BC WOMEN'S HOSPITAL+ 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

Contraception and Abortion in BC

4th BC Women's & CART Meeting

October 14, 2016

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The conference would not have been possible without the diligent efforts of the Organizing Committee and conference planning team, including:

- Ms. Cheryl Davies, Chief Operating Officer, BC Women's Hospital and Health Centre
- Dr. Jan Christilaw, Site Executive, BC Women's Hospital and Health Centre
- Dr. Tamil Kendall, Director, Women's and Maternal Health, Population and Public Health, Ministry of Health
- Ms. Edwina Houlihan, Ms. Caitlin Johnston and Dr. Brian Fitzsimmons, CARE Program at BC Women's Hospital and H*ealth Centre*.
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- Dr. Wendy Norman, Principal Investigator, CART-GRAC

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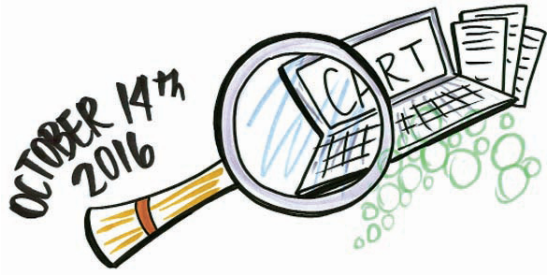
Executive Summary

On October 14, 2016, BC Women's Hospital and Health Centre, the BC Ministry of Health, and the Contraception and Abortion Research Team-Groupe de recherché sur l'abortion et la contraception (CART-GRAC) brought together policy makers, health care providers, patients, administrators, researchers and community organizations from family planning, abortion, and sexual health care sectors.

There is an urgent need to provide effective contraception and abortion services to women in British Columbia. Two innovative practices will soon be available to address this need. The goals of this conference were to explore barriers and facilitators to the implementation of these two innovative practices:

1. The Smart Methods at the Right Time (SMART) Program, a BC-wide initiative to provide one unit of a highly effective long-acting reversible contraceptive (LARC), or a hormonal method, at no cost to women at the time of abortion.
2. Mifepristone, the gold standard for medical abortion, which will soon be available in BC, and has the potential to increase women's access to abortion services, particularly in rural and remote communities.

Previous BC Women's-CART conferences (2009, 2010, 2011, 2014) have been successful to progressively advance contraception and abortion health policy, system and services in BC. Each conference presents best evidence to date; convenes a wide range of stakeholders to discuss evidence and stakeholder input on current BC gaps and opportunities; collects consensus from participants on barriers, facilitators and opportunities that need to be addressed; and results in identification and



prioritization of key questions and potential implementation/research approaches to improve health systems and services.

This 2016 conference built on the previous meetings to explore barriers and facilitators to implementing strategies for contraception and abortion health service and policy improvement, with a specific focus on the SMART Program and the pending practice of mifepristone medical abortion.

As always, the valuable collaboration and ideas brought forward by stakeholder participants and facilitators was successful to achieve:

- Clarification of the goals of the SMART Program with stakeholder input to the process for implementation.
- Excellent stakeholder input to improve SMART Program patient education, stock management, and data collection processes.
- Planning to optimize medical abortion access for rural women through opportunities available, as mifepristone is on the provincial hospital formulary.
- Stakeholder input to improve support to current and new abortion providers in BC and across Canada through the Canadian Abortion Providers Support (CAPS) community of practice.

Welcome from Provincial Leaders

Ms. Cheryl Davies, Dr. Jan Christilaw, and Dr. Tamil Kendall

ACKNOWLEDGEMENT OF UNCEDED TERRITORIES

Dr. Wendy Norman, Conference Co-Chair, Co-Lead of the national CART-GRAC research team, and Associate Professor in the Department of Family Practice, University of British Columbia, began the conference with a greeting and an acknowledgment of the Musqueam Traditional Territory on which the participants were gathered. She drew attention to the multiple partners involved in the meeting (see Acknowledgments) and to Lisa Edwards, the graphic illustrator who visually captured the thoughts and wisdoms from participants throughout the day. Her illustrations can be seen throughout these proceedings.

Overview of the Safe Methods At the Right Time (SMART) program

Ms. Cheryl Davies, Chief Operating Officer, BC Women's Hospital and Health Centre, welcomed attendees and expressed her pleasure at seeing partners and colleagues from around the province. She introduced Dr. Jan Christlaw, who reflected that it has been a journey to advance LARC and mifepristone medical abortion in the province. At BC Women's Hopsital the goal is to be the centre of a provincial network and to support the work that is done throughout the province.

Dr. Christilaw briefly introduced the Safe Methods At the Right Time (SMART) program, which will provide free contraception at the time of abortion and choice of contraceptive methods available for immediate placement or commencement. It is a provincial pilot program funded by the Ministry of Health. BC Women's Hospital is responsible for the roll-out, coordination, and evaluation of SMART. Dr. Christilaw emphasized that SMART is a program improvement initiative (not a research study).

Dr. Christilaw noted that if she were to envision a perfect world in health care, sexual and reproductive rights would be key to that: the cornerstones of healthcare. Healthcare providers, she continued, would be able to do their jobs without worrying if the woman in front of them can afford contraception. To start, we can offer contraception to women who have terminations. Without an effective method, she noted, most currently will go on to have a second termination in the following years because they cannot afford adequate contraception. The SMART Program is meant to provide women with contraception at the time of abortion if they wish it. The program begins as a pilot initiative to produce the data that will, ideally, make a difference. Health outcomes anticipated include 50% fewer unwanted pregnancies in ideal conditions. Dr. Christilaw then introduced Dr. Tamil Kendall who, she reflected, has been a partner in women's rights and reproductive rights.

Dr. Kendall spoke about how improving women's and girl's health is the key to population health. In holding the women's health and maternal and early child health portfolio, Dr. Kendall's responsibility is to make that argument with government, most recently through the provincial women's health strategy. Investing in information and sexual and reproductive lives, and having the ability to choose the number and spacing of our children is a good investment in our health system and in our society as a whole. In some parts of the province, she observed, women are eight times more likely to become teenage mothers, which is a preventable health inequity. Expanding the reach of abortion, she argued, will narrow such health gaps, and promote rights of women and girls.

Dr. Kendall wished to applaud and thank Dr. Perry Kendall, the BC Provincial Health Officer, who recommended a focus on abortion. She thanked BC Women's and particularly its executive members including Ms. Cheryl Davies, Dr. Jan Christilaw, and Dr. Dorothy Shaw. She thanked Dr. Wendy Norman and the CART team for their exemplary abortion research and their commitment to developing a smart business case for the SMART Program. Dr. Kendall expressed that this is where they showed their commitment to not only academic publishing but also the kind of information that can be used for policy making. She ended by stating her hope for turning that business case into a reality.

The purpose of this conference, Dr. Norman remarked at the close of the welcome and introductions, was to make participants' jobs more easy and effective. By providing feedback on the SMART Program and implementation of mifepristone in BC, participants would help researchers and decision makers to address their problems and scale up solutions. Dr. Norman provided an overview of the agenda and asked participants to consider the policy solutions that would be presented throughout the day. What would make these solutions work well in practice, and what future planning and solutions are also needed to support contraception and abortion access in BC? Finally, Dr. Norman provided a warm introduction to the various groups represented at the meeting, including physicians, trainees, clinic administrators, staff, and support people.

Discussion

The meeting hosts opened the floor for a brief discussion. Questions emerged about bringing early education in sexual health and prevention to the province, similar to the midwifery-led model in Europe. Dr. Kendall noted that comprehensive sexuality and sexual health education is part of the draft Women's Health Strategy. Gender transformative education that changes negative or harmful gender roles and promotes safe relationships (including reproduction) is a focus of government.

Contraception Update – LARC First

Dr. Brian Fitzsimmons

> **"A village would be nice but...it takes a long-acting contraceptive to prevent repeat adolescent pregnancies."**
> ***– Stevens-Simon, Kelly, & Kulick***

Dr. Brian Fitzsimmons began the day with a presentation on the state of the evidence for "long acting reversible contraception" (LARC) methods in BC. The four objectives of his talk were to:

1. Become familiar with the results of the Contraceptive Choice Project
2. Provide an update on recommendations for LARC
3. Clarify the relationship between the intrauterine device (IUD) and pelvic inflammatory disorder (PID)
4. Understand why LARC should be considered first for contraception

1 Stevens-Simon C et al., A village would be nice but... *Am J Prev Med.* 2001.

What Does "LARC First" Mean?

The message "LARC First" means that LARC methods are the most effective form of contraception for women, however financial barriers make them difficult to access. Contraception, he argued, ideally should be simple, inexpensive, readily available, highly effective, entirely safe, free of any symptoms or adverse effects, immediately reversible, and coitally independent. Low uptake of LARC in BC is surprising because of its effectiveness and ease of use, Dr. Fitzsimmons observed. It may be due to lack of recommendations from the medical community and misconceptions about side effects. There are many contraception choices available and deciding between the options may be confusing for women.

What Are the Options?

Dr. Fitzsimmons reviewed the LARC options available in Canada by directing participants' attention to the Bedsider.org contraception comparison chart, a patient decision support tool developed by researchers and health communication experts in California. The top-line or LARC options in Canada include hormonal Mirena (LNG IUS) and copper intrauterine devices (IUD), in that order. Together these are referred to as Intrauterine Contraceptives (IUC) and may be referred to as "reversible sterilization" Dr. Fitzsimmons noted, because they work as well as tubal ligation and can be reversed when the woman desires.[2] The percent of women who experience an unintended pregnancy in the first year is comparable between IUC (0.1-2%) and sterilization (0.5%).[3] Another LARC option, the hormonal implant (trade names include Implanon® and Nexplanon®), is not currently approved for use in Canada, but if available would offer women would offer women another highly effective LARC option.

The continuation rate is high with women who choose LARC. If they are given a choice and there is no cost barrier, women by and large stick with using LARC. Thus, it is important to educate not only women about LARC options but also health care providers. In Canada, two categories

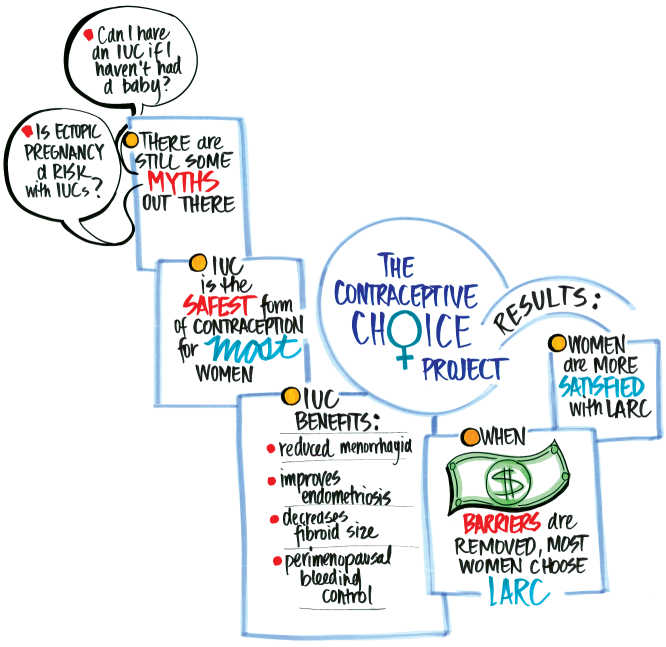
2 Andersson et al, *Contraception* 1994; Peterson, *Am J Obstet Gynecol* 1996.

3 Hatcher et al., *Contraceptive Technology 18th ed.*, 2004.

of IUC are available: copper intrauterine devices (IUD) and levonorgestrel-releasing PIDg intrauterine systems (LNG-IUS).[4] Intrauterine contraceptives are a form of long-term birth control inserted into the uterus.

Why is it Superior to Oral Contraceptive Pills?

When women discontinue using oral contraceptives, they typically choose a less effective method. In a USA nationwide prospective study of 1657 women initiating or switching to the use of a new contraceptive from private practices, clinics, and a health maintenance organization, of the 293 women who discontinued use, 42% did so without consulting the health care provider.[5] Of women who discontinued oral contraceptives but did not wish to be pregnant, 69% chose a contraceptive that is less effective than oral contraceptives (male condom, barrier methods, spermicides, or "natural" methods). Consequently, counselling should emphasize the possibility of side effects, stressing the fact that most will be transient, and the need to identify a backup method.



4 Black et al., Canadian Contraception Consensus, SOGC Clinical Practice Guidelines, *JOGC* 2004.

5 Rosenberg and Waugh, *Am J Obstet Gynecol* 1998.

The Contraceptive Choice Project

Dr. Fitzsimmons provided the example of the Contraceptive Choice Project at Washington University St. Louis, involving 9,256 participants presented with the options of free IUC or implant. It demonstrated that when financial barriers to contraception were removed 75% of women and teens chose a LARC method, and at one year 86% of LARC users were still using the method compared to those using other non-long-acting methods (55%). LARC users also reported the highest rates of satisfaction, and the lowest rates of unintended pregnancy. Dr. Fitzsimmons showed participants a video created by the study researchers illustrating the tremendous impact of the intervention (see YouTube channel videos: WUSTLChoiceProject).

What is the Mechanism of Action?

The contraceptive mechanism of action[6] for an IUC is the prevention of fertilization, which is done through different mechanisms based on the type of intrauterine contraception.[7] Ovulation is inhibited in some women with the levonorgestrel IUS, however this is not a primary mechanism of action contributing to contraceptive efficacy, which is mainly due to progestin induced thickening of cervical mucus. LNG-IUS effectiveness is superior to copper IUD and is comparable to a tubal ligation. There are also a number of non-contraceptive benefits of LNG-IUS, including decreased menorrhagia, anemia, and improved hemoglobin. It is also excellent for use in perimenopause for bleeding control and in many cases may be an alternative to hysterectomy.

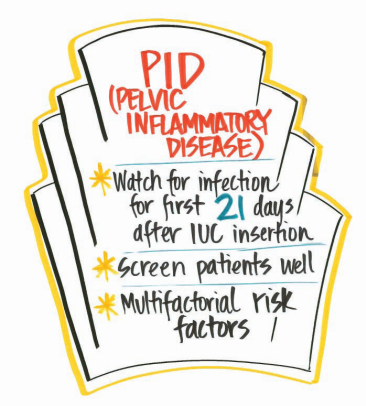
Who Can Use Intrauterine Contraceptives (IUC)?

IUC is the safest, and the most effective, form of reversible contraception in Canada. It is appropriate for use among women of any age who want contraception, want long-term contraceptive control, cannot tolerate estrogen (or where estrogen is contraindicated), who are postpartum and/or breastfeeding, and cannot take the oral contraception pill (OCP) at the same time every day. There

6 Mirena Product Monograph, Bayer Inc. May 11, 2010; ESHRE Capri Workshop Group, *Hum Reprod Update* 2008; Ortiz ME and Croxatto HB, Contraception 2007.

7 Costescu et al Canadian Contraception Consenus (Part 3 of 4): Chapter 7 – Intrauterine Contraception. *JOGC* 2016.

are some contraindications to IUC, including pregnancy, uterine anomalies, active pelvic infections and history of certain cancers.[8]



Dispelling Myths about IUCs

IUC expulsion is rare and most occur within three months. IUCs do not increase the overall risk of ectopic pregnancy. Overall, IUC users have a lower risk of ectopic pregnancy vs. non-contraceptive users (0.02-0.25/100 woman years vs 0.12-0.5/100 WY) due to the lower risk of pregnancy.[8,9] In the unlikely event that a woman should conceive with an IUC in place, the diagnosis of ectopic pregnancy should be excluded because the risk of ectopic when a pregnancy does occur ranges from 15-50%.[8] Risk of perforation is low (fewer than 0.3 to 2.6 in 1000 insertions) and lowest among professionals with experience in insertions.[8,10] The incidence of PID is low with the greatest risk due to introduction of bacteria at the time of insertion and presenting within the first 21 days of use, after which the rate of infection drops dramatically. The cause, when pelvic infections do occur, are multi-factorial, associated with exposure to a sexually transmitted infection, e.g., through lack of use of a concomitant barrier method such as a condom, and are typically not linked to the presence or absence of an IUC device. The risks of PID for women with medical conditions (i.e. multiple cardiovascular risk factors, HIV infection) are often low and the IUC advantages generally outweigh theoretical or proven risks.

In summary, Dr. Fitzsimmons stated, contraception adherence is high with LARC methods and IUC can be as effective as sterilization. For healthcare providers, time spent choosing the right method improves compliance and reduces the "switching effect"

Questions from Healthcare Professionals

Discussion after Dr. Fitzsimmons' presentation included questions about difficulty finding the string after inserting an IUD at the time of caesarean, any association between depression and use of LNG-IUS

Dr. Fitzsimmons responded that the string can get curled up, which is appropriate and completely beneficial. The literature on the association between IUS and depression is that in a small subset of women an LNG-IUS may make mood symptoms worse and a discussion of this possibility should be undertaken with individuals with a history of mood disorder prior to initiation. Dr. Fitzsimmons noted that both depression and contraception use are common among young women and the age of contraception initiation can also coincide with the age of onset of depressive symptoms. The data comes mostly from the large retrospective reviews and there are some flaws in the methodology.

8 Costescu et al Canadian Contraception Consenus (Part 3 of 4): Chapter 7 – Intrauterine Contraception. *JOGC* 2016.

9 Hubacher, Grimes, *Obstet Gynecol Surv.* 2002.

10 Black A, Francoeur D, Rowe T, et al. SOGC Clinical Practice Guidelines Number 143, 2004; *Contraception Guidelines (*part 2 of 3). JOGC 2004.

SMART Program: Evidence Supporting Policy Development

Dr. Wendy Norman

Dr. Wendy Norman began her presentation on the evidence underpinning the SMART Program by reflecting on the first CART meeting that took place in 2009. There attendees highlighted that there was a need to provide better contraception at the time of abortion. Since then, she reflected, CART has conducted post-abortion contraception studies with data from Population Data BC, which allowed for comprehensive analyses of outcomes for pregnancies, complications, and prescriptions. CART published the protocols for a randomized controlled trial (RCT), intake data, and at the request of government also conducted a secondary cohort analysis of the RCT data on costs and outcomes of the different policy options related to contraception post-abortion.

Dr. Norman provided an overview of the analysis, which was grouped by the contraception method participants received at clinic, how many pregnancies they had within two years follow-up. Approximately 1,000 women enrolled and were followed for three years.

The results clearly highlighted what we already know about the social determinants of health among women who seek abortion. One-third were mothers, one-third had had a previous abortion, and 50% had only high school education or less. Over 50% had an income lower than $15,000 per year. They were likely in their education years still, but may not have third party payers and may not have been on social assistance. Regarding contraception methods used, 14% of women in the province use sterilization, a very effective method, but only 1.7% in the cohort were using that method.

Most importantly, the analysis demonstrated that among the number pregnancies per 100 women within two years after abortion women using the most effective methods had very low rates of abortion. The women who used the best methods went on to have an intentional birth. Those with the least effective methods were most likely to have an abortion.

We have found that women who are offered it free and have "good information" choose LARC. The more women choose IUDs, the fewer unplanned pregnancies take place, and consequently the more expenditure the government saves. Nearly 40% of women will have a pregnancy within two years if they do not have a subsidy. If they receive a subsidy then that rate drops by half. Our results indicate that it costs about 20% cheaper to provide free contraception than to manage unplanned pregnancies. This provides strong evidence for providing free IUD contraception at the time of abortion.

Discussion

Ms. Cheryl Davies added that it is exciting to see the data and trends to inform policy and service development. A brief discussion included the potential barriers to women's access of the SMART Program. Currently nurses cannot insert IUDs, and cannot send lab orders or write prescriptions, but they can be certified to provide contraception, STI screening, and rural and remote health.

BC Women's SMART Program Proposal

Ms. Cheryl Davies, Ms. Caitlin Johnson

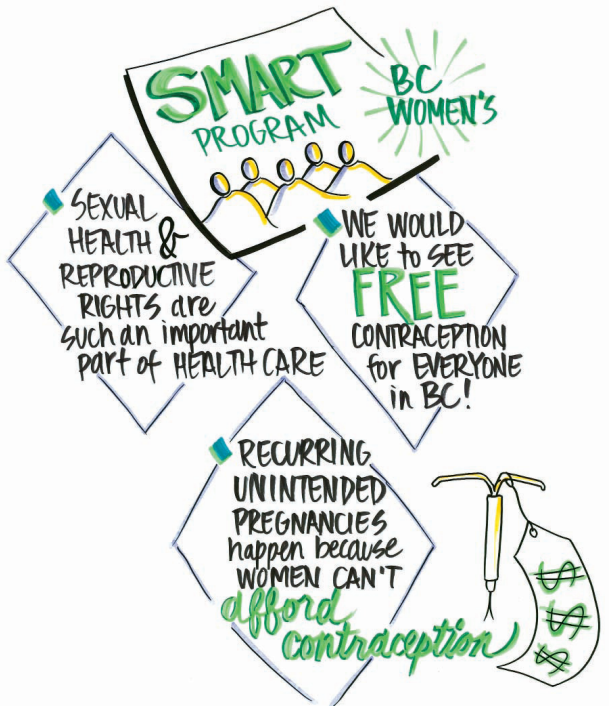
Ms. Cheryl Davies (Chief Operating Officer) and Ms. Caitlin Johnson (Ambulatory Program Manager) of BC Women's Hospital and Health Centre oriented attendees to the SMART Program. BC Women's Hospital, as an agency of the Provincial Health Services Authority (PHSA), is tasked with piloting SMART. The pilot program has been informed by research data, but, as emphasized in the meeting's introductory remarks, it is not a research project. The SMART Program is an improvement project that requires careful selection and collection of data.

For healthcare providers, they observed, the SMART Program offers three opportunities and benefits:

1) Increasing access to contraception for women who experience an unwanted pregnancy during the pilot program;
2) Evaluating outcomes to demonstrate how we can make population health impacts for women and young women, and impacts on health system resource allocation;
3) Providing pilot data on impacts that lead to advance policy for more universal access to contraception.

Program Requirements

The SMART pilot improvement project will have time limited funding, thus it is important to engage the maximum number of women possible to produce compelling results. Participants must adhere to clear eligibility criteria. This means that the program cannot include women with other access to contraceptive coverage to avoid duplication of other government coverage, and ensure appropriate data for tracking program outcomes. Standardized training and data management processes are necessary to uphold contract commitments and to achieve the best results for evaluation.



Eligibility

Eligibility criteria for participating in the SMART pilot improvement project will be limited to accredited facilities (i.e. hospitals, CPSBC accredited non-hospital surgical/ medical facilities), participants who are BC residents on BC MSP coverage only, and those who have only surgical terminations of pregnancy as contraception must be provided same day. Women who receive mifepristone medical abortions may also become eligible.

Project Commitments

BC Women's Hospital's commitment to the project will include developing program implementation and tools, providing logistical support to Facilities, providing standardized training to facilities, developing and providing patient information sheets, overseeing contraceptive inventory management and reimbursement processes, developing and providing patient data collection tools for program implementation, and providing a program evaluation summary.

Facilities, in turn, will complete a data sharing agreement with PHSA (BC Women's) and comply with required privacy obligations. They will also need to participate in standardized training (provided by the project in-person and/or online), and program data collection processes to support successful program implementation. Low-volume providers were encouraged to complete the online training. Although it will be challenging to exclude certain women as ineligible for this program, it will be necessary for facilities to comply with patient eligibility criteria and contraceptive reimbursement processes.

Ms. Davies emphasized that it is important to align the pilot program with what healthcare providers are currently doing to create minimal impact on time and energy.

Milestones and Next Steps

To date the program has reached development milestones. Facility and patient eligibility criteria have been confirmed, the baseline data collection tool developed, standardized training protocol identified, and evaluation support confirmed with UBC team (Dr. Wendy Norman).

Still under development were the patient information and data collection/sharing processes to comply with privacy requirements (HIPSOC), as well as contraceptive inventory management and reimbursement processes. This meeting was an opportunity, Ms. Davies noted, to gather feedback from stakeholders to inform development processes and tools for program implementation.

The Need for Stakeholder Engagement

Ms. Davies then invited attendees to consider ways to inform best processes and to ensure optimal program implementation and evaluation results. Key issues to be discussed through the morning's breakout sessions included:

1. Eligibility criteria: Agreement and compliance
2. Women already eligible for government-assisted contraception: What are current processes?
3. Contraceptive management and reimbursement processes: What will work best for healthcare providers?
4. Data collection and submission: What are efficient and best processes?

Q & A

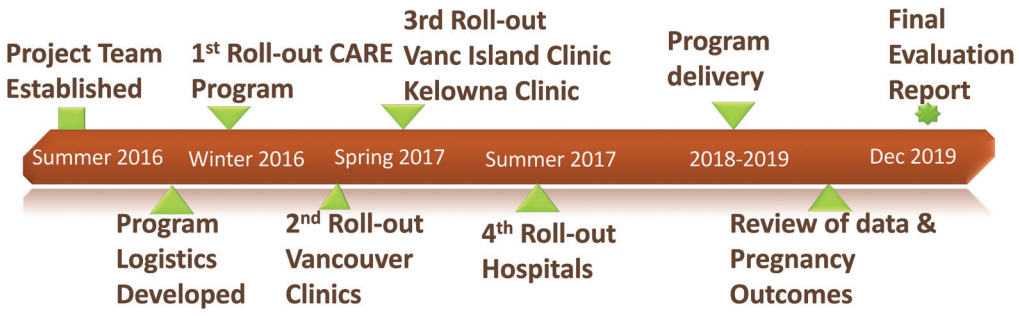
Prior to breakout sessions Ms. Cheryl Davies and Dr. Wendy Norman led an informal question and answer period.

Q: What method of LARC will be provided: Copper IUD or levonorgestrel-releasing intrauterine system (52 mg) (LNG-IUS)?

A: Both.

Q: Women have the opportunity to select a one-month free package of an oral contraceptive or one three-month injection of depo-medroxyprogesterone acetate (DMPA). If I had a client and gave her one month of contraception she would likely discontinue.

Smart Program: Proposed Timeline



A: Studies in BC and elsewhere have demonstrated that one month and three-month oral contraceptive prescriptions result in the same pregnancy rate. The funding envelope for the program is limited. It would also be challenging to set up a system where pharmacists could give women ongoing contraceptives after an abortion without compromising her confidentiality with respect to the abortion.

Q: This program is not to duplicate contraception coverage. What about third party and private insurers?

A: It is worthwhile to have a conversation about reimbursement plans, however at this stage the logistics of verifying and reimbursing for the extraordinary number of different plans weighs into the program budget. The program is currently undecided about how to do third party and private insurers as women would have to receive the program information in advance, and it is unclear if women would pay the deductible at time of post-abortion contraception.

Q: Will there be a defined follow up visit mandated for the evaluation process?

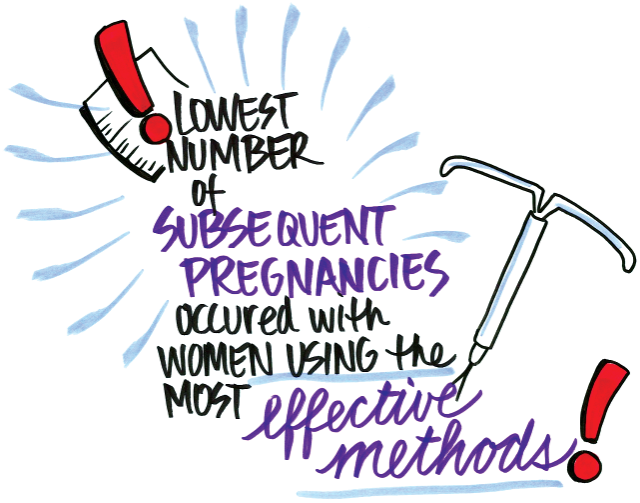
A: There is no clinical follow up. The only interaction with the patients in this program will be one time at time of abortion to collect administrative data. The woman's personal health number (PHN), birth date, and intake form will need to be sent to BC Women's Hospital. The evaluation requires data on all women who came for abortion who had MSP coverage in a given month and the proportion that took other contraception methods to model the pregnancy outcomes. Counseling will not change, however there will be the additional step to understand the option for the free contraceptives and the data collection.

Q: Will the woman go to purchase the LNG-IUS and get reimbursed or will it be stocked there at the facility?

A: Eligible women will be provided the LNG-IUS on site and given it free with no up-front payment. Contraception inventory management and reimbursement will be up to individual facilities and BC Women's with no impact on women.

Q: Will the program require that the LNG-IUS be inserted at the time of the abortion? I find my patients in the communitytwoweeks later.

A: Yes, it will be at the time of abortion. In CART's research, only 50% of the women given a postcard to go get a free LNG-IUS actually had one inserted. Immediate insertion appears to be the best fit with how busy and chaotic



women's lives are.

Q: Can you describe the patient education piece?

A: We will work with existing counseling approaches to develop consistent information and some information will be on BC Women's website.

Q: Is this government funded and what is the value? How many women will the project impact?

A: The government has provided over $3 million dollars, of which almost all is for the cost of contraception. A smaller amount of the budget is for evaluation and project management. CART and BC Women's staff involved are contributing time as part of their normal salaries. Currently 15,000 women in BC access abortion each year, which is declining because of increased use of IUD. In CART's model, 60% of women would take IUD if offered, which translates to approximately 10,000 IUDs annually. The government's expectation is that this is not a pilot program but will continue when it is shown to be successful through initial evaluation. Healthcare providers are needed to make that a reality.

Q: As a counselor, we try to figure out what insurance coverage women have. If a woman has partial coverage, or has First Nations status but does not have her number, what do we do? Is there a simple process to determine this information?

A: We do not have an answer and will have to discuss this in the breakout sessions.

Working Discussion Groups: SMART Program

Discussion Group 1: Clarify/reinforce the strict eligibility criteria for the pilot phase
1. Will any women who receive methotrexate and are compliant with follow up meet the criteria for the program?
2. Will women who are partially funded by Pharmacare (i.e. will owe $100 for the IUD) be eligible?
3. Will we turn away women who do not have MSP coverage?
4. What about women with a nonviable gestation? What about miscarriages?
5. Are there restrictions based on gestational age?
6. What about women who are seeking emergency contraception copper IUD?
Discussion Group 2: Streamline the process so there are no unintended effects for patients and the system
1. How do we make it seamless for patients who do not know if they have coverage?
2. How will smaller facilities be reimbursed? Could we work through the hospital pharmacy or will that cut off business for community pharmacies?
3. When do we engage women in the pilot and educate them? During the wait time for a same-day procedure? Via Telehealth? Via the Internet?
4. How do we take away any bias that we may have that IUD is the preferred method so that women can have an autonomous decision?
Discussion Group 3: Clarify how to manage contraceptives in clinics and pharmacies
1. What is the role of pharmacists in helping to educate and inform patients?
2. How do physicians conduct reimbursements in their own clinics? Do you connect with a community or hospital pharmacy?
3. Will clinics manage their own inventory? Will that be feasible?
4. How does the reimbursement process work in terms of working with a community pharmacist? How do they get their reimbursement? What modifications do they need to make to support the program?
Discussion Group 4: Streamline data sharing and collection processes
1. Will there be training for sites conducting data collection (Suggestions: video, instruction sheet, or webinar)
2. What is the best way to transport the data from centres to BC Women's? Can the original be faxed instead of copied? Could there be a check box in the patient chart?
3. Can women fill out information in advance of the appointment? (Suggestions: App, website)
4. Do we need to clarify for women that they will not need to provide consent?
5. What will clinics need for start-up instructions? (Suggestions: clinical algorithm, FAQ on coverage for First Nations patients, care provider instructional slide deck or video)
6. What information will need to be saved in the patient chart after the pilot is done?

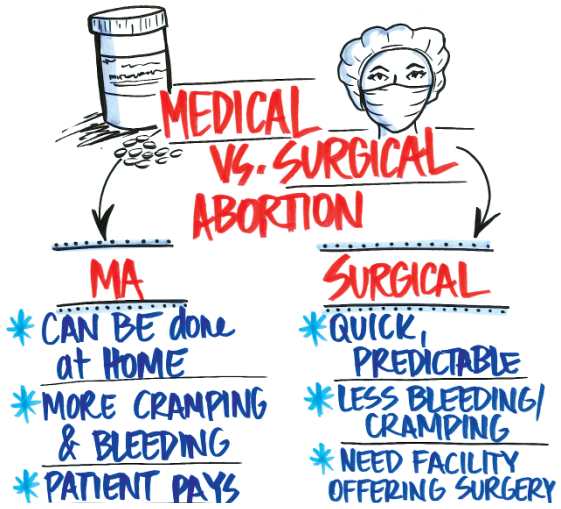
Mifepristone for 1st and 2nd Trimester Abortion Care

Dr. Regina Renner

In this first session of the Mifepristone portion of the meeting, Dr. Regina Renner provided an update on evidence-based best practices in 1st and 2nd trimester medical abortion (MA) for undesired or failed pregnancies, regimens including mifepristone or methotrexate, and complications arising during MA.

Of the 82,869 abortions in Canada in 2013, 90% took place in the 1st trimester but only 3.8% of 1st trimester abortions are medical. There is a higher percentage of MA in countries using mifepristone. There are numerous guidelines for MA.[11]

These provide consistent guidance for pre-abortion care, including pregnancy options counseling, abortion method, informed consent, and patient instructions. The options of medical and surgical abortion can be explained as follows:



MEDICAL ABORTION	SURGICAL ABORTION
PROS: • No anesthesia or instrumentation • Some feel more 'natural' • Can be done at home • Can be done where surgery is not offered (rural/international)	**PROS:** • Quick, predictable • No financial cost for patient • Less bleeding/cramping • Highly successful (>99%)
CONS: • Multiple visits/uncertain timing • More symptomatic – cramping/heavy bleeding • Higher failure rate than surgical • Patient pays for medications • Need access to emergency care	**CONS:** • Instrumentation and anesthesia • Rare complications • Need facility that offers this – may involve time/travel cost

11 SOGC (Society of Obstetrics and Gynaecology) 2016; NAF (National Abortion Federation), Clinical Policy 2016; SFP (Society for Family Planning) 2016; RCOG (Royal College of Obstetrics and Gynaecology) 2011; WHO (World Health Organization) 2012.

The SOGC guidelines outline the information a healthcare provider needs to provide MA care. Medical abortion options in Canada include a combination of methotrexate/misoprostol and the soon to be available mifepristone/misoprostol combination, which is the gold standard for MA. Mifepristone/misoprostol was approved by Health Canada in July 29, 2015. It is indicated for MA up to 49 days after LMP. Off-label use of mifepristone may include MA up to 49-70 days, MA and management of failed pregnancies in the 2nd trimester, and cervical ripening 24-48 hours prior to 2nd trimester D&E. The evidence-based regimen (Health Canada approved) will include the following:

DAY	LOCATION	REGIMEN
Day 1	Clinic	Mifepristone 200mg PO x 1
Day 2/3	Home	Misoprostol 800 mcg buccal x 1 • 2 x 200mcg tablets in each cheek x 30 minutes then swallow • Alternatives: sub lingual or vaginal (oral only up to 56 days)

This regimen is highly efficacious, meaning no additional surgery is needed for any reason.[12]

GESTATION (DAYS)	ORAL MISOPROSTOL	VAGINAL/BUCCAL MISOPROSTOL	ONGOING PREGNANCY RISK
≤49 days	97.6%	95.5-97%	0-1.2%
50 – 56 days	93.4%	91.3-98%	
57 – 63 days	86.8%	94.2-99.8%	0-3.5%
64 – 70 days		90-95.9% (buccal miso), 94.8% (sublingual miso)	

Effectiveness of various mifepristone and prostaglandins regimens according to gestational age

GESTATIONAL AGE	COMPLETE ABORTION RATE	RATE OF ONGOING PREGNANCY
≤42 days	95.8%–98.8%	0.6%–1.2%
≤49 days	92%–99%	0%–1.2%
≤56 days	91.3%–98%	0%–3%
≤63 days	87%–98.2%	0%–3.5%

Source: SOGC 2016

Evidence-based mifepristone-containing MA regimens

MEDICATION AND DOSE	GESTATIONAL AGE	EFFECTIVENESS
Mifepristone 200 mg oral/ misoprostol 800 mcg buccal or vaginal	≤49 days	95.5%–97%
Mifepristone 200 mg oral/ misoprostol 800 mcg buccal, vaginal, or sublingual	63 days	94.2%–99.8%
Mifepristone 200 mg oral/ misoprostol 800 mcg buccal	64-70 days	90%–95.9%
Mifepristone 200 mg oral/ misoprostol 400 mcg sublingual	64-70 days	94.8%

Source: SOGC 2016

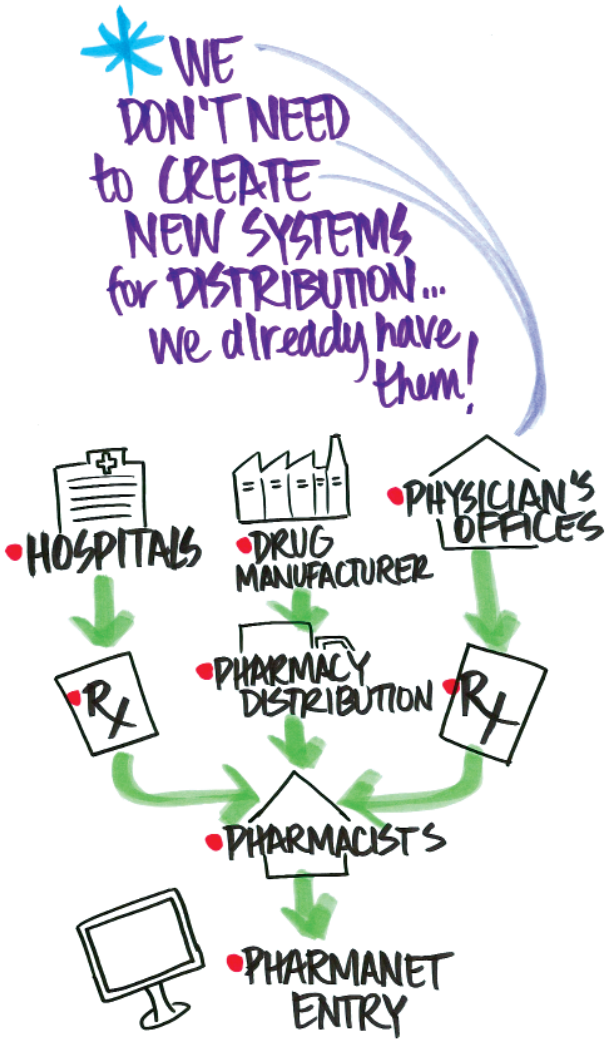
12 SOGC 2016, SFP 2014, NAF 2016, WHO 2012.

REGIMENS	SUCCESS RATE (%)	ADVANTAGES/ DISADVANTAGES	GESTATION AGE LIMIT
Mife/miso Mife 200 mg PO Miso 800 mcg PV, Buccal, or SL 24-48hrs later	95-99%	Less time to completion, fewer side effects, but higher cost	≤70 days (Health Canada: 49 days)
MTX/miso MTX 50mg/m2 IM Miso 800 mcg PV 3-5 days later	89-96%	Low cost and readily available but longer time to completion	≤63 days
Miso only Miso 800 mcg PV or SL q3hrs x 3 doses	84-85%	Low cost and readily available but less effective	≤63 days

A methotrexate regimen, in comparison to mifepristone, has lower efficacy, longer mean time to expulsion (7.1 vs. 3.3 days) and is associated with lower acceptance among women compared to mifepristone (83% vs 88%).

In summary, mifepristone takes less time to completion, has fewer side effects, but a higher cost in comparison to a methotrexate or misoprostol only regimen.[13]

Barriers to use of mifepristone in Canada include the mandatory ultrasound, gestational age limit, and requirement to take the medication in front of a physician. The cost is also prohibitive and expected to be $270 CAD (Mife 200mg + 800mcg Miso). Private member insurance coverage is currently unknown. It is predicted to be available in fall/winter 2016. All prescribers and pharmacists will be required by Health Canada to take a free online course through SOGC, which may also limit uptake of mifepristone MA.



13 SOGC 2016, SFP 2014, NAF 2016, WHO 2012.

Q & A

Q: Can we stock mifepristone in our clinic office?

A: Yes, however if the woman wants to arrange for payment through a government or third-party insurer she has to get a prescription, pick up the medication, and then take it back to the office.

Q: Is there any evidence that ulipristal (a progesterone antagonist) would work as an abortion drug?

A: No evidence.

Q: If the prescription is filled at the pharmacy, will Pharmanet needs be met?

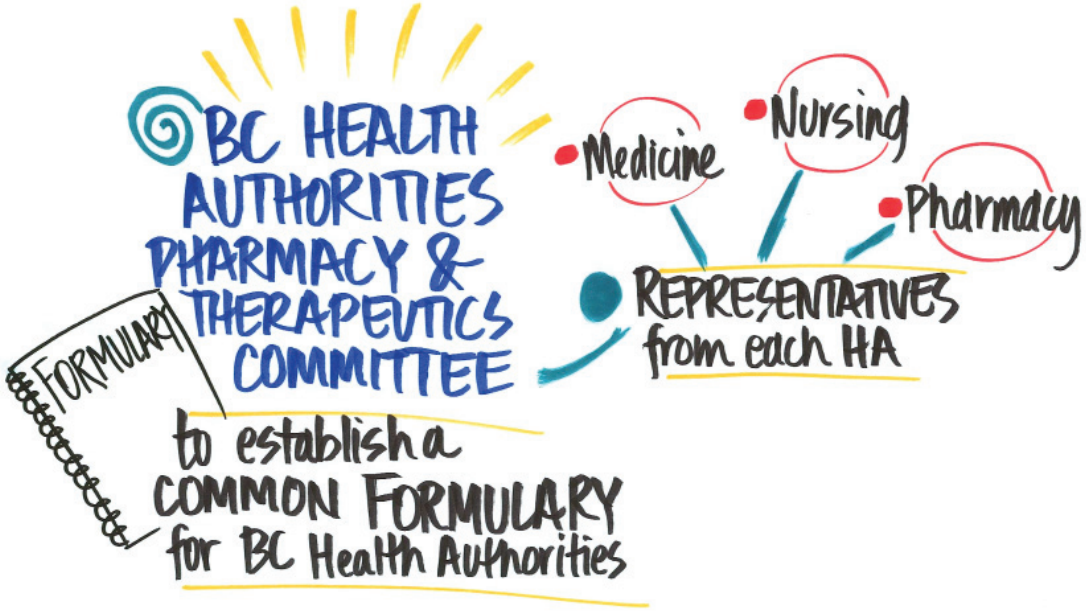
A: Yes.

Q: Whose guidelines are we going to follow – our college or Health Canada?

A: You are responsible to your college. Professional organizations wrote the guidelines and indicate that this is the highest standard of practice. Some of the best evidence has come by since Health Canada labels were approved.

Q: Is a portable ultrasound with low resolution sufficient?

A: Yes, there are no restrictions for ultrasound. Portable probes are available that can be plugged into a Smartphone.



Mifepristone Regulations and Dispensing Considerations for BC

Bob Nakagawa, Registrar,
College of Pharmacists of BC

Bob Nakagawa provided a presentation on the changing policy and regulation considerations for mifepristone in British Columbia. He drew the meeting's attention to the continued coverage this issue has received in the media, particularly from the Globe and Mail.

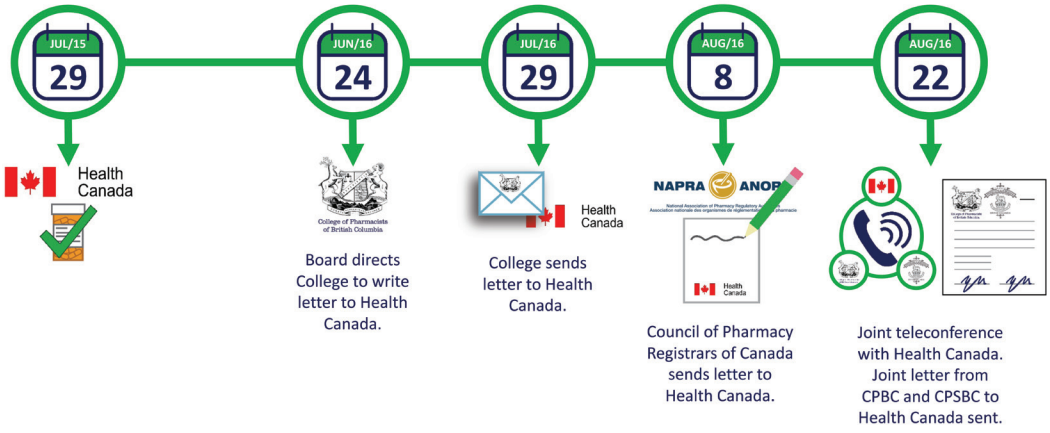
Health Canada approved Mifegymiso® for physician-only dispensing, which was an unusual requirement. The College of Pharmacists of BC (CPBC) board had concerns about the delivery and the limited accessibility of Mifegymiso®. He is not aware of another drug that asks healthcare providers to use a different distribution method. The current method of distribution, outlined in the BC Health Professions Act, has safety nets and requires pharmacist-only dispensing as pharmacy professionals are experts in dispensing.

In this context, Bob Nakagawa explained, British Columbia is clear on the roles of healthcare professionals. If the system changes, then people who do not meet requirements may be left to dispense drugs. Currently physicians can dispense in certain limited circumstances, however they must meet certain standards and complete a lengthy and rigorous approval process.

Pharmanet was established to bring one single source of truth for how people get drugs in their community. It is important to ensure that physician dispensers complete comprehensive entries of all drugs dispensed, into the system of Pharmanet. Pharmacists check to see before they enter a drug if there is anything in Pharmanet. If that patient ends up in an emergency department, for example, emergency health professionals would then be able to clearly assess the patient's current prescriptions.

Also of concern is the Notice of Compliance for Mifegymiso®, a notice from the government to which the manufacturer's submission complies, which does not reflect the distribution model in BC. The process is such that, Health Canada looks at the submission, the product, its storage, requires that the manufacturer cannot market it off label, and then authorizes it to be marketed in Canada.

Correspondence with Health Canada



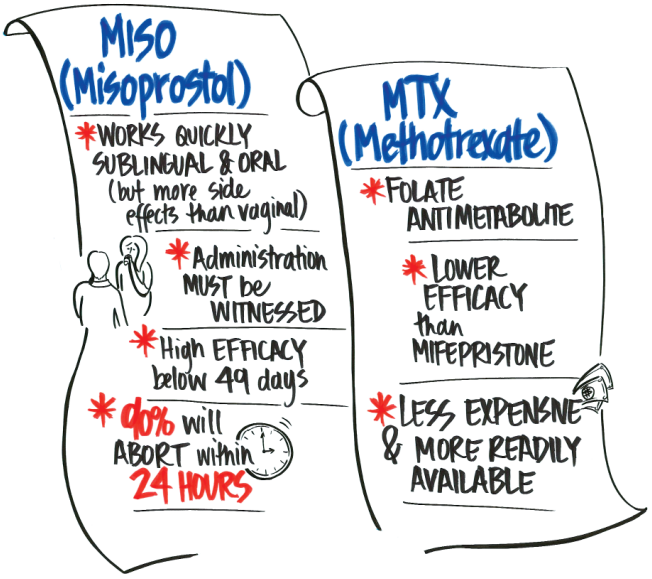
The drug is approved based on federal requirements; dispensing is overseen by each individual provincial body. The manufacturer will need to make a new submission to Health Canada for approval if it has new findings to support pharmacist dispensing.

Bob Nakagawa explained that, in the province, a physician writes a prescription, the patient takes it to the pharmacy, they get a Pharmanet check, and the pharmacist provides the product. The marketing axis is federal government's responsibility and delivery of services, particularly the scope of practice for health professionals, is provincial. Thus, these are distinct jurisdictional areas; provision and governance issues are provincial. The approval of Mifegymiso® disrupted these acknowledged jurisdictions.

There has been on-going discussion between the CPBC and other regulators and organizations. All provincial regulators have the same concerns regarding dispensing and accessibility to Mifegymiso® specifically to women in rural communities.

The CPhBC has concerns about the unusual process for Mifegymiso® that were expressed through correspondence with Health Canada. First, Bob Nakagawa explained, they wrote to Health Canada as a provincial board.

The physician only distribution system under the jurisdiction of CPSBC faces potential barriers including out-of-pocket costs for physicians and patients, challenges to ordering and stocking products with a one-year expiry date, no data entry for insurance and administrative databases such as Pharmanet, and rules against pharmacists acting as wholesalers. Physicians also lack training to ensure regulatory compliance and bylaws for dispensing drugs, and lack infrastructure to buy, sell and



manage drug inventory. One overarching consequence of these barriers is it will be harder for women in rural communities to get access to mifepristone. Bob Nakagawa expressed that the College has decided this is unacceptable for BC.

The system Health Canada had proposed for pharmacist distribution of Mifegymiso® would differ sharply from that of all other drugs. Health Canada proposed that a patient takes a prescription to a pharmacy (primarily a community pharmacy), the pharmacists would fill the prescription and then send it to the prescriber, who would "dispense" it to the patient. The alternative Health Canada proposed is that the physician would stock and sell and dispense the drug directly to the patient and then receives the drug. Patients may be uncomfortable with this but it would meet all legal requirements.

However, the College of Pharmacists, and the College of Physicians and Surgeons of BC, agree that standard prescribing and dispensing practices are safer than this alternative proposed by Health Canada. Thus, the regulatory Colleges for physicians working together with that for pharmacists, will allow their registrants in BC to prescribe and dispense mifepristone as per normal prescribing and dispensing practices. After explaining this alternative process, Bob Nakagawa invited questions.

Q & A

Q: What did you say in the letter?

A: The College indicated that there should not be a different distribution and dispensing system for this drug compared to any other drug. It is necessary to have pharmacists involved in the distribution and dispensing systems or patients may be at risk.

Q: Did the company have it in their application that this unusual mechanism of prescribing is how they wanted it?

A: Yes. The approved mechanism is the way mifepristone is provided in many parts of the world.

Q: Can a college choose to provide mifepristone differently, in the way you have described?

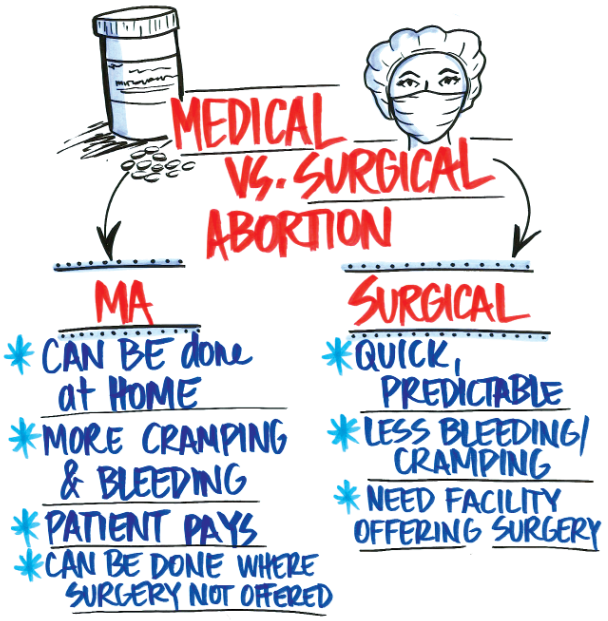
A: Yes. We as colleges will provide information to our registrants on how we feel the product should be dispensed. Our College informed Health Canada that we will provide guidance to members and support the option of usual practice where the physician writes the prescription and the patient gets it filled at a pharmacy. The Health Canada notice of compliance is not meant to influence usual practice. For instance, old drugs are used in many different ways that were not included in the original monograph.

Q: What will be the cost of the product? Is it available from other companies?

A: We are unsure. It took nearly 30 years for a manufacturer to bring it Canada, take a submission, and find a distributor.

Q: How will pharmacists be trained to provide this? What about conscientious objection?

A: Training will be provided through a free online course co-developed by the Canadian Pharmacists Association, the Society of Obstetricians and Gynaecologists and the College of Family Physicians of Canada. Conscientious objection could happen, but our College will need to make sure that patients are not negatively impacted by individual beliefs.



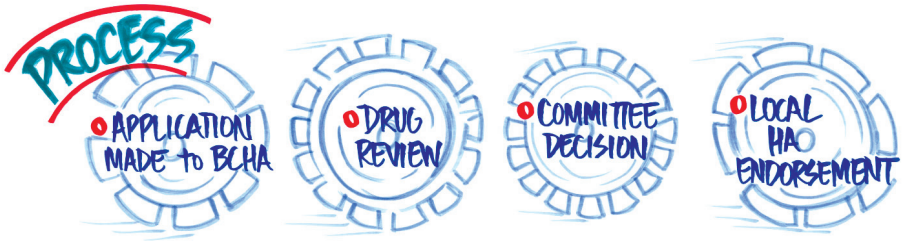
Q: The shelf life of misoprostol is much shorter than that of mifepristone. A pharmacist can put medication in blister packs or suspensions. Can a pharmacist put mifepristone and misoprostol separately in a bottle or card?

A: We are unsure. When the product is being unpackaged and repackaged that is considered "manufacturing." Pharmacists may not be interested to do that, but would be interesting. An alternative is to ship unused product to a high volume centre when it is close to expiring.

Q: Can you clarify that in BC the patient will not have to go back to the physician after receiving her filled prescription?

A: Correct. She can take the drug on her own after getting the prescription from the pharmacist. This is the view of our provincial college.

Strategies for Subsidy of Mifepristone



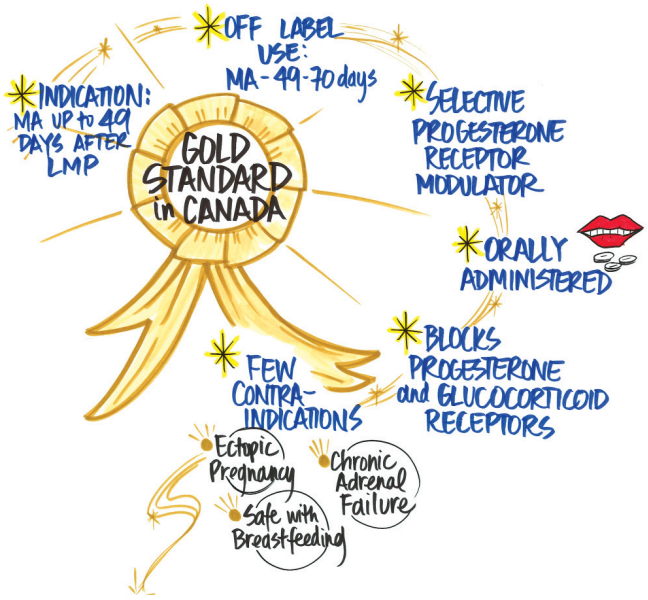
Linda Morris, BC Health Authorities Pharmacy and Therapeutics Committee, Director, Lower Mainland Pharmacy Service

Linda Morris provided an overview of how mifepristone was added to the provincial formulary and what this means for increasing access to medical abortion. Mifepristone was added to the formulary in September 2016. Never in BC has a drug been approved for the provincial health authorities' formulary before it was available. Once mifepristone is available on the market it will be brought into health authorities, hospitals, and available in the clinics associated with health authorities.

The BC Health Authorities Pharmacy and Therapeutics Committee was established to create equitable and consistent access to medications for patients in hospital and residential care settings. The formulary does not apply to private clinics and community pharmacy services – only hospitals and hospital clinics –and it is not related to Pharmacare.

If a health care provider wishes to have a drug added to the formulary, they make a submission to a drug review process. The committee considers evidence of efficacy, safety, and cost implications, and makes a recommendation whether the drug should be added to formulary, sometimes with feedback from expert stakeholders. A drug that is on the provincial formulary may not necessarily be stocked at every hospital, but if a patient is prescribed the drug while in a hospital then the hospital has to provide that drug.

Before inviting questions from the audience, Linda Morris asked Dr. Wendy Norman if the mifepristone and misoprostol will be administered separately, so that one part of the kit is administered in hospital and one part at home with the patient. Typically, in hospital, she explained, individual dispensing of each drug is preferred to kits of drugs. This will need to be discussed and decided by individual hospitals. Dr. Wendy Norman explained that mifepristone will be given to patients by hospitals.



Q & A

Q: Can hospitals decide that they do not want to buy the medication?

A: There are options for additional restrictions for different drugs. For example, a drug may be added to the formulary but be restricted only for pediatric patients or for use by an infectious disease physician. However, a hospital is required to provide it and adhere to fair access to patients around the province. Clinics funded by health authorities fall also within that formulary envelope.

Q: How will the patient get the medication from the hospital?

A: The patient will register as an ambulatory or inpatient in the hospital.

Q: What if a physician has hospital privileges but does abortions in their office? For instance, with WinRho injections, the patient goes to the hospital to get the drug and then returns to the clinic for injection.

A: Unsure. However, one could approach their hospital administrator and present the options: either they pay for mifepristone in my office or I could use hospital resources to do surgical abortions.

Q: The cost of mifepristone will be high for some women. Could we bill hospitals if Fair Pharmacare does not cover it?

A: CADTH conducts a common drug review for all provinces except Quebec. Each province takes a recommendation and decides whether it will be included in Pharmacare. The distributor of mifepristone has made the submission to CADTH but it will be many months before the Common Drug Review decision is available and before provincial governments assess the review and make a decision on inclusion in Pharmacare. Further, Pharmacare is likely to only provide coverage for women who are currently on social assistance or disability (i.e., when their usual prescriptions are covered). There is the provincial hospital formulary solution in the meantime.

Q: Does this mean that the provinces and health authorities cover prescriptions through the hospital formulary?

A: Temporarily we hope. We hope for mifepristone to be available through community distribution, not by using hospital resources. Pharmacoeconomic evaluation always looks at comparative costs and in provinces there is a budget impact assessment.

Q: Are clinics affiliated with the health authority included in the provincial formulary?

A: Probably. The clinic would need to have a conversation with its health authority contractor to clarify.

Q: We occasionally administer blood products in our offices but obtain the product from the hospital. This formulary route seems preferable to Pharmacare because of the amount that women will have to pay. Can mifepristone get slotted in the category like blood products?

A: There are examples of cancer and HIV drugs where there are no deductibles or costs to the patient. You can design the program to meet the needs of the patients. Vaccines and immunoglobins tend to be free. We have individual drugs where we try to support that process. We have a discussion of the drug, patient population, and other availability. It would not be consistent across every institution. In the Lower Mainland we are a consolidated department and we try to have consistency and control over those things.

Q: In rural we do primarily medical abortions. I worry about our ability to do Saturday, Sunday, and after-hours abortions if we have to do it in relation to hospital pharmacy business hours.

A: Business hours should not be a barrier to getting the drug. If it is necessary to make mifepristone available after hours then we agree as a combined stakeholder group (BC Health Authorities Pharmacy and Therapeutics Committee) to make this available.

Q: Does the drug have to be dispensed in the hospital where it is prescribed? This may be challenging for rural communities where there is no on-site pharmacist.

A: Individual patient prescriptions will not be required and thus it does not require a pharmacist to dispense the drug.

Mifepristone Providers Support and Access Study

Dr. Wendy Norman and Dr. Sarah Munro

Dr. Norman and Dr. Munro provided an overview of the study they are conducting to measure the effect of an online community of practice on increased uptake of mifepristone in Canada. Currently, access to abortion is limited for women living in rural/remote communities, and in PEI and New Brunswick. Many women travel long distances to access abortion, causing delays in care and later gestation at abortion. These access issues would be addressed in part by the availability of mifepristone medication abortion (MA).

However, data from the United States suggests that while mifepristone leads to an increase in MA providers over time, there remains huge variation from state to state and no major improvements in geographic access.[14] In Australia the health system and rural geography are more similar to Canada and the approval of mifepristone in Canada was patterned on Australia. Ten years after approval there were 1421 certified dispensers but only 663 certified prescribers.[15] A qualitative investigation of general practitioners and their role in medical abortion provision indicates that implementation of MA in Australia depended on local champions, mentorship, integration with nursing, and sharing of knowledge and resources.[16]

Dr. Norman, Dr. Tamil Kendall, and the CART co-investigators received CIHR and MSFHR funding to conduct a study of implementation of mifepristone in Canada, specifically to understand barriers and facilitators to uptake of mifepristone and impact on distribution of availability. The research consists of four core components:

- **Community of Practice:** Creation of a website (Canadian Abortion Providers Support) and analysis of data from the website to understand barriers/facilitators.
- **Surveys:** Online surveys of practice and experience with Mifepristone
- **Interviews:** Exploring perceptions of barriers/facilitators to implementation of Mifepristone
- **Integrated Knowledge Translation**: itk with key policy makers and stakeholders engaged throughout.

The community of practice website, Canadian Abortion Providers Support (CAPS), is available for any physician or pharmacist undertaking mifepristone MA, and their facility staff. Features include 'Ask an Expert,' 'Share a Case or Experience,' and resources including patient handouts and guidelines. Pharmacists will be invited to add their pharmacy to a map, allowing physicians to locate dispensing locations in their region.

The survey will be available for physicians and pharmacists who complete the SOGC medical abortion training program. Collected online at 6 and 12 months post training, the survey will seek to understand mifepristone practice, experience, the impact of the professional development training, and the impact of the CAPS website.

Follow-up interviews will be conducted with a sample of the survey participants, as well as policy and practice stakeholders, and healthcare providers who are women's health practitioners but do not choose to take up training and certification for mifepristone MA.

After this presentation, Dr. Norman and Dr. Munro then invited attendees to break out into small working groups and discuss potential barriers and solutions to mifepristone practice.

14 Finer, 2009.

15 Grossman & Goldstone 2015

16 Newton et al. *Australia and New Zealand Journal of Obstetrics and Gynaecology* 2016.

Join Canada's
online community
for health professionals
certified to provide
Mifepristone.

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CAPS CPCA
Canadian Abortion Providers Support
Communauté de pratique canadienne sur l'avortement
www.caps-cpca.ubc.ca

THE SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS OF CANADA
CANADIAN PHARMACISTS ASSOCIATION / ASSOCIATION DES PHARMACIENS DU CANADA
THE COLLEGE OF FAMILY PHYSICIANS OF CANADA / LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA
a place of mind THE UNIVERSITY OF BRITISH COLUMBIA
CART-GRAC

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January 24, 2017

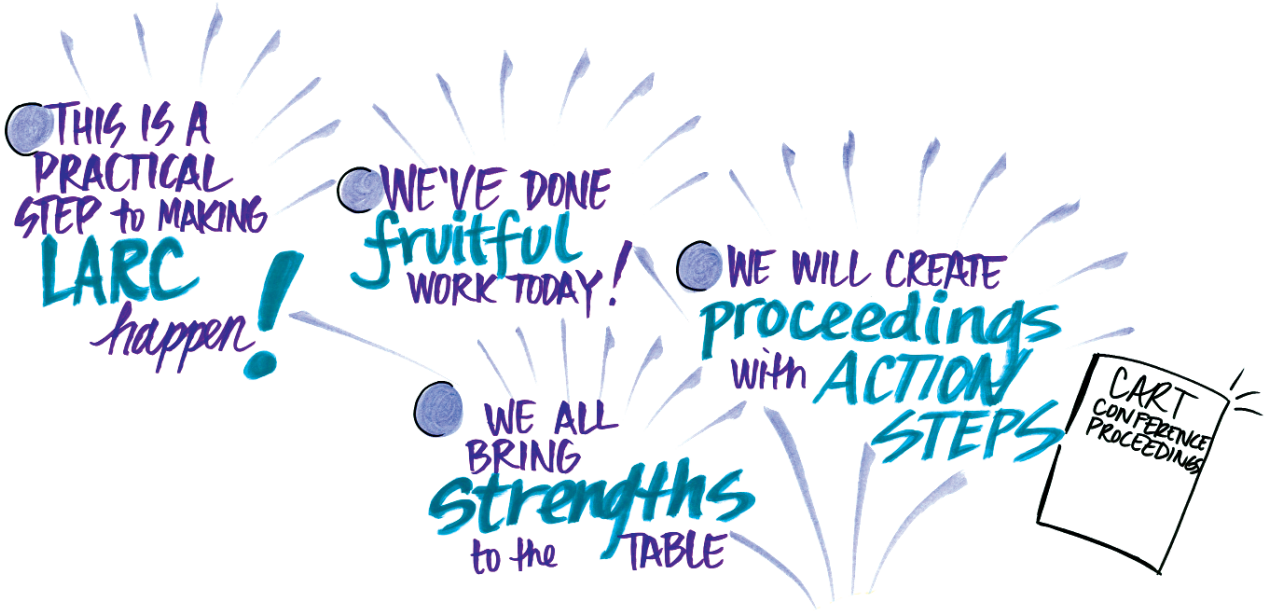
Working Discussion Groups: Mifepristone

A) Physicians
1. How do we provide a full counseling discussion into a 45 minute visit? (Suggestion: provide information pre-appointment)
2. When receiving the drug from a hospital formulary do we have space to administer it in hospital or can we have it sent to the office? "It's unclear for me about going to get the drug in the local hospital."
3. Who can patients contact if they need support? (Suggestions: 1-800 number, Opt, CARE, 811)
4. Do we need to conduct a blood test or ultrasound in follow-up in rural settings?
B) Facility Staff and Public Health
1. What new things will be added to the counseling discussion (i.e. cost) and how long will it take?
2. What new procedures will be added at abortion clinics that are currently surgical-only and how much might this cost? (i.e. intake forms, pre-screening, internal forms, consent forms, patient materials, billing process, time with counselors, patient visit schedule, professional development, booking software)
3. How will the physical space change in surgical clinics and how much might this cost? (i.e. teaching, history taking, ultrasound)
4. Can facility staff do the training module? Are there more understandable resources than the clinical practice guidelines? They will need to know the same standards of practice as physicians for teaching women.
5. How do we prevent this from becoming a two-tiered system where those who can pay out of pocket attend a community facility and those who cannot attend hospital programs like CARE?
C) Decision Makers
1. Can practice be expanded to include midwives and nurses?
2. Can Public Health and OPT clinics be leveraged for distribution?
3. Can we create pilot sites in rural communities? (i.e. a systems approach aligned with the provincial priorities)
4. How do we implement telemedicine for medical abortion?

Closing Remarks

Ms. Cheryl Davies and Dr. Tamil Kendall

The meeting co-hosts reflected on their excitement at the energy of the day. They suggested coming together regularly as virtual working groups and looked forward to identifying action steps with the participants and collaborators as these exciting new provincial services move forward. BC Women's Hospital and the Ministry of Health of BC are delighted to support implementation of health systems and services to ensure women throughout BC have access to the knowledge, services and methods they need to time and space their pregnancies.



Appendix A: Agenda

AGENDA: 4th BC Women's & CART Meeting
Contraception & Abortion in BC: Experience Guiding Research Guiding Care
Friday, October 14, 2016, Shaughnessy Auditorium at BC Women's Hospital, Vancouver, BC

MORNING	SMART PROGRAM A BC-wide initiative providing highly effective contraception at no cost to women at the time of abortion	
Participants: Invitation-only for all abortion provider clinicians and clinic staff, service providers and Perinatal leads, regional administrators, research team members, hospital administrators and government leaders		
TIME	ACTIVITY	SPEAKERS
8:15 - 8:30	Acknowledging unceded territory, Intro to First Talk	Dr. Wendy Norman
8:30 - 9:00	Contraception update – LARC First	Dr. Brian Fitzsimmons
9:00 - 9:15	Welcome from Provincial Leaders Overview of SMART Program context	Dr. Jan Christilaw Dr. Tamil Kendall Moderator- Cheryl Davies
9:15 - 9:30	SMART Program – CART research: Evidence supporting policy development	Dr. Wendy Norman
9:30 - 9:50	*Nutrition and Networking Break*	
9:50 - 10:30	BC Women's SMART Program: Presentation on proposed program Audience Discussion – Suggestions and considerations from the perspective of health authorities and health care providers	Cheryl Davies Caitlin Johnston
10:30 -11:45	Working Discussion Groups – what would work best in your setting? Table topic discussion groups, Report to plenary	Moderated by Cheryl Davies
11:45 - 12:00	Morning/SMART Program - Summary and Morning Session Closing Remarks	Dr. Tamil Kendall Cheryl Davies
12:00 - 13:00	*Networking Lunch*	All
AFTERNOON	**MIFEPRISTONE IN BC**	
TIME	ACTIVITY	SPEAKERS
13:00 - 13:20	Introduction to Afternoon sessions and context	Cheryl Davies Dr. Wendy Norman
13:20 - 14:00	Mifepristone for first and second trimester abortion care	Dr. Regina Renner
14:00 - 14:30	Mifepristone regulations and dispensing considerations for BC	Dr. Bob Nakagawa Dr. Wendy Norman
14:30 - 15:15	Strategies for subsidy of Mifepristone • Description of provincial formulary; discussion with audience on strategies that may work in various jurisdictions	Linda Davis Bob Nakagawa Moderator- Cheryl Davies
15:15 - 15:30	*Nutrition and Networking Break*	
15:30 - 16:45	CART- Mifepristone providers support, and access study Table topic discussion groups, Report to plenary	Dr. Wendy Norman Dr. Sarah Munro
16:45 - 17:00	Meeting Summary, Next Steps	Cheryl Davies Dr. Wendy Norman

Appendix B: Speaker Bios

Dr. Jan Christilaw

As Site Executive of BC Women's Hospital + Health Centre, and Vice President, Provincial Women's & Newborn Health, Provincial Health Services Authority, Dr. Jan Christilaw is a powerhouse for advancing women's health in British Columbia and a global leader in maternal care. Her 25+ years of accomplishments include: President, Society of Obstetrics-Gynecologists Canada; Expert Advisor, Canadian Institute for Health Information for Maternity; UBC Clinical Professor, Editorial Board of JOGC and Chair, BC Consensus Panel on Cesarean Birth. During her long career she has delivered thousands of babies in British Columbia. In recent years, she has been awarded the YWCA Women of Distinction Award in the Health and Wellness category, the British Columbia Community Service Award, the Queen's Diamond Jubilee medal, Waterloo University Distinguished Alumni Award, the National Leadership Award of the Federation of Medical Women, the Canadian International Surgery Volunteer of the Year award, and the Honorary Alumnus UBC Faculty of Medicine Award.

Ms. Cheryl Davies

Cheryl is currently the Chief Operating Officer at BC Women's Hospital + Health Centre, the largest maternity hospital in Canada and the only facility in BC devoted primarily to the health of women, newborns and their families. She has over 20 years' experience in women's health as a nurse, educator and senior leader, in both community and hospital settings. She is a passionate advocate for women's health, reproductive rights and social justice. A lifelong volunteer, she is currently an active Board Director with Health for Humanity. She believes firmly in the strength of servant leadership, and the importance of honouring women's values and voices in health care.

Dr. Brian Fitzsimmons

Dr. Fitzsimmons has been the medical director of the provincial CARE program for 12 years and is a practicing gynecologist at BC women's, Vancouver General and UBC Hospitals. He is Clinical Associate professor in Obstetrics and Gynecology at UBC and is the Director of the Residency rotation in Family Planning and UBC Family Planning Fellowship Program which is the first of its kind in Canada. He was an author on the new SOGC Guidelines on Medical abortion. He is a graduate of McGill (BSc), Calgary (MD) and did his residency training at UBC. Dr. Fitzsimmons has also been involved in international outreach and has been an active clinical member of the medical team "Health for humanity" (www.h4h.ca) which provides medical services and primary care to those in need in Guatemala.

Ms. Caitlin Johnston

Caitlin Johnston 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.

Dr. Tamil Kendall

Dr. Tamil Kendall has worked nationally and internationally as a women's health researcher and policymaker since 1999. Her particular areas of interest and expertise include sexual and reproductive rights, maternal health and HIV among women. She holds a PhD from the University of British Columbia, where she was a Trudeau Foundation and Vanier scholar. She completed her post-doctoral studies with the Women and Health Initiative at the T.H. Chan Harvard School of Public Health. Tamil is the Director of Women's and Maternal Health with the Population and Public Health Division of the BC Ministry of Health. Her main policy focus is currently on the renewal of the provincial Women's Health Strategy.

Ms. Linda Morris

Linda is the Director with Lower Mainland Pharmacy Service with responsibility for Children's & Women's Hospitals and Surrey Campus Pharmacies together with drug contracting and supply chain.

Dr. Sarah Munro

Dr. Sarah 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. Bob Nakagawa

Bob Nakagawa is the Registrar of the College of Pharmacists of British Columbia. He has over 30 years of pharmacy experience in British Columbia, and has worked in hospital and government settings developing innovative services and policies. He was President of the College of Pharmacists of BC, and of the BC and national branches of the Canadian Society of Hospital Pharmacists. He was also the Chair of the Medical Services Commission, the Drug Benefits Committee for BC PharmaCare, and the Federal Pharmacy and Therapeutics Committee for Canada.

Dr. Wendy Norman

Dr. Wendy Norman has been a family physician in BC for 26 years. She is an Associate Professor in the Department of Family Practice at the University of British Columbia and an associate member in the School of Population and Public Health and the Department of Obstetrics and Gynecology. She and her team are based in the Women's Health Research Institute of BC Women's Hospital and lead the national collaboration: Canadian Contraception Access Research Team/Groupe de recherche sur l'accessibilité à la contraception (CART/GRAC). In October 2014 the Canadian Institutes of Health Research and the Public Health Agency of Canada awarded Dr. Norman a five-year Chair in Applied Public Health Research for her family planning research program. In 2015, she received the Darroch Award for her work that combines excellence in research with practical application to public policy and programs in the field of sexual and reproductive health.

Dr. Regina Renner

Regina-Maria Renner has been a Clinical Assistant Professor at the Department of Obstetrics and Gynaecology of UBC since December 2012. Since May 2015 she is the Assistant Fellowship Director of the Family Planning Fellowship at UBC. In March 2013 she also joined the Department of Obstetrics and Gynaecology at Nanaimo Regional General Hospital. She completed her Family Planning Fellowship at Oregon Health & Science University, OR USA (OHSU, 2011), where she also did her residency. She completed a Master of Public Health at the Mailman School of Public Health, Columbia University, New York, USA (2005). Her research interest in pain management of first trimester surgical abortion developed in residency during which she authored a Cochrane review on this topic. Based on the review findings she completed a randomized controlled trial, which was published in "Obstetrics & Gynecology."


BC WOMEN'S
HOSPITAL+
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


Opt
Options for Sexual Health


MICHAEL SMITH FOUNDATION
FOR HEALTH RESEARCH
Discover. Connect. Engage.


Rural Coordination Centre of BC
Enhancing rural health through education and advocacy
RCC bc
Linking community needs and policy development with the JSC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