



Proceedings of a National
Research Planning Meeting

PLANNING CANADA'S MIDWIFERY ABORTION IMPLEMENTATION STUDY

Detailing the national meeting of midwifery regulators, associations, academic leaders and practitioners, with Canada's Contraception & Abortion Research Team – Groupe de recherche sur l'avortement et la contraception (CART-GRAC), to determine implementation research strategies appropriate to support the introduction of abortion care within the scope of midwifery

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- College of Midwives of Ontario (CMO)
- Women's Health Research Institute (WHRI)
- Canadian Institute for Health Research (CIHR)

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- Dr. Wendy Norman, Associate Professor, UBC
- Kelly Dobbin, Registrar, College of Midwives of Ontario
- Dr. Tamil Kendall, Provincial Executive Director, Perinatal Services BC

- Dr. Edith Guilbert, Institut national de santé publique
- Dr. Sheila Dunn, Women's College Hospital, and University of Toronto
- Alix Bacon, President, Midwifery Association of British Columbia
- Dr. Sarah Munro, Post-doctoral Fellow, UBC.

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Executive Summary

With the aim to explore the important role that midwives can play in abortion services, the College of Ontario Midwives, the Association of Ontario Midwives, and the Contraception and Abortion Research Team (CART-GRAC) hosted a meeting which engaged midwifery stakeholders from across the country. Twenty-nine stakeholders including midwifery regulators, association representatives, health researchers, front-line health care providers (midwifery, family medicine, pharmacy, gynecology and social work), health authority leaders and community organization representatives engaged to understand the potential and interest to advance the scope of midwifery to include abortion care. The aim of the meeting was to plan implementation steps and research to support high quality gender and sexual orientation appropriate abortion provision in Canada.

Around the globe midwives play an important role in sexual health planning, education and care delivery. Canadians increasingly choose midwives as their primary care provider and rely on their expertise in sexual and reproductive health, especially as it pertains to pregnancy. Midwives around the world are providing high quality, inclusive reproductive health care. In several countries, midwives are providing abortion services as safely and effectively as their physician counterparts. Access to abortion services is extremely limited in Canada, particularly in rural and remote communities and for underserved populations. Expanding the role of midwives in Canada to include full scope sexual and reproductive care, including abortion

Expanding the role of midwives in Canada to include full scope sexual and reproductive care, is an important step to facilitate equitable access to abortion services.

services, is an important step to facilitate equitable access to abortion services. With the recent introduction of the gold standard medication for medical abortion care, mifepristone, we have a timely opportunity to attain equitable access to abortion care across the country. Midwives are ready to be key facilitators in this process.

There was strong agreement on a wide range of potential benefits to midwifery provision of abortion care, and strong commitment among the delegates to work toward including first trimester medical and surgical abortion care within the scope of midwifery in Canada. The Canadian model of midwifery care has the flexibility to function well in both rural and urban settings, particularly recognizing the unique flexibility to directly support medical abortion care in the home or current housing for patients. This will make midwives well suited to ensuring that access to abortion care is more readily available across the country. The discussions identified key populations that experience significant barriers when trying to access abortion services, and highlighted how midwifery can provide the bridge to connect those underserved populations to safe, high quality and effective health care.

There was a clear motivation and drive to pursue expanding the scope of practice for Canadian midwives to include medical and surgical abortion care. Delegates agreed upon priority actions and next steps, including a plan to publish a position statement highlighting the role of midwives in abortion care, in concert with a review paper on the current landscape of midwifery regulation relating to the potential for abortion provision in Canada. CART will prepare a Canadian Institute of Health Research (CIHR) grant proposing implementation research to support the uptake and diffusion of this innovation in practice.

TAKE HOME MESSAGES:

1. Globally, midwives are experts in sexual health planning, education and care delivery, and endorse a scope of practice not yet realized in Canada.
2. Access to abortion care is inequitable in Canada, particularly in rural and remote communities, and for underserved populations.
3. Midwifery care is situated among urban, rural and underserved populations and has the potential to improve high quality, equitable and accessible abortion services throughout Canada.

Introduction

Welcome by Chairs

Dr. Wendy Norman, meeting co-chair, welcomed delegates on behalf of CART-GRAC. Dr. Norman and her team have been actively working on implementation projects for mifepristone across the country. Dr. Norman thanked the delegates for dedicating their time to the development of this important project and highlighted how delighted she was to explore the role of midwives as abortion care providers in Canada. Dr. Norman shared the overall aim for the day, to plan high quality research to support implementation of gender and sexual orientation appropriate medical abortion provision by midwives across the country.

Dr. Elizabeth Darling, meeting co-chair, welcomed delegates and shared her excitement regarding the creation of implementation research for midwives and abortion care, with the support of this experienced team. She identified how midwives have a unique opportunity to increase access to equitable abortion care across the country. She acknowledged the interdisciplinary and national representation in the room. Dr. Darling provided the context and plan for the day's events.

Round Table Introductions

Each delegate introduced themselves and provided some context for their interest in the discussions planned for the day.

Context Setting and Plan for the Day

The overall aim of Canada's Midwifery Abortion Implementation Study meeting was to plan high quality research to support implementation of gender and sexual orientation appropriate medical abortion provision by midwives across the country. The aim was developed in alignment with one of CART's overall goals, namely to plan implementation research that will inform health policy, system and service improvements that ensure accessible, equitable abortion care across Canada. The intention of this meeting was to plan implementation research to identify and mitigate barriers and facilitators of high

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quality, accessible midwifery provision of abortion care. As midwives excel among the range of care providers in the provision of sex and gender specific care, an additional underlying aim of the project is the development of tools to ensure high quality gender and sexual orientation appropriate mifepristone provision.

To understand the role of midwives as abortion care providers, one of the first steps of the meeting was to gain a clear grasp of the current abortion care landscape in Canada and globally, especially with respect to the recent introduction of the medical abortion pill, mifepristone, in Canada. Examples of similar prior implementation research conducted by the Contraception and Abortion Research Team (CART) were discussed to provide a framework for the research to be designed.

Another objective of the meeting was to understand the interest among stakeholders in advancing the midwifery scope of practice to include abortion care. The meeting also aimed to clarify jurisdictional regulations and policies governing the practice of midwifery across the country. Each province or territory has developed guidance scope of practice, compensation models, and prescribing power of midwives. We aimed to gather information about the relevant regulatory conditions of midwifery practice from provinces with delegates present, and to expand to fully articulate the national spectrum as a follow up activity to the meeting. This common understanding will provide a foundation to determine appropriate steps to support the expansion of midwifery scope, with actions that will be relevant both within and to share between Canadian jurisdictions.

Once working from a common understanding on the interest in expanding midwifery scope, and having delineated the regulatory potential for this expansion of scope, we then planned to discuss the potential unique contributions that midwives could make to provision of abortion services in Canada.

Finally, building on this base knowledge, participants would be asked to identify and prioritize key implementation research approaches to support the diffusion and successful integration of high quality gender and sexual orientation appropriate abortion care within the scope of midwifery practice throughout Canada.

Plenary Evidence on Current Gaps and Opportunities

Abortion access in Canada, and the potential to address gaps through midwifery care

WENDY NORMAN

To frame the discussion about access to abortion services in Canada, we begin with the context of abortion care across the country. Dr. Wendy Norman provided a detailed summary of current knowledge on the epidemiology of pregnancy, unintended pregnancy, births and abortion in Canada. She remarked that the decision to have a first birth is occurring at a later stage of the lifecycle, on average at age 30 across the country, while initiation of sexual activity is occurring earlier, at approximately age 16. Thus, in Canada people spend half of the reproductive lifespan at risk of unintended pregnancy.

Medical abortion is a safe and effective option and carries the potential to ensure abortion care is more accessible, especially in rural, remote and traditionally underserved populations.

In Canada, the rate of abortion is 14/1000 people of reproductive age per year. Prior to the introduction of mifepristone for medical abortion in January 2017, 96% of abortions were surgical abortions, and over 90% of these were provided in the largest cities, meaning that people often need to travel long distances to access to a centre that provides surgical abortion. This has led to inequitable access to abortion care across the country. Medical abortion is a safe and effective option and carries the potential to ensure abortion care is more accessible, especially in rural, remote and traditionally underserved populations. Medical abortion provides the opportunity for patients to receive care from the primary care providers that they have an established relationship with, closer to their home, and to allow for increased confidence and comfort in the process.

Increasing the number and range of providers offering medical abortion would further improve access to abortion, ensuring safety for those experiencing unintended pregnancy. Nurse Practitioners have been approved to prescribe mifepristone in five jurisdictions across Canada. Adding midwives to the group of care providers able to prescribe mifepristone and manage abortion care would further increase access and safety for Canadians.

Mifepristone Regulations in Other Countries

SHEILA DUNN

Although mifepristone was only approved for use in Canada in July 2015, and did not become available until January 2017, it has been the gold standard for medical abortion around the world for thirty years. To understand the Canadian context and what is needed for a pan-Canadian strategy, Dr. Sheila Dunn provided a summary of mifepristone regulation and provision around the world. Dr. Dunn identified that the availability of mifepristone depends on interdigitating factors such as abortion laws, drug regulatory approval, health professional regulations and health system factors, such as insurance.

Implementation of mifepristone in Canada has been modeled after the system in the United States and Australia. Mifepristone became more available in the US in 2016 as a result of a revision to the Risk Evaluation Mitigation Strategy (REMS), which changed regulation from explicitly restricting provision by physicians to allowing provision by a broader range of “health care providers”, among other updates. Still the US regulations have many restrictions, continuing to require that mifepristone be ordered, prescribed and dispensed by a health care provider who has completed a provider agreement, and that the patient sign a mandated, and not evidence based, consent form.

In Australia, availability of abortion depends on state regulation; in some states abortion is available only in hospitals whereas in others it is a criminal offence. Mifepristone in Australia may be prescribed and dispensed

by physicians who completed a training and registration process, or may be dispensed by pharmacists who have completed a training and registration process. Mifepristone is covered in primary care settings and in the public health care system. In New Zealand, two physicians must approve an abortion and it must occur in a licenced facility. Mifepristone is fully funded for residents, although it is challenging to access.

In Europe, abortion regulation varies greatly from country to country. Only physicians can provide abortions in the UK, Sweden and France. In Sweden nurse midwives are responsible for mifepristone distribution on a delegated act from physicians.

In the first year of mifepristone implementation in Canada, over 10,000 doses have been dispensed. Since the BCCDC began distribution of mifepristone in early 2018, they are dispensing enough doses to provide 1/3 of abortion services in BC. The initial estimates of medical abortion since mifepristone are approaching 30%, as a result of patient driven demand.

Dr. Dunn raised the important caution that although increasing access to medical abortion is extremely important, we need to remain committed to our surgical services. Safe and accessible surgical abortions services remain important, even as interest in medical abortion increases. Notably in some countries where the vast majority of abortions are now provided medically, the number of providers skilled in surgical abortion is becoming limited.

The availability of mifepristone depends on interdigitating factors such as abortion laws, drug regulatory approval, health professional regulations and health system factors.

Example of implementation research supporting new, quality practice: current CART Implementation studies

SARAH MUNRO

Dr. Sarah Munro provided a summary regarding the intention of implementation research, and how it can be conducted in a Canadian setting. She identified that the goal of our implementation research is to create a rich understanding of barriers and facilitators in practice and policy in order to improve access to equitable abortion health services. The role of integrated knowledge translation cannot be overstated in implementation research; partnering with health service decision makers at each stage of the research process makes it possible to interpret results from research and transform them into health policy effectively and efficiently. In order to accomplish this, we engage in continuous knowledge translation and exchange with partners across the country, providing current data on barriers and facilitators in their jurisdictions and receiving information on what works, for whom, in those different contexts. Conducting implementation research for mifepristone in Canada is particularly important as regulations are being refined and care providers, clients, and policy makers need clear, accurate resources.

CART-GRAC is currently working on a mifepristone implementation project for physicians and pharmacists across Canada. A community of practice website was created called Canadian Abortion Providers Support (CAPS), which serves as a space for abortion care providers across the country to access resources, training and support. CAPS has enabled CART-GRAC to collect information from abortion care providers. In the first twelve months of the community of practice, Dr. Munro reported 39% of physician members with CAPS have never provided abortion care before, and 8% of them practice in communities that have never had abortion services before. Dr. Munro provided a summary of the key findings of survey and interview data collection for the study. Poor communication to physicians and pharmacists about restrictive measures has been a key barrier to provision; innovative models of care provision are emerging in rural areas; and physicians

The goal of our implementation research is to create a rich understanding of barriers and facilitators in practice and policy in order to improve access to equitable abortion health services.

have expressed that access to CAPS is beneficial in providing medical abortion services. The potential impact of this research on health policy is demonstrated through changes made by the study's decision maker partners. In November 2017, for instance, Health Canada removed all restrictive policy measures that had previously impeded physician and pharmacist provision of mifepristone abortion care in Canada. Next, the CART-GRAC research team has submitted two project grants to CIHR: an observational study to investigate the effect of mifepristone on patient outcomes and a mixed methods implementation study to explore Nurse Practitioners' provision of mifepristone in Canadian primary care.

Midwifery regulations across Canada: payment mechanisms, scope of practice regulations and the ability to prescribe specific medication

Representatives from four Canadian jurisdictions (Ontario, British Columbia, Nova Scotia and Manitoba) were present at the meeting to discuss specific aspects of the regulation of midwifery in their provinces (see Table 1). Midwifery, unlike other health care professions, has a highly regulated scope that differs from province to province. Provinces and territories across the country have a range of definitions for the scope of midwifery care, and some have very specific restricted or controlled acts that midwives are, or are not, allowed to perform. Along with regulation of scope, there are also considerations regarding compensation models, and midwives' regulated ability to prescribe certain medications. All of these factors are potential barriers or facilitators to the introduction of abortion care within the scope of midwifery across Canada. Each section will need to be addressed across the country in order to

ensure sustainability, safety and efficacy of this scope expansion. Certain provinces or territories may be closer to implementing this scope of practice change due to their current regulations, compensation model and prescribing guidelines.

To begin we collated regulations in each jurisdiction (See Appendix D). To summarize, there are three main conditions that relate to the ability to introduce abortion care into the scope of midwifery in each jurisdiction: provincial legislation or regulations for scope of practice, compensation model for midwifery services, and the regulation of prescribing. Examining cross jurisdictional regulations, it appears that the scope of midwifery practice is broader in provinces and territories that have more recently regulated midwifery. Attendees agreed that for the purposes of abortion care integration, it may be easier to start with these provinces/territories as there are fewer legislative barriers to address. There is a lot of diversity across the country regarding scope, compensation and prescribing power. A key feature of a national implementation research study would be to learn from the natural experiments of midwifery integration into the varied health care systems across the country. Midwives as abortion care providers may be particularly relevant for provinces and territories that have fewer resources or more significant areas of underserved populations.

Delegates of this meeting acknowledged that we are missing the voice certain of populations including Indigenous peoples, those living in the far north, or living on reserves. There may be areas particular to these populations in which there is a strong need or desire for midwifery managed medical abortion and we are motivated to capture that through ongoing work. As we move forward with this project, we all have a dedication to create inclusive community driven and centered research. We commit to reconciliation in all of our actions including development and distribution of research and resources.

Table 1: Pertinent midwifery regulations in ON, BC, NS and MB

Jurisdiction	Demographics	Scope of Practice	Compensation	Regulation of Prescribing	Special Considerations
Ontario (Kelly Dobbin)	50% of Canadian Midwives	<p>The scope of RMs in Ontario is outlined in the Midwifery Act, 1991.</p> <p>Midwives are able to assess, monitor and provide care to a person who is pregnant, in labour and postpartum (up to 6 weeks)</p> <p>Relevant to abortion care, there are a number of “controlled acts” that midwives are authorized to perform: can put an instrument, hand or finger beyond the labia majora or anal verge during pregnancy, labour and the post-partum period; can prescribe and administer drugs from a list during pregnancy, labour and postpartum</p>	<p>Midwives are compensated per course of care (minimum of 12 weeks of service provided)</p> <p>Midwives are eager to work in new models, but compensation has been a barrier until recently</p> <ul style="list-style-type: none"> – Midwives are working w/ OBs in their communities – Midwives are running volunteer clinics <p>New funding in 2017/18 contract: pot of funding for pilot projects to explore alternative practice models and funding</p>	<p>Midwives can only prescribe certain medications as outlined by Ontario Regulation 884/93 Designated Drugs</p> <ul style="list-style-type: none"> – challenging to add new drugs to the list – currently advocating for change that would allow midwives to prescribe anything within their scope OR advocating for categories of medications 	<p>Due to the new pilot project funding certain projects are being tested: midwives working in community health centers (CHC), midwives working as a full time equivalent (FTE) sexual health providers</p> <p>Aspiration abortion and D&C may be within scope depending on interpretation of the Midwifery Act</p> <p>College has adopted the international definition of midwife in anticipation of change in scope</p>
British Columbia (Louise Aerts)	20% of Canadian Midwives	<p>Midwives are only allowed to insert an instrument, hand or finger beyond the labia majora for 4 reasons: episiotomies/amniotomies, internal examinations, repairing episiotomies/lacerations, or conducting an emergency vacuum assisted delivery</p> <p>2014 application to expand scope to include: ultrasound, well woman care, well baby care (up to 1 year), newborn frenectomy, evacuation of the uterus, prescribing and inserting IUDs</p>	<p>Mixed funding model: course of care and fee for service</p> <p>MOH is able to create fee codes quickly</p> <ul style="list-style-type: none"> – new fee code for midwives as consultants or second opinions for other providers (physicians, NP or other midwives) – may be a facilitator to compensation for abortion provision 	<p>Midwives can only prescribe certain medications as outlined by Ontario Regulation 884/93 Designated Drugs</p> <ul style="list-style-type: none"> – challenging to add new drugs to the list – currently advocating for change that would allow midwives to prescribe anything within their scope OR advocating for categories of medications <p>In contrast to Ontario: category and purpose of drug rather than individual drugs themselves</p> <p>Would need to add a new category of drug to include mifepristone</p> <p>Were able to add narcotics into drug regulations when Federal regulation changed (Nov. 2016)</p>	<p>Specialty certifications: acupuncture, contraceptive management, surgical first assists, oxytocin/epidural management</p> <p>IUD insertions on delegation from college of physicians</p> <p>Provincial government is highly motivated to make mifepristone accessible</p> <ul style="list-style-type: none"> – midwives can be an important avenue for ensuring accessibility <p>Provincial government is also committed to primary health teams</p> <ul style="list-style-type: none"> – midwives as primary HCPs can be very important in CHC development + sustainability

Jurisdiction	Demographics	Scope of Practice	Compensation	Regulation of Prescribing	Special Considerations
Nova Scotia (Kelly Chisholm)	9 registered midwives	There is nothing in the NS regulation that specifically excludes medical or surgical abortion from midwifery scope of practice – interpretation of the practice of midwifery may lead to possibility for change	Employee model, salaried Compensation does not depend on number of births attended Compensation does not restrict midwives from expanding scope, but it also does not support it (i.e. no extra funding for expanded scope activities)	Category of drugs rather than specific drugs that are within the midwifery scope Inclusion of mifepristone may just need adjustment of categories – were able to accomplish this with narcotic changes	Midwives in NS are very committed to practicing core midwifery Government is dedicated to midwives providing care to priority populations – expansion of midwifery could ensure that this work is being done Midwifery can also help address the primary care crisis in Nova Scotia with expanded scope
Manitoba (Kris Robinson)	59 practicing midwives	Similar to Nova Scotia Vague enough definition that there may be space for interpretation List of minor surgical and invasive procedures listed in Schedule C of legislation, no mention of internal exams	Employee model, salaried	Categories of drugs rather than specific drugs	Kris highlighted that there are barriers to implementation but that they are not enough to stop this from moving forward In rural communities it may better serve populations to increase midwifery services to include medical (/surgical) abortion

Federal Considerations

Federal patient coverage of mifepristone was approved in April 2018 therefore every federal patient has coverage for mifepristone. This includes corrections patients, Indigenous patients covered by federal health, those in the army, and refugees. With refugee populations the Interim Federal Health Program looks at the province formulary to see if a patient is eligible, unfortunately this means that some patients are eligible for coverage and others are not. Katrina Kilroy identified that midwifery does not have a federal job description with the treasury board. This is a very important step forward to ensure that midwives can be hired federally to provide midwifery care. If there is no job description, midwives cannot be hired for the role of providing midwifery care. There may be work-arounds; however, it is important to acknowledge this barrier. It is an important consideration to address when developing a pan-Canadian midwifery and abortion care study.

Indigenous Midwifery

The group identified that we were missing appropriate representation at the meeting from the Nation Aboriginal Council of Midwives (NACM). Going forward an invitation to NACM to participate in the project will be made. Katrina Kilroy, president of the Canadian Association of Midwives, provided a summary of legislation regarding Indigenous midwifery across the country. She highlighted the exception clause in the Ontario Midwifery Act that ensures that Aboriginal midwives (terminology used in the Midwifery Act) can practice autonomously without completing a western midwifery university program. Currently, Ontario is the only province where midwives are practicing under the exception clause. In June 2017, the federal government announced six million dollars of funding over five years to promote culturally safe midwifery for Indigenous communities. With this funding, there is also a dedication to establishing and sustaining community-led training programs that are focused on training Indigenous midwives. The goal is that everywhere there is an Indigenous midwife there will be a trainee to expand the role of Indigenous midwifery. There are currently twelve midwifery practices in Canada dedicated to providing care to Aboriginal communities. Six of these eleven practices are in Ontario, including two midwives who are practicing with an obstetrician in an Aboriginal Health Centre and are able to provide a broader scope of midwifery care. While there is no exception clause for Aboriginal midwives in BC, Alix Bacon identified that there are also three reserves in British Columbia that employ registered midwives to serve their communities.

Normalization of Abortion Care

There was an overall discussion about Canadian midwives caring for “normal” pregnancy, labour, birth and the postpartum. The definition of normal has altered overtime and has shifted to include different aspects of pregnancy and birth. Louise Aerts suggested framing the conversation around abortion care being a normal part of the reproductive lifecycle as 1 in 4 pregnancies end in intended abortion. With this statistic, there is a large potential for abortion to fit within the scope of normal and therefore the scope of midwifery.

Frederique Chabot raised the unsettling point that many of the people that contact the Action Canada help line are exposed to anti-choice rhetoric and have to face multiple barriers, including significant stigma when trying to access safe abortion care. She eloquently said that “adding abortion care to midwifery care will have an impact in terms of destigmatization or countering that kind of messaging”. She identified that including abortion into the scope of midwifery care would have an incredible psychological impact on people accessing abortion care with profound effects across the country. Expanding midwifery scope to include abortion would help drastically in normalizing abortion and reducing stigma. These two aspects of bringing abortion care into the realm of normal must be central in this implementation research.

“Adding abortion care to midwifery care will have an impact in terms of destigmatization.”

– Frederique Chabot

Midwifery Uptake

There was a lively discussion regarding the potential need to survey Canadian midwives regarding their desire to provide abortion care. The consensus was that Canadian midwives are dedicated to informed choice as a standard of care. Katrina Kilroy stated that midwives are strong advocates for choice and will engage in abortion work even without 100% uptake across the country. As evidenced by this meeting there is strong momentum and interest in midwives providing abortion services. We can use this momentum to ensure that the next steps of the meeting are achieved and we can create effective implementation research.

Priority Goals and Proposed Initiatives

Midwifery Specific Considerations

The meeting participants were highly motivated to discuss the important role that midwives could offer in abortion provision. It was highlighted that there is a unique perspective that will be added to the field through the midwifery model of practice. The Canadian midwifery model of care is a relational model that requires continuity of care and carers. Midwives are on call twenty-four hours a day, seven days a week for their

patients, which allows for seamless triaging of concerns and consultations. Midwives are able to provide care for their patients in their home communities and can directly admit their patients to the hospital, bypassing emergency rooms or urgent care centres. These facets of midwifery care along with community-based provision of care and informed choice were all identified as valued elements of midwifery care that would be highly acceptable and beneficial to abortion care.

Working Group Findings on Priority Goals and Activities for Implementation Research

Table 2: Identification and priorities for next-step activities and expected impact

Activity	What will we learn/impact	Priority
Canadian Association of Midwives (CAM) to write a position statement about the role of midwives in providing abortion care “midwifery model of care for abortion services” – Katrina Kilroy to do	Pressure government to consider midwives as abortion care providers Stakeholder engagement and mobilization Raise awareness within the profession Provide support for midwives to move forward in their communities	High
Writing a CJMRP article (Manavi, Lisa, Molly, Jenna, & Alix) – current state of where legislation is currently and why midwives need to be involved in abortion care	What is the current landscape of midwifery across the country? What are the barriers/facilitators across jurisdictions? What is the rationale for midwives to be abortion care providers? Raise awareness within the profession	High
Gathering current evidence: scoping review (patient preference, evidence, cost analysis)	What evidence is there? What needs to be accomplished? To have a common understanding of what is happening across the country (regulatory, funding) Prove a background for research, lobbying	High
SOGC course – additional module that is midwife specific Mentorship/clinical component	Is there interest in the course? Interest in MA provision by midwives? Learning about midwifery specific considerations	High
Fact sheet safety of mifepristone, and safety of practitioners (re: incidence of violence)	Safety for practitioners, knowledge translation, debunking myths	High
Promoting CAPS website to midwives and what would we want to ask midwives who are joining?	Uptake among midwives, barriers, facilitators? What could midwives tell us when they join CAPS?	High
Examine the role of miscarriage management scope expansion From MH study: midwives were eager to add miscarriage management to their scope	Impact on access to care, efficiencies that could result Is miscarriage management a stepping stone to abortion care provision? Can we engage early pregnancy clinics for training midwives in miscarriage management?	High
Framing benefits of midwifery care for abortion services: increased access to rural/remote areas, community centered care	Identification of hot button issues/priorities How can midwifery improve access to abortion? What does midwifery have to offer to abortion services?	High
Communication between associations/regulators of midwifery across the country	Find out who is working on change (Yukon and NFLD – MA could be included from the ground up)? Identify jurisdictional barriers and enablers	High
Research of midwives delivering mifepristone (Ontario – under medical directive)	Measuring safety, acceptability, cost, impact (how did it effect the midwifery practice – perceptions, losing clients, gaining clients)	High
Guidance document for midwives	Support for midwives to move forward	Medium
Knowledge translation for – Midwives, Public, Other health care providers	Awareness, interest, ideologies of public, motivation of public. Would mobilization of the public help to move policy forward?	Low
Explore the possibility of a delegated act	Can RMs prescribe under the order of a physician? Is this an interim solution? Caution as interim solutions are not enough	Low

There was strong concordance among the three groups on the key steps required to support implementation of high quality midwifery abortion care in Canada.

In addition to actions highlighted in the above chart, participants identified midwifery specific considerations to carry forward in the research plan. The potential for the unique midwifery model of care, providing attendance with patients where they are at throughout their abortion experience, presents an opportunity to offer new options and address unmet needs for care, particularly among vulnerable and disadvantaged populations. Participants agreed on the potential for midwifery scope to include abortion care both to increase access to abortion care and to offer an alternative service delivery model in Canada.

Midwifery Model for Abortion Services

Midwives can increase access to medical abortion in many underserved communities. All three groups identified that we can frame midwifery provision of mifepristone as a way to reach underserved populations. Increasing access was seen in a number of different ways: for rural and remote communities, for underserved communities in urban centres, for those living in emergency situations that have increased barriers when accessing health care and for those who have a distrust in the traditional medical model. How does midwifery increase access? First and foremost, having more practitioners in a community who are able to provide abortion care increases access. For communities that have established midwifery care but no abortion care providers, midwives would be able to bring abortion care to their community.

In addition to increasing access, midwives are able to take abortion provision beyond what is offered currently.

In addition to increasing access, midwives are able to take abortion provision beyond what is offered currently. The model of midwifery care means that midwives have the availability to provide care in alternative settings such as at home, in hotels, at midwifery clinics or in alternative safe spaces. This ensures that people can access abortion care within the privacy of a safe space with a care provider who

they have an established relationship with. Along with flexibility of care setting, midwives are also on call twenty-four hours a day, seven days a week, which provides their clients with an efficient way of addressing their urgent needs throughout the abortion process. If someone is concerned about complications or follow-up, they have the ability to page their midwife at any time of day or night.

It is particularly exciting to think that midwives might be able to provide care for those who really need someone with them for the duration of a medical abortion. Midwifery offers a completely unique experience for those who want someone by their side for their medical abortion, which has the potential to completely transform their experience. Although the desire for having a support person available for a medical abortion may be infrequent, this would provide a bridge for those who are not accessing medical abortion due to isolation of the process. There has been recent news coverage on abortion doulas in the Eastern part of the country where abortion services are limited, demonstrating that there is a need for this type of support. Midwives could provide support as well as medical expertise for those wanting a care provider with them through their medical abortion experience.

Frederique Chabot was able to contribute the voices of Canadian's from the Action Canada help line. Listening to the unique role of midwives in their ability to go into patient's homes and communities, Fred immediately saw a gap in care that midwives would be able to fill. On the line, Action Canada speaks to people who have trouble accessing abortion and there are trends regarding who they speak to. Fred contributed three main groups of people who would experience significant benefit from midwifery provision of abortion care. She noted that each one of these groups has complexity within it, but the goal was to summarize three identifiable populations. First, she discussed youth, in particular young youth, who end up waiting to access abortion either because they do not know what services are available or how to access said services. Secondly, Action Canada speaks to a lot of undocumented people, or temporary foreign workers. In particular, those who experience gaps in insurance of more than three months, which can end up having a significant delay on access to abortion services. Often their residency status is tied to the good will of their employer, and therefore they are unable to go seek services at a clinic, or away from their community. Thirdly, she identified a

broader category of people who are facing emergencies. Some examples would be people living in poverty, people with significant familial strains (elder care, child care), and people experiencing mental health concerns, homelessness, or substance use. For these specific groups, it would have a significant impact if midwives were able to see them in their communities as they are at high risk of exceeding the gestational limits of safe abortion.

The potential for midwifery to provide safety from a social network perspective was identified by Stephanie Begun. The privacy that is available from midwifery delivered abortion services has the potential to have a significant impact for people who cannot have anyone know that they've had an abortion. Stephanie was specifically thinking about youth that she works with who have a very limited social network or simply no social support at all. She believes that midwifery care offers an incredible service for these youth, to have someone who is willing to be with them through the process of abortion. Midwives offer a trusted and reliable relationship for youth when there is no other adequate support for them.

There is a profound argument to be made around midwives increasing safety of abortion care through earlier access to services. We know that abortion is safer at earlier gestations, and both surgical and medical abortions are safer than giving birth. By enabling midwives to provide this service for their clients, we are opening up another arena for earlier access to abortion care and therefore safer care, and better outcomes.

Jenna Robertson Bly summarized the potential for midwifery abortion services beautifully by stating that "midwives cannot simply replicate or increase the access to abortion services that exist but really must develop a model of care, in the way that we don't simply replicate birth services that exist in the system but offer a different approach that has inherent value." In particular for our position statement, we need to be intentional about extending the midwifery model of care to abortion care, and encapsulating everything that makes midwifery care unique in provision of abortion. This does not serve as an exclusionary means of abortion care provision, as midwives should be able to provide abortion care in already established clinics, but there should also be a dedication to the uniqueness of the midwifery model and its significant benefits through this scope expansion. Specifically, midwives can provide abortion care at home, in the community, or in an established clinic. Midwives are also dedicated to informed choice and patient driven care.

"Midwives cannot simply replicate or increase the access to abortion services that exist but really must develop a model of care, in the way that we don't simply replicate birth services that exist in the system but offer a different approach that has inherent value."

– Jenna Robertson Bly

Surgical Abortion Consideration

Sheila Dunn brought up the important point that abortion care should always be about choice for the patient. If medical abortion is integrated into the midwifery scope, there has to be a continued and strong dedication to offer people choice of medical or surgical abortion. A solution to this potential barrier was identified as expanding midwifery scope to include both medical and surgical abortion. As midwives have skills that lend themselves to acquiring competency in aspiration abortion, midwifery provision of both medical and surgical abortion services is feasible. If only medical abortion is included in the scope of midwifery care, midwives would need education regarding surgical abortion, as well as surgical abortion providers in their communities, in order to effectively counsel their clients.

Competency Regulation

Louise Aerts identified that once abortion care was within the midwifery scope that the intention would not be to have it over-regulated by the college. There would be a creation of competencies for abortion provision by midwives, and in order to provide that care, midwives would have to meet said competencies.

Canadian Context

Tamil Kendall introduced the idea of using this research project to get the national conversation going. The goal of this research is not only to look at the jurisdictional differences for midwives, but also for midwives working in different practice settings (such as solo practitioners, group practitioners or potentially midwives in community health teams). By including midwives in all settings, it will ensure that this scope expansion can be implemented for all midwives across the country. It is necessary for us to generate this evidence in a Canadian context in order to have an effective impact on government health policy.

Patients Voices

Lisa Morgan offered results from her research that was conducted in 2015, highlighting patient voices from Ontario's northern communities. Abortion services in northern Ontario are all hospital based, with four hospitals offering services and all abortions occur at 10 weeks regardless of patient desire. All the women who are having abortions are brought in at the same time; therefore there is no privacy in the system. Patients have a significant desire for privacy. The advice that those who had experienced abortions in the north were giving to others was to head south for their abortions. The voice of these patients made it evident for Lisa how important it was for midwives to provide abortion services because of the privacy of care offered. The participants in Lisa's study have a desire for midwives to provide this service and consider midwives experts in sexual and reproductive health.

Sustainability for Rural Midwives

Midwifery has been integrated into rural and remote communities with varying success across the country. Katrina Kilroy identified that midwives in Ontario have penetrated rural and remote communities across Ontario. Kim Campbell pointed out that sustainability of midwifery in rural and remote BC has posed a challenge due to our model's discreet scope, low birth volume in those settings and the current fee for service reimbursement schedule. Expanding scope to include first trimester medical abortion services would enhance midwifery scope to support community needs and improve sustainability of rural practitioners while also contributing to a more collaborative shared service model with physician and nurse practitioner colleagues. One of the barriers to midwifery integration in smaller sites is the narrow scope of practice and the limited opportunities for making a viable living. This is a consideration for provinces where midwives are compensated per birth or course of care and may be less relevant in a salaried model of midwifery services.

There are many ways of framing the positive aspects of midwives as abortion care providers from offering care in new communities, to home abortion care, to the potential to reduce the use of operating room resources and surgical wait times

Summary of Key Elements

In summary of the discussions and working group outputs, there were common key elements that the delegates identified as priority actions to accomplish to move forward:

- Develop and publish a Position Statement identifying core principals and model for midwifery led abortion care
- Conduct a scoping review of existing evidence for midwifery abortion care
- Present midwifery as a solution to access to abortion care for rural and remote populations, as well as for underserved populations
- Create or modify existing online course(s) and related resources for midwifery training in abortion care
- Plan a research project with midwives to study the implementation of abortion care by midwives in Canada
- Promote the Community of Practice for abortion care providers (CAPS-CPCA) website among midwives, and develop survey questions that are midwifery specific
- Prepare a *Canadian Journal of Midwifery Research and Practice* (CJMRP) article reviewing the case for midwifery provision of abortion care
- Identify physician champions for abortion service integration into midwifery scope in jurisdictions across the country

Final Thoughts

Each delegate around the room was encouraged to provide their final perspective, or to add anything to the determinations of the day that had not yet been articulated.

Frederique Chabot offered the support of Action Canada for Sexual Health and Rights moving forward on this project through whatever means may be helpful. Action Canada would be willing to provide the patient voice in the article to be written for the *Canadian Journal of Midwifery Research and Practice*, to provide further support for the need of midwifery abortion services.

Kelly Chisholm remarked at how refreshing it was that this conversation is happening on a national level. By having a national conversation, it ensures that all provinces and territories, regardless of size or availability of resources, are included in the development and implementation of expanding the midwifery scope. It is important to note that even with a pan-Canadian strategy for implementation research we need to understand the contextual nature of midwifery care from province to province. Each jurisdiction has various motivating factors for integration of midwifery care into the health care system, and in order to best support midwives in this new role, we must be cognisant of these context specific considerations. There are many ways of framing the positive aspects of midwives as abortion care providers from offering care in new communities, to home abortion care, to the potential to reduce the use of

operating room resources and surgical wait times. Each province will need a context specific approach to drive implementation.

Judith Soon motivated the midwife practitioners in the room to reach out to their local pharmacists for support and information. She highlighted that pharmacists can be “supportive and synergistic” for midwives regarding this expansion of scope. Constant communication between providers will help with education, and provision.

Another important consideration raised by Louise Aerts, pertained to communication with the public about midwives’ new role as abortion care providers. As this would be an emerging role for midwives, it would be important to gather information regarding the difference in perception of midwifery care brought about by this change. There would also need to be clear communication with the abortion help lines and organizations to ensure that they are aware of new providers in their communities and across the country.

Throughout the day, the importance of cultural safety for all communities was greatly acknowledged. In order to do this work, we need providers in each community who are providing culturally safe care. Allowing midwives to increase their scope to include abortion services would further work to ensure that we are aimed towards achieving culturally safe care.

Summary and Next Steps

At the end of the meeting, delegates expressed a high degree of motivation to advance the identified next steps. It was evident from the activities and discussion of the day that creation of a pan-Canadian strategy for midwives as abortion care providers has begun, and will continue to evolve. Consensus was reached on a number of clearly identified next steps for participants and the research team.

Katrina Kilroy, president of the Canadian Association of Midwives, committed to crafting a position statement from CAM highlighting the role of midwives of abortion care providers across the country. The goal of the position statement is to stimulate national conversation and engagement about the role that midwives can play in making abortion care more accessible. Having the position statement come from CAM sends a strong message of support to Canadian midwives who are motivated to participate in this ongoing scope expansion.

An article summarizing the current state of abortion care in Canada and the need for a midwifery perspective will be submitted to the *Canadian Journal of Midwifery Research and Practice*. The purpose of this article is to raise awareness among midwives, engage stakeholders and to identify midwifery champions across the country. The article will include a current summary of abortion care in Canada,

why midwifery should be involved moving forward and jurisdictional variations across the country. A plenary session submission to the CAM conference will also be submitted on this topic to further engage midwives in the ever evolving dialogue of midwives as abortion care providers.

The CART-GRAC team will circulate minutes from this meeting and will work on preparing a grant proposal for the CIHR grant project in September 2018. We are eager to have ongoing communication with stakeholders to inform and shape the research.

If anyone identified an aspect of this project that they feel motivated to participate in please do not hesitate to contact the CART-GRAC team. There are no words to describe the excitement and gratitude of the meeting attendees in regard to the pursuit of this work that all are so deeply passionate about. Thank you for your inspiring and unwavering dedication to health equity in Canada.

Further comments and ideas can be submitted to the CART-GRAC team at cart.grac@ubc.ca

Appendix A

Agenda

Canada's Midwifery Mifepristone Implementation Study

AIM: HIGH QUALITY GENDER AND SEXUAL ORIENTATION APPROPRIATE MIFEPRISTONE PROVISION BY MIDWIVES

Research Planning Day – by invitation only

2018 April 13th, Toronto, Ontario

Board Room, Association of Ontario Midwives, 365 Bloor East, Suite 800, Toronto, ON

10 am to 4 pm

MORNING SESSION

- 1. Welcome and Introductions** (ice breaker, round table)
– 30 mins [10:00-10:30]
- 2. Gaps and Opportunities** (35 min) [10:30-11:05]
 - a. Abortion Access In Canada (10 mins) (potential to address gaps through midwives)
 - b. Mifepristone regulations in other countries (5 min)
 - c. Midwifery regulations across Canada (payment mechanisms, scope of practice decisions) (10 mins)
 - d. Example of implementation research supporting new, quality practice: current CART Implementation studies (10 mins)
- 3 Aim and Goals** (10 minutes) [11:05-11:15]
 - a. Goal for the day: Identify research question, objectives, key elements of study
 - b. Timeline: to CIHR application, planned waypoints, project start
- 4. Networking/nutrition break** (15 min) [11:15-11:30]
- 5. Gaps and Opportunities** (continued) (30 min) [11:30-12:00]
 - a. Identifying areas to support and improve high quality, accessible abortion care by midwives
 - tools required
 - policy and practice barriers and facilitators.
 - b. Current midwifery abortion policy and practice barriers and facilitators

- Midwifery scope, payment mechanism decisions; inter-jurisdictional challenges
- Group discussion

- 6. Key Study Elements** – Group discussion (60 min) [12:00-13:00]
 - a. Brainstorm on key elements for midwifery abortion provision, potential for a research process to support the key elements

NETWORKING LUNCH (60 mins) [13:00-14:00]
get to know somebody new!

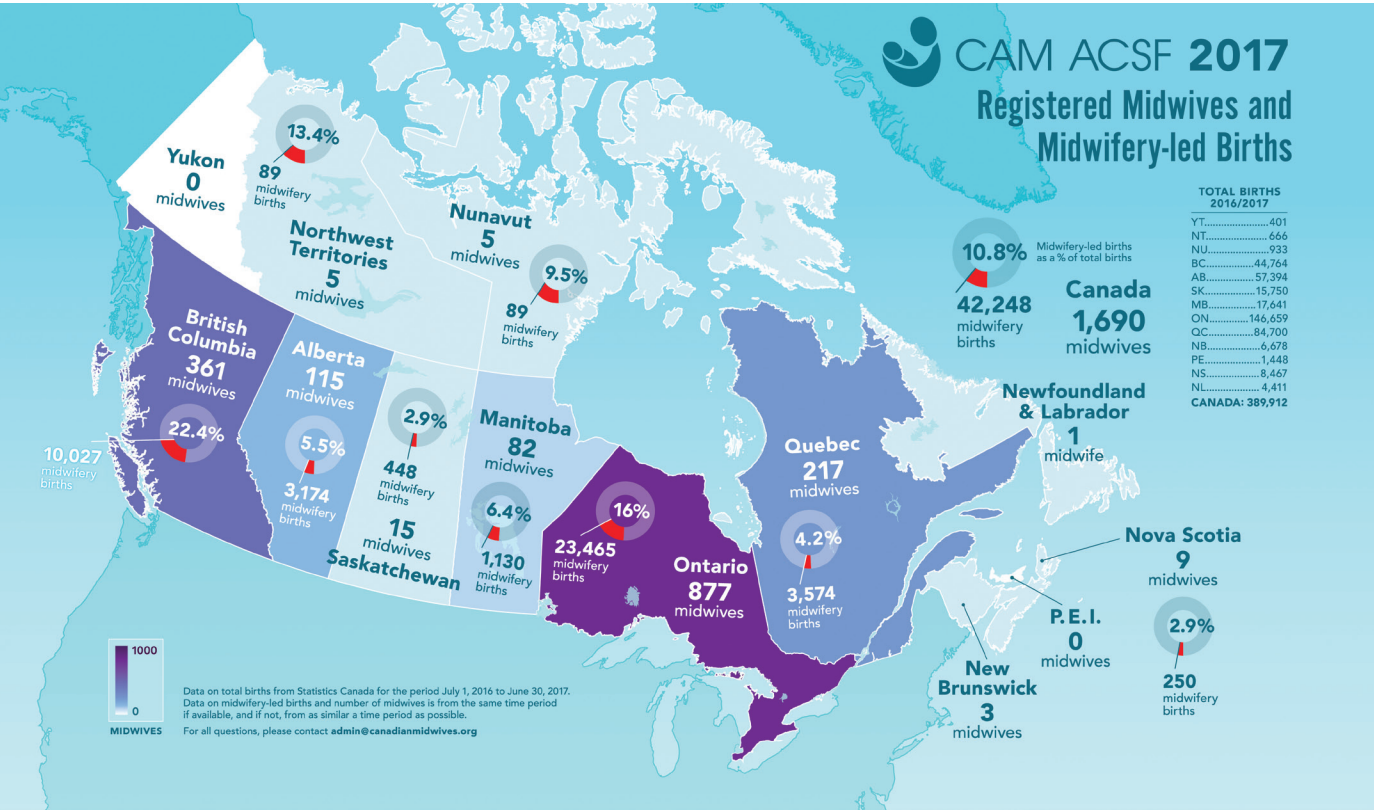
AFTERNOON SESSION

- 7. Summary of key elements** from group work (30 mins) [14:00-14:30]
 - a. prioritizing exercise or consensus
- 8. Refining the Research Question** (20 mins) and objectives (10 mins) [14:30-15:00]
- 9. Identification of ideal team** (20 mins) [15:00-15:20]
- 10. Summary, Next Steps and Round table of final thoughts** (20 mins) [15:20-15:40]
- 11. Round Table of Final Thoughts** – all participants (20 mins) [15:40-16:00]

Adjourn by 4 pm – Safe Travels!

Appendix B:

Number of Registered Midwives and Midwifery-led births in Canadian Provinces and Territories, 2017



https://canadianmidwives.org/wp-content/uploads/2018/06/CAM_Newsletter-V8No1_EN_v8-1.pdf

Appendix C:

Current Canadian Midwifery Regulations and Conditions, by Province or Territory

Jurisdiction	Regulation of Midwifery Scope	Financial compensation	Restrictions on Prescribing of Pharmaceuticals	Additional considerations	Readiness to Implement Mifegymiso for Medical Abortion
British Columbia	Midwives are only allowed to insert an instrument, hand or finger beyond the labia majora for 4 reasons: episiotomies/ amniotomies, internal examinations, repairing episiotomies/lacerations, or conducting an emergency vacuum assisted delivery (1) 2014 application to expand scope to include: ultrasound, well woman care, well baby care (up to 1 year), newborn frenectomy, evacuation of the uterus, prescribing and inserting IUDs (1)	Mixed model of funding Course of care + fee for service fee codes (2) Ability to create new fee codes for care that is within the midwifery scope (c/s first assists, consultations). (2) – may be a facilitator to compensation for abortion provision	Categories of drugs and their purpose – Example: Antibiotics for urinary tract infections (Amoxicillin, Cephalexin, Nitrofurantoin, Cefixime) (1) Were able to add narcotics into drug regulations when Federal regulation changed (Nov. 2016)	Able to insert IUDs as a delegated act. (3) – no compensation for this as not within scope Additional training for: acupuncture in labour, contraception management, epidural/ oxytocin management, surgical assists. (4)	
Alberta	List of 13 actions midwives may do, including: providing counselling and education related to childbearing, advising on family planning (in the postpartum period) – no mention of minor invasive procedures, no mention of timeframe or reason for internal examinations. (5)	Course of care payments allocated by the RHA (6) Some midwives will provide services privately (7) Some midwives will provide services privately (7)	Specific drugs rather than categories except for antibiotics (for the purpose of GBS, mastitis, cystitis and asymptomatic bacteriuria), antifungals (safe in pregnancy and for the newborn) (5) – On the order of a physician relating to a particular client, administer any drugs by the route and in the dosage specified by the physician. (5)		
Saskatchewan	“Assess and monitor women during normal pregnancy, labour and the post-partum period” (8) “Authorized Invasive Procedures” – internal examinations during pregnancy, labour, delivery and post-partum period (9) – able to insert IUDs, fit caps, or diaphragms (9)	Salaried**, employee model (6)	Drugs and categories: analgesics, antibiotics, antiemetic, contraceptives, Prostaglandins, etc. (9) Of note: If there is a medication that is associated with an invasive procedure that midwives are not allowed to perform, the ability of prescribing that medication does not allow a midwife to perform said act (9)	Contraception in scope (8)	

Jurisdiction	Regulation of Midwifery Scope	Financial compensation	Restrictions on Prescribing of Pharmaceuticals	Additional considerations	Readiness to Implement Mifegymiso for Medical Abortion
Manitoba	<p>No specific definition of a midwife other than: "assumes primary responsibility for providing all aspects of midwifery care, including prenatal, intrapartum and postpartum care, and care of the newborn" (10)</p> <ul style="list-style-type: none"> – list of minor surgical and invasive procedures: fitting cervical caps, inserting IUDs (10) – no mention of internal exams 	<p>Salaried**, employee model (6)</p>	<p>Categories of drugs and some specific drugs (33 categories/ drugs in total) (10)</p> <ul style="list-style-type: none"> – injectable, oral or topical antibiotics (10) – hormonal contraceptives (10) – prostaglandins for postpartum use (10) 	<p>Contraception in scope (10)</p>	
Ontario	<p>The scope of RMs in Ontario is outlined in the Midwifery Act, 1991.</p> <p>Midwives are able to assess, monitor and provide care to a person who is pregnant, in labour and postpartum (up to 6 weeks) (11)</p> <p>Relevant to abortion care, there are a number of "controlled acts" that midwives are authorized to perform: can put an instrument, hand or finger beyond the labia majora or anal verge during pregnancy, labour and the post-partum period; can prescribe and administer drugs from a list during pregnancy, labour and postpartum (11)</p> <p>Relevant to abortion care, there are a number of "controlled acts" that midwives are authorized to perform: can put an instrument, hand or finger beyond the labia majora or anal verge during pregnancy, labour and the post-partum period; can prescribe and administer drugs from a list during pregnancy, labour and postpartum (11)</p>	<p>Midwives are compensated per course of care (minimum of 12 weeks of service provided)</p> <p>Midwives are eager to work in new models, but compensation has been a barrier until recently</p> <ul style="list-style-type: none"> – Midwives are working w/OBs in their communities – Midwives are running volunteer clinics <p>New funding in 2017/18 contract: pot of funding for pilot projects to explore alternative practice models and funding</p>	<p>Specific drugs designated with specific purposes</p> <ul style="list-style-type: none"> – Application in with the government to change to medications that would be within the scope of a midwife (12) 	<p>Funding from the provincial government for pilot alternative practice arrangements such as midwives working in CHCs or as FTE sexual and reproductive health care providers</p> <p>Aspiration abortion and D&C may be within scope depending on interpretation of the Midwifery Act</p> <p>College has adopted the international definition of midwife in anticipation of change in scope</p>	

Jurisdiction	Regulation of Midwifery Scope	Financial compensation	Restrictions on Prescribing of Pharmaceuticals	Additional considerations	Readiness to Implement Mifegymiso for Medical Abortion
Quebec	The practice of midwifery includes: "any act the purpose of which is provide the professional care and services required by a woman during normal pregnancy, labour and delivery" (13) – Midwifery also includes: "counselling and information on parenting, family planning, contraception" (13)	Salaried independent professionals (6) – not employed by the government	– Specific medications with specific indications of when to use (14) Eg. Lorazepam to be given PO or SL for manual removal of the placenta (14)		
Newfoundland	"Midwifery" means the application of knowledge, skills and judgment to assess, monitor and provide care to healthy women in respect of health promotion, pregnancy, labour, delivery and the postpartum period, and healthy infants(15) – prescribing medications, tests, performing minor surgical and invasive procedures need to be approved by the college – not clearly defined in the act (15)	Model is not decided yet (6)	List of medications that midwives can prescribe but are not limited to (draft document 2016) (16)		
New Brunswick	"practice of midwifery" means the care, assessment and monitoring of women during normal pregnancy, labour and the postpartum period (17)	Employee model	List of drug categories and their purpose (18)	List of advanced competencies including: IUD insertions, cervical caps, well baby care and well woman care up to 1 year (19)	
Nova Scotia	"Clinical practice of midwifery" means provision of antepartum, intrapartum, postpartum and newborn care as a primary care provider" (20)	Salaried** model	List of category and indication – Example: antibiotics for lower urinary tract infection, treatment of vaginal/cervical infections, etc. (20) – Analgesics/sedatives require a training course, and prostaglandins for induction of labour and oxytocin for induction/augmentation of labour all require consultations	Midwives fighting for better integration into the health care system – may be focused on providing core midwifery services	
P.E.I.	n/a	n/a	n/a		
Yukon	Midwifery remains an unrecognized profession in the Yukon (6)	n/a	n/a	– Could allow for medical/surgical abortion from the beginning of midwifery regulation	

Jurisdiction	Regulation of Midwifery Scope	Financial compensation	Restrictions on Prescribing of Pharmaceuticals	Additional considerations	Readiness to Implement Mifegymiso for Medical Abortion
Northwest Territories	"A registered midwife is entitled to apply midwifery knowledge, skills and judgment: to provide counselling and education related to childbearing" (21)	Two programs: Hay River and Fort Smith Both salaried programs (6)	List of 67 medications allowed to be prescribed within the midwifery scope or in consultation with a physician – the use is not specified. No categories of drugs. (22)		
Nunavut	"The practice of midwifery means the application of midwifery knowledge and judgement to assess, monitor and provide care to women of reproductive age in respect of health promotion, pregnancy, labour, delivery and the postpartum period;" (23)	Salaried employees of the department of health. Paid an annual salary and an annual allowance. Currently two midwifery practices: Rakin Inlet and Cambridge Bay (6)	List of medications – categories of drugs with no use specifications – antibiotics, contraceptives, uterotonics for postpartum use (24)	Contraception in scope – IUDs with specialty certification (24)	

**Of note: salaried models may allow for easy integration as there is no specific fee code needed to be created but we must ensure that midwives are being compensated for their extra work if providing abortion services through a salary increase



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