World Health Organization

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WHO recommendations on self-care interventions

Self-management of medical abortion, 2022 update

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 worker.

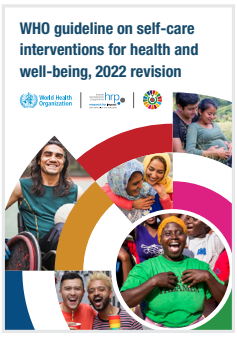
What are self-care interventions?

Self-care interventions are evidence-based, quality medicines, 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 guideline on self-care interventions for health and well-being

- There is an estimated shortage of 18 million health workers by 2030, mainly in low-middle income countries.
- 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 certain health services, incorporating self-care interventions can be an innovative strategy to strengthen primary health care, improve universal health coverage (UHC) and help ensure continuity of health services which may otherwise be disrupted due to health emergencies. In 2022, WHO revised the global normative guidance on self-care interventions for health and well-being, with each recommendation based on extensive consultations and a review of existing evidence.



WHO guideline on self-care interventions for health and well-being, 2022 revision
https://www.who.int/publications/i/item/9789240052192

What is safe abortion care?

Abortion is a common health intervention. Six out of 10 (61%) of all unintended pregnancies, and 3 out of 10 (29%) of all pregnancies, end in induced abortion.[1]

Globally, around 73 million induced abortions take place each year. However, nearly 1 out of 2 (45%) abortions are unsafe.[2]

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

When carried out using a method recommended by WHO appropriate to the pregnancy duration, and by someone with the necessary skills, abortion is a safe health care intervention.

Abortion can be effectively managed by a wide range of health workers using medication or a surgical procedure, all of which can be provided at the primary care level. In early pregnancy, medical abortion can also be self-managed. The choice of health worker or management by the woman, girl or other pregnant person, and the location of service provision depends on the values and preferences of the pregnant person, available resources and the national and local context. A plurality of service delivery approaches can co-exist within any given context.

Self-management of medical abortion

- In the first 12 weeks of pregnancy, a medical abortion can also be safely self-managed by the pregnant person outside of a health care facility (e.g., at home), in whole or in part. This requires that the woman, girl or other pregnant person has access to accurate information, quality medicines and support from a trained health worker (if they need or want it during the process).

- Medical abortion can be self-managed using tablets of mifepristone and misoprostol in combination or misoprostol alone. This is a highly acceptable option to pregnant persons.

Three main components of self-management of medical abortion care:

1. Self-assessment of eligibility (determining pregnancy duration; ruling out contraindications).

2. Self-administration of abortion medicines and management of the abortion process outside of a health-care facility without the direct supervision of a trained health worker.

3. Self-assessment of the success of the abortion.

1. Bearak J, Popinchalk A, Ganatra B, Moller A-B, Tunçalp Ö, Beavin C et al. Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019. Lancet Glob Health. 2020 Sep; 8(9):e1152-e1161. doi: 10.1016/S2214-109X(20)30315-6.
2. Source: Abortion: Key Facts - https://www.who.int/news-room/fact-sheets/detail/abortion

Health systems barriers to accessing medical abortion services

- When women, girls or other pregnant persons face barriers to attaining safe, timely, affordable, geographically reachable, respectful and non-discriminatory abortion, they often resort to unsafe abortion.

- Unsafe abortion can result in a range of outcomes that negatively affect the pregnant person's quality of life and well-being, with some women, girls or other pregnant persons experiencing life-threatening complications.

- Barriers to accessing safe and respectful abortion include high costs, stigma for those seeking abortions and health care workers, and the refusal of health workers to provide an abortion based on personal conscience or religious belief. Access is further impeded by restrictive laws and requirements that are not medically justified, including criminalization of abortion, mandatory waiting periods, provision of biased information or counselling, third-party authorization and restrictions regarding the type of health workers or facilities that can provide abortion services.

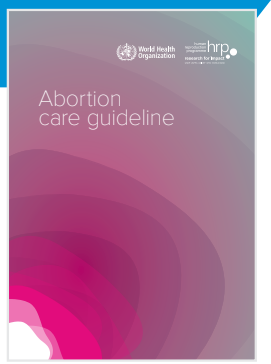
- Among the many barriers that limit access to safe abortion care, the lack of trained health workers is one of the most critical: in many countries, rural areas and the public sector are especially affected by this.

- Even where services are available, health workers refusal to offer information or support, and abortion stigma may leave women, girls and other pregnant persons at risk of an unsafe abortion, particularly those who are already marginalized, including less-educated, poor, adolescent, or unmarried people.

Learn more:

Abortion care guideline
https://www.who.int/publications/i/item/9789240039483

This guideline presents the complete set of all WHO recommendations and best practice statements relating to abortion.



Self-management of medical abortion is one of the safe and effective options of abortion care https://www.who.int/multi-media/details/individuals-can-self-manage-medical-abortion-in-the-first-trimester

Safe, feasible, acceptable - what the evidence tells us

Evidence has demonstrated that in gestational ages less than 12 weeks, pregnant persons can safely and effectively manage their own medical abortions using mifepristone and misoprostol in combination or misoprostol alone. Enabling this option can significantly improve access to safe, timely, affordable and person-centred abortion care.

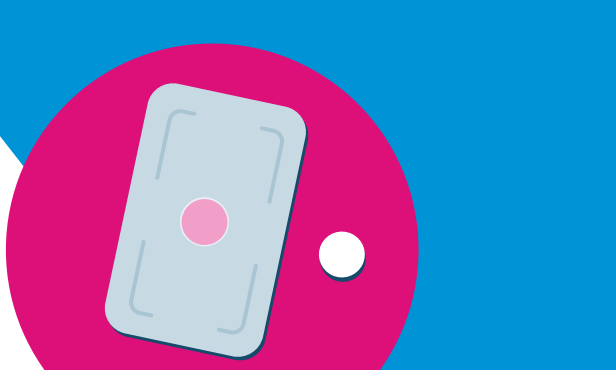
- Research shows that health workers and potential users generally approve of the concept of self-management and believe that it could be a feasible, safe and effective option.

- Self-management approaches can be empowering for women, girls and other pregnant persons and help to triage care, leading to a more person-centred and more optimal use of health resources.

- Self-management can be appealing for several practical reasons including lower costs, ease of scheduling, reduced transport needs, ability to manage stigma, and ability to avoid delays in receiving care.

How does self-management of medical abortion work?

Women, girls and other pregnant persons eligible for medical abortion can manage their abortion process using a combination of mifepristone and misoprostol, or misoprostol alone.



Combination of mifepristone and misoprostol

The 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). Repeat doses of misoprostol can be considered to achieve success of the abortion process. The minimum recommended interval between use of mifepristone and misoprostol is 24 hours.

1. 200mg mifepristone, orally
2. Wait 1-2 days
3. 800µg misoprostol, administered buccally, sublingually or vaginally

Mifepristone and misoprostol are available separately, or packaged together in the appropriate dosage. They can be taken outside of a health facility and direct supervision of a health worker is not required.

Misoprostol only

The misoprostol alone regimen involves taking 800µg buccally, sublingually or vaginally. Repeat doses of misoprostol can be considered to achieve success of the abortion process.

1. 800µg misoprostol, administered buccally, sublingually or vaginally

WHO recommends that pregnant persons in the gestational age < 12 weeks can opt to self-administer mifepristone and/or misoprostol medication without the direct supervision of a health worker.

Women, girls and other pregnant persons should have a source of accurate information and access to a health worker should they need or want it at any stage of the process.

After taking the medication

Pregnant persons can self-assess the completeness of the abortion process using pregnancy tests and checklists. Women, girls and other pregnant persons should also have the option to immediately initiate contraception, should they desire it.[3]

[3] 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 of self-management of medical abortion for gestational age < 12 weeks

- **Information and support** - Women, girls and other pregnant persons must be provided with accurate, non-biased and evidence-based information related to self-management of abortion. Counselling should be available when desired.
- **Supportive health system** - Self-management approaches require ready access to information or support by a trained health worker/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 reviewed, adapted, developed and/or harmonized towards achieving an enabling policy environment.

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 this 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 these medications.

Learn more:

Self-care interventions communications toolkit https://cdn.who.int/media/docs/default-source/reproductive-health/who-selfcare-comms-kit.pdf?sfvrsn=45461bca_3

References:

WHO guideline on self-care interventions for health and well-being, 2022 revision
https://www.who.int/publications/i/item/9789240052192

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/

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

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

Abortion care guideline
https://apps.who.int/iris/handle/10665/349316

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