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 & Abortion in BC

Experience Guiding Research Guiding Care

6th BC Women's & CART Meeting

Friday, March 6, 2020

ACKNOWLEDGEMENTS

The 6th *Contraception & Abortion in BC: Experience Guiding Research, Guiding Care* Conference was made possible by the sponsorship and support of the following organizations and individuals:

- BC Women's Hospital and Health Centre (BC Women's)
- BC Ministry of Health
- The Contraception and Abortion Research Team-Groupe de recherché sur l'abortion et la contraception (CART-GRAC)
- Options for Sexual Health (Options)
- Canadian Institutes of Health Research (CIHR) Public Health Agency of Canada (PHAC) Chair in Applied Public Health Research (CPP-137903)
- Rural Coordination Centre of BC (RCCbc)
- Women's Health Research Institute (WHRI)

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

- Cheryl Davies, Chief Operating Officer, BC Women's Hospital and Health Centre
- Dr Natasha Prodan-Bhalla, Chief Nursing Officer, BC Ministry of Health
- Dr Glenys Webster, Director of Women's Health, BC Ministry of Health
- Michelle Fortin, Executive Director, Options for Sexual Health
- Edwina Houlihan, Program Manager, BC Women's Hospital and Health Centre
- Nicole Pasquino, Clinical Practice Director, Options for Sexual Health
- Dr Sarah Munro, Assistant Professor and Investigator, CART-GRAC, UBC
- Dr Wendy V. Norman, Principal Investigator, CART-GRAC, UBC

We thank the policy makers, health care providers, front-line staff, hospital administrators, health authority leaders, students, patients, community organization representatives, and researchers who attended the conference. As well we thank Avril Orloff for her graphic illustration, Peggy Cady for the graphic design of this book, Michelle Goulet and Katherine Rabicki for taking notes, and Michelle Goulet for creating the first draft of these proceedings.

Finally, thank you to BC Women's Hospital and Health Centre for hosting this meeting. Your enthusiastic leadership continues to shape the future direction of contraception and abortion health system improvement in British Columbia and beyond.

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EXECUTIVE SUMMARY

On March 6, 2020, BC Women's Hospital and Health Centre, the BC Ministry of Health, Options for Sexual Health BC, and the Contraception and Abortion Research Team-Groupe de recherché sur l'abortion et la contraception (CART-GRAC) united policy makers, health care providers, patients, administrators, researchers and community organizations from family planning, abortion, and sexual health care sectors.

Previous BC Women's-CART provincial stakeholder consensus conferences (2009, 2010, 2011, 2014, 2016, 2018) have been successful to progressively advance contraception and abortion health policy, systems and services in BC. Each conference presents best evidence to date; convenes a wide range of stakeholders to discuss and provide input on current BC gaps and opportunities; distills 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 conference series focuses on the overarching goal to improve health for women* and families through equitable access to high quality contraception and abortion care.

In line with this goal, **the 2020 conference objectives were the following**:

1. To learn about the latest tools and methods available for contraception and abortion
2. To identify the BC specific opportunities to expand nursing and midwifery scope of practice to include more comprehensive provision of abortion and contraception
3. To improve equitable access to high quality family planning health services in BC

* As is the convention for BC Women's Hospital, we will use the terms "woman" and "women" throughout this document to be inclusive of all people who are biologically female, while acknowledging that many people who are female do not identify as a woman.

Our expert conference speakers and widely representative participants brought excitement, new advances and deep knowledge of BC population health equity gaps and opportunities to the table at the 2020 conference. This proceeding aims to capture their enthusiasm and the identified priorities to guide research and policy toward advancing our province's success to ensure universally equitable access to contraception and abortion knowledge, methods and services for people throughout BC.

Key Priorities identified focussed on:

- Improving Indigenous cultural safety for people to access contraception and abortion care services.
- Expanding the scope of practice particularly for registered nurses and midwives to provide a wide range of contraception and abortion services throughout the lifespan.
- Improving provincial referral and support systems for patients and providers.

PART I: PLENARY

Welcome from BC Women's Hospital & Provincial Leaders

Acknowledgement of Unceded Territories

Dr Wendy V. Norman, Conference Co-Chair, Co-Lead of the national CART-GRAC research network, and Associate Professor in the Department of Family Practice, University of British Columbia, began the conference with an acknowledgment of gratitude for the opportunity as uninvited guests for us to gather on the unceded traditional territories of the Coast Salish Musqueam peoples. She also acknowledged the work of the organizing committee, the contributions of the multiple partners involved in the meeting, and a thank you to the staff team of Anita Chiu and Maria Vas for their efforts. Avril Orloff, the graphic illustrator who visually captured thoughts and wisdom from participants during the day, was introduced and participants were encouraged to feedback to her throughout the meeting to ensure all ideas were captured in our meeting illustrations.

The BC Women's – CART Provincial Meeting has been traditionally organized on or near International Women's Day. This year it also celebrates that 2020 is the "Year of the Nurse and Midwife", as designated by the World Health Organization (WHO)[1] . In a 'stand up' visual demonstration participants identified their roles in a wide range of health professional disciplines (registered nurses, nurse practitioners, midwives, pharmacists, physicians, researchers, trainees and students) and from a variety of organizations across all health authorities in British Columbia (Northern Health, Interior Health, Fraser Health, Vancouver Coastal Health and the Provincial Health Services Authority (PHSA), and among not-for-profit, governmental, as well as practice regulation representation at the meeting.

1 World Health Organization. (2020). Year of the Nurse and the Midwife 2020. Retrieved March 19, 2020, from https://www.who.int/news-room/campaigns/year-of-the-nurse-and-the-midwife-2020

Welcome from Meeting Chair, Cheryl Davies

Chief Operating Officer, BC Women's Hospital and Health Centre

Cheryl Davies, welcomed attendees and expressed her pleasure at seeing partners and colleagues from around the province. She thanked everyone for their demonstrated interest in women's health and continuing the dialogue in this important area. She spoke of how International Women's Day is approaching and the role of our collaboration between professions, individuals and regions to find our strength to advance policy, develop research, and promote women's health. Our goal to advance sexual and reproductive health and rights continues to be active on the BC agenda.

She emphasized that BC Women's is delighted to have hosted and supported these CART meetings for the last decade. One of the mandates and commitments of BC Women's to the health of women and girls has been around supporting the full range of reproductive choice. She praised how this forum is an excellent example of how effective policy and service improvements follow when interdisciplinary leaders including researchers, administrators, policy makers, service providers and students come together to prioritize key directions in this way. Ms. Davies elaborated on how ideas developed in these meetings led to reach research that has advanced important policy work, to successfully advance our systems. She then introduced Dr Natasha Prodan-Bhalla, the Inaugural Chief Nursing and Professional Practice Officer of the Government of British Columbia and our Ministry of Health.

Welcome from Dr Natasha Prodan-Bhalla

Chief Nursing and Professional Practice Officer, Government of British Columbia (BC)

As the Chief Nurse position is new within the Ministry of Health Dr Natasha Prodan-Bhalla briefly explained her role. The objective of her ten-person team is to advance effective nursing health care in BC. As part of the orientation to her new role Dr Prodan-Bhalla is very interested to learn of any barriers to a registered nurse's scope of practice for contraception and abortion provision. In particular, in this Year of the Nurse and Midwife, she expressed hope to understand how the ministry could enable facilitators to limit these barriers and advance the scope of practice such that people throughout BC have better access to the care they need.

Snapshot of Dr Prodan-Bhalla's team within the Ministry:

- **Team examines** practice, education, research, leadership, legislation and regulation.
- **Key divisions:** advanced education, mental health & addictions, primary care, population and public health, and specialized community service programs
- **Key partners/stakeholders:** Health authorities, post-secondary institutions, British Columbia College of Nursing Professionals (BCCNP), Nurses and Nurse Practitioners of BC (NNPBC), and General Practice Services Committee (GPSC)

She elaborated on the new **Ministry of Health Strategy**. This plan is focused on:

- **Population and Public Health** (includes access to contraception and abortion care)
- **Primary Care Strategy** (includes access to contraception and abortion care)
  - Specialized Community Service Programs
  - Access and Wait Times, particularly Surgery and Diagnostic Imaging

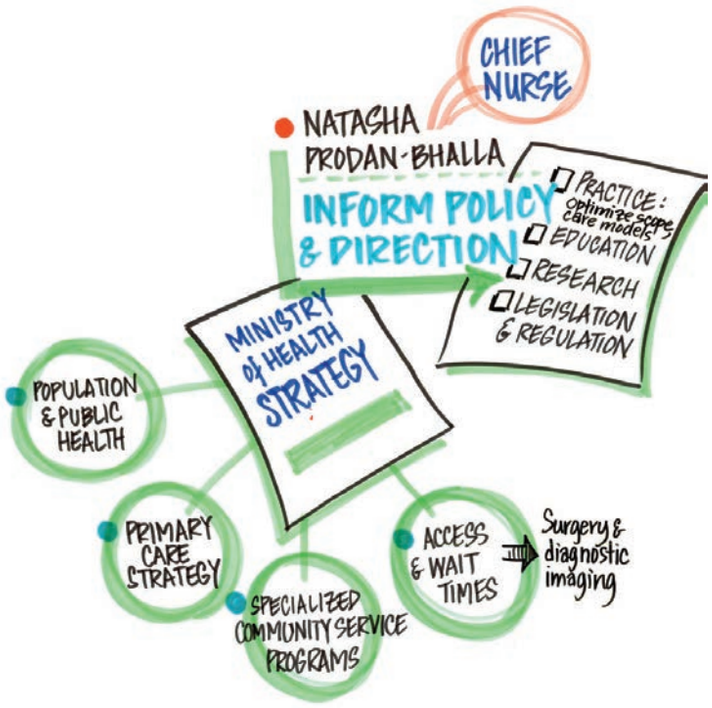
How do we think about Women's Health?

- Women outnumber men by population in BC – we need to think about our strategy as women age and their numbers continues to increase in BC.
- Access in primary care is critical:
  - Need to improve our discussions around equity, compared to equality
    - This is relevant to women accessing abortion
    - How are we figuring out the "right" (equitable) access to abortion?

Now is an important opportunity to advance our progress on these questions and to celebrate and leverage that **2020 is the Year of the Nurse and Midwife!**

Dr Natasha Prodan-Bhalla closed with asking the question: What is next for Registered Nurses and Midwives, in terms of prescribing for medical abortion?

What is next for Registered Nurses and Midwives, in terms of prescribing for medical abortion?

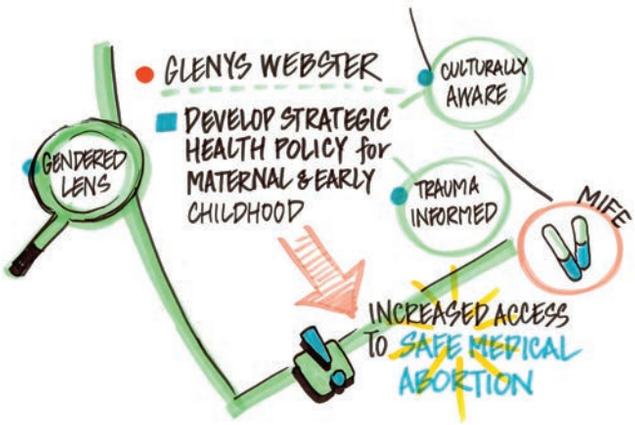


Welcome from Dr Glenys Webster

Director of Women's, Maternal and Early Childhood Health, Population and Public Health Division, Ministry of Health, Government of BC

Dr Glenys Webster gave a warm welcome on behalf of the Ministry of Health. She described the role of her team, which is to develop strategic health policy and provide direction to the health system for women's and early childhood health. They work with ministries, PHSA, Indigenous governing bodies, academic, non-profit organisations, professional regulatory colleges, patients and other partners to aim for the provision of culturally safe and trauma-informed healthcare that reflects the varied needs of the population of women and gender diverse individuals. They are striving to provide a women's and gender diverse health lens across the ministry. Timeline of recent contraception and abortion policy advancements include:

- The CART 2015 report on to cost-effectiveness of providing free contraception at the time of abortion, led the BC Ministry of Health to fund PHSA in 2016 to launch the SMART (Safe Methods at the Right Time) program. Starting in January 2017, this program has provided access to free contraception at the time of abortion throughout BC, a provincial initiative unique in Canada.
- In 2018, our Ministry increased access to safe and legal medical abortion by providing universal no cost coverage to mifepristone. This decision is a result of close partnership with CART and evidence provided by CART. Within the first two years, preliminary data suggest that abortions using mifepristone make up 50% of first trimester abortions, and that access through primary care and in rural areas is increasing.
- Longstanding work with CART has facilitated the government, BC Women's and regulatory colleges to ensure all people have access to mifepristone. For example, these alliances forged policy for pharmacists in BC to be the first in Canada to be allowed to dispense mifepristone (first announced at 2016 CART conference!)



- The CART 2017 government report on the results of the BC 2015 Sexual Health Survey[2] (which she describes as providing rich data unique in Canada) results were presented in 2017. This identified gaps and served to inform policy to better align sexual health services.
- CART used the Sexual Health Survey data as well for simulation analyses to develop the sophisticated 2018 Contraception Cost-Effectiveness model for BC. This confidential report to government has been foundational for the Ministry of Health to understand the implications of providing increased access to contraception, for example through subsidy.
- In 2019, the Ministry provided province-wide funding for the Options for Sexual Health (including Sex Sense)
- In 2019, the Ministry reduced the deductible for 250,000 families accessing contraception and other health care.

Dr Webster stated that we have come a long way, however there is still a long way to go. She thanked everyone on behalf of the Ministry for their commitment to the health of all BC women, girls and people of all gender identities and their families.

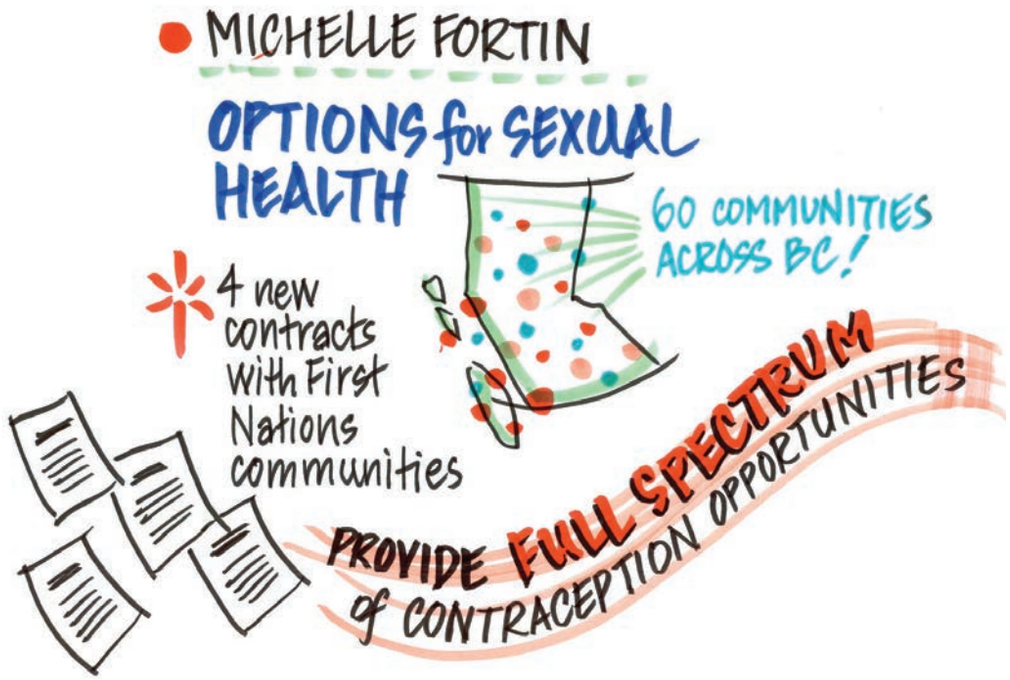
2 Norman, W. V., & Bryan, S. (2017). British Columbia 2015 Sexual Health Indicators. Vancouver. Retrieved from http://med-fom-cart-grac.sites.olt.ubc.ca/ files/2017/08/2015-BC-Sexual-Health-Indicators-CART-CSHS_2017-06-15.pdf

Welcome from Michelle Fortin

Executive Director, Options for Sexual Health

Michelle Fortin began her welcome by bringing attention to the opportunity for impact of gender specific recommendations from Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG)[3]. The report came out with 230 recommendations – Michelle Fortin used this as an opportunity to remind us that we as a sector should always think about what we could be doing better to support individuals across the province. In the last year Options for Sexual Health (Options) has negotiated four new contracts with First Nations communities to support their clinical practices and to include formulary in their conversations.

She emphasized Options position that all contraception methods should be offered as choices. Further, Options advocates that when we get to universal coverage of contraception, it should include a full complement of choices (including the things we do not necessarily think about as usual contraceptive options). Ms. Fortin further explained that Options is a nurse-led program and that they are excited to be present at the CART meeting and for this to be the Year of the Nurse and Midwife. Options continues to be excited about and committed to further opportunities to work with BC Women's, the Ministry of Health, and CART.



3 National Inquiry into Missing and Murdered Indigenous Women and Girls. (2019). *Reclaiming power and place* (Vol. 1a). Retrieved from https://www.mmiwg-ffada.ca/ wp-content/uploads/2019/06/Final_Report_Vol_1a-1.pdf

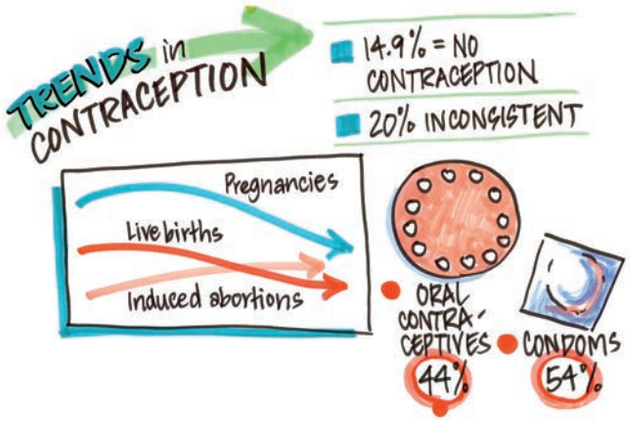
What's New in Contraception?

Subdermal Implant Contraception: What You Need to Know about a New Class of Drug Coming Soon

Dr Nicole Todd & Dr Regina Renner

Dr Nicole Todd is a Clinical Associate Professor in the Department of Obstetrics and Gynaecology of UBC and a member of the medical staff in the Department of Obstetrics and Gynaecology at BC Women's Hospital, BC Children's Hospital and Vancouver General Hospital. Dr Regina Renner is a Clinical Associate Professor in the Department of Obstetrics and Gynaecology of UBC and a member of the medical staff in the Department of Obstetrics and Gynaecology at Nanaimo Regional General Hospital and BC Women's Hospital.

Both Family Planning experts presented on an exciting new development in Canadian contraception – the subdermal implant.

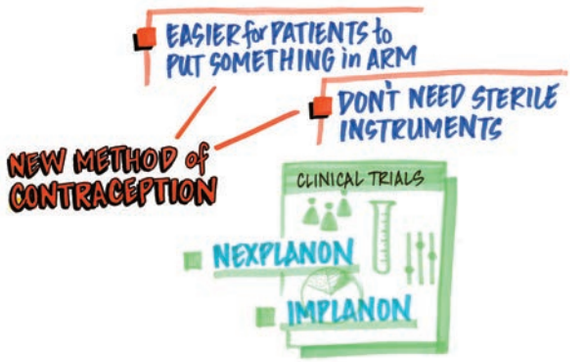


Trends in reproductive health

- Canadian women spend less than three years of their lives pregnant, attempting to achieve pregnancy, or being post-partum and more than 30 years attempting to avoid pregnancy.
- Average age of a mother at her first birth is over 30 years in BC.
- One third of Canadian women have at least one induced abortion in their reproductive lifetime
- Thus, our populations have a large unmet need for accessible effective contraception choices

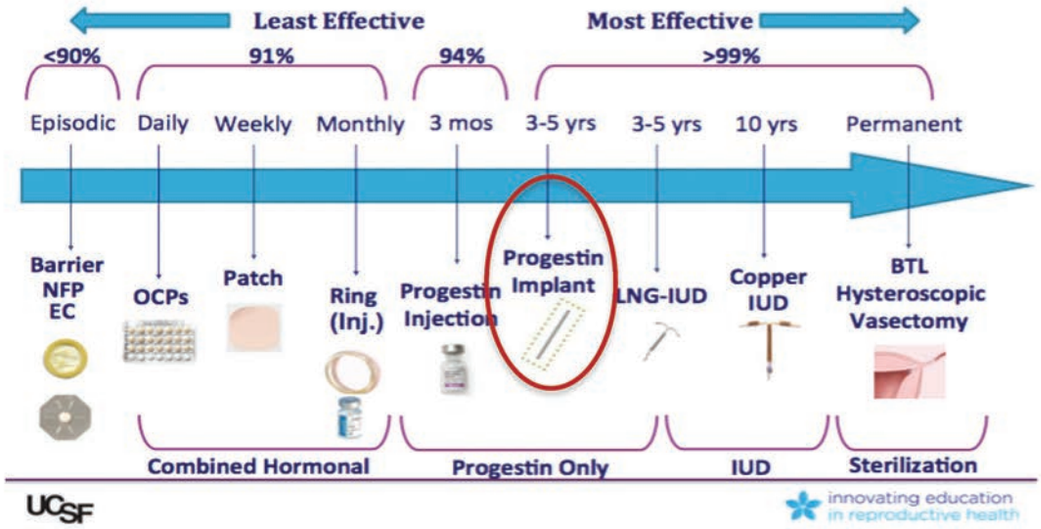
Results from 2006 Canadian Contraception Survey[4]

- 15% of sexually active women in Canada who did not wish to become pregnant were not using contraception at last intercourse, 20% were using contraception inconsistently
- Oral contraceptives (OCP, 9% per year pregnancy rate) and condoms (12% pregnancy rate) were most common methods with withdrawal (27% pregnancy rate) as the third most commonly used contraception method.
- Significant variations in contraception use included very low rates of use ("high unmet need") among vulnerable populations such as youth.



4 Black, A., Yang, Q., Wen, S. W., Lalonde, A. B., Guilbert, E., & Fisher, W. (2009). Contraceptive Use Among Canadian Women of Reproductive Age: Results of a National Survey. *Journal of Obstetrics and Gynaecology Canada*, 31(7), 627–640. https://doi.org/10.1016/S1701-2163(16)34242-6

Contraception methods options and their effectiveness



- The most highly effective reversible contraception available in Canada now is the levonorgestrel-releasing intrauterine device (LNG-IUD)
- There are two LNG-IUD options in Canada now, both last for up to five years

Where to access evidence-based contraception guidelines

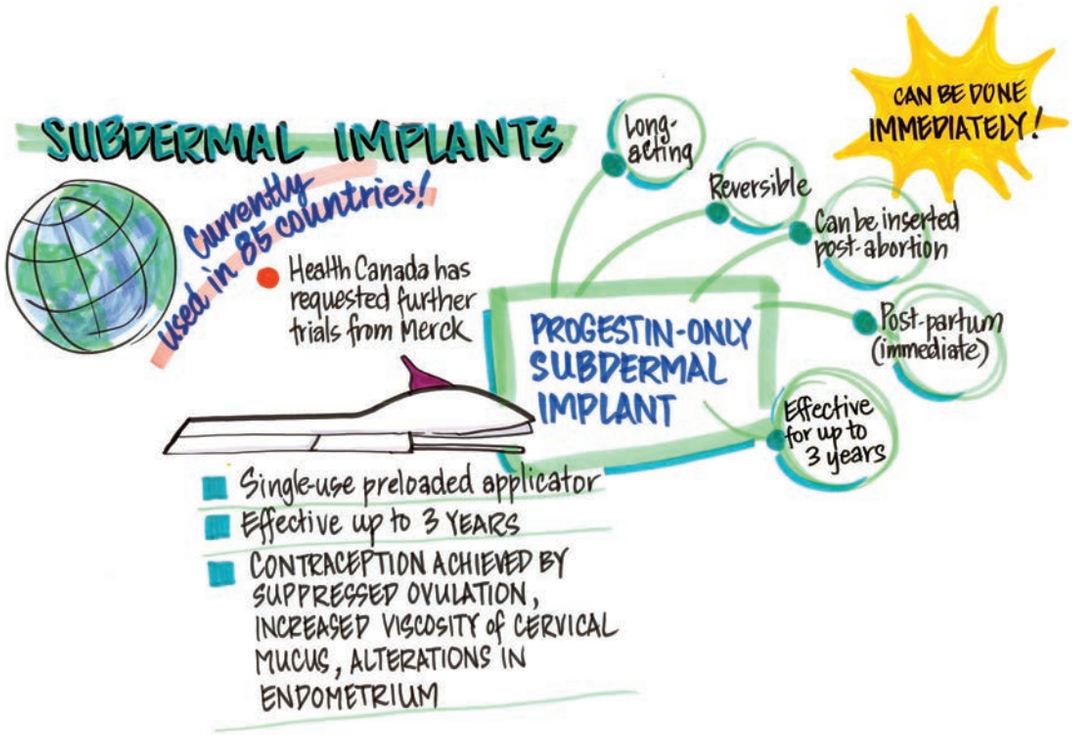
- World Health Organization: Medical eligibility criteria for Contraceptive Use, 2015 https://www.who.int/publications/i/item/9789241549158
- CDC Medical Eligibility for Contraceptive Use, 2016 http://dx.doi.org/10.15585/mmwr.rr6503a1
  - Includes an app which can be a very useful bedside tool – can search based on clinical condition which contraception is appropriate. Contraception options are then given a category based on appropriateness.
- SOGC Contraceptive Guidelines, 2016 https://www.jogc.com/article/S1701-2163(16)30033-0/fulltext
- United Kingdom Medical Eligibility for Contraceptive Use, 2016 (updated Sept 2019) https://www.fsrh.org/standards-and-guidance/documents/ukmec-2016/

Subdermal Contraceptive Implant: An exciting new contraceptive method!

Drs Renner and Todd discussed how the subdermal implant is available in 85 countries globally. Although it has not yet been available in Canada, a prior implant "Norplant" (a 6-rod subdermal implant) was discontinued in Canada more than 20 years ago, after manufacturing inconsistencies. We have not had a subdermal implant since. Health Canada has recently improved their regulatory requirements to ensure their review for hormonal contraceptives is evidence-based (prompted by evidence briefs and publications by CART highlighting their prior inequitable and non-evidence-based criteria). Currently, an application is under review for approval of a subdermal implant made by Merck Canada, the manufacturer of the one rod subdemal etonorgestrel implant (see further details below under Nexplanon Clinical Trial).

The Progestin Only Subdermal Implant

- Single-rod, progestin-only (etonogestrel 68 mg) subdermal implant about the size of a matchstick
  - Placed at the inner side of the upper arm, just underneath the skin
  - Contains barium sulphate, allowing for visualization on X-ray and/or ultrasound
- Effective for up to three years, and with an effectiveness rate of greater than 99%.
- Continuation rate at one year is ~ 84%, which is approximately the same as the LNG-IUD
- Contraception effect achieved by suppression of ovulation, increased viscosity of the cervical mucus, and alternations in the endometrium.
- Insertion
  - Should be inserted subdermally and be palpable after insertion
  - Deep insertion has been associated with hematoma, migration, or paresthesia due to nerve injury



– Pain can also be a side effect so insertion should be done with local anaesthesia

- It is a great option for adolescents, nulliparous women, and those wishing to avoid an intrauterine insertion procedure or living where the sterilized instruments or IUD insertion skills are not readily available.
- Common side effects include menstrual cycle disturbances, acne, weight gain (up to 2 kg), and potential complications with insertion

"Subdermal Implants can be inserted post-abortion (including on the first day of a medical abortion), post-partum (immediately, including among breastfeeding patients) and in obese patients."

Subdermal Implant

Dr Renner outlined the various properties of etonorgestrel single-rod subdermal implants, emphasizing a need to consult with the package label and national or international guidelines for specific details. https://www.jogc.com/article/S1701-2163(15)00025-0/pdf. She noted "Subdermal Implants can be inserted post-abortion (including on the first day of a medical abortion), post-partum (immediately, including among breastfeeding patients) and in obese patients." Indications and contraindications were reviewed. Drs Todd and Renner presented a video summary of the insertion procedure and some of the implant properties.

As well Dr Renner highlighted:

- **Non-contraceptive benefits**
  – Of women with baseline dysmenorrhea, 77% report complete resolution of painful menstruation.

  – Pain associated with endometriosis is also improved
  – Small randomized controlled trial (RCT) demonstrated decreased pain in women with pelvic congestion syndrome
- **Medication Interactions**
  – Medication interactions may occur including: NNRTIs and anticonvulsants, rifampicin, bosentan, St. John's Wort, and ulipristal aceta

Nexplanon Clinical Trial data
https://www.fertstert.org/article/S0015-0282(08)00515-3/pdf

- Studies show pregnancy rate is under 1% (similar to or better than LNG-IUDs)
- No severe side effects
- **Myth:** Return to fertility is delayed with use of implant
  – Rapidly reversible (similar to IUDs), different from Depo-Provera (6 pregnancies conceived within 14 days of implant removal)
- No evidence of decreased efficacy in obese patients
- For implants, perfect use = typical use

For implants, perfect use = typical use

Q&A for Subdermal Implant Contraception

Cheryl Davies led the question and answer period. Answers provided by Drs Regina Renner and Nicole Todd.

Q1: What is the comparison between the continuation rate of implants compared to Progesterone IUD?

A1: Levonorgestrel IUD and implant have similar continuation rate (~85% after one year).

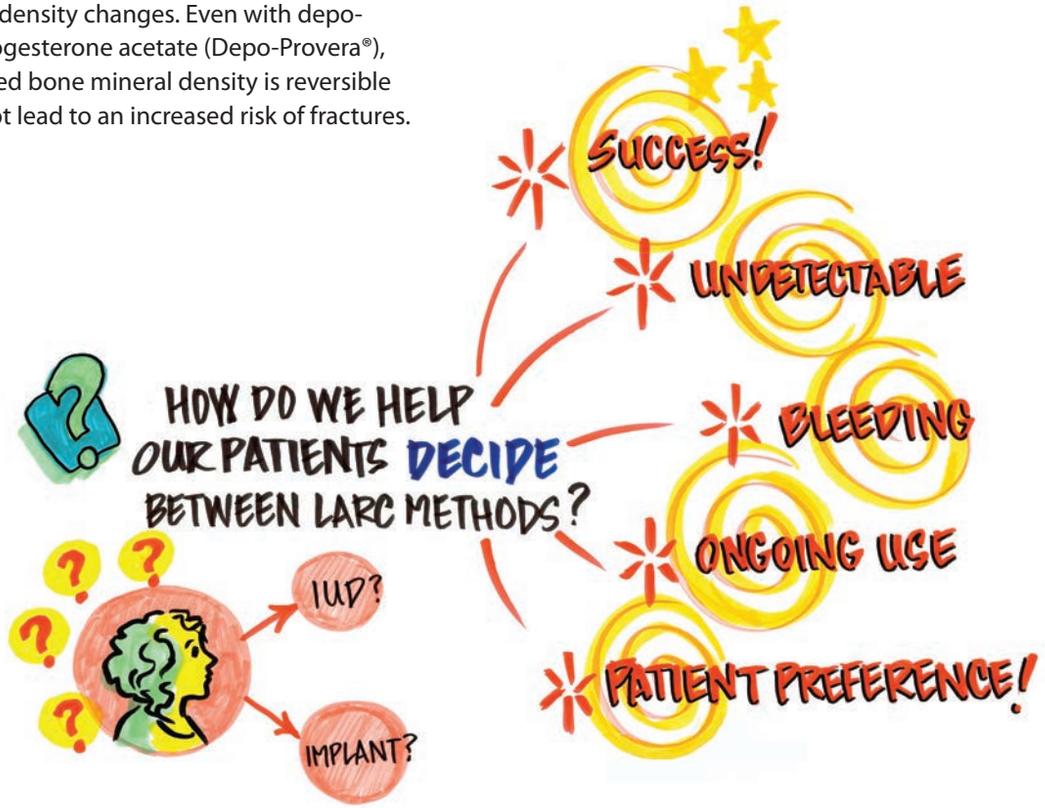
Q2: What about bone density?

A2: SOGC guidelines committee did examine the evidence on bone density with etonorgestrel implant use and did not find a significant decline. If anything, it appeared those using implants had fewer bone density changes. Even with depo-medroxyprogesterone acetate (Depo-Provera®), the decreased bone mineral density is reversible and does not lead to an increased risk of fractures.

Q3: And, what about the cost?

A3: We are expecting approval later this year from Health Canada. The company providing the implant has not disclosed the cost, hinting it will be equivalent to the cost-per-year for the LNG-IUD. We are hoping that it will be covered for as many of our patients as possible.

There will be a big advantage for our rural BC communities as we do not need a whole set of instruments, or an autoclave for sterilization, or to send people to have two-week trainings to learn the insertion skill. This [implant] insertion skills may be can be trained virtually, and even at a conference.



BC Women's Provincial Complex Contraception Clinic

Dr Nicole Todd

Dr Nicole Todd presented an overview of BC's new Complex Contraception clinic. She began her talk with examples of complex patients where health care providers may be interested to seek assistance to determine appropriate contraceptive options to recommend. She segued into reminding conference attendees: "The CDC Medical Eligibility Criteria for Contraception app is a terrific resource to work out contraceptive options!"

Our patients often come to us with difficult circumstances, and one or many underlying conditions. This is where the Complex Contraception Clinic comes can assist your practice.

CDC Medical Eligibility for Contraceptive Use (2016)	
CATEGORY	**RECOMMENDATION**
1	A condition for which there is no restriction for the use of the contraceptive method
2	A condition for which the advantages of using the method generally outweigh the theoretical or proven risks
3	A condition for which the theoretical or proven risks usually outweigh the advantages of using the method
4	A condition that represents an unacceptable health risk if the contraceptive method is used. This method should not be used

http://dx.doi.org/10.15585/mmwr.rr6503a1

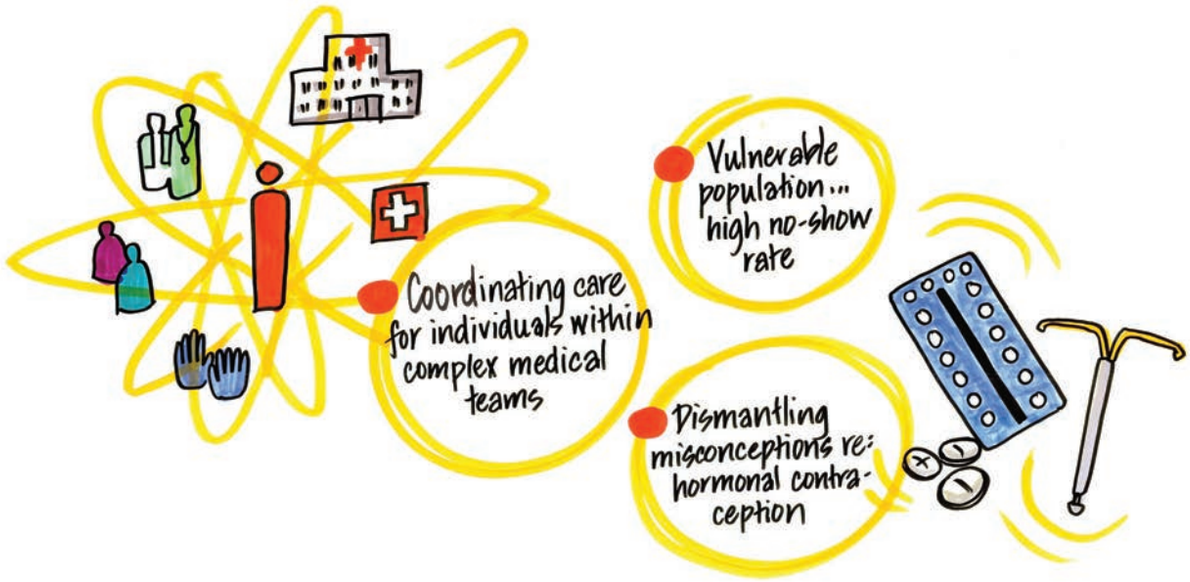
The CDC Medical Eligibility Criteria for Contraception app is a terrific resource to work out contraceptive options!

- **BC's Complex Contraceptive Clinic** is a clinic that exists to help coordinate care for individuals with complex medical issues. We work with patients who are generally in the "orange and red zones" (referring to CDC Medical Eligibility for Contraceptive Use chart) based on their medical history.
- Clinic goals:
  - Provide up to date, evidence-based contraception care
  - Provide individuals rapid access to reliable methods of contraception in the context of complex medical histories
  - Acknowledge and help support patient autonomy
  - We work using a "Harm Reduction" model
- Challenges:
  - We aim to dismantle misconceptions about hormonal contraception
  - We work with vulnerable populations
  - Currently, the majority of referrals come from family physicians and gynecologists, but we are working to reach to the full range of health care providers

- Inclusion criteria:
  - Patients must be over 15 years old, wish to use contraception, and have:
  - At least ONE relative and/or absolute contraindication to contraception
  - Or a history of intolerance to standard contraception methods
  - We also assist for difficult IUD insertions, and any IUD complications
  - We are the provincial referral centre for subdermal implant removal
- The **referral form** is available online and reviews inclusion criteria: http://www.bcwomens.ca/our-services/gynecology/complex-contraception
- **Telehealth appointments** can be offered and a request for this should be written on the referral form. Physical examination of the patient may often not be required. In these cases telephone counselling may be offered, after which a comprehensive consult note will be provided to the referring practitioner

BC Women's Complex Contraception Clinic can develop a safe contraceptive plan in the setting of relative or absolute contraindications to standard contraceptive options.

- The clinic does not currently accept referrals from registered nurses except for those in the Options BC system, but we are considering this option for the future.
- In summary, Dr Todd closed by stating the BC Women's Complex Contraception Clinic can help practitioners and their patients develop a safe contraceptive plan in the setting of relative or absolute contraindications to standard contraceptive options.



Q&A for Complex Contraception Clinic

Cheryl Davies led the question and answer period. Answers provided by Dr Nicole Todd.

Q1: Can you walk us through the approach with patients who want to use a "Category 4 method"?

A1: To patients with contraindications to specific contraception but who want to use that option, the risk of unplanned pregnancy carries a higher risk in almost every case than does the use of contraception. For example, this is true even in the extreme case of the risk of stroke. A discussion of ALL options and risks should ensue. If after that discussion the only acceptable option for the patient is the Category 4 method, then it is up to the practitioner to document that discussion and proceed. Now that we have the Complex Contraception Clinic, we are well equipped to have these discussions with your patients, and to prescribe contraindicated methods when necessary for your patients. As healthcare providers, we have to do our best to provide what the patient chooses as their best option.

Q2: Do you have capacity to do Telehealth?

A2: Yes, we currently provide virtual consultations over the telephone, however my personal preference is to move towards video. Happy to offer either of those (can indicate on referral form what is preferred).

Q3: Can the Complex Contraception Clinic take referrals directly from RNs?

A3: Yes, if it is coming from Options BC. Otherwise, not at the moment but we are continuing to look at and expand our referral options.

Q4: Where do you see recommending barrier methods that are less effective backed up with abortion? In other words, counselling to use something that is more compliance driven when the result might end up that they need an abortion?

A4: It is always important to support patients to use whatever option works in their context, and the option that they prefer. At our clinic, our providers will tend to outline the approach recommended by the CDC or WHO in our counselling, for example by starting with the most effective and least contraindicated methods such as long acting reversible contraception (LARC) and moving down through the list of less effective or more contraindicated methods. If only condoms are acceptable, then we promote that. However, if abortion access is not available (e.g. due to extremely remote residence), I would be hesitant to recommend the patient rely on a plan for abortion as part of their method.

The SMART Program: Pilot Program Results to Date

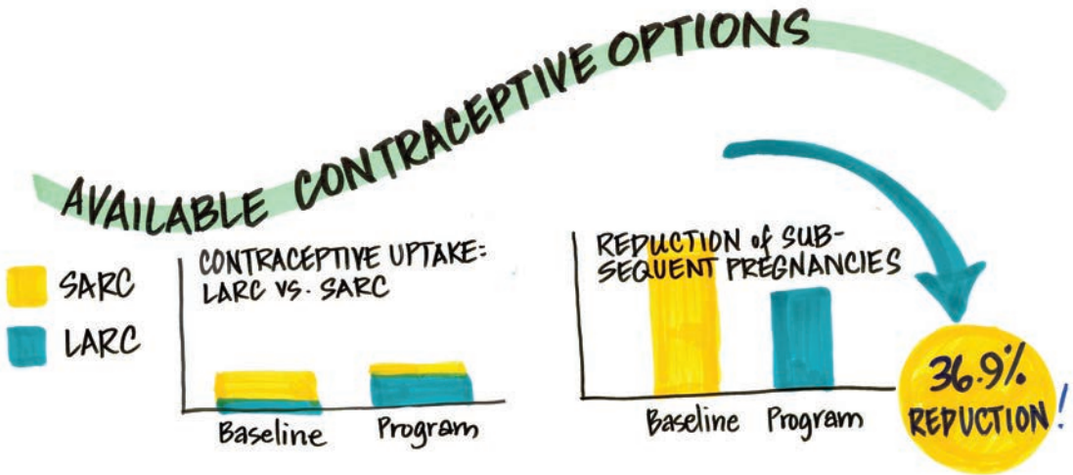
Dr Sheila With and Suzie Maginley

Dr Sheila With is a Clinical Instructor in the UBC Department of Obstetrics and Gynaecology, and a member of medical staff at both BC Women's Hospital and Vancouver General Hospital and is the Medical Director of the BC Women's Hospital CARE Program. Suzie Maginley is a PhD candidate at the Centre for Health Services and Policy Research in the School of Population of Public Health at UBC. Dr Sheila With and Suzie Maginley presented the results to date in BC's pilot program providing free post-abortion contraception.

Suzie Maginley introduced the SMART program outlining CART studies findings that approximately half of all women in BC who access abortion will have another pregnancy within two years if they are unable to initiate contraception at the time of abortion. Based on CART evidence which had modelled Randomized Controlled Trial results linked to provincial health administrative data, the BC Ministry of Health funded BC Women's Hospital and Health Centre to implement the **S**afe **M**ethods **A**t the **R**ight **T**ime (SMART) Program. The SMART Program aims to reduce future unintended pregnancies by providing

free post-abortion contraception to BC residents at the time they have an abortion. As of January 2020, the SMART Program is offered in 18 facilities across all regional health authorities. Eligible facilities must be accredited by Accreditation Canada, the College of Physicians and Surgeons of British Columbia (CPSBC) or the National Abortion Federation (NAF). Eligible participants must reside in BC, have provincial health insurance coverage and present for an abortion at a participating facility.

Participants can choose between long acting or short acting reversible contraception (LARC or SARC). LARC options include LNG-IUD or copper IUD, and SARC options include one package of combined oral contraceptive pills (OCP) or one injection of depot medroxyprogesterone acetate (DMPA).



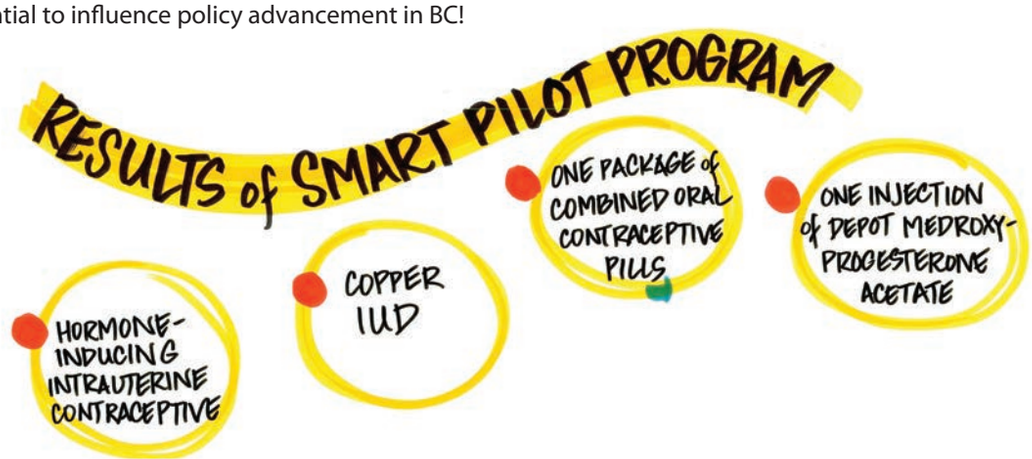
Within two years the SMART Program resulted in an estimated reduction of over 3000 subsequent pregnancies, or 37%.

Interim Evaluation Results

An interim evaluation was conducted reviewing all program-eligible women from January 2017 to September 2019. In total, there were 22,876 women eligible for the program during this period included in the analysis. In 2019, the SMART program reached an estimated 2/3 of women having an abortion in BC, this is an increase from 1/3 in 2017! With the implementation of the program, LARC (IUD) uptake increased from 14% to 58.4% of eligible women. However, barriers exist for women having a medical abortion as there is less uptake of LARC. For instance, women who have had a medical abortion require a follow-up appointment as they cannot have an IUD inserted immediately.

Key points/summary

- Within two years the SMART Program resulted in an estimated reduction of over 3000 subsequent pregnancies, or 37%
  - Because LARC continue to be effective for many years, we expect to see ongoing reductions
- The program is demonstrating positive health system impacts across the province and has the potential to influence policy advancement in BC!



Q&A for SMART Program

Cheryl Davies led a question and answer period. Answers provided by Dr Sheila With, Suzie Maginley, and Dr Norman

Q1: Have you found the greater use of intrauterine device (IUD) after surgical abortion is because it is more convenient to do both at once or is it that patients who get medical abortion are scared to get an IUD?

A1: I think we see this difference due to the degree of opportunity. For surgical abortion, we are able to provide point of care contraception in one visit. However, if a person wants an IUD after a medical abortion, they need to return for a subsequent visit. Also, in many cases people may access medical abortion through a virtual visit, but would need to make an additional in person visit if they wanted a IUD for their post-abortion contraception.

Q2: Our frustration is that you get IUD for free if you get surgical abortion. Sometimes patients who otherwise may be interested in a medical abortion with their NP, might choose surgical abortion [to get the free IUD] . Problem is important for NPs in clinics providing medical abortions, where our patients then need to pay for the IUD.

A2: As this is a pilot project there are strict facility criteria. However, we hear the concerns! In the pilot phase the objective is to use data to demonstrate that we can save money and promote Women's Health by offering free post-abortion contraception. Using the evaluation data from this strict pilot program, we hope we are able to support future advances to expand the availability of free contraception.

Q3: How is SMART program funded? How are we going to show cost savings with the most expensive contraception having the highest uptake?

A3: Even if you compare the cost of a highly effective method and compare with lower cost methods (e.g. condoms), the cost to the health system (due to the cost to manage unintended pregnancies) is highest with the lowest cost methods. IUDs have the lowest cost to the health system overall, whereas birth control pills are the most expensive prescription method to provide and condoms or no contraception is this most expensive overall. The problem is that our patients, particularly those among disadvantaged populations cannot access the high upfront cost of effective methods. The government is providing highly effective methods free, a because it saves the health system costs of managing unintended pregnancy. Providing free LARC is the least expensive contraceptive for the health system, and it offers people the most advantages.

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Q4: Remarkable slide, a 37% reduction [of unexpected subsequent pregnancies in the first two years after index abortion]. How do you know these numbers and what are the confidence intervals on them?

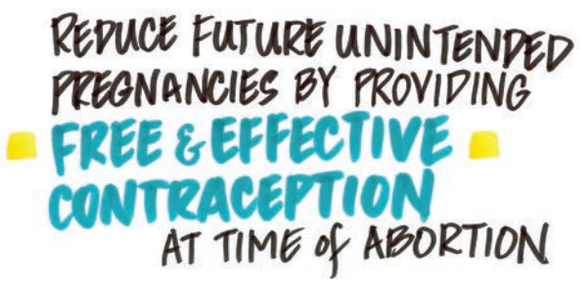
A4: This is based on all eligible people at participating facilities: both those participants for whom a contraceptive method was given during their visit, as well as non-participants who indicated their contraceptive method intention. Although we accept that intention is not a perfect indicator of actual use. Our prior BC CART studies followed people at the time of abortion for five years through the BC Health Administrative government records to measure how many subsequent pregnancies are associated with each method selected by a person on the day of

their abortion. Thus, for the SMART program we can estimate subsequent pregnancies using the rate of pregnancy known for each post-abortion contraception method, and the known methods chosen on the day of abortion. In 2023 we will be able to access the Health Administrative Government records to count the actual pregnancies among those in this program. So, for the estimates provided, we have used actual data from BC matching people who had an abortion with their contraception method and to see how many pregnancies resulted. Confidence interval was within +/- 3% or so around this estimate with greater accuracy among the more effective methods.

Q5: Do we have estimation of cost reduction to province of BC per unintended pregnancy avoided and how much this would save?

A5: Yes, although we don't have that data here, we have used this to calculate the proposed cost savings of the program, and will do so in the final analysis to show the effectiveness of the pilot program overall.

[**Comment from Dr Nicole Todd**]: For those who like numbers, we know from Dr Black's 2015 study https://doi.org/10.1016/S1701-2163(16)30074-3 that the cost of unintended pregnancy in Canada is $320 million/year, $220 million is from imperfect adherence. The cost of contraception in Canada is $261 million. The minimum duration to reach cost neutrality by giving everyone an IUD in Canada is 12 months, at a cost of $35 million dollars.



Q6: Is the SMART program continuing, and if yes, for how long?

A6: At the current time, we are using our current funding, analyzing all program data and working on future options for ongoing support. We will have to provide an update at a later date.

Q7: When trying to roll out into other health authorities there have been challenges for small hospitals to incorporate inventory for not a large number of potential participants. In our centre, we ended up having inventory at the referral hospital and have physicians borrow from that and account for how they use it.

A7: Tailoring inventory to each site has been important, and challenges are bound to arise. When we get to a "steady state" we will have to look for nuances and tailor to it. We are open to how inventory works best in your community.

First Nations Cultural Safety & Relation to Family Planning Access

Dr Unjali Malhotra

Dr. Unjali Malhotra is a Clinical Assistant Professor, Department of Family Practice, UBC, a practicing women's health focused physician, and the Women's Health Medical Director at the First Nations Health Authority (FNHA) of BC.

Dr. Malhotra opened her presentation with her intent to present today on cultural safety issues in relation to family planning as well as to discuss strategies to mitigate cultural safety for our patients. She began by discussing how cultural humility and safety are the backbone of what the FNHA work towards. She explained that cultural humility is a process in which we reflect upon our own personal biases as well as those within the system in which we work and live; it is a lifelong process. Cultural safety is the outcome, the space we want to get to. Cultural humility and cultural safety across the health care system will improve the health and well-being of all British Columbians.

She discussed that the FNHA recognizes that systemic racism has been and continues to be a barrier to accessing many services, including sexual and reproductive health services, and a barrier to achieve better health outcomes. Systemic racism is also very much a part of reproductive health. We need to have this discussion because without it, patients face a loss of choice and voice. In reproductive health care many First Nations patients report being faced with attitudes such as "you should feel lucky you had a good outcome" despite mistreatment along the course of treatment, "your actions led to…" and body language such as eyerolls, raised eyebrows and dismissive attitudes. Even the "safest" providers can think, "that doesn't happen at my hospital" but it does. It happens everywhere. If we maintain this closed thought process, we are closing reflection upon the services we're providing. She welcomed participants into the patient journey:

Consider taking a deeper dive into the system itself:

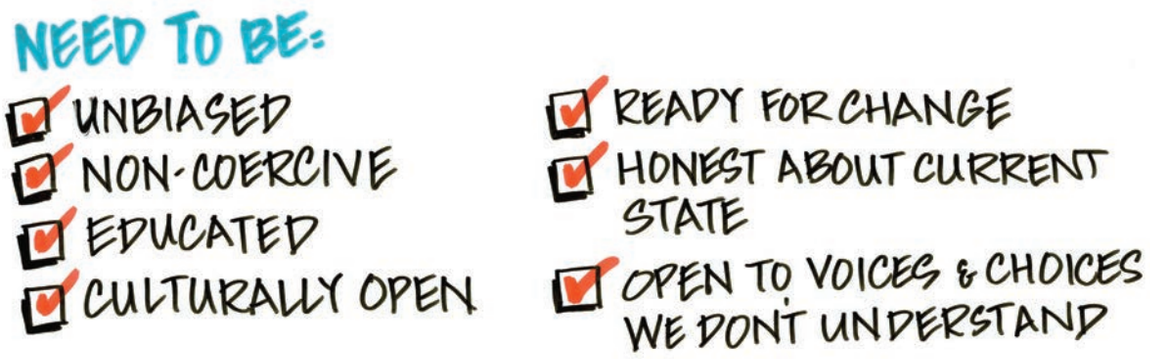
- We all say that we "take" a history – we extract information to get to our assessment or plan which we impose upon someone
  - We need to consider – are we doing history recording the right way for every person coming into the office? Do we need to change how we're getting that information?
- Charting, procedures, and forms we impose upon people
  - Well-intended but the form itself is often not culturally safe, it may not reflect a range of values inclusive of First Nations perspectives, and often doesn't offer an 'opt out' option
- Important to focus on how we relatively value 'data or history extraction' versus affirmation
  - **True informed choice**: this is the uncoerced, unbiased ability to provide information to someone and to listen, hear, and act on someone's views if they're different from yours in some way that's mutually agreeable
  - Provide care in the way that someone wishes to receive it
- There may be other barriers:
  - Travel, lack of services, lack of trained professionals

Where we need to be:

- Unbiased
- Non coercive
- Educated (culturally) and open
- Ready for change no matter the rhetoric of "we have done it a certain way for so long"
- Honest and with admission of the current state
- Open to voices and choices one may not understand / be different from one's own

How do we move forward?

- Education
- Partnered change
- Sharing change successes
- Leading trauma informed care
- Leading culturally safe care



- **Documenting voices**
  - This can be uncomfortable, however it is very important to document people's journeys
  - A great example of this is the storytelling collection CART research project being led by Drs Sarah Munro and Unjali Malhotra (currently in three communities)
    - What kind of care have you received in reproductive health?
    - How would YOU like to receive your care?

A challenge and request to you, the conference participants:

Look within and outside of your microsystem – are there ways your operations can change within your clinical system? Then, turn around and walk through your system in the shoes of the powerless, go through your systems as though you had no power at all – imagine if you did not understand the forms, the medical language etc. When we talk about consent, people often feel that they do not have a true choice because there is such a differential between the health care provider and the patient with respect to the power dynamic. It is therefore always important to consider the goal of care to be the care the person wants to receive (which might be different than what you thought they would want or than what you would advise).

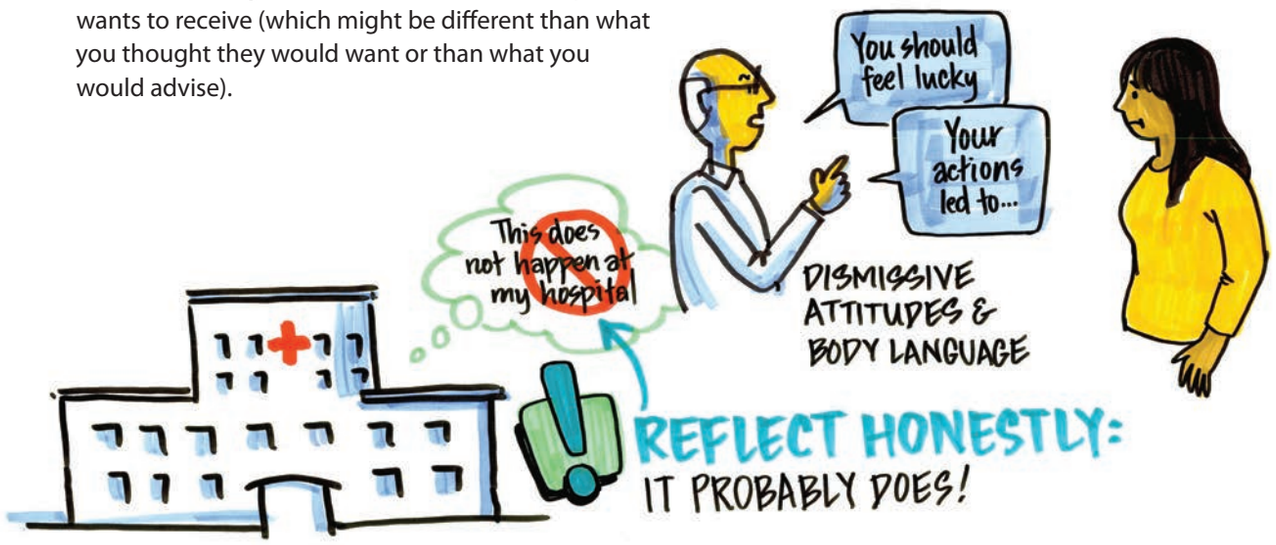
Q&A for Indigenous Cultural Safety

Cheryl Davies led a question and answer period. Answers provided by Dr Unjali Malhotra.

Q1: Do you have a list of resources for improving cultural safety?

A1: Our First Nations Health Authority (FNHA) has a list of resources on their website, including training videos (trauma informed care, trauma informed spaces etc.). https://www.fnha.ca/ about/news-and-events/news/cultural-safety-and-humility-in-health-services-delivery

If conference participants are interested, we could work with BC Women's leadership to provide a follow up workshop on this topic. (Participants provided very clear enthusiastic support for this suggestion, and a follow up workshop was hosted by BC Women's and the FNHA later in the year).

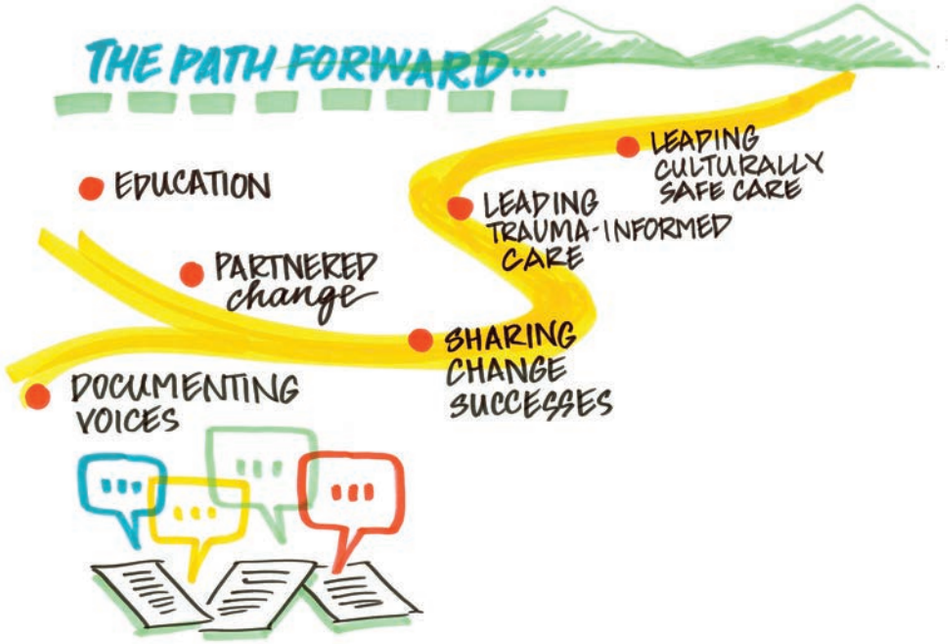


Q2: I have a fair number of [Indigenous] patients that have parents/mothers/aunties etc. who were sterilized and feel very resentful. I have a tough time navigating when I would like my patients to have access to contraception, but don't want them to feel that they have to accept contraception?

A2: The big part to consider in this communication dilemma is "how well do you know that person?" Do you know how far they travelled, who they live with etc? This is very impactful on the decision piece. This understanding of the 'wholeness' of the person in front of you, these very important pieces as among those that we were never taught to 'extract' from people. But all clinical conversations should start with culturally appropriate consideration to better understand these aspects. Consider asking: "*Where are you from? How did you get here? Who lives with you? What is going on at home? What are you hoping for today?*" It is important to know the person before discussing the options or offering information. Generally, it makes the experience a lot more pleasant and you end up with a lot more information.

"We are all part of a system of care. Often providers are anxious that this is the moment, however a positive experience may support somebody to re-enter the system, and engage with the next care provider."

Comment from Cheryl Davies: "We are all part of a system of care. Often providers are anxious that this is the moment, however a positive experience may support somebody to re-enter the system, and engage with the next care provider."



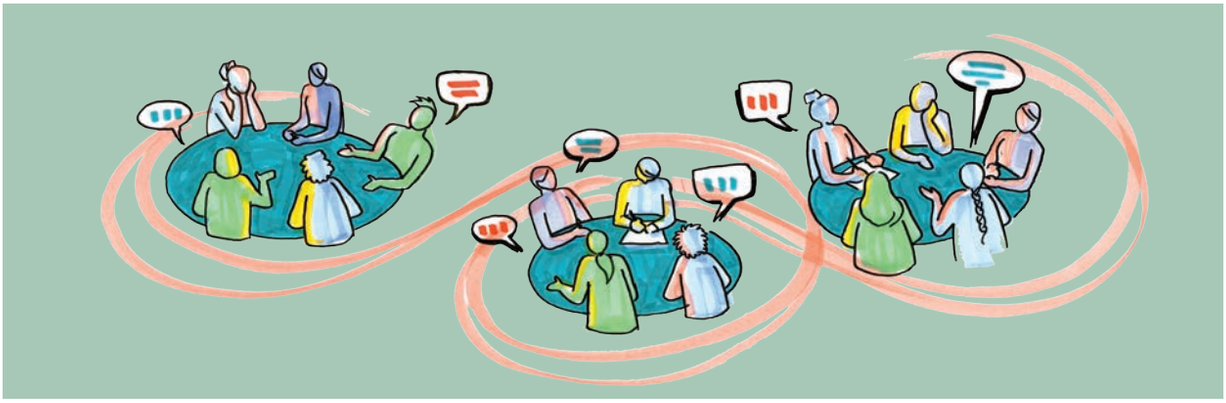
Priority Gaps Focus Group Discussions

All participants convened after the morning break to join "Priority Topic" discussion tables:

1. Indigenous Cultural Safety
2. Services and Challenges faced by Options for Sexual Health clinics
3. Implementation issues for pending arrival of Subdermal Implants
4. Expanding scope of contraception and abortion practice for NPs and Registered Nurses
5. Expanding the scope for contraception and abortion care among Midwives
6. Expanding the scope for contraception and abortion care among Pharmacists

Each Cross-sectoral, interdisciplinary working group developed a list of priority gaps and opportunities, and suggestions to implement change, as captured in the report-back table below.

Table topic discussion	What is the… Problem, gap and/or opportunity?	What can we do? Implementation needs
1. Indigenous Cultural Safety	**Need to understand values, beliefs, cultural norms** and how these affect perceptions and people's willingness to receive treatment **How do we improve consent discussion?** Need to understand that many people may be involved in an individual's consent, to take into account what is important to the community as well as to the individual	**Take the time to elicit what is driving their choice** Ensure each person you see feels they are in a position of power. **Opening conversation to the other side:** Ask "What do you want to discuss today?" Offer choices, and live with them. Walk through your office/process in the other person's shoes – get feedback from members of the community that you serve. **Microsystem changes:** Change forms! Look at the words on our forms, are they respectful? Offer options for help in filling out forms.



2. Services and Challenges faced by Options for Sexual Health clinics	How can we support people to access their preferred choices that may be anywhere on the continuum (especially rural and remote communities)? Options has the benefit of not being a single site (we serve 60 communities in BC) In some communities Options are the only walk-in health care professionals. How can we shift our practice/be of service? **How can we use our provincial network to shift any practice that we currently do?** **How can our social profit role help issues move forward in the system?** There are levels that Options has access to that those working within the system do not always have access to Social media is affecting privacy of providers – How can we address this? Continues to be a lot of stigma regarding abortion providers in many communities, particularly in Fraser Health Authority and Interior Health Authority. As noted by Dr Malhotra. "The safety issue is real […] it's blatant, it's outright, it's on every main road and it is a huge issue for providers to come out"	Willow Women's Clinic in Vancouver provides a lot of telemedicine services for medical abortion. Is this an option for Options? How can Options support telemedicine in rural and remote communities? Anti-stigma campaign would be really valuable in BC at this time. Options to look at this during their next board meeting. **Share available *resources*** *(resources that came up in discussion)*: 1. **Choice Connect** – https://choiceconnect.ca/ an interesting model of a patient-facing public service in Ontario that assists patients to find their nearest abortion provider through a self-managed online tool. 2. **Options** maintains an internal referral list of providers and resources (via SexSense). Providers can contact Options to assist with referrals to closest abortion providers for patients in need. 3. **NAF** offers full-day training on what mifepristone is, how to administer it, what matters/what doesn't in terms of side effects, etc. There is also a component on patient counseling and stigma around provision of abortion care (i.e., stigma that impacts providers, not just patients). The one-day training is of good value and offers CME credits at a very low cost. 4. **Rapid Access to Consultative Expertise (RACE)** http://www.raceconnect.ca/ For providers in the lower mainland, expertise for support on contraception and abortion care may be accessed through the Vancouver Coastal Health and Providence Health service: "RACE line". Willow Women's Clinic is happy to support providers who want to prescribe mifepristone in their own community anywhere in BC.

3. Implementation issues for pending arrival of Subdermal Implants	Need universal free contraception coverage. Need a broader range of contraceptive choices in BC, and attention to ensure health care providers are supported to provide contraception Many of the current barriers regarding the implementation of subdermal implant (which is not yet approved for use in Canada, but is soon expected) come from the lack of information regarding cost, clinical implications and side effects, most health care providers know too little at this time. Many questions coming from clinicians and prescribers regarding general information. How to navigate positive and/or negative messaging that will come up on social media? Concern for how to remove implants, particularly those inserted in primary care or Options clinic settings without adequate equipment.	At a minimum have a compassionate program to supply some discretionary free implants as the implant becomes available. MSP billing code for implants is needed, also, there is a need to address contraception services payment systems for other health care providers. Need to work on **continuing professional development (CPDs)** Need to "train up" health care professionals before implants get rolled out. For every possible person in the contraceptive plan (pharmacy, nurses, NPs, family practice etc.) Options clinic nurses will need to find a champion in the local community. The experts can come together and review evidence-base in the literature and build a consensus and educate their peers. Need all healthcare professional organizations to have a unified message that "this is coming, and this is safe". Need for more accessible information to help our patients understand this new method, the effectiveness, the side effects and how they can be managed. Culture-appropriate education and counselling will be needed. Need to be mindful of healthcare access (if implant goes in, will the patient be able to access the appropriate healthcare comfortably/easily when they need to get this out?).

4. Expanding the scope for contraception and abortion care among NPs and Nurses	Scope of autonomous practice for RNs isn't well defined. RNs currently are unable to prescribe contraception and have limited access to some 'physician-only' programs (e.g., SOGC compassionate access doesn't recognize NPs or RNs). No legislation or regulation preventing RNs from providing contraception and/or medical abortion. At the level of the college it's complicated, not all about "can RNs do it". Other things need to be in play, in terms of competencies, what is in their community, etc. RNs are seeking our NPs for guidance, however, NPs do not bill fee for service, and there is no way for NPs to receive pay to have after-hours call/videoconference, etc.	Nursing regulators should consider a model allowing Contraception Certified Practice RNs to prescribe, such as is used in Quebec. Insertion of subdermal implants could also be an included skill for Certified Practice RNs. Nursing colleges working around what it looks like in terms of standards, limits and conditions and how to roll into current decision support tools (DSTs). **Create** remuneration models for after-hour care. **Explore** telehealth supports and service models. **Improve** access to ultrasound for nurses. **Improve** interprofessional communication and understanding on roles/practice with labs and range of health care providers. Notion of legitimizing sexual and reproductive choices in health (contraception/abortion): Would be great to have a **standard of excellence around reproductive care** to have a group coming together – a content expert working group for contraception and abortion.
5. Expanding the scope for contraception and abortion care among Midwives	Currently **restricted in scope** by legislation (in BC can only serve women if pregnant now, or in the last 3 months). Globally midwives serve all women in reproductive age range (15-55 years). Although there is a passion to continue learning, continuing education is currently not funded. A lot of bias/stigma around midwives. Some of the general public (including HCPs) continue to disparage the work of midwives. Midwives have the training and competence (can insert IUDs, prescribe hormonal contraceptives), however, there is no billing/fee code for this. Midwives graduating in 2020 will be able to prescribe hormonal contraception. Midwives could learn to insert subdermal implants.	**Improve scope** of practice and range of patients that midwives can see to ideally meet the International Midwifery Federation definition of lifelong sexual and reproductive health care provision. Expanded models would reduce burnout. **Revise compensation** to support providing these services. **Adapt compensation** to support continuing professional development for these services. Provide advanced practice certificates. New remuneration methods will be required to support expanded scope of practice initiatives around contraception and abortion care. **Create leadership** opportunities to ensure growth of discipline.

6. Expanding the scope for contraception and abortion care among Pharmacists	How to increase access to medical abortion? Pharmacists are an untapped resource given the training, experience and resources that they have. Pharmacists have developed a tool for how to dispense mifepristone. https://www.caps-cpca.ubc.ca/index.php/Main_Page Mifepristone drug shortage concerns More information needed on pre-stocking and expiry dates of mifepristone Concerns of having only sole mifepristone manufacturer in Canada	Improve payment model/how to compensate providers Address recurrent mifepristone drug supply shortages. Canada's National Drug Schedule: to change mifepristone to a Schedule II Drug (less regulated than Schedule I and does not require a prescription). Bench science is needed to continue evaluation of mifepristone shelf life. Advocate for mifepristone to be on the essential drug list (already in WHO list of essential medicine https://www.who.int/groups/expert-committee-on-selection-and-use-of-essential-medicines/essential-medicines-lists) to make it more of a priority .

Afternoon Rapid-Fire Presentations

Cheryl Davies welcomed delegates back after the networking luncheon, and introduced the speakers for the next series of 'rapid-fire' topical presentations.

What's New in Abortion?

Mifepristone for Medical Abortion in BC: Easy Implementation of MA into primary care practice

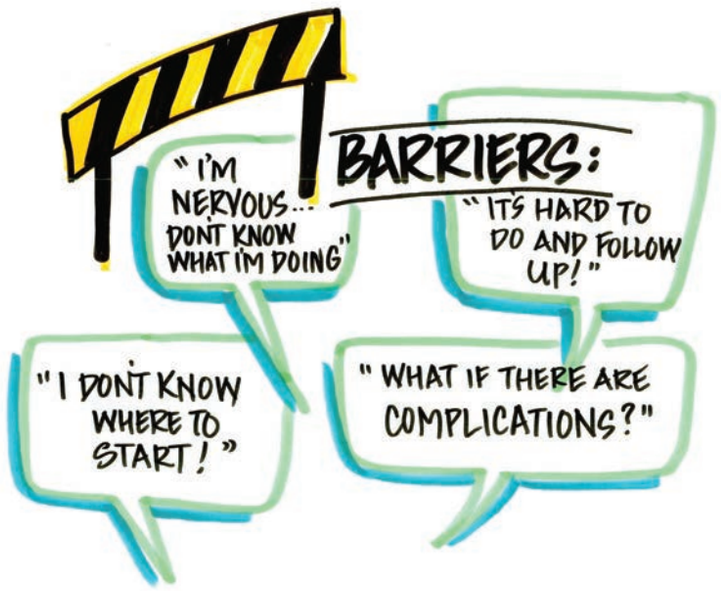
Hannah Varto, NP

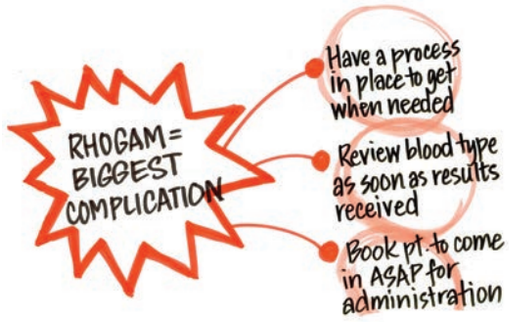
Hannah Varto is a Nurse Practitioner, based in Fraser Health.

Ms. Varto introduced her presentation drawing from her practical experience supporting other NPs and family physicians to begin to implement medical abortion. The common rhetoric she would hear from providers [regarding medical abortion] is "I'm nervous, I don't know what I'm doing". Her presentation will focus on the workflow and practice tools she developed and implemented in her clinic (Please see appendix for resources including Ms. Varto's workflow sheets and the prescriber checklists developed by CART, and the SOGC Virtual Medical Abortion protocol). Her step-by-step assessment can be adapted for your own clinical workflow.

Principles:

- Keep it simple!
- An U/S is not required as the standard for every medical abortion (MA)
- As few appointments as are necessary
- As easy as possible for provider and patient
- Clear education and consent





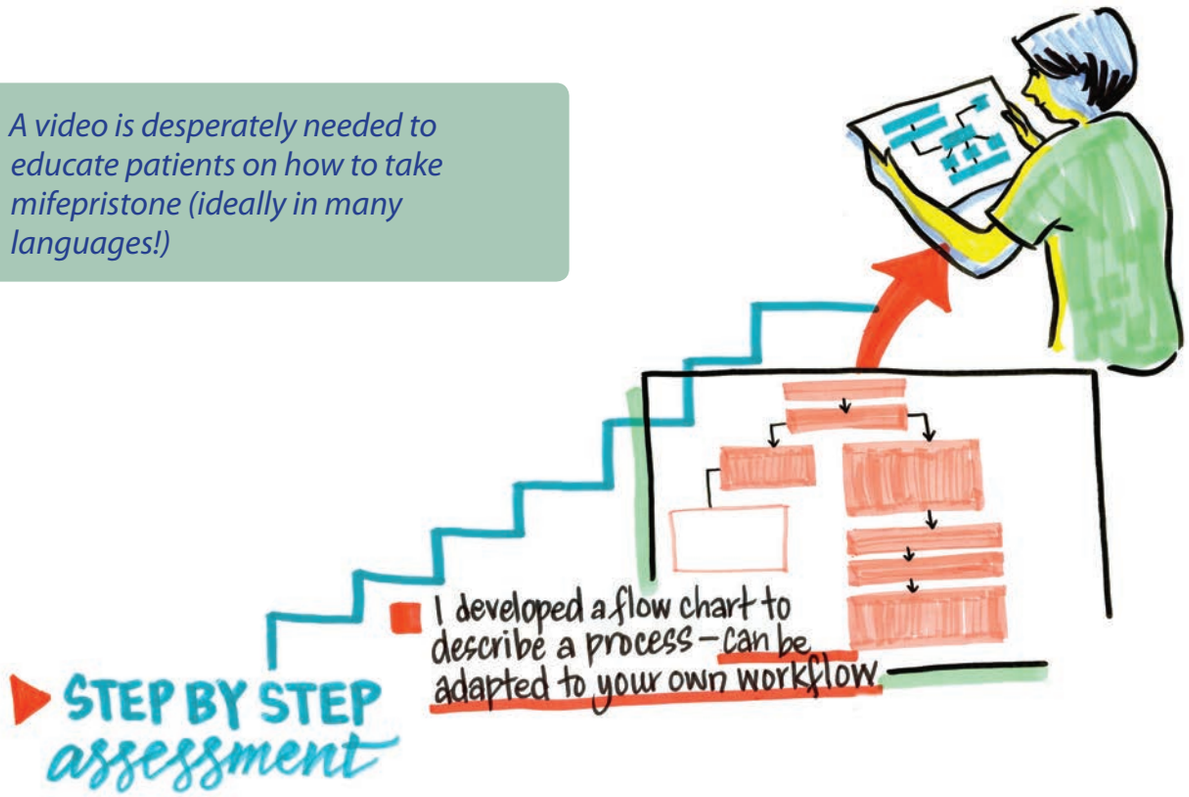
Rhogam:

- Biggest challenge of the whole process is arranging testing and access to Rh Immune Globulin.
- Have a process in place for patient to get this when needed.
- Review blood type as soon as results received and book patient to come in as soon as possible for administration.

Patient Education:

- Patient education is the most important step for providing a medical abortion!
  - Appointments take approximately 30 minutes
  - Simplify the information as much as possible
  - **Need: A video is desperately needed to educate patients on how to take mifepristone (ideally in many languages!)**
- Follow-up phone calls are well-received and tend to keep patients on track, they feel well-cared for and seems to encourage patients to go get their last lab work done
  - Patients lost to follow-up seem to have decreased since phone calls have been started

A video is desperately needed to educate patients on how to take mifepristone (ideally in many languages!)



Q&A for Mifepristone for Medical Abortion in BC

Cheryl Davies led a question and answer period. Answers provided by Hanna Varto.

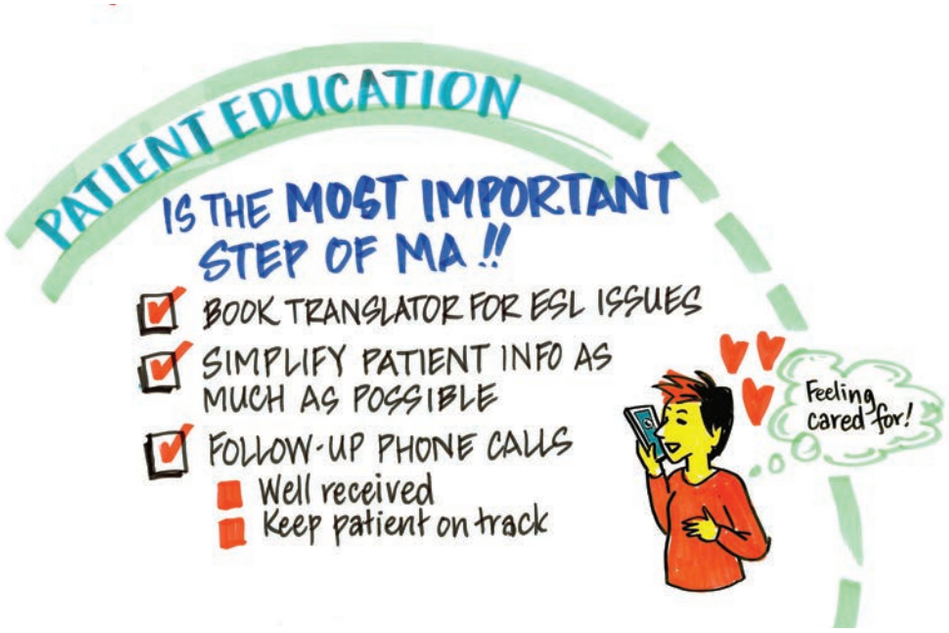
Q1: This is regarding fax request to LifeLabs. Is there a magic code word which prevents them to sending it to Canadian Blood Services (CBS)? Must it always be treated like a prenatal screen?

A1: No, there is no way to prevent this, it has to go to CBS. Generally, try to get the Rh test ASAP. Most of the time it takes 10 days to get the result back – have to be brought back in for Rh. If patients pay privately at LifeLabs for blood typing ($25), they get it done quickly. Some people circumvent the sometimes-lengthy delay in getting blood typing done by having bloodwork done at a hospital outpatient lab.

Recent guidelines are beginning to suggest we may not need it. [Editor's note: By April 2020, SOGC Guidelines, among others, recommended no need for Rh testing or Rh IG administration for pregnancies under 10 weeks. https://sogc.org/common/Uploaded%20files/Induced%20Abortion%20-%20Pandemic%20Guidance%20.pdf

Q2: I have a concern with comparing a second quantitative bHCG to the baseline done before the medication is taken. I'm giving women the latitude to choose when they fill the prescription and also when they decide to take the medicine. Do you have a hard time chasing down patients for this, do you use texting for this?

A2: Yes, we do text with our patients. We sometimes do the second quantitative afterwards. Depending on the result, we consider in relation to the day they took the mifepristone (step 1). We look at it from step 1 and seven days from step 1 and then look when they got the bHCG done. For the vast majority, they are seeing us within two days of lab work being down, and it depends how much it has dropped. For example, if the decline in the bHCG is less than 90%, no matter what the timing, we will ask the patient to have another sample drawn.

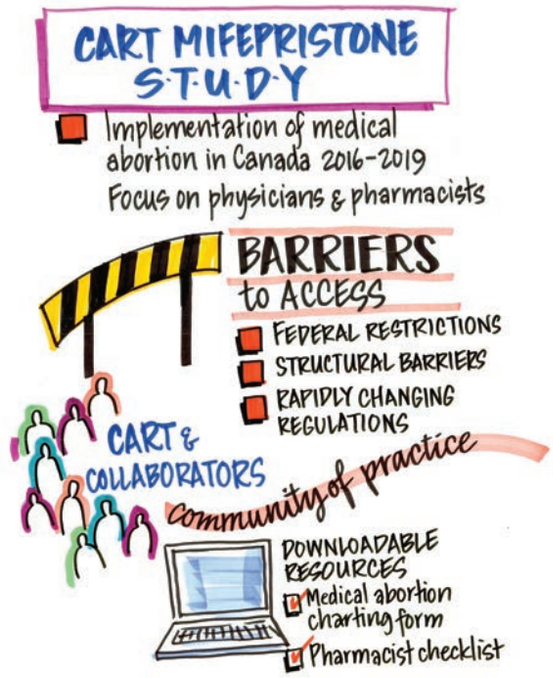


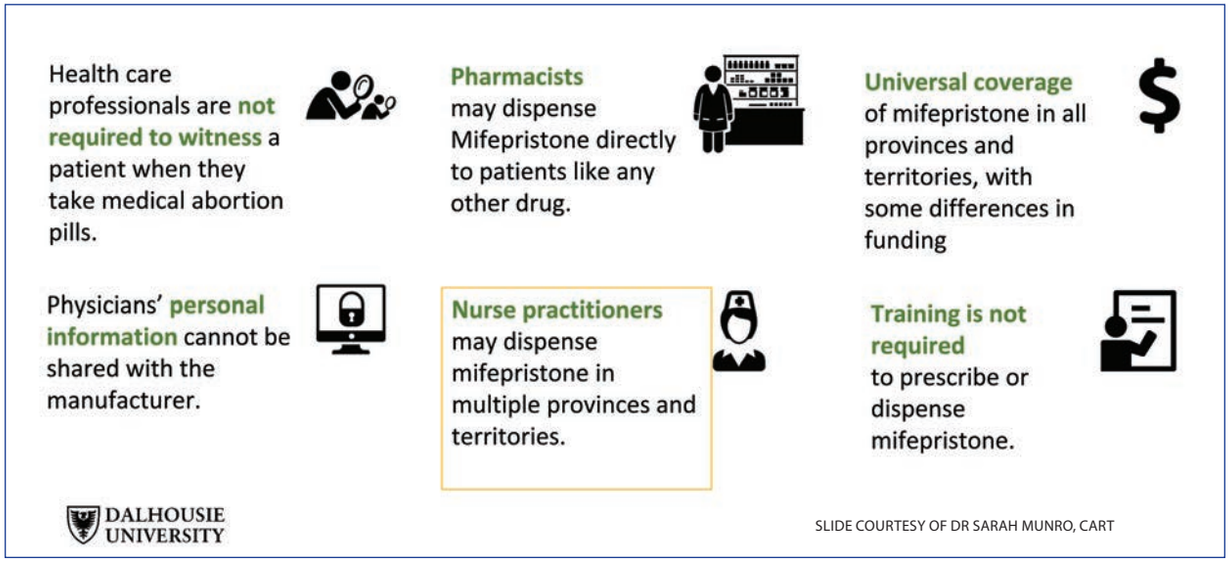
Canada's NP Mifepristone Study

Dr Andrea Carson, School of Nursing at Dalhousie University

Dr Andrea Carson is a postdoctoral fellow at the Dalhousie University School of Nursing in Halifax, Nova Scotia. She is conducting the CART NP Mifepristone Implementation study across Canada.

Dr Carson opened with her goals in this presentation to introduce Canada's NP Mifepristone study, as well as to discuss strategies to improve support for NPs to independently provide medical abortion. She provided an overview of the timeline of medical abortion in Canada, starting with Health Canada's approval of Mifegymiso (mifepristone 200mg + misoprostol 800mcg) in 2015. However, implementation was delayed, and mifepristone was made available January 2017. The right to abortion is enshrined in the Canada Health Act. Dr Carson noted that although many restrictive regulations were in place at the time of initial approval, by November 2017 all federal restrictions were removed, including the limitation of medical abortion provision by physicians only. The final regulation (requiring an ultrasound in every case prior to providing a prescription for Mifegymiso) was removed in April 2019.





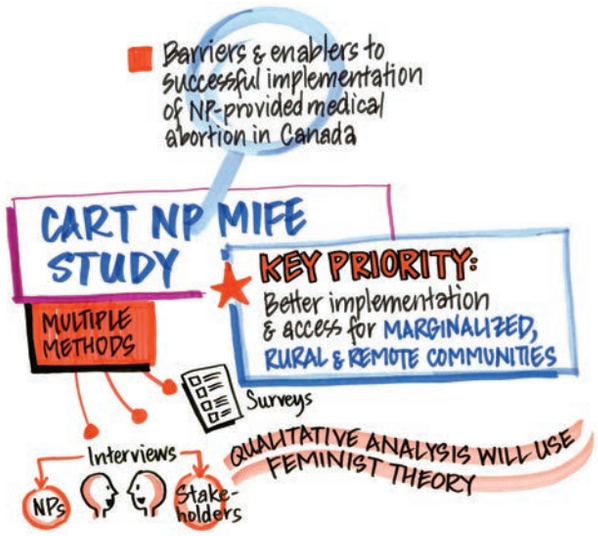
Initial study: Mifepristone implementation in Canada (The CART-Mife Study)

- This study is run by CART, funded by CIHR, MSFHR, and BC Women's Hospital, and led by principal investigator Dr Wendy Norman, UBC, BC Women's Hospital) https://doi.org/10.1136/bmjopen-2018-028443
- Evaluation of the implementation of medical abortion in Canada (2016-2020)

Focused on supporting practice initiation and continuation by physicians and pharmacists.

Once Nurse Practitioners (NP) were able to prescribe mifepristone this led to… The CART Canadian Nurse Practitioner (NP) Mifepristone Implementation Study!

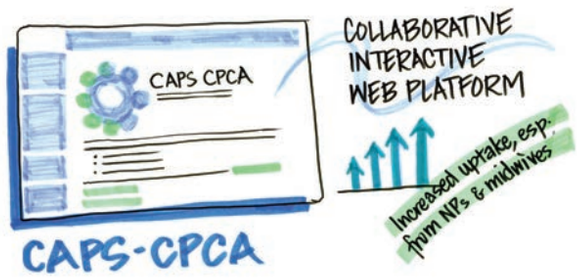
- Collaboration between CART, The Canadian Nurses Association, UBC, Dalhousie and knowledge user partners (co-PI's Dr Wendy Norman, Dr Ruth Martin-Misener and Josette Roussel), funded by CIHR
- **Examined:** What are the barriers and enablers to successful implementation of NP-provided medical abortion in Canada?
- **Key priority:** Better implementation and access for marginalized and rural or remote communities across Canada
- Focus on provincial differences and comparison between practice settings
- **Study utilizing multiple methods:**
  - A survey will be launched in April 2020 to NPs
  - Semi-structured interviews with NPs and stakeholders will be conducted
- Qualitative analysis will utilize **feminist theory**
  - This includes a thoughtful exploration of socio-political context, gendered social expectations and values, relationships and interactions, marginalization that affect implementation of NP provision of medical abortion



- The Canadian Abortion Providers Support (CAPS) interactive web platform will be used. https://www.caps-cpca.ubc.ca

Optimizing the Nurse Role in Abortion Care

Dr Carson continued to describe the initiative of a "Research and Planning Day" held September 2019. The aim of this session was to identify key priorities to support optimization of RN scope of practice in provision of high-quality medical abortion.



Key study insights:

- Misinformation amongst providers about current regulations is still rampant.
- Successful implementation of medication is about coordinating and communicating with pharmacies about stock, access to ultrasound etc.
- De-mystifying abortion provision in primary care is also important.
- NPs frequently lose patients to follow-up – some are exploring solutions via telemedicine.
- Medical abortion training, mentorship, and resource-sharing are important for provider confidence and better patient experiences.
- Making medical abortion more accessible to users is also a priority (e.g. mitigating barriers for marginalized populations, offering "patient-friendly" resources)

Next steps for the CART NP Mifepristone Study:

- "The Nurse Practitioner Medical Abortion Survey" – estimated release April 2020
- Qualitative stakeholder interviews are currently being conducted

Events coming up:

- **Nurse practitioner and Advanced practice nursing global conference will next be held in Halifax.** https://npapn2021.com/
  Half-day workshops, combining clinical teaching and facilitated discussions. Organized by the Nurse Practitioner Association of Nova Scotia (NPANS) in collaboration with the International Council of Nurses (ICN). Our team plans to host workshops related to NP mifepristone practice.

BC Mifepristone Provider Study Results

Dr Sarah Munro, Dr Laura Schummers, Kate Wahl

Dr Sarah Munro is an Assistant professor in the UBC Department of Obstetrics and Gynecology, an Investigator in the CART team, and leads a program of qualitative health services and implementation science research. Dr Laura Schummers is a post-doctoral fellow in the CART team, and a reproductive and perinatal epidemiologist. Kate Wahl is a PhD student in the UBC Department of Obstetrics and Gynecology and on the CART team. They briefly presented on current and potential strategies to best support maximizing the scope of practice of different health professionals to improve equitable access to abortion. Kate Wahl highlighted two recent CART studies and one upcoming study (abstracts below).

1. Perspectives Among Canadian Physicians on Factors Influencing Implementation of Mifepristone Medical Abortion: A National Qualitative Study
Munro S, Guilbert E, Wagner MS, Wilcox ES, Devane C, Dunn S, Brooks M, Soon JA, Mills M, Leduc-Robert G, Wahl K, Zannier E, Norman WV.
https://doi.org/10.1370/afm.2562

PURPOSE: Access to family planning health services in Canada has been historically inadequate and inequitable. A potential solution appeared when Health Canada approved mifepristone, the gold standard for medical abortion, in July 2015. We sought to investigate the factors that influence successful initiation and ongoing provision of medical abortion services among Canadian health professionals and how these factors relate to abortion policies, systems, and service access throughout Canada.

METHODS: We conducted one-on-one semistructured interviews with a national sample of abortion-providing and nonproviding physicians and health system stakeholders in Canadian health care settings. Our data collection, thematic analysis, and interpretation were

guided by Diffusion of Innovation theory.

RESULTS: We conducted interviews with 90 participants including rural practitioners and those with no previous abortion experience. In the course of our study, Health Canada removed mifepristone restrictions. Our results suggest that Health Canada's initial restrictions discouraged physicians from providing mifepristone and were inconsistent with provincial licensing standards, thereby limiting patient access. Once deregulated, remaining factors were primarily related to local and regional implementation processes. Participants held strong perceptions that mifepristone was the new standard of care for medical abortion in Canada and within the scope of primary care practice.

CONCLUSION: Health Canada's removal of mifepristone restrictions facilitated the implementation of abortion care in the primary care setting. Our results are unique because Canada is the first country to facilitate provision of medical abortion in primary care via evidence-based deregulation of mifepristone.

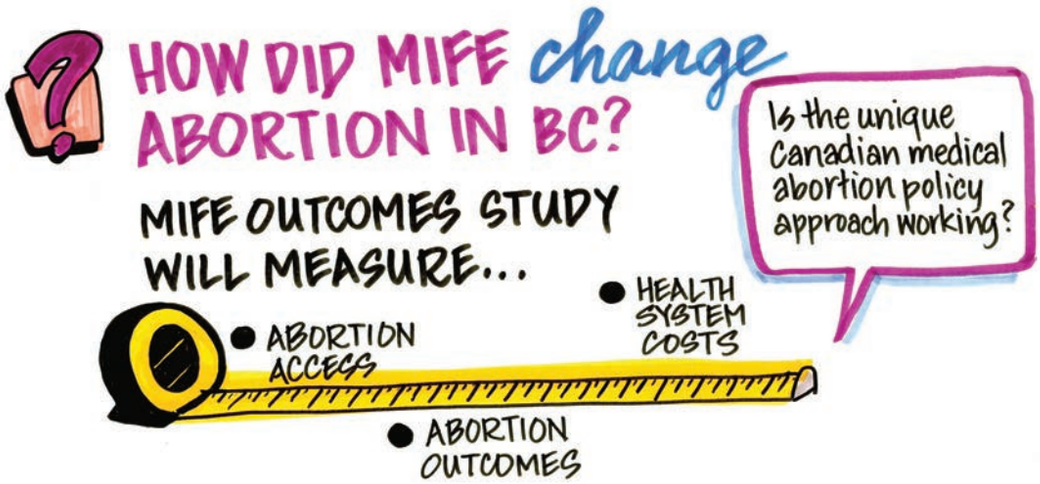
KEY POINTS from the CART-Mife Study
https://doi.org/10.1136/bmjopen-2018-028443

- How did mifepristone change abortion in BC?
  - Abortion access
  - Abortion complications
  - Health system costs
- Is the unique Canadian medical abortion policy working?
  - Is this policy working?
  - What are the costs?
  - Are we increasing access?
  - Are there adverse outcomes?
- We are using administrative data and are comparing data since mifepristone has become available to what would have happened, had it not been made available

2. Prescriber checklist: Development and implementation of a prescriber checklist and reference guide for mifepristone medication abortion
Munro S, Wahl K, Wylie A, Van Esch K, Williams A, Dunn S, Guilbert E, Norman WV.

OBJECTIVE(S): To develop and implement a medical charting checklist and quick reference guide to support adoption of medical abortion among Canadian health care providers who wish to deliver care.

STUDY METHODS: The preliminary checklist and reference guide were adapted from seven clinical exemplars using the 2016 SOGC guidelines on medical abortion. Materials were subjected to expert review (n=6). Front-line providers (n=5) gave feedback on the revised materials in 'think-aloud'



interviews and rated the materials using the System Usability Scale (SUS). Final materials were approved by the expert reviewers and English and French versions were posted on the Canadian Abortion Provider Support website.

RESULTS: Expert reviewers were four clinician-researchers, one community stakeholder, and one qualitative researcher. Front-line participants were two family physicians, one obstetrician-gynecologist, one family medicine resident, and one registered nurse. Front-line participants had between two and 20+ years in practice; three had previous experience with mifepristone medication abortion and two did not.

Changes to the materials focused on alignment with clinical guidelines and best practices as well as the fit of the tool to the clinical context. The median SUS was 86.25 (69.4-97.5), indicating good-to-excellent usability. Between April 2018 and July 2019, the checklist was downloaded 1016 times (963 English, 53 French) and the reference guide was downloaded 760 times (700 English, 60 French).

CONCLUSION: Many Canadian prescribers are adding medical abortion to their scope of practice for the first time. The tools described above support the implementation of medical abortion services in the Canadian context. https://www.caps-cpca.ubc.ca/index.php/Main_Page

What CART Research Is Coming Up?

Kate Wahl continued to announce some new research conducted by herself, Dr Sarah Munro and a team of co-investigators. This research is made possible thanks to a 2020 Catalyst grant from the Women's Health Research Institute, with the plan to use these stories to support health system decision makers to understand ongoing service challenges. A short summary of this study is found below.

It can take years for governments to integrate new discoveries into health policy. One way to solve this problem may be to share research evidence about the healthcare system using real-life stories of Canadians accessing the system.

1. A good story well told: Exploration of stories as a tool for tool for knowledge translation with decision makers

Munro S, Wahl K, Brooks M, Wilcox E, Dunn S, Norman WV.

It is vital for the well-being of Canadians that the healthcare system operates using the most up-to-date information. However, it can take years for governments to integrate new discoveries into health policy. One way to solve this problem may be to share research evidence about the healthcare system using real-life stories of Canadians accessing the system. To test this theory, we will interview a group of provincial and federal policy makers about how stories affect their decision-making on reproductive

and sexual health. Next, we will use what we learn to help ask Canadians about their experiences accessing reproductive and sexual healthcare and turn these experiences into stories for policy makers. The last step will be to test the preliminary effect of stories on policy makers' knowledge, attitudes, and intentions. This study will provide a new set of methods to promote the use of research evidence in government. The methods will be created with and for policy makers and will be evaluated so that other scientists have tools to get research evidence into the hands of people who are responsible for the healthcare system. By closing the gap between science and government, this study will help ensure that the healthcare system provides the best possible care to all Canadians.

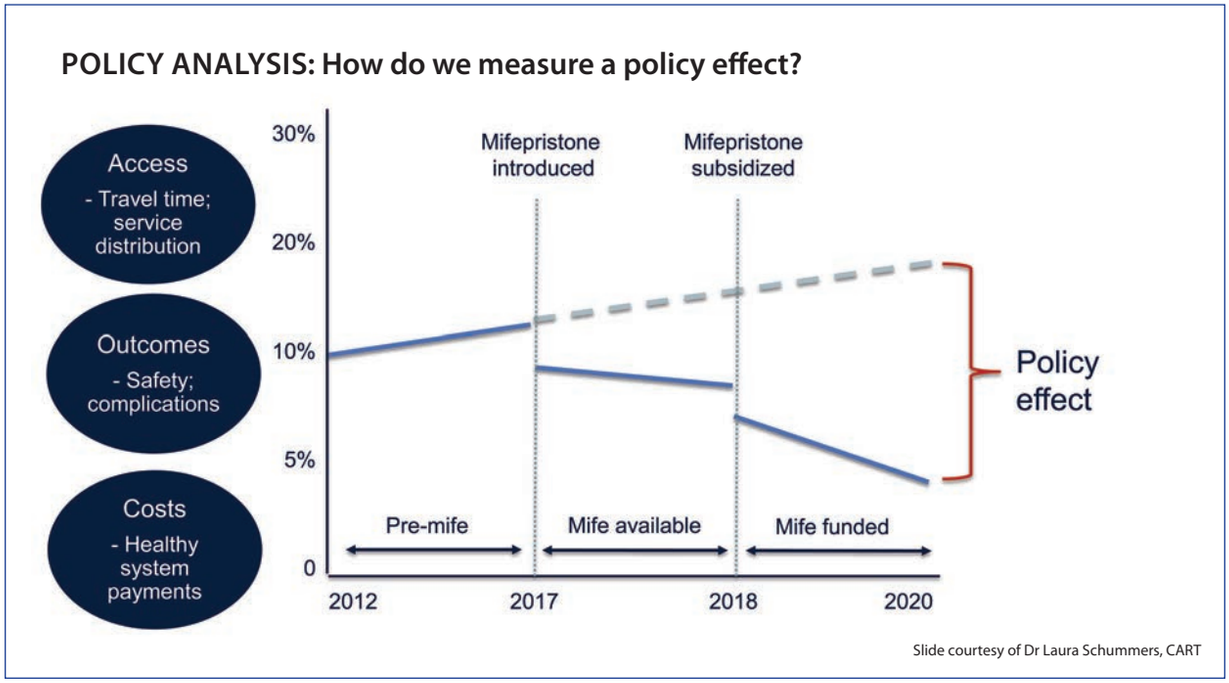
2. CART Mifepristone Outcomes Study: Examining the effect of mifepristone on Canadian Abortion Access, Outcomes, and Costs

Dr Laura Schummers discussed a four-year research study that is now being launched to examine the effect of mifepristone on abortion access, outcomes, and costs. This study will answer the question, what happens when health policymakers listen to scientists, researchers, and clinical experts to create evidence-based abortion policy? Has the deregulated Canadian policy approach to medical abortion succeeded in improving access? Was there an impact on abortion safety, complications? What about the overall costs to the health system to provide abortion services?

Has the deregulated Canadian policy approach to medical abortion succeeded in improving access?

To study this, CART will use linked administrative health data (data collected from MSP billing, prescription, and hospitalization records) to study all abortions from BC from 2012-2020. This data source lets us truly see what is happening across the province in the entire population.

We will then use a gold standard statistical approach for understanding the effect of a policy, with new mifepristone policies acting as a natural experiment. This lets us compare our measures of access, outcomes, and costs under this policy approach to what access, outcomes and costs would have been if mifepristone had not been implemented.



The above figure provides an example of what this might look like. For example, what proportion of women travelled more than one hour to reach an abortion provider? With improved access, we expect to see that this will have been reduced as a result of these policies. We will then compare the proportion of women that did travel more than one hour in the 2018-2020 period with what we would have expected with mifepristone.

3. Pregnancy Spacing: Determining the optical interpregnancy interval for high-risk populations

Then, Dr Laura Schummers gave a brief overview of another active area of CART research related to pregnancy spacing. Interval pregnancy regulations have been produced by the WHO, http://www.who.int/maternal_child_adolescent/documents/birth_spacing.pdf however we do not know whether these data apply to patients after perinatal loss and other specific high-risk populations (e.g. advanced maternal age and individuals with infertility).

•

- Recent CART research examining short interpregnancy intervals:
  - JAMA Internal Medicine – Association of Short Interpregnancy Interval with Pregnancy Outcomes According to Maternal Age, article published looking at optimal interpregnancy intervals https://doi.org/10.1001/jamainternmed.2018.4696
  - AJOG: Interpregnancy Interval and Perinatal Outcomes after a Perinatal Loss https://doi.org/10.1016/j.ajog.2019.11.1088
    - Result following a perinatal loss: short interpregnancy interval increased spontaneous preterm birth risk however there was no increased adverse fetal-infant outcome risk
- Current studies will look at interpregnancy intervals for high-risk women:
  - Spontaneous preterm birth
  - Ovulation stimulation treatment for infertility
  - Miscarriage

Q&A for Rapid-Fire Presenters on CART Research

Cheryl Davies moderated the question period with answers provided by Drs Carson and Schummers and Kate Wahl.

Q1: You mentioned having research with billing codes, will this apply to NPs who use a different set of billing codes?

A1: Yes, it should. It parallels all implementation studies, looking at the proportion of abortions provided by NPs over time.

Q2: How do you differentiate between a spontaneous abortion or surgical abortion (D&C)?

A2: From the accompanying diagnostic codes, and the codes are different.

What's New at OPTIONS for Sexual Health?

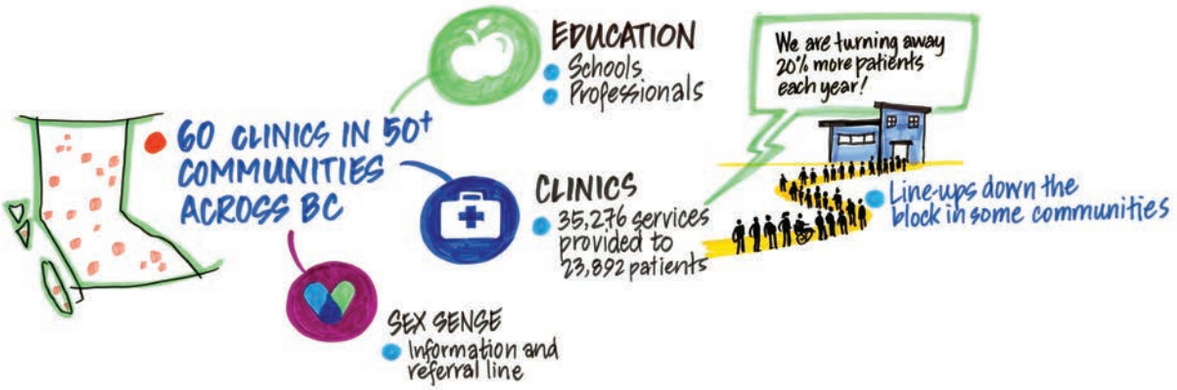
Nicole Pasquino, Clinical Practice Director

Nicole Pasquino provides practice support for over 100 nurses and clinical staff in role as Clinical Director at Options for Sexual Health (formerly Planned Parenthood BC), helping to create provincial practice standards for nurses in sexual and reproductive health. She was also the driving force behind the creation and implementation of the Contraception Management and STI Management courses in BC, which allows nurses to provide contraception and STI care after becoming certified.

Nicole is the faculty lead for sexual health at the BC Institute of Technology (BCIT), where she leads advance practice education for nurses in contraception, pelvic exams, and sexually transmitted infection care. These courses support registered nurses to provide sexual and reproductive health care that would otherwise not be available in many of the communities in B.C. She continues to practice and provide patient care at Options clinics and with the BC Women's Hospital Sexual Assault Service.

Nicole presented a wide range of interesting information on current and new initiatives at Options for Sexual Health (Options). Options currently offers services in BC and the Yukon. They offer current sexual and reproductive health care, information, and education from a feminist, pro-choice, sex positive perspective. https://www.optionsforsexualhealth.org/what-we-do/

She began by providing an overview of Options for Sexual Health, outlining that the mission is to champion and celebrate the sexual health of all people in BC by supporting, providing and promoting inclusive and accessible health care and education. Options has 60 clinics in over 50 communities in BC. They operate on a mixture of appointment based and drop-in, with varying hours but mostly in the evening. Options holds education sessions both in schools and for professionals and run the Sex Sense information and referral line. In 2019 Options saw over 23,000 patients and provided over 35,000 services ranging from pregnancy testing to contraception to STI care and treatment.



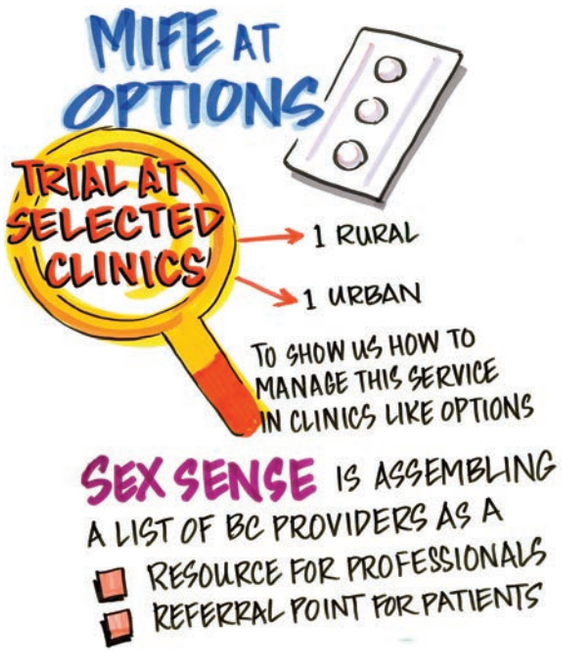
In 2019 Options saw over 23,000 patients and provided over 35,000 services ranging from pregnancy testing to contraception to STI care and treatment.

Partnerships

- Working within partnerships is critical as there has not been any funding increases for clinical services. The partnerships have been key in continuing to meet the needs of communities across BC.
  - four clinics exist in First Nations communities
  - Options has services within Foundry clinics https://foundrybc.ca/, clinics for youth and each clinic has at minimum 25 community partners before they can open care.

Mifepristone at Options

- Options is looking at a trial of providing mifepristone for medical abortion services
- In 2020, they plan to implement a trial of this first at a few select clinics (in both urban and rural settings)
- This trial will aim to inform decision making on how this service would best be managed in clinics like Options
- Sex Sense has a list of abortion providers across the province that people can call in and access



  - Approach Nicole Pasquino, Helena Palmqvist De Felice, or Michelle Fortin and they will help arrange it if you wish to be on this list.
  - Contact leadership team: https://www.optionsforsexualhealth.org/what-we-do/about-the-people/about-the-staff/

Other key points at Options

- Welcome Dr Blanka Jurenka as the new Medical Director of Options for Sexual Health!

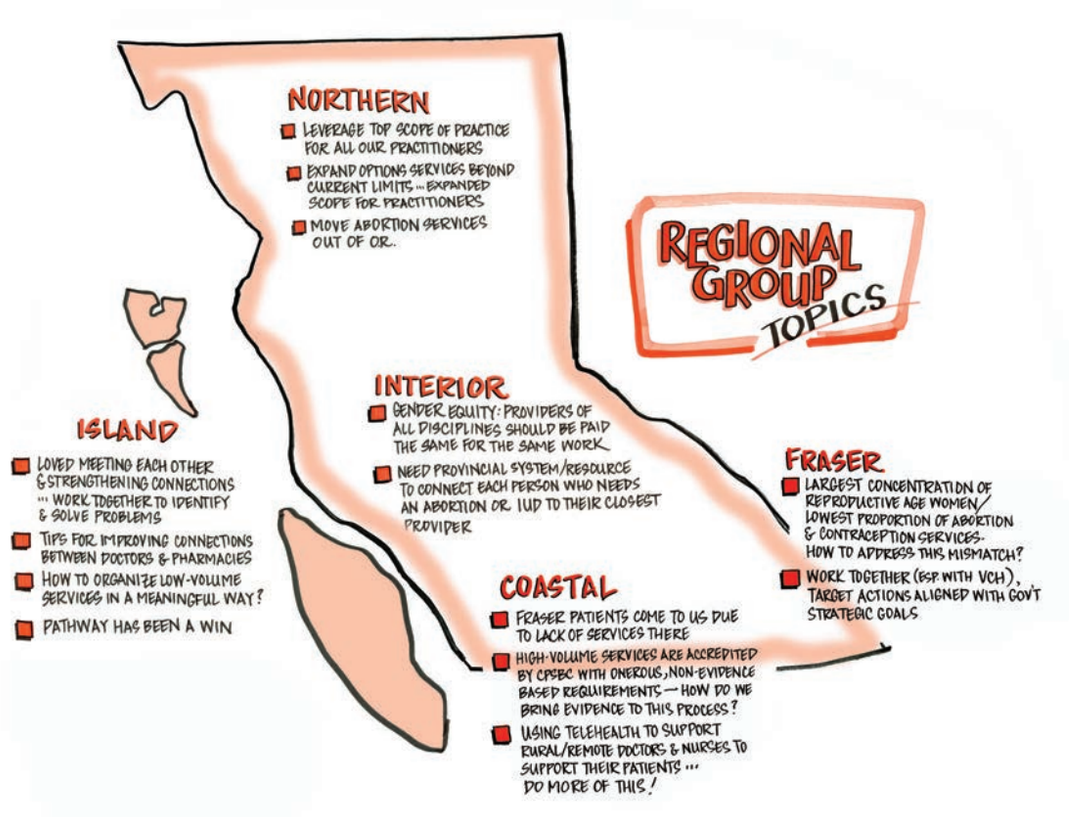
Regional Table Group Discussions: How to Improve Access to Contraception and Abortion in Your Region?

Cross-sectoral, interdisciplinary Working Group Results

In depth discussion was held around problems, gaps and opportunities for access to contraception and abortion care across all BC health authorities. Cheryl Davies reminded all participants that although the pace of change and innovation may sometimes appear slow, we cannot forget the advances that we are making. She highlighted that participants are sitting here today as physicians, nurses, midwives, pharmacists, researchers, government and regulatory decision makers and trainees together working to advance care, and options for our patients.

Furthermore, BC Women's celebrates that we are here advocating together with physicians for task sharing away from traditional physician-only roles, to be inclusive of the best use for the skills of nurses, midwives and pharmacists as a part of the care team.

All participants gathered in Health Authority specific groups to identify regional Problems, Gaps or Opportunities, and to also outline potential Implementation Strategies.

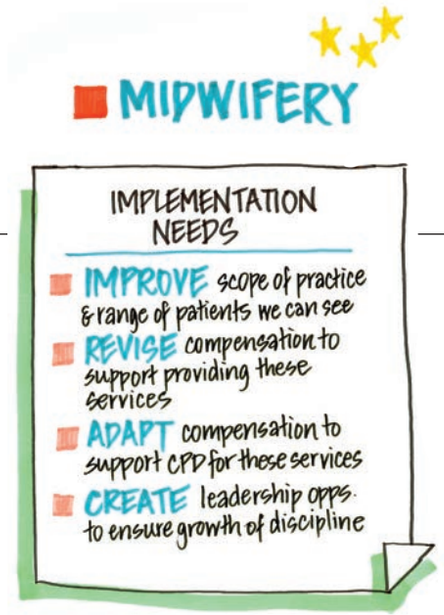


DISCUSSION GROUPS REPORT-BACK

Table topic discussion	Problem/Gap/Opportunity	What can we do? Implementation needs
1. Northern Health (NH)	Need more efficient approach for surgical wait times Need to leverage scope of practice of all colleagues (e.g. Can nurses put in IUDs? Can nurses dispense mifepristone, and insert subdermal implants in remote communities?) What is the scope of practice for nurses, midwives and pharmacists? And if it is not in scope, why not? Need more robust sexual reproductive health (SRH) centres, beyond Options & Foundry. (Options is only up to age 26 and Foundry is ages 12-24 very similar services for a particular age group.) Need more remote access	Move abortion services from the OR into another setting (e.g. ambulatory care, procedure rooms, freestanding clinic etc.). Doesn't need to be in the OR. Need funding for surgical action plan Making services such as **Foundry** https://foundrybc.ca/ become a more robust contraceptive service Expand to overall SRH clinic (include Pap tests etc.) Offer same day IUD insertion, medical termination, surgical termination and ultrasounds, at the point of care. Telehealth + team-based approach Increase access to SMART program with a wider access to free contraception, including LARC and a range of methods.
2. Interior Health (IH)	Lack of awareness of where providers are and what services are available Separate billing codes for NPs, midwives, nurses and physicians (working in silos) Lack of second-trimester abortions outside of Vancouver Island and Vancouver lower mainland (there is limited access in Kamloops) There is a perceived barrier to gender equity in access to services and the gender awareness of health care personnel at some services.	Services will need to truly shift to a patient centered view, patient centered lens Increased need for funding arrangements that work for providers in rural areas (e.g. NPs, RNs, midwives, pharmacists) IH needs a centralized IUD booking (or perhaps referral) system, so we know which providers are providing services and when those services are next available. MSP billings should be harmonized across professions—equal pay for equal work. Gender analysis is needed. Providers of all disciplines should be paid for the same work.

3. Fraser Health (FH)	Disappointment and frustration over lack of services in FH. Low access to abortion care. Fastest growing population/largest concentration of reproductive age women, however lowest proportion of abortion & contraception services. How to address this issue? No hospitals in Fraser Health offer Surgical abortion – Why? Services are "Vancouver-centric" **Antichoice organizations:** There are centers "crisis pregnancy centers" that patients are getting referred to for care. Detriment to our vulnerable populations.	Invite FH and VCH to come together to come up with solutions – not a legal barrier to move around services. **Improve resource allocation:** Abortion services are one of the best examples of how things have been improved (by moving things OUT of the hospital, showing that we can provide it safely IN the community). All hospitals could be providing abortion. Not to target only FH, but all hospitals could be providing abortion. Need to remove stigma in all health authorities. Possible legal action against the misdirecting anti-choice organizations offering "Crisis Pregnancy centers"?

4. Vancouver Coastal Health (VCH)	Many participants in non-hospital based surgical facilities noted the increasing difficulties and very high bar of standards that are enforced by the College of Physicians and Surgeons of BC (CSPBC) Non-Hospital Surgical Facility Accreditation system. This is over-regulated and expensive, enforcing non-evidence-based CPSBC regulations; and, they are gradually increasing the regulations. Abortion clinics are lumped into other clinics (e.g. dermatology), there are no specific regulations for abortion clinics and some regulations for other clinics do not apply to our populations, yet are very expensive to adhere to, frustrating and limit access to services for clients. There are over regulation issues but also the cost is a big issue. Clinics are required to pay very expensive fees for this obligatory accreditation. The intermittent supply shortages of mifepristone have been a barrier. Need to have more community pharmacies stock mifepristone. Mifepristone is very expensive if someone is uninsured, or insured in a different province. Billing could be improved if the physician (MSP) billing codes for insertion (IUD or implant) could be billed the same day as a consult. Lack of services in Fraser Health cause problems for providing services in VCH (60% of VCH patients are from FH).	Change in the CPSBC accreditation program – to have an abortion provider on their committee and/or to have the CPSBC accept a plan to have a specific set of standards that are sensible for abortion facilities which have a very different population than other non-hospital surgical centres. One approach may be to nominate a colleague to the board of CSPBC (position voted by the organization). Telehealth can be a solution to the Fraser Health patients, even just for follow-up to better support patients. Better use could be made of technologies for facilitating telephone consults and follow-ups. Physician and allied health practitioner compensation for S&RH, particularly contraception and abortion provision, needs an overhaul and a better compensation structure than current MSP fees. Looking into provincial call services for mifepristone for patients? Patients need someone they can contact after hours; someone on-call 24/7. [Editor's note: the BC NurseLine generally can assist a patient in need.]



5. Vancouver Island Health Authority (VIHA)	What resources can we refer patients to? Healthcare providers not always aware of where to refer to (although access to Pathways improving this). Operating Room (OR) time for surgical abortions can be an issue (Abortions scheduled on the regular OR slate). This can lead to cancellations or delays due to the priorities and emergencies among other services competing for the time. How to organize low volume services in a meaningful way? Pharmacy relationships: Pharmacies not all stocking mifepristone. Remuneration and space to provide both contraception and abortion services can be barriers	Get providers together more often to strengthen connections; to work together to identify and solve problems. Creating a list of pharmacies that stock mifepristone on the island would be helpful. Increased communication between island pharmacists and other HCPs

PART II: MEETING SUMMARY, NEXT STEPS

Cheryl Davies

Cheryl Davies reflected on her excitement at the energy of the day, recognising that there were a lot of actionable points made throughout the presentations and working group report-back sessions. First and foremost, she emphasized how imperative it is to strive for a women and patient-centered perspective. She then provided a summary of the common themes, proposed solutions and tangible recommendations identified throughout the conference.

Considering the scope of practice, she acknowledged that there is a lot of work to be done starting with the development of an action plan. Regarding provincial resources, there is a need for centralized referral systems, increased use of telehealth and to improve standardization of services. The message is clear that there needs to be a provincial coordinated approach. She also noted that change regarding compensation and remuneration frameworks, in particular as so many of the working groups raised for contraception and abortion care among both MDs and the range of health care disciplines, is difficult, however much needed.

Cheryl Davies closed the conference by reminding everyone not to underestimate the value of networking, that it is important to have people reaching out on different levels. She brought up West Coast LEAF http://www.westcoastleaf.org/ as a resource/key partner for any legal cases involving health care providers. She encouraged conference attendees to consider forming interdisciplinary partnerships, following great examples of interdisciplinary models elsewhere in the province.

In the closing discussion a conference attendee commented that "we have heard several times today that mifepristone uptake was approximately 50% of all medical abortions…wondering how this information is used and where does the information go"?

Dr Wendy Norman explained that the final analyses for this particular study will come in the next one to two years, although there will be some preliminary data coming out later in the year. She explained how previous conferences have guided the research which then gets transformed into regional and provincial initiatives. That is part of the aim: "*Experience guiding research guiding care*", the experience of today (and previous conferences) has been turned into implementation research successful to advance policies in BC such as the SMART Program, the deregulation of mifepristone (led by BC and first announced at an earlier conference in this series), the introduction of subdermal implants in Canada, and the current proposal to the provincial government to provide all contraception free to people in BC.

In summary, BC Women's Hospital and the Ministry of Health of BC continue to be delighted to support implementation of health policies, systems and services to ensure women throughout BC have access to the knowledge, services and methods they need to time and space their pregnancies. The next steps of the CART process are to review the conference proceedings, with emphasis on the input and actions prioritized by the participants. Our goal is to take advantage of the political will and timely evidence from all the efforts described today and advance contraception and abortion care in BC with our alliances.

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

APPENDICES

Appendix A: Resource List

Resource	Details	Contact information
Choice Connect	Choice Connect is an Ontario based service that assists people to find their nearest abortion provider based on their needs. The app features detailed referral information for more than 120 abortion providers and clinics across Canada. The web app is anonymous and free to use.	https://choiceconnect.ca/
Foundry	Foundry offers young people ages 12-24 health and wellness resources, services and supports – online and through integrated service centres in communities across BC.	https://foundrybc.ca/
Pathways	Pathways is an online resource that provides physicians and their office staff/teams quick access to current and accurate referral information, including wait times and areas of expertise of specialists and specialty clinics. Pathways can also provide access to hundreds of patient and physician resources, as well community service and allied health information that is categorized and searchable.	https://pathwaysbc.ca/ login
RACE	RACE is a novel strategy to enhance patient care within Vancouver Coastal Health and Providence Health referral areas. An educational interaction with knowledge transfer is encouraged when the specialist answers the call. In the spirit of "capacity building", specialists are recruited for their interest in teaching and communication as well as their recognition as key opinion leaders.	http://www.raceconnect.ca/
Sex Sense	Sex Sense is a free, pro-choice, sex-positive, and confidential service. Our team of registered nurses, counsellors, and sex educators offer information and resources on sex, sexuality and sexual health, for people living in British Columbia and the Yukon, Canada.	https://www.optionsforsexualhealth.org/sex-sense/
West Coast LEAF	LITIGATION: West Coast LEAF advances gender equality through our involvement in equality rights cases at all levels of court. LAW REFORM: Day-to-day equality issues are affected by legislation. West Coast LEAF tracks existing and proposed legislation and responds to governments when it affects gender equality and human rights. EDUCATION: One of the best ways to protect Charter and human rights is to educate people on how to use them.	http://www.westcoastleaf.org/

Appendix B: Agenda

Contraception & Abortion in BC: Experience Guiding Research Guiding Care

MORNING	WHAT'S NEW IN CONTRACEPTION?	
Time	***Activity***	***Speakers***
7:30 – 8:00	Registration with Continental Breakfast	
8:00 – 8:30	Welcome from BC Women's Hospital Welcome from Provincial Leaders	Cheryl Davies (chair), Drs Natasha Prodan-Bhalla & Glenys Webster; Michelle Fortin
8:30 – 9:10	"Next up – Subdermal Implant contraception: What you need to know about a new class of drug coming soon	Drs Regina Renner, Nicole Todd
9:10 – 9:20	Complex Contraception Clinic	Dr Nicole Todd
9:20 – 9:30	SMART Program: Pilot program results to date	Dr Sheila With/Suzie Maginley
9:30 – 9:50	Audience Discussion in Plenary	
9:50 – 10:05	Nutrition and Networking Break	
10:05 – 10:25	Cultural Safety and relation to family planning access	Dr Unjali Malhotra
10:25 – 10:40	Audience Discussion	Moderator Cheryl Davies
10:40 – 11:10	Table topic discussion: Cultural Safety/ OPTIONS /Implants / NPs & Nurses/ Midwifery/Pharmacy	Moderator: Cheryl Davies
11:10 – 11:50	Report to plenary	Moderator: Cheryl Davies
11:50 – 12:00	Morning Session Summary	Cheryl Davies
12:00 – 13:00	Networking Lunch	All

AFTERNOON	WHAT'S NEW IN ABORTION?	
Time	*Activity*	*Speakers*
13:00 – 13:05	Introduction to Afternoon sessions and context	Cheryl Davies
13:05 – 13:20	Mifepristone for Medical Abortion in BC Easy Implementation of MA into Practice: Step by Step	Hannah Varto
13:20 – 13:35	Canada's NP mifepristone study	Dr Andrea Carson
13:35 – 13:50	BC mifepristone provider study results	Dr Sarah Munro, Kate Wahl, Dr Laura Schummers
13:50 – 14:05	What's new at OPTIONS for Sexual Health?	Nicole Pasquino
14:05 – 14:30	Questions and Discussion	Moderator: Cheryl Davies
14:30 – 14:50	Nutrition and Networking Break	
14:50 – 15:40	Regional table groups discussions: how to improve access to contraception & abortion in your region?	Introduction: Cheryl Davies
15:40 – 16:15	Regional tables report to Plenary	Moderator: Cheryl Davies, Dr Wendy Norman
16:15 – 16:30	Meeting Summary, Next Steps	Cheryl Davies

The program has been accredited by SOGC (up to 6.5 credits) and CFPC (up to 6 Mainpro+ credits).

Appendix C: Speaker Bios

Cheryl Davies

Cheryl Davies is the Chief Operating Officer, BC Women's Hospital + Health Centre, one of the largest maternity hospitals in Canada and the only facility in BC devoted primarily to the health of women, newborns and their families. Cheryl has over 30 years of experience in women's health as a nurse, educator and senior leader, in both community and hospital settings. At BC Women's, she has led the implementation of performance management and continuous improvement systems to drive operational excellence through a culture of learning and improvement. She is a passionate advocate for women's health, reproductive rights and social justice. She believes firmly in the strength of servant leadership, and the importance of honouring women's values and voices in health care.

Dr Natasha Prodan-Bhalla

Natasha is the current Chief Nursing and Professional Practice Officer in the Ministry of Health. Previous to this she was the NP Lead in PHSA. Natasha graduated with her BScN from the University of Western Ontario, her MN/NP from the University of Toronto, and her doctorate from the University of Colorado. Her current role focuses on informing policy and models of care for all nursing designations in BC. She also works as an NP one day a week at BC Women's Health Centre and her current focus is women's health that includes reproductive and sexual health care for women with disabilities and heart disease in women. She is adjunct faculty at both UBC and University of Victoria. She is passionate about being an NP and a nurse and the contribution nursing can make to improve the health care system in BC.

Dr Glenys Webster

Dr Glenys Webster is the Director of Women's, Maternal and Early Childhood Health in the Population and Public Health Division at the BC Ministry of Health. She holds a PhD in Environmental Epidemiology from UBC Health and received support for her postdoctoral work from the Michael Smith Foundation of Health Research and CIHR. As a policy maker, Glenys and her team work closely with Dr Wendy Norman and partners to explore ways to enhance equitable access to sexual and reproductive health services – including contraception and abortion – for BC women and girls.

Michelle Fortin

She/her pronouns. Michelle recognizes that she has had many privileges in life. She believes that knowing this has allowed her to stay curious, be open and seek out opportunities that made her uncomfortable and able to grow. Working in the social service sector since 1985, she has learned to approach the world through a social justice lens and think critically about systems. An academic background in psychology, counselling and, most recently, leadership has prepared Michelle for her current position as Executive Director at Options for Sexual Health. Michelle says that supporting the mission at Options is easy because she too embraces a pro-choice, sex positive approach to reproduction and sexual health for all. As an executive director she is responsible for oversight of finances, board governance, program development and evaluation as well as fundraising. Michelle enjoys family, travel and music in her spare time as well as serving as Co-Chair of the Vancouver Pride Society and as a board member of CCEC Credit Union.

Dr Regina Renner

Regina-Maria Renner is a Clinical Associate Professor at the Department of Obstetrics and Gynecology of UBC where she first joined in December 2012. Since May 2015 she is the Fellowship Co-Director of the Family Planning Fellowship at UBC. In March 2013 she also joined the Department of Obstetrics and Gynecology at Nanaimo Regional General Hospital. Her recent research has focused on in implementation of mifepristone for medical abortion in Canada and she currently is the principal investigator on a CIHR grant to survey Canadian abortion providers. Her prior research in pain management of first trimester surgical abortion has led to a Cochrane review and several randomized controlled trials on this topic.

Dr Nicole Todd

Dr Nicole Todd completed residency in Obstetrics and Gynecology at the University of British Columbia. Following residency, she completed a fellowship in Pediatric and Adolescent Gynecology at the University of Ottawa. Additionally, she received a Health Care Education Scholars Program Diploma from the Academy for Innovation in Medical Education at the University of Ottawa. She has joined the UBC Department of Obstetrics and Gynecology as a Clinical Associate Professor, and the medical staff at BC Women's Hospital, BC Children's Hospital and Vancouver General Hospital. She has opened several multi-disciplinary clinics including Hematology-Gynecology, BMT-Gynecology, Rapid Access IUD Clinic, Complex Contraception, and Transition Access Clinic for young women with complex medical conditions and/or barriers to accessing gynecological care.

Dr Sheila With

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

Suzie Maginley

Suzie Maginley is a PhD candidate at the Centre for Health Services and Policy Research in the School of Population and Public Health at UBC. She completed her MSc in population and public health at UBC in 2017. Her research interests include the use of large, linked, population-based administrative health datasets to investigate questions related to contraception and reproductive health services and policies in Canada. She is co-supervised by Drs Kim McGrail and Wendy Norman and her research is funded by the Women's Health Research Institute and the UBC Department of Family Practice.

Dr Unjali Malhotra

Dr Unjali Malhotra, CCFP Women's Health, FCFP NCMP, is a Certified Menopause Practitioner through the internationally accredited organization, The North American Menopause Society. Dr Unjali Malhotra is a Primary Care Physician with extensive training and expertise in Women's Health. She graduated from Family Medicine in Winnipeg, Manitoba, and went on to create and complete the Women's Health fellowship program at the University of Manitoba. She went on to work at the Bay Centre for Birth Control at the Women's College Hospital in Toronto. She moved to Vancouver in 2008 when she took the role as Medical Director of Options for Sexual Health British Columbia (2008 – 2013). She is affiliated with BC Women's Hospital and is a Clinical Assistant Professor at UBC where she is also Program Director of the UBC Women's Health Residency Program. She is currently the Women's Health Medical Director at the First Nations Health Authority. Her current research interests surround health advocacy and access in Women's Health. Her practice focuses on well-woman care including contraception (including IUD insertion), abnormal bleeding (endometrial biopsy), HPV-related issues, and menopause/perimenopause.

Hannah Varto

In Hannah's 14 years as a Nurse Practitioner she has focused her practice primarily on sexual reproductive health, adolescent medicine, forensic health care and women's health. For the past five years Hannah as led the development of the Forensic Nurse Practitioner role with the Embrace Clinic, a part of Fraser Health's Forensic Nursing Service. In addition to her expertise in providing post-violence care, Hannah also ensures access to reproductive choice in her community by offering IUD insertions, STI testing, Pap clinics and medical abortions for any woman needing these services. Hannah was one of the first NPs in BC to provide medical abortions and had mentored many providers to integrating this important service into their own practices.

Dr Andie Carson

Dr Andie Carson is a postdoctoral fellow at the Dalhousie University School of Nursing in Halifax, Nova Scotia. She received her PhD in Public Health Science from the University of Toronto in November 2019. Dr Carson's program of research applies critical social theories and qualitative methodologies to understand and improve individuals' experiences with reproductive health services in Canada. Her doctoral research took a feminist narrative approach to women's experiences discontinuing infertility treatment. As a postdoctoral fellow, she leads the research activities of the "CART Canadian Nurse Practitioner Mifepristone Implementation Study" under the supervision of Co-PI's Dr Wendy V. Norman and Dr Ruth Martin-Misener.

Dr Sarah Munro

Dr Sarah Munro is a qualitative health services researcher whose focus is knowledge translation and implementation science in women's health. Dr Munro completed her graduate studies at the University of British Columbia and a postdoctoral fellowship at the Dartmouth Institute for Health Policy and Clinical Practice. Dr Munro teaches and supervises in qualitative methods, mixed methods, knowledge translation, and implementation science. Her particular teaching interest is in developing capacity in patient-oriented knowledge translation and shared decision-making among graduate and clinical learners. Dr Munro's program of research focuses on investigating the factors that influence implementation of evidence-based innovations in women's health care. She leads integrated knowledge translation studies on implementation of shared decision-making tools for use in the childbearing year and best practices in family planning. Dr Munro also develops and tests tools that support effective patient-oriented knowledge translation, including decision aids and short documentaries.

Dr Laura Schummers

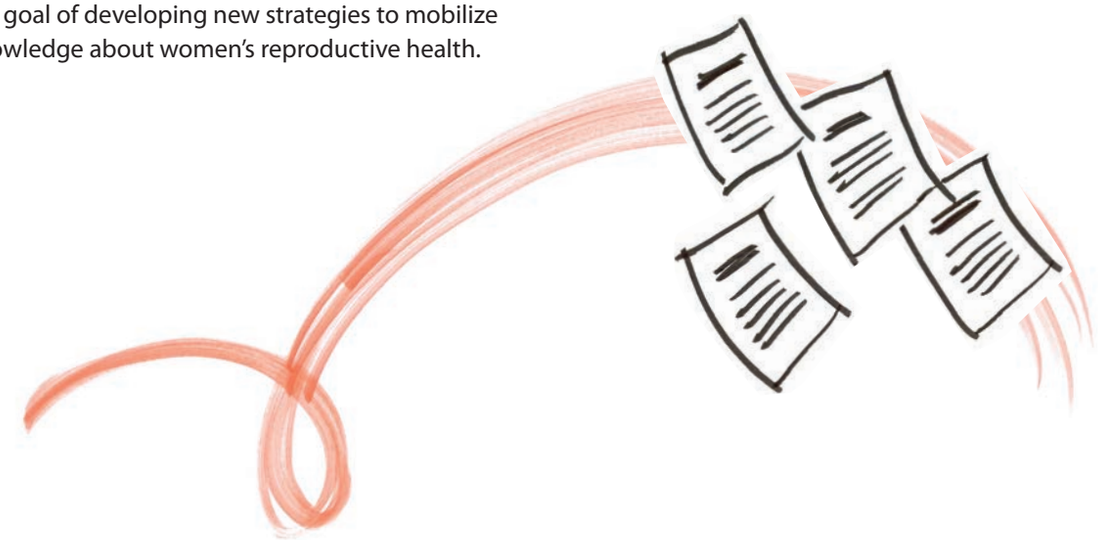
Dr Laura Schummers is a reproductive and perinatal epidemiologist. After completing her doctorate of science in epidemiology from the Harvard School of Public Health, Dr Schummers joined the Contraception and Abortion Research Team in the Department of Family Practice at UBC as a postdoctoral fellow. She holds a BC Ministry of Health-CIHR Health System Impact Fellowship and a Research Trainee award from the Michael Smith Foundation for Health Research. Dr Schummers' research uses large population-based administrative health databases to examine health services, policy, and clinical research questions related to women's reproductive and perinatal health.

Kate Wahl

Kate Wahl is a PhD candidate in the Department of Obstetrics and Gynecology at the University of British Columbia. Her work focuses on understanding and leveraging the factors that influence uptake of evidence-based interventions in clinical, organizational, or policy contexts. As a member of the Contraception and Abortion Research Team, she conducts qualitative research about how evidence is adopted into family planning care and policy, with the goal of developing new strategies to mobilize knowledge about women's reproductive health.

Nicole Pasquino

Nicole Pasquino is a Registered Nurse and the Clinical Practice Director at Options for Sexual Health. She is also the Faculty Lead for Sexual Health at BCIT. She practices at Options clinics and with the BC Women's Sexual Assault Service. She has been involved with RN certified practice at various policy levels since its initiation and has contributed to the development and revision of the CM & STI DSTs and co-led the Pelvic Exam DST creation. Her passion lies in patient-centered and trauma informed sexual health care, equitable access to all sexual health care and the elimination of gender-based violence against all people who identify as women and girls. Nicole's educational background includes undergrads in Health Science & Policy as well as Nursing and a Master's Degree in Health Studies and Leadership.



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