International Consortium for Medical Abortion

International Conference on Second Trimester Abortion

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London, UK

Conference Report

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International Conference on Second Trimester Abortion

CONFERENCE COORDINATION AND ORGANISATION

Rodica Comendant, ICMA Coordinator, organised and ran the conference. The ICMA Steering Committee planned the conference agenda and decided upon the speakers:

- Marge Berer, UK
- Peter Fajans, Switzerland
- Bela Ganatra, India
- Sharad Iyengar, India
- Wanda Nowicka, Poland
- Mariana Romero, Argentina
- Beverly Winikoff, USA

Conference administration and travel were coordinated by Irina Tarasenco and the ICMA Coordination office staff in Moldova.

FINANCIAL SUPPORT

Fundraising for the conference was carried out by the ICMA Coordination office with the support of members of the ICMA Steering Committee.

The following donors provided financial support for the conference as a whole and/or for travel and conference attendance costs for participants from developing countries and countries in transition. The following NGOs provided funding for travel and conference attendance costs for some participants from developing countries and countries in transition as well as for one or more of their own staff.

Donors	**NGOs**
Canadian International Development Agency	Concept Foundation
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Swedish International Development Authority	International Women's Health Coalition
	Ipas
	IPPF Western Hemisphere
	PATH

Ten additional NGOs plus the World Health Organization in Geneva funded the travel and costs of members of their own staff.

CONFERENCE REPORT

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September 2007

International Conference on Second Trimester Abortion

In March 2007 the International Consortium for Medical Abortion (ICMA) convened a three-day conference in London to address second trimester abortion issues. The conference was attended by 90 expert clinicians and advocates from Africa, Asia, Western and Eastern Europe, Latin America, the Caribbean, North Africa, and North America.

The three-day Conference agenda included 11 panel sessions with over 33 different speakers. The speakers sought to:

- highlight the importance of second trimester abortion as a women's health, ethical and public policy issue;
- review the situation with respect to second trimester abortion in relation to safety and efficacy of methods, legal and policy dimensions, access and service delivery issues, and the contribution of second trimester abortions to maternal morbidity and mortality;
- delineate the place of medical methods within second trimester abortion; and
- provide a forum to share this information, start a process of developing guidance on these matters and disseminate the information globally.

In addition, the Conference included reports from many different countries about the legal status of abortion, service delivery challenges, and clinical and advocacy innovations in those settings, providing case examples for the broad themes of the conference.

Conference Summary

I. The Need for Second Trimester Abortions

> *How late in pregnancy abortions should be permitted and carried out is a matter of great controversy among almost everyone – except the women who need them. (Marge Berer)*

Abortion is a stigmatised procedure in most countries, and second trimester abortions are particularly stigmatised. Many countries that allow first trimester abortions severely restrict "later" abortions. The definition of a "later" abortion varies globally; some less restrictive countries allow elective abortion only up to 10 weeks. While women face problems accessing abortion care even when abortion is legal, the stigma of later abortions (generally understood to be after the first trimester - post 12-13 weeks) creates additional access barriers.

While first trimester abortions are safer, easier to access, and have more public and political support, women will always need access to later abortions, and will risk their

health and lives to obtain this service. If a woman cannot access safe, legal abortion at whatever stage of pregnancy she needs it, she will either have an unsafe procedure from an unskilled person and risk morbidity or death, or will be forced to carry the unwanted pregnancy to term.

Access to second trimester abortion is limited in many countries due to a range of factors, including:

- Legal restrictions, as many country's abortion laws do not permit second trimester abortion at all, except to save the life of the woman. Those countries which do permit second trimester abortion usually have highly restricted grounds and bureaucratic approval processes;
- Increased stigma for women needing later abortions and for the clinician s who provide them;
- Decreased number of providers willing to carry out abortions after 12–16 weeks of pregnancy and the even smaller number willing to provide abortions beyond 20 weeks;
- Lack of good training for those providers willing to provide abortions, and the use of less safe methods; and
- Lack of appropriate facilities, medications, instruments and resources.

Second trimester abortions are a small percentage of all abortions worldwide. In all settings, including countries where second trimester abortion is legal and there is good training for clinicians, the second trimester procedure carries somewhat more risks than a first trimester abortion but it is still a very safe procedure. While only 10% of all induced abortions occur in the second trimester, these abortions are responsible for two thirds of all major complications (WHO 1997). In legally restricted settings, morbidity and mortality rates are also greater from complications of second trimester abortion compared to first trimester procedures. The reasons are often due not just to the lateness of the pregnancy but also to greater risks from self-medication, the conditions in which the abortion is performed, the use of unsafe methods, and the lack of timely, skilled follow-up care to treat complications. As is true of all abortion statistics in legally restricted settings, there is little good data on second trimester abortion from these countries, and abortion deaths are hidden in statistics on maternal deaths or not reported at all.

Complications related to second trimester abortion include uterine perforation, uterine rupture, haemorrhage, cervical laceration, complications from anaesthesia, and infection. Women facing the highest risk of death are those having no access to legal abortion or to treatment for complications of abortion, those who are young and poor, and women who have anaemia or other health problems.

In spite of the stigma and health risks, however, women around the world seek later abortions. Universally, women seeking late abortions are disproportionately younger and of lower economic status. Women seek later abortions for a variety of reasons:

- Some women fail to recognize their pregnancy during the first trimester or admit to themselves that they are pregnant.
- Confronting the fact of an unwanted pregnancy is not easy and deciding to terminate it not always straightforward. Some women need time to sort through social pressures, religious attitudes, and changes in relationship status to make the decision to seek abortion. For other women, changed circumstances (e.g. abandonment by partner) cause them to seek an abortion after initially planning to carry to term.
- Second trimester abortions cost more, and finding the money may be hard and time-consuming.
- The barriers to accessing second trimester services may cause delays. When it is difficult to find someone to do a late abortion, the abortion becomes even later.
- Most fetal abnormalities can only be diagnosed in the second trimester.
- Because of legal restrictions in their country of origin, many women are forced to travel, including to other countries, and making these arrangements and finding the money to cover the costs takes time.

In most studies, women gave multiple reasons for needing abortions in the second trimester. It was striking to learn during the course of this conference that women all over the world often had the same reasons for second trimester abortion.

Conference Recommendations on Access

- While it is important to support improved access to sex education, contraception and first trimester abortion, access to good quality second trimester services is an essential part of safe abortion services.
- Unsafe second trimester abortions contribute disproportionately to abortion mortality and morbidity in legally restrictive settings. Investment in better access to, safety and quality of second trimester services should be a priority for governments.
- Data on the extent of second trimester abortions – unsafe and safe, in legal and illegal settings, is lacking. Demographic and Health Surveys and similar surveys should include questions on abortion and the use of abortion services, including second trimester abortion. Reporting of abortion procedures by providers should be encouraged; this should not serve as the primary mechanism of administrative regulation.

II. Laws and Policies

In every country, second trimester abortions take place, legally or otherwise, or women travel elsewhere to obtain them. Laws either create access or create barriers. (Marge Berer)

Laws on abortion differ dramatically across the globe. While 40% of the world's population lives in countries where first trimester abortion is generally available on request, there is wide variation in these countries' regulation of second trimester abortion. Some allow second trimester abortion for broad therapeutic, economic and social reasons

(Denmark, Great Britain, Russia, former Soviet Union countries, South Africa, United States) while others liberally interpret health/mental health exceptions. Many countries that allow second trimester abortions do so with specific restrictions, including the need for approval by commissions or one or more physicians. Others allow second trimester abortions only to preserve the health or life of the mother, for fetal indications, and/or when the pregnancy is the result of rape or incest. Some countries have unclear laws on what constitutes a legal second trimester procedure. For the 60% of the world's population that live in countries where all abortion is legally restricted, rates of maternal morbidity and mortality from abortion are high. It is unknown what percentage of this morbidity and mortality is due specifically to unsafe second trimester abortion.

Conference Recommendations on Laws and Policies

- Abortion in the first and second trimester should be decriminalized.
- Governments need to clarify scope of abortion laws and their laws should adhere to international human rights standards. Steps to ensure that health care providers and women clearly understand the scope of abortion laws must be in place.
- Mental health should be included in any health indication especially in countries with restrictive laws.
- Judicial approval or administrative requirements for rape should be removed.
- There should be no imposition of an upper time limit in the second trimester. The imposition of a time limit on abortion at less than 24 weeks restricts access for the few women who need a late abortion, with all the attendant negative consequences. Those who seek abortions at 20-24 weeks are usually the poorest, the youngest and the most vulnerable, and women with a previously wanted pregnancy in which serious abnormalities have been diagnosed, and they deserve support and access to services, not condemnation.
- The extent of maternal morbidity and mortality due specifically to unsafe second trimester abortion should be the subject of research.

III. Overview of Methods and Advantages of Different Methods In Different Settings

> *There are myriad issues and each setting is different. There is no one right way to provide second trimester abortions. It is necessary to assess the environment, resources and facility, to offer choices when possible, and most important, to maintain high quality. (Traci Baird)*

Around the world, different levels of health care resources, different laws on abortion, and varying access to medications and surgical training determine what methods of second trimester abortion are available and preferred. While ideally a woman should have a choice of methods, in reality provider preference, influenced by setting, usually

restricts what type of procedure is available. Worldwide, a range of second trimester abortion methods is currently in use.

Vacuum aspiration (with electrical or manual vacuum aspiration) is commonly used up to 13 weeks LMP. Although some providers continue to use aspiration alone up to 16 weeks LMP, in many countries dilation and evacuation (D&E) is the preferred method after 13 or 14 weeks. The D&E procedure involves dilating the cervix with either laminaria or a prostaglandin such as misoprostol, and then removing the fetal tissue using specialized forceps and vacuum aspiration.

The use of medical methods to terminate second trimester abortion has developed considerably during the last 30 years. Misoprostol alone is used in clinical settings in many countries to terminate pregnancies at 17-24 weeks LMP with good safety and efficacy outcomes. In countries where mifepristone is also available, the use of mifepristone before misoprostol for priming increases efficacy and allows for a lower dose of misoprostol, and therefore fewer side effects (nausea, cramping, bleeding).

Different routes of administration and different dosage levels of misoprostol with and without mifepristone are used effectively in different countries. The differing regimens are influenced by whether abortion is legally restricted, what medications are available, clinician experience with different regimens, and a wide range of published studies showing efficacy with different administration routes and protocols.

There are advantages and disadvantages to both surgical and medical abortion. In the hands of an experienced provider, abortions done at less than 20 weeks are likely to have fewer complications with D&E than with medical abortion. D&E is a relatively quick outpatient procedure, is close to 100% effective in ending a pregnancy, and reduces the need for in-patient bed space. The procedure is easier for the women but can be difficult for clinicians, both technically and emotionally. D&E requires a level of resources not available in some settings, including specialized training and the maintenance of an adequate caseload to maintain these skills, specialized forceps, stronger anaesthesia, and the ability to adequately dilate the cervix. For electric suction, there must be a reliable source of electricity. Generally, ultrasonography is also required for D&E procedures.

Medical abortion can be provided by less experienced clinicians. It is easy to administer and does not require as much training as surgical abortion does. Medical abortion takes more time for completion, and requires hospital beds and supportive staff, including nurses and midwives.

For the patient, a surgical abortion is a short procedure which is very effective, and is safe in the hands of a skilled provider. If there is a complication such as perforation of the uterus, it can be quite serious if there is inadequate medical back-up, however. Medical abortion is highly effective, safe, relatively inexpensive, and requires no instrumentation. The duration of the procedure is somewhat unpredictable, and the experience can be difficult, physically and emotionally, for women and the nurses who attend them.

Methods such as dilation and curettage, sharp curettage, hysterotomy (sectioparva), intra-amniotic injection, hypertonic saline/hyperosmolarurea, intra-or extra-amniotic administration of ethacridine lactate (Rivanol), parenteral, intra or extra-amniotic administration of prostaglandin analogues and administration of oxytocin are generally considered less safe and therefore less desirable; however, these methods are still used in some settings. In India and China, extra-amniotic injections of ethacridine lactate are being widely used to induce second trimester abortion, as it is relatively safe and inexpensive, particularly where providers have not been trained in other methods or where there are inadequate facilities for surgical abortion. It is typically only used late in the second trimester and thus its use may result in women being told to return at a later stage of pregnancy for their abortion. Although this method is effective, WHO does not recommend it due to the considerably longer intervals to complete abortion (and thus greater risk of complications) in comparison to the use of mifepristone and misoprostol or misoprostol alone. Its use will probably be phased out once the effectiveness of mifepristone/misoprostol and misoprostol alone in the second trimester is more widely appreciated.

Conference Recommendations on Abortion Methods

- The risk of complications from second trimester abortion is related in part to the use of outdated methods such as hypertonic saline instillation and hysterectomy. These methods should be discontinued and replaced by safer methods.
- The use of a curette to complete second trimester medical abortion should be avoided, and should be replaced by suction.
- The available evidence on the extra-amniotic instillation of ethacridine lactate suggests that it is relatively safe, effective and inexpensive, but with a considerably longer interval to completion of abortion and thus a higher risk of complications than with mifepristone/misoprostol or misoprostol alone. Further documentation of the rate of complications with ethicridine lactate and better guidance on medical methods for physicians, including the limitations of ethicridine lactate, are needed.
- Women should be offered an informed choice regarding the method of termination (medical vs. aspiration) when both types of procedure are available.
- Studies are needed comparing the safety and acceptability of surgical and medical techniques in the second trimester of pregnancy, especially after 20 weeks. Studies are also needed on the impact on clinicians, recognizing that in surgical methods the provider takes the greater burden of the procedure, while with medical methods the women carries the greatest burden.
- There is a need for cost analysis and cost-effectiveness studies of second trimester abortion services. This must cover the cost to the health system or clinic and to the patient.

IV. Service Delivery Issues in the Provision of Second Trimester Abortion

In countries where second trimester abortion is legal, there are service delivery issues that must be addressed to ensure quality services. These include:

- Finding staff who are supportive of women having 2nd trimester abortion and making sure that they are well trained;
- Setting policies about the viewing of the fetus and disposal of fetal tissue that comply with the law and respect women's choices;
- Ensuring adequate space for women waiting for services and for recovery; and
- Equipment, medicines and supplies to treat any complications.

For providing aspiration abortion, specific issues include:

- Procuring necessary equipment for D&E (vacuum source, appropriate forceps);
- Availability of ultrasound; and
- Adequate supply of a cervical preparation agent/mechanism.

For providing medical abortion, specific issues include:

- Accommodating ongoing inductions after daytime hours;
- Adequate beds for induction; overnight stay if required;
- Toilet facilities; and
- Assured supplies of mifepristone and/or misoprostol.

There are also decisions to be made as to whether second trimester services should be provided within obstetrical and gynaecological services or as stand-alone services. Integration within a hospital service allows the leveraging of available human and infrastructure resources, can facilitate greater confidentiality, and can decrease the marginalization of the procedures and providers. Stand-alone abortion services, on the other hand, can greatly enhance patient access, though they should be linked to hospitals for emergency back-up.

A universal service delivery issue is the serious shortage of second trimester abortion providers worldwide. The number of skilled second trimester surgical abortion providers is declining, and in most countries where second trimester procedures are permitted, new providers lack access to caseloads for learning and/or are less willing to learn this procedure. While training is a major issue for providing D&E procedures, there are other issues that contribute to the scarcity of clinicians willing to provide later abortions. These include a lack of compassion for women who need later abortions, the low status and marginalization of abortion providers within medicine, personal/moral discomfort with later procedures, threats of violence towards providers (USA), and an unwillingness to take on the risk of providing later abortions for fear of legal liability. In some countries, higher malpractice insurance rates, restrictive laws, lack of adequate financial reimbursement, and lack of good facilities also discourage physicians from providing later abortions.

As there are fewer physicians to treat the numbers of women who need second trimester abortions, those who do provide the service have heavy caseloads. This leads to a risk of clinician burn-out, which results in clinicians leaving the field or treating their patients less respectfully.

The question of whether a fetus can experience pain and the consequences for second trimester abortion have emerged in recent years, and is important for providers, women seeking second trimester abortion and advocates. Speculation that the fetus may experience pain first arose from a discussion in medical journals about dealing with pain in neonates. In the USA the assertion that fetuses feel pain has been used as a justification to introduce laws that women must be informed about fetal pain, as if it were established fact, and to sway public opinion against second trimester abortions. In fact, the difference between a reaction to a sensation and the cognitive development necessary to experience that sensation as pain must be recognized. We can be confident that the fetus prior to 26 weeks does not experience pain because the developmental processes necessary for experience have not occurred. Whether after 26 weeks a fetus can experience pain is currently a matter of scientific debate, but this debate should not interfere with women's rightful access to abortion. Efforts to inform women seeking abortion of the potential for fetal pain are not supported by evidence and could expose women to inappropriate intervention, risk and distress.

Conference Recommendations on Service Delivery

- Physician trainees should have the option of training in D&E, using models to build their skills before they begin to practice on patients.
- Platforms and networks for sharing and interaction among second trimester abortion providers would help to reduce isolation and foster solidarity – their establishment deserves high priority.
- The motivation of providers needs due consideration – doctors, midwives, nurses, and other personnel in an abortion team should be well rewarded for undertaking second trimester abortions, especially after 20 weeks of pregnancy.
- Malpractice liability should not be a barrier to physicians who are trained and wish to provide second trimester abortion services.
- Programmes and services must invest in destigmatizing second trimester abortion providers and protecting them. The need of providers for discretion and privacy regarding their role must be respected.
- The emotional needs of providers and burn-out among them, including all members of the abortion team, should be studied and addressed, in order to support them and ensure ongoing access for patients.
- The dehumanizing effect of overloaded services must also be acknowledged and addressed.

- Services should establish a clear policy on conscientious objection in which any provider who is unwilling to provide second trimester abortion is required to refer the woman to someone else who will. In cases where conscientious objection is invoked in order to nudge women towards commercial services, this practice should be exposed and stopped.
- Policy and service guidelines must emphasize a non-judgmental approach to women seeking second trimester abortions and avoid stigmatization or punitive treatment such as denial of pain control.
- Providers working in busy services should strive to see women seeking abortion in a timely manner to prevent service-related delays and respect their reasons for seeking late abortion.
- The direct (trainer and staff time) and indirect costs (facility costs, longer procedure time for patients) of training of abortion providers should be studied. Training of abortion providers is always a worthwhile investment.
- Women seeking second trimester abortion should not be informed of the potential for fetal pain or be expected to accept treatment for this, because it is not supported by evidence. The scientific debate on fetal pain must be separated from the political question of women's right to access second trimester abortion.

V. Advocacy Issues

I believe that asking the question "is abortion moral or immoral?" is asking the wrong question. The right question is can women be trusted to make moral judgments on their own or are women morally incompetent to make these decisions and they need men in robes or elderly men to make these decisions for them? (Mahmoud Fathallah)

In those countries where there is majority support for legal abortion, public support diminishes as the gestational age advances. Abortion is often seen as something that women should usually be able to avoid, and when absolutely necessary, an abortion should be obtained early in the pregnancy. There is little understanding of the reasons why women need later abortions, and little empathy for them or the clinicians who provide later abortions. Contributing to public discomfort with second trimester abortion has been widespread discussion, promoted by anti-choice organisations using spurious pseudo-scientific information, about whether fetuses feel pain and what constitutes "viability". For some, the moral balancing of women's rights and fetal rights changes as the pregnancy progresses, and the focus shifts away from the right of the woman to control her own body. Many clinicians reflect this public sentiment, and are unwilling to participate in providing later abortion procedures.

Although there are many arguments about when a fetus is viable, the reality is that babies born before 28 weeks gestation have a very poor survival rate and often have multiple and serious developmental problems. Policies that require resuscitation often ignore the needs of the woman and whether or not the pregnancy was wanted.

In some countries where sons are heavily favoured, abortion is used to avoid a girl child being born, more often in families where there are already one or more girls. Cultures that favour boy children and encourage sex selection discriminate against women; however, challenging and reducing sex discrimination rather than regulating abortion services is the only solution.

Conference Recommendations on Advocacy

- Values clarification exercises, when related to the local cultural context and using interactive techniques, are an effective way to help all the members of an abortion service team to understand and support women seeking abortions.

- In countries where sex selection is being practised, advocates should recognize it as a form of discrimination against women and shift the focus away from abortion and onto the discrimination. To ensure access, it is important to publicize and support the legal indications for abortion while discouraging sex selection.

- Advocates must work to build support for safe, legal abortion internationally, as early as possible, but also in the second trimester of pregnancy at the request of the woman concerned.

Summary Conference Recommendation

While it is important to support improved access to sex education, contraception and first trimester abortion, access to good quality second trimester services is an essential part of comprehensive safe abortion services. Advocates must work to build support for safe, legal abortion in the second trimester of pregnancy. This work should include developing better data on the occurrence and need for second trimester abortion, the elimination of legal, regulatory and social barriers to second trimester abortion, a commitment of resources to training clinicians to provide later abortions, and research on the best medical methods in different settings.

Conference Agenda with list of Speakers can be accessed at
http://www.medicalabortionconsortium.org/activities/international-conference-on-second-trimester-abortion-1.html