



Misoprostol-Only Medication Abortion: Quick Reference Guide

1 Protocol

DOSING REGIMEN (≤ 12 weeks): 3 DOSES MISOPROSTOL + 1-2 ADDITIONAL DOSES, 800 ug each, 3 hrs apart

RECOMMENDED ROUTES OF ADMINISTRATION — BUCCAL, SUBLINGUAL, VAGINAL*

Dose 1 800 μ g misoprostol Hour 0	Dose 2 800 μ g misoprostol +3 hrs	Dose 3 800 μ g misoprostol +6 hrs	Dose 4 (optional) 800 μ g misoprostol +9 hrs	Extra dose 800 μ g misoprostol If needed (see below)
---	---	---	--	--

Source: [Raymond et al, Contraception, 2023](#)

Additional dose indication: Patient should take the additional dose/s if, within 3 hours after the last scheduled dose, there has been no more than scant bleeding, if patient is unsure whether the pregnancy has passed, or if the patient desires additional assurance that the abortion will be complete.

All three primary doses should be taken at 3-hour intervals even if pregnancy products are passed before the third dose

* GI side effects may be less intense with vaginal administration. In a physical exam, tablet remnants may be visible after vaginal administration – appropriate counseling on risk mitigation strategies depending on care seeking context is recommended.

2 Effectiveness & Safety

~ 90% Complete abortion (Using above regimen)	4–5% ongoing pregnancy rate (manage with repeat misoprostol regimen, combined regimen, or procedural intervention)	<1% Major complications across >15,000 patients
--	---	--

Sources: [Raymond et al, Contraception, 2023](#); Moseson, et al, [NEJM Evidence, 2024](#)

3 Patient Experiences

Data on misoprostol-only experiences from the patient perspective is limited. We do know from a global study conducted in non-clinical settings ([SAFE study](#), n=637) that:

- 50% started **bleeding** after dose 2, with heaviest bleeding occurring after dose 3
- 89% noticed **expulsion** within 24 hours of dose 1; median time to expulsion was 12 hours
- 92% reported **painful cramping**, 52% **nausea**, 36% **fever**, and 28% **diarrhea**

KEY CONSIDERATIONS FOR PATIENT COUNSELING

Providers should note that existing data suggest that in clinical settings, the misoprostol-only regimens may have slightly lower effectiveness than the combined regimen (~90%), including a potentially higher rate of continuing pregnancy (~5%).



- **Reassure patients that misoprostol-only is safe and highly effective.** Ongoing legal attacks on mifepristone have created real confusion and doubt — not just about mifepristone, but about medication abortion broadly. Providers are well-positioned to counter this destabilization directly: every clinical encounter is an opportunity to affirm that both the combined regimen and misoprostol-only are safe, effective, and evidence-based options for abortion care.
- **Address side effects proactively.** Experiences may differ between the combined regimen and the misoprostol-only regimen, owing to multiple (as opposed to one) doses of misoprostol, however research describing patient experiences is limited. What we do know is patients who are well-prepared for what to expect report better experiences. Direct and honest descriptions of side effects and symptoms are important for understanding and trust.
- **Set accurate expectations for the experience — neither minimizing nor overstating.** Labeling misoprostol-only as a "worse" method or overstating negative experiences with misoprostol-only regimens may increase concern about normal symptoms and side effects, and/or increase unnecessary follow-up care that may expose people to an increased risk of criminalization. It is important to prioritize counseling that accurately sets expectations, supports patients in assessing completion, and creates clear pathways for follow-up information, care, and support.
- **Counsel patients on teratogenic risk in plain, reassuring language.** Misoprostol is teratogenic. The risk of fetal anomaly following misoprostol exposure in a continuing pregnancy [is low](#), however, patients should be clearly informed of this risk and supported in making a plan if the abortion is not complete.

Sources/Resources:

1. Raymond, Elizabeth G., Mark A. Weaver, and Tara Shochet. "Effectiveness and safety of misoprostol-only for first-trimester medication abortion: An updated systematic review and meta-analysis." [Contraception](#) 127 (2023): 110132.
2. Raymond et al. (2023). Medication abortion with misoprostol-only: A sample protocol. [Contraception](#), 121, 109998.
3. Society of Family Planning. Science Says: Misoprostol Only is Safe and Effective (Aug 2023). [societyfp.org](#)
4. Ibis Reproductive Health. Experiences with misoprostol-only for medication abortion (Oct 2023). [ibisreproductivehealth.org](#)
5. Moseson et al. How Effective Is Misoprostol Alone for Medication Abortion? NEJM Evidence. [EVIDcon2300129](#)
6. Jayaweera R et al. (2023). Medication Abortion Safety and Effectiveness With Misoprostol Alone. *JAMA Network Open*, 6(10):e2340042. [JAMA Network Open](#)
7. Reproductive Health Access Project (Oct 2025). [How to use Misoprostol-only for medication abortion](#)