World Health Organization

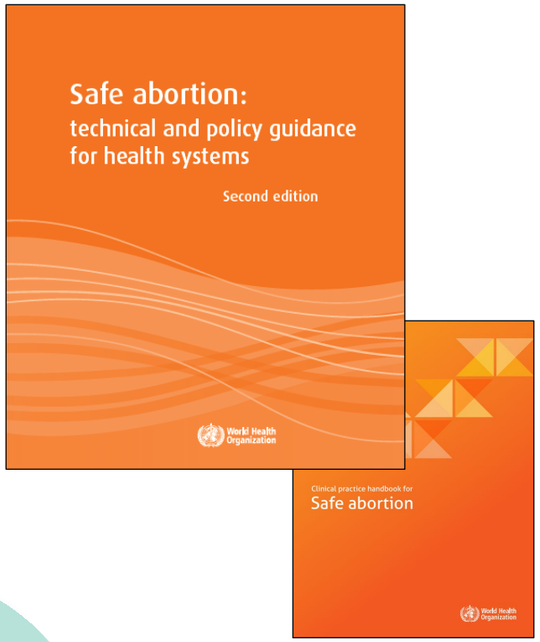
human reproduction programme hrp
research for impact
UNDP·UNFPA·UNICEF·WHO·WORLD BANK

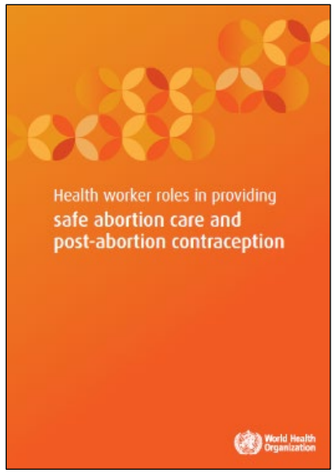
Abortion care guideline: Self management approaches

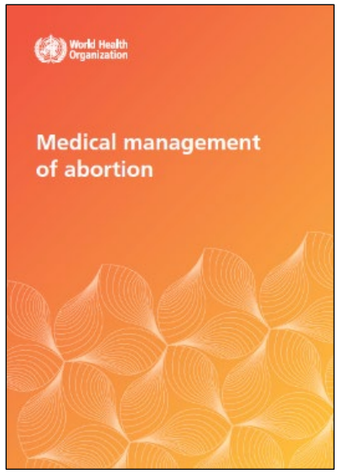
Caron R. Kim, MD, MSc
2 June 2022

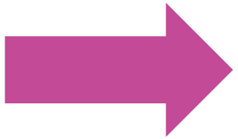
What is this guideline?

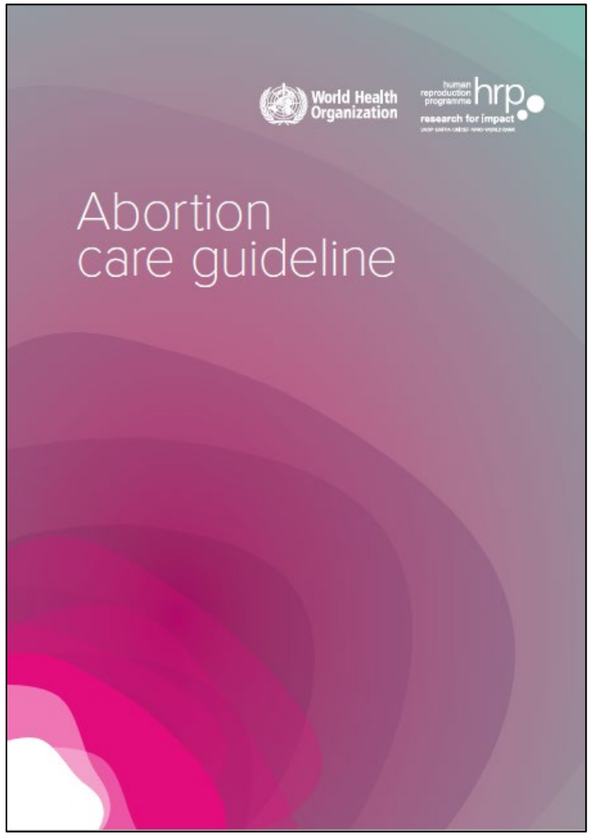
This guideline updates and replaces the recommendations in three previous WHO guidelines



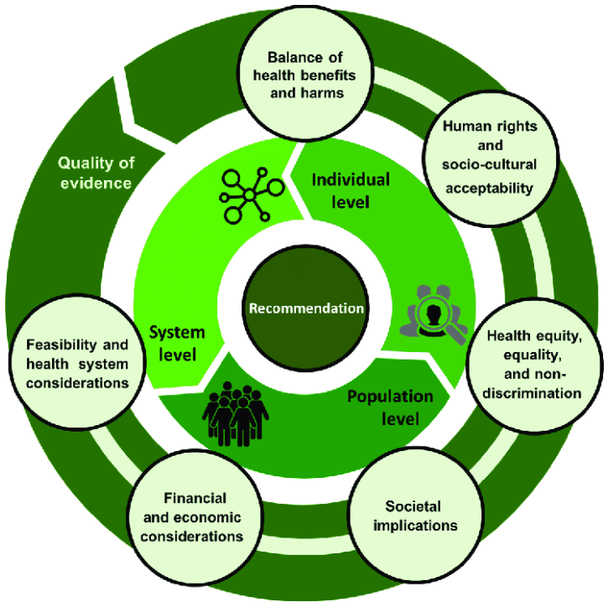


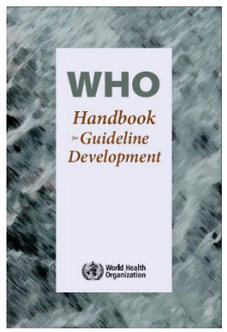






Recommendations based on evidence reviews and expert input





2018

Pre-scoping survey

Clinical scoping

Law & Policy scoping

2019

Clinical and Law & Policy evidence synthesis

Health system scoping

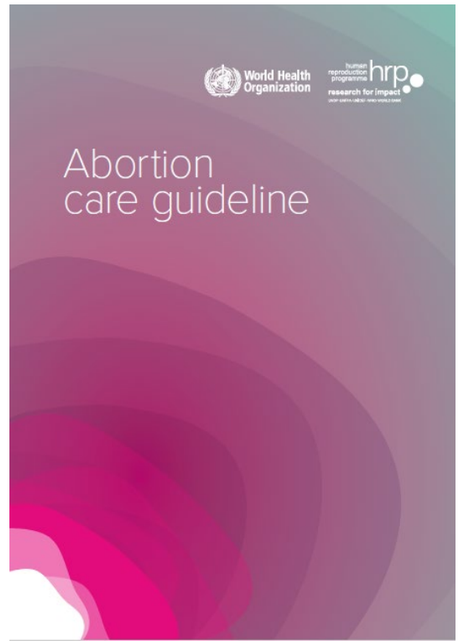
GRC* planning proposal

2020-2021

Health system evidence synthesis

ERRG** meetings

GDG** meeting

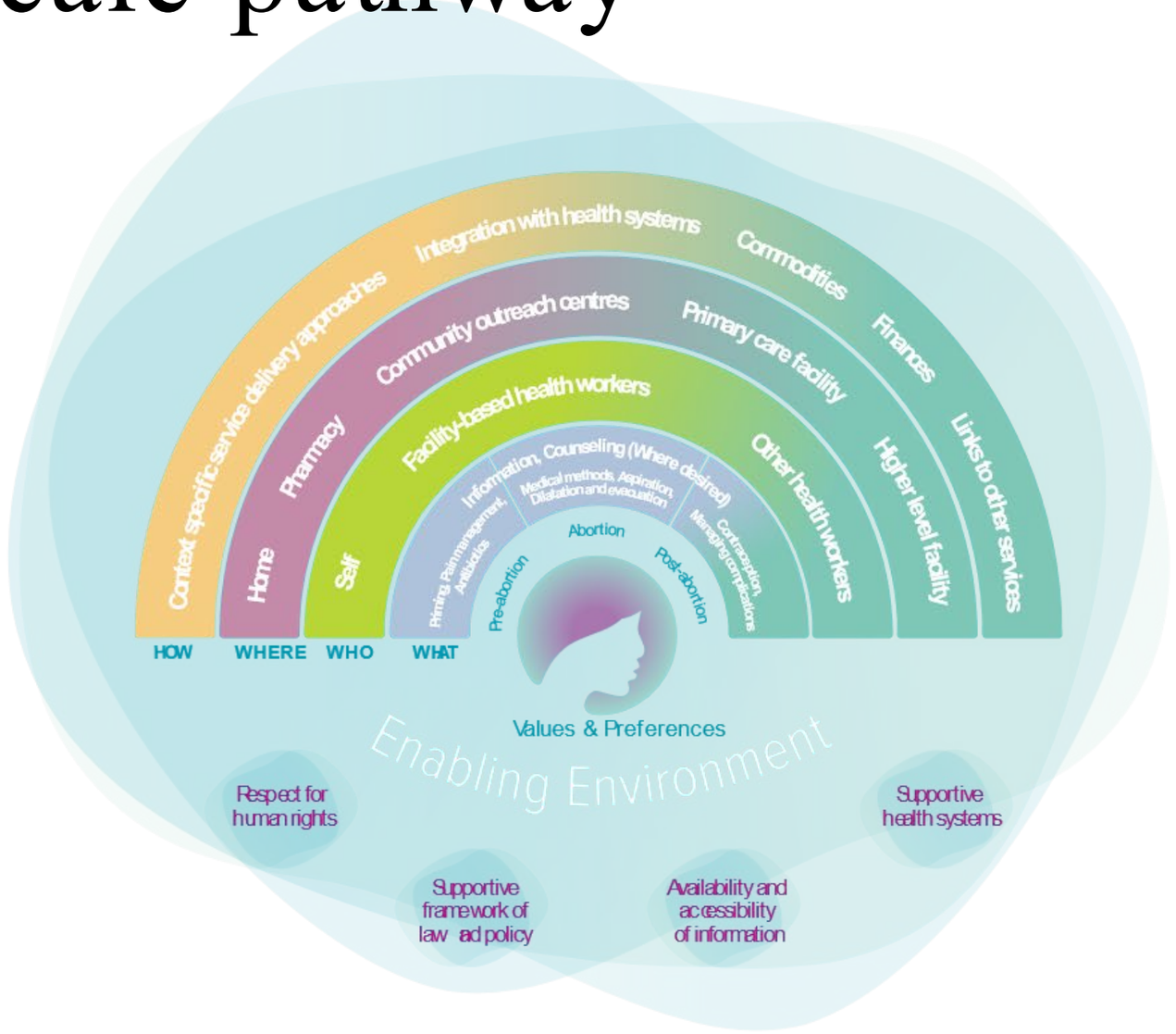


* GRC Guideline Review Committee

** ERRG: Evidence and Recommendation Review Group; GDG=Guideline Development Group

STRUCTURE AND KEY CONCEPTS OF THIS GUIDELINE

Providing recommendations across the abortion care pathway



Recommendation categories

- Recommend
- Suggest
- Recommend against

Key concepts

SELF-MANAGEMENT APPROACHES

Self-management approaches

SELF-MANAGEMENT OF MEDICAL ABORTION

FOR MEDICAL ABORTION UP TO 12 WEEKS (USING THE COMBINATION OF MIFEPRISTONE PLUS MISOPROSTOL OR USING MISOPROSTOL ALONE):

UPDATE!

Recommend the option of self-management of the medical abortion process in whole or any of the three component parts of the process:

- **self-assessment of eligibility** (determining pregnancy duration; ruling out contraindications)
- **self-administration of abortion medicines** outside of a health-care facility and without the direct supervision of a trained health worker, and management of the abortion process
- **self-assessment of the success** of the abortion

Remarks:

- Requires access to accurate information, quality-assured medicines including for pain, support of trained health workers, and access to a health care facility and referral services.
- Restrictions on prescribing and dispensing authority for abortion medicines may need modification.
- Where? No requirement for location.

METHODOLOGY

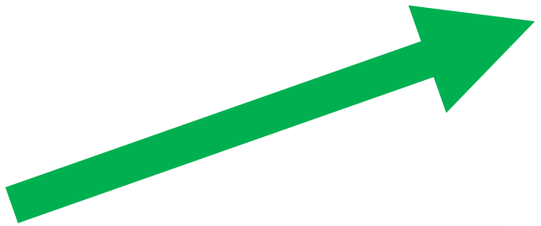
WHO Guideline Development Process

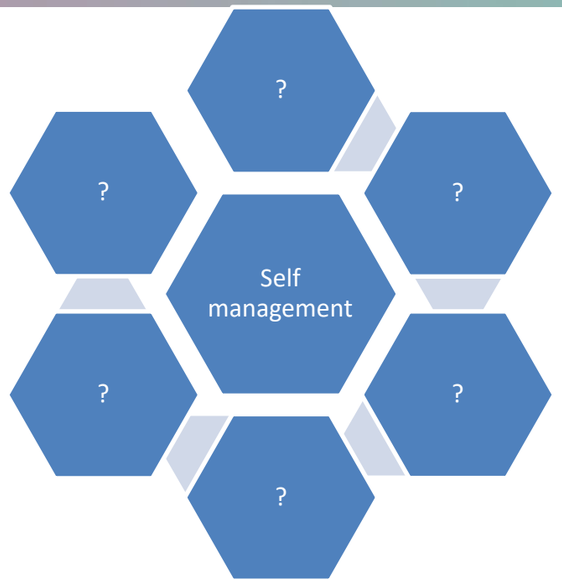
In summary, the process includes:

- identification of priority questions and critical outcomes;
- retrieval of the evidence;
- Assessment* and synthesis of the evidence;
- formulation of recommendations by the Evidence and Recommendation Review Group
- Finalization of recommendations by the Guideline Development Group; and
- planning for dissemination, implementation, impact evaluation and updating.

*WHO uses GRADE (Grading of Recommendations Assessment, Development and Evaluation)

Recommendation from the 2015 Health worker guide line

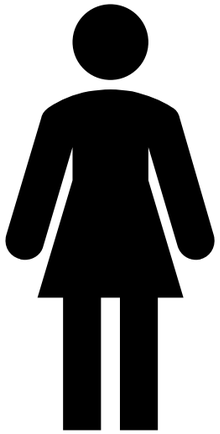




Role of self-management approaches

	Self
Medical abortion in the first trimester	No recommendation for overall task – recommendations for specific components as below
Self-assessing eligibility	R
Managing the mifepristone and misoprostol medication without direct supervision of a health-care provider	✓
Self-assessing completeness of the abortion process	✓

PICO Questions: Self management of medical abortion



1.1 eligibility

- *Can pregnant persons themselves self-assess eligibility* for medical abortion? (5 studies)*

1.2 administration

- *Can pregnant persons themselves correctly* administer medications for medical abortion? (*18 studies*)

1.3 outcome assessment

- *Can individuals who underwent medical abortion themselves self-assess success of their abortion? (10 studies)*

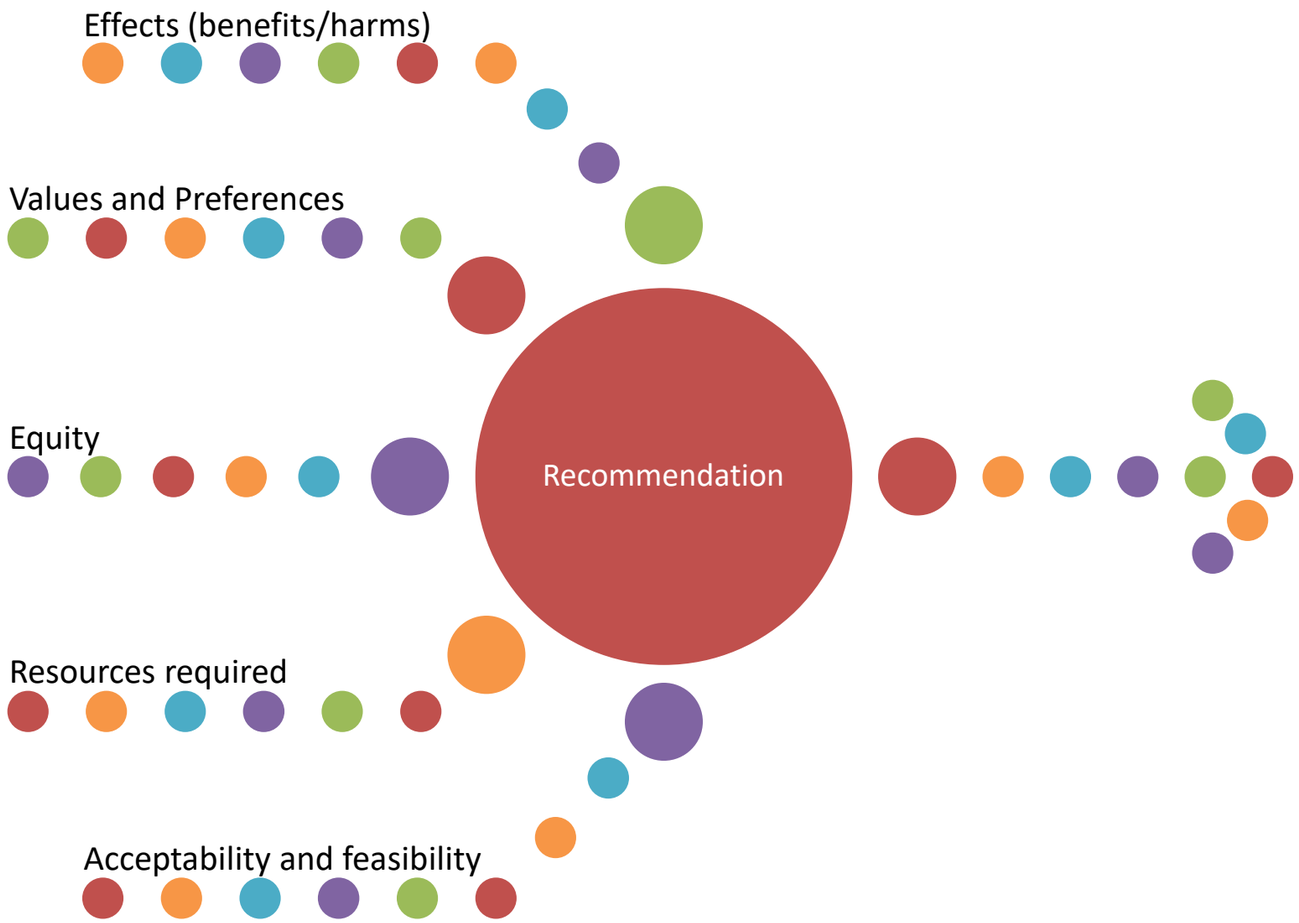
*Can pregnant persons themselves manage the process of medical **abortion in whole** or in part (assessing eligibility, administration of mifepristone and or misoprostol, self-assessing success) without direct provider supervision?*

Overview: 1.2 Self administration

Self-administered compared to provider-administered for health problem or population

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)
	Risk with provider-administered	Risk with Self-administered			
Success of medical abortion - RCTs	963 per 1.000	954 per 1.000 (934 to 973)	RR 0.99 (0.97 to 1.01)	919 (2 RCTs)	⊕⊕⊕◯ MODERATE [a]
Success of medical abortion - NRS	940 per 1.000	931 per 1.000 (912 to 950)	RR 0.99 (0.97 to 1.01)	10124 (16 observational studies)	⊕⊕◯◯ LOW
Ongoing pregnancy	8 per 1.000	10 per 1.000 (5 to 20)	RR 1.28 (0.65 to 2.49)	6691 (11 observational studies)	⊕◯◯◯ VERY LOW [b]
Any complication requiring surgical intervention	26 per 1.000	56 per 1.000 (21 to 150)	RR 2.14 (0.80 to 5.71)	2452 (3 observational studies)	⊕◯◯◯ VERY LOW [b]
Hemorrhage	4 per 1.000	4 per 1.000 (1 to 30)	RR 1.14 (0.16 to 8.03)	1005 (2 observational studies)	⊕◯◯◯ VERY LOW [b]
Infection	12 per 1.000	3 per 1.000 (0 to 58)	RR 0.23 (0.01 to 4.68)	305 (1 observational study)	⊕◯◯◯ VERY LOW [b]
Requiring hospitalization	0 per 1.000	0 per 1.000 (0 to 0)	RR 1.58 (0.08 to 29.81)	2147 (2 observational studies)	⊕◯◯◯ VERY LOW [b]
Incomplete	33 per 1.000	37 per 1.000 (27 to 51)	RR 1.12 (0.81 to 1.55)	7645 (12 observational studies)	⊕⊕◯◯ LOW
Nausea	335 per 1.000	285 per 1.000 (238 to 342)	RR 0.85 (0.71 to 1.02)	3874 (7 observational studies)	⊕◯◯◯ VERY LOW [c]
Heavy bleeding	209 per 1.000	218 per 1.000 (191 to 251)	RR 1.04 (0.91 to 1.20)	3272 (5 observational studies)	⊕⊕◯◯ LOW
Vomiting	123 per 1.000	135 per 1.000 (110 to 165)	RR 1.09 (0.89 to 1.34)	3568 (6 observational studies)	⊕⊕◯◯ LOW
Pain/cramps	315 per 1.000	302 per 1.000 (271 to 340)	RR 0.96 (0.86 to 1.08)	1640 (4 observational studies)	⊕⊕◯◯ LOW
Fever/chills	160 per 1.000	173 per 1.000 (142 to 209)	RR 1.08 (0.89 to 1.31)	2643 (4 observational studies)	⊕⊕◯◯ LOW
Diarrhea	90 per 1.000	86 per 1.000 (65 to 116)	RR 0.96 (0.72 to 1.29)	3286 (4 observational studies)	⊕⊕◯◯ LOW
Satisfied or highly satisfied	909 per 1.000	919 per 1.000 (882 to 955)	RR 1.01 (0.97 to 1.05)	7582 (13 observational studies)	⊕◯◯◯ VERY LOW [b]
Would choose MA again	536 per 1.000	558 per 1.000 (515 to 611)	RR 1.04 (0.96 to 1.14)	3515 (6 observational studies)	⊕◯◯◯ VERY LOW [b]
Would recommend to a friend	527 per 1.000	595 per 1.000 (511 to 690)	RR 1.13 (0.97 to 1.31)	3513 (6 observational studies)	⊕◯◯◯ VERY LOW [c]
Perfect use	980 per 1.000	980 per 1.000 (960 to 1.000)	RR 1.00 (0.98 to 1.02)	2988 (3 observational studies)	⊕⊕◯◯ LOW
Did not complete protocol	20 per 1.000	12 per 1.000 (2 to 65)	RR 0.61 (0.11 to 3.28)	2164 (4 observational studies)	⊕◯◯◯ VERY LOW [b]
Misoprostol not taken on time	19 per 1.000	8 per 1.000 (3 to 20)	RR 0.43 (0.18 to 1.05)	2608 (4 observational studies)	⊕⊕◯◯ LOW
Did not return to confirm abortion status	30 per 1.000	13 per 1.000 (1 to 110)	RR 0.42 (0.05 to 3.69)	2988 (3 observational studies)	⊕◯◯◯ VERY LOW [b]
Called clinic/hotline	117 per 1.000	158 per 1.000 (76 to 329)	RR 1.35 (0.65 to 2.81)	5277 (6 observational studies)	⊕◯◯◯ VERY LOW [c]
Unscheduled clinic visits	83 per 1.000	81 per 1.000 (55 to 118)	RR 0.98 (0.67 to 1.43)	5774 (6 observational studies)	⊕⊕◯◯ LOW

Evidence to Decision (ETD) Framework



Multiple steps before recommendation formulation

SELF-MANAGEMENT APPROACHES

Share or print

CONTENTS

3.6.3 Self-management approaches for post-abortion contraception

All contraceptive options may be considered after an abortion. For further information, refer to section 3.5.4: Post-abortion contraception. Many family planning methods are entirely self-managed (i.e. self-procured over the counter or online and self-administered) and generally available without a prescription, including barrier methods and some hormonal contraceptives, including some oral contraceptive pills (OCPs), and also emergency contraceptive pills. For methods that have traditionally required a prescription from a doctor and/or administration by a health-care provider, shifting to include the option of using self-management approaches, such as over-the counter OCPs and self-injection of hormonal contraceptives, may improve continuation of contraceptive use by removing barriers, such as the need to return to a health-care facility every three months for a repeat injection. These approaches could expand access to contraception for those facing challenges in accessing health-care settings regularly, and in places where there are shortages of health-care providers, thus potentially greatly reducing the incidence of unintended pregnancy.

What & Who | Where | How

SELF-MANAGEMENT Recommendation 51: Self-administration of injectable contraception (initiation and continuation)[1]

Recommend the option of self-administration of injectable contraception in the post-abortion period.

- States must take steps to reduce maternal mortality and morbidity.
- In line with human rights requirements, self-management of abortion should not be criminalized. Criminalization of self-management of abortion may result in delays in or barriers to seeking assistance or post-abortion care where needed. Self-management of medical abortion should be available as an option on the basis of clinical appropriateness. It should not be restricted for non-clinical reasons such as age.

For further information and sources, please refer to **Box 1.2** and **Web annex A**: Key international human rights standards on abortion.

Related topics & recommendations

- All recommendations related to law and policy (Recommendations **1**, **2**, **3**, **6**, **7**, **21**, **22**)
- **Provision of information on quality abortion care (section 3.2.1)**
- **Provision of counselling (section 3.2.2)**
- **Informed consent (in section 1.3.1: Human rights)**
- **Pain management for abortion (section 3.3.6)**

Self-management approaches

SELF-MANAGEMENT OF MEDICAL ABORTION:

FOR MEDICAL ABORTION AT < 12 WEEKS (USING THE COMBINATION OF MIFEPRISTONE PLUS MISOPROSTOL OR USING MISOPROSTOL ALONE)

Implementation considerations:

- Access to accurate information about the process and other options available, to enable informed decision making
- Access to quality-assured medicines (for abortion and for pain management)
- Referrals to (or provision of) post-abortion contraception, if wanted
- Health workers supporting women in their self-management of abortion
- The financial burden should not be transferred to the woman

SERVICE DELIVERY MODELS AND SELF-MANAGEMENT APPROACHES

SERVICE DELIVERY MODELS

Where & How

TELEMEDICINE

Telemedicine:

A mode of health service delivery where providers and clients, or providers and consultants, are separated by distance.

ADDITIONAL

Recommend the option of telemedicine as an alternative to in-person interactions with the health worker to deliver medical abortion care in whole or in part.

Remarks:

- The above recommendation applies to assessment of eligibility for medical abortion, counselling and/or instruction relating to the abortion process, providing instruction for and active facilitation of the administration of medicines, and post-abortion care, all through telemedicine.
- Hotlines, digital apps or one-way modes of communication (e.g. reminder text messages) that simply provide information were not included in the review of evidence for this recommendation.

Where & How

BEST PRACTICE STATEMENTS FOR SERVICE-DELIVERY APPROACHES FOR PROVISION OF INFORMATION, COUNSELLING AND MEDICAL ABORTION

ADDITIONAL

Part 1.

There is no single recommended approach to providing abortion services.

The choice of specific health worker(s) (from among the recommended options) or management by the individual themself, and the location of service provision (from among recommended options) will depend on the values and preferences of the woman, girl or other pregnant person, available resources, and the national and local context.

A plurality of service-delivery approaches can co-exist within any given context.

Where & How

BEST PRACTICE STATEMENTS SERVICE-DELIVERY APPROACHES FOR PROVISION OF INFORMATION, COUNSELLING AND MEDICAL ABORTION

ADDITIONAL

Part 2.

Given that service-delivery approaches can be diverse, it is important to ensure that for the individual seeking care, the range of service-delivery options taken together will provide:

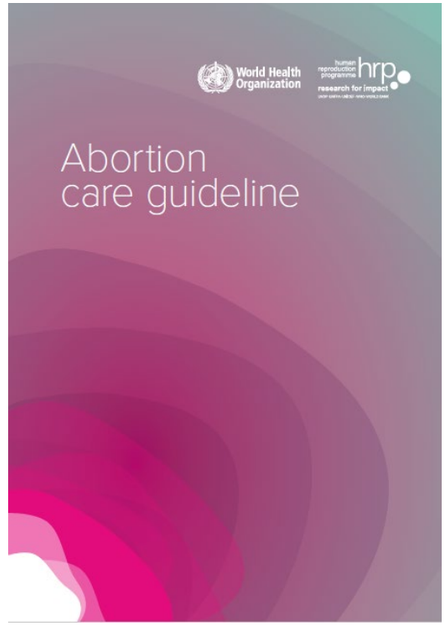
- access to scientifically accurate, understandable information at all stages;
- access to quality-assured medicines (including those for pain management);
- back-up referral support if desired or needed;
- linkages to an appropriate choice of contraceptive services for those who want post-abortion contraception.

USING
THIS GUIDELINE

This guideline is available in various formats

Interactive web-based format:

srhr.org/abortioncare



PDF document available for download:

https://www.who.int/publications/i/item/9789240039483

Thank you for your attention.

MORE INFO:

www.srhr.org/abortioncare

www.who.int/health-topics/abortion

CONTACT THE WHO PREVENTION OF UNSAFE ABORTION UNIT:

srhpua@who.int