tion were less likely than those having surgical procedures to be married (73% vs. 84%) and to have been using a contraceptive (38% vs. 59%). The differences in age and length of gestation, however, were no longer statistically significant once we controlled for study site (not shown).

**Method Choice and Adherence to Protocol**

Upon enrollment in the study, women were asked to name up to three reasons for their method selection. Among women who selected the medical method, 59% did so to avoid surgery or anesthesia (43%), or because they believed that it was the safer option (40%) or that it would be less traumatic (30%).

As with the medical patients, safety concerns loomed large in the minds of surgical patients (47%). Large proportions of women also decided to undergo surgery because it entailed fewer visits (28%) or was convenient (26%). Fear of side effects was not a major concern to women in either group when they selected their method.

Only three medical abortion patients did not complete the protocol. One woman, feeling worried and fatigued, went to another clinic before taking misoprostol and obtained a surgical abortion. Another woman did not return to the clinic in time to receive misoprostol and had a surgical intervention. The third woman requested a surgical abortion at another clinic after taking misoprostol because she had experienced only spotting and not heavy bleeding. All three are included in the analysis.

**Efficacy and Safety**

Since medical abortion clients selected their method to avoid surgery, we considered any of these women who underwent a surgical procedure for any reason to represent a treatment failure. All surgical abortion patients who had more than one surgical procedure were also deemed to represent treatment failures.

Three types of failures can occur among medical patients: user choice, provider choice (or error) and true drug failures. User choice failure occurs when a woman asks for surgical intervention prior to the end of the study or is unable or chooses not to take the complete medical treatment. Provider choice failure occurs when a provider performs or recommends medically unwarranted surgical interventions (either out of impatience or in reaction to a concern with no clear medical basis). True drug failure occurs when an adverse event requires surgical intervention during the study period or when an abortion is not complete by the end of the study.

Failure rates for both abortion methods were extremely low (Table 3). Only one surgical patient (1%) required a backup intervention. Among medical patients, there were 10 failures (for a rate of 4%): six user choice, one provider choice and three true drug failures.*

Diligent efforts were made to minimize loss to follow-up. All women who did not report for a scheduled appointment were sent up to three reminder letters. Only after providers made home visits in an effort to trace these patients were the women designated as lost to follow-up. In total, nine surgical patients (7%) and three medical abortion patients (1%) were lost to follow-up. All available data from these 12 women are included in our analysis.

Side effects—nausea, vomiting, cramping, pain, diarrhea and bleeding—were far more common among the medical abortion clients than among the women who chose surgery (Table 3). However, although we have included cramping and bleeding as side effects, they may be symptoms of a medical abortion; indeed, if they do not occur, the woman is unlikely to have a successful medical abortion.

Furthermore, medical abortion patients were observed on more occasions (at least three visits vs. at least two) and for a longer period of time (17 vs. 15 days) than were surgical abortion patients. More important, even for medical clients, none of the observed side effects represented a serious medical risk.

Side effects of medical abortion varied at different stages of the procedure (Table 4). Women were more likely to report nausea and vomiting after taking mifepristone than later in the abortion process, but this may reflect symptoms of pregnancy. (Indeed, upon enrollment in the study, 43% of all women reported nausea—42% who chose medical abortion and 46% who opted for surgical—and 6% reported vomiting.) Cramping and abdominal pain increased sharply during the four-hour observation period immediately after administration of misoprostol, but subsided later. Profuse bleeding, although never experienced by more than 5% of the medical abortion clients, was also most likely during these four hours.

*At the follow-up visit, three medical abortion patients had had incomplete abortions and were permitted to keep waiting for their abortions to become complete. Two of these women had complete abortions confirmed when they returned for an additional follow-up visit, a few days to one month after the first; the third woman received a surgical intervention, because her abortion still was not complete three days after her initial follow-up visit.