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Effectiveness of self-administered Versus provider-supported medical abortion in the early and late first trimester: A prospective cohort study in southern Ethiopia

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Background: Medical abortion using mifepristone and misoprostol is considered safe for use up to nine weeks of gestation, whether administered in clinical settings or self-managed at home. However, evidence on the effectiveness of self-administration, especially in the late first trimester and in low-income settings such as Ethiopia, remains limited. In countries like Ethiopia, self-managed medical abortion is often excluded from national guidelines due to a lack of localized data. This study aimed to evaluate the effectiveness of self-administered medical abortion during both early and late first trimesters.

Methods and materials: A prospective, multi-center cohort study was conducted from March 16, 2024, to January 15, 2025, across six purposively selected healthcare facilities and medication abortion outlets in Hawassa City, Southern Ethiopia. Participants were eligible if they were aged 15 years or older, opted for medical abortion, and agreed to have outcome assessment after 2-4 weeks. Based on informed choice following counseling, participants were assigned to a self-administered and provider-supported group. The primary outcome was successful abortion, defined as complete uterine evacuation without the need for additional medical or surgical intervention. Secondary outcomes included participant satisfaction and post-abortion contraceptive uptake. Outcomes were assessed via ultrasound 2–4 weeks after misoprostol administration or by phone for participants unable to return.

Results: Out of 626 enrolled participants, 554 (88.5%) completed the follow-up. Of these, 341 were in the self-administration group and 213 in the provider-supported group. The mean participant age was 24.1 years (SD 4.2), with significant age differences between groups (24.7 vs. 23.1, p=0.000). The mean gestational age was 6.4 weeks for the self-administered and 7.5 weeks for the provider group (p=0.000). Overall, 92.4% (95% CI: 89.9–94.5%) experienced a successful medical abortion. Success rates were 93.8% (95% CI: 91.3–95.7) for gestational age <9 weeks and 84.5% (95% CI: 76.2–92.9) for ≥9 weeks. Self-administration had a success rate of 96.8% (95% CI: 94.3–98.4) versus 85.4% (95% CI: 80.0–89.9) in the provider group (RR: 1.13; 95% CI: 1.07–1.20; p=0.000). After adjusting for known predictors of abortion success, the odds of success for self-administration remained significantly higher (AOR: 6.42; 95% CI: 2.95–13.95). The common causes of failure included excessive bleeding (4.0%; 95% CI: 2.5–5.8), retained tissue (2.9%; 95% CI: 1.6–4.5), and continued pregnancy (0.7%; 95% CI: 0.2–1.6). No significant difference was found in mean duration of bleeding (7.3±4.6 vs. 7.7±5.1 days; p=0.14). Satisfaction was high in both groups (self: 98.1%; facility: 96.8%; p=0.43). Post-abortion contraceptive use was similar (self: 64.0%; provider: 70.4%, p=0.172), but long-acting method uptake was significantly lower in the self-administration group (19.9% vs. 53.3%; p=0.000).

Conclusion: Self-administration of medical abortion is both effective and acceptable, demonstrating that, with proper counseling, medication abortion can be safely administered outside of health facilities. This approach has the potential to significantly expand access, especially for women in rural or underserved areas, while also promoting women's self-care. However, the lower uptake of long-acting contraceptives among self-administering participants should be addressed before the method implementation in a large context

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