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Descriptive Report

Implementing Free Medication Abortion in a Low-Resource Student-Run Clinic

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Abstract

Joan Viteri Memorial Clinic (JVMC) is a student-run clinic in Sacramento, California that serves marginalized and often stigmatized patient populations. The reproductive clinic within JVMC set out to provide medication abortion services to provide more equitable reproductive health care to its patients during a time in which these rights are being threatened across the United States. This descriptive report outlines the hurdles and victories in implementing protocols to offer no-cost medication abortions in a low-resource setting.

Introduction

The United States Supreme Court ruling on Roe versus Wade provided protection for individuals' rights to pregnancy termination, however this protection was overturned in June 2022. Consequently, numerous states immediately outlawed abortion or implemented restrictions to abortion access. California, on the other hand, became a sanctuary state for individuals seeking abortion.[1] While abortion remains legal in the state of California, low-income and other marginalized individuals continue to experience barriers to accessing medication abortions.

Joan Viteri Memorial Clinic (JVMC) is a student-run clinic (SRC) which serves a patient population predominantly consisting of people who use drugs, are experiencing homelessness, engage in sex work, or identify as transgender. Studies have shown that these groups commonly face stigma when seeking medical care.[2–5] It is the JVMC mission to serve our patient population with nondiscriminatory and equitable care, which includes providing trauma-informed care and access to otherwise unaffordable care. SRCs often act as healthcare safety nets for marginalized communities, thus access to medication abortion services at SRCs would close gaps in providing equitable care to all populations. JVMC set out to offer medication abortions for free to pregnancy-capable individuals desiring

Table 1. Medications for abortion management

Medications	Purpose
200 mg Mifepristone x1	Blocks progesterone receptor preventing progesterone delivery to pregnancy
200 mg Misoprostol x4	Induces uterine contractions
800 mg Ibuprofen	Alleviates pain
10000 mg Acetaminophen	Alleviates pain
4 mg Zofran	Alleviates nausea

This table shows the medications JVMC provided to patients undergoing medication abortion.
mg: milligrams

Table 2. History to assess ectopic pregnancy risk

Questions to assess risk for ectopic pregnancy
Have you had any abnormal bleeding during this pregnancy?
Have you had any severe abdominal pain during this pregnancy?
Have you ever had an ectopic pregnancy before?
Do you currently have an IUD in place?
Have you ever been told you have or have a history of pelvic inflammatory disease?

This table demonstrates important questions to ask pregnant patients to comfortably rule a pregnancy low risk for ectopic location in the absence of an ultrasound machine.
IUD: intrauterine device

this care. While acknowledging that the ability to know of every service offered by every established SRC in the United States is difficult, according to the archives and current publishing repertoire of the Journal of Student Run Clinics, there have been no submissions regarding abortion since its first volume in 2015, and there are currently no other SRCs that offer medication abortions. This descriptive report outlines the process, challenges, and lessons learned in implementing new protocols into practice at JVMC for the provision of medication abortions and can be utilized by other SRCs seeking to implement this service for their patients.

Methods

Protocols were generated by author Chase Clark from January 2023 to June 2023 using the mifepristone manufacturer's patient eligibility requirements as references.[6] These documents were iterative and adjusted as new guidelines regarding medication abortions with misoprostol and mifepristone were established and the specific capabilities of the student-run clinic were determined. Three separate physicians who practice medication abortions in hospitals, academic clinics, and independent abortion clinics reviewed the protocols for feasibility, safety, and accuracy, and adjusted as necessary from June 2023 to August 2023. Between August 2023 - November 2023, a certified prescriber was enrolled via the mifepristone manufacturer and approved to prescribe the medication at the JVMC site. Mifepristone, as well as additional necessary medications, see Table 1, were added to JVMC pharmacy stock during November 2023. The protocols included screening questions to assess the risk for ectopic pregnancy, see Table 2, and questions to ask at follow up appointments, see Table 3, and were implemented into practice in December 2023. Institutional Review Board review was not indicated as this descriptive report was not human subjects research. Future analyses will assess the efficacy and efficiency of the developed protocols.

Results

The process of initial protocol development to implementation of medication abortion services took 12 months in total. During the first six months (January-June 2023), multiple protocols were written outlining how to determine patient eligibility for a medication abortion, how to counsel on what to expect with a medication abortion, and how to educate patients on how, when, and which pills to take to complete a medication abortion. Additionally, handouts for patients with directions on how to take the pills, what to expect after taking the pills, what symptoms to look out for, and a help line they can call were created in both English and Spanish. The last protocols developed were templates for follow up appointments and referral sheets should an incomplete medication abortion occur for a patient. From July to August, three providers who practice medication abortions in different healthcare settings with different resources available reviewed the protocols for feasibility and patient

Table 3. Follow-up protocol one week after medication abortion

Questions for follow-up appointment
Did you have cramping and bleeding heavier than your normal period within 24 hours of taking misoprostol?
Do you feel like the passed the pregnancy? Did you see any clots?
Are your pregnancy symptoms resolving (nausea, vomiting, chest tenderness)? Do you currently have an IUD in place?
Is your bleeding lighter now than the heaviest bleeding after taking misoprostol?

This table shows the questions that are asked of patients one week after taking mifepristone and misoprostol to ensure the appropriate completion of abortion.
IUD: intrauterine device

safety. Between September and November, a certified prescriber was onboarded with a mifepristone manufacturer and approved to oversee mifepristone prescriptions at the JVMC site and all medications needed for a medication abortion were ordered and added to the clinic's in-house pharmacy. JVMC is the first SRC at University of California, Davis to offer medication abortions. It does so at no cost to pregnancy-capable individuals.

Discussion

The goal of the reproductive clinic at JVMC was to provide completely free, equitable, and nonjudgmental abortion access to underserved and often stigmatized populations. The information and patient data obtained from patients pursuing medication abortion is handled in the exact same manner as all patient data is, with privacy protection through the Health Insurance Portability and Accountability Act. The consent process involves informed consent, as is standard with all procedures, and includes a written and signed consent. This student-run clinic is staffed by students and physicians who volunteer their time. Students receive several values clarification and bioethics experiences throughout their education to determine their level of comfort and ethical considerations in providing abortion care. Therefore, students who do not feel comfortable providing abortion care are not required to provide it. Over the course of this project, several hurdles arose and had to be addressed.

When the authors first started to write protocols, there was conflicting evidence regarding the use of opioid medications for pain management during a medication abortion. Studies and guidelines from the World Health Organization (WHO) and American College of Obstetricians and Gynecologists (ACOG) recommend routine nonsteroidal anti-inflammatory drug (NSAID) use and do not recommend routine opioid use as it had not been shown to reduce the amount or duration of pain during a medication abortion.[7,8] Some studies, on the other hand, recommended considering narcotic prescriptions in addition to ibuprofen prescriptions.[9,10] This posed a challenge as JVMC does not prescribe narcotics; however, the clinic director was agreeable to making an exception in the specific case of medication abortions given the unclear guideline recommendations at the time. The next challenge was that JVMC uses a written prescription system which patients bring into the pharmacy to fill, and pharmacies in California no longer accept written prescriptions for controlled medications.[11] Multiple pharmacies including local businesses were called, but no one would make an exception, nor would any pharmacy accept a verbal order for a scheduled narcotic. This delayed the protocol generation for a month, during which we reexamined the evidence and practice trends surrounding pain control during medication abortion. We found convincing evidence for the efficacy of ibuprofen and a general trend away from opioid analgesics.[12,13] JVMC followed this shift and planned to provide ibuprofen and acetaminophen to patients for pain control. Table 1 shows the medications used in the JVMC protocols for a medication abortion.

Many organizations, including ACOG, WHO, and Planned Parenthood, support the use of medication abortion up to 12 weeks or more depending on the clinical setting and patient eligibility.[8,14,15] In some cases, it is necessary to rule out ectopic pregnancy before prescribing for a medication abortion.

For these reasons, access to an ultrasound (US) that is sensitive for pregnancy dating and identification of pregnancy location would be required, however JVMC did not have ultrasound access during the generation of the protocols. Instead, as many telehealth providers have adopted, we protocolized a checklist of specific questions to be asked of patients during the history portion of the interview in order to assess the risk of ectopic pregnancy and to ensure the pregnancy was not beyond the gestational limit of the clinic which was set to 12 weeks.[16,17] Subsequently, JVMC did invest in an US for other clinic services that does have sensitivity for pregnancy dating and location. However, since medication abortions can be practiced safely and effectively in settings that do not have US capacity using the screening, the use of this US was not written into our protocols, but rather could be used by providers for reassurance if that is their preference.[16]

Given the limited operating hours of the reproductive clinic within JVMC, another challenge was setting patients up with adequate follow-up and support in case of emergency as the reproductive clinic only operates one day each month. While the success rate of medication abortions is greater than 96%,[18] clinic protocols were adopted from the National Abortion Federation as an added safety net to identify patients who may experience a failed medication abortion.[19] A follow-up phone call one week after the medication ingestion was made as a protocol to assess patient's symptoms and ensure their pregnancy symptoms were resolving. Additionally, referral sheets for patients to bring to higher level care facilities in the area were generated in the rare case of requiring a procedural abortion or other care outside of the capacity of JVMC.

The last challenge to address was onboarding a certified prescriber. Once a physician who could serve in this position was identified, the registration process was initiated with the manufacturer. During this time, our key faculty supervisors (clinic medical director and certified mifepristone prescriber) were unavailable, so gathering all the pertinent information for the paperwork was delayed and required a deadline extension from the manufacturer. Ultimately, the approval went through, and medication abortions were added to the list of services offered at JVMC.

Limitations

The protocol and process for offering medication abortions at a low-resource student-run clinic was rolled out in December 2023, and this paper discusses the process of developing protocols and workflows to address possible patient needs after medication abortion. These protocols have not yet been tested in the clinical environment (no patient need yet at the time of writing), so we are unable to comment on the operationalizing of this system of care and any potential issues that might arise. Future work will evaluate the use of these protocols and any necessary modifications.

Conclusions

Offering medication abortion services at student-run clinics is feasible and can be a vital resource for communities, especially those who are underserved and encounter issues accessing health care. Though there were some challenges during the process, the reproductive clinic within JVMC was able to develop and implement medication abortion protocols and became the first student-run clinic at University of California, Davis to offer medication abortion.

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Disclosures

The authors have no conflicts of interest to disclose.

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