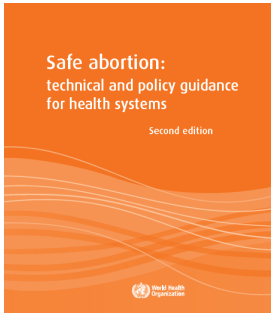
Session 9.3
Sexual and Reproductive Health Guidelines

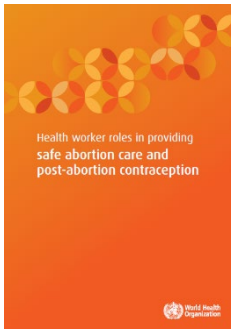
Abortion care guideline
& Medical abortion medicines

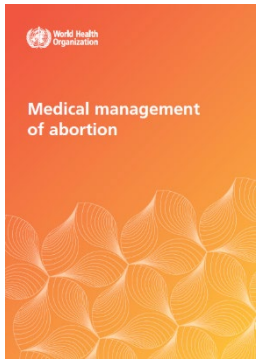
Laurence Läser (laserl@who.int), Prevention of Unsafe Abortion
WHO Department of Sexual and Reproductive Health and Research

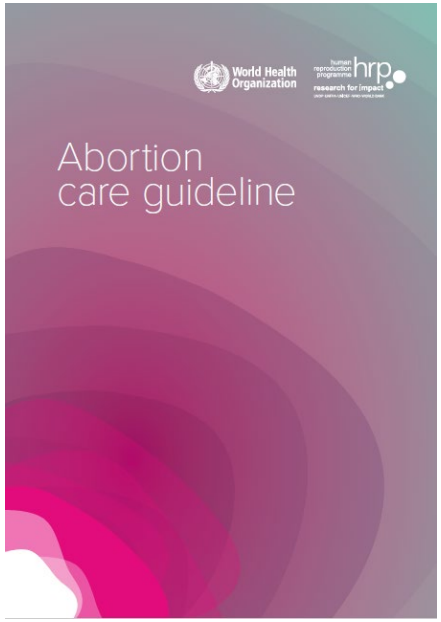
New WHO Abortion care guideline – Launched in March 2022

Abortion Care Guideline (2022) is an updated consolidated guideline, which replaces the previous three separate WHO guidelines.









New WHO Abortion care guideline – Launched in March 2022



Interactive web-based format: srhr.org/abortioncare
PDF document available for download: https://www.who.int/publications/i/item/9789240039483

Recommended management options

- **Surgical abortion** methods, depending on gestational age:
  - manual or electric vacuum aspiration (MVA or EVA) < 14 weeks
  - dilatation and evacuation (D&E) ≥ 14 weeks

- **Medical abortion** regimen include:
  - sequential use of mifepristone followed by misoprostol
  - in settings where mifepristone is not available (or is restricted for certain clinical indications) use of misoprostol alone
  - as a new alternative for induced abortions, use of letrozole in combination with misoprostol

→ Availability of affordable quality-assured surgical abortion equipment and medical abortion medicines is essential

Medical management of abortion & post-abortion care (1)

Different dosages of abortion medicines are used for:

- Cervical priming prior to surgical abortion

Prior to surgical abortion at < 12 weeks:

a. If cervical priming is used: **Suggest** the following medication regimens:

- Mifepristone 200 mg orally 24–48 hours prior to the procedure
- Misoprostol 400 µg sublingually 1–2 hours prior to the procedure
- Misoprostol 400 µg vaginally or buccally 2–3 hours prior to the procedure

- Medical management of induced abortion

For medical abortion at < 12 weeks:

a. Recommend the use of 200 mg mifepristone administered orally, followed 1–2 days later by 800 µg misoprostol administered vaginally, sublingually or buccally. The minimum recommended interval between use of mifepristone and misoprostol is 24 hours.*

b. When using misoprostol alone: **Recommend** the use of 800 µg misoprostol administered vaginally, sublingually or buccally.*

For medical abortion at ≥ 12 weeks:

a. Suggest the use of 200 mg mifepristone administered orally, followed 1–2 days later by repeat doses of 400 µg misoprostol administered vaginally, sublingually or buccally every 3 hours.* The minimum recommended interval between use of mifepristone and misoprostol is 24 hours.

b. When using misoprostol alone: **Suggest** the use of repeat doses of 400 µg misoprostol administered vaginally, sublingually or buccally every 3 hours.*

→ A **NEW** regimen is now also suggested for medical management of induced abortion (<12 weeks)

c. **(NEW) Suggest** the use of a combination regimen of letrozole plus misoprostol (letrozole 10 mg orally each day for 3 days followed by misoprostol 800 µg sublingually on the fourth day) as a safe and effective option.*‡

Medical management of abortion & post-abortion care (2)

Different dosages of abortion medicines are used for:

- Missed abortion

For missed abortion at < 14 weeks, for individuals preferring medical management: **Recommend** the use of combination mifepristone plus misoprostol over misoprostol alone.

- Recommended regimen: 200 mg mifepristone administered orally, followed by 800 µg misoprostol administered by any route (buccal, vaginal or sublingual).*
- Alternative regimen: 800 µg misoprostol administered by any route (buccal, vaginal or sublingual).*

- Intrauterine fetal demise (IUFD)

For medical management of IUFD at ≥ 14 to ≤ 28 weeks: **Suggest** the use of combination mifepristone plus misoprostol over misoprostol alone.

- Suggested regimen: 200 mg mifepristone administered orally, followed 1–2 days later by repeat doses of 400 µg misoprostol administered sublingually or vaginally every 4–6 hours.* The minimum recommended interval between use of mifepristone and misoprostol is 24 hours.
- Alternative regimen: repeat doses of 400 µg misoprostol administered sublingually or vaginally every 4–6 hours.*

- Incomplete abortion

35. For incomplete abortion at < 14 weeks:
Recommend either vacuum aspiration or medical management.

36a. For the medical management of incomplete abortion at < 14 weeks uterine size: **Suggest** the use of 600 µg misoprostol administered orally or 400 µg misoprostol administered sublingually.

36b. For the medical management of incomplete abortion at ≥ 14 weeks uterine size: **Suggest** the use of repeat doses of 400 µg misoprostol administered sublingually, vaginally or buccally every 3 hours.*

Availability of abortion medicines

*Abortion medicines are in the **WHO EML** and the **WHO Prequalification EOI** for Reproduction Health.*

Table 1.1 Medicines included in the WHO Model List of Essential Medicines (EML) and their indications

Indication included in EML	Medicines included in the EML
Induced abortion	• Mifepristone (200 mg) and misoprostol (200 µg) • The medicines are available individually or co-packaged. • The EML specifically mentions the following co-packaged formulation: 1 tablet mifepristone (200 mg) + 4 tablets misoprostol (200 µg).
Management of incomplete abortion and miscarriage	• Misoprostol (200 µg)

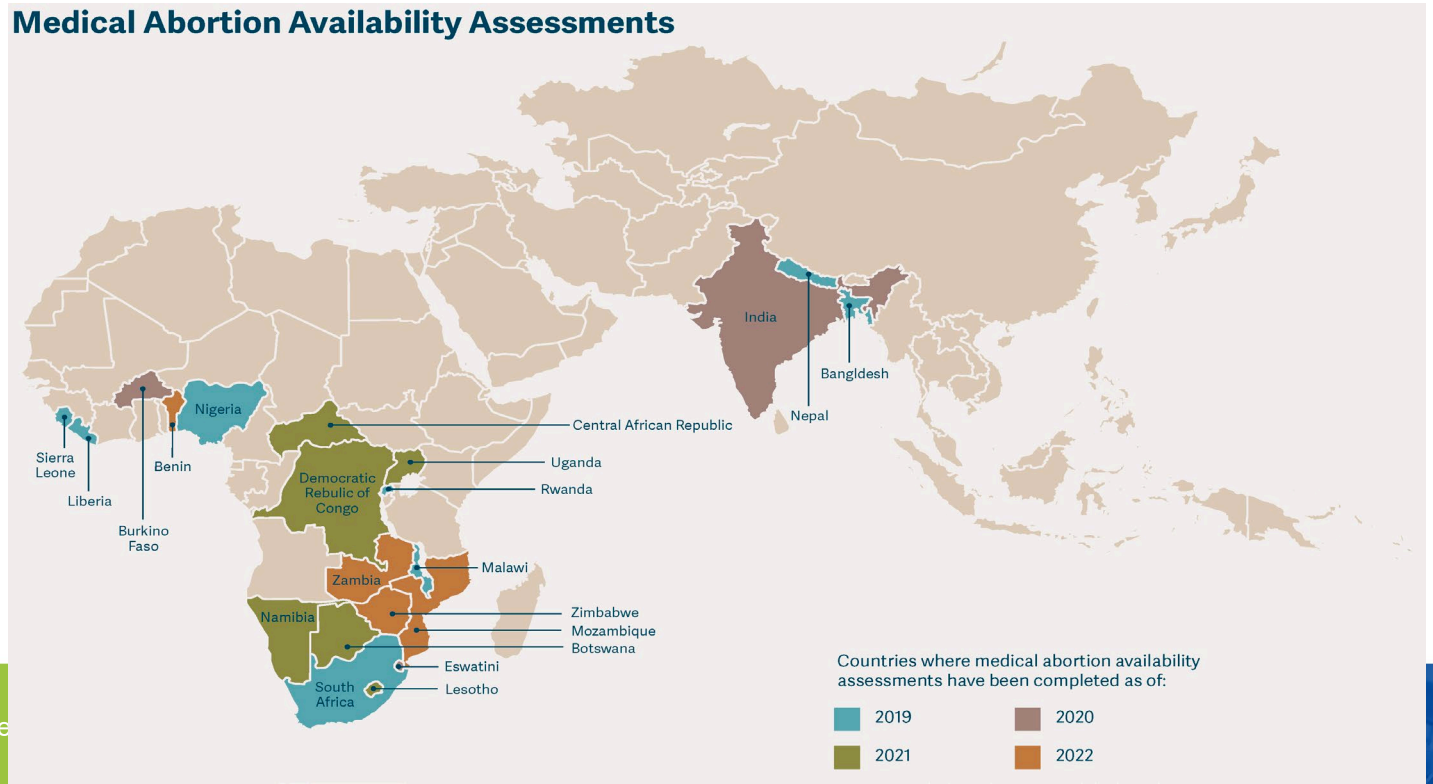
Source: WHO EML – 21st list, 2019 *(107)*, 22nd list, 2021 *(108)*.

	Number of products prequalified
Misoprostol FPP	4
Mifepristone FPP	3
Combi-pack	1
Misoprostol API	1
Mifepristone API	1

WHO/HRP's work on medical abortion medicines (1)

Landscape assessment of the availability of medical abortion medicines in 21 countries (2019-2022):

- Country-specific findings and opportunities to improve access to MA commodities
- Evidence briefs to support policy dialogue
- Journal supplement to disseminate the findings



WHO/HRP's work on medical abortion medicines (2)

Research studies:

- **Letrozole-misoprostol combination regimen**
  Generate further evidence to determine the safety, effectiveness and acceptability of the letrozole-misoprostol combination regimen, including at different gestational ages, especially in comparison with the mifepristone-misoprostol combination regimen.

- **Early menstrual induction (EMI)**:
  Test the combination of levonorgestrel a and mifepristone) to induce endometrial shedding between using emergency contraception and the next menstrual period.

- **Impact of COVID-19 on abortion care services**
  (& evaluation of programme adaptations) **and on medical abortion medicines procureme**


Open access Original research

BMJ Open **Disruptions to the procurement of medical abortion medicines during COVID-19: a scoping review**

Natasha Cassinath,[1] Patricia Titulaer,[1] Laurence Läser,[1] Antonella Lavelanet,[1] Safia Ahsan,[2] Francelle Kwankam Toedtli,[3] Stephen Mawa,[3] Ulrika Rehnstrom Loi [1]

Article available (open access) at: https://bmjopen.bmj.com/content/bmjopen/12/10/e064848.full.pdf

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https://www.who.int/health-topics/abortion#tab=tab_1

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Additional information – The burden of unsafe abortion

- Each year, more than **25 million unsafe abortions** take place globally
  - Unsafe abortions are **nearly half** of all abortions (45%)

- Each year, up to **39 000 women and girls die as a result of unsafe abortions** and millions more are hospitalized with complications
  - Most of these deaths are concentrated in developing countries
  - Nearly every death or injury resulting from unsafe abortion is entirely preventable through access to high quality abortion care and family planning services

→ Access to quality abortion care is a critical part of the universal 'right to health' and essential to protect the health of women and girls everywhere