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Original research article

Evaluating the capacity of California's publicly funded universities to provide medication abortion☆

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ABSTRACT

Objective: To explore capacity of University of California (UC) and California State University (CSU) student health centers (SHCs) to provide medication abortion (MA) and SHC staff perspectives on providing MA.
Study design: SHC staff completed an online survey; we conducted site visits and conference calls with a subset of SHCs. The survey focused on barriers to abortion, resources needed for MA, and potential benefits and challenges.
Results: 11 UCs (100%) and 20 CSUs (87%) completed surveys. All facilities provided basic primary care, including sexual and reproductive health services and some contraceptive services, but not abortion. All sites had adequate staffing and physical plant, but most would require training, access to ultrasound when needed, 24-hour hotlines (CSUs), and back-up care to provide MA.
Conclusion: It would be feasible to provide MA at SHCs, but investment is needed to support staff training, equipment, 24-hour hotlines, back-up care, and minimal security upgrades, in order to implement MA services.
Implications: If SB320 is passed, provision of MA services at student health centers could improve access to early abortion for students in California. This model may be scaled up at other universities around the country.

1. Introduction

The California State legislature is considering Senate Bill 320, which would mandate the University of California (UC) and California State University (CSU) systems to offer medication abortion (MA) services on campus at student health centers. Three recent trends in particular support efforts to implement the provision of on-campus MA services: higher unintended pregnancy rates among younger women, growing use of MA in the US, and an increasing uptake of MA services within primary care.

Nearly half (45%) of US pregnancies are unintended (2.8 million annually), and approximately 40% end in abortion [1]. The highest rates of unintended pregnancy occur among women ages 20 to 24, years that often correspond to university attendance. Women[1] ages 18 to 24 obtain 42% of all abortions. According to the 2017 American College Health Association, only 56% of students reported using contraception the last time they had vaginal intercourse [2]. Abortion services are therefore an important health care option for university students.

Although the overall US abortion rate has declined in recent years, the proportion of abortions performed with medication has increased. In 2005, 14% of all nonhospital abortions were performed with medication; by 2014, this proportion more than doubled to 31% [3,4]. MA is an effective, safe, and acceptable method of pregnancy termination for patients who choose it [5,6].

Although most abortions in the US (59%) are performed at abortion clinics, 36% are provided at nonspecialized clinics [3], including primary care or family medicine clinics. At least nine California family medicine

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[1] Some people seeking abortion have different gender identities and may identify as gender nonconforming or transmen.

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residency programs offer abortion care training [7]. Qualitative research on patient abortion experiences in family medicine settings shows high satisfaction, and an appreciation of the privacy, convenience, and continuity of care afforded by accessing abortion in one's usual primary care setting [8]. Student health centers (SHCs) represent another primary care site where abortion services could be offered.

Minimal data are available on MA provision on college campuses. In 2006, the University of Illinois at Chicago initiated MA provision. Between October 2006 and April 2009, the on-campus clinic performed 46 MAs [9]. In 2015, two unidentified US colleges reported providing MA [10].

This study explores the capacity of UCs and CSUs to provide MA. We identify gaps in resources required to implement MA provision, with regard to personnel, training, equipment, and supplies, and explore SHC staff perspectives on the benefits and challenges of providing MA.

2. Materials and methods

2.1. Study setting

The UC system includes 11 campuses, including UC Hastings, and roughly 274,000 students [11]. The CSU system includes 23 campuses and roughly 479,000 students [12]. UC students are required to have health insurance, and all but one UC bills to the student health insurance plan, which covers abortion care. CSU students are not required to have insurance; student fees subsidize SHC services and some CSUs bill Family PACT, a state program that provides free family planning services to low-income people. About 10% of CSU students lack health insurance [13], and about 23% are enrolled in California Medicaid (Medi-Cal) [14]. Greater numbers of poor and underrepresented minority students enroll at CSUs compared to UCs [15]. None of the UCs bill Medi-Cal or Family PACT.

2.2. Data collection

From August to November 2017, we invited key informants to participate in a 30-min self-administered online survey. We visited sites or held conference calls with a subset of SHCs who completed the survey; visits included a tour of the facility and in-person interviews with staff. Clinicians, administrators, and counselors who worked at a UC or CSU SHC were eligible to participate. We recorded interviews with participant consent.

2.3. Measures

MA requires little specialized training or equipment. We reviewed the American College of Obstetricians and Gynecologists practice bulletin and the Mifeprex® provider agreement to identify basic requirements for providing MA [16,17]. MA must be provided by or under the supervision of a healthcare provider who is able to: assess pregnancy duration using ultrasound and/or clinical assessment of uterine size, rule out ectopic pregnancy and other contraindications, and provide surgical intervention if needed (including by referral). For this analysis, we defined SHC capacity to provide MA in terms of ability to meet the following eight requirements: 1) have a private exam room with ability to perform pelvic exams when needed[2]; 2) able to diagnose pregnancy with urine tests and/or pelvic exams; 3) able to perform lab testing (hemoglobin, Rh status, and quantitative serum hCG) on-site or by sending to outside lab; 4) able to date pregnancy; 5) have providers trained in MA provision[3] and in counseling; 6) provide after-hours triage, such as a 24-hour nurse- or clinician-staffed telephone hotline; 7) able to perform aspiration or surgical abortion on-site or by referral in case of incomplete MA or ongoing pregnancy; and 8) able to refer to specialists for management of adverse events as needed (including patients at risk of ectopic pregnancy).

The survey included questions about: barriers to abortion care, resources needed to provide MA, potential benefits and challenges of providing MA on campus, and interest in two alternative models to provide MA at SHCs (telemedicine and traveling clinicians). The survey also asked about clinic volume, service availability, staffing, security, and health insurance.

2.4. Analysis

Using descriptive analyses of quantitative survey data, we examined services currently provided, resources available, and UC and CSU perspectives on providing MA. We coded interviews and open-ended survey questions using thematic content analysis. To assess SHC capacity to provide MA, we compared SHC resources and equipment with the desired and required resources described in Section 2.3, noting the gaps. We conducted quantitative analyses in Stata 14.

UCSF's Institutional Review Board approved this study.

3. Results

Eleven UCs (100%) and 20 CSUs (87%) completed the survey. We conducted site visits or conference calls at four UCs and one CSU; we contacted additional CSUs but they declined due to time constraints or staff availability.

3.1. Current sexual and reproductive health services

All SHCs provided basic reproductive health services (Table 1) and some contraceptive methods. Not all SHCs offered long acting reversible

Table 1
Sexual and reproductive health services currently provided at student health centers (SHCs)

Sexual and reproductive health services	University of California (UCs) (n=11)	California State University (CSUs) (n=20[a])
Well woman exam	11	20
Cervical cancer screening/Pap smear	11	20
Sexually transmitted infection testing	11	20
Sexually transmitted infection treatment	11	20
HIV counseling and testing	11	19
Pre-exposure prophylaxis (PrEP) for HIV	11	6
Contraception	11	20
Pregnancy testing and counseling	11	20
Transgender care	11	9
Sexual assault services, on campus	11	20
On-site at SHC	8	16
Miscarriage management care[b]		
On-site	3	1
Referral to local clinics	7	17
Referral to physician's office	5	12
Referral to hospital/urgent care	10	17
Abortion care[b]		
On-site	0	0
Referral to local clinics	5	18
Referral to physician's office	1	6
Referral to hospital/urgent care	5	4
Ultrasound[b]		
On-site	1	0
Referral to local clinics	6	16
Referral to physician's office	8	13
Referral to hospital/urgent care	9	8
Referral to local imaging centers	7	16
Additional counseling if indicated[c]	3	7

[a] Three out of 23 CSUs did not participate in the survey.
[b] Respondents could select multiple responses for referral.
[c] Additional counseling available on-site included general counseling, counseling on STIs, crisis counseling, and contraceptive or pregnancy counseling.

[2] If telemedicine is used, a laptop with camera, internet connection, and access to a HIPAA-compliant platform is needed.
[3] In California, any physician or advanced practice clinician can screen and counsel patients and dispense mifepristone, if trained.

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