Abstract: There will always be women who need abortions after 12 weeks of pregnancy, and their reasons are often compelling. Although second trimester abortions carry relatively more risks than first trimester abortions, abortion is still very safe throughout the second trimester if done in safe conditions. This paper is about law and policy on second trimester abortions, which are allowed on more restrictive grounds than first trimester abortions in most countries, if at all. It focuses on countries where most or at least some second trimester abortions are allowed, including in Europe, where many women are still forced to travel for second trimester abortions, and countries in the developing world, where most second trimester abortions remain unsafe. The need for second trimester abortion should be met in a safe, timely and sympathetic manner. Abortion should be legal at the woman’s request up to 24 weeks and on therapeutic grounds after that, and no other barriers or hurdles should be imposed on women seeking second trimester abortion. In-depth, country-based research is needed, to bring out the facts on second trimester abortion, as evidence of why it should be treated as a legitimate form of women’s health care and supported in public health policy.
Abstract: In Mozambique, since 1985, induced abortion services up to 12 weeks of pregnancy are performed in the interest of protecting women’s health. We asked whether any women were being adversely affected by the 12-week limit. A retrospective record review of all 1,734 pregnant women requesting termination of pregnancy in five public hospitals in Maputo in 2005–2006 revealed that it tended to be those who were younger and poorer, with lower levels of education, literacy and formal employment who were coming for abortions after 12 weeks. Countries such as Mozambique that endeavor to enhance equality, equity and social justice must consider the detrimental effect of narrow gestational limits on its most vulnerable citizens and include second trimester abortions. We believe the 12-week restriction works against efforts to reduce maternal deaths due to unsafe abortion in the country.

Nr.3 Reasons for Second Trimester Abortions in England and Wales

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Abstract: This paper summarises the findings of a study on second trimester abortion in England and Wales in 2005. Second trimester abortions constitute a relatively small proportion of the total number of legal abortions performed in these countries yet attract quite substantial public, and particularly media, attention. Discussion of these abortions has, however, been conducted within a context of little understanding of the factors which explain why they happen. This paper starts with a brief introduction to the policy context for provision of second trimester abortion, and a summary of existing research in the area. It then presents the results of a survey of 883 women on their own reasons why they had abortions in the second trimester. The key concept is that of “delay” and reasons for delay in seeking or obtaining abortion at five stages in the pathway to abortion. No clear, single reason emerges. Amongst the main reasons identified are uncertainty about what to do if they were pregnant, not realising they were pregnant, experiencing bleeding which may have been confused with continuing to have periods, and changes in personal circumstances. The paper ends with a consideration of the implications of the results for education, policy development and service provision. A2008 Reproductive Health Matters. All rights reserved.
Nr. 4 Factors Influencing the Percentage of Second Trimester Abortions in the Netherlands

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Abstract: Second trimester abortion has been legal in the Netherlands since 1984. Factors influencing second trimester abortion in the Netherlands may be different from those that play a role in first trimester abortions. This is important for professionals in counselling and education. In this paper national registration data are used to complement data from a small, qualitative, exploratory file study conducted in three clinics, on the factors associated with second trimester abortions. In 2006, 6.6% of all abortions registered in the National Abortion Registry took place after 12 weeks of gestation. In the qualitative data, relationship problems with the partner were mentioned more frequently as the main reason for second trimester abortions than for first trimester abortions. Factors associated with delay in obtaining an abortion were young age, inability to recognise pregnancy, ambivalence towards the pregnancy, having to travel to the Netherlands for abortion and to a lesser extent being an immigrant from specific countries. Information should be provided for young women and women from specific immigrant groups on early awareness of pregnancy, contraception and reduction of fear about seeking abortion and sexuality education should be provided. A2008 Reproductive Health Matters. All rights reserved.

Nr 5 Second Trimester Abortions in India

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Abstract: This article gives an overview of what is known about second trimester abortions in India, including the reasons why women seek abortions in the second trimester, the influence of abortion law and policy, surgical and medical methods used, both safe and unsafe, availability of services, requirements for second trimester service delivery, and barriers women experience in accessing second trimester services. Based on personal experiences and personal communications from other doctors since 1993, when I began working as an abortion provider, the practical realities of second trimester abortion and case histories of women seeking second trimester abortions are also described. Recommendations include expanding the cadre of service providers to non-allopathic clinicians and trained nurses, introducing second trimester medical abortion into the public health system, replacing ethacridine lactate with mifepristone-misoprostol, values clarification among providers to challenge stigma and poor treatment of women seeking second trimester abortion, and raising awareness that abortion is legal in the
second trimester and is mostly not requested for reasons of sex selection.

**Nr 6  Late-Term Abortion for Fetal Anomaly: Vietnamese Women’s Experiences**

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Abstract: Screening for fetal anomalies in the second trimester of pregnancy is increasingly becoming a part of antenatal care. As a consequence, more pregnant women are learning that the child they are expecting has an anomaly. This article derives from anthropological research in a hospital in Hanoi, Viet Nam, from 2003–2006 that investigated 30 women’s experiences after a fetal anomaly was detected. We followed the women from the ultrasound scan through the process of deciding whether to continue their pregnancy or have an abortion. This article focuses on the 17 women who had an abortion and the support they received from health care providers. Their loss of a wanted pregnancy led to feelings of guilt, pain and sadness and fear and uncertainty about being able to have a healthy child in the future. Two years after the abortion, most of the women had come to terms with the loss, especially those who had had a healthy child since. We recommend that the Vietnamese health care system seeks to ensure that women receive counseling and support that answers their questions about what happened and why. To do this, health care staff need additional training in fetal medicine and counseling skills and sensitisation to the social and emotional challenges that detection of fetal anomalies and second trimester abortion bring to antenatal care.

**Nr 7  Termination of Pregnancy for Fetal Abnormality: The Perspective of a Parent Support Organisation**

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Abstract: Antenatal Results and Choices (ARC) celebrates its 20th anniversary as a UK registered charity in 2008. ARC’s remit is to provide information and non-directive support to parents before, during and after antenatal screening. Much of its core work is supporting parents who are considering or who have already undergone a termination after a diagnosis of fetal abnormality. This paper describes ARC’s history and how its work has changed over the 20 years, and looks at terminations, mostly in the second trimester, in the UK from ARC’s experience as a parent support organisation. It summarises the law on when terminations for fetal abnormality can be offered and explores some of the issues that have affected the parental
experience of termination after an antenatal diagnosis. It describes how standards of care have changed for the better, partly due to the training and information they provide widely, and parents’ experience and perspectives on the importance of having contact with others with the same experience.

Nr 8  A Week in the Life of an Abortion Doctor, Western Cape Province, South Africa

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Abstract: South Africa legalized abortion in 1996. I am originally from the Netherlands and came to South Africa in 2000, to assist in the Termination of Pregnancy programme. In March 2007, at an international conference on second trimester abortion, I described my life as an abortion doctor living in Cape Town, South Africa. I was urged to write down what my working life in the Western Cape is like, and this paper is the result. It is a diary of a typical work week, recorded in early 2008.

Nr 9  Second Trimester Abortion Provision: Breaking the Silence and Changing the Discourse

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Abstract: How do abortion providers determine how late in pregnancy they will provide abortion services? While law, training and socio-political factors likely play a part, this essay considers additional factors, including: personal and psychological aspects, visceral responses to the fetus and fetal parts at later gestations, feelings that second trimester abortion is violent, and ethical concerns with second trimester abortion. Providers may censor themselves with respect to these issues, fearing that honest acknowledgement of difficult aspects may be dangerous to the pro-choice movement; that is, such acknowledgements could appear to legitimise the anti-abortion stance that second trimester abortion is gruesome and morally unacceptable. I argue that this silence is harmful to providers, the pro-choice movement and the women who need abortion services. I make the case for pro-choice discourse that is honest about the nature of abortion procedures and uses this honesty to strengthen abortion care, including second trimester abortion.

Nr 10  Decision-Making after Ultrasound Diagnosis of Fetal Abnormality

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Abstract: During the last few decades, the use of ultrasonography for the detection of fetal abnormalities has become widespread in many industrialised countries. This resulted in a shift in timing of the diagnosis of congenital abnormalities in infants from the neonatal period to the prenatal period. This has major implications for both clinicians and the couples involved. In case of ultrasound diagnosis of fetal anomaly there are several options for the obstetric management, ranging from standard care to non-aggressive care to termination of pregnancy. This essay explores the context of both clinical and parental decision-making after ultrasound diagnosis of fetal abnormality, with emphasis on the Dutch situation. While normal findings at ultrasound examination have strong beneficial psychological effects on the pregnant woman and her partner, the couple are often ill-prepared for bad news about the health of their unborn child in the case of abnormal findings. When parents consider end-of-life decisions, they experience both ambivalent and emotional feelings. On the one hand, they are committed to their pregnancy; on the other hand, they want to protect their child, themselves and the family from the burden of severe disability. These complex parental reactions have implications for the counselling strategy.

Nr 11  Maintaining Access to Safe Abortion and Reducing Sex Ratio Imbalances in Asia

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Abstract: High sex ratios at birth (108 boys to 100 girls or higher) are seen in China, Taiwan, South Korea and parts of India and Viet Nam. The imbalance is the result of son preference, accentuated by declining fertility. Prenatal sex detection with ultrasound followed by second trimester abortion is one of the ways sex selection manifests itself, but it is not the causative factor. Advocates and governments seeking to reverse this imbalance have largely prohibited sex detection tests and/or sex selective abortion, assuming these measures would reverse the trend. Such policies have been difficult to enforce and have met with only limited success. At the same time, such policies are starting to have adverse effects on the already limited access to safe and legal second trimester abortion for reasons other than sex selection. Moreover, the sex selection issue is being used as a platform for anti-abortion rhetoric by certain groups. Maintaining access to safe abortion and achieving a decline in high sex ratios are both important goals. Both are possible if the focus shifts to addressing the conditions that drive son preference.

Nr 12  Implications of the Federal Abortion Ban for Women’s Health in the United States

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Abstract: In 2007, the US Supreme Court upheld the Partial Birth Abortion Ban Act of 2003, also known as the Federal Abortion Ban or “the Ban.” The decision undermines decades of
established US abortion law that had recognised the preservation of the health of women as a paramount consideration. The Ban asserts that the state’s interests in how an abortion is performed and in fetal life override women’s rights. It thus further erodes access to safe and legal abortion care. The new law negatively affects evidence-based clinical practice, the training of new providers and clinical innovation. It may also lead to additional legal restrictions on abortion access in the US and has implications for abortion service delivery internationally. Advocates must develop strategies that focus on women’s right to control their fertility throughout the trajectory of an unwanted pregnancy. A2008 Reproductive Health Matters. All rights reserved. Keywords: abortion law and policy, second-trimester abortion, dilatation and evacuation, partial birth abortion, United States

Nr 13 Clarifying Values and Transforming Attitudes to Improve Access to Second Trimester Abortion

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Abstract: Access to safe second trimester abortion services is poor in many countries, sometimes despite liberal laws and policies. Addressing the myriad factors hindering access to safe abortion care requires a multi-pronged strategy. Workshops aimed at clarifying values are useful for addressing barriers to access stemming from misinformation, stigmatisation of women and providers, and negative attitudes and obstructionist behaviours. They engage health care providers and administrators, policymakers, community members and others in a process of self-examination with the goal of transforming abortion-related attitudes and behaviours in a direction supportive of women seeking abortion. This is especially important for women seeking second trimester abortion, which tends to be even more stigmatised than first trimester abortion. This paper reports on some promising experiences and results from workshops in Viet Nam, Nepal and South Africa. Some recommendations that emerge are that values clarification should be included in abortion training, service delivery and advocacy programmes. Evaluations of such interventions are also needed.

Nr 14 Fetal Pain: Do We Know Enough to Do the Right Thing?

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Abstract: Raising the possibility of fetal pain continues as a tactic to undermine support for abortion in the US and the UK. This paper examines anatomical and psychological developments in the fetus to assess the possibility of fetal pain. Neurobiological features that develop at 7, 18 and 26 weeks gestation suggest an experience of pain in utero. Pain, however, cannot be inferred from these features because they are not informative about the state of consciousness of the fetus and cannot account for the content of any presumed pain experience. We may be confident the
fetus does not experience pain because unique in utero neuroinhibitors and a lack of psychological development maintain unconsciousness and prevent conscious pain experience. Before an infant can experience sensations and emotions, the elements of experience must have their own independent existence in the infant’s mind. This is achieved after birth through discoveries made in action and in patterns of adjustment and interaction with a caregiver. Recommendations about anaesthetic practice with the fetus and the newborn or young infant should not focus on pain but on outcomes with obvious, and measurable, importance. In the case of an unwanted pregnancy, the health of the woman should guide anaesthetic practice. In the case of a wanted pregnancy, the survival and long-term health of both the woman and fetus should guide anaesthetic practice. In any case, current evidence does not support efforts to inform women of the potential for fetal pain. Any policy to mitigate fetal pain could expose women to inappropriate intervention, risk and distress.

Nr 15  Applying the WHO Strategic Approach to Strengthening First and Second Trimester Abortion Services in Mongolia

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Abstract: Abortion was made legal on request in Mongolia in 1989, following the collapse of the socialist regime, and later bound by a range of regulations. Concerned about the high number of abortions and inadequate quality of care in abortion services, the Ministry of Health applied the World Health Organization’s Strategic Approach to issues related to abortion and contraception in 2003. The aim was to develop policies and programmes to reduce unintended pregnancies, mitigate complications from unsafe abortion, and improve the quality of abortion and contraception services for all socio-economic groups, including adolescents. This paper describes the changes that arose from a strategic assessment, highlighting the introduction of mifepristone–misoprostol for second trimester abortion. The aim was to replace mini-caesarean section and intra-uterine injection of Rivanol (ethacridine lactate), so that second trimester abortions could take place earlier than at 20 weeks gestation. National standards and guidelines for comprehensive abortion care were developed, the national pre-service training curriculum was harmonised with the new guidelines, at least one-third of the country’s obstetrician–gynaecologists were trained in manual vacuum aspiration and medical abortion, and three model comprehensive abortion care units were established to provide high quality services to women, high quality training for providers and serve as nodes for further scaling up. A2008 Reproductive
Nr 16 Establishing Second Trimester Abortion Services: Experiences in Nepal, Viet Nam and South Africa

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Abstract: This paper describes experiences and lessons learned about how to establish safe second trimester abortion services in low-resource settings in the public health sector in three countries: Nepal, Viet Nam and South Africa. The key steps involved include securing the necessary approvals, selecting abortion methods, organising facilities, obtaining necessary equipment and supplies, training staff, setting up and managing services, and ensuring quality. It may take a number of months to gain the necessary approvals to introduce or expand second trimester services. Advocacy efforts are often required to raise awareness among key governmental and health system stakeholders. Providers and their teams require thorough training, including values clarification; monitoring and support following training prevents burn-out and ensures quality of care. This paper shows that good quality second trimester abortion services are achievable in even the most low-resource settings. Ultimately, improvements in second trimester abortion services will help to reduce abortion-related morbidity and mortality.

Nr 17 Second Trimester Abortion in Viet Nam: Changing to Recommended Methods and Improving Service Delivery

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Abstract: In Viet Nam, abortion has been legal up to 22 weeks of pregnancy since the 1960s. There are about one million induced abortions every year. First trimester abortion is provided at central, provincial, district and commune level, while second trimester abortion is provided only at central and provincial level. For second trimester abortion, dilatation and evacuation (D&E) has been introduced at some central and provincial hospitals, and medical abortion protocols have been included in the draft National Standards and Guidelines currently being updated. However, Kovac’s, an unsafe method, is still often used at many provincial hospitals. While access to first trimester abortion services is not difficult, there are still many barriers to second
trimester abortion, especially for young, unmarried women. In order to prevent unwanted pregnancies, increase access to safe abortion and improve quality of care, the Vietnamese Ministry of Health is working with others to establish national policies and developing effective models for women-friendly comprehensive abortion care, including post-abortion family planning. This paper, based on published information, interviews and observations by the second author of service delivery in 2006–2008, provides an overview of second trimester abortion services in Viet Nam and ongoing plans for improving them.

Nr 18  Surgical Abortion in the Second Trimester

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Abstract: The development of dilatation and evacuation (D&E) as a method of second trimester surgical abortion occurred soon after abortion law reform took place in the 1960s and 1970s in Europe and the United States. Today, D&E is the predominant method of second trimester abortion in many parts of the world. Debate still exists as to whether surgical or medical methods are optimal for second trimester pregnancy termination. A continuing challenge to provision of D&E is the availability of a large enough pool of skilled providers. This article reviews the current surgical methods used in second trimester abortion, as well as their safety, advantages and disadvantages, acceptability and associated complications. Methods used to ensure safe and efficient surgical termination of second trimester pregnancies such as cervical preparation and ultrasound guidance are also reviewed. A2008 Reproductive Health Matters. All rights reserved.

Nr 19  Second Trimester Medical Abortion with Mifepristone–Misoprostol and Misoprostol Alone: A Review of Methods and Management

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Abstract: Second trimester abortions constitute 10–15% of all induced abortions worldwide but are responsible for two-thirds of major abortion-related complications. During the last decade, medical methods for second trimester induced abortion have been considerably improved and become safe and more accessible. Today, in most cases, safe and efficient medical abortion services can be offered or improved by minor changes in existing health care facilities. Second trimester medical abortion can be provided by a nurse–midwife with the back-up of a gynaecologist. Because of the potential for heavy vaginal bleeding and serious complications, it
is advisable that second trimester terminations take place in a health care facility where blood transfusion and emergency surgery (including laparotomy) are available. This article provides basic information on regimens recommended for second trimester medical abortion. The combination of mifepristone and misoprostol is now an established and highly effective method for second trimester abortion. Where mifepristone is not available or affordable, misoprostol alone has also been shown to be effective, although a higher total dose is needed and efficacy is lower than for the combined regimen. Therefore, whenever possible, the combined regimen should be used. Efforts should be made to reduce unnecessary surgical evacuation of the uterus after expulsion of the fetus. Future studies should focus on improving pain management, the treatment of women with failed medical abortion after 24 hours, and the safety of medical abortion regimens in women with a previous caesarean section or uterine scar.

**Nr 20 Complications after Second Trimester Surgical and Medical Abortion**

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Abstract: Second trimester abortion is associated with higher rates of complications compared to first trimester abortion. Dilatation and evacuation (D&E) and medical induction using misoprostol alone or a combination of mifepristone and misoprostol are the methods most commonly used for later abortion in developed countries, yet little research has directly compared them. We reviewed the literature on PubMed and identified only one small randomised controlled trial and one retrospective cohort study with comparative data for these methods, although the cohort study did not include cases using the mifepristone regimen. We expanded our search to include case series and cohort studies for a single method. In the randomised trial, women undergoing medical induction reported significantly more pain and experienced more adverse events. In the cohort study, incomplete abortion was significantly more common among women undergoing medical induction. In the single method studies, serious complications such as uterine perforation, uterine rupture and haemorrhage were rare, although the latter may be more common with medical induction. Mild infection may also be more prevalent after medical induction. Current evidence suggests that, given trained providers and where otherwise feasible, D&E is preferable to medical induction. A larger randomised controlled trial is needed that directly compares outcomes between the two methods, examines acceptability to women and explores clinicians’ perspectives on providing them.

**Nr 21 The Choice of Second Trimester Abortion Method: Evolution, Evidence and Ethics**

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Abstract: Decades after its introduction, dilatation and evacuation (D&E) is still not universally offered by gynecologists who provide second trimester abortion. Three lines of evidence point to D&E as the preferred method for most women. First, the uterus has evolved to expel its contents early and late in pregnancy, not in the middle. Hence, induction of labour with medical abortion forces the uterus to perform a task it is not designed to do. Second, cohort studies and randomised, controlled trials over the past 30 years have consistently shown that D&E is safer and more effective than labour induction abortion, regardless of the abortifacient used. Third, the ethical principles of beneficence, autonomy and justice require that D&E be routinely offered by gynaecologists who perform second trimester abortions. The uneven geographical availability of D&E may stem from lack of information, lack of requisite equipment and training, or lack of motivation. According to the principles of evidence-based medicine and bioethics, these barriers to better care for women can and should be overcome.

Nr 22  Misoprostol Preferable to Ethacridine Lactate for Abortions at 13–20 Weeks of Pregnancy: Cuban Experience

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Abstract: Outdated second trimester abortion methods are still being used in some countries, and very few studies have compared them to currently recommended methods. To this end, we studied the efficacy and safety of vaginal misoprostol used alone for abortions in 189 women at 13–20 weeks gestation, in 2004–2006. We also retrospectively collated similar data from an historical cohort of 189 women drawn consecutively and chronologically from hospital records from 2003–2006, also at 13–20 weeks gestation, who had had abortions with a combination of extra-amniotic 0.1% ethacridine lactate solution, oxytocin and sharp curettage. At 24 hours, misoprostol was 92.6% effective in inducing abortion versus 76.2% with the ethacridine lactate regimen (OR 4.2, 95% CI 2.3–8.0). The misoprostol cohort experienced fewer complications than the ethacridine cohort (4 vs. 38 cases, OR 0.086, 95% CI 0.03–0.23). We conclude that in the absence of mifepristone, misoprostol alone is preferable to the ethacridine regimen for the
termination of pregnancy in the second trimester, because it works faster, has a higher success rate in a shorter period of time, and fewer complications.

**Nr 23  An Historical Overview of Second Trimester Abortion Methods**

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Abstract: The methods used for abortion in the second trimester have changed considerably in recent years. The surgical procedure dilatation and evacuation (D&E) has replaced hysterotomy. Instead of injecting different compounds, such as hypertonic saline, prostaglandin analogues are administered by non-invasive routes. The most effective medical method is combining a prostaglandin analogue with mifepristone. The consequence of these developments is that abortion in the second trimester can be performed significantly more effectively and that the currently recommended methods being used are associated with fewer side effects and complications.