NOT TO BE CITE

"Women's abortion seeking behavior under restrictive abortion laws in Mexico"

**Fatima Juarez, Jose Luis Palma, Thoai D. Ngo,
Isaac Maddow-Zimet, Akinrinola Bankole, Susheela Singh***

Introduction

Unsafe abortion as defined by the World Health Organization is a procedure for the termination of an unintended pregnancy performed by people lacking the necessary skills, or in an environment that does not conform to minimum medical standards, or both (WHO, 1993). Unsafe abortion remains an important public health problem in Mexico, and it has negative effect on women and their families as well as the public health system. A large number of Mexican women resolve unintended pregnancies through abortions each year (1,026,000 induced abortions per year, Juarez and Singh, 2012). Mexico City (Federal District) is the sole area in the country where termination of pregnancy (before the twelfth week gestation) is legally permitted; almost all terminations occurring elsewhere in the country are practiced clandestinely (Juarez and Singh, 2012; GIRE, 2013; Becker and Olavarrieta, 2013). Furthermore, women resorting to illegal clandestine abortions risk their health and social standing by resorting to a highly stigmatized and often unsafe practice

In Mexico, abortion is regulated at the state level and is highly restricted in all 31 states, with varying degrees of constraint. In all states, it is permitted if the pregnancy is a result of rape; in 25 states, to save the life of a pregnant woman; in 12 states, if the pregnancy poses a severe risk to a woman's health; and in 13 states, in cases of fetal impairment (GIRE, 2013). Despite abortion being permitted on the basis of some criteria in all 31 states, very few women seek a legal abortion when they meet the relevant requirements and even if requested, it is almost without exception denied. This situation possibly derives from the profound stigma against abortion at the social level and from the absence of sufficient state-level mechanisms to warrant that women who qualify with the legal criteria for a legal abortion (for example, abortion due to rape, which is allowed in all states in the country) will be able to obtain one.

For many women, accessing safe abortion services has become more difficult since the decriminalization of abortion in Mexico City in 2007. Between 2008 and 2011, 16 states[1] added constitutional clauses protecting the life of the fetus from conception (GIRE, 2012a), presumably to prevent similar legal change. These states did not, however, amend their penal codes. Thus, the coexistence of penal codes allowing abortion in some circumstances with a constitution defining life at conception has created substantial legal confusion and uncertainty. Moreover, at least eight states[2] have started similar legal initiatives to add constitutional clauses protecting the life of the fetus from conception which have not yet been finalized (GIRE, 2012b).

* Fatima Juarez, El Colegio de Mexico and Guttmacher Institute; Jose Luis Palma, INSAD; Thoai D. Ngo, MSI; Isaac Maddow-Zimet, Akinrinola Bankole and Susheela Singh, Guttmacher Institute.

[1] Baja California, Chiapas, Colima, Durango, Guanajuato, Jalisco, Morelos, Nayarit, Oaxaca, Puebla, Queretaro, Quintana Roo, San Luis Potosi, Sonora, Tamaulipas and Yucatan.

[2] Aguascalientes, Baja California Sur, Hidalgo, Mexico, Sinaloa, Tabasco, Tlaxcala and Zacatecas.

A recent investigation (Juarez and Singh, 2012) provided estimates of the dimension of the problem, and indicated that unintended pregnancies resulted in more than one million induced abortions in Mexico in 2009. The abortion incidence rate for the country as a whole is 38 per thousand women in reproductive age, a level higher than the rate for Latin America as a whole (32 per 1,000 in 2008) (Sedgh et al., 2012). Juarez and Singh (2012) also showed that induced abortions occur all over the country and in all age groups, but with a much higher prevalence among young women.

Over the past 15 years, there is growing evidence of the widespread use of a relatively inexpensive and accessible pill that causes abortion, misoprostol, in Mexico. Misoprostol was originally developed to prevent gastric ulcers, but its off-label use for ending pregnancy is widely known to be effective (Clark et al., 2007). However, the pill's efficacy at inducing abortion depends on it being used correctly—that is, that it be taken at the appropriate time in pregnancy and at the correct dosage. Unfortunately, such correct practices cannot be assured in Mexico, where misoprostol is usually taken clandestinely and sometimes without proper instruction (Juarez et al., 2008; Billings et al., 2009; Wilson et al. 2010).

In general, because of the secrecy that surrounds induced abortion, due both to stigma and its illegality in much of the country, it is very difficult to know the level of induced clandestine abortions and the degree of abortion safety. We are fortunate to have estimates of the prevalence of induced abortion in Mexico and abortion morbidity and treatment; however, addressing the issue of unsafe abortion practices continues to be a challenge due to the lack of data and very little research on the topic. At present, there is no information on the socio-demographic and economic characteristics of the women seeking abortions besides their age and the state of occurrence; research is missing on women's experiences of abortion and their abortion seeking process. In addition, new patterns of abortion seeking and the complications that develop may be emerging. Some women that use misoprostol for an induced abortion may experience complications that need treatment in a health facility, while others might just arrive at health facilities because they are frightened of the heavy bleeding they experience, or prefer to seek care to ensure that the abortion is completed as were told by the person who prescribed it to do so the moment they are bleeding. It may also be the case that some women are still unaware of this medical abortion method and continue to follow more traditional patterns of abortion seeking behavior, which tend to result in more negative experiences for women and possibly more severe abortion complications.

.OBJECTIVES OF THE PAPER

Little is known on women's experiences of clandestine abortion. We have thus developed a research project to advance the body of knowledge on this issue. The aim of this study is to document Mexican women's abortion practices in three different states where the legality of abortion varies. Three main questions are central to our research: Who are the women who are having induced abortions that were treated for hospital complications related to the procedure? What is the experience of women seeking a clandestine abortion? How do these differ by the prevailing level of legal restriction of abortion? Thus, the specific objectives of the study are: 1) To identify the socio-demographic profile of women experiencing complications related to an induced abortion (educational level, marital status, number of children, previous use of a

contraceptive method, etc.); 2) To explore the key elements of the process of abortion seeking, such as gestational age at the abortion, involvement of the husband or others in the decision-making process and reasons for the abortion; and 3) To provide a description of common abortion methods and sources, women's degree of persistence as measured by the number of attempts made to obtain an abortion, the use or non-use of misoprostol and its pattern of use, and if no use, the women's knowledge of this new procedure. The analysis will consider the differences between women living in three settings with different levels of abortion legislation restriction.

DATA AND METHODOLOGY

The population under study is women of reproductive age 18 years (the age of adulthood in Mexico) or older who had an abortion in one of three settings.

Given that abortion laws in Mexico are determined at the state level, it is particularly important that state legislatures and policy makers have state-level information in regards to women's barriers to reproductive health. As different levels of restriction are present across Mexico's 31 states and Mexico City (Federal District), three states with different degrees of restrictiveness of the abortion law were selected for this research study: (1) Guanajuato, a highly restrictive state, where abortion is only allowed under two criteria (rape and "imprudencial o culposo" (imprudence)); (2) Tabasco, a state that permits abortion under four criteria (rape, an extended definition of "imprudencial o culposo", to save the life of the woman, and artificial insemination without the consent of the woman) and where the incidence of abortion and abortion complications is among the highest in the country; and c) Estado de Mexico, a state that also permits abortion under four criteria (rape, "imprudencial o culposo," to save the life of the woman, and serious genetic or congenital malformation) but where the conditions have been shown to be very favorable to potentially changing the law.

Two types of data, in 2 hospitals in each state, are collected among women presenting for post-abortion care (PAC) at public health facilities for this study: quantitative information collected through a screening questionnaire and qualitative in-depth interviews. The screening questionnaire is being administered to women receiving treatment for abortion complications in government hospitals (PAC patients). Data collected using this questionnaire is being used to identify the socio-demographic profile of women having complications. Participants for the IDIs are women who induced their abortion and are recruited through the screening questionnaire administered to PAC patients. Eligible PAC patients are then interviewed one or two weeks after they are discharged from the hospital about their experiences with the abortion. This information will give us the key elements of the abortion seeking process, including who was involved in the decision and the steps taken to obtain an abortion once a decision was made to terminate the pregnancy. The instruments are the same in all three states.

Additional participants for the IDIs are being recruited using a snowball sampling design, starting with women recruited from clinics known to perform safe illegal abortions in each state. At the end of each interview, women are asked if they know of anyone else who has had an induced abortion – safe or unsafe – who might be willing to talk to the study team. If they answer affirmatively, they are given information about the study to pass on to the woman they would like to refer; the referred woman then can

contact the study team if they are interested in participating. In this way, through multiple referrals, we hope to get a broader range of induced abortion experiences than possible among women with access to safe facilities. In addition, we suspect that women will be more comfortable speaking about their abortion experiences when contacted outside of a hospital setting and with referral from a friend or family member, thus mitigating some of the stigma present with this type of topic.

The expected number of screening questionnaires per state is 120, with an additional 20 in-depth interviews. The complete study will therefore collect up to a total of 360 screening questionnaires and 60 in-depth interviews. Data collection initiated in January 2014.

The initial Screening Questionnaire contains different topics: basic background and demographic characteristics; recent pregnancy and the decision process; and contraceptive use, among others. The in-depth interview (IDI) guidelines ask about the following topic areas: Current sexual partner and contraceptive patterns; views and experiences regarding unwanted pregnancy and contraceptive practices; views and experiences regarding abortion; and knowledge of and experiences with misoprostol, among others.

The project obtained Ethical Approval from The National Population Council (Consejo Nacional de Población (CONAPO), Mexico; Guttmacher Institute's Institutional Review Board (DHHS identifier IRB00002197), USA; and from the MSI Ethics Review Committee (number 016-12-FT-A), UK.

RESULTS

We are currently implementing data collection for this study, and it is expected that data will be ready for analysis in December 2014, and analysis will be completed in February 2015. We hypothesize that given the high prevalence of contraception in Mexico, most women resorting to induced abortion were using contraceptive methods but were using it inadequately, and that the majority of women were at the initial stage of their family formation (parity zero or low parity, intending to space their births). We also hypothesize that friends play an important role in informing women on where to obtain abortion methods or find clandestine providers. Given that it can be used clandestinely more than other potentially effective methods, we opine that a large proportion of women having abortions are probably using misoprostol and that women who do not use misoprostol will have more severe abortion complications. It is likely that for women living in settings with more legal restrictions there will be a greater stigma about abortion, which will result in more unsafe abortion and severe complications and lower likelihood of receiving treatment for the complications.

Although analysis is not yet complete, we present below some preliminary findings from a subset of interviews in one of the states under study, Queretaro.

Demographic characteristics of PAC patients

Table 1 shows the distribution of various demographic characteristics among the 122 PAC patients administered the screening questionnaire in Querétaro. The majority were ages 20-24 (36%), followed by 18 and 19 year olds (20%) and those aged 25-29 (18%). Relatively few were in their early 30s and even fewer were age 40 or over. This

distribution is consistent with recent estimates of induced abortion rates by age for the year 2009 (Juarez et al, 2012), which found that women 20-24 years had the highest rates of abortion, followed by those aged 15-19 and then 25-29. Most had at least a secondary education; relatively few had graduated from preparatory school (19%) or university (9%). These parallel the distribution of educational attainment in the country. The majority of PAC patients reported their occupations as homemakers (66%), and most were either married (25%) or in union (57%). Parity, in general, was low – almost 40% of the women in our sample were nulliparous, and 30% had only one child. In addition, most reported being relatively early in their pregnancy: 46% were under 8 weeks and 26% were 9-12 weeks. Only around 20% reported being more than 12 weeks into their pregnancy at the time they were admitted.

Abortion-related decision-making process

Most of our respondents described themselves as the primary maker of the majority of the decisions relating to contraception and pregnancy termination. This is consistent with findings from previous studies (e.g. Juarez and Bayer, 2011),

Partner and other involvement

Given the sensitive and controversial nature of abortion, only participants who reported having had an abortion and willing to be interviewed were asked about their personal experiences with abortion. When asked about the decision-making process around their abortions, women largely reported making the decision themselves. In most cases they discussed the matter with their partners, friends or sisters, but felt that the final decision had been theirs. Most of the partners were informed about the pregnancy. In some cases, the partners felt it was fine to have a child, but independent of their desire, the partners, generally left the decision to the woman, and they supported whatever decision she made. Women were very specific in what they characterized as support, however. Support for the women was not characterized as the verbal response of the partner, but in terms of the actual actions they were expecting from him. Respondents wanted the male partner to be supportive emotionally and economically, to help her find the provider for the termination, and to be there with her in this difficult situation.

> Interviewer: Did you inform your partner you were pregnant? Did he support you?
> Participant: "When I found out I was pregnant -- as I told you before, my partner is married -- I asked him what we should do. And he asked me what I wanted to do, and I said I do not want it. He cannot offer me anything as he is married. ...It hurt both of us, but it was convenient for both parties..... I did not wanted to be a single parent, I already had a child without a partner. John helped me, he started looking on the Internet, he is good with computers, and he found someone that could help with the pregnancy termination. That person explained the procedure [misoprostol], …I did it alone, he was on the phone, and he paid…" (Cynthia, 34 years, 1 child, single)

> Participant: "He wanted the child, so I took the decision alone. I consulted my family (sister and brother in-law) and those close to me (best male friend). He did not help me, not economically, nor emotionally, .. " (Giselle, 26 years, 2 children, single)

The experience of MISOPROSTOL

Despite its widespread use, until now little has been known in regards to where women obtain misoprostol, who advises them how to use it, and whether it is taken in adequate doses. We next describe the abortion process of two women who used misoprostol to induce abortion.

> Interviewer: What method did you use?
> Participant: John [her partner] found it through the Internet and contacted a person that we met…near the park. He explained the procedure to us. He had 4 or 5 pills and some sheets where everything that was going to happen was explained. He told me to trust him, that I should not be nervous. … He gave us 4 or 5 pills, I do not remember well. It was Cytotec, misoprostol. But they were not in a box with the brand name, which gave me a little distrust.
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> Interviewer: Please tell us how you did the procedure
> Participant: It was very ugly, very ugly. I was in my room, it [the instructions] said that I had to put my legs up … and I had to introduce 1 pill, and an hour or hour and a half later, I had to introduce another into the vagina. …I was so nervous that I did not read all the instructions.
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> Interviewer: You did not read the manual at the beginning?
> Participant: I read how I should insert them. One first and another 1 hour later, but I didn't continue reading. There were too many pages, and I am not good at reading those things, and later it said (and I did not read), that you might feel muscle cramps ("calambres"), dizziness. … I had extremely horrible leg cramps. I could not move my legs and they were shaking very hard. And then the cramps moved to the abdomen, but it was more extreme in the legs. After the first pill, I allowed 1 hour and a half to insert the second pill. I do not remember well the time, I was very tired and it was midnight. I inserted another, but the second pill broke. A little piece fell off, I was very nervous, and then I fell asleep. I started again at mid-day to insert another pill, when I was working**.**
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> Interviewer: Did you go to work?
> Participant: Yes, I had to, I do not have social security, and I would lose the day of pay… I had to continue 24 hours later with the other 2 pills. By then I had a chance to read the instructions and it mentioned the cramps. The instruction said that if a large blood clot was expelled, then I should introduce the 5^{th} or 4^{th} pill, I do not remember. After the 3^{rd} pill I expelled a blood clot and my partner called the person who sold us the misoprostol. The person (seller of misoprostol) was telling me that I was doing very well, that I only have to wait. It has been almost a year and I continue with blood clots. I went for a medical check-up 3 weeks later at the hospital…. as the man instructed me I told them that I have menstrual pain.
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> Interviewer: How do you feel about your health now?
> Participant: For about 2 or 3 months I continue expelling blood clots. And now I have migraines, which I attribute to the procedure. (Cynthia, 34 years, 1 child, single)

IMPLICATIONS FOR POLICY

We expect that results on the health consequences of unsafe abortion procedures will be helpful in raising awareness and knowledge among key stakeholders on the extent of clandestine abortion and the burden suffered by women who attempt to terminate unwanted pregnancies. This information could stimulate policies and programs to improve the prevention of unplanned pregnancy and the reduction of unsafe abortion (following the model of Mexico City) and thus, improving the reproductive health of women.

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Table 1. Demographic characteristics of hospitalized women due to abortion complications, Querétaro 2014

Selected variables	N	%
Total	122	100
Age		
18-19	24	19.7
20-24	44	36.1
25-29	22	18.0
30-34	14	11.5
35-39	11	9.0
40+	7	5.7
Education		
Primary	33	27.0
Secondary	56	45.9
Preparatory	23	18.9
University	10	8.2
Occupation		
Employed	32	26.2
Homemaker	81	66.4
Student	3	2.5
Unemployed	4	3.3
Other	2	1.6
Current Marital Status		
Married	30	24.6
In Union	69	56.6
Single	23	18.9
Parity		
0	48	39.3
1	36	29.5
2	23	18.9
3	11	9.0
4+	4	3.3
Gestational Period		
8 weeks or less	56	45.9
9-12 weeks	32	26.2
>12 weeks	25	20.5
Don't know	9	7.4