .014) if they were to need an abortion again in the future.

Conclusion: This study demonstrates an equal level of satisfaction for women choosing either modality in Barbados and provides support for the implementation of both methods to meet the need of women seeking an abortion.

Keywords: Misoprostol, Termination, Caribbean, Cytotec, Pregnancy

Synopsis

The availability of Misoprostol as an alternative to surgical abortions yields equal levels of patient satisfaction, increases access and improves the security of women's health.

Introduction

Many countries in the Caribbean and Latin America are experiencing low rates of modern contraception, high rates of adolescent pregnancy and difficulties in access to abortion services [1]. In Barbados, 40% of pregnancies are to women under twenty years of age, and that percentage continues to increase [2]. The Barbados Family Planning Association (BFPA) has estimated that the number of teen pregnancies exceeds the number of teen births. Their data has shown that teenagers between the ages of 13-15 are more likely to continue their pregnancy, while those ages 16-19 more often opt to abort [3]. Furthermore, it has been reported that half of the providers in Barbados have refused to dispense emergency contraception [4].

Notably, Barbados is one of the few countries in the Caribbean where women have legal access to abortion. As a result, clandestine abortions are rare in Barbados in comparison to many of its neighboring West Indian countries [5]. It is also quite common for women from surrounding islands to fly to Barbados in order to legally obtain abortion services. Abortion, however, is still seen as a taboo topic by the general population and rarely overtly discussed by the government. Furthermore, legality does not automatically signify safety or actual access [6].

The dominant method for abortion in Barbados has been surgery, since its legalization in 1983 [2]. Worldwide, the use of medication to induce abortion, such as misoprostol, mifepristone, and methotrexate, has come to the forefront for early abortion [7]. Misoprostol is a cheap, low maintenance and widely available prostaglandin analog that was originally used to treat gastric ulcers. It has a reported success rate of 87-97% when used alone as an abortifacient at ≤ 9 weeks gestation [8]. Its durability and low

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cost, makes misoprostol, alone, the more feasible option for first trimester terminations in countries with scarce resources and few skilled providers. If neither mifepristone nor methotrexate is available, then a regimen of misoprostol 800 mcg vaginally repeated every 24 hours up to three doses is the next alternative under the World Health Organization's first trimester medical abortion guidelines [9]. Increased access to misoprostol has been associated with improvement in women's health in developing countries, and studies are currently being performed to refine the regimen for its use, alone, as an abortifacient [6].

For many years, women in Barbados have been illegally obtaining misoprostol from pharmacies and dangerously self-medicating to induce an abortion without the guidance of a health professional [10]. In the summer of 2011, a medication abortion program with misoprostol, alone, was implemented at the BFPA, making it the first and only public health facility providing both options (surgery and medication) on the island. There is no cost differential between the modalities (500$ BDD/250$ USD). All pregnancies are confirmed by urine βHCG (pregnancy) testing, with 9 and 10 weeks gestation used as the cut off for medication and surgical abortion, respectively.

The objective of this study was to retrospectively assess and compare the level of patient satisfaction regarding medication vs. surgical abortion experiences at the BFPA and the factors associated with the choice of both modalities.

Materials and Methods

This study took place from May 2012 to August 2012 at the BFPA, in St. Michael, Barbados. Our inclusion criteria consisted of an age ≥ 18 years and history of an abortion performed between May 2011-August 2012 at the BFPA. A review of the abortion records revealed that a total of 282 abortion procedures (142 surgical and 140 medical) were performed from May 2011-August 2012. This specific time frame was used for both surgery and medication patients as the medication option became available in May 2011, and the goal was to assess those patients who had an option of both modalities at the time of their initial presentation. An attempt was made to contact each patient to request participation in this study. Excluding those who did not meet our inclusion criteria, those who declined participation, and those with incorrect contact information, a total of ninety-one female patients were sampled. Out of the 91 participants, 46 had received a medication abortion and 45 had a surgical abortion (Figure 1). A previously applied and field tested patient satisfaction survey on abortion experience in the US created by the Reproductive Health Access Project was adapted to the Barbados context and administered to both groups over the telephone or in person, privately, at the clinic. Oral consent was obtained privately, prior to each interview. The purpose of the study was explained, and a hand out was given to each patient further detailing it. All patients were informed that participation was completely voluntary. The survey contained multiple choice, likert scales and open-ended questions about their abortion experience at the BFPA and factors contributing to their decision. A single interviewer collected all data and it took approximately 20 minutes to complete each. All data was recorded without identifiers and entered into Excel and the Statistical Package for the Social Sciences (SPSS) for further analysis. Categorical variables were compared using chi-square and continuous variables with a t-test. The total sample was split at the median age and a one way anova analysis was done to ascertain further interpretation. IRB approval was given by the University of Connecticut Health Center.

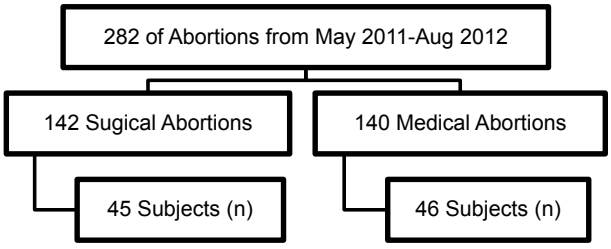

Figure 1: Subject Flow chart .

Results

Subjects choosing medication abortion did not differ demographically from those choosing surgical abortion. The mean age for both groups was 27 (range 18-45), with secondary school as the average level of education. All subjects were English speaking. The mean estimated gestational age (EGA) was significantly different between the groups, with a mean EGA in the medication group of 5 weeks and in the surgical group of 7 wks (p = 0.043). Of total subjects, 68.5% reported complete satisfaction with their abortion experience, with no significant difference between groups (p=0.81, Figure 2). There was a significant difference in their reasons for modality selection. Medication abortion patients chose their method based on perceptions of safety (p < 0.001) and relatively less pain and invasiveness (p <0.001); while patients choosing the surgical method placed more emphasis on success rate (p = 0.001). When asked which method they would choose next time, 64 % of the total subjects reported that they would choose the same modality again, with no significant difference between groups (p=0.22). When split at the median age, younger women (≤26 yo) were significantly more likely to choose medication, while older women (≥27 yo) were more likely to choose surgery (p =0 .014) if they were to need an abortion again in the future (Table 1). All of the patients in the medication abortion group reported that they would refer others in need of abortion to the BFPA.

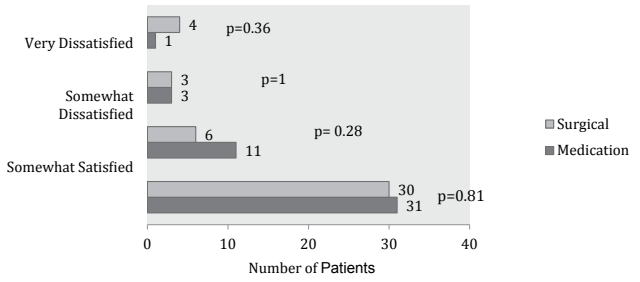

Figure 2: Patients' Experience.

	Future Modality		
	Medication	Surgery	Deferred
Total subjects	44	34	13
Medical group	28	12	6
Surgical group	16	22	7

[a] Subjects were asked which type of abortion they would opt for, if they were to need another in the future.

Table 1: Future Modality Selection.

Of the 45 surgical abortion patients, 7 reported recent history of medication abortion failure as their reason for undergoing surgery. The average age of this subgroup was 28 and tertiary school was the average level of education. Mean EGA was 6 weeks. Three reported complete satisfaction with their medication abortion experience, and 6 of the 7 reported that they would refer the BFPA to a friend in need of an abortion. When asked which modality they would choose if they were to need an abortion again, 1 deferred, 3 reported medication and 3 reported surgery.

Discussion

This study demonstrates an equal level of patient satisfaction for women choosing either modality. The implementation of this medication abortion program has provided Barbadian women with a safe alternative to surgery. Though women were able to obtain misoprostol beforehand, self-medicating with a drug with abortive capabilities can be dangerous and life threatening without regulation and clinical management. The BFPA offering medication as an option for abortion provides a setting in which trained clinicians not only educate patients on how to self administer the drug, but also explain side effects and emphasize their gravity while being available to intervene if necessary. It is interesting to note that although medication abortions have been associated with heavy bleeding, cramping, and inconvenience, the majority of the medication abortion patients in our study reported that they were completely satisfied, would choose medication again if necessary and would recommend it to others [11]. These results are consistent with prior studies and further accentuate the importance of how education, counseling and simply giving women a choice impacts overall satisfaction [12]. Therefore, it is crucial for providers to appreciate that the factors involved in patient preference are complex and will involve preconceived notions of that modality.

Our study revealed that women in Barbados selected their method of abortion based on personal perception of pain, safety, success rates and gestational age, which is also consistent with prior studies [11]. Patient age and level of education were not predictors of choice. However, patient age was the only socio-demographic factor that maintained association with future modality decisions: older patients reported that they would choose surgery and younger patients reported that they would choose medication, if they were to ever need another abortion. Collectively, these results are inconsistent with some previous studies that have shown that patients who were older and those who had a higher level of education tended to opt for medication [11]. An explanation for this difference noted within the Barbadian population in this study could be based in West Indian culture. As discussed earlier, abortion is considered a taboo topic in Barbados. Older patients, who may have a stronger connection to the traditional negative perspective on abortion, may appreciate the definitive nature of surgery, the more well known modality on the island with a better efficacy rate. In comparison, younger patients may be more open-minded when it comes to attempting a new modality as treatment if the presumption is that less pain is involved, despite the wide variation in efficacy. Nevertheless, it is important to note that most studies were performed in developed countries and details of their medication protocol and circumstances may differ greatly from the women and services in Barbados.

There are limitations in this study that may affect generalizability through selection, sampling, or length time bias and therefore, warrant further research. This study was done solely at the BFPA, a public government clinic that is centrally located. The results from our study may not represent the opinion of Barbadian women living at a great distance from the clinic and those who rely on private clinics throughout the island, creating a sampling bias. It is also very possible that women who were more satisfied with their abortion experience were also more willing to participate in this study compared to those who were not satisfied or who failed to follow up, creating a selection bias. Unfortunately, the number of patients approached to participate in this study was not recorded, as this data would have been advantageous in assessing some of the basic differences between these two groups. Lastly, it should be taken into account that the time period between the abortion and data collection varied. The views of those who received a medication abortion closer to the beginning of the implementation of this option could differ from those who received it later. Even though there was no difference in the misoprostol administration protocol throughout this time frame, the views of the general population may have evolved as more women experienced a medication abortion. The decreasing novelty of this option through time could have lead to later patients gaining a greater sense confidence and understanding of the procedure, creating a length time bias.

As mentioned earlier, this study is unique in that the medication abortion protocol at the BFPA involves only misoprostol. Most studies that have compared satisfaction between medications vs. surgical abortion have a medication abortion protocol that involves mifepristone or methotrexate, with or without misoprostol added in for a synergistic effect. The success rates of mifepristone and methotrexate are much higher in comparison to misoprostol alone, which would be a significant factor in the level of satisfaction reported in those studies and should be noted when comparing our results. The majority of the misoprostol abortion failure subgroup reported overall dissatisfaction with their abortion experience. Nonetheless, the majority also reported adequate counseling and was open to recommending the BFPA to a friend in need of an abortion. The modality reported to be chosen in the future by this subgroup, greatly differed from the answer reported by all patients combined. Excluding the one who deferred, half of the medication failure patients reported that they would attempt medication again, while the other half would bypass attempting medication and choose surgery instead. This underscores the strength of the association between success rate and patient satisfaction. It also supports the importance of refining the misoprostol protocol for it use alone in abortion.

In conclusion, our study demonstrates the success of this medication abortion program. It provides evidence that the medication approach to abortion can be implemented in a manner that is preferred and acceptable. The availability of medication as an option not only offers Barbadian women a choice, but it also increases their overall access to abortion services and the security of their health. Therefore, it is imperative that research focused on perfecting the regimen of misoprostol, alone, for its use in first trimester abortion continues. The medication abortion option should be expanded worldwide, as it is an important component for any facility to completely meet the reproductive needs of women.

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Conflicts of Interest

None

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