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Early Medical Abortion:
Issues for Practice
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Dear Colleague:

Whether or not your practice provides abortion care, you are likely to be affected by the availability of mifepristone. This new drug, along with advances in other forms of early abortion and early pregnancy diagnosis, is changing women’s options and, therefore, clinician practices. As a health care professional who cares for reproductive-age women, you are almost certain to encounter patients who:

- present with an unintended pregnancy;
- ask for your help in confirming a pregnancy and considering options;
- ask you about medical abortion, the “abortion pill,” or early abortion;
- request prenatal or abortion care, or a referral if services are not available in your practice;
- present for follow-up care after having an early abortion;
- report using a medication to induce abortion without medical guidance.

A clear understanding of all pregnancy options—including early medical abortion—is important for clinicians who care for women during their reproductive years. Prompt access to services, provided directly or through referral, is also essential. Medical options for early abortion are possible only during the first few weeks of pregnancy.

This monograph summarizes information about early abortion as well as the steps needed to ensure early identification and accurate assessment of pregnancy. For clinicians who want to consider expanding their scope of practice to include medical abortion services, as well as those who refer patients for care, this document provides an overview and useful resources.

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Philip D. Darney, MD, MSc
Co-Director, UCSF Center for Reproductive Health Research & Policy
Benefits of Early Pregnancy Diagnosis and Care

Diagnosing pregnancy accurately and establishing precise gestational dates are important, whether or not the woman plans to continue the pregnancy. Diagnosis during the first few weeks of pregnancy is essential for any woman who may want to consider early medical abortion. Early diagnosis is also helpful for a woman who may need some time to consider options and come to a decision. It is important to treat appointments for the diagnosis of pregnancy as urgent, and to schedule a test and exam as soon as possible.

Widely used office (and home) urine pregnancy tests are sensitive enough to detect β-hCG levels of 25 to 50 mIU/ml. They provide reliable and accurate confirmation of pregnancy within 7 days after implantation—several days before the woman’s next menstrual period is due. More expensive serum or quantitative tests have no advantage for pregnancy confirmation. Quantitative tests, however, may be useful if ectopic or molar pregnancy is suspected, when there is a doubt about whether an early abortion procedure has been successful, or when spontaneous abortion is suspected.

Transvaginal ultrasound can be used to identify a gestational sac in the uterus as early as 4.5 weeks after the last menstrual period (LMP), identify most ectopic pregnancies, and reliably confirm the absence of a gestational sac following an abortion.

If the woman decides to continue the pregnancy, optimal care during the first trimester helps to ensure the most positive outcome possible. Early pregnancy diagnosis makes early prenatal care possible, providing an opportunity for:

- counseling about proper nutrition and folic acid supplementation;
- identifying and/or addressing medical problems, such as diabetes, that require careful management during pregnancy;
- providing education and encouragement to avoid tobacco, alcohol, and other harmful substances;
establishing an accurate gestational age to aid later decisions about management;
identifying ectopic pregnancy early, when management is most successful in preserving future fertility (see box, Warning Signs During Early Pregnancy); and
planning for early prenatal diagnosis of fetal problems, when appropriate, using techniques such as chorionic villus sampling, multiple marker screening, or alpha-feto protein screening.

For those who decide to terminate a pregnancy, early diagnosis expands women’s options; early abortion can now be performed as soon as a pregnancy is diagnosed and the woman has made a decision. Early diagnosis is especially important, since some early options for abortion care are possible only during the first 3 to 5 weeks after a woman misses her period (see Figure 1).

### Warning Signs During Early Pregnancy

#### Possible ectopic pregnancy

- Sudden intense pain, or persistent pain, or cramping in the lower abdomen, usually on one side or the other.
- Irregular bleeding or spotting with abdominal pain when a menstrual period is late or after an abnormally light period.
- Fainting or dizziness persisting more than a few seconds. These symptoms may indicate internal bleeding. (Internal bleeding is not necessarily accompanied by vaginal bleeding.)

#### Possible miscarriage

- Current period later than expected, with heavy bleeding (possibly with clots or clumps of tissue). Cramping more severe than usual.
- Prolonged and heavy period—5 to 7 days of “heaviest” flow.
- Abdominal pain or fever.

When a woman elects to terminate a pregnancy, early provision of services can benefit her health and well-being:

- Abortion during the first few weeks after the woman's last normal menstrual period is extremely safe, with few women experiencing complications.
- Early provision of services eliminates the physical and emotional stress of waiting for an abortion.

Medical abortion, in particular, may give a woman more privacy during her abortion and may offer a sense of greater personal control over the experience.

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**Figure 1. Diagnostic and Care Options in Early Pregnancy**

<table>
<thead>
<tr>
<th>Weeks from date of last normal menstrual period (LMP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>X First day LMP</td>
</tr>
</tbody>
</table>

*Some clinicians may provide these services earlier than 4½ weeks LMP.
†Some clinicians may not provide very early vacuum abortion.
Early Medical Abortion

There are several options for early abortion. Manual vacuum aspiration (MVA) and early electric vacuum aspiration have the advantage of being one-step procedures, with immediate assurance in almost all cases that the woman is no longer pregnant. Medical regimens include methotrexate plus misoprostol and mifepristone plus misoprostol. Methotrexate regimens utilize inexpensive, widely available medications and, in addition, have the advantage of providing effective medical management for early, unruptured ectopic pregnancy. Because of its more predictable and prompt effect, however, mifepristone used with misoprostol is likely to become the most widely recommended method for medical abortion. Appendix A provides an overview of all early abortion methods.

Mifepristone Plus Misoprostol

Mifepristone—formerly called “RU-486”—was developed in France and approved for clinical use there in 1988. Mifepristone is an anti-progestin. It blocks the action of progesterone (which is necessary to establish and maintain placental attachment). Mifepristone is used in conjunction with misoprostol, a prostaglandin analogue, available in the United States under the brand name Cytotec®. When administered orally or vaginally, misoprostol stimulates uterine contractions that expel the embryo and placental tissue. The mifepristone-plus-misoprostol regimen has been safely used by millions of women around the world.

The U.S. Food and Drug Administration (FDA) approved mifepristone for use in the United States on September 28, 2000. In the United States, it is distributed by Danco Laboratories, L.L.C., under the brand name Mifeprex™. It is distributed directly to physicians and is not available through pharmacies. Mifepristone is also approved in Austria, Belgium, China, Denmark, Finland, France, Germany, Greece, Israel, Luxembourg, the Netherlands, Norway, Russia, Spain, Sweden, Switzerland, Tunisia, Ukraine, and the United Kingdom.
Protocols for use

While the FDA has approved a specific regimen for mifepristone use, clinical trials with mifepristone suggest that alternative regimens are equal to or more effective than the FDA-approved regimen, may have decreased side effects, and are more convenient for women (see Table 1). This section describes regimens commonly used in the United States and elsewhere that are based on evidence from U.S. clinical trials. Use of an approved product for a purpose that is not included in its labeling is common and in accord with FDA guidelines if there is published evidence to support such use.

Pre-abortion patient evaluation

- Confirm pregnancy using a sensitive urine pregnancy test and/or ultrasound. Although ultrasound was used in U.S. clinical trials, it is not required by the FDA.
- Confirm gestational age and rule out ectopic pregnancy through last menstrual period history, bi-manual exam, and ultrasound, if indicated; gestation should be estimated in “days” of pregnancy, not weeks or months.
- Counsel and obtain informed consent and signature for the Patient Agreement required by product labeling for mifepristone. If an evidence-based protocol is used, obtain signature for a Supplementary Consent (see Legal Issues, p 17).
- Review medical history and lab work (including Rh factor and, if indicated, hemoglobin or hematocrit, sexually transmitted infection, and other tests).
- Provide family planning information and discuss plans for initiating a contraceptive method following abortion.

Treatment steps

- In patients ≤ 63 days LMP, administer 200 mg mifepristone orally.
- If patient’s blood type is Rh-negative, provide Rh immune globulin, 50 mcg, i.m.
- Inform patient what to expect in terms of bleeding, pain, and other side effects. Provide follow-up instructions.
- Provide analgesic information and prescription. Ibuprofen 800 mg can be used and does not reduce abortion treatment effectiveness; a prescription for an oral narcotic such as acetaminophen 300 mg with codeine 30 mg also may be provided to use if needed.
- Provide 800 mcg misoprostol with instructions for vaginal self-administration at home 1 to 3 days after mifepristone dose.

Follow-up visit

- Within 2 weeks after the misoprostol dose (preferably in the first week), perform a pelvic exam or ultrasound to confirm abortion. If results are unclear, check for decreasing serum β-hCG levels using serial quantitative tests.
Repeat vaginal dose of misoprostol at home if indicated.

If the abortion is incomplete (persistent, empty sac, or debris), arrange for continued waiting and another follow-up visit; vacuum abortion may be performed if the patient prefers this option.

If there is evidence of embryonic cardiac activity on day 14 or later, a vacuum abortion is recommended.2,12

Review family planning information and provide services (see Section 4: Post-Abortion Care and Contraception).

**Effectiveness**

Clinical trials evaluating mifepristone 600 mg followed by orally administered misoprostol 400 mcg in pregnancies of no more than 49 days LMP (the FDA-approved regimen) have found effectiveness ranging from 92% to 97%.10 Studies of the 200-mg mifepristone dose followed by 800 mcg of vaginal misoprostol have found about 97%

<table>
<thead>
<tr>
<th><strong>Table 1. Comparison of Mifepristone Regimens</strong></th>
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<tbody>
<tr>
<td><strong>FDA-approved Regimen</strong></td>
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<tr>
<td><strong>Recommended gestational age</strong></td>
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<tr>
<td><strong>Mifepristone dose</strong></td>
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<tr>
<td><strong>Misoprostol dose</strong></td>
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<tr>
<td><strong>Administered during second office visit</strong></td>
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<tr>
<td><strong>Misoprostol timing</strong></td>
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<tr>
<td><strong>Follow-up office visit</strong></td>
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<tr>
<td><strong>Minimum office visits</strong></td>
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<td><strong>Approximate cost to patient</strong></td>
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<tr>
<td><strong>Advantages</strong></td>
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*Note: The 24- to 72-hour misoprostol treatment time frame has been studied only in women ≤ 56 days LMP.
effectiveness through 63 days LMP.\textsuperscript{3,4} About half of the women in U.S. trials of the FDA-approved regimen aborted within 4 hours after taking the misoprostol, and 75% aborted within 24 hours after the misoprostol dose.\textsuperscript{14}

**Contraindications**

Contraindications to mifepristone include:\textsuperscript{2}

- confirmed or suspected ectopic pregnancy or undiagnosed adnexal mass (methotrexate may be used; see box below);
- IUD in place (must be removed before treatment);
- adrenal failure;
- current long-term systemic corticosteroid therapy;
- history of allergy to mifepristone;
- hemorrhagic disorder or current anti-coagulant therapy; or
- inherited porphyria.

Contraindications to misoprostol include:

- allergy to misoprostol or other prostaglandins;
- uncontrolled seizure disorder; or
- acute inflammatory bowel disease.

Although hypotension and severe anemia are not cited as specific contraindications to mifepristone or misoprostol, they are considered reasons for caution for abortion procedures in general. No data exist on use of medical abortion while breastfeeding.\textsuperscript{12} Individual evaluation of patients with serious systemic illnesses is recommended to determine the safest method of abortion.\textsuperscript{12}

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**Methotrexate for Ectopic Pregnancy**

Methotrexate has been used in U.S. clinics as a method of early abortion (see Appendix A). It is also an effective treatment for early, unruptured ectopic pregnancy, and has been used for this purpose since the early 1980s. The standard protocol for ectopic pregnancy is a single intramuscular injection of methotrexate in a dose of 50 mg per square meter of body-surface area. Serum $\beta$-hCG is measured on the fourth and seventh day after the injection. If levels do not drop more than 15\% between days 4 and 7, another dose is given; approximately 20\% of women require the second methotrexate injection. This regimen is at least 90\% effective in treating early unruptured ectopic pregnancy with sac diameter up to 3.5 centimeters.\textsuperscript{15}
Side effects and complications

Medical abortion appears to have no long-term adverse health effects. In addition to the expected effects of vaginal bleeding and cramping, the most common side effects reported after use of the mifepristone and misoprostol regimen are:\(^6\)

\[\begin{array}{ll}
\text{nausea (36\% to 67\%)} & \text{diarrhea (8\% to 23\%)} \\
\text{headache (13\% to 32\%)} & \text{dizziness (12\% to 37\%)} \\
\text{vomiting (13\% to 34\%)} & \text{fever or chills (4\% to 37\%)}
\end{array}\]

Women in a U.S. study of mifepristone reported bleeding for a median of 13 days.\(^4,14\) The heaviest bleeding typically happens while the abortion occurs, and may last for 1 to 4 hours, though bleeding patterns can vary. The most serious potential side effect is heavy bleeding—particularly bleeding that requires a blood transfusion. This complication is very rare and is most likely to occur 1 to 3 weeks after taking the medications. Based on clinical trials in the United States, between 1 and 3 women per 1,000 will require a blood transfusion; in the largest single trial, only 0.1\% (1 woman per 1,000) required a transfusion.\(^4,17\)

Approximately 2\% to 5\% of patients treated with a mifepristone-plus-misoprostol regimen will require vacuum abortion to resolve an incomplete abortion, terminate a continuing pregnancy, or control bleeding.\(^6,18\) The rate of vacuum abortion following medical abortion typically goes down as clinicians gain more experience with the method.

Drugs used in medical abortion have been reported to have possible teratogenic effects, so they potentially could increase the risk for birth defects in an exposed pregnancy. A woman considering medical abortion needs to understand this risk, as well as the

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**Warning Signs After Early Abortion**

Women who experience any of the following signs after early abortion should contact their provider promptly:

\[\begin{array}{l}
\text{Soaking 2 or more maxipads per hour for 2 consecutive hours.} \\
\text{Sustained fever (100.4^\circ\text{F}; 38^\circ\text{C}) or onset of fever beginning more than 6 to 8 hours after misoprostol.} \\
\text{No bleeding within 24 hours after using misoprostol (may indicate ectopic pregnancy or lack of response to treatment).}
\end{array}\]

possibility that a vacuum abortion procedure may be necessary to complete the abortion process if the medical treatment is unsuccessful. Clinicians must be able to provide or arrange for vacuum abortion if medical abortion is incomplete.

**Misoprostol Alone: Self-Administration Reported**

Reports of self-administration of misoprostol alone to induce abortion are increasing. While women are most likely to try to self-induce using misoprostol in areas where legal abortion is unavailable, as in Latin America, anecdotal evidence suggests that some U.S. women also have access to the drug and are using it to induce abortion. As word spreads through informal information networks, the practice may grow.

As the following chart indicates, one survey of an urban, largely Hispanic U.S. population found surprisingly high levels of knowledge and use of misoprostol alone to induce abortion.

### Knowledge and Use of Misoprostol Alone (Percent)

<p>| | | | |</p>
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<thead>
<tr>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Had heard of misoprostol</td>
<td>40</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Knew someone who had used it</td>
<td>30</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Had used it themselves</td>
<td>20</td>
<td>10</td>
<td>0</td>
</tr>
</tbody>
</table>

Women surveyed (n=610)

Misoprostol-only regimens that have been reported involve multiple doses. In one study of 800 mcg misoprostol administered vaginally between 43 and 49 days LMP, the drug was 69.0% effective after one dose, 86.4% effective after two doses, and 91.7% effective after three doses; doses were given in 24-hour intervals. In another study, 800 mcg misoprostol administered vaginally up to 63 days LMP was 78% effective after one dose, 91% effective after two doses, and 92% effective after three doses.

Women may present for follow-up treatment after self-administration of misoprostol to induce abortion. Clinicians need to be aware of this use and know how to provide or refer women for follow-up care, if needed. Given misoprostol’s possible teratogenicity, vacuum abortion should be considered if attempted misoprostol abortion is unsuccessful.
Counseling and Education for Patients

Counseling and patient education are part of high-quality abortion care. Appropriate topics for discussion may include the factors influencing the woman’s decision to have the abortion (including obtaining assurance that the woman's decision has been made without coercion); her concerns and anxieties, if any; her support system; and her future family planning needs. In some states, other counseling topics may be legally mandated.

Medical abortion is new and unfamiliar to most U.S. women, so the clinician will need to present complete information. A survey of clinicians found that counseling for a medical abortion may take as long as 30 to 60 minutes. Clinicians in this study acknowledged, however, that following a brief learning period, medical abortion counseling becomes more routine and less time-consuming. A woman making an abortion decision needs to understand:

- that if her pregnancy is diagnosed in the first few weeks, she may have a choice between medical and vacuum abortion options; and
- the risks, benefits, and efficacy of the options available.

A woman needs more detailed information about the specific method chosen, including:

- the number and timing of visits and medication doses;
- the length of time she can expect the entire process to take;
- the amount of bleeding she may experience, including the size of clots and—for medical abortion—the embryonic tissue she may see;
- warning signs and possible complications;
- pain management, follow-up care, and what to do if she has any questions;
- the need for a vacuum abortion procedure if medical abortion is incomplete or unsuccessful; and
- the range of emotions she may experience during and after the abortion.
Planning for future contraception, including providing information about possible method options and instructions for use (see Table 2) and information about sexually transmitted infections, is also an essential education and counseling goal. Fertility returns promptly following early abortion. Most women can expect to ovulate within 2 to 3 weeks following abortion, so will need contraceptive protection immediately if they want to prevent pregnancy.

Other useful information for women with early pregnancies may include:

- information about local abortion loan funds or other financing options;
- information about prenatal care options, including low-cost or free services and sources of financial support; and
- information about adoption.

See Appendix B for sample patient information about medical abortion using mifepristone plus misoprostol.
Effective follow-up for either medical or vacuum abortion entails:

- **Providing women with instructions about when and where to call for help.** Patients should be encouraged to contact their abortion clinician first if they have any concerns or possible problems. These frequently can be handled over the telephone or at the office without the need for an emergency room visit. A 24-hour call system similar to that needed for management of spontaneous abortion problems should be in place.

<table>
<thead>
<tr>
<th>Method</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined oral contraceptive pills</td>
<td>Pills can be provided at the time of abortion, with instructions to begin a new pack on the day after the vacuum abortion or confirmation of completed medical abortion.</td>
</tr>
<tr>
<td>Progestin-only pills</td>
<td>Pills can be provided at the time of abortion, with instructions to begin a new pack on the day after the vacuum abortion or confirmation of completed medical abortion.</td>
</tr>
<tr>
<td>Injectables</td>
<td>Injection may be administered at the same time as vacuum abortion or immediately after confirmation of completed medical abortion.</td>
</tr>
<tr>
<td>Implants</td>
<td>May be inserted during the visit for vacuum abortion or immediately after confirmation of completed medical abortion.</td>
</tr>
<tr>
<td>IUDs</td>
<td>May be inserted at the conclusion of a vacuum abortion or immediately after confirmation of completed medical abortion.</td>
</tr>
<tr>
<td>Condoms, female condoms, diaphragm, cervical cap</td>
<td>May be used immediately after any abortion.</td>
</tr>
<tr>
<td>Fertility awareness methods</td>
<td>May be used after a normal menstrual pattern has been re-established.</td>
</tr>
<tr>
<td>Sterilization</td>
<td>May be scheduled concurrently with vacuum abortion or any time after a vacuum or medical abortion. Mandatory waiting periods may apply in some states (and for Medicaid patients).</td>
</tr>
</tbody>
</table>
MVA can be the initial method for early abortion as well as the treatment for incomplete spontaneous abortion (miscarriage). MVA is also an appropriate backup method for medical abortion patients who must have a vacuum abortion. It is a simple method that can be used by trained clinicians in a variety of practice settings.

- **Treating or referring patients for abortion-related side effects and complications.** Heavy bleeding can occur after medical abortion, and management of bleeding concerns is one of the most common issues for clinicians and staff. Most clinicians, however, have not found follow-up calls from their early abortion patients to be burdensome. Although serious complications are rare, all clinicians must be able to provide or arrange care for emergencies if they arise. Expertise in recognizing and providing treatment or arranging appropriate referral for treatment of ectopic pregnancy is also necessary for all clinicians (see boxes on pages 2 and 7).

- **Ensuring vacuum abortion backup for failed medical abortion.** Clinicians who do not offer vacuum abortion must be able to refer patients to appropriate services if a medical abortion is not successful. This is especially important because of the possibility that drugs used in medical abortion may have teratogenic effects. MVA is an appropriate intervention for unsuccessful medical abortion. Clinicians who do not currently offer vacuum abortion in their practice may consider adding MVA to provide backup for failed medical abortion (see box above). Although the procedure is relatively simple, comprehensive training is required (see Appendix C for organizations that offer training). Clinicians who do not perform vacuum abortions (including MVA) must have established referral procedures for this service. As clinicians gain more experience in providing medical abortion, the frequency of surgical intervention after medical abortion typically declines.

- **Providing contraceptive information and services.** Fertility returns almost immediately after an abortion, so providing family planning information and methods are important components of post-abortion care. Although intercourse is generally discouraged for 1 to 2 weeks after the abortion is complete, most family planning methods can be initiated immediately (see Table 2). Early follow-up to confirm that medical abortion is complete promotes timely contraceptive initiation. Condom use should be encouraged for intercourse that occurs prior to the follow-up visit, and all patients should receive information about emergency contraception in case it is needed in the future.
Establishing Medical Abortion Services

Early medical abortion is a simple technology that can be provided in a standard office setting. Offering medical abortion services can help ensure that a practice remains responsive to women’s needs for comprehensive reproductive health. A variety of types of clinicians have expressed interest in offering medical abortion services (see box on page 15).

Facilities, Equipment, and Supplies

In general, the facility and equipment requirements for offering medical abortions are very simple:

- a private room for counseling and conducting the physical exam;
- medications used in medical abortion;
- sensitive urine pregnancy test kits and supplies for other laboratory tests;
- ultrasound availability (on site or through referral); and
- equipment and medications for handling medical emergencies (such as an allergic reaction), including an oxygen delivery system, oral airways, and epinephrine.30

State or local facility requirements also may apply (see Legal Issues, page 17). As is the case for any medical facility, compliance with the U.S. Occupational Safety and Health Act (OSHA) provisions to protect staff from blood or tissue exposure is required.25

With the exception of mifepristone, medications and supplies needed can be ordered as for other medical supplies (see Appendix D). Mifepristone must be ordered directly from Danco Laboratories. With the first order, the prescriber placing the order must sign a one-page “Prescriber’s Agreement” outlining qualifications and guidelines for use of the product. Forms needed can be printed from the Danco website (go to www.earlyoptionpill.com, then “Health Care Professionals”—“How to Order Mifeprex”)
Clinicians Show Growing Interest in Medical Abortion Services

A nationally representative telephone survey of U.S. obstetrician/gynecologists, family practice physicians, nurse practitioners, and physician assistants found that many health professionals who do not now include abortion in their practices are interested in offering early medical abortion.

Establishing Emergency Back-up and Referral Services

Clinicians who provide early abortion services must ensure 24-hour coverage to deal with emergency or follow-up concerns. Referral arrangements for or capacity to perform electric vacuum aspiration or MVA also must be in place for management of incomplete or unsuccessful medical abortion.

Clinicians who wish to offer electric vacuum abortion or MVA will also need:
- an exam room with sufficient space to conduct the procedure;
- a comfortable space where the woman can rest after the procedure;
- equipment and capacity to properly process instruments, identify the products of conception (a clear bowl, light, and water), and dispose of medical waste; and
- appropriate medications for managing emergencies.

Billing and Insurance Issues

Most insurance and Medicaid plans treat mifepristone abortion in the same way as vacuum abortion (i.e., if vacuum abortion is covered, it is likely that mifepristone abortion will be covered). Because there is currently no American Medical Association (AMA)
CPT (Current Procedural Terminology) code specifically for medical termination of a first-trimester pregnancy, each component of the service must be billed separately. The U.S. marketer of mifepristone is applying for a CPT code to cover medical abortions using mifepristone. Some state Medicaid programs have issued specific instructions for billing medical abortion services.

Regardless of coverage provisions for an abortion procedure, complications from abortion are typically covered by insurance.\textsuperscript{33} Also, even if the abortion procedure itself is not covered, it may be possible to bill for the associated laboratory work, ultrasound, and office visits.\textsuperscript{33} Some suggested billing codes are indicated in Table 3.

As with any new service, clinicians will need to check with their medical malpractice insurance carriers to determine their coverage before initiating medical abortion services.

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**Table 3. Suggested Billing Codes for Medical Abortion**

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Established patient eval/mgmt visit level IV (visit 1 of mifepristone protocol)</td>
<td>. . . . 99214</td>
<td></td>
</tr>
<tr>
<td>New patient eval/mgmt visit level IV (visit 1 of mifepristone protocol)</td>
<td>. . . . 99204</td>
<td></td>
</tr>
<tr>
<td>Counseling and informed consent (by physicians)</td>
<td>. . . . 99402</td>
<td></td>
</tr>
<tr>
<td>Office visit (follow-up evaluation—visit 2 and visit 3, depending on protocol)</td>
<td>. . . . 99213 or 99214</td>
<td></td>
</tr>
<tr>
<td>History and physical (new patient level II)</td>
<td>. . . . 99202</td>
<td></td>
</tr>
<tr>
<td>Pelvic exam</td>
<td>. . . . 57410</td>
<td></td>
</tr>
<tr>
<td>Vaginal ultrasound</td>
<td>. . . . 76830</td>
<td></td>
</tr>
<tr>
<td>Abdominal ultrasound</td>
<td>. . . . 76815 or 76805</td>
<td></td>
</tr>
<tr>
<td>Rh typing</td>
<td>. . . . 86901</td>
<td></td>
</tr>
<tr>
<td>Hemoglobin</td>
<td>. . . . 85018</td>
<td></td>
</tr>
<tr>
<td>Anti-D globulin</td>
<td>. . . . 90742</td>
<td></td>
</tr>
<tr>
<td>Venipuncture</td>
<td>. . . . 36415</td>
<td></td>
</tr>
<tr>
<td>Surgical intervention for incomplete abortion</td>
<td>. . . . 59812</td>
<td></td>
</tr>
<tr>
<td>Surgical abortion (D&amp;C)</td>
<td>. . . . 59840</td>
<td></td>
</tr>
<tr>
<td>Surgical abortion (D&amp;E)</td>
<td>. . . . 59841</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug reimbursement codes</td>
<td>. . . . J8499 or J3490</td>
<td></td>
</tr>
<tr>
<td>Mifepristone, oral, 200 mg</td>
<td>. . . . S0190*</td>
<td></td>
</tr>
<tr>
<td>Misoprostol, oral, 200 mcg</td>
<td>. . . . S0191*</td>
<td></td>
</tr>
<tr>
<td>Medically induced abortion by oral ingestion of medication, including all associated services and supplies (e.g., patient counseling, office visits, confirmation of pregnancy by hCG, ultrasound to confirm duration of pregnancy, ultrasound to confirm completion of abortion) except drugs</td>
<td>. . . . S0199*</td>
<td></td>
</tr>
</tbody>
</table>

Legal Issues

Clinicians should confer with local legal experts to assess the state requirements and restrictions that may apply to their practice or facility. Appendix C includes information about organizations that can provide guidance in this area. Issues to consider include:

Informed Consent

Product labeling for mifepristone requires that each patient receive information about the product and sign a Patient Agreement. If an evidence-based alternative regimen is being used, the patient should in addition sign a “Supplemental Consent” that contains:

- Information about the alternative regimen and how it differs from the FDA-approved regimen;
- Patient agreement to use the alternative regimen rather than the regimen described in the Medication Guide and Patient Agreement form;
- Explanation that agreement to the Supplemental Consent means that, where it differs from the Patient Agreement, the Supplemental Consent will be followed;
- Patient agreement to undergo needed follow-up visits and/or home self-administration of misoprostol, if that is part of the planned regimen; and
- Basic information about risks, benefits, and alternatives for medical care during pregnancy (product labeling forms do not provide this information).

Physician-only laws

Forty-four states have “physician-only” laws that restrict the provision of abortion to licensed physicians. However, many states have language that allows advanced-practice clinicians (nurse practitioners, nurse-midwives, and physician assistants) to prescribe and dispense medications and perform procedures similar to abortion. Specific provisions and interpretations may differ across states, and legal advice should be sought before initiating service.

Targeted regulation of abortion providers

In some states, specific laws govern the facilities where abortions are performed and impose staffing, licensing, or physical plant requirements. Many of these laws do not apply to private physicians’ offices where only first-trimester abortions are provided.

Reporting requirements

Most states have laws that require clinicians to report selected abortion statistics. Information on reporting requirements is available from the state Department of Health.
Tissue examination and disposal laws

Many states have laws that require examination of tissue to confirm the abortion; other laws mandate specific methods for disposing of the tissue after an abortion. Whether tissue-examination laws will apply to medical abortion (where the abortion takes place neither at a specific time nor at a medical facility) is unclear at this time.

Other state laws concerning the provision of abortion services also apply to medical abortion, including parental involvement requirements, waiting periods, and informed-consent policies.

Addressing Staff Concerns

While many staff welcome the opportunity to provide expanded information and services to their patients, practices that add early abortion services must be prepared to address staff concerns. A common concern is increased workload caused by the need to provide education and counseling about medical abortion (experienced staff report they do not find the additional work burdensome\textsuperscript{25,37}). Another concern may be security, which can be addressed through facility improvements (if needed) and staff training and support. Clinicians also may encounter staff who express conscientious objections. The American Medical Association code of ethics states that “the patient’s right to self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice . . . . The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice.”\textsuperscript{38} Thus, it is important to ensure that staff providing care or referral are able to do so in a supportive, nonjudgmental way.
Appendices

Appendix A
Methods of Early Abortion: An Overview

Appendix B
Common Questions About Medical Abortion With Mifepristone

Appendix C
Organizational Resource List

Appendix D
Product Information
### Methods of Early Abortion: An Overview

<table>
<thead>
<tr>
<th>Mechanism of action</th>
<th>Mifepristone &amp; Misoprostol</th>
<th>Methotrexate &amp; Misoprostol</th>
<th>Early Manual Vacuum Aspiration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mifepristone blocks progesterone, causing the uterine lining to thin and detach; misoprostol causes uterine contractions that expel the embryo and placental tissue.</td>
<td>Methotrexate stops cell division, so is toxic to trophoblast tissue; misoprostol causes uterine contractions that expel the embryo and placental tissue.</td>
<td>Cervix opened with dilators or misoprostol; cannula then attached to manual suction device to remove the embryo and placental tissue from the uterus.</td>
</tr>
<tr>
<td>Recommended gestational age</td>
<td>Evidence-based regimen through 63 days LMP; FDA-approved regimen through 49 days LMP.</td>
<td>From pregnancy confirmation through 49 days LMP.</td>
<td>From pregnancy confirmation through 84 days LMP.</td>
</tr>
<tr>
<td>Dose</td>
<td>Evidence-based regimen: 200 mg mifepristone taken orally followed by 800 mcg misoprostol used vaginally 1 to 3 days later.</td>
<td>Methotrexate given orally (50 mg) or by i.m. injection (50 mg/m²) (average dose 50–75 mg i.m.; 2–3 ml of 25 mg/ml solution); 800 mcg misoprostol administered vaginally 3 to 7 days later.</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>About 97% for evidence-based regimen.</td>
<td>94%–96%</td>
<td>97%–99%</td>
</tr>
<tr>
<td>Visits needed*</td>
<td>Clinical evidence supports two-visit regimen with home use of misoprostol. FDA-approved regimen specifies three visits.</td>
<td>Typically used in two-visit regimen, though a third visit may be necessary in some cases.</td>
<td>One visit. A second visit may be necessary in some cases.</td>
</tr>
<tr>
<td><strong>Side effects, complications</strong></td>
<td><strong>Mifepristone &amp; Misoprostol</strong></td>
<td><strong>Methotrexate &amp; Misoprostol</strong></td>
<td><strong>Early Manual Vacuum Aspiration</strong></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Nausea, vomiting, diarrhea, headache, dizziness, fever or chills, anemia (rare). Possible need for vacuum abortion or (rarely) blood transfusion.¹⁶</td>
<td>Nausea, vomiting, diarrhea, headache, fever or chills, stomatitis (rare), anemia (rare). Possible need for vacuum abortion or (rarely) blood transfusion.</td>
<td>Rare complications include excessive blood loss, pelvic infection, cervical injury, uterine perforation, acute hematometra.⁴²</td>
<td></td>
</tr>
<tr>
<td><strong>Expected bleeding</strong></td>
<td>Average length of bleeding is 13 days.¹⁴</td>
<td>Average length of bleeding is 10–17 days.¹⁶</td>
<td>Typical length of bleeding is 9 days.⁴³</td>
</tr>
<tr>
<td><strong>Ectopic pregnancy</strong></td>
<td>Not effective treatment.</td>
<td>Treatment is 90% effective for early, unruptured ectopic pregnancy 3.5 cm or less in size with initial β-hCG less than 5,000 mIU/ml.¹⁵</td>
<td>Can be useful in diagnosing ectopic pregnancy.</td>
</tr>
<tr>
<td><strong>Follow-up needs</strong></td>
<td>Must return for confirmation of abortion. If unsuccessful, vacuum abortion is necessary.</td>
<td>Must return for confirmation of abortion. If unsuccessful, vacuum abortion is necessary.</td>
<td>Follow-up visit may be required to confirm abortion. If unsuccessful, re-evacuation is necessary.</td>
</tr>
<tr>
<td><strong>Teratogenicity</strong></td>
<td>Mifepristone: reported.¹⁷ Misoprostol: reported.⁴⁴,⁴⁵§</td>
<td>Methotrexate: yes, at doses used for cancer treatment.⁴⁶,⁴⁷ Misoprostol: reported.⁴⁴,⁴⁵§</td>
<td>Not applicable.</td>
</tr>
<tr>
<td><strong>Regulatory status</strong></td>
<td>Mifepristone is FDA approved for early abortion. Misoprostol is FDA approved for other uses.</td>
<td>Both drugs are FDA approved for other uses.</td>
<td>MVA instruments marketed as medical devices in the United States.</td>
</tr>
</tbody>
</table>

* Waiting periods required in some states may necessitate an additional clinic visit.
† Bleeding and cramping are expected effects of all abortion procedures.
§ Teratogenicity has been reported although the relationship, if any, is unclear.
Appendix B

Common Questions About Medical Abortion With Mifepristone

The following pages contain general information for patients about medical abortion using mifepristone (evidence-based protocol). The pages are designed so that they can be photocopied onto both sides of a single sheet of paper to form a patient handout. The information can be adapted to reflect variations in practice and reproduced in other formats.
Common Questions About Medical Abortion with Mifepristone

**What is medical abortion?**

Medical abortion (sometimes called “the abortion pill” or nonsurgical abortion) uses two medications—mifepristone and misoprostol—to end a pregnancy. Mifepristone is taken by mouth (swallowed) and misoprostol tablets are either put in the vagina to dissolve or taken by mouth. These medications cause changes in the lining of the uterus (womb) and muscle contractions that expel the pregnancy tissue. Most women have cramping and bleeding like those that may occur during an early miscarriage or a very heavy menstrual period.

**When in pregnancy is medical abortion possible?**

Medical abortion is **recommended only in early pregnancy**. It can be done as soon as the pregnancy is confirmed up until 63 days (9 weeks) after the first day of the last normal menstrual period. It is important that a woman confirm a pregnancy as soon as possible if she wants to consider medical abortion.

**How long does the medical abortion process take?**

Medical abortion involves several steps and requires at least two medical visits. During the first visit, the pregnancy is confirmed and the woman and her clinician review information about possible options. After the woman makes a decision, she will have a brief physical exam and take the first medication (mifepristone). The second medication (misoprostol) is inserted into the vagina at home 1 to 3 days later. The abortion usually occurs within 4 hours after inserting the second drug, but it can take 24 hours or longer. In some cases, the woman may need to return to her clinician for another dose of medication. A final clinician visit is required within the next 2 weeks for a checkup.

**How effective is medical abortion?**

Medical abortion is about 97% effective. This means that 97 out of 100 women who take the medications will have a complete abortion with no further medical treatment. In the 3 out of 100 cases in which abortion does not occur or is not complete, a vacuum abortion procedure is required. Once a medical abortion has been started, it must be completed, because the drugs used for medical abortion could cause birth defects.

**How safe is medical abortion?**

Medical abortion is extremely safe. The drugs used in medical abortion have been widely studied and are approved by the U.S. Food and Drug Administration. Millions of women all over the world have used medical abortion safely for more than 10 years. Complications are rare. Prolonged or heavy bleeding is the most common complication, occurring in about 1 in 100 women. In some cases, this may require vacuum abortion to stop the bleeding. Problems requiring emergency treatment are very rare: bleeding heavy
enough to require blood transfusion occurred for less than 1 woman in 1,000 in a U.S. study. Infection is also possible, but less common with medical abortion than with vacuum abortion procedures.

**What are the side effects of medical abortion?**

Vaginal bleeding and cramping are expected effects of medical abortion and show that the drugs are working. Common side effects are nausea, vomiting, and diarrhea. Some women also experience headaches, dizziness, and fever or chills. Some of these effects can be reduced by using non-prescription pain relievers and/or anti-nausea medications.

**What will the bleeding be like, and how long will it last?**

The amount and length of bleeding after medical abortion is different for each woman and depends on how far along the pregnancy is. There is usually more bleeding and cramping than during a heavy period, with blood clots (sometimes large) and, possibly, some gray or tan tissue (at 8 weeks the pregnancy is about 1/2 to 3/4 inch long but may not be clearly visible). Women typically report some amount of bleeding for about 13 days after taking the drugs.

**What happens after a medical abortion?**

Medical abortion has no long-term effects on a woman's health. Fertility returns quickly—ovulation is likely within the first two or three weeks after the abortion, with a normal menstrual period expected about two weeks after that. It is important to begin using an effective family planning method immediately.

**Is there an alternative to medical abortion?**

Yes. Vacuum aspiration abortion, also called surgical abortion, is possible during early pregnancy and also can be used after the 9-week limit for medical abortion. Vacuum aspiration involves stretching the opening of the woman's cervix slightly (dilation), and placing a hollow tube (cannula) through the cervical canal into the uterus. Suction is then used to remove the pregnancy tissue. The procedure takes about 5 to 10 minutes, can be done in one clinic visit, and is about 99% effective. Typically, local anesthesia is used; general anesthesia is not required. More information about this option is available from providers.

**Is medical abortion the right choice for all women?**

Each woman will have a unique perspective on the advantages and disadvantages of different abortion options. Some women who choose medical abortion say that they want to avoid surgery and anesthesia, have a more “natural” and less “invasive” experience, and participate in the process more actively. Women who choose vacuum abortion say that they like the method's speed, simplicity, and effectiveness.

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Appendix C  Organizational Resource List

The Abortion Access Project
552 Massachusetts Avenue, Suite 215, Cambridge, MA 02139  (617) 661-1161  www.abortionaccess.org
Coalition of women’s health care providers. Works to increase access to abortion services, integrate abortion into medical/nursing school curricula, and educate the public to view abortion as an integral part of health care. Resources: Advanced Practice Clinicians as Abortion Providers: A Guide to Researching the Legal Issues; Start a Hospital Access Campaign in Your Area: The Hospital Access Project Organizing Kit; Caring for the Woman with an Unplanned Pregnancy (a PowerPoint lecture for nursing students); Abortion Training: A Guide to Establishing an Effective Program at Your Facility.

The Alan Guttmacher Institute
120 Wall Street, 21st Floor, New York, NY 10005  (212) 248-1111  www.agi-usa.org
Conducts analysis to inform individual decision-making, enlighten public debate, and promote the formation of sound public- and private-sector programs and policies. Resources: Sharing Responsibility: Women and Abortions Worldwide; The Status of Major Abortion-Related Laws in the States; scientific journals, fact sheets, and policy summaries.

American College of Nurse Midwives
818 Connecticut Avenue, NW, Suite 900, Washington, DC 20006  (202) 728-9860  www.midwife.org

American College of Obstetricians and Gynecologists
409 12th Street, SW, P.O. Box 96920, Washington, DC 20090-6920  (202) 638-5577  www.acog.org
40,000 physician members. Advocates for quality health care for women, sets standards of clinical practice and continuing education for its members, promotes patient education, raises awareness of the changing issues facing women’s health care. Resources: Medical Management of Abortion (ACOG Practice Bulletin); Induced Abortion: Important Medical Facts; Planning Your Pregnancy; Pregnancy Choices: Raising the Baby, Adoption, and Abortion; Guidelines for Perinatal Care, Fourth Edition; and Abdominal Ultrasound: Principles and Techniques.

American Medical Women’s Association
801 North Fairfax Street, Suite 400, Alexandria, VA 22314-1767  (703) 838-0500  www.amwa-doc.org
Provides and develops leadership, advocacy, education, and mentoring to 10,000 women physician members. AMWA’s Reproductive Health Initiative produces educational resources to increase training medical students receive on contraception, abortion, infertility, sexually transmitted diseases, and psychosocial issues. Resources: The Fourth-Year Elective Curriculum in Reproductive Health; Journal of the American Medical Women’s Association; The Woman’s Complete Health Book; The American Medical Women’s Association Guide to Pregnancy and Childbirth.

Association of Reproductive Health Professionals
2401 Pennsylvania Avenue, NW, Suite 350, Washington, DC 20037-1718  (202) 466-3825  www.arhp.org
Provides reproductive health services and continuing medical education, conducts research, and influences health policy. Resources: Manual Vacuum Aspiration Slide and Lecture Presentation (co-produced with PRCH and Ipas); Choosing a Birth Control Method (video, brochure, and website questionnaire); clinical monographs; Health and Sexuality Magazine.


Center for Reproductive Health Research & Policy  
UCSF, 3333 California Street, Suite 335, Box 0744, San Francisco, CA 94143-0744  
(415) 502-4086  
http://reprohealth.ucsf.edu  

Center for Reproductive Law and Policy  
120 Wall Street, 14th Floor, New York, NY 10005  
(917) 637-3600  
www.crlp.org  
Litigation, policy analysis, legal research, and public education to further women's equality in society and ensure that all women have access to appropriate and freely chosen reproductive health services. Resources: Roe v. Wade at 25 (video); Reproductive Freedom News; Providing Medical Abortion: Legal Issues of Relevance to Providers; Making Abortion Safe, Legal, and Accessible: A Tool Kit for Action; Medical Abortion: Providing Medical Abortion Within the Limits of the Law.

Clinicians for Choice  
c/o The National Abortion Federation, 1755 Massachusetts Avenue, NW, Suite 600, Washington, DC 20036  
(202) 667-5881  
www.cliniciansforchoice.org  
Educates clinicians and the public about the role a wide range of clinicians can play in ensuring access to abortion care. Resources: The Role of Physician Assistants, Nurse Practitioners, and Nurse-Midwives in Providing Abortions: Strategies for Expanding Abortion Access; Clinicians for Choice internships; newsletters.

Consortium of Abortion Service Providers for Planned Parenthood Affiliates  
Planned Parenthood of Southwest and Central Florida,  
21-A 9th Street South, St. Petersburg, FL 33705  
(727) 898-8199  
Offers clinical training materials and technical assistance on medical and surgical abortion, primarily to Planned Parenthood affiliates. Resources: First Trimester Abortion (video available in English and Spanish); Surgical Abortion Before Six Weeks Gestation (video).

Ipas  
300 Market Street, Suite 200, Chapel Hill, NC 27516  
(919) 967-7052 (800) 334-8446  
www.ipas.org  
Manufactures and distributes manual vacuum aspiration instruments; supplies educational and training resources on reproductive health technologies; and provides research, research tools, and information to policymakers. Resources: Summary of Clinical and Programmatic Experience with Manual Vacuum Aspiration; Early Abortion Services: New Choices for Providers and Women; Manual Vacuum Abortion Guide for Physicians; The Counseling and Information Guide for Medical Abortion; Manual Vacuum Aspiration Slide and Lecture Presentation (with ARHP and PRCH).

Medical Students for Choice  
2041 Bancroft Way, Suite 201, Berkeley, CA 94704  
(510) 540-1195  
www.ms4c.org  
A network of support and resources for pro-choice medical students and residents. Works to reform medical school curricula and training to include abortion and reproductive health. Resources: On-line Ob/Gyn Residency Guide; Medical Students & Abortion Education: Questions & Answers; Reproductive Health Externship Program.

National Abortion and Reproductive Rights Action League  
1156 15th Street, NW, Suite 700, Washington, DC 20005  
(202) 973-3000  
www.naral.org  
Conducts research and legal analysis, educates Americans and officeholders about reproductive rights and health issues, and helps to elect pro-choice candidates at all levels of government. Resources: Who Decides? A State-by-State Review of Abortion and Reproductive Rights 2000; The Difference Between Emergency Contraception (ECPs) and Early Abortion Options; What You Should Know About Mifeprex; Singling Out Abortion Providers for Onerous and Unnecessary Regulation.
National Abortion Federation
1755 Massachusetts Avenue, NW, Suite 600, Washington, DC 20036 (202) 667-5881 www.prochoice.org
Professional association of abortion providers in the United States and Canada working to ensure the safety and high quality of abortion practice with standards of care, protocols, clinical policy guidelines, quality improvement programs, and accredited continuing medical education. Also educates consumers and policymakers about abortion practice. Resources: Early Options: A Provider's Guide to Medical Abortion; Early Medical Abortion with Mifepristone or Methotrexate: Overview and Protocol Recommendations; Clinical Training Curriculum in Abortion Practice; A Clinician's Guide to Medical and Surgical Abortion; Clinical Policy Guidelines.

National Women's Health Network
514 10th Street, NW, Suite 400, Washington, DC 20004 (202) 347-1140 www.womenshealthnetwork.org
Works to give women a greater voice in the health care system in the United States, advocates for better federal policy on women's health, and provides women with information and resources to assist them in making better health care decisions. Resources: Diagnostic Ultrasound Imaging in Pregnancy; Mifepristone and Misoprostol for Early Abortion; Abortion and Breast Cancer.

National Women's Law Center
11 Dupont Circle, NW, Suite 800, Washington, DC 20036 (202) 588-5180 www.nwlc.org
Brings women's concerns to policymakers, advocates, and the public through public policy research, monitoring and analysis; litigation, advocacy and coalition-building; and public education. Resources: Making the Grade on Women's Health: A National and State-by-State Report Card; Health Care Provider Merger Resources and Tools; Hospital Mergers and the Threat to Women's Reproductive Health Services: Using Antitrust Laws to Fight Back.

Pacific Institute for Women's Health
2999 Overland Avenue, Suite 111, Los Angeles, CA 90064 (310) 842-6828 www.piwh.org
Works through advocacy, training, community involvement, applied research, and evaluation to build bridges between local and international women's health advocacy groups, and among researchers, practitioners, policymakers, and activists. Resources: A Clinician's Guide to Providing Emergency Contraceptive Pills; California Guidelines for Pharmacies Providing Family Planning Services to the Community; From Secret to Shelf: How Collaboration is Bringing Emergency Contraception to Women; Community Level Dynamics of Unsafe Abortion in Western Kenya and Opportunities for Prevention.

Physicians for Reproductive Choice and Health
55 West 39th Street, 10th Floor, New York, NY 10018 (646) 366-1890 www.prch.org
Works to enable concerned physicians to take a more active and visible role in support of universal reproductive health. Offers continuing education and other resources for pro-choice physicians. Resources: The Manual Vacuum Aspiration (MVA) Presentation (co-produced with ARHP and Ipas); Why I Provide Abortions; Medical Abortion Slide and Lecture Presentation; Reproductive Health Resource Guide 2000; Minors' Rights to Reproductive Health Care (laminated summary cards for providers in GA, NJ, NY, PA).

Planned Parenthood Federation of America
810 Seventh Avenue, New York, NY 10019 (212) 541-7800 (800) 230-PLAN www.plannedparenthood.org
Provides reproductive and complementary health care services, advocates for reproductive rights and reproductive health issues, and provides technical and training assistance to its affiliates. Resources: Medical Abortion: Questions and Answers; A Social Contract: The Abortion Provider Crisis (video).

Planned Parenthood of New York City, Inc.
26 Bleecker Street, New York, New York 10012 (212) 274-7200 www.ppnyc.org
Provides clinical services, education, advocacy, and professional training for surgical and medical abortion, emergency contraception, and contraceptive counseling. Resources: Counseling Guide for Clinicians Offering Medical Abortion; A Physician's Guide to Patient-Centered Care: Providing Support to Women During First-Trimester Abortion Procedures; Surgical Abortion Education Curriculum; New Choices: Medical Abortion; Counseling for Medical Abortion (video).
Population Council
1 Dag Hammarskjold Plaza, New York, New York 10017  (212) 339-0500 www.popcouncil.org
Conducts research on a broad range of population issues, including biomedicine, social science, and public health. Conducted the U.S. clinical trials of mifepristone and sponsored mifepristone’s new drug application to the Federal Drug Administration. Resources: Abortion: Expanding Access and Improving Quality; Acceptability of First Trimester Medical Abortion; Is Medical Abortion Acceptable to all American Women?; Misoprostol Alone—A New Method of Medical Abortion?

ProChoice Resource Center
16 Willett Avenue, Port Chester, NY 10573  (914) 690-0938 www.prochoiceresource.org
Provides training and technical assistance to grassroots groups so they can counter anti-choice efforts, mobilize community support for reproductive rights, and create policies that protect women’s health. Resources: Conscientious Exemptions; Co-opting Conscience: The Dangerous Evolution of Conscience Clauses in American Health Care Policy; ProChoice Matters.

Reproductive Health Technologies Project
c/o Bass and Howes, P.O. Box 33344, Washington, DC 20033  (202) 530-2900 www.rhtp.org
Builds support for a research agenda to promote development of early abortion options; educates the media, policymakers, and the public about early abortion; and convenes meetings that bring together representatives from the pharmaceutical/medical device industries and consumer advocates to develop strategies for expanding access to early abortion. Resources: Information kit on early abortion options; Facts About Fertility.

Kenneth J. Ryan Residency Training Program in Abortion & Family Planning
UCSF, 3333 California Street, Suite 335, Box 0744,
San Francisco, CA 94143-0744  (415) 502-4091 www.familyplanningfellowship.org
Helps establish resident training programs and offers technical assistance in establishing abortion and family planning services, including business plans, training materials, evaluation tools, and financial start-up support. Resources: Medical Abortion Information Packet; Speakers’ Bureau for grand rounds and presentations; Model In-Hospital Residency Training Program.
This Appendix contains information about selected sources of medications, supplies, and equipment used in providing early abortion. Inclusion of a supplier on the list does not represent an endorsement.

**Medications**

**Methotrexate**

**Boehringer Ingelheim Pharmaceuticals**
900 Ridgeway Road
Ridgefield, CT 06877-0368
(203) 798-9988
www.boehringer-ingelheim.com

**Immunex Corporation**
51 University Street
Seattle, WA 98101
(206) 587-0430
www.immunex.com

**Lederle American Home Products Corporation**
Five Giralda Farm
Madison, NJ 07940
(973) 660-5000
www.ahp.com

**Mifepristone**

**Danco Laboratories, L.L.C.**
P.O. Box 4816
New York, NY 10185
(877) 432-7596
www.earlyoptionpill.com

**Misoprostol**

**Pharmacia**
Route 206 North
Peapack, NJ 07977
(908) 901-8000
www.pharmacia.com

**Supplies**

**Allegiance Healthcare Corporation**
Cardinal Health Company
1430 Waukegan Road
McGaw Park, IL 60085
(800) 964-5227
www.allegiance.net

**Bergen Brunswig Corporation**
4000 Metropolitan Drive
Orange, CA 92863-5915
(714) 385-4000
www.bergenbrunswig.com

**Equipment**

**Berkeley Medevices, Inc.**
1330 South 51st Street
Richmond, CA 94804
(800) 227-2388
www.berkeleymedevices.com

**Ipas**
300 Market Street, Suite 200
Chapel Hill, NC 27516
(919) 967-7052; (800) 334-8446
www.ipas.org

**MedGyn Products, Inc.**
328 North Eisenhower Lane
Lombard, IL 60148
(800) 451-9667; (630) 627-4105

**Milex Products, Inc.**
4311 N. Normandy Ave.
Chicago, IL 60634
(773) 736-5500; (800) 621-1278
www.milexproducts.com

**Other supply sources**

Members of the National Abortion Federation (NAF) may order medications and supplies directly from NAF at a discounted rate.

**National Abortion Federation**
1755 Massachusetts Avenue, NW, Suite 600
Washington, D.C. 20036
(202) 667-5881
www.prochoice.org


