Abortion Without Borders: Safe Abortion Care Access in the Texas-Mexico Border Region

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SPHG 722
May 1, 2022

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Executive Summary

The Texas legislature has been aggressively hostile to abortion access for years. The passage of SB8 in 2021 was a direct attack on abortion access that incentivized anti-abortion citizens to act as vigilantes. In June of 2022, with the Supreme court’s decision in Dobbs v. Jackson Women's Health, any remaining federal protections for abortion access in Texas crumbled. Abortion access is a key aspect of obstetric and gynecological health care and one of the most significant protectors against maternal mortality. The Guttmacher Institute has reported regularly that restrictive legal environments do not lower the numbers of abortions sought, but make the abortions that people receive unsafe in turn (Guttmacher Institute, 2017). Worldwide, unsafe abortion is responsible for 13% of global maternal mortality, making it the lead cause of avoidable maternal death (Haddad & Nour, 2009). Currently Texas has a severely restrictive legal environment, with legislation prohibiting abortion in almost all circumstances. This means that populations seeking abortion care in southern Texas who lack the resources to travel to states with less hostile environments are now at increased risk for unsafe abortion and the

resulting risks to their lives and health.

At Abortion Without Borders (AWB), our goal is to increase the safety and access to options for comprehensive abortion care in the border region of Southern Texas. Southern Texas is home to more than 19 million people within 100 miles of the border (The U.S.-Mexico Border Region at a Glance, 2021). This region's population is highly diverse, with indigenous peoples, undocumented persons, and people of color (P.O.C.) making up higher proportions of the population in comparison to non-border counties. The border region population experiences a higher frequency of poor health outcomes and economic hardship, while education, work status, and household income are relatively low compared to the rest of the state (Pillai & Artiga, 2022). Healthcare provider density in this region is particularly low– with the density of obstetrics and gynecology providers being 33% lower in Texas border counties compared to non-border counties (Pillai & Artiga, 2022). This exacerbates the risk for negative health outcomes and perpetuates the cycle of ill health amongst border populations, who are already particularly vulnerable to systemic discrimination and neglect.

Our priority population within this region is low income individuals who fall at or below 200% of the federal poverty line. Abortion care can be expensive, and having to obtain that care outside of one's home state can be even more costly than typical in-state procedures. The current median cost for in-clinic medication abortion in the U.S. is approximately $560 USD, but providers report the cost of Mifeprex to be significantly lower at about $90 USD per pill (Kaiser Family Foundation, 2023; Upadhyay et al., 2022). These estimates do not account for the cost of interstate or cross-border travel, which can cost hundreds or thousands of dollars. This is highly limiting for most populations, but particularly those which are low-income, who might choose to rely upon unsafe abortion methods (utilizing coat hangers, knitting needles, overdosing on birth control, etc.) as the best alternative to mitigate cost barriers (Disi et al., 2022). As a result, this population is especially vulnerable to the harms of reducing accessibility of care options. It is vital that we provide a mechanism by which this group can circumvent some of the major expenses that might otherwise be required to obtain care outside of our network. The option of cross-border travel to utilize physician-facilitated, self-administered medication abortion services can serve as a safer alternative for pregnant people in the target population. AWB aims to make this alternative attainable for pregnant people through educating patients on their options, connecting pregnant people to AWB staff who can connect them to medication resources, and strengthening community social networks to provide social and emotional support.

Our intervention is a multidimensional, grassroots, and equity based approach to increasing the safety of early abortion access in the Texas-Mexico border region. This solution will succeed by enhancing and strengthening grassroots activists networks, distributing educational materials to key abortion seeker touchpoints like Texas community centers and

Mexican pharmacies, and providing medication abortion kits to the most resource poor abortion seekers. Misoprostol – the medication proposed for this intervention– has been proven to be safe and very effective, and can be procured easily and legally in many Mexican pharmacies (Ona Singer, 2016). Our intervention is modeled on the work of pre-existing clandestine abortion access networks in Mexico such as Las Libres that have decades of experience providing safe self managed medication abortion (Ona Singer, 2016). Academic literature has proven the success and efficacy of utilizing telemedicine to prescribe and procure SMA (self-managed abortions) materials, suggesting our intervention model to be both feasible and effective (Aiken et al., 2021). Folks in southern Texas experience complicated and sometimes opposing challenges to accessing abortion care including varying language preferences, documentation status, and health literacy. By providing multiple methods of abortion access and opportunities to provide education to patients this intervention will more equitably increase abortion access safety.

Our initiative focuses on three main objectives: 1) Increasing the availability of English language informational/educational materials about abortion options in Mexican pharmacies, 2) Increasing the successful delivery of medication abortion to low income individuals in Texas who are seeking it, and 3) building the density of abortion options information centers in the border region. To evaluate the effectiveness of our program in providing care/meeting these goals, we will examine the data we collect from partnered pharmacies, patient experience surveys as well as surveillance data on abortion options centers, performing a quasi experimental analysis largely utilizing one-group pre-post observational methods. Data on the density of abortion care options will be recorded at the baseline and the outset of the material dissemination phase (year 2). Mixed-methods analysis will be used; quantitative analysis will focus on changes in provider density and border proximity, while qualitative analysis will examine accessibility and engagement with program materials in pharmacies and care clinics. These analyses will inform the success of the objectives within the program framework, and can inform future interventions utilizing community social networks for reproductive health interventions.

We seek to serve a population whose reproductive rights are quickly disappearing. Comprehensive abortion-related care is vital to the overall health of those who can become pregnant, especially in an area that is already affected by socioeconomic challenges, poor maternal health outcomes, and the injustices of structural racism on health. In the face of the downstream effects of Roe v. Wade's repeal on Texas's abortion restrictions, it is now more important than ever to ensure that people living in the border region have options for safe abortion care. In a state that actively seeks to limit options for people facing pregnancy, we aim to build extensive networks of care that can alleviate the individual burden of those facing unwanted pregnancy. Our program adapts aspects from several successful interventions in similarly polarized political climates to fit our population and region of interest.

Description of the Health Problem

Community Context

Since the US Supreme Court's decision in June of 2022 to end federal protections of the right to abortion care, accessibility of care has rapidly diverged across the country (Dobbs et al. v. Jackson Women's Health Orgn. et al., 2022). Both historically and in the present day, reproductive control has been particularly violently and coercively directed at poor, immigrant, and non-white women (Hiemstra, 2021). The examples are numerous: widespread forced sterilization of nearly one third of Puerto Rican women by the 1960s, the "Mississippi Appendectomy" of the 20th century South, or the Trump administration's policies refusing abortion access for detained immigrant teens (Mass, 1977; Hiemstra, 2021). The social and cultural makeup of the US-Mexico border region in Texas creates particular challenges for those seeking abortion care. Access to self-administered chemical abortion care through medications

such as misoprostol is less inhibited in nearby Mexico, leading a growing number of people to cross national borders to access these medications (Burnett, 2022). The large BIPOC (black, indigenous, and people of color) and immigrant communities in the area of interest, however, are particularly challenged in accessing cross-border movement as a method of care access. Local institutionalized racism, over-policing of the border, and economic inequality further exacerbate these challenges in an environment where crossing the border is already a dangerous, traumatizing experience for many (The U.S.-Mexico Border Region at a Glance, 2021).

Geography also plays a pivotal role in abortion care access. As one of the largest countries by landmass, much of the conversation concerning travel for abortion care services in the United States is concentrated on state to state travel. However, the 1,933 mile long U.S.-Mexican border may have a significant impact on the abortion options and accessibility of the

roughly 22 million people who live within 100 miles north or south of it. The northern side of the border is more densely populated, leaving roughly 19 million people in the region of interest at risk of impact by increasingly restrictive US abortion laws (The U.S.-Mexico Border Region at a Glance, 2021).

Despite the wide breadth of challenges currently presented to those seeking care, existing social frameworks in Mexico model a path towards increasing care access (Veldhuis et al., 2022). Therefore, we propose programming that will create cross-cultural opportunities for engagement with these long standing acompañantes organizations to locate, provide resources, and support folks looking for safe abortion related care (Zavarise & Haroun, 2022) . Establishing communication networks between Mexican organizations, local US border-region Community Health Centers, local Mexican pharmacists, and volunteers with lived experience will help us to provide full patient centered care; in hopes of circumventing ever-changing legal risk or health ramifications for patients in need of time-sensitive care. Although this proposed intervention has several limitations, including its extra-legality and lack of availability of public and federal funding, its proven efficacy remains promising (Veldhuis et al., 2022).

Determinants

Abortion restrictions disproportionately affect those who already face various intersecting barriers to accessing basic needs, including healthcare. Abortion restrictions fall most heavily on people with low incomes, Indigenous peoples, people of color, young people, and immigrants (Adams & Arons, 2014). These populations are disproportionately impacted by abortion restrictions due to economic barriers, geographic challenges, and racism that are a longstanding and unfortunate part of the U.S. healthcare system (National Partnership, 2018). Federal and state abortion-related policies further target people living with low incomes. For example, federal funding restrictions have created a significant financial barrier to accessing abortion care services for racial and ethnic people with low income. These restrictions for abortion care in the U.S. date back to 1976 (Harvey et al., 2021). The Hyde Amendment prohibits spending federal Medicaid funds on abortion coverage. State Medicaid funds can be used for abortion, but only seven states have affirmatively provided this coverage (Guttmacher Institute, 2023). Due to the persistent exclusion from economic opportunity, Black, Latinx, and Indigenous populations are disproportionately impacted by these policies (Harvey et al., 2021). The Hyde Amendment works in opposition to one of the fundamental goals of Medicaid: to protect people with low incomes from financially catastrophic medical expenses. However, the financial costs of abortion are not limited to the procedure itself. For example, even when low income people in Texas are able to secure financial aid through abortion funds to cover the procedure's cost, many still lack access to care because they cannot afford related travel costs or childcare (National Women's Law Center, 2022).

Abortion Without Borders aims to increase the safety of self managed abortion in southern Texas in order to reduce maternal mortality and promote reproductive justice.

Reproductive justice and health justice place similar emphasis on structural barriers and structural solutions. Health justice is a framework that "addresses the social determinants of health that result in poor health for individuals and consequential negative outcomes for society at large" (Wiley et al., 2022). Likewise, the reproductive justice paradigm emphasizes meaningful state and social support throughout one's life and in all reproduction areas (Wiley et al., 2022). Abortion Without Borders will apply this holistic approach which recognizes that individuals' and communities' health depends on their environments and the resources at their disposal. AWB will be established in two main offices–one in the US and one in Mexico–which will allow our intervention to better serve people seeking care on both sides of the border, facilitate patient travel, and ensure organized transportation of medication packets while avoiding legal complications that might arise from being solely based in the U.S. Furthermore,

our intervention seeks to integrate various equity considerations including varying language needs, socioeconomic realities, limits on patient freedom of movement due to documentation status, and/or fears of the criminal justice system and border patrol due to systems of racism and oppression.

Identifying Community Assets and Needs

Our team's first approach will be to identify networks of community partners present within several communities in the U.S.-Mexico border region of southern Texas. We anticipate the need to take extra care in reaching out to community partners who have a positive attitude towards abortion rights and thus can guarantee a safe space environment for community outreach and discussion. We will begin to assess community assets by reaching out to a set of initially identified local community partners such as acompañantes programs, local LGBTQ+ centers, community health clinics, progressive religious organizations, and select federal health services. Using a snowballing technique to identify additional stakeholders as evidenced in Franco-Trigo et al. (2020), community partners will be asked to identify and provide connections to additional partners in the community that may be able and willing to offer services, meeting spaces, hosting community nights, and other support. In order to promote equitable access and community partnerships, both Spanish and English speaking organizations will be included and communicated with in their preferred languages. Though community partners may be limited due to local politics, explicit efforts will be made to contact and include organizations with indigenous, undocumented, and non-white memberships. Gaps in data collection, groups who aren't able to be represented, and other vital information that is not identified will be supplemented by available census, CDC, and other publicly available relevant surveillance information.

Our second step will focus on engagement with community members, informing them of the purpose of the Community Health Assessment and facilitating discussion to identify important directions for intervention. This will be achieved through conducting a series of focus groups and public forums hosted by safe community spaces identified in the first step. These focus groups will hone in on needs of individual partner groups–like patients, doulas or acompañantes, or pharmacists–aimed at helping to illuminate possible inconsistencies or missteps when working with vulnerable populations. Community forums and listening sessions will be held in six different Texas cities near the border region and include all partners involved in receiving and providing care. When possible, we will encourage focus group leadership by community members in order to promote community engagement. All sessions will be recorded and transcribed following all individual focus group attendee's approval if granted. These sessions will serve as a platform for community members to voice their concerns and workshop visions for locally relevant abortion access interventions. To promote a locally focused solutions based workshop environment, topic questions will include how community members might approach seeking abortion services in the event of pregnancy, what options they feel they have, concerns and needs regarding the abortion process, perceptions of safety in the border region

both in Texas and northern Mexico, and their comfort with the concept of crossing the border to obtain care. We will use the resulting qualitative data to identify leverage points for improving abortion care accessibility. These community forums will help to identify community fears, strengths, priorities, and cultural preferences when seeking abortion care. Spanish-speaking facilitators will be present during focus groups and public forums, to allow all to participate in their native language.

Stakeholder Inclusion for Community Health Assessment

Our intervention is seeking to promote safer abortion accessibility for southern Texas residents, particularly those who have limited abilities to reach less restrictive areas of the

country for care. Our primary beneficiaries of this program therefore are folks with limited means who currently need an abortion or may need an abortion in the future. The inclusion of various multi-level actors is necessary to maximize intervention impact and protect individuals seeking abortion care. Our community partners range in serviceability, with folks working within their own communities all the way to federal health services with the power to help provide safe and care access for all folks within the country. This group of partners provide a range of personable care, safety measures, and resources to aid folks navigating barriers to safe abortion care. Our partners are: sexual and reproductive health (SRH) organizations (such as The Brigid Alliance and Whole Women's Health) Mexican and US (non-Texas) or retired clinicians, Mexican pharmacies, local activist groups, community health workers, local grassroots acompañantes networks, and Human Health Services (HHS). Prior to partner engagement, the research team will ensure that there are adequate levels of Spanish fluency within the research team in order to maximize the potential for community engagement.

We will expand efforts with local grassroots & acompañantes organizations like Las Libres, which have existed for decades throughout Mexico helping provide individual support through companionship, protection, and holistic care for pregnant people seeking abortions during periods of local or national restriction. On the U.S. side, volunteer Abortion Doulas will provide emotional, social, and practical support to individuals seeking abortion care through our initiative.

Two key considerations for engagement strategies must be established to successfully assemble our partner network. Firstly, building partnerships will allow for streamlined communication and the connecting of existing networks. Second, rebuilding trust is vital for folks who have experienced or heard of experiences of poor abortion care. Therefore, we have identified many grassroots organizations within the area with whom we will partner with to assess and understand current community needs and implement strategies for acting on those needs.

Our inclusion initiatives will scale from individual partner involvement up to cross national program wide annual gatherings in Mexico or the U.S. These gatherings will provide opportunities for continuous quality improvement, collaboration on program initiatives, and to celebrate current achievements. The inclusivity of these gatherings provides opportunities for patients, providers, and partners to share needs and create future planning and work to holistically address community needs acknowledging the various players and powers.

Stakeholder Engagement Methods for Community Health Assessment We will generate awareness and encourage the spread of our impact in the rural Texas setting by combining methods of social marketing with a community-based distribution approach for the assessment and intervention steps of our model (Prata et al., 2013). Our team plans to incorporate a well established unifying symbol for abortion care into each step of our CHA process and proposed solution plan. The green handkerchief (pañeulos verdes) began as a symbol of abortion care access among activists in Argentina and has since become a powerful international emblem for abortion rights (Hernandez, 2022). Our strategy is to adopt this symbol

as a way to create an allied sense of network and community that connects us to other efforts both in the US and beyond borders. We aim to unite the efforts of the United States based Brigid Alliance with Mexican acompañantes organizations under the Reproductive Justice Framework in order to center the concept of reproductive autonomy rather than only the right to abortion in the community we aim to serve (Messing et al., 2020). Through this alliance under this framework our intervention is poised to counter attempts at reproductive control that stem from white supremacy and xenophobia. This framework also opens the possibility for our intervention to change reproductive priority with changing legal environments: for example, if there are future threats to birth control access.

Finally, the HHS (Human Health Services) represents the federal voice of health, specifically the border health commission representing the areas we are focused on. The Federal government has had a loud voice in opposing the sweeping restrictions enacted state by state upon abortion related care and services, but has yet to deploy HHS–a federal entity–in helping individuals gain proper access to the care the federal government has deemed all individuals deserve. Using a human rights based approach, we will demand the engagement of federal entities like the HHS to ensure the protection of the right to health of the southern Texas population, regardless of Texas state law or the documentation status of individuals (UNSDG, n.d.). Through partnerships with federal organizations grounded in the internationally recognized human rights framework, we seek to maximize legal and social protections for individuals and organizations working in a pro-choice capacity in hostile state territory.

Data Collection Methods

Although there is limited quantitative research regarding abortion in the Texas-Mexico border region, there are four secondary sources we plan to use to inform our community health assessment. The following sources report abortion incidence and the characteristics of people who obtain abortions in the U.S: the Centers for Disease Control and Prevention (CDC), the Guttmacher Institute, and the Society of Family Planning's (SFP) #WeCount project (Ranji & Diep, 2022). We plan to obtain quantitative data using the CDC Abortion Surveillance System, which documents the number and demographic characteristics of patients receiving legal induced abortions, as well as the number of abortion-related deaths in the United States (CDC, 2021). This data will provide us with the characteristics of people in Texas obtaining abortions such as age, race/ethnicity, marital status, period of gestation, and type of abortion. Data from the Guttmacher Institute studies will provide us with trends in abortion service provision at the state and national level (Guttmacher, 2023). We acknowledge the limitations of these data sources as there might be some individuals that seek abortions in an informal capacity (e.g. seek abortion outside of an official medical facility). However, obtaining crucial data and policy analysis on the characteristics of people seeking abortions will aid in painting a comprehensive picture of met and unmet reproductive health needs in southern Texas. Lastly, the US Census will provide us with a better view of social determinants of health (SDOH) and the possible effects of SDOH on outcomes.

We will also utilize qualitative data to inform our community health assessment plan. We will conduct focus groups discussions (FGDs) in both English and Spanish in six Texas cities in the border region to solicit community input regarding access to abortion care services. This will be critical in informing our design and delivery of our intervention which aims to reduce the gaps in access to safe abortion. To protect the privacy of individuals who participate in FGDs and community forums, we will take the following measures; host FGDs and community forms in a safe and accessible venue to community members, avoiding medical and governmental facilities. During FGDs and community forums we will encourage participants to avoid using their first or last name (or any identifying information that may put them at risk) and instead use a pseudonym. The research team will store all data in a password protected (Redcap) database that can only be accessed by the research team. Once data is transcribed, we will omit any

identifiers from transcripts to maintain participants' confidentiality. Findings from FGDs and community forums will be reported in summary form and only contain de-identified data. Following the qualitative data analysis from the focus groups discussions and community forums, an anonymous individual survey will be distributed to identified partners, clinics, and other centers offering services that may be given out with patient forms or by center staff. To identify existing efforts by local organizations to improve abortion care access within southern Texas communities we plan to interview potential community partners. The quantitative data obtained from this survey will help to ascertain the priority of different needs and key points for

intervention regarding access to abortion care services that were identified in the qualitative sessions on a larger, community wide scale. We aim to collect responses from a large and diverse group of individuals who are representative of the community served. We anticipate a significant non-English-speaking population; therefore, survey questions will be translated from English to Spanish. The triangulation of data collected using different data collection methods (informal conversations, FGDs, surveys and in-depth interviews) and from the different stakeholders will provide us with substantial material for cross checking and detecting emerging themes and patterns as well as ambiguities and contradictions. For instance, the accounts from community members, pharmacists, and community health workers, will provide us with diverse perspectives on the question of access to medical abortion and simultaneously lead to a more comprehensive understanding of the access situation of abortion in Southern Texas.

Reviewing and Prioritizing the Evidence: L.E.A.D. Evidence Report

Decision Maker - from EBDM Part 3

This evidence report is intended to inform the decisions of potential funders–such as The Safe Abortion Access Fund, The David & Lucile Packard Foundation, etc–as well as the existing local organizations with which we wish to partner to support the implementation and evaluation of a program aimed at increasing safety of and access to options for comprehensive abortion care in the Texas-Mexico border region. For the benefit of decision makers, this report aims to answer the following question:

> How can community-based care networks (such as those utilized by the acompañantes networks in Mexico) be utilized to improve access to abortion medications in our region of interest?

Strategy for Locating Evidence

Needs Assessment

Our Community Health Assessment (CHA) employed a multi-layered strategy for assessing community needs. We conducted three main phases of inquiry to evaluate the abortion care related needs of pregnant people and people who can become pregnant in the Texas-Mexico border region. As a preliminary assessment, we utilized data from the US Census, CDC, and other relevant surveillance data sources to characterize the overall health status of our region of interest. Next, we interviewed potential community partners to identify existing efforts by local organizations to improve abortion care access within southern Texas communities. Thirdly, we administered a series of locally guided solutions based community focus groups in both English and Spanish in six Texas cities in the border region to allow community members to input and workshop key priorities for intervention.

Literature Review: Search Strategy

Our team performed a literature search using PubMed, UNC Articles+, and Google Scholar. This search was implemented to investigate and compile evidence for effective intervention strategies for increasing abortion medication access in southern Texas. We also

searched for evidence of previously executed strategies addressing abortion care access in other border populations that mirror the restrictive climate of our region, as well as alternatives based on cross-border travel for abortion care and self-managed abortion with telemedicine support. Our team utilized the L.E.A.D. framework to categorize and evaluate the quality of each piece of evidence. Two representative search strings used in our search strategy were: [abortion AND (South* "Texas" or TX) AND Mexic* AND travel] and [abortion AND (self-manag* OR self-induc* OR medication OR pill) AND (solution OR intervention) AND cross-border]. The

literature review also leveraged an existing bibliography obtained from our white paper entitled "Early Abortion Care Accessibility in the US-Mexico Border Region and Cross-border Movement for Chemical Abortion Care Services."

Screening

The results of the literature review were screened at the following levels:

Identification Records identified through database searching: n~600
(~300 deemed not relevant, excluded from consideration)

Screening (abstract) Records screened at the abstract level: n~120

Records included for full-text screening: n~65

Screening (full text) Records screened at the full-text level: n~65

Included	Sources included in informative literature review for White Paper: n=32 Studies included in Evidence Table: n=11

Stakeholders

Our team identified and engaged primary stakeholders to inform the main directions of our evidence-based intervention (EBI). People in southern Texas who are pregnant or can become pregnant are the most obvious beneficiaries for our intervention. Additionally, medical service providers are the cornerstone for providing safe medication-based abortion care. Both pharmacists and physicians are responsible for the facilitation and provision of the materials and consultation required to utilize this care. Physicians and medical professionals often serve at the advisory or leadership level for healthcare policy; on the AWB advisory board they serve as advocates for policies to promote sexual and reproductive health at the local level. Thirdly, local grassroots & sexual and reproductive health organizations provide preexisting social and activism networks, which our intervention will rely upon. We also considered the positions of local and state level politicians in Mexico as well as Human Health Services.

We constructed a Pugh matrix to evaluate each stakeholder's top priorities (Appendix II, Table 5). We then designed four potential intervention alternatives and graded the potential of each to address the most common stakeholder priorities: medication access, telemedicine access, human rights, and safety.

Evidence Table

Please refer to Appendix I for the L.E.A.D Framework Evidence Table

Summary of Evidence

Why Limited Access to Safe Abortion Care Options in Southern Texas is a Problem

Reproductive autonomy is a vital human right that must be protected and promoted. It is estimated that approximately one in four women in the US will have an abortion by age 45 (Jones & Jerman, 2017). The lack of access to abortion-related care to birthing folks in over 20 states leaves all of those people vulnerable, with the power of their personal health in the hands of politicians and the state. Evidence has shown that restricting access to abortion has a direct impact on increasing rates of unsafe abortions (WHO, 2021). Restrictive abortion laws will disproportionately affect those who already face structural barriers to healthcare, especially

Black, Indigenous and other people of color, immigrants, and those working to make ends meet (KFF, 2021). Texas already has higher rates of maternal mortality than most of the United States (22.9 deaths per 100,000 live births) (CDC,2021). Research shows that trends like these will likely only worsen over time under the weight of abortion access restrictions, with states that restrict abortion experiencing a higher perinatal and neonatal death rates compared to more liberalized states (Commonwealth Fund, 2022).

Due to the recent overturning of Roe v. Wade and a deficit of large community-wide care efforts, it is vital that we work to fund and maintain robust, sustainable, and community responsive efforts towards easing access to safe and proper abortion related care. The extreme volatility of the abortion legislation landscape is somewhat novel, meaning many blueprints have not yet been created for how to most effectively increase sustained access to safe abortion related care. To establish an adaptive response to reach more folks seeking proper abortion care in our region of interest, we must establish a new care system that integrates the resources in the area into a new network of efforts.

What Should Be Done About Limited Access to Safe Abortion Care Options Improve abortion access in the Texas-Mexico border region. Due to the stigmatized nature of abortion care and the novelty of the emergent legal landscape both established evidence-based interventions as well as data-supported individual patient solutions were examined. Our criteria for evidence required sufficient quality and quantity of data proving the effectiveness of an intervention or sufficient quality and quantity of historic data that could be applied as predictive of patient behavior in newly restrictive environments. Our four potential interventions were 1) Supporting the travel of patients to neighboring (or distant) states with liberal abortion laws; 2) Providing telemedicine counseling and mailing abortion medication to patients; 3) Supporting the international travel of patients across the Texas-Mexico border to acquire medication and care in Mexico; 4) A hybrid cross-border solution that addresses both the movement of abortion seeking patients and abortion medication across the border. Based on the decision criteria identified with stakeholders (medication access, telemedicine access, human rights, safety, counseling for priority populations, and cost), the hybrid approach was selected. Though the hybrid solution and the telemedicine-only solution received the same score in the decision matrix, the hybrid solution was selected due to its resiliency to changing legal environments which make it more appropriately suited to the highly volatile legal environment currently present in the US.

Rationale

Access to abortion care is highly time sensitive. Thus it is important that, when designing alternative solutions to care in highly restricted environments, careful attention be paid to the local landscape and how it may be leveraged to facilitate care. There is a historic precedent for the distribution and education of medication abortion care materials through grassroots efforts across Latin America (Walsh, 2020). Our theory of change is to expand these networks and knowledge across the US border into southern Texas by leveraging the cultural and community connections throughout the border region. Furthermore, research that shows increased rates of Texas residents seeking abortions in other states after restrictive legislation was put in place makes it clear that people are already traveling to obtain abortion care (Raifman et al., 2021).

By centering these interventions in Spanish speaking and cross border communities this promotes access for US populations that are already at a higher risk for socio-economic barriers to accessing abortion care through more traditional means (SFP, 2022).

Effectiveness

Several emerging findings establish that the demand for telemedicine and self

administration of medication abortion (SMA) in the United States increases in hostile policy climates (Aiken et al., 2021). For example, recent data from the Society of Family Planning (2022) proves the need for alternatives to the medical establishment for safe abortions in Texas. Furthermore, research indicates that priorities for alternative solutions for abortion care access should be placed on travel for care in situations in states like Texas where legislation is so restrictive (Raifman et al., 2021). We will modify a model of community-based distribution to fit our intervention's cross-border population. This method of misoprostol distribution for early abortion care with provider guidance and followup is effective and provides a framework for safe abortion with community support (Foster, 2017). These findings align with the updated World Health Organization guidelines that now thoroughly recommend self-managed medication abortion as part of a full range of safe and effective options for abortion care (WHO, 2022). We plan to complement this strategy with telemedicine services. Compelling evidence shows no test telemedicine abortion is safe, effective and improves care (Aiken et al., 2021). In this study of telemedicine versus in-person abortion care, the effectiveness of abortion services was higher with telemedicine, and more abortions were provided earlier in the gestational period. By implementing a telemedicine-hybrid model for medical abortion, we expect to see improvements along the same lines after implementing these strategies for our population in the Texas-Mexico border region.

Estimated Reach/Impact

There are an estimated 520,000 pregnancies in Texas each year, with more than 39% reported as being unwanted or unintended (Maddow-Zimet & Kost, 2021). We aim to establish local community networks providing resources for safe abortion care options throughout the Texas-Mexico border region, which is home to more than 2.7 million Americans (Texas DHHS, 2017). Due to the constant bidirectional movement across the border, recent estimates of this region's pregnant population are unclear. Various demographic characteristics of the region suggest a relatively high proportion of the population is pregnant (in comparison to other regions of both Texas and the United States), indicating a need for increased access to reproductive care (Vasquez et al., 2015). This intervention will be carried out at the community level to connect local providers and individuals facing pregnancy. Local networks will be connected to each other across the region via digital communication platforms in order to disseminate information and resources. The success of networks along the most restrictive areas of the border region will likely lead to the expansion and adoption of new, community-level networks farther from the border region. Ultimately, this intervention aims to provide support to as many pregnant people across Texas and other border states as possible. We anticipate to evaluate the estimated benefit through a reduced percentage of unwanted pregnancies carried to term and a reduced maternal mortality and morbidity associated with unsafe abortion and unwanted pregnancy.

How to Implement with Priority Population

We anticipate our evidence-informed intervention will be best implemented by connecting extant grassroots abortion services networks, pharmacists, and medical providers in Mexico with identified community partners across the border in Texas. We can adapt aspects of successful community-based distribution solutions to the long-distance medication delivery or cross-border travel model that best fits our priority population. Our proposed recommendations

may inspire hesitancy from stakeholders that feel an intervention should be staged solely on one side of the border. Information regarding the need for a multipronged, internationally collaborative effort should be readily provided to inform interested parties in both English and Spanish. Our intervention is also likely to receive attention from lawmakers or organizations that oppose increasing access to abortion care, as the topic of abortion is so highly contested within

the United States and Mexico alike. We should leverage our partnerships with funding organizations, human rights groups, and political stakeholders in conjunction with Human Health Services (HHS) to build a flexible approach that provides layers of access through multiple avenues and resists possible pushback.

Program Alternatives and Recommendations for Policymakers and Practitioners Using the previously enumerated evidence, we conducted a structured decision-making process with several relevant stakeholders. In discussion with our stakeholders, in selecting possible solutions we combined both evidence-based solutions that have existed in non-US contexts as well as including unstructured solutions that there is clear existing evidence for within the United States. There is clear evidence that when abortion access is threatened, patients travel across state lines to seek access (Raifman et al., 2021). Though these solutions are patient-led and are not necessarily associated with interventions from public health professionals, they represent the most regularly accepted and publicized option for patients living in restrictive states. Existing evidence-based interventions such as telemedicine options were included as examples of more intentionally developed evidence-based solutions, though the difference of context necessitated close scrutiny of appropriateness for the target population and environment (Aiken et al., 2021). Criteria for comparing evidence-based solutions were selected through a participatory multivoting process.

We structured our decision-making using a Pugh Matrix tool, evaluating each of the potential solutions with respect to the agreed upon criteria. Based on the results of this process, two possible solutions were found to be equally suited to deliver on the criteria prioritized by the participating stakeholders (Appendix I, Table 5). Telemedicine consultations with delivery of medication by mail was found to be equivalent to the proposed hybrid solution that would combine the aforementioned remote option with the facilitation of patients traveling to Mexico to obtain their medication directly. However, due to the volatile legal and regulatory environment at the border, and after consultation with stakeholders, it was decided that the added resiliency of a hybrid solution is necessary to maximize patient protection. Furthermore, aspects of the target population may be better served by various aspects of the hybrid solution. Therefore, based on the results of our stakeholder analysis reviewed in the legal, demographic, and environmental context of the problem, we recommend that the hybrid intervention be implemented. This intervention should be structured with strong organizational ties to existing grassroots abortion services networks such as Las Libres and pharmacists and medical providers in Mexico. The intervention should be expanded and supported through partnerships with US based stakeholders such as Whole Women's Health, the Brigid Alliance, HHS, supportive politicians, and US based non-Texan or retired medical service providers. Based on the evidence as well as a thorough analysis of the personal, environmental, and legal landscape the target population must navigate, we are able to make a strong recommendation with respect to the effectiveness and feasibility of establishing a hybrid intervention approach that will support the travel of both people and medication across the Mexico-US border with telemedicine based consultations.

Gaps in Evidence - Match, Map, and Patch

The scarcity of evidence-supported solutions for improving access to abortion care is a limitation. The sociopolitical climate of the Texas-Mexico border is unique from many other regions of the world in which past abortion access interventions have been successfully

established. However, we plan to implement our intervention using the best available "real world" data. By using existing systematic records collected by community-based organizations providing access and support for self-managed abortion (SMA) and building close partnership with these trusted groups, we can obtain additional expertise from the community in the form of

qualitative data and address these limitations by translating developed approaches into a local context.

Design and Implementation

Program Plan

Narrative Summary

Our program will increase the safety of clandestine early abortion access in southern Texas along the Mexico-US border. This will be done through a three-pronged approach. First, we will source, package, and distribute misoprostol only medication abortion kits that will include instructions and contact information for additional support. To ensure that these kits meet the WHOs definition of safe abortion we will organize a network of telemedicine support by enlisting volunteer providers and abortion experts from other US states and Mexico. Access to these providers will be included in the misoprostol kits. Finally, to support abortion care seekers who may choose to travel to Mexico to seek care, we will ensure that resources with instructional information and network access are available in Spanish and English in Mexican pharmacies near the border.

Our program takes into account multiple aspects of the SEF. At the individual characteristics level we account for differences in documentation status and resources by supporting two pathways to SMA access–patients driving themselves to Mexico or the AWB network delivering kits to them. At the interpersonal connections level or work to increase grassroots organizational connections will expand opportunities for patients to come in contact with the network and thus receive the additional education and medical resources AWB can provide. The dual-methods of access intervention that we have designed is an adjustment to the models of existing abortion networks like Las Libres because it takes into account the added impacts of the international border to patient access and safety. Our program design assumes that patients who can cross the border themselves will be motivated to do so in order to access combination mifepristone-misoprostol abortion which generally provides a more pleasant patient experience as it is more effective and associated with fewer gastrointestinal side effects (Ngoc et al., 2011).

The program will be delivered by the Abortion Without Borders team which will include regional leadership, as well as translators, drivers, community liaisons, and data and research specialists that will together organize, implement, and evaluate the AWB intervention. Together, this team will advance partnerships between grassroots progressive community organizers in order to expand patient catchment and reduce the population at risk of unsupported unsafe abortion. This team will also develop and distribute 10,000 English Language instructional pamphlets and 5,000 misoprostol only self-managed abortion kits. Finally, this team will implement a thorough patient experience evaluation process in order to evaluate the program for sustainability and make adjustments to react to community needs.

Our intervention seeks to consider varying positionalities and priorities of the potential abortion seeking populations in Southern Texas. Various equity considerations were kept in mind when selecting methods of intervention and how each of these methods meets the needs of different populations. For those with the financial resources and documentation, they may choose to travel to Mexico themselves to seek care, thus the inclusion of English and Spanish language instruction and network resources to ensure that border crossing patients receive the necessary education and safety net that is required to ensure that their abortion is safe. Combination mifepristone and misoprostol abortion may be available to these patients who are

able to cross the border themselves, which may act as a motivating factor. However, our deliverable misoprostol only kits are available to patients who are unable to cross the border themselves due to any number of reasons including: documentation status, financial resources,

childcare restraints, and ability to take time off of work. For these patients we will supply medication, information, and access to telemedicine directly.

Below are our primary goals with associated short and long term objectives. The goals summarize the outcomes and impacts demonstrated in the logic model.

Goals and Objectives

Goal 1: Increase safety of abortion care in the Texas-Mexico border region.

Short-term:

1. Increase successful provision of self-managed abortion low-income individuals seeking it in Texas by 20% by year 5
2. Increase the number of Mexican pharmacies by 15% with English language abortion educational resources by year 2

Long-term:

1. Reduce the number of unsafe abortions in the region by 40%
2. Reduce the number of hospital visits for adverse outcomes from self-managed abortions by 70%.
3. Reduce Texas maternal mortality rate by 5%

Goal 2: Increase knowledge of abortion options and safety within the region.

Short-term:

1. Build density of abortion options information centers by 25% by year 2
2. Increase the number of connected grassroots abortion workers/doulas by 50% in the Texas-Mexico border region by year 3 of the program

Long-term:

1. Increase local understanding of realistic abortion options and reduce stigma regarding abortion
2. Increase the political support for liberalizing abortion laws in the region

Logic Model

Below we have inserted our logic model. The logic model details priority steps and input resources in achieving the desired outcomes and impacts of our program. Activities and outcome goals were structured to include equity considerations for socioeconomic challenges as well as differing language needs in our region of interest. Supporting outputs detail ways in which we can approach the process of fulfilling these outcomes.

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES	IMPACTS

At least 75% of hired staff are either native speakers and/or have at least a CEFR level B2 proficiency in both languages. A platform (i.e. signal) in which to have safe, unsurveilled communication for patients and abortion workers Partnering Mexican pharmacies who can legally provide misoprostol Local pro-choice doulas/abortion workers willing to participate in activism efforts Local grassroots staff/activists with training in abortion options education & outreach Funding to employ several local program directors to begin implementation and recruitment efforts at the local level	1.Develop 2 pamphlets: One explaining how to access SMA in MX or how to access the miso distribution network. The 2nd on the safety of medication SMA, the risks of unsafe methods, and how to seek medical attention if necessary. 2. Identify community partners – local organizations, coalitions, clinics that support the target population. 3. Train and support doulas/acompañantes 4. Disseminate 10,000 copies of each pamphlet to all partner organizations through community events and the post. Keep count of where, how many, and to whom materials are distributed. 5. Build relationships with activists in Mexican border communities 6. Reach out through professional networks (linked-In) and foundation inquiry websites to potential local or national long-term funders. Invite potential funders to join a listserv which will distribute quarterly newsletters sharing program results, evidence, community testimonials, and future needs. 7. Develop patient experience surveys to be administered at consultation and after services have been provided 8. Survey administered to 100% of patients seeking services.	1. 5,000 green scarf related distrutables printed/manufactured and delivered to partner organizations 2. 40 community partnership events held for networking + connection strengthening 3. 40 Abortion doula/acompanante training events 4. 20,000 English & Spanish language information pamphlets distributed to partnered clinics 5. Procure 5,000 medication abortion packets on the Mexican side of the border by end of year 1. 6. 100 fundraising inquiries sent to potential donors 7. Pre- & Post-intervention surveys administered to abortion seekers who sought and/or received any resources from AWB including SMA packets. These surveys will identify key gaps in care, most relevant metrics of quality of experience, social determinants affecting care access, and other feedback to improve patient experience. These surveys will be used in an iterative evaluation process that AWB will use to respond quickly to changing access dynamics.	1. Increase the number of Mexican pharmacies by 15% with English language abortion educational resources by year 2. 2. Increase successful provision of self managed abortion low income individuals seeking it in Texas by 20% by year 5. 3. Build density of abortion options information centers by 25% by year 2.	1. Reduce the number of unsafe abortions in the region by 40% 2. Reduce the number of hospital visits for adverse outcomes from self-manage d abortions by 70%. 3. Increase local understanding of realistic abortion options and reduce stigma regarding abortion. 4. Reduce Texas maternal mortality rate by 5%

Implementation Plan

OUTPUT 1: 20,000 English & Spanish language information pamphlets distributed to partnered clinics

Strategy/activity:	Resources required:	Lead personnel*:

1. Design and manufacture abortion options information pamphlets in English and Spanish	(AWB) official style guide - 4 computers, drawing tablets, and software license sets (Adobe Photoshop + Illustrator) - Funding for pamphlets, shipping, & tax - US main office and servers for remote work	2 Spanish Language Translators (1.0 FTE) 2 Abortion care providers for fact checking (1.0 FTE) 1 Logistics & Transportation Coordinator (1.0 FTE) 2 Logistics & Transportation Assistants (1.0 FTE)
2. Deliver pamphlets to partnered pharmacies and clinics	- Shipping supplies to mail pamphlets to partners - MX main office	1 Curriculum Director (1.0 FTE) 1 Logistics & Transportation Coordinator (1.0 FTE) 2 Logistics & Transportation Assistants (1.0 FTE)
3. Collect clinic feedback + monitor supply, and provide refills as needed - Program, clinic, and sponsor logos - Abortion Without Borders	- 4 computers for remote work - US & MX main offices 1 Curriculum Director (1.0 FTE) 2 graphic design artists (1.0 FTE)	

Health equity considerations: Ensure that the clinics partnered with/housing these materials are in a variety of locations that can reach all parts of the communities we want to reach. Make sure pamphlets include equitable language and provide information about resources that also support health equity. Make sure pamphlets have information in English and Spanish.

*Refer to budget (Appendix II) for wages

OUTPUT 2: Procure 5,000 medication abortion packets on the Mexican side of the border by end of year 1.

Strategy/activity:	Resources required:	Lead personnel*:
1. Identify & reach out to local pharmacies and pharmaceutical distributors that can serve as suppliers	- Mexico main office - 2 computers for remote work	Program Managers (MX) 2 Drivers (1.0 FTE)
2. Secure medication supply and assemble SMA kits - Cars for pharmacy visits - Funding for meeting costs with local pharmacies & fuel - Drivers	- Vans - Misop - Cus packag guidan of med - Mexic - 1 com 2 AWB Provisional	1 Logistics & Transportation Coordinator (1.0 FTE) 2 Logistics & Transportation Assistants (1.0 FTE) 2 Drivers (0.5 FTE)

3. Distribute kits to patients and selected partnered networks - Mailing supplies - Signal for discrete coordination	of medication kit movement and delivery 1 Logistics & Transportation Coordinator (1.0	FTE) 2 Logistics & Transportation Assistants (1.0 FTE)

Health equity considerations: Ensuring that medication is available to the most vulnerable demographic groups should be of primary importance. This will require a specific emphasis placed on ensuring medication is supplied to priority distributors. These will be defined as Mexican pharmacies which are either located closest to the lowest SES Texas border counties or border municipalities where migrants/BIPOC make up a large proportion of the population. Background research and project planning has shown that these communities are most vulnerable to the negative effects of increasing restrictions on contraceptive/abortion care access (Nash et al., 2021).

*Refer to budget (Appendix II) for wages

OUTPUT 3: Patient experience surveys distributed in order to identify key gaps in care, most relevant metrics of quality of experience, social determinants affecting care access, and other feedback to improve patient experience

Strategy/activity:	Resources required:	Lead personnel*:
1. Develop patient experience survey materials (SOP, questionnaire, informed consent, Spanish language translation and cultural adaptation)	- Consultant with expertise on validated patient experience surveys - Consultant with expertise on sexual and reproductive health - 1 Spanish & 1 English	Community Advisory Board (Paid) 1 Curriculum Director (1.0 FTE) 2 Spanish Language Translators (1.0 FTE) 1 Community Partner Liaison (1.0 FTE)
2. Apply for IRB approval - US & Mexican Offices		1 Research & Data Manager (1.0 FTE) 2 Research & Technical Staff (1.0 FTE)
3. Set up secure data storage system & SOPs for safe data collection of completed surveys	- 3 computers for remote work -10 Licenses for Electronic Data Capture (REDCap) - 8 Tablets with REDCap software for clinic/partner sites to administer surveys	1 Research & Data Manager (1.0 FTE) 2 Research & Technical Staff (1.0 FTE)
4. Identify & train all personnel hosting the distribution of the survey (AWB Staff and any partners who connect individuals with the network)	- Training sessions for clinic/network staff who will administer survey	1 Curriculum Director (1.0 FTE) 2 Provincial Program Managers (1.0 FTE)
5. Officially disseminate patient experience survey & maintain a team that stores, analyzes, and summarizes survey data	- Cars - R (data analysis software)	1 Research & Data Manager (1.0 FTE) 2 Research & Technical Staff (1.0 FTE) 3 Drivers (1.0 FTE)

Health equity considerations: The team should take special consideration that health equity is incorporated into as many aspects of the survey as possible. They should also ensure that the methods/locations of survey distribution do not selectively exclude/reduce accessibility for any specific

groups. All safety and privacy requirements should be thoroughly adhered to. The organization should develop a specific data ethics team whose job is to monitor ethical concerns during all stages of survey creation, implementation, data storage, and data analysis.

*Refer to budget (Appendix II) for wages

Stakeholder Engagement Strategy for Implementation

Stakeholders engagement throughout implementation will be an iterative and decentralized procedure that will prioritize continual community feedback throughout. Our patient surveys will serve as a key strategy to ensure appropriateness and effectiveness of intervention. Additionally, the AWB advisory board will meet quarterly throughout intervention implementation. All AWB advisory board meetings will be virtual due to the wide variety of locations that medical professionals will be placed in. The purpose of these meetings will be to ensure appropriateness of medical intervention and ensure accessibility and capacity of the telemedicine system. Additionally, community partners will meet monthly in person with community partner liaisons who will collect feedback to be reported to provincial program managers to adjust the intervention as needed in response to community needs. Maintaining active relationships with community partners is critical for intervention success, as knowledge and access to the AWB network is reliant, particularly initially, upon the referral of abortion seeking patients to the network through prior existing community relationships. These community partners must be regularly referred to and incorporated in decision making in order to develop interprogram trust. Additionally, community partners are most knowledgeable about the particular needs of their communities and what positionalities are making abortion seekers most at risk to unsafe abortion and its negative outcomes. The insights of community partners, in conjunction with the knowledge of the AWB advisory board, will allow us to ethically respond to changing abortion access environments and patient needs efficiently and effectively.

Timeline

Please refer to Appendix III for GANTT Timeline

The intervention was designed over a three year timeline. This first year will be the most labor intensive year. Within the year, we will design informational material, develop community partnerships, set-up misoprostol acquisition and distribution supply chains, and design the patient experience surveys. The second year we will focus on the distribution of 5,000 SMA kits as well as continued community partnership building events such as doula trainings. The third year will continue the previous work and will also include data analysis and report development based on program evaluation.

Sustainability and Scalability

The current intervention is planned and budgeted for the initial three years. However, as it is highly unlikely that abortion will become more accessible in Texas for the foreseeable future we anticipate an ongoing need for AWB. Because of the Hyde and Helms amendments, it is illegal for any US federal funds to be spent on abortion (IBIS & IPAS, 2021). Thus, all current and future funding must come from non-governmental or foreign sources. Our current funding projections are for roughly 1.5 million which is less than half of our projecting budget. However, our expecting funding partners are generally large donors such as the Hewlett and Packard

foundations which have a history of setting up long term and high dollar relationships with abortion organizations. We are confident that after proof of concept during the initial three years we will be able to attract additional funders or more high value gifts. Additionally, we expect the cost of program continuity to be much lower than initial start up costs because labor costs

should drop significantly once supply network and funding streams are organized. Additionally, through program evaluation efforts we expect to be able to streamline and concentrate AWB's focus in the future in the case of reduced funding.

Our intervention should have good sustainability because although the supply of medication-based resources might eventually end, social awareness and community-based resources will retain their validity. This gives the intervention good sustainability based on bottom-up social participation. A strong body of academic literature supports this projection, and demonstrates that sexual health interventions are particularly successful and perpetuated when they operate through and utilize social networks to reach target communities (Erwin et al., 2007).

Evaluation and Dissemination

Evaluation Plan

<u>Outcome 1.</u>

Outcome Increase the number of Mexican pharmacies with English language abortion educational material by 15% by year two.

Sampling Strategy

Comparison Group

Community intervention partners– serving as representatives of their participating community, and participating communities being defined as localities (towns, suburbs, counties, neighborhoods, etc.) within 20 miles of the US-Mexico border where community leaders have agreed to work with AWB– will survey at least 85% all mappable pharmacies within the geographic boundaries of their community.

The initial survey will be collected at baseline, and will be surveillance based. Community intervention partners will visit or call (via telephone) mappable pharmacies to determine if they provide any abortion educational materials within their storefront/clinic (Y/N). The secondary survey will occur between 24 and 26 months post-baseline, and will use the same methods and objectives as the initial survey procedure. AWB community intervention partners will visit pharmacies within their localities to collect qualitative information on the nature of provided pamphlets. This will determine if local AWB efforts to distribute educational pamphlets (referenced in the Logic Model) were successfully distributed and stocked.

The baseline will be the number of pharmacies within 20 miles of the US Texas border that provide English language abortion education material. Comparisons may also be made to pharmacies along the US-Mexico border with other states.

Data Collection activities and methods	Data will be collected by community intervention partners from pharmacies directly. The location of Mexican pharmacies within 20 miles of the Texas Mexico border will be obtained through a dual-approach method to maximize efficiency and accuracy. Through digital satellite maps with business information (i.e. Google Maps) we will produce a cursory map

Specific measures
(using ArcGIS) of all pharmacies within 20 miles of each US-Texas crossing location. We will follow up and confirm the accuracy of this digital mapping through in-person community surveillance by AWB employees. Data will be collected regarding the initial availability and ongoing quality of english language abortion education resources at the individual pharmacy level.

We will survey the existence of English language abortion materials in each pharmacy, which will be represented by a binary y/n variable. Measurements will be collected to capture the count of likely patient encounters for each pharmacy and measure the physical quantity of booklets and brochures, which will be used as qualitative measures.

Timing of data collection	Baseline data collection will occur at the outset of the program (year 0, months 0-1). Secondary data collection will occur at the outset of year 2.

Outcome 2.

Outcome Increase successful provision of self-managed abortion to low-income individuals seeking it in Texas by 20% by end of year five.

Sampling Strategy

The sample will include all patients in/from Texas who engage with the AWB network with the intention of acquiring self-managed abortion (SMA) medication. All patients who request care or assistance through the AWB program are asked to complete a patient survey. The survey will collect qualitative information on which services the patient is seeking and their level of background knowledge on these services. Within this sample we will specifically assess the subset of patients who are at or below 200% of the federal poverty line. Because the aim is to measure the percentage of patients to which we are successfully providing care, we will not further select subsets of this population to measure this outcome. However, data analysis will be performed to identify disparities between different demographic strata.

Comparison Group

SMA kits will be created by the end of year 1 of the program and then distributed in year 2. Baseline comparison data will be acquired after year 2 for the percentage of patients who reached out to AWB in year 2 that received SMA medication services through AWB and its community partners. Data from the following years will be compared to this baseline to monitor trends and progress.

Additionally, data between low-income patients will be compared to that of high income patients in order to identify possible disparities and detect if the program is delivering care as effectively to low-income patients as high income patients, and any additional associated disparities in care provision.

Data Collection activities and methods	Patients requesting services from AWB will need to fill out a survey with the desired specific measures listed below and any other relevant patient information. This information should come with informed consent in both spanish and english. Surveys should be distributed upon contact with AWB through whichever channel (directly, through community partners, clinics, etc.) and matched with patient health records to be associated with data regarding fulfillment status of requested SMA kits/other services. Standardized, unique IDs based on medical record number will be used in order to avoid misclassification or missingness. Data should be de identified and encrypted, stored safely and with proper IRB approval.
Specific measures	Outputs to measure: The number of patient visits, what services the patient is seeking, number of SMA kits provided, other services provided, & demographic information for those who sought and received kits (SES, race, ethnicity, age, gender identity, sexual orientation, etc.) Additionally, data concerning primary spoken/written languages, availability of transportation, and reasons any requested services might not have been provided will be collected.
Timing of data collection	Baseline data collection will occur at the end of year 2. Further data collection will occur on an ongoing basis, and evaluation will occur at the end of years 3, 4, and 5.

Outcome 3.

Outcome Build density of abortion options information centers by 25% by end of year 2.

Sampling Strategy

Comparison Group

Output to measure: changes in abortion care access availability will be measured by tracking the number of abortion options information centers at year 0 and year 2, tracking the percent increase. The aim is to increase care access indirectly by providing pregnant people with more opportunities to learn about the medical process, safety, cost, and logistics of obtaining abortion care.

The geographic search radius will be within 20 miles and 50 miles of the US-Mexico border in Texas and Mexico, respectively.

The number of abortion care centers at year 0 (outset) and year 2 of program implementation will be compared to determine the effect of the intervention’s goal: to increase abortion care accessibility for pregnant people along the Texas-Mexico border.

To provide context, the final outcome measure can be compared to the number of care centers at year 0 and year 2 in adjacent border states where access to reproductive care has been similarly restricted (Arizona and New Mexico).

Data Collection activities and methods	The locations of abortion information centers will be obtained through one of three methods depending on feasibility: through digital satellite maps with business information (i.e. Google Maps), through maps provided by municipal public record, or through in-person community surveillance by AWB employees. The first option of digital mapping is preferred for ease of-use, cost, and efficiency, with community surveys as a second priority and public records requests as a third alternative (due to the uncertainty of request processing time of public records).

Specific measures
Geographic location (latitude and longitudinal data) will be recorded as well as the name of the center and approximate size (number of employees).

Timing of data collection	Initial data collection will occur at the outset of the program (baseline). Secondary data collection will occur at approximately 24-26 months from the outset of the program.

Summary of evaluation design:

For evaluation of Outcomes 1 and 3, we have selected a non-experimental design based on simple pre and post program comparisons of pharmacies providing English language abortion care informational materials and density of abortion options information centers. This design was selected because our aim for these two outcomes is to simply assess if the program has been effective in increasing the amount and quality of informational services available within the region. Evaluation of Outcome 2 will occur on a non-experimental basis as well. Because the effectiveness of SMA via medication and telemedicine has been previously well documented, this is not the goal of our evaluation (Endler et al., 2019). Additionally, we have not used a RCT design because it would be an ethical violation to randomly assign provision of requisition abortion care to a subset of participants seeking care. Because our aim is to assess the success of our program in providing the services that low-income patients seek, we can instead use a similar pre/post comparison from baseline.

Summary of sampling strategy:

For evaluation of Outcome 1, the sample will include all identifiable pharmacies within 20 miles of the Texas-Mexico border. For evaluation of Outcome 3, sampling will include the region (radial) within 20 and 50 miles of the Texas-Mexico border respectively. The sample for Outcome 5 will include all AWB patients who seek services through the network. Sampling strategies for Outcomes 1, 2, and 3 are non-stratified and non-clustered. While we do aim to analyze disparities between different strata (based on SES, race/ethnicity, gender identity, etc.), we wish to sample data from our entire population of patients and entire area of interest to get a comprehensive idea of our progress in these three evaluations.

Analysis plan:

For analysis of Outcome 1, quasi-experimental analysis of prevalence of pharmacies in the area providing English language abortion educational materials at time points year 0 and year 2 will be performed. We will use descriptive statistics to analyze the quality of materials before and after the intervention. The number of possible patient encounters and quantity of education materials will be used as qualitative proxies for accessibility. Accessibility will be analyzed using an internally produced 1-5 scale of material. We will then use a repeated cross sectional

(quasi-experimental) analysis to compare the year zero and year 2 timepoints. Accessibility will be factored into the analysis by weighting each pharmacy based on its distance from the nearest border crossing. We will wait to strictly define this scale based on the feedback from community partners more familiar with the layout and norms of Mexican pharmacies.

We will perform descriptive statistical analyses of the pharmacy results on this scale at baseline and year 2 time points. This will include calculating the prevalence and geographic density of pharmacies providing educational materials. We will also perform linear regression analysis to compare the material accessibility scores to the pharmacy's distance from the nearest border crossing point. This analysis will be done at both measurement intervals (baseline and approximately 2 years). We will be looking to measure changes in the availability

of English language resources in Mexican pharmacies as well as analyzing the overall quality and availability of these resources.

For analysis of Outcome 3 similar analysis methods to Outcome 1 will be employed. The change in prevalence of abortion care points over the defined geographic area will be compared between year 0 and year 2. Additionally, descriptive statistics analyzing the employee numbers at each care point will be compared between year 0 and year 2. We will be looking for any changes in the density of abortion care points as well as any changes in the number and distribution of support staff throughout the region.

For analysis of Outcome 2, repeated cross-sectional data collection at baseline, year 3, year 4, and year 5 will provide data for statistical analyses. To assess the increase in percentage of patients seeking SMA medication, proportions will be calculated and compared for each timepoint by percent increase per year and over the total 3 year period. Further risk analyses will be performed via logistic regression to assess differential risk (RD, RR, and OR) of not receiving requested services across strata of race/ethnicity, SES, gender identity, sexual orientation, and other possible determinant factors of interest that appear during analysis.

Ethical approval:

IRB approval will be required for quantitative survey data collection related to evaluation of Outcome 2 and patient data will be properly de-identified once matched to health records, encrypted, and stored on a secure server with access limited only to approved individuals. No names will be shared while reporting qualitative interview data, the names of abortion information facilities that are working to provide information in underground or grassroots capacities will not be reported in dissemination, but can be shared to individuals in need of care without capabilities to find information centers themselves.

Community partner engagement activities:

We will enlist community partners in the surveying of both pharmacy educational materials (1) and abortion information centers (3). We will collect additional qualitative data from community members to provide a timeline for intervention uptake between baseline and the data collection point at approximately 2 years. We will also rely on community partners for qualitative analysis of intervention success to ensure that the intervention remains appropriate and culturally competent.

Community partnered clinics and pharmacies will be relied upon to distribute surveys to AWB medication recipients. Community partners will be relied upon to express the importance of survey completion to medication recipients and ensure their anonymity and safety. Partners will continue to uphold evaluation activities through regular check-ins with regional leaders, ensuring that the priority population is receiving continual high-quality care and access to services. Community partners in direct contact with patients will also be relied upon to provide translation and interpretation services when necessary. Once data collection ends program

efficacy will no longer be measured quantitatively unless additional funding allows for it. This intervention is foreseen to be highly sustainable, however, due to its ability to operate through social networks.

Dissemination Plan

Due to the sensitive nature of the reproductive legal landscape and the personal nature of abortion care, dissemination of results during the program will be largely private. Ultimately, we hope our work can contribute to future abortion access models, but to protect participants and preserve the efficacy of the intervention we will focus on disseminating results to community partners and intervention participants during program implementation.

Community partners will receive twice annual Partner Reports created by Provincial Program Managers with the assistance of Community Partner Liaisons. These reports will

contain results-based recommendations for improving patient engagement and education. They will also contain summaries of ongoing program planning and summaries of how partners will be affected by the intervention. Reports can be disseminated electronically via newsletter. Program progress can also be shared through the publication of a data dashboard, which will serve as a visualization tool to support partner engagement. The RADx-UP Data Dashboard can be used as a framework for communication and design (D’Agostino et al., 2022). This design will enable community partners to engage with program results through access to intuitive and informative data visualization, allowing them to generate new questions, provide feedback, and disseminate results information within their organizations. The evolution of the Data Dashboard and newsletters throughout the program will inform how results will be communicated to an academic audience as community partners provide feedback and questions.

Individuals seeking care through the AWB program will directly learn about program progression through their process of receiving care. Secondarily, bi-monthly short form AWB press releases will be produced and disseminated at participating clinics and pharmacies. We will recommend that participating pharmacists include AWB press release brochures with at least 50% of all distributed misoprostol prescriptions. Participating clinics will display AWB press release materials with other AWB informational materials provided to patients. Press releases will differ from materials geared towards community partners; emphasis will be placed on communicating ongoing changes in the legal landscape of abortion care in the U.S., supply (medication packet) availability, and community networking event calendars (to help patients connect with local resources). This strategy will be the most effective for reaching patients by encouraging continued program participation through the timing and location of press release dissemination at acute and ongoing care access locations (clinics and pharmacies).

Throughout the program plan research assistants will be responsible for appropriate record-keeping of ongoing data analysis. Following the conclusion of the program– or changes in the legality of abortion care which reaffirms legal rights to abortion care– compiled program data analyses will be submitted to regional program directors and funders. Large-scale funders such as the Fred and Flora Hewlett Foundation can then provide further support to fund translation of program results into academic journal articles, which can be submitted to professional publications such as BMJ Sexual & Reproductive Health and Frontiers in Reproductive Health. Articles can focus on the success of community and partner engagement methods and the efficacy of using a social network-based intervention.

Budget and Budget Justification

Below we have included our line item budget justification as well as the budget itself. Labor costs account for the majority of our budget costs. As our intervention has a heavy focus on relationship building we believe this reflects our identity as a grassroots, community centered organization that prioritizes collaboration and highly values the cost of human labor.

Furthermore, due to the politically controversial and potentially legally gray nature of our intervention we have prioritized the construction of a strong internal team that is primarily full time. Our high labor costs are offset by our lower overhead and supplies costs. Our headquarters in Mexico allows us to keep overhead costs, particularly medication costs very low. Furthermore, our US headquarters in New Mexico allows for comparatively cheap overhead costs compared to other US cities. Other ways that we are minimizing costs are by utilizing zoom and other online business software that will minimize our need for large office space or an expansive travel budget. We expect our yearly budgetary needs to shrink consecutively as initial relationship building and supply chain organization will be the most cost intensive portions of our intervention.

Line Item Budget Justification

Personnel - All personnel salary items were estimated using average salary information for each position.

▪ Country Director (US)

o 1x FTE at base salary $60,000 and $20,000 fringe benefits

o The US Country Director will help oversee all partners involved on the American side of care, create engagement opportunities within the US and work with the Mexican Country Director to establish communication between nations. The director will have a voice in possible implementation or timeline changes, but all power will be deferred democratically to each partner involved in the program. ▪ Country Director (Mexico)

o 1x FTE at base salary $27,750 and $9,250 fringe benefits

o The Mexican Country Director will help oversee all partners involved on the Mexican side of care, creating community outreach opportunities within Mexico and work alongside the US Country Director to help grow communication channels between each partner group providing care within this program. While the Mexican Director will have a powerful voice in establishing changes or reworking implementation plans, they will also have to defer power in this project democratically to each person involved in this care initiative throughout Mexico. ▪ AWB Provincial Program Managers (US)

o 2x FTE at base salary $48,750 and $16,250 fringe benefits

o The US Provincial Program Managers will oversee regional event managers for community event planning and oversee the regional distribution of SMA packets. ▪ AWB Provincial Program Managers (MX)

o 2x FTE at base salary $22,500 and $7,500 fringe benefits

o The Mexico Provincial Program Managers will oversee regional event managers for community event planning, the regional procuring of misoprostol, and the building of SMA packets for transport and distribution.

▪ Office/IT Assistants

o 2x FTE at base salary $16,500 and $5,500 fringe benefits

o The office and IT assistants will maintain the condition of all technology resources, organize meeting technology logistics, and troubleshoot unexpected technological challenges. They will also support other staff members in the use of unfamiliar software.

▪ Financial Director

o 1x FTE at base salary $45,000 and $15,000 fringe benefits

o The Financial Director will oversee the accumulation, assignment, and distribution of funding. They will also oversee funding predictions and lead planning and organization for future budgetary needs.

▪ Finance Officers

o 2x FTE at base salary $22,500 and $7,500 fringe benefits
o The Finance Officers will assist the Financial Director in accumulation, assignment, and distribution of funds. They will also be responsible for the detailed regional allocation of funding resources.

▪ Curriculum Director
o 1x FTE at base salary $33,750 and $11,250 fringe benefits
o The Curriculum Director will oversee the development of patient experience survey materials and the testing and revising of said materials. They will also oversee the development of instructional cards for the misoprostol kits. They will also oversee the production and approval of any marketing and event materials. ▪ Graphic Design Artists
o 2x contracted at hourly salary totaling $10,000 per year with no fringe benefits

o The Graphic Design Artists will be short-term and contracted partners that will design AWB logos, instructional materials for patients, and marketing and event materials.

▪ Spanish Translators/Interpreters
o 2x contracted at hourly salary totaling $12,000 per year with no fringe benefits o Though all staff members will be Spanish and English speakers, Spanish translators and interpreters will be used for professional translation of materials between Spanish and English. They may also occasionally be present at community events to promote communication between those with different language skill levels.

▪ Research and Data Manager
o 1x FTE at base salary $45,000 and $15,000 fringe benefits
o Will oversee the establishment of a secure data storage system that adequately meets privacy needs. Will oversee data collection, handling, and distribution. Will oversee the dissemination and secure collection of patient feedback surveys. Is ultimately responsible for routine server maintenance to ensure data security. o Will oversee data analysis and report construction.

▪ Research & Technical Staff
o 3x FTE at base salary $26,250 and $8,750 fringe benefits
o Will assist and support the Data Manager in the secure collection, handling, and distribution of data. Will assist in the secure maintenance servers to protect private data.
o Will analyze data and collate and publish reports for iterative program evaluation. ▪ Logistics and Transportation Coordinator
o 1x FTE at base salary $33,750 and $11,250 fringe benefits
o Oversee the collection, compiling, and redistribution of SMA kits. Finalize suppliers and arrange supply delivery timelines. Oversee storage and delivery of kits.

▪ Logistics and Transportation Assistants
o 2x FTE at base salary $26,250 and $8,750 fringe benefits
o Will assist Logistics and Transportation Coordinator with all responsibilities. ▪ Event Coordinators
o 4x contracted at hourly salary totaling $17,000 per year with no fringe benefits o Organize, promote, budget, and lead community outreach events and Abortion DOULA training clinics.

▪ Drivers
o 3x contracted at hourly salary totaling $12,000 per year with no fringe benefits o Deliver misoprostol and SMA kits to collation and distribution sites. Assist in safe transport of patients seeking direct pharmacy care in Mexico.

▪ Training Facilitators
  o 10x contracted at hourly salary totaling $5,000 per year with no fringe benefits
  o Lead Abortion DOULA Training Events.
▪ Community Partner Liaison
  o 1x FTE at base salary $37,500 and $12,500 fringe benefits
  o Will organize and oversee the partnering and coordination between existing grassroots organizations and community centers.
▪ Community Advisory Board Members x8
  o 8x contracted at hourly salary totaling $240 per year with no fringe benefits
  o Recruited from grassroots organizations to advise the Community Partner Liaison and AWB on community centered solutions

Monitoring and Evaluation

▪ Evaluation Consulting for Evaluation Planning ($7,500): Some of the planning process will occur prior to bringing in external evaluation help, and some will occur during the contracting process.
▪ Monitoring & Supervision Visits by Program Managers, in-person community surveillance by AWB employees ($2,400).

Planning and Administration

▪ Office Supplies ($3,600): basic cleaning supplies and office amenities such as post-its, paper, notebooks, files and other general planning and administration basic tools. ▪ Translation and Interpretation ($6,000): Translatory and Interpretation on-call available services to help with office visits, patient coordination and follow-up

Overhead

▪ Office Space in Mexico ($54,000): 950 sqft office space, available to the project team for program and administrative activities as an in-kind contribution.
▪ Office Space in US ($86,400): 950 sqft office attached to the church will be made available to the project team for program and administrative activities as an in-kind contribution.
▪ Utilities ($28,800): Utilities such as internet will be provided by the church as an in-kind contribution
▪ Technological Communications Costs ($28,800): 1 laptop will be procured for each team member and 1 Fax Machine/Printer will be procured for the project in each office ▪ Printed Materials Shipping ($1,500): Distributing informational packets, providing awareness for outreach opportunities and creating a dual-national network for this project

Supplies

▪ Paper supplies ($8,654): english language pamphlets [tri-fold, full-color, 8.5” x 11”, no perforation] misoprostol instruction cards [3.5” x 5” 2-sided recycled full-color], medication abortion packet boxes (Brochures Printing, n.d.; GreenerPrinter, n.d.; Papermart, n.d.).
▪ Misoprostol ($ 375,375): Patients will be given medication abortion in the form of misoprostol only. Dosages will not include mifepristone due to its exorbitant cost [~$200 per pill] compared to misoprostol [~175$ per bottle of 28 Cytotec 200 mcg pills] (Eckholm, 2013). Additionally, mifepristone is not reliably available for purchase over the-counter in Mexico, so procuring the pills for the packets might present challenges. While the future of mifepristone approval in the US court system is unknown and might face restrictions or shortages, misoprostol–due to its wide range of medical usages–is

resistant to challenges of its safety and appropriate usage in the future. Due to these factors, our program follows International Federation of Gynaecology and Obstetrics [FIGO] recommended guidelines for misoprostol-only dosing of medication abortion [2-3 doses of 800 mcg, each pill containing 200 mcg] (Morris et al., 2017) .

- Promotional materials ($15,000): Green abortion right bandanas to be distributed by community partners and at AWB events to unite efforts under pre-existing abortion rights iconography in the region (Planet Apparel, 2023).
- Computers for employees ($25,000) and projectors ($2,400): Used by AWB staff to conduct business remotely and in-office across US and Mexico sites.
- Server & maintenance ($15,000): For secure hosting of AWB sites and secure storage of patient data.

- Adobe Creative Cloud Business Licenses ($15,298): Used by Curriculum Director and Graphic Design Artists to create and maintain materials.
- RedCap ($0): Secure Data storage software for use by Research and Data Manager and staff.
- R ($0): Data Analysis software for use by Research and Data Manager and staff. ▪ Qualtrics ($15,000): Secure survey collection software for use by Research and Data Manager and staff.

Event Spaces

- Doula Trainings ($48,000): Average cost for full day 50-person occupancy conference space rental is around $1,000-$1,500.
- Community Partner Engagement Events ($40,000): 300-person occupancy event space rental for 2-4 hours on average is around $1,000.

Travel

- Travel of training facilitators to training locations | 40 Sessions, 10 facilitators - 4 trips/facilitator over 3 years ($40,000): Cost per visit ($1,000) includes average round-trip flight/fuel cost depending on distance, average one-night hotel stay, and stipend for additional travel to and from airports and hotels)
- Travel of provincial program managers | Cost of average monthly fuel consumption for provincial managers who travel to various provincial site locations for monitoring and leadership ($170/program manager/month)
- Travel of country directors |($36,000):2 trips/country director over 3 years to conduct group leadership meetings and attend major program-related events. Cost per visit: ($3,000) includes average round-trip flight/fuel cost depending on distance, average three-night hotel stay, and stipend for additional travel.

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APPENDICES

APPENDIX I: L.E.A.D. EVIDENCE-BASED DECISION MAKING

Table 1. L.E.A.D Framework Evidence Table

Part A. Why should we do something about this problem in our situation? (Type I Evidence)

Potential Intervention evidence Level Risk of Findings

(surveillance data, observationa l study, evaluation, etc.) Bias Inconsistency Imprecision Overall Quality Size

1 Report - - - - - - - - Proves the need for alternatives to the medical establishment for safe abortions in Texas. Abortion rates in Texas have fallen at least 87% every month since June of 2022

National Abortion Numbers

Maternal Mortality in Texas 2 Surveillance Data - - - - - - - 20.1 - 25.7 deaths per 100,000 live births Texas has high rates of maternal mortality 22.9 deaths per 100,000 live births

High

Issue Brief	-	-		-

3

Perinatal mortality linked to abortion restriction

1. Society of Family Planning (2022, Oct 28). #WeCount Report.
https://www.societyfp.org/wp-content/uploads/2022/10/SFPWeCountReport_Apr toAug2022_ReleaseOct2022-1.pdf 2. Centers for Disease Control and Prevention. (2021). Maternal deaths and mortality rates: Each state, the District of Columbia, United States, 2018-2020. U.S. Department of Health and Human Services.
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3. Commonwealth Fund. (2022, December 14). The U.S. Maternal Health Divide: The limited maternal health services and worse outcomes of states proposing new abortion restrictions. Area of Focus: Advancing Health Equity. Retrieved from https://www.commonwealthfund.org/publications/issue-briefs/2022/dec/us-maternal-health-divide-limited-services-worse-outcomes#:~:text=Differences%20in%20Perinatal%20Health%20Outcomes&text=States%20with%20abortion%20bans%20or%20restrictions%20also%20had%20higher%20neonatal,after%20birth%20(2.16%20deaths%20vs

Part B. What specifically should we do about this problem? (Type II Evidence)

Potential Intervention	

evidence (surveillan ce data, observatio nal study,

Level (Score)	Ris of Bia (Sc)

evaluation, etc.)

Patient Medicine Vendors (PMV)
4 Qualitative Interviews
C (1) Intermedi ate Risk of Bias
(2)
N/A N/A 1.5 (Moderat e)
27 N/A N/A Intermediat e: PMVs serve as an analogous position which can be compared to the role of community health workers which our interventio n plans to employ.
The efficacy of PMVs is nuanced and can have broader effects on health systems. PMVs suffer from exceeding available service provisions, creating greater demand than supply.

Self managed abortion using misoprost ol only from telemedic ine service
5 Retrospect ive Cross sectional
B (2) Low Risk of Bias
(3)
N/A 2 2.33 (Moderat e)
568 88% reported successfully ending their pregnancy without instrumentatio n intervention. 2% reported serious adverse events, 4% reported symptoms of possible complications.
95% CI: 84.6– 90.2
High: Demonstra tes that self administrat ion of misoprosto l can be both safe and effective with telemedicin e services
Self managed abortion with only misoprost ol is safe and effective

Historical example of increasing border state abortion when Texas restricts access	6	Repeated cross sectional	B (2)	Low Risk of Bias (3)	N/A	3	2.33 (Moderate)		Texas resident abortions in all border states nearly doubled following HB2's implementation [IRR]=1.92 (IRR adjusted for time trends and abortion seasonality). From 2012 to 2014, the proportion of Texas resident abortions in New Mexico that were medication abortion	95% CI: 1.67 - 2.20	High: Indicates that priorities for solutions should be placed on travel for care in situations where legislation is so restrictive.	HB2 increased rates of Texas residents seeking abortions in border states

7 Mixed Methods Study

from 5% to 20% ($p < 0.001$) and the proportion that were ≥22 weeks from LMP decreased from 40% to 23% ($p < p<0.001$).

that we may be able to mirror or modify for our intervention in another cross border population

Community-based distribution program of misoprostol with provider guidance/ support

B (2) Low Risk of Bias (3) increased

N/A N/A 2.5 (High) 918 96.4% effective at preventing pregnancy at follow-up N/A High:

Offers a model of community -based distribution

Community based distribution of misoprostol for early abortion care with provider guidance/followup is effective and provides a framework for community support and safe abortion

Safe and effective medical abortion can be provided via a telemedicine-hybrid model.	8	Cohort study	A (3)	Low Risk of Bias (3)	N/A	3	3 (High)	52,142	More abortions were provided at ≤6 weeks' gestation (40% versus 25%, P < 0.001). Effectiveness was higher with telemedicine than in person care (99.2% versus 98.1%, P < 0.001)."	N/A	High: A telemedicine-hybrid model for medical abortion that includes no-test telemedicine and treatment without an ultrasound is effective, safe, acceptable and improves access to care.	Compelling evidence shows no test telemedicine abortion is safe, effective and improves care.

4. Adebayo, A., Oluwasanu, M., Okunade, F., Ajayi, O., Akindele, A., & Ajuwon, A. (2022). Contextual factors influencing the roles of Patent Medicine Vendors in the Provision of Injectable Contraception Services in Nigeria. https://doi.org/10.21203/rs.3.rs-1688274/v1

5. Johnson, D. M., Michels-Gualtieri, M., Gomperts, R., & Aiken, A. R. A. (2023). Safety and effectiveness of self-managed abortion

using misoprostol alone acquired from an online telemedicine service in the United States. Perspectives on sexual and reproductive health, 10.1363/psrh.12219. Advance online publication. https://doi.org/10.1363/psrh.12219 6. Raifman, S., Sierra, G., Grossman, D., Baum, S. E., Hopkins, K., Potter, J. E., & White, K. (2021). Border-state abortions increased for Texas residents after House Bill 2. Contraception, 104(3), 314–318. https://doi.org/10.1016/j.contraception.2021.03.017
7. Foster, A. M., Arnott, G., & Hobstetter, M. (2017). Community-based distribution of misoprostol for early abortion: Evaluation of a program along the Thailand–Burma border. Contraception, 96(4), 242–247. https://doi.org/10.1016/j.contraception.2017.06.006
8. Aiken, A., Lohr, P. A., Lord, J., Ghosh, N., & Starling, J. (2021). Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study. BJOG : an international journal of obstetrics and gynaecology, 128(9), 1464–1474. https://doi.org/10.1111/1471-0528.16668

Part C. How do we implement this information for our situation? (Type III Evidence)

Potential Intervention (surveillan ce data, observatio nal study, evaluation, etc.) evidence el Risk of Bias Inconsiste ncy Imprecisi on Overall Quality Size Lev ngs

Implementing a risk reduction model to prevent unsafe abortion related care
9 Mixed Methods Study
- - - - - - - - High: It is feasible to implement this risk reduction model in a traditional community in any country irrespective of its abortion laws.
Though these outcomes are in many ways culturally specific, many factors—like pre and post care counseling— helped folks in comparison to those who didn't receive care under the risk reduction model

Feminist Networks of Misoprostol Distribution Across Mesoamerica
10 Qualitative - - - - - - - - "Underground feminist networks offer one of the few possibilities for pregnant people to obtain a safe abortion, facilitated by women whose principal motivation is feminist solidarity, rather than profit."

Increasing access to safe abortion medication for US citizens at the US/Mexican border	11	Intervie w	-	-	-							utilizing the grass-roots networks from Mexico to help aid folks from across the continental US receive safe abortion medication along the border.

9. Fiol V, Briozzo L, Labandera A, Recchi V, Piñeyro M. Improving care of women at risk of unsafe abortion: implementing a risk-reduction model at the Uruguayan-Brazilian border. Int J Gynaecol Obstet. 2012 Sep;118 Suppl 1:S21-7. doi: 10.1016/j.ijgo.2012.05.006. PMID: 22840266
10. Walsh, A. (2020). Feminist Networks Facilitating Access to Misoprostol in Mesoamerica. Feminist Review, 124(1), 175–182. https://doi-org.libproxy.lib.unc.edu/10.1177/0141778919888070
11. Haroun, A., & Zavarise, I. (2022, Aug 21). Hundreds of Americans a week are seeking abortion help from Mexico - and most of them want a safe hand-off of abortion drugs at the border. Business Insider
http://libproxy.lib.unc.edu/login?url=https://www.proquest.com/newspapers/hundreds-americans-week-are-seeking-abortion help/
docview/2704644551/se-2

L.E.A.D Evidence Table Legends

<u>Levels of Evidence:</u>

Score Level of Evidence (LOE) Interpretation

3 A (Evidence-Based) Meta-analyses
Multiple peer-reviewed studies
One high-quality peer-reviewed study with multiple sites/settings

2 B (Effective) One high-quality peer-reviewed study
Peer-reviewed reports and evaluations

1.5 C (Promising) State or federal government reports or datasets (without peer review) High quality program evaluations (without peer review)
Other high-quality datasets, posters, and presentations

1 D (Emerging) Stakeholder input (without systematic collection method) Pilot studies
Expert opinion/communications
Studies or evaluations still in-progress

* Unclear Evidence categorized as "unclear" is missing information, making it difficult to assess the level of evidence.

N/A	Not Applicable	Evidence is not of a type that can be meaningfully assessed using these tools.

SPGH722 Evaluating Quality of Evidence Template [Class handout]. Canvas.
https://uncch.instructure.com/courses/20819/assignments/95551

<u>Risk of Bias:</u>

Score Risk of Bias (ROB) Interpretation

3	Low/No Serious Risk of Bias	Implies confidence on the part of the reviewer that results represent the true treatment effects (or true representation of occurrence of an outcome of interest; study results are considered valid). The study reporting is adequate to judge that no major or minor sources of bias are likely to influence results.

2 Intermediate/Mixed One major or several minor limitations that do not seriously compromise findings. Implies some confidence that the results represent true treatment effect (or true representation of occurrence of an outcome of interest). The study is susceptible to some bias, but the problems are not sufficient to invalidate the results (i.e., no flaw is likely to cause major bias).

1 High/Serious Risk of Bias
Crucial or several minor limitations that seriously compromise findings. Implies low confidence that results represent true treatment effect (or true representation of occurrence of an outcome of interest).

The study has significant flaws that imply biases of various types that may invalidate its results; these may arise from serious errors in conduct, analysis, or reporting, large amounts of missing information, or discrepancies in reporting.

* Unclear A study categorized as “unclear” risk of bias is missing information, making it difficult to assess limitations and potential problems.

N/A	Not Applicable	Evidence is not of a type that can be meaningfully assessed for risk of bias using these tools.

SPGH722 Evaluating Quality of Evidence Template [Class handout]. Canvas. https://uncch.instructure.com/courses/20819/assignments/95551

Inconsistency:

Score Inconsistency (IN) Interpretation

3 Low/No Serious Inconsistency
No large, statistically significant differences in effect size across studies, or significant differences exist but can be adequately explained by differences among sub-groups or other suitable hypotheses. The resulting evidence can be confidently used for decision-making after accounting for any such issues.

2 Intermediate/Mixed Some significant or borderline-significant differences among studies that cannot be adequately explained by differences among sub-groups or other hypotheses, or large significant differences that can be somewhat (but not entirely) explained. The resulting evidence can still be used for decision making after accounting for any such issues.

1 High/Serious Inconsistency
Large, significant differences in effect size across studies that cannot be adequately explained by differences among sub-groups or other suitable hypotheses. These issues are serious enough that the evidence cannot be confidently used for decision-making.

* Unclear A study categorized as “unclear” is missing information, making it difficult to assess inconsistency.

N/A	Not Applicable	Evidence is not of a type that can be meaningfully assessed for inconsistency using these tools.

SPGH722 Evaluating Quality of Evidence Template [Class handout]. Canvas. https://uncch.instructure.com/courses/20819/assignments/95551

Imprecision:

Score Imprecision (IM) Interpretation

3	Low/No Serious Imprecision	Confidence intervals do not span the no-effect level and the study is adequately powered: imprecision does not limit the usefulness of this evidence for decision-making.

2 Intermediate/Mixed Confidence intervals may span the no-effect level, or the study may be somewhat underpowered. However, the effect size is sufficiently large or these limitations are sufficiently minor that we are still reasonably confident that this evidence can be used to make decisions.

1 High/Serious Imprecision
Confidence intervals span the no-effect level, and/or the study is seriously underpowered. These limitations are sufficiently serious that we are not confident this evidence can be used to make decisions.

* Unclear A study categorized as “unclear” is missing information, making it difficult to assess imprecision.

N/A	Not Applicable	Evidence is not of a type that can be meaningfully assessed for imprecision using these tools.

SPGH722 Evaluating Quality of Evidence Template [Class handout]. Canvas. https://uncch.instructure.com/courses/20819/assignments/95551

Overall Quality Assessment/Scoring:

Score (x) Overall Quality

x > 2.5 High

1.5 < x < 2.5 Moderate

x <= 1.5 Low

* Unclear

N/A	Not Applicable

Strategy - For each piece of evidence, numerical values were averaged. This average number was used as the overall quality score. The highest possible score is 3 (best quality evidence) while the lowest possible score is 1 (worst quality evidence). All non-numerical values were excluded from average calculations entirely and did not contribute to the denominator (n). A mathematical representation of the overall quality assessment is: ������� + ������� + ����� +

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Where n is number of evaluation categories for which there is a numerical value for that piece of evidence

Table 2. Community Partners

HHS (Human Health Services) Human rights, Legislation, Legal Protection/Council

Local SRH Organizations	Medication Access, Human Rights

Table 3. Community Partner Priorities

Partners Medica tion	Access Teleme	dicine Access Transp	ortatio n Access	Legal Protect ion/Co uncil	Legisla tion Cost Human Rights	Couns eling for	Priority Popula tion Safety
				Grassroots Organizations			
Medical Service Providers				Local/State Level Politicians i i i i i i i i i			

Brigid Alliance i i i

i i i

Local SRH organizations

Whole Women's Health

i i i

TOTAL	5	4	1	1	2	2	4	2	3

Table 4. Decision Criteria & Weights

Cost	2

Table 5. Pugh Matrix Program Evaluation

Top Criteria	Weights	Program Options 1 (reference)	2	3	4
Medication	5	S	+	S	+
Telemedicine Access	4	S	+	-	+
Counseling for Priority Population	2	S	S	-	S
Score (unweighted)	20	20	20	20	20
Score (weighted)		20	23	18	23

Program options:
1 = Traveling to another US state (Current standard)
2 = Mail delivered self-managed abortion (SMA) w/ telemedicine support (L.E.A.D. Evidence Table source 5)
3 = Travel to Mexico (L.E.A.D. Evidence Table source 6)
4 = Hybrid cross-border system w/Mexico that includes movement of medication & people

APPENDIX II: BUDGET

Funding Sources	Year 1	Year 2	Year 3	Total
The Safe Abortion Access Fund	$ 40,000.00	$ 40,000.00	$ 80,000.00	$ 160,000.00
The David & Lucile Packard Foundation	$ 100,000.00	$ 100,000.00	$ 100,000.00	$ 300,000.00
The William & Flora Hewlett Foundation	$ 333,333.33	$ 333,333.33	$ 333,333.33	$ 1,000,000.00
Collaborative For Gender + Reproductive Equity	$ 10,000.00	$ 10,000.00	$ 10,000.00	$ 10,000.00
Total Funding	$ 483,333.33	$ 483,333.33	$ 523,333.33	$ 1,470,000.00

Budget Categories	Year 1	Year 2	Year 3	Project Total
Total Program Costs	$ 1,579,535.07	$ 1,091,306.07	$ 1,021,306.07	$ 3,400,127.20
Total Overhead Costs	$ 62,750.00	$ 61,250.00	$ 31,200.00	$ 185,250.00
Project Total	$ 1,642,285.07	$ 1,152,556.07	$ 1,052,506.07	$ 3,585,377.20

Description	Unit	Unit Cost	Quantity	Amount in USD	Year 1	Year2	Year 3
Human Resources		Per Year		Per Year			
Country Director (US)	Staff	$ 80,000.00	1	$ 80,000.00	$ 80,000.00	$ 80,000.00	$ 8
Country Director (Mexico)	Staff	$ 37,000.00	1	$ 37,000.00	$ 37,000.00	$ 37,000.00	$ 3
AWB Provincial Program Managers (US)	Staff	$ 65,000.00	2	$ 130,000.00	$ 130,000.00	$ 130,000.00	$ 13

AWB Provincial Program Managers (Mexico)	Staff	$ 30,000.00	2	$ 60,000.00	$ 60,000.00	$ 60,000.00	$ 6
Office/IT Assistants	Staff	$ 22,000.00	2	$ 44,000.00	$ 44,000.00	$ 44,000.00	$ 4
Financial Director	Staff	$ 60,000.00	1	$ 60,000.00	$ 60,000.00	$ 60,000.00	$ 6
Finance Officers	Staff	$ 30,000.00	2	$ 60,000.00	$ 60,000.00	$ 60,000.00	$ 6
Curriculum Director	Staff	$ 45,000.00	1	$ 45,000.00	$ 45,000.00	$ 45,000.00	$ 4
Graphic Design Artists	Staff	$ 10,000.00	2	$ 20,000.00	$ 20,000.00	$ -	$
Spanish Translators/Interpreters	Staff	$ 12,000.00	2	$ 24,000.00	$ 24,000.00	$ 24,000.00	$ 2
Research & Data Manager	Staff	$ 60,000.00	1	$ 60,000.00	$ 60,000.00	$ 60,000.00	$ 6
Research & Technical Staff	Staff	$ 35,000.00	3	$ 105,000.00	$ 105,000.00	$ 105,000.00	$ 10
Logistics & Transportation Coordinator	Staff	$ 45,000.00	1	$ 45,000.00	$ 45,000.00	$ 45,000.00	$ 4
Logistics & Transportation Assistants	Staff	$ 35,000.00	2	$ 70,000.00	$ 70,000.00	$ 70,000.00	-
Event Coordinators	Staff	$ 17,000.00	4	$ 68,000.00	$ 68,000.00	$ 68,000.00	$ 6
Drivers	Staff	$ 12,000.00	3	$ 36,000.00	$ 36,000.00	$ 36,000.00	$ 3
Training Facilitators	Staff	$ 5,000.00	10	$ 50,000.00	$ 50,000.00	$ 50,000.00	$ 5
Community Partner Liaison	Staff	$ 50,000.00	1	$ 50,000.00	$ 50,000.00	$ 50,000.00	$ 5
Community Advisory Board Members	Staff	$ 240.00	8	$ 1,920.00	$ 640.00	$ 640.00	$
Subtotal A				$ 1,045,920.00	$ 1,044,640.00	$ 1,024,640.00	$ 95
Training	**Unit**	**Unit Cost**	**Quantity**	**Amount in USD**	**Year 1**	**Year2**	**Year 3**
Event space for trainings (doulas)	Event	$ 1,200.00	40	$ 48,000.00	$ 16,000.00	$ 16,000.00	$ 1
Travel Costs for Facilitators	Visit	$ 1,000.00	40	$ 40,000.00	$ 13,333.33	$ 13,333.33	$ 1
Subtotal B				$ 88,000.00	$ 29,333.33	$ 29,333.33	$ 2
Equipment	**Unit**	**Unit Cost**	**Quantity**	**Amount in USD**	**Year 1**	**Year2**	**Year 3**
Green abortion rights bandanas	Unit	$ 3.00	5,000	$ 15,000.00	$ 8,000.00	$ 3,500.00	$

Misoprostol (Cytotec, 28 200mcg pills)	Unit	$ 175.00	2,145	$ 375,375.00	$ 375,375.00	$ -	$
Instruction/Resource cards	Unit	$ 1.92	5,000	$ 9,600.00	$ 1,100.00	$ -	$
Boxes	Unit	$ 1.17	5,000	$ 5,854.00	$ 5,854.00	$ -	$
Computers (Laptops)	Unit	$ 1,000.00	20	$ 20,000.00	$ 20,000.00	$ -	$
Computers (Desktops & Monitors)	Unit	$ 1,000.00	5	$ 5,000.00	$ 5,000.00	$ -	$
LCD Projectors	Unit	$ 1,200.00	2	$ 2,400.00	$ 2,400.00	$ -	$
Server	Unit	$ 10,000.00	1	$ 10,000.00	$ 10,000.00	$ -	$
Server Maintenence	Year	$ 500.00	3	$ 1,500.00	$ 500.00	$ 500.00	$
Drawing Tablets	Unit	$ 1,000.00	2	$ 2,000.00	$ 4,000.00	-	-
Adobe Creative Cloud Business License (36 months)	Month	$ 84.99	4	$ 15,298.20	$ 5,099.40	$ 5,099.40	$
Qualtrics	Year	$ 5,000.00	3	$ 15,000.00	$ 5,000.00	$ 5,000.00	$
RedCap Software	Month	$ -	-	$ -	$ -	$ -	$
Cars/Vans	Unit	$ 10,000.00	4	$ 40,000.00	$ 40,000.00	-	-
Event space for community partnership events	Event	$ 1,000.00	40	$ 40,000.00	$ 13,333.33	$ 13,333.33	$ 1
Subtotal C				$ 557,027.20	$ 495,661.73	$ 27,432.73	$ 2
Communication Materials	**Unit**	**Unit Cost**	**Quantity**	**Amount in USD**	**Year 1**	**Year2**	**Year 3**
English language information pamphlets	Unit	$ 0.17	20,000	$ 3,400.00	$ 3,400.00	$ 3,400.00	$
Subtotal D				$ 3,400.00	$ 3,400.00	$ 3,400.00	$
Monitoring and Evaluation	**Unit**	**Unit Cost**	**Quantity**	**Amount in USD**	**Year 1**	**Year2**	**Year 3**
Evaluation Consultant for evaluation planning	Hours	$ 100.00	75	$ 7,500.00	$ 2,500.00	$ 2,500.00	$
Monitoring & Supervision Visits by Program Managers	Visit	$ 60.00	40	$ 2,400.00	$ 800.00	$ 800.00	$
Subtotal F				$ 9,900.00	$ 3,300.00	$ 3,300.00	$
Planning & Administration	**Unit**	**Unit Cost**	**Quantity**	**Amount in USD**	**Year 1**	**Year2**	**Year 3**
Office Supplies	Month	$ 100.00	36	$ 3,600.00	$ 1,200.00	$ 1,200.00	$
Translation and interpretation	Hours	$ 60.00	100	$ 6,000.00	$ 2,000.00	$ 2,000.00	$
Subtotal G				$ 9,600.00	$ 3,200.00	$ 3,200.00	$
Overhead	**Unit**	**Unit Cost**	**Quantity**	**Amount in USD**	**Year 1**	**Year2**	**Year 3**
Office/Building Rent (US)	Month	$ 2,400.00	36	$ 86,400.00	$ 28,800.00	$ 28,800.00	$ 2
Office/Building Rent (Mexico)	Month	$ 1,500.00	36	$ 54,000.00	$ 18,000.00	$ 18,000.00	$ 1
Utilities	Month	$ 400.00	72	$ 28,800.00	$ 9,600.00	$ 9,600.00	$
Communications Costs	Month	$ 200.00	72	$ 14,400.00	$ 4,800.00	$ 4,800.00	$
Insurance	Year	$ 50.00	3	$ 150.00	$ 50.00	$ 50.00	$
Printed Materials Shipping	Year	$ 750.00	2	$ 1,500.00	$ 1,500.00	$ -	$
Subtotal H				$ 185,250.00	$ 62,750.00	$ 61,250.00	$ 3
Grand Total				$ 1,899,097.20	$ 1,642,285.07	$ 1,152,556.07	$ 1,05

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APPENDIX III: TIMELINE

GANTT Timeline Chart: Abortion Without Borders

Year 0 Year 1 Year 2 Year 3

Project Launch

Generate Abortion Without Borders (AWB) official mission statement and style guide

Hire essential staff

Secure Funding

Establish AWB headquarters offices

Output 1: 10,000 English language information pamphlets distributed to partnered clinics

Create & manufacture pamphlets in English & Spanish

Deliver pamphlets to partnered clinics & pharmacies

Collect feedback, monitor supply, restock as needed

Evaluation

Identify & reach out to local pharmacies and pharmaceutical distributors that can serve as suppliers

Secure medication supply, assemble kits

Deliver SMA kits to community distributors

Provide SMA kits to patients seeking medication abortion w/AWB

Evaluation

Output 3: Patient experience surveys distributed in order to identify key gaps in care & program effectiveness

Develop patient experience survey materials (SOP, training materials, questionnaire, informed consent, translation and cultural adaptations)

Obtain IRB approval

Set up RedCap Data Storage System									

45

Finalize data management plan of completed surveys from clinics/partners

Train partner staff that will be hosting distribution of the survey

Disseminate survey, analyze data & summarize results

Evaluation						

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