World Health Organization

human reproduction programme hrp research for impact
UNDP·UNFPA·UNICEF·WHO·WORLD BANK

WHO recommendations on self-care interventions

Self-management of medical abortion

What is self care?

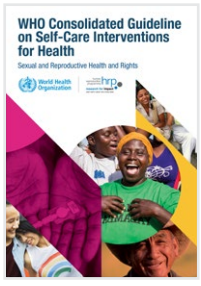
WHO's definition of self care is the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a health-care provider.

What are self-care interventions?

Self-care interventions are evidence-based, quality drugs, devices, diagnostics and/or digital products which can be provided fully or partially outside of formal health services and can be used with or without the direct supervision of health care personnel.

WHO consolidated guidelines on self-care interventions

- Worldwide, an estimated shortage of 18 million health workers is anticipated by 2030.
- At least 400 million people worldwide lack access to the most essential health services.
- During humanitarian emergencies, including pandemics, routine health services are disrupted and existing health systems can be over-stretched.



For select health services, incorporating self care can be an innovative strategy to strengthen primary health care, increase universal health coverage (UHC) and help ensure continuity of health services which may otherwise be disrupted due to health emergencies. WHO published global normative guidance on self-care interventions, with the first volume focusing on sexual and reproductive health and rights (SRHR). Each recommendation is based on extensive consultations and a review of existing evidence.

What is safe abortion care?

Access to safe and legal abortion is an essential part of sexual and reproductive health services.

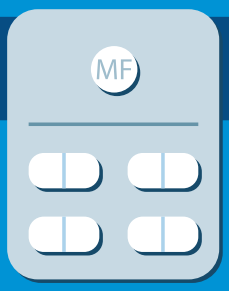
- Medical abortion can be provided using tablets of mifepristone and misoprostol in combination or misoprostol alone. This is a non-invasive and highly acceptable option to pregnant persons.
- Surgical abortion is a procedure that can be provided at the primary care level.
- These recommended abortion methods for the 1st trimester allow for provision of abortion services at the primary care level.
- Globally, between 2010-2014, an estimated 25% of all pregnancies ended in abortion.
- When conducted or supported by an appropriately-trained provider, using an appropriate WHO-recommended method, abortions are very safe procedures.

Current challenges to health systems to provide medical abortion services

- When individuals do not have access to safe abortion care, they may resort to unsafe abortions. Based on data from 2010–2014 there are approximately 25 million unsafe abortions annually.
- Unsafe abortion can result in a range of outcomes that negatively affect quality of life and well-being, with some individuals experiencing life-threatening complications.
- Individuals around the world often cannot access safe abortion care due to: restrictive laws and other regulatory barriers, poor availability of services, high cost, stigma, conscientious objection of health-care providers, and unnecessary requirements designed to delay and restrict access (for example, mandatory waiting periods, counselling, medically-unnecessary tests, third-party authorization).
- Among the many barriers that limit access to safe abortion care, the lack of trained providers is one of the most critical: in many countries, rural areas and the public sector are especially affected by this.

Self-management of medical abortion in the 1st trimester infographic https://www.who.int/reproductivehealth/publications/self-care-infographics/en/

- Even where services are available, stigma towards accessing services may leave some individuals, particularly those who are already marginalized, including less-educated, poor, adolescent, or unmarried, at risk of unsafe abortion.



WHO recommends that individuals in the first trimester (up to 12 weeks pregnant) can self-administer mifepristone and misoprostol medication without direct supervision of a health-care provider.

How does self-management of medical abortion work?

Individuals clinically eligible[1] for medical abortion may be offered the choice to self-adminster can self-administer a combination of mifepristone and misoprostol.

The appropriate combination regimen consists of 200mg mifepristone, administered orally. This is followed 1–2 days later by 800µg misoprostol, administered vaginally, sublingually (under the tongue) or buccally (in the cheek). The minimum recommended interval between use of mifepristone and misoprostol is 24 hours.

Mifepristone and misoprostol are available separately, or packaged together in the appropriate dosage. It can be taken anywhere, including at home. Direct supervision of a health-care provider is not required.

Later, individuals can self-assess the completeness of the abortion process using pregnancy tests and checklists. Individuals should also have the option to immediately initiate contraception, should they desire it.[2]

Individuals should have a source of accurate information and access to a health-care provider should they need or want it at any stage of the process.

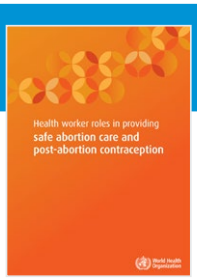
1. 200mg mifepristone, orally

2. Wait 1-2 days

3. 800µg misoprostol, administered vaginally, sublingually or buccally

Learn more:

Health worker roles in providing safe abortion care and post-abortion contraception https://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion-task-shifting/en/



Safe, feasible, acceptable - what the evidence tells us

Evidence has demonstrated that in the first trimester, individuals can safely and effectively manage their own medical abortions using mifepristone and misoprostol in combination. This strategy can offer crucial support in providing access to safe abortion care.

- Health-care providers and potential users generally approve of the concept of self-management and believed that it could be done feasibly, effectively and safely.
- Self-management can be appealing for several practical reasons including lower costs, ease of scheduling, reduced transport needs, ability to manage stigma, and quicker termination of pregnancy.
- Individuals also value the sense of control over the abortion process and the ability to maximize comfort and support.

[1] Eligibility: includes diagnosing and dating the pregnancy to be no more than 12 weeks gestational age, ruling out medical contraindications, screening for possible ectopic pregnancy. Full eligibility criteria can be found in WHO's *Clinical practice handbook for safe abortion*

[2] Generally, almost all methods of contraception can be initiated immediately following a medical abortion. 'Immediately' refers to the day the first pill of a medical abortion regimen is taken. Some methods, including DMPA, can be self-administered.

Considerations for success for self-management of medical abortion in the first trimester

- **Information and support** - Individuals must be provided with clear information related to self-management. Counselling should be available when desired.
- **Supportive health system** - Self-management approaches require ready access to information or support by a trained provider/facility, where desired or needed.
- **Quality products** – Relevant regulatory agencies should ensure that quality products are available in adequate quantities and appropriate dosages.
- **Policy and regulatory frameworks** – Existing national sexual and reproductive health policies should be adapted, developed, and/or harmonized to include abortion-related self-care interventions.

Enabling access to self-management of medical abortion in the first trimester

There are many possible public and private sector approaches to making medical abortion available. Mifepristone, misoprostol, and the combination packaging of the two are included in WHO's Essential Medicines List. Further development of combination packaging of mifepristone-misoprostol could facilitate ease of use.

Countries can enable greater access if they register and include mifepristone and misoprostol on their national Essential Medicines Lists and work towards procurement of the medication.

Learn more:

Self-care interventions communications toolkit https://www.who.int/reproductivehealth/self-care-interventions/WHO-Self-Care-SRHR-Comms_Kit.pdf

References:

WHO Consolidated Guideline on Self-Care Interventions for Health Sexual and Reproductive Health and Rights
https://apps.who.int/iris/bitstream/handle/10665/325480/9789241550550-eng.pdf?ua=1

Fact sheet: Self-care health interventions
https://www.who.int/news-room/fact-sheets/detail/self-care-health-interventions

Global abortion policies database
https://abortion-policies.srhr.org/

Preventing unsafe abortion Key Facts – WHO website
https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion

Abortion overview – WHO website
https://www.who.int/health-topics/abortion

Safe abortion: technical and policy guidance for health systems
https://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf?sequence=1

Clinical practice handbook for safe abortion
https://apps.who.int/iris/bitstream/handle/10665/97415/9789241548717_eng.pdf?sequence=1

Medical management of abortion
https://apps.who.int/iris/bitstream/handle/10665/278968/9789241550406-eng.pdf?ua=1

Health worker roles in providing safe abortion care and post-abortion contraception
https://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf?sequence=1

WHO/SRH/20.11