BC WOMEN'S HOSPITAL+ HEALTH CENTRE

An agency of the Provincial Health Services Authority

Contraception and Abortion in BC

Report of Proceedings, March 9, 2018

Acknowledgements

Contraception and Abortion in BC: Experience Guiding Research, Guiding Care: This Conference was made possible by the efforts of numerous individuals and organizations.

The conference organizers, British Columbia Women's Hospital and Health Centre, the Contraception & Abortion Research Team (CART), and Options for Sexual Health BC, would like to thank the following organizations for their sponsorship and support of this conference:

- The Michael Smith Foundation for Health Research
- The Rural Coordination Centre of BC (RCCbc)
- The National Abortion Federation (NAF)
- Women's Health Research Institute (WHRI)

The conference would not have been possible without the diligent efforts of the Organizing Committee, including conference chair, Cheryl Davies, Chief Operating Officer of BC Women's Hospital and Health Centre, CART leads Dr. Wendy Norman and Dr. Bonnie Henry, BC's Chief Provincial Health Officer, Dr. Tamil Kendall – Interim Provincial Executive Director, Perinatal Services BC; Michelle Fortin, Executive Director, Options for Sexual Health BC; Kim Campbell, Midwifery faculty member, Department of Family Practice, University of British Columbia (UBC); Dr. Natasha Prodan-Bhalla, Nurse Practitioner lead, Provincial Health Services Authority and BC Ministry of Health, and Dr. Sarah Munro, Post-doctoral Fellow, Department of Family Practice, UBC.

Thank you to graphic facilitator and recorder, Lisa Edwards.

Above all, CART wishes to thank the 94 policy makers, government strategists, health care providers, front-line health care staff, hospital administrators, health authority leaders, students, patients, community organization representatives, and researchers who attended the conference and provided critical input into the contraception and abortion health system gaps and opportunities in British Columbia.

Contents

Executive Summary

Purpose of the Conference

Equitable access to abortion care is a problem in BC, particularly for disadvantaged and rural populations. Rapid changes in regulations on the provision of abortion care and a new program improving access to contraception present important and timely opportunities to better meet the needs of British Columbians. At this exciting juncture BC Women's, in partnership with UBC's CART and health professionals, health administrators and health system leadership came together for the fifth *Contraception & Abortion in BC: Experience Guiding Research Guiding Care* Conference.

The previous conference (4th *Contraception and Abortion in BC: Experience Guiding Research Guiding Care*, October 2016) identified potential initial implementation strategies for the proposed SMART (free contraception post-abortion) Program, that proved key to the successful launch and scale up of this important initiative throughout BC since that time. Similarly, delegates identified the barriers in the pre-release medical abortion pill (mifepristone) regulations and the key changes required to implement in primary care, over 90% of which have now been addressed through the work of CART.

This year, we aim to examine BC-specific opportunities for provision of medical abortion and post-abortion contraception, to improve equitable access to high quality family planning health services in BC. The over-arching goal is improved health for women and families through equitable access to high quality contraception & abortion care.

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Plenary Best Evidence

On the heels of yesterdays' International Women's Day, and acknowledging tomorrow's International Abortion Providers' Day, delegates were welcomed to the morning plenary by Cheryl Davies, the Chief Operating Officer of BC Women's Hospital and Health Centre. Best evidence presentations engaged delegates on preventing recurrent unintended pregnancy, improving access to medical abortion, and current BC programs to provide free contraception and free medical abortion pills. Afternoon plenary sessions emphasized the opportunities and processes specific to BC and the perspectives and challenges faced in various roles.

Regional, Discipline Specific, and High Needs Topic Working Groups

Plenary presentations were followed by inspiring working group deliberations on innovative solutions to address the health equity and access opportunities and gaps for contraception and abortion care in BC. These inter-professional, inter-sectoral group discussions fostered participants to share their professional and practice perspectives, identifying policy, system and services gaps. Participants provided their expertise to develop and prioritize solutions to the identified challenges.

Conference Chair Cheryl Davies closed the day with agreement from the delegates to form a provincial steering committee, supporting the work of regional working groups, to systematically address the implementation of the health policy, system and service improvements agreed upon at this day. She thanked the delegates for their hard work and for sharing their expertise and valuable perspectives to advance the goal for improved health for British Columbians through equitable access to high quality contraception & abortion care.


CONTRACEPTION & ABORTION in BC:
BC WOMEN'S -CART- OPT MEETING
CEREMONY...
CLEANSING with CEDAR BOUGHS removes NEGATIVE ENERGY
WELCOME from ELDER ROBERTA PRICE Coast Salish
UNCONDITIONAL LOVE
WE ALL NEED IT E·V·E·R·Y·D·A·Y
FATHER SKY
LEFT PALM UP
WHENEVER WE COME TOGETHER WE JOIN HANDS in a CIRCLE...
RIGHT PALM DOWN
MOTHER EARTH
BC Provincial Health Officer
DR. BONNIE HENRY
THIS WORK is MAKING TREMENDOUS STRIDES in ACCESS for WOMEN!
DR. TAMIL KENDALL
Executive Director, Perinatal Services, BC
WE are doing GROUNDBREAKING WORK!
Dr. MARISA COLLINS
Medical Director, Options for Sexual Health
Opt
USED to BE PLANNED PARENTHOOD BC
WE'VE BEEN PARTNERING with CART for 5 YEARS

Part 1: Plenary

Welcome

The conference began with a traditional First Nations welcome to the Musqueam Traditional Territory by **Elder Roberta.** Elder Roberta led the participants in a prayer and the giving of thanks.

Cheryl Davies, Chief Operating Officer of BC Women's Hospital and Health Centre (BC Women's) and Conference Chair, welcomed provincial leaders and conference delegates, and provided the context and aim for the day. BC Women's recognizes the tremendous value delegates have brought during the prior four conferences in this series. Cheryl highlighted policy, system and service advancements that have been a direct result of the feedback and working group input at prior conferences. She noted the integrated research work of the Contraception & Abortion Research Team (CART) to translate the stakeholder input to the research needed to implement the changes and address the gaps.

Dr. Bonnie Henry, BC's Provincial Health Officer, welcomed delegates on behalf of the BC Ministry of Health. Building on the introduction of Cheryl Davies, Dr. Henry noted that the longstanding partnership of the Provincial Health Officer and the BC Ministry of Health with the CART program of research is unique and effective. She noted provincial policies have resulted from CART research and this series of CART provincial stakeholder collaboration meetings, such as the recent policy to provide free medication abortion pills, and the SMART Program policy providing free post-abortion contraception throughout BC. In summing up Dr. Henry encouraged delegates to share their experiences and contribute to the working group discussions ahead in the day. The conference collaborations, such as today's "5th Contraception & Abortion In BC", are great examples of how we can use research activities to inform policy changes that improve lives throughout British Columbia.

Policy system and service advancements have been a direct result of the feedback and working group input at prior conferences of this series.

Dr. Tamil Kendall, Interim Provincial Executive Director, Perinatal Services BC (PSBC) welcomed delegates and shared her excitement to be involved with this groundbreaking work to move the contraception and abortion access and equity agenda forward throughout the province. Dr. Kendall noted that supporting British Columbians to access high quality care to time and space their children is key for maternal and infant health and well-being, and thus an important aim supported by PSBC.

Dr. Marisa Collins (Options for Sexual Health BC, "Opt") spoke eloquently of the aims and services of Opt and of the value and rich advancements achieved over the years through these 5 collaborative meetings and the ongoing partnership with BC Women's and CART.

Dr. Wendy Norman, CART Director, set the stage for the day's events. She acknowledged the interdisciplinary and geographically diverse representation in attendance.

Plenary Best Evidence Sessions

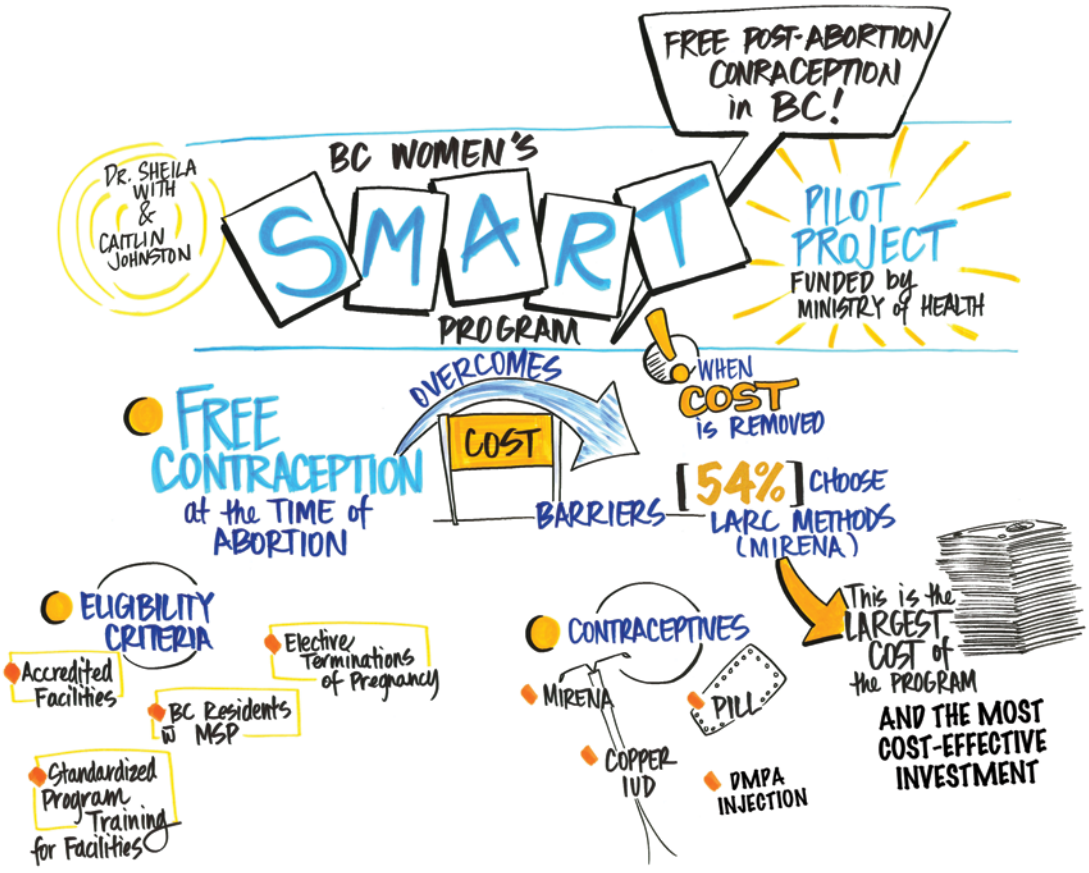
BC Women's SMART Program: Free Post-Abortion Contraception in BC!

DR. SHEILA WITH & CAITLIN JOHNSTON

Dr. With is an OB-GYN at Royal Columbian Hospital as well as the Medical Lead of the BC Women's Hospital CARE Program. **Caitlin Johnston** is the Ambulatory Program Manager at BC Women's Hospital. Together, they provided a summary of the innovative Safe Methods At the Right Time Program ("The Program") where an individual's choice of contraceptive methods is available for immediate commencement following a medical or surgical abortion. This provincial pilot program, funded by the Ministry of Health and administered by BC Women's Hospital, offers important benefits for BC residents, including: improving equitable access to contraception, and positive system and population health impacts across BC.

> **"When cost is taken out of the equation, women are choosing the LARC [Long Acting Reversible Contraceptive] option as post-abortion contraception."**
>
> ***– Dr. Sheila With***

Dr. With highlighted that the one-year program evaluation findings demonstrated the uptake of Long Acting Reversible Contraceptives (LARC) among all BC residents having an abortion is 54%, representing a significant increase from baseline data that suggested a 14% uptake. She notes "When cost is taken out of the equation, women are choosing the LARC option." Two-thirds of participants reported no additional health care insurance or benefits that could potentially cover the cost of contraception. She also noted that the data allows them to predict that The Program achieved at least a 39% reduction in the number of subsequent pregnancies within 2 years after the index abortion.



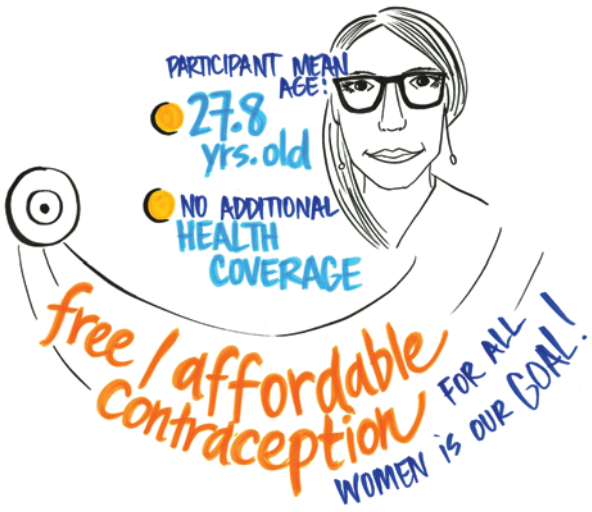
Discussion:

The discussion acknowledged the progress that has been made in contraceptive management in BC but also set the stage for ongoing advocacy and policy work by addressing some of the limitations of The Program. For example, the distribution of non-LARC methods has been a challenge; some medications in The Program provide contraception for 5-10 years (IUDs) whereas (i.e. Depo-Provera) are offered to individuals for 3 months (one dose) and birth control tablets for 1 month. As The Program offers participants a free contraception at the time of abortion and has no mechanism for sustained provision, this is an inherent limitation.

Another limitation identified by the audience was the eligibility criteria. The Program only includes women who are residents of BC with MSP coverage, thereby excluding a vulnerable sub-population. The project team highlighted that The Program remains a publicly funded program with a mandate to support the residents of BC. The long-term goal is to use the data generated from The Program to support a proposal that all women (i.e. not just 'BC residents') should have easy access and affordable (or free) contraception, including any method they choose.

The audience was interested in the extension of The Program to interior and northern health regions, as well as Fraser Health Authority. Dr. With noted that this process is already taking place as providers are being identified, meeting the project team and participating in the onboarding process.

The pilot project and evaluation of this program is scheduled to continue until the end of 2019; the number of providers and the amount of contraception used may impact this timeline.



Mifepristone Implementation in Canada: Current Progress and Challenges Ahead

DR. WENDY NORMAN

Dr. Norman is a family physician and an Associate Professor in the Department of Family Practice at UBC and the Director of CART. Dr. Norman is the principal investigator on a national project to support mifepristone practice across Canada. The heart of her research collaboration is the engaged CART front-line clinicians who provide care in all provinces and territories in Canada.

The distribution of abortion prior to the advent of mifepristone was as surgical abortion in large city centers. The goal of Dr. Norman's research project is to answer the question: can a primary care practitioner (physician, NP or midwife) in a regular primary care visit provide mifepristone?

To answer this question, Dr. Norman's research

> **"8% of those physicians who have completed a survey indicating they are new to abortion care, practice in communities that have never had abortion services before."**
>
> ***–Dr. Wendy Norman***

project incorporates four key components:

1. Surveys and interviews among those health practitioners interested to provide mifepristone,
2. The Canadian Abortion Providers Support (CAPS) community of practice platform,
3. Interviews with key health system and services decision makers,
4. Real-time, continuous, integrated knowledge translation (iKT) interactions with knowledge users and decision makers

In 2012, the CART National Abortion Survey estimated there were ~240 abortion providers across Canada. Today, Dr. Norman has collected ~400 physician surveys in the mifepristone implementation study, and Quebec physicians (almost half of the prior number) have not yet begun using mifepristone nor joining the study. Thus we estimate Canada now has twice as many abortion providers as prior to mifepristone availability. Dr. Norman expects this phenomenal shift will continue to increase since Health Canada (HC) removed restrictive constraints on the distribution and administration of mifepristone in November 2017. Preliminary findings from her research suggest that 40% of those physicians interested to provide mifepristone have never provided abortions before, 8% of which represent communities that have never had abortion services before.

Dr. Norman's team has been working closely with organizations across the country, including regulatory colleges and national associations to support the practice of healthcare practitioners. In addition, her team meets via teleconference with the leads of HC quarterly who have become active participants in discussions supporting the uptake of mifepristone in Canada. This is the first partnership of its kind, as identified by HC, with a research team.

Recently, leaders in NP practice have joined the CART-GRAC collaboration to support the uptake of mifepristone in NP clinical practice. NPs now have explicit guidelines to support their provision of mifepristone in five jurisdictions across Canada. Meetings with national midwifery leaders to form similar research policy partnerships are planned for next month.

Early learnings have been that there is a tremendous enthusiasm among HCPs, professional organization policymakers and government to support mifepristone medical abortion practice; timing and communication

is everything. The project has been successful to date to revise several national and provincial regulations that were previously barriers and are now seen as facilitators to provision of medical abortion within routine primary care.

Dr. Sarah Munro, CART post-doctoral fellow and a co-investigator on the mifepristone implementation study, introduced a document that was produced in partnership with Planned Parenthood Ottawa in response to a need identified by CAPS members: a Prescriber Checklist. The purpose of the checklist is to support new providers bringing mifepristone to their clinical practice. The near final version was distributed to the more than 60 primary care professionals in the room, who returned revisions and comments for improvement to the CART researchers.

Discussion:

The audience was interested to discuss restrictions to NP provision of mifepristone. Dr. Norman clarified that in Canada, a practitioner's scope of practice is not decided federally; they are decided by provincial colleges. The basis for the NP license is not exhaustive; colleges typically take the approach that as a trained and licensed provider, they expect you to understand, know and provide care in your practice that is within your competencies.

Virtual Care Tools to Support a Virtual Family Planning Strategy in BC

DR. JOHN PAWLOVICH

Dr. John Pawlovich is a Clinical Associate Professor in the Department of Family Practice at UBC and a family physician practicing in Fraser Health, as well as throughout the North via Tele-Health. He is a senior leader in the Rural Coordination Centre of BC, a sponsor of the conference. Additionally, he is involved in many telehealth initiatives in the province of BC. He is a co-founder and co-lead of the BC Virtual Health Grand Rounds. Dr. Pawlovich describes himself as a "rural generalist" who uses the power of technology to support access points and allow safe patient

care – whatever their need is. He conducts between 800 to 1000 virtual health visits a year. He was the first of two presentations, focusing on the role of technology in primary care.

Dr. Pawlovich provided a gripping context for his work. He highlighted that rural Canada accounts for 90% of Canada's land mass and is home to almost a third of Canadians. He identified the significant issue in Canadian healthcare is that rural Canadians do not have equitable access. He shared statistics indicating that Indigenous peoples remain on the margins of society, including that rural residents have higher overall mortality rates and shorter life expectancies compared to Canadian residents in urban areas.

Dr. Pawlovich shared incredible photographs of remote communities he visits across BC. He recalled memories of when the first road was built into some of these communities and others that remain fly-in access only. Through these visuals he highlighted that barriers to access are geographical, climatic and cultural.

He presented a photograph of a video conference call using a secure program on a specific iPad. Here, we saw a patient sitting in a health center with a blood pressure machine and Dr. Pawlovich on the other end of the call. Using visuals, he showcased ways technology is now available in some of these communities, reaching patients and supporting nurses. Dr. Pawlovich acknowledges that although he uses a lot of virtual care technology, technology is not the end game; technology is just a tool to support patient centered care. He describes that the right technology is the technology that helps that person in that moment in time. Often times, this is done through "texts" to patient phones.

"Rural Canadians do not have equity to access… technology is not the end game, technology is just a tool to support patient centered care."

-Dr. John Pawlovich

Mifepristone by Telemedicine

DR. ELLEN WIEBE AND CHERYL COULDWELL

Dr. Ellen Wiebe is a family practice physician and Clinical Professor in the Department of Family Practice at UBC. She is the medical director and **Cheryl Couldwell** is the executive director at Willow Women's Clinic in Vancouver. They have worked together for over 38 years to provide medical and surgical abortion and contraception services. Together, they delivered the second presentation focusing on telemedicine, specifically for medical abortion.

Willow Clinic is a high-volume abortion clinic. Here, practitioners have supported telemedicine abortions since 2012. Since that time, annual telemedicine abortion data indicated an increase from 15 abortions in 2012 to 88 abortions in 2017 when mifepristone became available in Canada. Mifepristone has a safer drug profile than previously used methotrexate. Dr. Wiebe noted of those 88 cases in 2017, 46 were <1 hr from the Interior Health Region's surgical abortion program at Kelowna (a facility which typically has a 3 week-waitlist). This suggests a gap in access even within a BC metropolitan area.

Dr. Wiebe described that before practitioners at Willow Clinic can order tests for a patient, they must **see and speak** to them. This is often done over FaceTime or Skype from a clinic iPad or computer to the patient's own device. Cellular and internet coverage has been a challenge with some connections.

Dr. Wiebe discussed medical issues when providing mifepristone through telemedicine. First, she identified that any **contraindications** for the use of mifepristone can be done by oral history. This will inform whether a practitioner moves forward with a telemedicine abortion or if other arrangements are required. When deciding if a patient requires an ultrasound (US), Dr. Wiebe highlights the evidence, noting as per the SOGC Medical Abortion Clinical Practice Guidelines for Canada, that this will depend on the reliability of dating. She notes that in some situations, the practitioner may want to book a back up appointment for surgery, in the event the US takes a long time to schedule and/or have done.

In terms of **Rh Immune status**, Dr. Wiebe notes that in some communities, lab tests are only done in the hospital setting which may impact confidentiality, although it is then available free of charge to the patient. In communities that have a "Life Labs" available to do this test, the patient

will have to pay for the lab. In other situations, labs may send the sample collected on to Canadian Blood Services which takes close to two weeks for results. These barriers are important to consider.

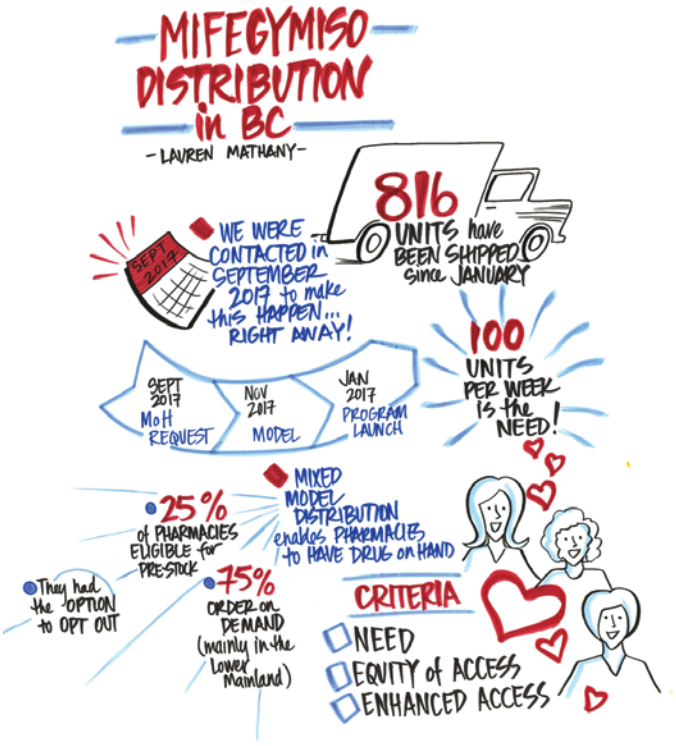
In response to questions about follow up using serum beta-HCG tests, Dr. Wiebe suggested if the **HCG falls < 80%**, the clinician should consider ordering an US, and advising to plan a trip to Vancouver for assessment and management. She highlighted that since providing mifepristone, her clinic has had to manage fewer of these scenarios, than had been the case with Telemedicine provision of methotrexate medical abortion.

Cheryl described some of the administrative challenges that come with providing mifepristone via telemedicine, including finding a **local pharmacy willing to dispense** the medication and the overall cost for the service if the patient is not a resident of BC. She reports her team will call a pharmacy ahead of time to see if they will dispense mifepristone. When necessary, a Vancouver pharmacist working with her team does courier the medication to the patient. This however, is done at a cost to the patient. Additionally, if the patient is not a BC resident, the **cost** of the full healthcare services can be ~$900 (three visits, the medication and the tests). In BC, there is a telemedicine billing code that practitioners can use for remuneration from MSP. Dr. Wiebe notes that her team has been happy to offer the SMART Program to their patients (LARC methods may be inserted up to 2 weeks after the abortion).

Overall Dr. Wiebe and Cheryl report that their patients are so grateful to have telemedicine in their community. Telemedicine brings more choice, less stress, less cost and less travelling to their communities. Staff at Willow Clinic report that they can have the same type of relationship with a patient over the phone and in some cases it is an even better relationship because they are calling from the comfort of their own home/environment. Finally, Dr. Wiebe notes that her experience with prochoice physicians in rural/remote areas are so grateful for the support and option to refer their patients to Willow Clinic Telemedicine.

"Prochoice physicians in rural/remote areas are so grateful for the support and option to refer their patients to Willow Clinic Telemedicine."

-Dr. Ellen Wiebe



Mifepristone Distribution in BC

CHERYL DAVIES AND LAUREN MATHANY

Lauren Mathany is responsible for the distribution of mifepristone to community pharmacies across BC at the BC Centre for Disease Control. Lauren reports the BCCDC was contacted by the Ministry of Health in September 2017 to develop an interim strategy to distribute free mifepristone across the province using a process that could be operationalized expeditiously (the province announced universal coverage which was implemented by BCCDC on January 15th, 2018). The BCCDC is responsible for purchasing and distributing all publically funded vaccines in BC, as well as a limited number of STI and TB drugs.

Lauren's team along with the Ministry of Health decided to identify community pharmacies that would qualify as a "Pre-Stock Site". The criteria to identify these pharmacies would be based on greatest need (historically high and medium volume), equity of access (rural and remote locations), and/or enhanced access (identification of known provider areas). 'On Demand Sites' are those pharmacies that would be required to order mifepristone directly from the BCCDC when a patient presents to them with a

prescription, and the pharmacy would receive a shipment within 1-2 business days. Across BC, 25% of pharmacies are eligible to pre-stock mifepristone, the remaining 75% have mifepristone available to them on demand.

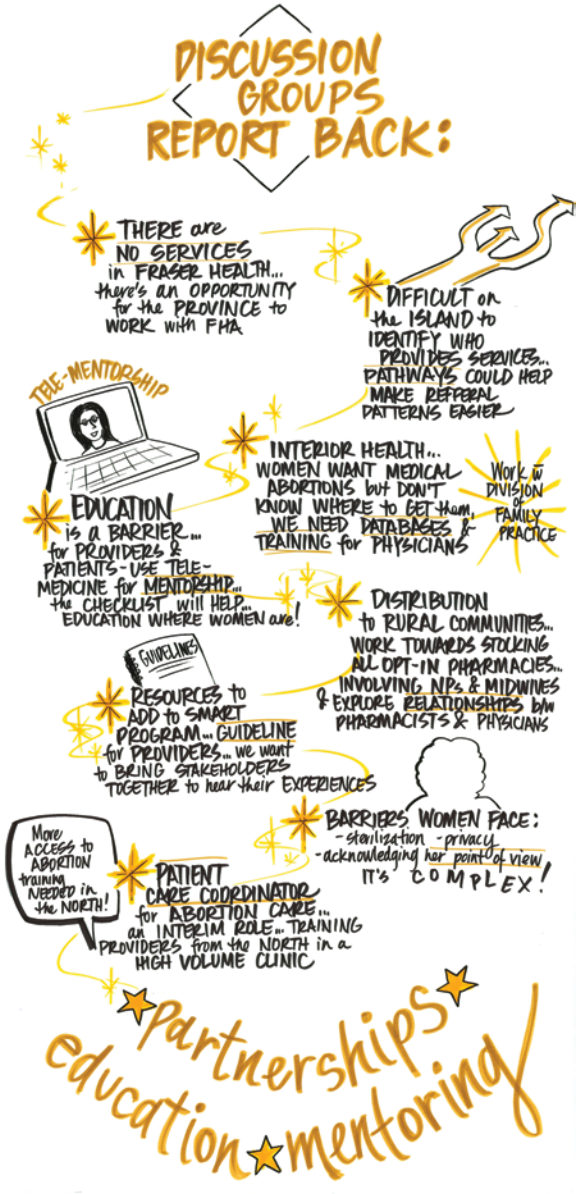
The primary challenges with this model have been manufacturer drug shortages, additional pharmacy requests for pre-stock, and the pharmacy opt-out option, where some pharmacists choose not to dispense the medication. To date, 176 of the 332 identified pre-stock sites have placed an order, and 20 on-demand sites have placed an order. So far, the BCCDC has shipped 816 units and this process is starting to normalize, averaging 100 units per week. This equates to medical abortion provided to more than a third of the number that are overall provided in BC in any year, and thus a massive shift away from surgical abortion and travel to surgical sites to access abortion.

Among the identified pre-stock sites, 15 have opted out, i.e., chosen not to pre-stock the medication (they could easily reverse this if needed). In those towns that have pharmacies who have opted out, should the opt-out facility be the only pharmacy in town, then potentially a patient seeking to fill a prescription for mifepristone would have to go to a neighboring town to obtain the medication. This along with the other challenges and barriers to the program will be monitored with the Ministry of Health to explore solutions. Lauren reports the BCCDC is expected to manage mifepristone shipments across the province for about 18 months. By that time the provincial government is hoping to have established the legislative or regulatory changes that will allow the normal payment processes, i.e., PharmaCare to manage universal coverage of this medication.

Discussion:

Conference attendees voiced some frustration around the opt-out option that was given to pharmacies and the challenges with rural access that may result. Pharmacist attendees provided informative insights about the operation of pharmacies as a business, unlike hospitals which are part of the public sector. Similarly, a pharmacist is regulated and can practice autonomously, like a physician. Similar to any health care provider's right to be a conscious objector for provision of care against their personal principles, a pharmacist also has that right.

Opt Clinic representatives shared that their clinics might be able to provide a convenient site where people can access the medication, if mifepristone distribution would consider including Opt clinic sites. There was discussion around providers that participate in the CAPS platform, using CAPS as a mechanism to bring this type of information forward (i.e., practice concerns) so Dr. Norman and her team may attempt to address them.



Nurse Practitioner Role in Mifepristone Care

DR. NATASHA PRODAN-BHALLA

Dr. Natasha Prodan-Bhalla is a Nurse Practitioner (NP) and the leader of Nurse Practitioner care within the Provincial Health Services Authority (PHSA) as well as the recently appointed Primary Health Care Lead in the Nursing Policy Secretariat in the Ministry of Health. Dr. Prodan-Bhalla began her presentation by providing an overview of NPs in BC: there are currently 450 NPs working in BC in all care settings, 60% of whom are primary care providers in rural areas. The majority of these NPs are employees of health authorities (which mean they are in a salaried position). In addition to diagnosing, prescribing and treating patients across the spectrum of care, NPs provide an important nursing leadership role within the healthcare system.

Following the Health Canada mifepristone regulation changes in November 2017, the College of Registered Nurses of BC conducted a policy review and granted prescribing authority of Mifegymiso® to NPs with no limits or conditions. Like physicians, NPs have a professional obligation to practice within their scope of competencies and follow evidence-based best practice guidelines. Dr. Prodan-Bhalla identified that all NPs should consider taking the SOGC training to support their practice. In addition to these standards, Dr. Prodan-Bhalla highlighted that NPs have their own standards of practice to adhere to (i.e., ethics, consent, prescribing and dispensing drugs, duty to provide care). She noted that like physicians and pharmacists, NPs can have a conscientious objection to abortion care but that, similar to the expectation for physicians, it is their professional obligation to find out who will provide that care.

Dr. Prodan-Bhalla described NPs as alternate providers in the system with similar competencies and overlap with other roles (i.e., family practice, social work or counselling) but a difference in their approach. She argued that NPs take a Health Equity Approach in their care delivery. NPs also have an important role in Telemedicine and within the interdisciplinary team. For instance, in the provision of medical abortion, there are many appointments and intersections with the health system an individual will experience. Medical abortion care requires a

full team approach and as a discipline, NPs have the ability and mobility to provide care in rural/remote areas in part because they are salaried.

Discussion:

> **"There are currently 450 NPs working in BC in all care settings, 60% of whom are primary care providers in rural areas."**
>
> ***– Dr. Natasha Prodan-Bhalla***

The audience was interested in the mobility of NPs because they are a salaried profession. An individual questioned if NPs could provide private practice which Dr. Prodan-Bhalla responded no, but like physicians, NPs will be moving forward with other compensation packages being offered. Interestingly, when asked how many NPs are currently providing mifepristone in Canada, there was no clear answer. One NP believed perhaps 2 were practicing in Fraser Health but similar to issues with physician provision of abortion services, there is a gap in our knowledge about who provides care, and where to refer patients. Dr. Prodan-Bhalla echoed that we should be moving towards integration and networking in our BC community of practice and perhaps we could update the current BC Women's hosted "Pregnancy Options Line" that maintains a confidential network of abortion providers, to create access for health professionals and women around BC to connect with practitioners who are providing or are ready to provide. This was compared to NPs are providing MAiD to which the audience had an answer since a system is already in place to track/refer patients. Other issues were raised to support NP provision of medical abortion, including a system for being on-call for patients (perhaps using the Provincial Nurse Help line such as other provinces have decided to do, could address this need), and the value as with so many aspects of practice, to be connected to surgical back up services ahead of need.

Midwifery Role in Mifepristone Care

KIM CAMPBELL & LOUISE AERTS

Kim Campbell is an Instructor in the Division of Midwifery and Lead for the Midwifery CPD Program at UBC. Kim has been a Registered Midwife in BC for 20 years. **Louise Aerts** joined the College of Midwives of British Columbia (CMBC) in October 2014 as the Registrar and Executive Director. Together, Kim and Louise described the legislation and regulations limiting midwifery practice in BC.

They began their presentation by describing the legislation of Midwives in BC. Under the Health Professions Act falls the Midwives Regulation, which is the guideline defining the scope of Midwifery practice in BC, and is followed by the College of Midwives of BC. Kim acknowledged that while in other health professions, once a college defines a scope of practice, they aren't overly prescriptive however, this is NOT the case with midwifery, as the legislated regulation is very proscriptive already. They demonstrated this to the audience by showcasing the highly detailed and specific definition of midwifery practice. For example, in their practice, they can only care for a pregnant woman, for the duration of her pregnancy, up to 3 months post-partum. They also demonstrated the limitations placed on midwifery use of medications by showing one example of a drug category, description of a drug, and its purpose (which was limited). For example, midwives can provide medications for cervical ripening for the induction of labour. As mifepristone is a new medication it is uncertain how this will be related to the current legislation. Kim reports that to add a new drug to the formulary, it may be necessary to apply for an amendment.

To date, no Canadian midwifery regulations have mifepristone or medical abortion in their scope. Many midwives are committed to providing this choice however, and many women come to midwives even when they don't want a pregnancy. Louise validates "we are relevant!" Currently in BC, there are 300 practicing midwives and 60 non-practicing. The International Confederation of Midwives (ICM) definition of the scope of midwifery practice is much more broad and inclusive of the provision of abortion care, as this is a key role for midwives in many countries. Their definition of scope includes: "The midwife has an important task in health counselling and education,

not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care." In Ontario, midwives are already seeking approval to align the scope of midwifery practice with ICM Definition.

Louise and Kim highlight that changes to *Midwives Regulation* are required. They support a push for primary care to:

1. Amend the drug schedule,
2. Expand scope to include medical abortion, and
3. Well Baby Care – up to 1 year.

Discussion:

Kim and Louise had the audience's full attention; gasps and chatter of disbelief regarding their profession's regulatory restrictions indicated this information was not familiar among most other providers. One audience member asked about midwifery current scope of practice around spontaneous abortion. Louise responded that they can provide post-partum care, counselling and follow-up. Another audience member asked if midwives could provide misoprostol for a spontaneous abortion, to which Louise responded yes, but only for the purpose of: cervical ripening between a stated timeline, or advanced maternal age or for post-partum hemorrhage.

"Many women come to midwives, for a range of reproductive care needs, even when they don't want to continue their pregnancy- we are relevant to abortion care!"

– Kim Campbell

NAF Canada – Education, Members Services and Supports

JILL DOCTOROFF

Jill Doctoroff is the Canadian Director at the National Abortion Federation (NAF). NAF is the professional association of abortion providers with the mission to ensure safe, legal and accessible abortion care, which promotes health and justice for women. NAF's Canadian members include 36 facilities (free standing clinics and in-hospital services) and 45 individual members (independent providers). More than 80% of the abortions that are provided in Canada are provided at NAF member facilities.

NAF offers its members Medical Education (i.e. Continuing Professional Development accredited education programs, Webinars, A Comprehensive Clinical Textbook on Medical Abortion and Surgical Abortion, a "Ultrasound in Abortion Care" electronic workbook, and accredited Conferences: Annual and Regional, as well as online and on-site trainings), a Quality Assurance Program (i.e. Clinical Policy Guidelines, Facility Accreditation, Quality Assurance Monitoring like annual complication statistics), and Safety and Security (i.e. 24hr support services, security assessments and training, and tracking violence and disruption activities). NAF has a robust public policy program: they testify as experts, dispel myths and counter misinformation both within the health care and broader public communities, engage with media, influence care provision (i.e., supporting the approval of mife by Health Canada), work with the regulatory colleges, and advocate against proposed inappropriate anti-choice legislation.

Finally, NAF offers a patient access to services and financial assistance hotline through the Dr. Morgentaler Canadian Patient Assistance Fund (for example, uninsured abortion care and travel or accommodation expenses for folks who have to travel to access abortion care services).

Discussion:

Regarding the fund, workshop participants were interested in whether or not this was applicable to medical abortion or is it only surgical; the answer was yes, to both. Jill was asked if this travel fund would cover the cost of having the medication couriered to a patient. Jill reports they have not had that come up in the past but the patient should be eligible. She reminded the audience that the travel fund is dependent on contributions from donors, and encouraged those interested to connect with her for more information.

Patient Voices: "Sex Sense" line hears from British Columbians!

DAWN PETTEN & OPT STAFF

Dawn Petten is the Coordinator of the Sex Sense Line with Options for Sexual Health (Opt). She began with Opt as a volunteer, 19 years ago. Dawn began her presentation by reading emails Sex Sense has received from individuals across BC. This valuable presentation brought the voices and concerns of vulnerable British Columbians front and center for the workshop participants, and served as a stark reminder of the conditions and barriers facing so many of our patients.

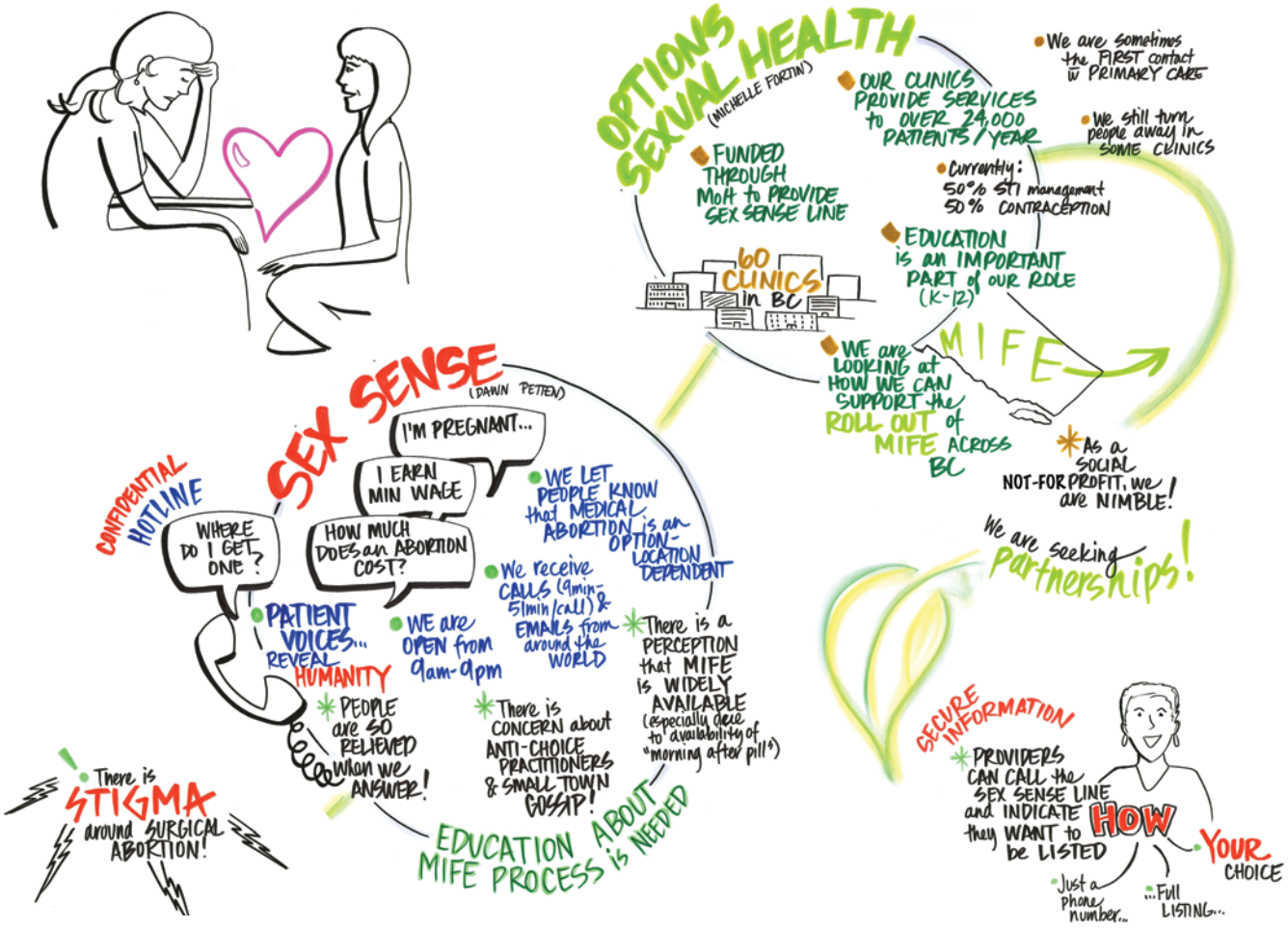
Dawn had selected emails that focused on 5 common themes of questions received at Sex Sense. Availability, Assumptions, Anxiety, Answers, Patient Voices. Sex Sense is available to support individuals about everything related to sexual health from 9am – 9pm, Monday to Friday. Individuals connect with trained registered nurses and certified sexual health educators. Dawn highlights that

"Options "Sex Sense" service answers over 9000 calls or emails a year, more than 6000 of those are abortion related."

-Dawn Petten

when triaging emails, her team flags those emails that are time sensitive, to ensure priority responses to concerns such as access to emergency contraception and abortion care.

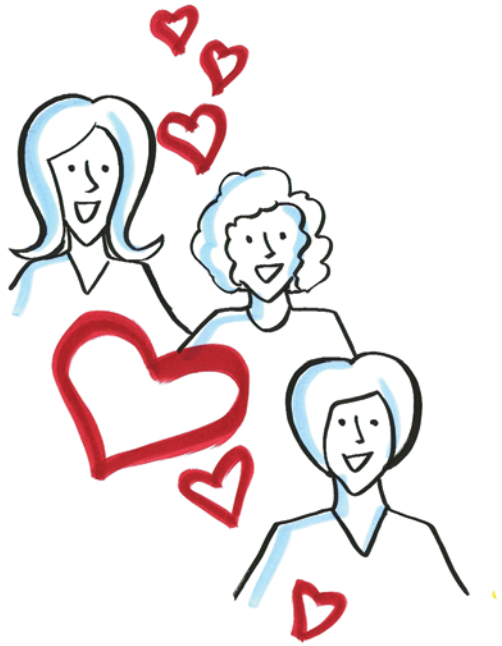
Sex Sense answers over 9000 enquiries via email or telephone call a year; over 6000 of those are abortion related. The average duration of abortion related calls is 9 minutes, the range can be up to 51 minutes. Sex Sense responders will discuss any topic and will not limit the conversation due to content. The only limitation staff at Sex Sense experience when they are on line is when they need to answer: "I don't know". Dawn explained that this is most often related to "where is the closest abortion provider", and that when this occurs, they refer people to the BC Women's Hospital Pregnancy Options Service line, the "POS" line. They have learned to warn their patients that often they may need to leave a message at POS, and that it might be



some time before they receive a response. BC Women's leaders present flagged these needs for further evaluation.

Dawn identified that her team needs to know where they can direct people for abortion care. She reports many individuals think that any doctor will provide abortion, assuming this is related to the current availability of the emergency contraceptive pill (ECP). In some cases, her patients are dealing with anxiety, or worry about anti-choice providers, and the need to avoid becoming a source of small town gossip.

Workshop participants voiced surprise that such a longstanding service had a disconnect with providers: The need for a provincial database of abortion providers, that could be accessible to Sex Sense and to appropriate health services and perhaps patients needing care, seemed clear. This conversation has been happening the whole time the line has been open, although not in a multisectoral context such as we have here today. Opt recognizes that there is a security piece for the confidential information for providers, and many factors to consider, we need a provincial solution! Any provider can contact the Sex Sense line and decide with Sex Sense how you want to be listed. Many potential solutions were considered and dilemmas discussed, such as the need to ensure provider privacy/confidentiality where appropriate and yet ensure patient access.



Opt BC – Role Advancing Mifepristone Care in BC

MICHELLE FORTIN

Michelle Fortin is the Executive Director for Options for Sexual Health, and has worked for many years in organizations providing support for disadvantaged and vulnerable populations.

Michelle spoke eloquently of the work of Opt, and the scope of services provided in the Province. Opt is Canada's largest not for profit provider of sexual health services. Their 60 clinics throughout BC serve over twenty four thousand British Columbians each year. Some are open for a few hours each of five days each week, while others may open just for two evenings a month. Opt has been operating sexual health clinics in BC since 1968, initially as Planned Parenthood BC, a branch of the then Planned Parenthood Federation of Canada and the International Planned Parenthood Federation.

In addition to the Sex Sense Line, and the 60 sexual health services clinics, Opt also trains educators and directly delivers sexual health education in schools throughout the province. These programs engaged more than eight thousand British Columbian students and many parents or parent groups last year.

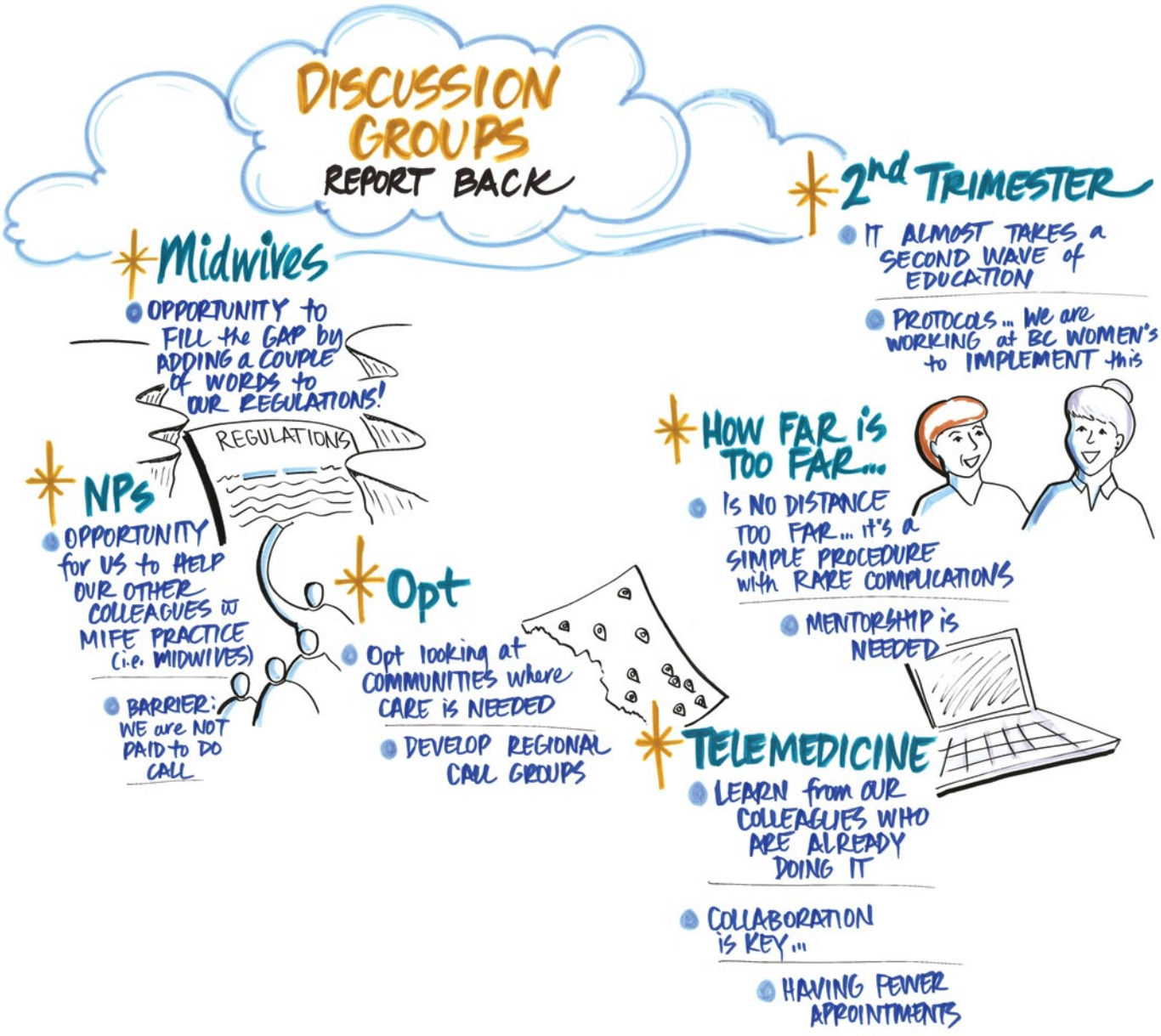
Opt continues to explore how they can best serve the sexual health needs of British Columbians. At the current time they are strategizing on how Opt might best support the provision of medical abortion across the province, and how Opt can be of value, and services to support more equitable access to medical abortion across BC. This is a new role for Opt, which has never provided abortion services directly, although they have been very engaged in referral, follow up and other supports for patients seeking or having had abortion.

One model of care Opt would like to see considered is the ability to create an Advanced Nursing Practice role for nurses to become certified in the practice of providing mifepristone medical abortion. If this were achieved, then Opt could consider models of care similar to that for certified nurses in advanced contraception care practice delivering contraception at their clinics. Opt is also interested to see how NP care could be incorporated at

their clinics and if there is a role at Opt for NPs or midwives. Funding models may need adjusting to accommodate this, but the extent of services could be immediately expanded.

Similarly, could Opt become a site dispensing mifepristone? Discussion from the audience and feedback in working groups later raised issues related to the current inability of Opt staff to log dispensed medications on the provincial PharmaNet system, a patient safety measure required for all other drugs dispensed in BC. Because Opt already provides a large proportion of contraception, this limits the emergency room access to a history of contraceptive use, and general provincial knowledge of prescription patterns, practices, and consequences. Would it be possible for provincial funding and nursing regulations to equip Opt with the ability to log dispensed medications in the PharmaNet system?

Finally, Michelle highlighted that as a non-governmental organization, Opt is governed by a board of directors, both overall at the provincial level, but also by branch boards at the small city or town and rural community level throughout BC. In Vancouver, there are a lot of progressive, pro-choice directors, but rural and remote branch boards may not have the same willingness to advance services toward this new area of care and risk. There are lenses here that we don't have at the provincial board level yet.



Part 2: Opportunities and Gaps by Region

FRASER HEALTH

What are the opportunities or gaps?

There are no surgical abortion services in Fraser Health, despite nearly half of reproductive age women residing here. Typically, those seeking abortion travel to VCH. We need services (medical and surgical abortion, and more sexual health and contraception services) in Fraser that are easy for patients to find.

Current gaps seem to include:

- the will or drive at the health authority and health services administrative level to address these needs;
- the ability to institute sexual health, medical and surgical abortion services
- to design or provide services to support both networking and connections between these services;
- to support easy access for patients and their referring primary care providers to abortion and sexual health service;
- cost for the best contraception methods is a barrier for patients.

What can facilitate this change?

At our table, NP, OBGYN, Family practice are all willing and eager to collaborate, and would like to assist to develop the networking, linking to confidential provincial referral sources, and surgical service initiation that this health region needs.

PHSA, PSBC and the Ministry of Health could facilitate advancing discussions with FH decision makers.

Options for Sexual Health has several clinics in the health authority already, and is well positioned to work with or support FH toward increasing collaboration or advancing additional sexual and reproductive health service.

What changes might be made?

Opportunity at the provincial level to work with FH to establish services. Some providers are beginning to offer medical abortion, and through linking and networking and safe service referral (e.g., through BC Women's Pregnancy Options and Referral Line, or Options for Sexual Health's Sex Sense Line) these services could be more accessible.

Provincial ministry, PSBC or PHSA leadership could facilitate discussions with FH leadership and decision makers to advance support for surgical services (at least as back up for medical abortion services, and ideally offering surgical options as well).

What might impede this change?

Discussion group members are concerned that there may be no internal will in the health authority leadership to improve service deficits, despite mandate. "We feel there has to be a carrot or a whip."

What are the opportunities or gaps?

We see a key role for education and support for potential abortion providers among primary care disciplines, particularly GPs and NPs. We think there is a hesitancy or reluctance ("a fear") among providers to implement MA in their offices due to the lack of knowledge and experience for this new service.

- For example, the conflicting information between the package label and government announcements indicating mandatory ultrasound requirements, compared to the SOGC guidelines best practices which does not require ultrasound;
- Providers also need knowledge around how to manage, lab tests and organizing all needed information into a routine primary care visit.

Also, primary care providers already have concerns for the timely access to US and note that recent provincial guidelines did not include early pregnancy dating for medical abortion as a priority indication;

NPs will need support for provision of on-call service for patients seeking medical abortion, and all need working effective linkages to surgical back-up for medical abortion failures.

Our group also noted a need among our patients for more information and resources, particularly to assist with decisions around long acting reversible contraception (LARC) vs other methods, and with the choice between Medical and Surgical abortion (Ed Note: the follow up recommendations for this are addressed in the "need" specific working group results in the next section).

What changes might be made?

Mentorship from high volume providers either at a high-volume site or through Telemedicine (this service can be used for providers, not just the patients!)

A provider checklist for a medical abortion visit would be very handy.

Changing the BC Government guidelines on radiology priorities to reflect the SOCG clinical practice guidelines.

Finding a way to provide on-call coverage for NPs who provide medical abortion.

What can facilitate this change?

- Health professional pre-licensure and continuing education delivered by BC leaders in each professional discipline, and particularly from the experienced physicians with our allied health providers and empowering a range of new practitioners to take up the medical abortion or LARC insertion practice;
- Promoting the use of the CART based online community of practice (CAPS) resources and networking for practice questions/ support;
- the new/pending Prescriber Checklist that CART has developed;
- supporting pharmacist/physician/NP collaboration (e.g., through CAPS and CPD events) could allow people to feel less fearful about providing;
- Could BC's current "Nurse help line- 811" provide the on-call service for NPs' patients who have had medical abortion?
- Patient education opportunities for LARC and medical vs surgical abortion- Going to places where women are (even on-line resources). Consider not just the perspective of the provider. Education has to be in places where women go – where they work, where they play, where they are. Conduct a focus group with women to identify where they perceive gaps in care.
- Offering LARC contraception Free.

What might impede this change?

- Funding;
- Ability for interested primary care providers to find resources and services for their own education/support and for that of their patients.

What are the opportunities or gaps?

There are large discrepancies throughout the island in access to:

- medical abortion;
- post abortion IUD insertion;
- surgical abortion;
- It is difficult to know who provides what service not only for women but for practitioners (i.e., improvements for both patient and providers in finding services and some sort of networking of services is needed).

What changes might be made?

We may be able to leverage and adapt current services, for example: Using a professional website like "pathwaysbc.ca" (only for registered GP users so far- could NPs and Midwives be added?) to be able to find out who provides abortion services.

Ideally, this website would also be accessible to other health care professionals. Ideally, this would improve referral patterns for abortion providers.

Establishing some network or connection between providers of family planning services throughout the island, this could help between disciplines for back up and consultations, but also to share resources and provide local mentorship.

What can facilitate this change?

Create a better "back-up" system with gynecologists to contact in case there is a problem.

Better decision-making counselling pre-abortion (i.e., a service to assist patients to understand both about contraception choices but also how to choose and understand what to expect with medical or surgical abortion.

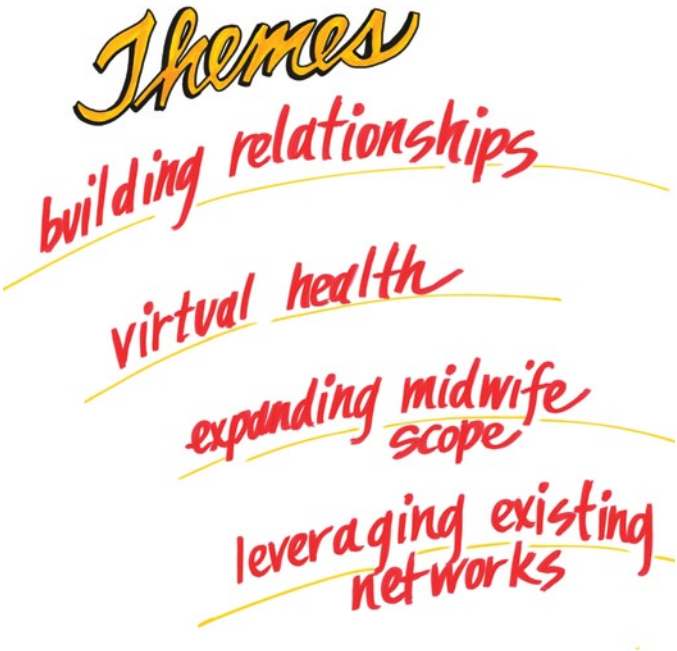
Also, we need some service to support GPs who are not well equipped to do this counselling. Perhaps patients could be referred to the Options for Sexual Health "Sex Sense" line or the BC Women's CARE program "Pregnancy Options Service" counseling and referral line could help with counselling.

What might impede this change?

Some GPs offering abortion do not want to be listed as an abortion provider on a publicly accessible website. How can this be both accessible AND confidential?

Currently there do not seem to be enough pharmacies that stock mifepristone, and how do we deal with pharmacies (particularly if they are the only one in a small town, who choose not to stock mifepristone?

Patient wait times for both IUD insertion and medical abortion can be an issue - more provider training and support and linkages to find the providers would help a lot.



What are the opportunities or gaps?

Women are requesting medical abortions but in many communities, there are barriers to access abortion services. Many providers are not even sure where to send patients for a surgical abortion. In some areas, there is a reported "climate of fear" around the provision of abortion services.

We think there is a clear need for:

- explicit resources for primary care providers to know where their closest contraception and abortion services are;
- for patients themselves to access their closest services;
- and for providers of family planning services particularly in rural areas to network with each other and to those in urban areas for mentorship, support, referrals and to address stigma and resilience.

What changes might be made?

Collaborating with and leveraging our extant resources like Opt, Sex Sense, POS, CAPS, and

creating a database of providers who are willing to take patients for a medical abortion.

Those resources should be used to support Family Doctors, and other primary care professionals to provide medical abortion.

Better access to IUD inserters and for patients to access affordable contraception would be an asset.

What can facilitate this change?

Training physicians, NPs, midwives

Engaging with the division of Family practice.

Continuing education that we can do and trying to have voices at all the big meetings for family physicians and other primary care providers to encourage them to take up the practice with the resources that are available.

Health authority and provincial resources to aid in referral, networking and mentorship between primary care family planning providers and also for patients to find a provider near to them.

What might impede this change?

Lack of funding for Opt to address the gaps in interior health and take on a greater role to support practitioners and patients across the region.

Lack of funding for contraception for patients.

What are the opportunities or gaps?

There is an opportunity for health care providers to adequately acknowledge there are barriers that First Nations women experience when they seek primary healthcare services, including fear. HCP can engage in culturally safe contraception and abortion care through an awareness of recent cultural trauma, multiple facets for distrust of the system: sterilization, privacy, follow-up etc.

What changes might be made?

Acknowledging the person and taking the time to develop that relationship and gain their trust. We can also take what we have learned from culturally safe practice education, and ensure our colleagues learn the same clinical practice considerations.

What can facilitate this change?

The use of Peer Navigators in primary care family planning networks and services could help facilitate timely access to care and provide a culturally sensitive perspective to clinical practice. Focusing on primary care networks also aligns with the current ministry of health agenda.

What might impede this change?

Women still have to come to us; they still have to walk through our doors.

The volume of patients seen at primary care clinics may not allow the time necessary to develop the rapport essential to their care.

Literacy and lack of trust in the system may prevent women from seeking help, even at low barrier clinics.

Caution of creating an element of "Tokenism" if including Peer Navigators.

What are the opportunities or gaps?

There is a real need for a regional or perhaps even provincial patient care coordinator, particularly to assist those in the north; this would ideally be someone who understands contraception and abortion care and the systemic barriers facing practitioners and patients. This position would help streamline the process in a timely way (i.e., coordinating transportation, labs, ultrasound, medication, pharmacies, telemedicine support etc.) and could perhaps aim to establish system pathways and service networks to enable provider and patient self-navigation in the future.

What changes might be made?

More training for northern care providers (including NPs) on contraception (particularly long acting reversible contraception), and abortion care, particularly mifepristone medical abortion care, and cultural sensitivity.

Establishing a Coordinator, or Navigator to clarify referral and self-referral pathways, mentorship for and between providers and expert consultants (especially telemedicine linkages.)

What can facilitate this change?

Training care providers from northern settings in a high-density clinic to gain experience and bring that training back to their community.

Utilizing NPs (and potentially midwives and certified practice nurses) to their full scope of practice.

Northern physicians and NPs could take on the telemedicine role and support surrounding communities.

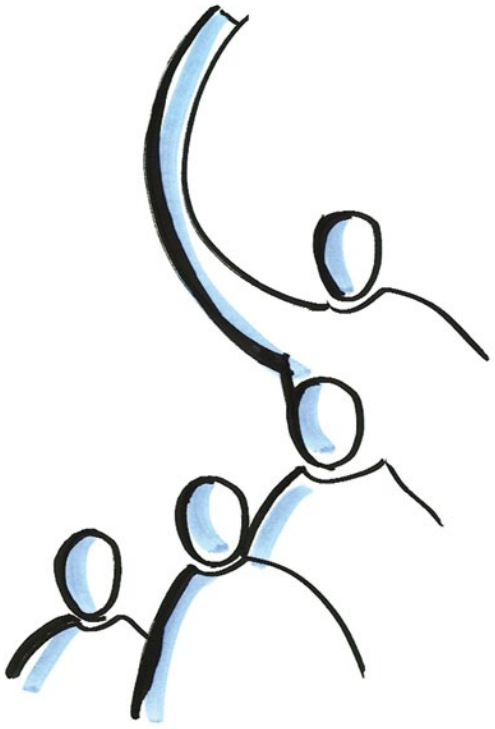
The use of patient navigators could also support communication, building relationships and timely intervention, and perhaps to establish pathways and systems to facilitate self-navigation.

What might impede this change?

While Northern Health provides an orientation to physicians with different cultural backgrounds, there is concern stigma or an unwillingness to change their practice is higher amongst physicians in the north.

There are not many NPs in the North East of BC.

Finally, the lack of access to ultrasounds, and confusion over the need for an ultrasound, and the priority (none seems currently to be established) for early dating prior to medical abortion, has been viewed as a 'stalling tactic' to delay individuals requesting referral for an abortion.



Part 3: Opportunities and Gaps by Discipline or Need

Cross-sectoral, interdisciplinary Working Group results

Change topic	What is the gap or opportunity?	What changes might be made?	What can facilitate or impede this change?
1. The Distribution of Mife	British Columbia became the 6th province/territory in Canada to announce universal coverage in January, 2018, following NB, AB, ON, NS, and QC.	Confusion around the Health Canada regulations required re-education amongst practitioners; initial restrictions instilled fear. Challenges with supply; backorder of the medication impacting timely access. Distribution in rural communities; consideration of confidentiality, historical trauma from both the provider and patient perspectives.	Education regarding rare adverse reactions and safety of the medication. Mapping communities where eligible pharmacies have opted out of stocking mifepristone; involvement of Opt clinic where pharmacies are not available. NP and Midwife prescribing.
2. SMART Program	The SMART program is growing; we can envision moving to a fully funded ongoing provincial program, and are considering what additional contraceptives we would like to add to the program.	There have been challenges implementing the SMART program following a medical abortion: Firstly, there is not enough time to insert an IUD at the first MA follow-up appointment therefore insertion requires a second appointment. Secondly, physician education regarding protocols for when to start contraceptives post-mife. Thirdly, access to 1. Other methods and more choices of contraceptives including LARC and implants and 2. Access to The Program within Fraser Health Authority (funding required for a new facility is costly). Finally, issues with compensation for both the physician and the remuneration for contraceptives as they require reporting to funders.	To develop a practice document that gives physicians working with the program a general guideline on how they should be practicing, following up educating etc. A stakeholder roundtable discussion about the issues and challenges providers are experiencing. To establish a sexual health clinic within Fraser Health Authority, including access to surgical abortion facilities, with health authority leadership and the Ministry of Health support. To develop and foster NP interest in the provision of this service (including surgical support). Advocate for a change in midwifery scope of practice. To develop a confidential and anonymous way to link patients to providers.

Change topic	What is the gap or opportunity?	What changes might be made?	What can facilitate or impede this change?
3. Nurse Practitioner	NPs are ideally situated to increase access to mifepristone in rural areas. As salaried professionals with a focus on comprehensive patient centered care, the current political climate for interdisciplinary teams and approaches to alternative payment approaches is an opportunity to support NPs in the provision of mifepristone to their practice. Increasing SMART program to include women involved in addictions services might be a bit of a window to push addictions has in their mandate to support women's sexual and reproductive health. Opt is now working with The Foundry; these partnerships are valuable for youth and adolescents to access the care.	How to manage the on-call piece for NPs providing mifepristone; there is no compensation model for NPs to be on call. Guidelines around US use are unclear. In the rare opportunity of a failure, what do we do? List of providers. Where do we go to? – Language barrier when leaving it as "here is a number for you to call" (at least on Opt you get someone). – Usually a significant cost differentiation between a rapid test vs a lab test. – Episodic care. – RH for free? Pre-natal blood work (in Nanaimo this took 1 month, in Vancouver it takes a few days) Rurally – could you put a stat on it? Treat it like a miscarriage? – Can a GP give an US reading to another HCP? No. They aren't a radiologist. – If you had access to somebody who is providing MA to a list of providers, would that work? – Emergency IUD providers? Access to a list of IUD inserters? 3 months to get into the Opt clinic – Immediate post-partum IUD insertion (Midwives should be inserting) – Pathways (on the island), Division issues – Access to RH (can we do this in your clinic?) and access to US (point of care) – there is now a mechanism for NPs to make a referral to a GP?	Develop clear guidelines for NPs provision of mifepristone, including a compensation model for the on-call coverage. Training NPs to provide US and developing a plan to assist NPs in maintaining this competency, particularly in rural practice. Develop RN certified practice. Nurse Help Lines in Ontario are now doing call for providers. BC hub baseline data – not getting what they need because all the systems are opt in, not opt out. This would be a large systems policy change. Health Authority compensation for NPs to work with Opt.
4. Midwifery	In Ontario, the midwifery association has already developed regulations that support IUD insertion (must be provided by the midwife in charge of the patient, and already have a delegation from doctors that allow them to insert the IUD). There is vast interest from midwives to be able to offer medical abortion, not just the peripartum care; well-women care.	These changes need to be accompanied with monetary compensation, otherwise midwives will stop providing this care, even if they are allowed to do it. An "abortion fee code" needs to be added. Logistics to change the regulations can be difficult (need backing from Federal to make the change into provinces, or try to make BC a leader and hopefully other provinces will follow).	To add both mifepristone and IUD insertion (post-abortion, not only post-partum) to the midwifery scope of practice. Or, move away from these regulation lists altogether and create a scope of practice, which is much less prescriptive.

Change topic	What is the gap or opportunity?	What changes might be made?	What can facilitate or impede this change?
5. How can Opt support access to abortion?	Opt is made up of 2 elements: the Sex Sense phone line for patients & stand-alone clinics throughout communities in BC. Opt is a member of NAF so they are supported for training and security risk. In areas where there is limited access (i.e., follow-up care, limited dispensing etc.) how can we leverage Opt?	The working hours of the clinics would be a limitation and, clinics are already running at or nearing capacity. If Opt is dispensing medication, it is done so outside of PharmaNet (this is already an issue with contraceptives). There would also be a funding impact of adding a computer and PharmNet access across Opt clinical sites and/or increasing their capacity for 24/7 on-call coverage.	For Opt clinics to work in collaboration with Family Physicians so that individual providers wouldn't have to be on call all the time, some of the calls could be filtered through Sex Sense. There is also potential for Opt to fill access gaps by leveraging existing relationships with NPs, midwives, and advanced practice nurses (RN certified practice) for providing mife.
6. Telemedicine	It would be really useful and effective to learn from our colleagues who are already practicing telemedicine. For example, we assume that with MA, there is a fear regarding safety when in fact, we need to recognize that telemedicine deals with far more complex issues.	Establishing a secure database for providers similar to POS (a database not shared with providers) to help women access care where they are (i.e., specifically in rural and remote areas) and, with fewer appointments. Funding and overlapping interests could be a barrier moving forward.	To collaborate with other providers and learn from them, what their needs for efficiencies and for support to provide abortion and contraception services are.
7. How far is too far?	Among all discussion participants, there was consensus that there is no "too far".	Geographic isolation does make access to care more challenging. These challenges include: loss to follow-up, obtaining the medication to dispense, on-call coverage, emergency plan for a surgical intervention, remote transport issues, maintaining privacy, conscientious objections or lack of support from remote providers.	Educating the providers: catastrophic outcomes are rare. Ensure patients understand the potential risks and benefits for their options for abortion or pregnancy care, and provide informed consent. Mentorship for rural providers, including an on call support Line (i.e. 811 Call Group or CARE).
8. Mifepristone for 2nd Trimester Abortion	Hospital pharmacies are stocking mifepristone and using it for cervical ripening in the 2nd trimester.	Using mifepristone for 2nd trimester abortion is the gold standard internationally. Logistics make it not as straightforward (i.e., women will need to make multiple heath care appointments) and at this point, it will require a second wave of education amongst providers.	To develop guidelines around mifepristone use in the 2nd trimester and educate providers.

Needs

Topics identified throughout the day by delegates and plenary discussions as important potential advances or needs to address for BC

Needs	What is the gap or opportunity?	What changes might be made?	What can facilitate or impede this change?
1. Patient Resources	So far, resources for health care practitioners like the SOGC training and the pharmacist checklist, have been extremely helpful however, there is a gap in resources that have been made available for patients.	Providing "Sex sense" with a list of all pharmacies and prescribers so that they can easily direct patients. Helping patients to choose appropriate contraception for their context and needs, improving factual education and eliminating myths on options such as long acting reversible contraception. Helping patients seeking abortion to choose between medical or surgical options.	To develop a moving whiteboard story- video with pictures/ information about medical vs surgical abortion and offering voice-over in several relevant different languages. To develop a set of patient shared decision making tools on both contraception and abortion. These could detail choices and be a style of checklist for patients that can be adapted across provinces, and clinical sites. The checklist should be written with grade 5 literacy and provide a section where the individual can track their symptoms overtime.
2. Organizational Barriers for Primary Care Providers	Half of reproductive aged women in province of BC live within Fraser Health Authority yet, there are no services or resources there. Lack of services in Fraser Health is a big problem locally. Some abortion clinics in Vancouver, report >60% of their patients come from Fraser Health Authority regions. Enhancing mechanisms to support primary care provision of medical abortion through central organizations could facilitate regional care providers to more easily cope with offering IUD insertions and medical abortion care. Concerns also arose about current contraception, and potential future medical abortion pill, provision through Options for Sexual Health Clinics. These services do not record prescription drug dispensing in the universal system "Pharmanet" used by physicians, pharmacists and accessed for emergency health information by providers throughout the province. Opt currently does not have a plan to engage with PharmaNet.	Access to timely ultrasound is an issue throughout the province and particularly it does not seem to be considered a priority from the perspective of radiology services. In a busy family practice, it is challenging to triage women who are calling in for medical abortion when we are booking 3 weeks ahead. If patients had access to decision making tools prior to their appointment, and a way to pre-book tests such as ultrasound or serology tests through a central service prior to the primary care appointment, this would be a huge facilitator to primary care provision and tight schedules. The Planned Parenthood group in Ottawa is offering a service such as this for local primary care practices. When given for free at Opt, contraception and potentially medical abortion pills leave no record on PharmaNet. Could a system be developed to begin to capture this information in the interests of patient safety and the improved ability to follow patient quality improvement initiatives and surveillance through the linked health administrative data?	Provincial support for leadership, funding and coordination in Fraser Health Authority to establish services. Sharing 'call', i.e., establish regional call groups or potentially utilizing the provincial "NURSE" LINE 811. Leverage community resources that do exist, i.e., Options Sex Sense line or the BC Women's Pregnancy Options Line could provide counselling to help patients choose medical vs surgical options and perhaps even arrange to refer and could pre-order serology or ultrasound? Government to fund free access to contraception, particularly LARC methods. Provincial leadership to equip Options for Sexual Health with PharmaNet access at all sites dispensing prescription medication so that this may be captured in the comprehensive PharmaNet system. CART's pending prescriber medical abortion checklist and pharmacist dispensing checklist for how to encompass all needed components in the brief primary care visit are widely anticipated and exceptionally detailed. Feedback on the near final drafts was offered by several delegates.

Needs	What is the gap or opportunity?	What changes might be made?	What can facilitate or impede this change?
3. Sharing Provider Information Among Trusted Partners	Many call lines exist (Opt) for people asking about their abortion options, but right now, it is really hard to be able to offer a referral for services. Callers need to know what to expect when calling a help line (automatic message saying: we might not be able to find you a medical provider). Using technology to make access to abortion easier. – POS line review to understand how that information can be used in a safe and effective manner – Ways for organizations to work together	Security issues around providing the names of abortion providers. Rural practitioners are more vulnerable to threats than an urban provider. Sometimes, it is a challenge just to get the blood test, therefore some women only get the prescription for mifepristone and we never hear back from them. Was the abortion successful? The idea of a central provincial service (patient navigator, or professional pathways service, and particularly a patient accessible referral and counselling on-line and telephone service) came up and was identified as an important potential facilitator and coordination mechanism for care.	Dream situation: • having one general phone line "abortion line", that would work as triage, and • could refer women to an appropriate provider available in the region, • with a general database of all abortion providers, • give information about wait times, • what is offered, organize the transportation/ accommodation • if necessary, book the appointment. "getting the whole picture". • This central line would also receive feedback of bad experiences, • what steps the person took when they had an abortion (did they go for the blood test, did they come back for a follow up visit?) – what do abortion providers need in terms of safety/security – what makes a trust partner?
4. Substance Use and Family Planning	There are concerns amongst abortion providers that individuals who use substances are less likely to attend follow-up appointments for a medical abortion, versus a surgical abortion. Opt and The Foundry are working together to educate young people not just substance use and mental health issues but also reproductive health; 'upstream' focus.	Barriers identified include challenges with coercion (i.e. influencing a substance user) and providing more intensive counselling due to assumptions being made by provider vs vulnerability of the substance user. Beware in counselling for all contraception and abortion patients, but particularly those with adverse childhood experiences (ACES) including those with mental health and substance use issues, the substance use issues, the issue of power dynamics (marginalized populations vs physician) , coercion, judgment, respect, context.	Reconsider where we as health practitioners, provide this information. Consider demographics and geographic needs, i.e., create an IUD clinic at UBC. Target education not only to female students but also, empower and educate male students.

Final Session requested by Clinician Delegates

"Ask an Expert" your clinical contraception and abortion questions

	Question	Expert Response
Ask An Expert: "How-to" Questions	A. Following a medical abortion post-procedure ultrasound (US), when would you choose NOT insert that IUD?	As long as there is not a gestational/endometrial sack visible on the US. Is it important to factor in symptoms and treat the patient based on their clinical picture rather than the US. If your patient is presenting asymptomatic but it looks like there might be clots on the US, consider – what would be worried about? Infection? Would it be expelled? In those patients who don't have an US, experts work off of Beta-HCG level. We know from the data that we significantly over-treat complete abortions with a D&C.
	B. What is the typical follow-up after providing mifepristone?	For a completion, a typical follow-up would involve an appointment at 1 week after taking the medication, then another appointment 2 weeks later. It can be 3 weeks before the IUD. This time-period is because the clinic is so high volume its logistically impossible. However, if looked complete at 7 days, you could insert the IUD then. The longer you wait to place something, the less likely the patient will get it.
	C. What does a typical case of medical abortion look like?	Mifegymiso® is made up of 2 pills, separately packaged. First, 200mg mifepristone on DAY 1. Second, 800mcg of Misoprostol 48 hours later (Buccal – hold in check for 45 minutes then swallow what is left). Nausea, few women may start bleeding after mife, most this happens after the miso (2 pads/hr for more then 2 hours = too much).
	D. How much cramping and bleeding is considered "more" than can be managed at home?	Amongst chosen candidates, up to 5% will ultimately need D&C, either because they have a remaining pregnancy (1%), retained products, or acute hemorrhaging. Tell patients to take Ibuprofen & NSAIDs, will also consider prescribing something stronger (i.e. Tramadol or Tylenol #3) as well as Gravol. Cramping does seem to last for quite a while. Up to 10 weeks, it might be important to warn women that they might see something they recognize just so they don't freak out. We also ask women to look, so that we will know if they work. For a surgical abortion, anesthesia standards are covered in SOGC guidelines and there is a Cochrane review. It is a mix of patient choice, resources, setting and what works.
	E. Will you prescribe more pain medications to adolescents?	At Willow Clinic, they have access to it already however, we know that adolescents report more pain; you can tell your pharmacist to make sure they provide analgesics.

	Question	Expert Response
Ask An Expert: "How-to" Questions	F. Does it matter if the pregnancy is intrauterine or ectopic?	You can absolutely not treat an ectopic pregnancy with Mifegymiso®. This is different than with methotrexate. For a low risk ectopic pregnancy, you may need closer monitoring of a beta HCG level – assess 48 hrs after the miso in taken.
	G. What percent of patients need a second dose of the miso??	If it is truly an ongoing pregnancy, you could theoretically give full dose of Mifegymiso® again, however, it is more likely you will just give a second dose of the miso. International data suggests that only 2% require second dose of miso (< 7 weeks GA) but this increases at 9 weeks. It is important to consider what the Health Canada regulations versus what the evidence says (aka HC says 9 weeks, but the SOGC guidelines says 10 weeks). Past that, the efficacy goes down and chances of needing an intervention goes up. Up to 3% would need a D&C, after 63 days. It is also important to note that the miso is tetra-genic.
	H. What do I really need to know about Asthma and Mife?	Mifegymiso® is an absolute contraindication for individuals with Severe Asthma. This is because Mife is a very strong anti-glucocorticoid that will inactivate the steroids (i.e. Flovent) prescribed for the ongoing treatment of asthma. It is important to ask how many times they have an asthma attack and require their safety. For those patients who use steroids regularly to prevent an acute exacerbation, surgical abortion might be a better option. However, it is also important to note that uncontrolled asthma is also a contraindication for an abortion at a clinic- it must be done in a hospital setting. If the patient refuses a surgical abortion, you could consider doing a stress dose of the steroid before the medical abortion.
	I. Porphyria: is this also a contraindication?	Individuals with Porphyria appear to have more prolonged bleeding, causes a flare. Individuals with thrombophilia, are more prone to clotting, not bleeding, therefore it is not a contraindication.

Next Steps

Moving Forward

As the conference came to a close, there was an excitement, confidence, and commitment on the part of the participants to remain engaged in their individual advocacy efforts. Cheryl Davies provided a summary of the common themes, proposed solutions and tangible recommendations identified throughout the conference. Conference attendees expressed a dedication to overcome barriers through persistence and collaboration within imperfect contexts to serve women with contraception and abortion services.

Using evidence to drive policy and practice change through real-time continuous integrated knowledge translation was recognized as an important material impact to move our system forwards. For example, striving for equity across the province by providing contraception for all women, regardless of geographical location or health coverage. Other innovations like virtual health pilot programs and the development of interim women's health programs may support quick solutions that generate evidence that will eventually solidify policy change.

There was tremendous passion among the group to improve access to Nurse Practitioners and support the expansion of the scope of practice for Midwives. Educating and supporting providers through collaborative practice, the development of clear practice guidelines, checklists, mentorship opportunities and work towards sustaining practice. The creation of a provincial coordinator role to facilitate women's healthcare in rural remote regions was one great example of novel ideas presented today, to consider as we move forward in our advocacy work.

The development of a secure, private, database to support practitioners across the province was addressed throughout the day. Collaborating with POS, Pathways, CARE, 811, Opt, Sex Sense etc.

Finally, conference attendees highlighted what our province is doing well, and recognized while there are gaps and opportunities to improve care, there are existing provincial and local resources that we can leverage. Educating providers and women to use those existing resources and supports like the CAPS website, Divisions of Family Practice or Opt clinics is one step in the right direction we can take today.

The next steps of the CART process are to review the conference proceedings and the input and actions prioritized by participants. Our goal is to take advantage of the political will and timely evidence from of all the efforts described today and advance contraception and abortion care in BC with our alliances. We are supported by the provincial and association leaders here today to bring stakeholders together and develop an agenda from our valuable discussions today. We aim to engage the support of professional and regulatory bodies.

– What are the resources we need to develop? How do we make them available and accessible?

– Hearing from women – what are their barriers?

Further comments, ideas and suggestions can be directed to the CART team at: cart.grac@ubc.ca

Appendix A: Agenda

MORNING	Exploring Supports for Rural Abortion Provision in BC & The SMART Program	
TIME	ACTIVITY	SPEAKERS
8:00 - 8:15	Acknowledge First Nations unceded territory, Welcome from First Nations Elder	Elder Roberta
8:15 - 8:30	Welcome from BC Women's Hospital Welcome from Provincial Leaders	Cheryl Davies, Drs. Bonnie Henry & Tamil Kendall
8:30 - 8:50	Round Table Introductions	
8:50 - 9:30	BC Women's SMART Program: Free Post-abortion Contraception in BC! Audience Discussion in Plenary	Dr. Sheila With, Caitlin Johnston
9:30 - 9:40	Mifepristone implementation in Canada: Current progress – challenges ahead	Dr. Wendy Norman
9:40 – 9:55	Nutrition and Networking Break	
9:55 - 10:25	Telemedicine Abortions	Dr. Ellen Wiebe/Cheryl Couldwell Dr. John Pawlovich
10:25 - 10:40	Free Mifepristone in BC- How does this work?	C. Davies / Lauren Mathany
10:40 - 11:45	Regional table groups discussions: strategies to improve access to abortion; SMART Program.	Moderator: Dr. Sarah Munro
11:45 - 12:00	Morning Session Summary	Drs. Henry & Kendall, C. Davies
12:00 - 13:00	Networking Lunch	All
AFTERNOON	**Health Professional Roles for Abortion Care**	
TIME	ACTIVITY	SPEAKERS
13:00 - 13:15	Introduction to Afternoon sessions and context	Cheryl Davies/Dr. Sarah Munro
13:15 - 13:25	Nurse Practitioners' role in mifepristone care	Dr. Natasha Prodan-Bhalla
13:25 - 13:35	Midwifery & Mifepristone	Louise Aerts/Kim Campbell
13:35 - 13:45	NAF's role in abortion care in Canada	Jill Doctoroff, Canadian Director, NAF
13:45 - 14:40	Discussion Groups: Maximize family planning scope of practice; Barriers in your setting? What facilitators could help/did help? Report to plenary	C. Davies and all participants
14:40 - 14:50	Patient Voices: "Sex Sense" line hears from BC!	Dawn Petten
14:50 - 15:00	The role of Options for Sexual Health in Medical Abortion	Michelle Fortin
15:00 – 15:15	Nutrition and Networking Break	
15:15 - 16:00	Table topic discussion groups: New Family Planning (FP) issues/research needed; FP & Substance use- improving quality care/access	Introduction, W. Norman C. Davies
16:00 - 16:15	Report to plenary	Moderator: S. Munro
16:15 - 16:30	Meeting Summary, Next Step	C. Davies

Appendix B: Presenter Bios

Cheryl Davies

Cheryl is the Chief Operating Officer at BC Women's Hospital + Health Centre, one of the largest maternity hospitals in Canada and the only facility in BC devoted primarily to the health of women, newborns and their families. With a background in nursing and adult education, she has over 20 years of experience in women's health leadership from community to hospital settings. She is a passionate advocate for women's health, reproductive rights and social justice and is an active international health volunteer in her spare time. She believes firmly in the strength of servant leadership and the importance of honoring women's values and voices in health care planning and system improvement.

Dr. Bonnie Henry

Dr. Henry was appointed as provincial health officer for the Province of BC effective February 1, 2018. She was the deputy provincial health officer for three years starting in August of 2014 and prior to that served as the interim provincial executive medical director of the BC Centre for Disease Control from December 2013 until August 2014. Dr. Henry is an associate professor at the University of British Columbia, Faculty of Medicine. She is a specialist in public health and preventive medicine and is board certified in preventive medicine in the U.S. She graduated from Dalhousie Medical School and completed a Master in Public Health in San Diego, residency training in preventive medicine at the University of California, San Diego and in community medicine at the University of Toronto.

Dr. Tamil Kendall

Dr. Kendall is the Interim Provincial Executive Director at Perinatal Services BC. She has a strong track record in perinatal and women's health, with over 20 years of provincial, national, and international experience in strategic planning, program/policy development, research, knowledge translation, and health care provider education. In her previous role as Director, Women's and Maternal Health, Population and Public Health Division at the Ministry of Health, Tamil was responsible for the development of evidence-based policy, guidelines, and educational material for health care providers and perinatal women and families. Tamil completed her PhD in 2012 at the University of British Columbia, and spent two years as a postdoctoral fellow with the Harvard School of Public Health's Women and Health Initiative/Maternal Health Task Force, where she was also a Takemi Fellow in International Health.

Dr. Sheila With

Dr. With is a graduate from the University of British Columbia Obstetrics and Gynecology residency program. She obtained her bachelor degree in Cell and Developmental Biology at UBC and Master's degree in Developmental Neuroscience at the University of Toronto, prior to returning to Vancouver to complete her medical degree at UBC. She is a full-time Obstetrician/Gynecologist at the Royal Columbian Hospital, in New Westminster, BC. Dr. With is the Medical Lead of the BC Women's Hospital CARE Program. She also is an abortion provider at the CARE Program as well as at the Elizabeth Bagshaw Woman's Clinic. She has a special interest in complex contraception and family planning.

Caitlin Johnston

Caitlin is an Ambulatory Program Manager at BC Women's Hospital + Health Centre. Caitlin manages programs and research related to women's sexual and reproductive health including: contraception and abortion services, pregnancy assessment and loss, management of chronic pelvic pain, reproductive healthcare for women with disabilities, sexual assault examination and support services, and community primary care clinics for women with limited access to health services, including newcomers to Canada.

Dr. Wendy Norman

Dr. Norman has been a family physician in BC for 30 years. She is an Associate Professor in the Department of Family Practice at the University of British Columbia and the Director of the national collaboration Canadian Contraception and Abortion Research Team/ Groupe de recherche sur l'avortement et la contraception (CART/ GRAC). She holds the Canadian Institutes of Health Research and the Public Health Agency of Canada Chair in Family Planning Public Health Research, Canada's first national family planning research Chair. In 2015, The Guttmacher Institute awarded her their prestigious "Darroch Award" for her work combining excellence in research with practical application to public policy and programs in the field of sexual and reproductive health.

Dr. Ellen Wiebe

Dr Wiebe is a Clinical Professor in the Department of Family Practice at the University of British Columbia. After 30 years of full-service family practice, she now restricts her practice to women's health and assisted death. She is the Medical Director of Willow Women's Clinic in Vancouver and provides medical and surgical abortions and contraception. She developed Hemlock AID to provide consultations for doctors and patients about aid in dying and provides assisted death. She has published widely on women's health and now is researching the experience of assisted dying in Canada.

Cheryl Couldwell

Cheryl is the Executive Director of the Willow Women's Clinic. She has worked with Dr. Ellen Wiebe for over 38 years and has been instrumental in establishing the Medical Abortion and Telemedicine Programs at this clinic. She has done numerous presentations over the years at National Abortion Federation Annual Meetings and other conferences on these subjects.

Dr. John Pawlovich

Dr. John Pawlovich is a Clinical Associate Professor in the Department of Family Practice at the University of British Columbia, and the Medical Director for Carrier Sekani Family Services. He is involved in many telehealth initiatives in the province of BC. He is a co-founder and co-lead of the BC Virtual Health Grand Rounds and the e-Health theme lead for the UBC Faculty of Medicine. Using new technology such as telehealth from his home office in Abbotsford BC, Dr. Pawlovich is able to connect to multiple remote aboriginal communities to help provide the daily primary care they deserve and need. He continues to make monthly visits to northern aboriginal communities to ensure the closeness of his relationship to the people remains strong.

Lauren Mathany

At the BC Centre for Disease Control, Lauren is responsible for the Mifepristone distribution in BC, and for the effective and efficient management of public health services within the Immunization Program and Vaccine Preventable Disease Service and the Communicable Disease Prevention and Control Service lines. Previously, Lauren worked in PHSA Workplace Health for 8 years and managed the Health Promotion program and Occupational Health Nursing Services. Lauren holds a Master of Public Health from the University of Waterloo, a certificate in Workplace Wellness and Health Promotion from Centennial College, and a Bachelor of Arts (Hons) Degree from Queen's University.

Dr. Sarah Munro

Dr. Munro is a qualitative health services researcher whose focus is knowledge translation and implementation science. Her postdoctoral fellowship is funded by the Michael Smith Foundation for Health Research and conducted jointly between the UBC Department of Family Practice and Dartmouth College. Dr. Munro's research focuses on the development and evaluation of shared decision-making tools, and the investigation of factors that influence implementation of patient-centred practice and policy. She is currently involved in studies related to choice of next birth after caesarean, choice of contraception, and medical abortion practice.

Dr. Natasha Prodan-Bhalla

Dr Prodan-Bhalla graduated with her BScN from the University of Western Ontario and her MN/NP from the University of Toronto. She has worked as an NP in cardiac surgery, cardiology and women's health. Her current practice focus is women's health that includes reproductive and sexual health care for women with disabilities and heart disease in women. She has recently graduated with her DNP from the University of Colorado and is adjunct faculty at both UBC and University of Victoria. She is passionate about being an NP and the contribution NPs can make to improve the health care system in BC.

Louise Aerts

Louise joined the College of Midwives of British Columbia (CMBC) in October 2014 as the Registrar/Executive Director. In this role she provides strategic leadership, organizational and financial management, and carries out the duties set out for the registrar in the Health Professions Act and the College Bylaws. Louise has over 10 years of Executive Director level experience in various non-profit environments such as education, arts, and health related causes. After completing her Master of Business Administration, Louise devoted her career to the non-profit sector. The CMBC is continually working towards regulatory excellence and Louise is helping to move the board to a risk-based regulation framework. Louise is highly committed to professional self-regulation and governing the practice of health professionals in the public interest, fairness in decision-making and due process, and interprofessional collaboration.

Kim Campbell

Kim is an Instructor in the Division of Midwifery and Lead for the Midwifery CPD Program within the UBC Faculty of Medicine. Kim has been a Registered Midwife in BC since regulation in 1998. She has served on the boards of the Canadian Association of Midwives, the Midwives Association of BC, the College of Midwives of BC, the SOGC Council and was the first Head of Midwifery for Fraser Health. She is a national educational lead for fetal health surveillance and neonatal resuscitation and is active in supporting lifelong learning and midwifery capacity building.

Jill Doctoroff

Jill is the Canadian Director at the National Abortion Federation (NAF). Previously, she managed Public Health programs and the Bridge refugee clinic with Vancouver Coastal Health. The bulk of Jill's career has been in the non-profit sector serving as the Executive Director of the Elizabeth Bagshaw Women's Clinic, the Asian Society for the Intervention of AIDS (ASIA) and Planned Parenthood Ottawa. Jill served on the Boards of Directors for NAF and Canadians for Choice. She is currently the president of the Board of Directors of Options for Sexual Health.

Dawn Petten

Dawn is a Coordinator on the Sex Sense Line with Options for Sexual Health. Her relationship with Opt and sexual health education began in 1999 when she became a volunteer with what was then known as the Sex Sense Line. She is a graduate of Opt's inaugural Sexual Health Certification program, and has worked on the Sex Sense Line for the past 10 years. She also works as a casual counselor at Everywoman's Health Centre. When Dawn isn't working with Opt, she is treading the boards of local theatre companies as an actor.

Michelle Fortin

Working in the social service world for most of her adult life, Michelle has learned to approach the world through a social justice lens and think critically about systems. An academic background in psychology, counselling and, most recently, leadership has prepared Michelle for her current position as Executive Director at Options for Sexual Health. Michelle says that supporting the mission at Opt is easy because she too embraces a pro-choice, sex positive approach to reproduction and sexual health for all. As an executive director she is responsible for board governance, program development and evaluation, oversight of finances, as well as fundraising. Michelle has done volunteer work throughout her life from working with youth with disabilities, to VP of the Downtown Eastside Slowpitch League, Co-chair of her credit union board and is currently the co-chair at Vancouver Pride Society.


BC WOMEN'S
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HEALTH CENTRE
An agency of the Provincial Health Services Authority


CART-GRAC
Contraception and Abortion Research Team
Groupe de recherche sur l'avortement et la contraception


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Options for Sexual Health


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Enhancing rural health through education and advocacy
RCC bc
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