CONTRACEPTION AND ABORTION IN BC

Experience Guiding Research Guiding Care

7th BC Women's and CART Meeting

March 4, 2022

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

Acknowledgements

Acknowledgement of Unceded Territories

We acknowledge the ancestral and unceded homelands of the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh Úxwumixw (Squamish Nation), and səl̓ílwətaʔ (Tsleil-Waututh Nation) on which the meeting was hosted.

Sponsorship and Support

The 7th Contraception & Abortion in BC: Experience Guiding Research, Guiding Care Conference was made possible by the sponsorship and support of the following organizations:

- 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)
- Rural Coordination Centre of BC (RCCbc)
- Women's Health Research Institute (WHRI)

The conference was supported by a **Michael Smith Health Research BC** Convening and Collaborating Grant.

We thank the **trainees** who supported this event: Madeleine Ennis, Ali Fuchshuber, Zeba Khan, Kate Wahl, and Enav Zusman.

We also 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.

Organizing Committee

The conference would not have been possible without the diligent efforts of the following people:

Conference Co-Chairs

- Cheryl Davies, Chief Operating Officer, BC Women's Hospital and Health Centre
- Sarah Munro, Assistant Professor, Department of Obstetrics and Gynaecology, UBC

Committee

- Wendy Norman, Professor, Department of Family Practice, UBC; Director, CART
- Regina Renner, Clinical Associate Professor, Department of Obstetrics and Gynaecology, UBC
- Natasha Prodan-Bhalla, Chief Nursing Officer, BC Ministry of Health
- Erin Price Lindstrom, Manager of Women's, Maternal and Early Childhood Health, BC Ministry of Health
- Michelle Fortin, Executive Director, Options for Sexual Health
- Robert Finch, Executive Director, Perinatal Services BC
- Unjali Malhotra, Medical Director, Women's Health, First Nations Health Authority
- Astrid Cristofferson-Deb, Medical Director, BC Women's Population and Global Health
- Nicole Pasquino, Clinical Practice Director, Nursing, Options
- Brittany Bingham, Director of Indigenous Research, VCH Indigenous Health
- Daniele Behn-Smith, BC Deputy Provincial Health Officer

We thank **Fuselight Creative** for the graphic recordings and CART staff for their efforts: Ama Kyeremeh and Carly Rivers (meeting administration), Zeba Khan (drafting the proceedings), and Maple Lei (graphic design).

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Welcome

Welcome from Elders

Dr. Elder Roberta Price and Elder Glida Morgan

Dr. Elder Roberta Price of the Snuneymuxw and Cowichan Nations and Elder Glida Morgan of the Tla'amin Nation set the stage for today's meeting with an invitation to open our hearts and minds to new knowledge and teachings. Elder Glida shared a song, 'One voice, one people', and reminded us of the importance to come together in a good way. We shared a moment of silent reflection and were invited to stand in solidarity with those affected by the opioid crisis, recent weather events, and international political disturbances.

Welcome from CART, BC Women's Hospital, and Provincial Leaders

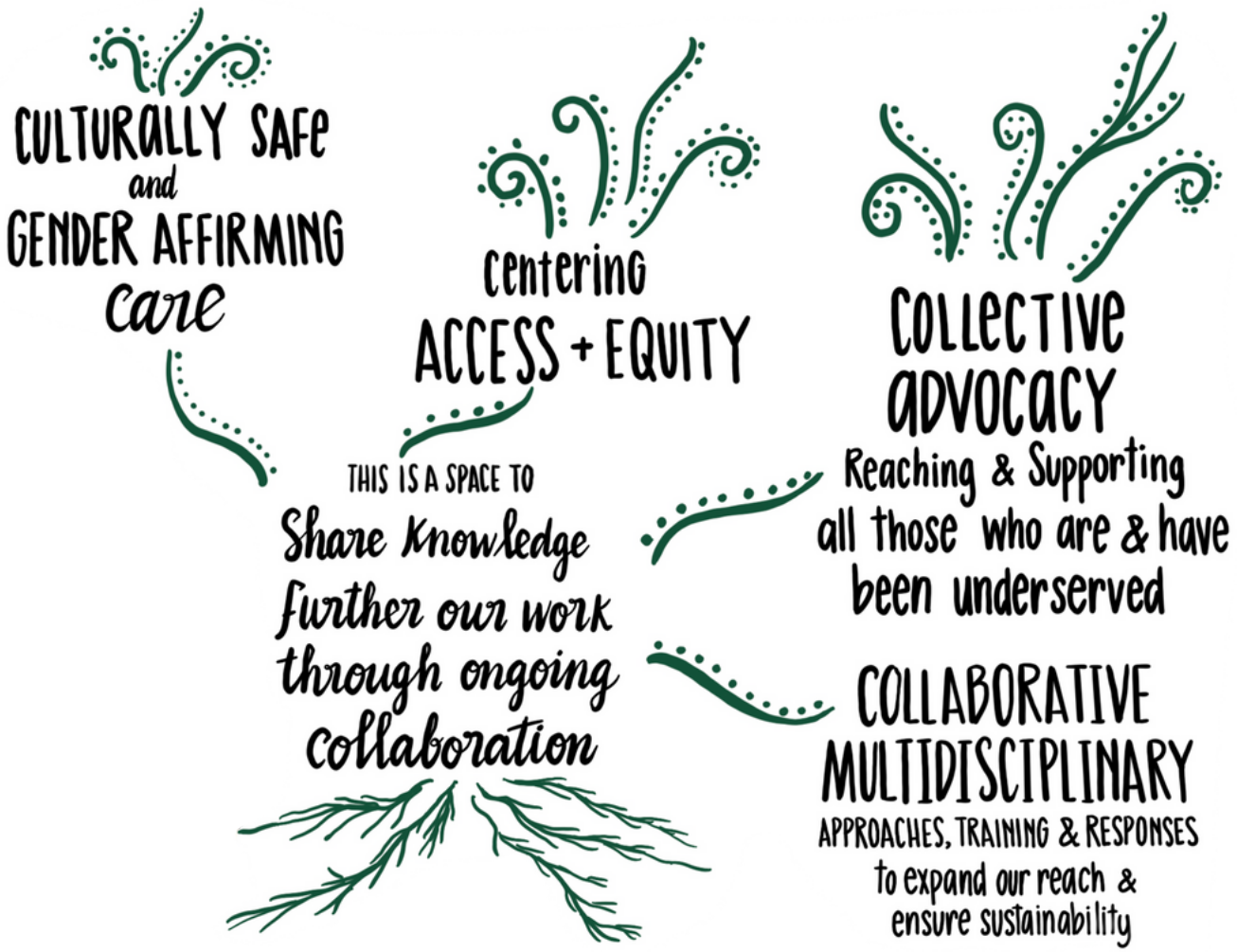
The meeting co-chairs welcomed attendees to the first virtual iteration of this bi-annual conference. The longstanding collaboration between the Contraception and Abortion Research Team, BC Women's Hospital, the BC Ministry of Health, and Options for Sexual Health helps to fulfil our collective responsibility of supporting reproductive rights and choice through engaged research.

Our collaboration enables us to bring people together bi-annually and have our work flourish and grow over time, ultimately improving the quality and quantity of reproductive health services for people in British Columbia.

Cheryl Davies observed that, by coming together, we share knowledge, strengths, and opportunities. Researchers in turn generate high-quality evidence to inform decision-making. This bi-annual meeting is a key forum for convening stakeholders across systems and sectors, to ensure experience guides research and, in turn, care.

Dr. Sarah Munro thanked everyone. She expressed her gratitude for CART Director, Dr. Wendy Norman, who was not able to join the meeting. She emphasized the need to focus on culturally safe and gender-affirming care, before providing an overview of the agenda and the breakout rooms.

The agenda, developed closely with the organizing committee members, is a representation of the strength and accomplishments of our research-practice-policy collaborations. Our shared goal of the meeting is to determine how we can improve equitable access to family planning services for all.


CULTURALLY SAFE
and
GENDER AFFIRMING
care
centering
ACCESS + EQUITY
COLLECTIVE
advocacy
Reaching & Supporting
all those who are & have
been underserved
THIS IS A SPACE TO
Share knowledge
further our work
through ongoing
collaboration
COLLABORATIVE
MULTIDISCIPLINARY
APPROACHES, TRAINING & RESPONSES
to expand our reach &
ensure sustainability

Attaining equitable access and expanding contraceptive options for all in BC

An update from the Ministry of Health

Erin Price Lindstrom, Manager, Women's, Maternal and Early Childhood Health, BC Ministry of Health

Erin Price Lindstrom provided updates from the Ministry of Health regarding their planned roll-out of free, universal contraception, as well as reflections about the subdermal contraceptive implant.

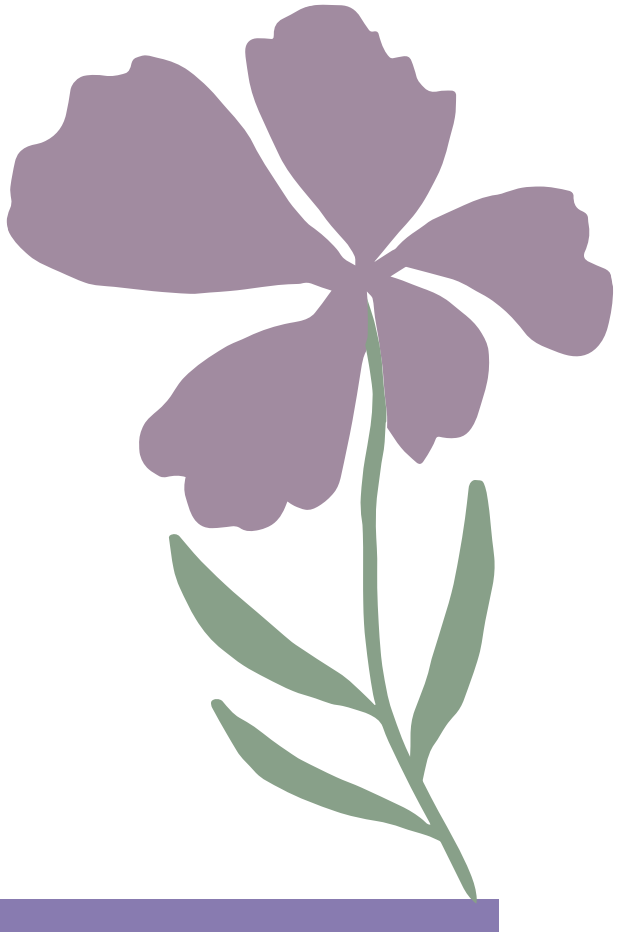
The healthcare system has a lot to learn from rural and remote communities; frontline perspectives inform the policy work within the Ministry of Health's Women's, Maternal, and Early Childhood Health portfolio.

The history of partnership between the Ministry and CART has led to a number of remarkable outputs including the launch of the Canadian Sexual Health survey, piloted in BC in 2014. This survey looked at pregnancy intentions and contraceptive needs and made a lasting impact on policy work, paving the way for federal commitments to develop and implement a national survey on sexual and reproductive health. Our collaboration also led to the evidence-based inclusion of mifepristone on the provincial formulary, to reduce cost barriers and facilitate equitable access to all abortion methods.

The 2020 commitment from the provincial government to provide free prescription contraception is a reflection of related advocacy and high-quality research. Since September, this connection between policy and research has been strengthened through PhD student and CART trainee Kate Wahl, who is a Health System Impact Fellow embedded in the policy team.

Finally, the Ministry shared its excitement for the subdermal contraceptive implant, which has been available since fall 2020, and highlighted it as an important expansion of choice for equity-deserving populations.

The roll-out of the **prescription contraception subsidy** for individuals in British Columbia is complex. The Ministry is taking due time to understand the various barriers and facilitators, including options around access points, with one being nurse-led clinics. The goal is to make this output equitable and responsive to diverse needs.



Strategies to support consent, culturally safe and trauma-informed care and access to contraception

Dr. Unjali Malhotra, Medical Director, Women's Health, First Nations Health Authority (FNHA)

Unjali Malhotra introduced an informed consent tool for contraceptive care, co-developed by FNHA, Senator Yvonne Boyer, and Perinatal Services BC with input from Indigenous leaders and community partners.

In BC, there was a Eugenic Sexual Sterilization Act in place for 40 years, until 1973, that disproportionately impacted Indigenous women. Stories of reproductive coercion continue to surface and Class Action lawsuits are underway. Joyce Esheqan, a 37-year-old Atikamekw woman who recorded and shared her experience of healthcare discrimination on social media, had also experienced coerced terminations.

This context points to the critical need for humility and allyship in providing culturally sensitive care to Indigenous clients. Malhotra shared, "We have heard the stories, now we need to move on to challenge the norms, and make meaningful changes based on the stories we have heard, even when it is uncomfortable."

Stories are being shared that demonstrate clients are not being asked the right questions about their contraceptive needs when trying to access contraception. The consent form supports culturally safe and trauma-informed contraceptive care. The consent form will take time for healthcare providers to implement. It includes questions that clients want asked.

Access the Informed Consent for Contraception Shared Decision Making Guide here:

https://www.fnha.ca/what-we-do/chief-medical-office/informed-consent-for-contraception

Audience discussion in plenary

Dr. Unjali Malhotra, Medical Director, Women's Health, First Nations Health Authority

Question 1

What does good contraception care look like to the clients and communities you work with?

Answer

The progress has been great. It is important to understand what “free” means. Making it physically and geographically free is important, however, people need to be able to get care at home, in their own community.

Question 2

As a provider, what do we do if our client's beliefs about contraception are not evidence-based?

Answer

Provide knowledge and find common ground. Seek first to understand, then to be understood.

Question 3

How and when can this [shared decision-making] happen in clinics?

Answer

The relationship is the most important part of the care we offer. Conversation is part of this care. Knowing where someone comes from and having a dialogue changes things and creates a safe space for the provider as well.

Question 4

Are there any thoughts on what policy is needed to support choice, for instance for people living in poverty?

Answer

The FNHA is researching a series on client rights. We're answering questions like, "During a pap, can I bring someone with me? Can I do the speculum myself?" These questions tell us that we need to go back to the basics of what people are asking for. As clinicians, we need to shift our practice standard to address the basic things that we have missed. The next step is to examine the legal aspects of care.

State of the Science: Contraception Practice Updates

Dr. Madeleine Ennis moderated this discussion with Dr. Renee Hall and CART trainees Ali Fuchshuber and Enav Zusman. They provided updates on the etonogestrel contraceptive implant, the nurse scope of practice, and the pharmacist scope of practice.

Etonogestrel Contraceptive Implant

Dr. Renee Hall, Clinical Associate Professor, Faculty of Medicine, The University of British Columbia

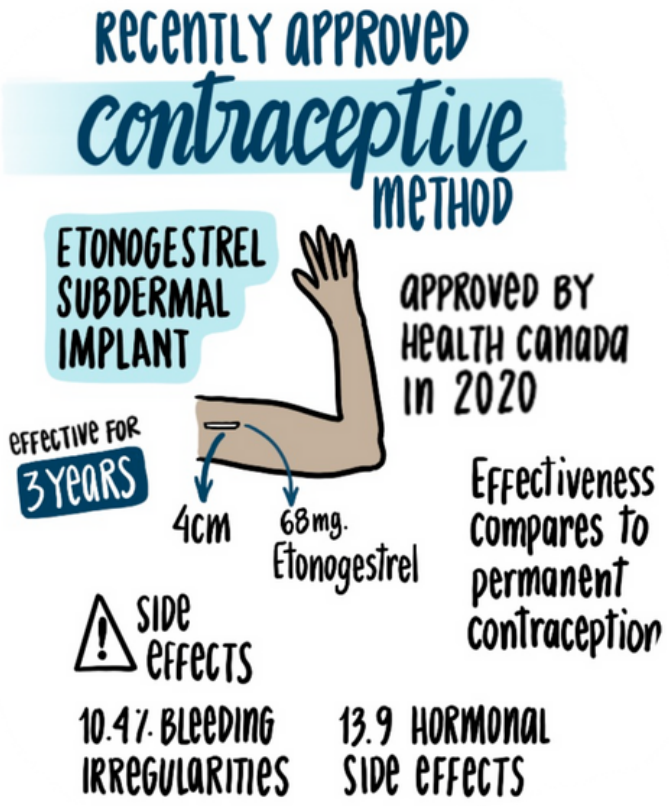
Renee Hall reviewed the risks and benefits of the etonogestrel contraceptive implant and discussed the inclusion of the etonogestrel contraceptive implant in routine contraceptive counselling. This contraceptive method was approved in Canada in May 2020. It is roughly the size of a matchstick and contains progestin only.

She highlighted that contraceptive counselling is about listening and asking, and the choice of a less effective option is not a failure on the part of the clinician. A key question to ask clients is, when do you want to become pregnant? If it's less than one year, Long-Acting Reversible Contraception (LARC) may still be an excellent contraceptoin option because return to fertility is quick (<7 days) with both the contraceptive implant and . The Canadian Pediatric Society endorses LARC as first line contraception methods for adolescents.

Who are the ideal clients for the implant? Individuals with a history of (intrauterine device) IUD expulsion, no local IUD inserters or failed insertions, uterine anomalies, history of sexual or medical trauma, gender diversity, or developmental delay may benefit from the non-uterine placement of the implant. It can also be used for individuals, such as those with thrombotic disorders (except lupus), who need a non-estrogen contraceptive option. The most common reasons for discontinuation of the implant are bleeding irregularities and hormonal side effects.

Dr. Hall discussed special cases, such as lactation, and how the implant is not known to impact milk or quantity, however the Academy of Breast-Feeding Medicine suggests delaying the insertion of the implant until breastfeeding has been established.

What are the best counselling practices for providing medical abortion and insertion of the implant at the same time? It can be a lot to provide both counselling as well as recommendation and insertion on the same day, but to do so, you ask your client the same questions that you would if the procedures were on separate days, and you pay extra attention to bleeding.



Nurses' Scope of Practice

Ali Fuchshuber, RN, MSc./MPH and CART Trainee

Ali Fuchshuber discussed the role that nurses play in contraceptive management in rural and remote locations, and the barriers that they face while administering contraceptives. She shared that it is important for nurses to be able to prescribe and suggested a possible solution: providing free prescription contraception at clinics, similar to what is available through sexually transmitted infection [STI] programming models.

Barriers that hinder nurses' abilities to administer contraceptives include:

- Lack of standardized competencies
- Lack of education for nurses providing contraception
- Pharmanet fee for user system that each clinic will have to pay to use.

Pharmacists' Scope of Practice

Enav Zusman, PhD Student and CART Trainee

Enav Zusman described pharmacists' expanded scope of practice and how they can support their patients' reproductive health. Pharmacists receive extensive reproductive health training. Licensed pharmacists are required to stay up-to-date on these areas of practice.

There are many strengths of expanding the scope of pharmacists' practice. Pharmacists are accessible and often have little to no wait-times which would enable people to have health questions answered promptly. This also also allows for same-day or next-day delivery of medications which can be billed directly.

Several areas of inquiry persist, including:

- How can we ensure medications work the way they are supposed to?
- What are the side effects? When should patients go to the emergency room?
- When (what time of day) should the medication be taken? How important is adherence?

There are other responsibilities that pharmacists could take on, including if there is a shortage of drugs, drug recall, vaccinations, and communication and documentation (i.e. following up with patients for refills, missed pills, etc.).

An expanded scope of practice for pharmacists should be explored in other provinces.

Improving access and integrated care for underserved populations

In this session, panelists discussed what 'good' contraception care looks like for underserved populations, and strategies for improving this care.

Panelists

- **Travis Salway,** Assistant Professor at Simon Fraser University
- **Miranda Kelly,** Director, Indigenous Women and Family Health, Indigenous Health, Vancouver Coastal Health
- **Keisha Charnley,** Indigenous Midwife, BC Women's Hospital + Health Centre
- **Olivia Louie,** Doula, Vancouver Coastal Health
- **Jessy Dame,** RN, Vancouver Coastal Health
- **Zeba Khan,** Research Assistant and Board Member for Options for Sexual Health

Moderator

- **Danette Jubinville**, PhD Student, Simon Fraser University; Strategic Lead for Doula Care, Vancouver Coastal Health

Moderator Question 1

What does good contraception care look like to the clients and communities you work with?

Responses

R1: We can imagine what it would feel like - we, Indigenous people, want to feel seen and heard, in the journey of walking alongside families, there isn't enough time and space for informed consent; more broadly in society, we need to bring sacredness back to sex and address the shame around it. We need education on our bodies, if we don't know who to speak about our bodies, how can we be empowered to speak openly with our providers?

R2: We don't know what it looks like because we haven't asked the right questions yet. You need to know how to navigate the system, what is covered versus what is not, and language is a barrier.

R3: There is a difference between connecting to a healthcare provider and connecting with healthcare providers. Connecting with is a form of protection.

R4: We should strive for safe, continuous access, with limited hoops, and as few barriers as possible. Problems arise when folks who identify outside of the binary are forced to conform to a binary gender code to access care.

R5: We should think about the words sovereignty and unceded which means never having given up our rights. For a lot of Indigenous folks and others who are not represented in mainstream healthcare, we know what we don't want, but we don't know what we want because it has never been offered to us. What is continuity of care? It needs to be familial, fun and empowering and connects us to our sovereignty.

R6: How can newcomers identify health care providers they trust in their community? There is an opportunity to loop in service care providers (e.g., settlement) to provide holistic sexual and reproductive healthcare and informational support to newcomers.


IT'S A PROCESS OF LEARNING & UNLEARNING
ongoing ITERATIVE conversations
3D CARE
GOIN DEEP
BEYOND THE SURFACE
TRUST
OPENNESS
HONESTY
ACCESSIBILITY
Reimagine the system
ONE SIZE DOES NOT FIT ALL
RECLAIMING THE SACREDNESS OF SEX/SEXUALITY
PRIORITIZE
sexual health
DISMANTLE COLONIAL STRUCTURES
PEAL BACK
THE BARRIERS
SYSTEMIC RACISM, SHAME.
GENDER BASED BINARY STRUCTURES
THEY ARE HARMFUL & RESTRICTIVE
COMPREHENSIVE EDUCATION & CARE
EXPANSIVE UNDERSTANDING OF FAMILY
REAWAKENING
OUR TRADITIONAL WAYS OF KNOWING & OFFERING CARE
CREATE ALTERNATIVE PATHWAYS
FOR THOSE WHO HAVE BEEN SYSTEMICALLY EXCLUDED & ERASED
Sovereignty
CONNECTION TO OURSELVES & LAND.
THIS WORK TOWARDS LIBERATION ISN'T JUST WORK.
IT IS THE LIVES WE LIVE.

Moderator Question 2

What are the strategies that providers can use to enhance cultural safety and access to care?

Responses

R1: We have been, in this region, focused in our delivery of healthcare for so long. We need to ask how we can connect people with similar experiences and cultures. We have a responsibility to support those connections (e.g. connections to providers in the community; have humility to step back and connect to others who are better placed to provide care). We could think about this as a 3 dimensional (3D) model of care.

R2: Healthcare providers need to have humility, an openness to feedback and the goal to create a kinder environment for clients.

R3: Education for healthcare providers is a problem. Sexual health is a specialty when it should not be. Sexual health should not be treated as a side portfolio.

R4: Contraception care should be a conversation, not a check box. There needs to be space for an ongoing and iterative conversation about contraception.

R5: Holistic care. We know that service users will not always have access to a primary care provider and may be struggling with their mental health. Providers need help to refer to mental health services. One-off cultural competence training has its limits - we need more of a feedback loop to prompt humility and self-reflection and encourage providers to ask “Where am I at in terms of creating an affirming environment?”

R6: Take inventory of what kind of provider you are and what you have to offer. Everyone comes into the world with a gift, and our job is to help them foster their gift and grow and witness that. We need providers that say, “I acknowledge that if I am not the best person for this then I can guide you to where/whomever that is."

R7: In some cases, certain kinds of contraception have been offered or pushed, but what might be most relevant to someone is not always discussed. Make the counselling conversation enjoyable. People show early on what they’re passionate about when you lay the options at their feet. There is an opportunity for peer-to-peer education as well.

Moderator Question 3

How does comprehensive sex education improve access to contraception?

Responses

R1: There is a new level of respect and understanding in younger people today who were raised in sex positive environments, and their strength and advocacy are very different. If we decrease discrimination, shame, and stigma in one care setting and patient population, it benefits all.

R2: My Grade 2 daughter has a “body science” workshop featuring words like uterus and vulva. I felt very proud - this generation has access to better education, and can fact check for themselves.

R3: In my mind, sex education requires ceremonies and culture. For Anishnaabe girls, this is a berry fest during which girls abstain from eating berries for a year. Relatives tempt girls with berries so that they learn to say no and how to take care of their own community even if they don't benefit by participating in berry picking.

R4: When we talk about majority, it is a statistical, systemic view to silence smaller groups. As the majority are cis-gender folks, we have a responsibility to create alternative pathways for folks who don't identify in that spectrum. TURF - trans-exclusionary radical feminism - is a problematic view because it goes against what we want.

Audience Question

Is there progress on clinician assumptions about gender and sexuality?

Responses

R1: We need accountabilities in place for measurable progress and one of the messages is to start with a more holistic, person-centred approach to care.

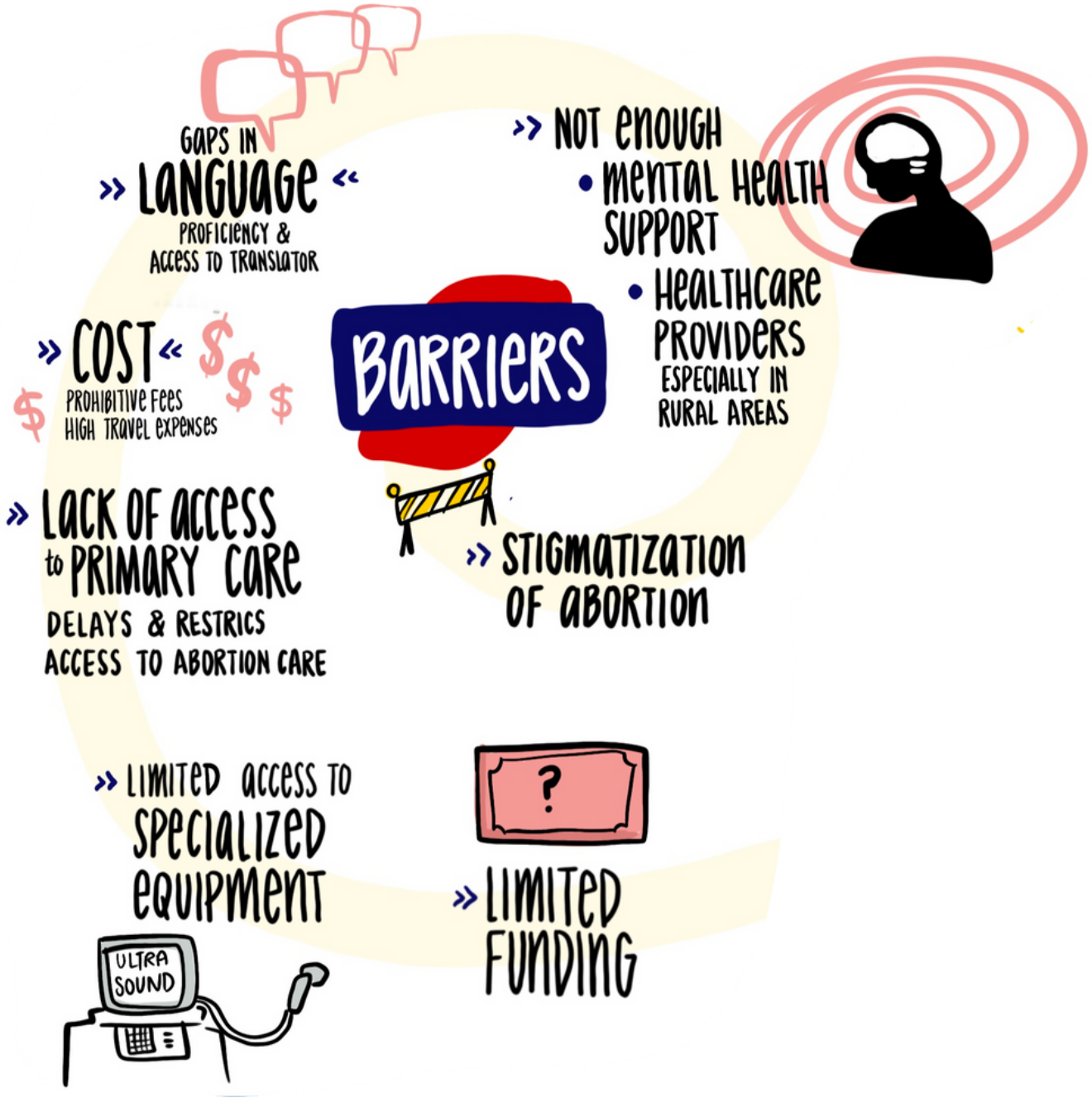
R2: This conversation happening at all is a sign of progress, but this doesn't always make its way into clinical practice. Our current system was designed to silence and separate people.

R3: An example of change is that there is a new antenatal record (2020), which now has a space for pronouns and expands the idea of family. In my practice, all clients are asked what their pronouns are at the start of the care relationship.

Final Remarks

R1: One barrier to the whole patient population is funding. During training 30 years ago, we were taught patient-centred care and you left the training with this vision. What becomes obvious is that the system of payment will penalize you for this kind of care. Billing has not changed in so long; it is hard to provide the care we want to provide in this model of the health system.

R2: Do we know how to speak about our bodies and address racism in healthcare? Bringing ceremony back has many teachings and honour for young women, including their moontime, across this country. We need to decolonize language as well. It's important to bring back healthy sex, lifestyles, and teachings right across the medicine wheel.


GAPS IN
» LANGUAGE «
PROFICIENCY &
ACCESS TO TRANSLATOR
» NOT ENOUGH
• MENTAL HEALTH SUPPORT
• HEALTHCARE PROVIDERS
ESPECIALLY IN RURAL AREAS
» COST «
PROHIBITIVE FEES
HIGH TRAVEL EXPENSES
BARRIERS
» LACK OF ACCESS to PRIMARY CARE
DELAYS & RESTRICS
ACCESS TO ABORTION CARE
» STIGMATIZATION OF ABORTION
» LIMITED ACCESS TO SPECIALIZED EQUIPMENT
ULTRA SOUND
?
» LIMITED FUNDING

Options for Sexual Health: Our Journey to Maintain Access

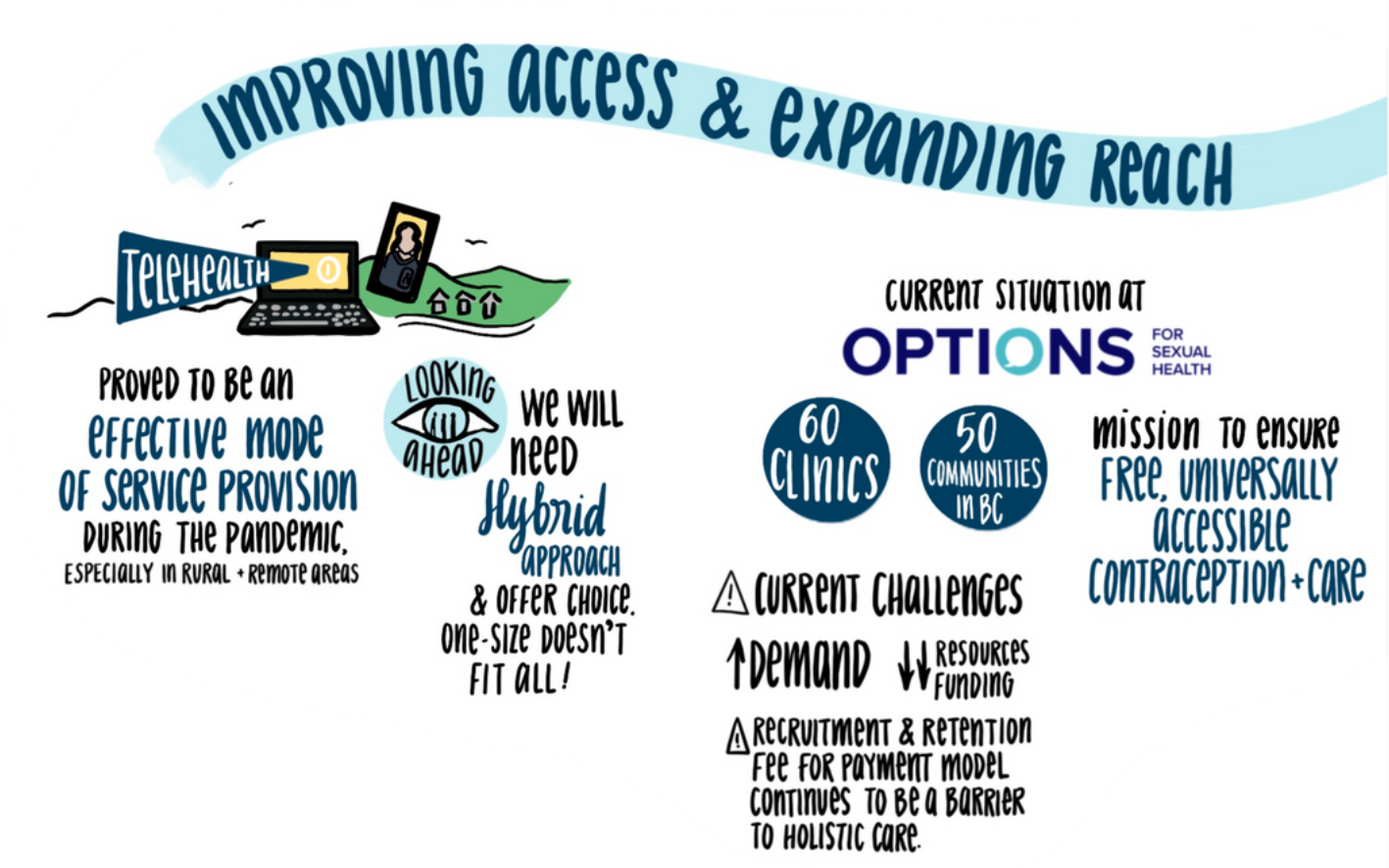
Dr. Blanka Jurenka, Medical Director, Options for Sexual Health

Dr. Blanka Jurenka discussed the challenges and opportunities faced by Options during the pandemic.

Options for Sexual Health launched a virtual clinic, enabled by Ministry funding. It was possible to bill fee for service codes for telehealth appointments (1900 patients in 2020), which supported individuals in areas without easy access to patient-centred reproductive care.

Options also pivoted to online learning, offering the Sexual Health Education Certification program entirely online.

Options has been resilient in the face of challenges with the retention of nurses and, in some cases, clinic closures. Looking forward Options will continue to provide critical, evidence-based services for contraception and abortion care.



Discussion Groups: Contraception

Meeting attendees were divided into smaller, virtual breakout rooms to discuss the following question:

What are the contraception access gaps for underserved populations and their healthcare providers?

Attendees chose their breakout group based on their preferred topic of discussion related to contraception access. Each topic had 2-3 break out groups, allowing participants to engage in a rich discussion. Each breakout room discussed one of the following topics and their discussions are summarized in the following pages.

1. Virtual / telehealth contraception care

- Several advantages of virtual/telehealth contraception care were discussed, including the ability to make contraception care accessible for patients who are unable to travel.

- Many opportunities to strengthen virtual/telehealth contraception care were also identified. Underserved populations may not be registered in family medicine clinics. Patients report difficulties accessing care in their own communities and Options identifies the need for the referral process to be strengthened in rural communities. We need a coordinated, centralized referral system for contraception care in BC.

- Scope of practice for nurses is a barrier. A tiered approach to allow every provider to work at the top to their scope could increase access.

- The ongoing problems of privacy and assuring the absence of coercion in telemedicine were identified. Diverse people face a lot of discrimination in some communities. Telemedicine could be used to provide non-judgmental counselling.

- Telemedicine abortion has its limits: for example, instances where patients cannot reliably report last menstrual period (LMP) or access mifepristone at their pharmacy render in-person appointment(s) necessary.

- There are also challenges around technology and providers not having the opportunity to demonstrate or explain products over the phone.

2. Contraception consent form

- Indigenous clients who access abortion are often women that have lost reproductive choice and have endured violence. Supporting Indigenous clients can be complex in this context and also because of stigma around abortion. Teachings from Indigenous Peoples can bring back respect to Indigenous women and support their ability to make their own choices. Currently, there is minimal trust in the system and there is a need for unconditional love and support to help women understand that their body is their own and that they can ask questions.

- On the topic of the provider-client relationship, colonial practices are still observed.

- We do not want clients to feel pressured into taking contraception following abortion.

- It is important to build trust between practitioners and patients. Acknowledging that silence is okay and waiting for the client to speak is very powerful. There are no boundaries when supporting people.

- If clients do not know where to start, asking them about the women in their lives and their contraception can open up the idea of beliefs and give the healthcare provider an idea of what could be acceptable.

- Informed consent is to ensure people are accessing the care that they want. Written consent is necessary. This is crucial when you have people coming forward who will not access gynaecological care because of fear of coerced sterilization.

- Options for Sexual Health offers formal training for physicians that affirms that they will provide sex-positive and pro-choice care.

3. Reaching underserved populations

- Challenges were acknowledged with a fee-for-service system, which restricts the fee that can be received for contraceptive counselling.

- The financial costs of providing care in a trauma-informed and culturally safe way are incredibly high. Contracts and policies reflect the government wanting to decolonize practices, however, there is no financial support to access the training and resources needed.

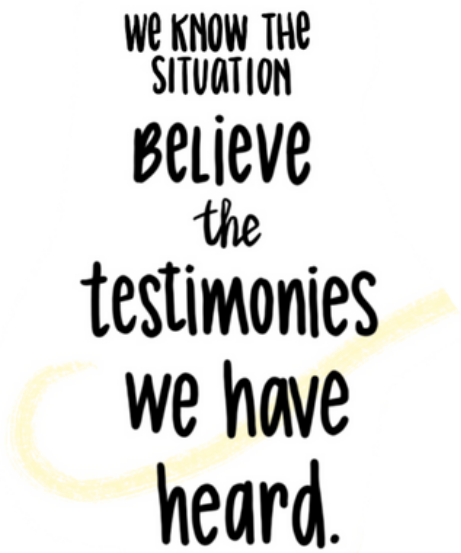
- When thinking about opportunities for improvement, participants suggested that finding ways to support racialized and Indigenous nurses, and creating intentional partnerships with 2SLGBTQIA+ folks can help organizations or clinics to be recognized as a safe place for contraception access.

- At the same time, it is also important to ensure that underserved populations are at the table including the considerations of people living in rural and remote communities.

- The pre-exposure prophylaxis (PREP) program model was discussed as an example of a successful program. The availability and training and uptake of PREP for predominately gay men rolled out quickly. People took it on. It is free. It would be helpful to understand why this program was so successful. Thinking about a number of folks who can get pregnant in this province, and the number of unplanned pregnancies - why would contraceptive care not be addressed similarly?

- It is important to promote these services through the usage of graphics (such as Indigenous arts) to reach the target populations.

- There is an interest in finding more ways to stay connected to the community of practice.



4. Rural contraceptive care

- There are challenges for learners and providers new to contraceptive care in rural areas to find hands-on learning opportunities where they live and practice. The University of British Columbia Division of Continuing Professional Development (UBC CPD) is an effective remote alternative.

- Specialists' wait times for clients requiring LARC and permanent contraception vary across the province but the general consensus is that they are too long. Some pockets of the province experience little to no wait times for the same services.

- Free contraception can be provided within 2 weeks following an abortion by the same provider via the SMART program.

- The British Columbia College of Nurses and Midwives (BCCNM) is readying itself to support nurse provision of contraception when free, universal access is rolled out next year.

- There is a need to improve how comprehensive transgender care is provided, and who the experts are that can be contacted to gain access to resources and additional support.

- Available training often focuses on basic skills for general gender-affirming and trauma-informed care. There is a need for **more guidance on gender-affirming contraceptive care and sexual health care**. The Trans Care BC 3-part series, in particular 2 and 3, and their clinical practice guidelines is a potential resource

5. Pharmacist skills and scope of practice

- Discussion explored pharmacist scope of practice in prescribing contraception, the scope of practice in other countries like Australia, and prescribing emergency contraceptives.
- Some issues patients could face when going to pharmacists that dispense contraceptives include prejudice, different opinions on the topic, community resistance, and the pharmacists' refusal to prescribe/dispense contraceptives.
- Potential solutions to the challenges above are listed. For example, pharmacists should have the ability to refuse to prescribe, however, they would be responsible for arranging alternative care for the patient. There is a strong belief that judgment from pharmacists would be considered unethical.
- Participants also discussed policies regarding prescribers' referrals to pharmacies, UBC's interprofessional education, team-based care, and cultural safety.
- When discussing future opportunities and the road map, it is important to ask: What can we expect to see in the future? Will implants be administered at pharmacies? What policy strategies need to be in place?

6. Nursing skills and scope of practice

- Topics discussed included expansion of nurses' scope of practice to include prescribing long acting reversible contraceptive methods and integrating a holistic approach to contraceptive counselling that would include discussing mental health and well-being with clients.
- Expanding the scope of practice will strongly benefit the Northern regions, and reduce barriers to contraceptive care.
- In order for nurses to expand their scope, it is necessary to create opportunities for nurses to receive enhanced training that would allow them to provide more effective contraceptive counselling.
- Discussion also focused on opportunities for certified nurses to come together in learning and practice to address the opioid crisis, mental health, abortion, and gender inclusive care.
- Having experienced nurses support the growth and training of newer nurses is crucial, as new professionals in the field rely heavily on the expertise of established clinicians.
- Attendees discussed a perception that practitioners in bigger cities like Vancouver are more connected and have more access to other practitioners, which helps to provide clients with comprehensive care.
- Virtual care has improved access in general. However, contraceptive care is still difficult for youth to access and there are issues about being able to provide private and safe access to contraception for youth when they access care virtually.

7. Midwives' skills and scope of practice

- Attendees discussed the important role that registered midwives currently play for contraception care in BC. Clients can feel very comfortable discussing contraception options with midwives. This is not only for clients seeking postpartum contraception, but also for counselling and support provided to members of communities more broadly.

- Trust and care can be developed between midwives and clients, which is a unique area for midwives and an area for growth.

- There is an excitement about the merging of the College of Nurses and Midwives and a sense of allyship.

- Lack of remuneration options outside a course of care model creates another barrier to the midwife's role in contraception. This results in hesitancy for midwives to engage with contraception care on a larger scale.

- Midwifery regulation makes the scope of practice restrictive. There is plenty of opportunity for that role to increase.

- COVID-19 has slowed down reforms to what is in the scope of practice for midwives. Additionally, returning to practice has been difficult with COVID. Midwives with children are facing an especially large challenge with this right now as there are less childcare services accessible post pandemic.

- Improving access to rural and remote areas could be helped through enhanced scope of practice. There are roughly 400 practicing midwives who could contribute to rural access.

Access to Abortion for Indigenous Clients

Dr. Sarah Munro, University of British Columbia
Danette Jubinville, Simon Fraser University

Sarah Munro and Danette Jubinville discussed the launch of a community-led project: **Improving access to family planning services for Indigenous peoples through storytelling (The STORY Project)**.

This study aims to use storytelling approaches to understand Indigenous people's experiences in accessing family planning care in Canada. Miranda Kelly, Unjali Malhotra, Sarah Munro, and Danette Jubinville are co-leads of this project.

Danette Jubinville shared that the community-led approach also includes a decolonizing and feminist approach to research, focusing on Indigenous women, and Two-Spirit people. It also integrates a Two-Eye Seeing Approach, bridging Indigenous and non-Indigenous ways of knowing.

Phase 1 of the project will focus on kinship and collaboration, supported by an advisory circle of Matriarchs and Knowledge Keepers. Phase 2 will focus on gathering data from Indigenous people who have accessed family planning care in Canada and healthcare providers. Phase 3 will be centred around knowledge translation.

Sarah Munro highlighted the collaboration with the government to remove some of the barriers and shared that the next step is to partner with clients. This project also has a strong capacity-building piece, providing opportunities for new trainees.

Dr. Renée Monchalin, Assistant Professor, School of Public Health and Social Policy, University of Victoria

Dr. Renée Monchalin discussed a pilot study, which investigated access to abortion services for Indigenous Peoples in Canada.

This pilot study was funded by a grant from the University of Victoria. She shared that the advisory committee for this study included members from the Abortion Support Services Atlantic, ekwi7tl doula collective, Northern Health and more.

Participants of this study included self-identified Indigenous people, 19+ years of age, who have accessed or tried to access abortion care in Canada. Renée Monchalin emphasized that there was a significant gap in our understanding of how abortion care is accessed by Indigenous clients, and there is a lot of taboo and stigma surrounding abortion care in Indigenous communities. She discovered great interest from people wanting to participate. Research participants were diverse (n=15), representing 9 provinces and territories.

She shared key results from the study, which found that Indigenous clients had to travel from rural to urban locations to access abortions, which took place anywhere between 5-10 years prior to the interview. Indigenous clients reported poor experiences with accessing services and feared that religion or the Church would be a strong influence on the care received.

Participants from her study shared that they experienced judgement from healthcare providers and noticed that non-Indigenous clients were receiving better care. Participants suggested that Indigenous nurses and healthcare providers could make a difference, but the healthcare provider's personal beliefs were still a concern. Indigenous culture recognizes pregnant people's self-determination for contraception and abortion choices.

Renée Monchalin also shared that there is a need for incorporating cultural safety in abortion service access, as well as improving access to abortion doulas. Incorporating culturally safe care may include smudging, having an Elder/ Knowledge Keeper to speak to afterwards, and/or having the option to bury the fetus/placenta following an abortion or miscarriage, and incorporating Indigenous medicinal knowledge in the process.

Abortion Practice Updates

Telemedicine

Regina Renner, Clinical Associate Professor, Department of Obstetrics and Gynaecology, UBC

Dr. Regina Renner described the use of telemedicine in abortion care and shared the results of a 2019 study. She explained that having fee codes for telemedicine will further increase access to telemedicine. She discussed a low-touch protocol for testing, which includes:

- Hybrid models: triaging patients based on risk factors.
- If patients are eligible for the no-test method, the provider provides instructions or arranges for the prescription to be mailed.

She shared that the introduction of mifepristone and associated guidelines led to changes such as:

- The majority of abortion providers are now family physicians
- Rejuvenation of workforce
- Increase in first-trimester medical abortion provision
- Decreased rural/urban disparities
- The moderate use of telemedicine

Abortion Emerging Best Practices

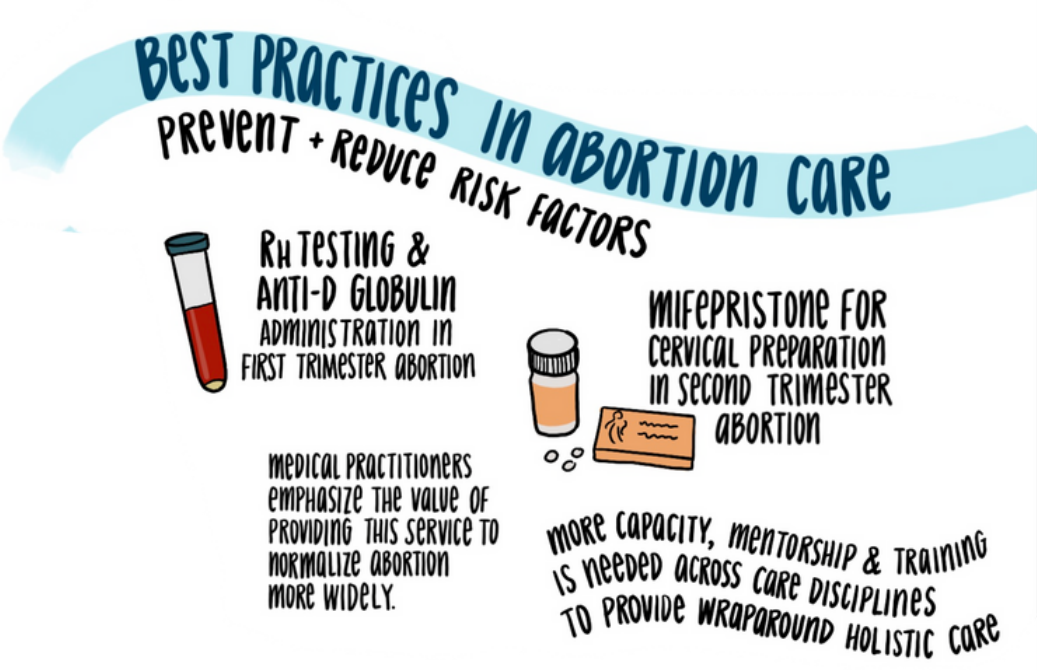
Pallavi Sriram, Fellow, Department of Obstetrics and Gynaecology, UBC

Dr. Pallavi Sriram discussed the emerging practices in abortion care using mifepristone in second trimester. She reviewed the evidence for Rhesus (Rh) testing and anti-D immune globulin administration in first trimester abortion and discussed the implementation of mifepristone for cervical preparation in second trimester abortion.

The National Abortion Federation (NAF) developed a policy on forgoing Rh testing for people who are Rh unknown under 56 days of the last pregnancy. The next step is to implement this policy at the BC Women's Abortion Clinic (CARE program) located at BC Women's Hospital.

Dr. Sriram discussed the steps involved in cervical preparation for mifepristone use in the second trimester, which include:

- Mechanical dilation with graduated rigid dilators
- Preoperative osmotic dilators
- Preoperative ripening agents



These steps reduce the risk of cervical laceration in second-trimester surgical abortion. Dr. Sriram reviewed the protocol for second-trimester cervical ripening prior to mifepristone, which required three visits to the clinic.

A quality improvement project at the CARE program is currently in progress, where clients are introduced to mifepristone on day one and surgical abortion on day two, reducing the cervical preparation time from two days to one day. The protocol has since been revised to address the cervical lacerations that were observed with mifepristone.

Clients who do not have these risk factors can safely use mifepristone for cervical preparation.

Canadian Abortion Providers Survey (CAPS) workforce results in BC

Madeleine Ennis, PhD, Postdoctoral Fellow, UBC

Madeleine Ennis discussed the results from the 2019 national Canadian abortion provider workforce survey, with a focus on data from BC. She also discussed the changes that have occurred in the Canadian abortion provider workforce in the last decade.

In BC, 57.5% of participants responded that they had less than 5 years of experience with abortion. BC was the only region that had more rural than urban respondents. Of respondents, 92.7% offered first-trimester abortion and less than 13% offered second-trimester abortions in rural areas.

The 2019 survey also identified that despite rapid growth of the workforce there remains opportunity to improve access in rural communities.

To learn more about this survey, read this selection of the team's articles:

Abortion services and providers in Canada in 2019: results of a national survey
www.ncbi.nlm.nih.gov/pmc/articles/PMC9578753/

Second- and Third-Trimester Medical Abortion Providers and Services in 2019: Results From the Canadian Abortion Provider Survey
https://pubmed.ncbi.nlm.nih.gov/35183788/

Telemedicine for First-Trimester Medical Abortion in Canada: Results of a 2019 Survey
https://pubmed.ncbi.nlm.nih.gov/36126299/

State of the Science: Mifepristone in Canada since 2017

Kim McGrail, Associate Professor, School of Population and Public Health, UBC

How did the removal of restrictive measures in 2017 impact abortion outcomes? Kim McGrail shared results of the Mifepristone Outcomes Study, which investigated this question and described safety-related outcomes of abortion care in Canada before and after the removal of federal restrictions.

Analysis of linked administrative data from Ontario allowed researchers to answer this question, using an interrupted time-series design. The key finding from this study was that, following the removal of restrictions, the proportion of medical abortions increased to account to 30-40% of all abortions in Ontario. Complications with mifepristone-induced abortions were low. The evidence provided by this study helped inform the FDA's decision to remove such restrictions in the US.

To learn more about this study, read the team's article in the New England Journal of Medicine:

Abortion Safety and Use with Normally Prescribed Mifepristone in Canada
https://pubmed.ncbi.nlm.nih.gov/34879191/

Rapid Fire Research Updates

Impact of COVID-19 on access to abortion care

Madeleine Ennis, PhD, Postdoctoral Fellow, UBC

During the early months of the COVID-19 pandemic, the Society of Obstetricians and Gynaecologists of Canada (SOGC) created a guideline to support abortion care in Canada. Madeleine Ennis reported on results of a mixed methods study (qualitative and quantitative surveys) that explored experiences of care providers who offered abortion care in the context of this new best practice guideline.

Results of the study indicated that participants felt abortion care had to be maintained during the pandemic. Few respondents reported short-lasting clinic closures. Some perceived they provided improved access to abortion care, through a switch to telemedicine.

Many respondents reported an increase in provision of medical abortion, compared to surgical abortion. Among respondents, 16% provided telemedicine services prior to the pandemic but 89% began to provide telemedicine services after. Participants observed a decrease in provision of ultrasounds, Rh testing, and Beta HCG testing. They reported an increase in the gestational age (GA) limit for abortion in some clinics. Challenges reported included increased costs of COVID-19 infection prevention, staffing shortages, and billing changes.

The pandemic has been a catalyst in Canada for increasing low-touch abortion care. Madeleine Ennis shared a quote from a study respondent: “I plan to continue to provide telemedicine services due to the success I have had and the positive feedback received from my patients.”

To learn more about this study, read the team's article in the journal Family Practice.

The Perspective of Canadian Health Care Professionals on Abortion Service during the COVID-19 Pandemic
https://pubmed.ncbi.nlm.nih.gov/34448482/

Mifepristone Provision by Nurse Practitioners (NPs)

Andrea Carson, PhD, Health Outcomes Scientist, Nova Scotia Health Authority

Andrea Carson described key results of the Nurse Practitioners-Mifepristone Study. There are 6600 nurse practitioners working in various settings across Canada, including community health and sexual and reproductive health (SRH) clinics. In the study, researchers interviewed 40 healthcare providers and surveyed 181 nurse practitioners. There was representations from all provinces and territories. Key facilitators identified included the importance of mentorship to support provision using mifepristone. For more on this study, please read the following publications:

Nurse practitioners on 'the leading edge' of medication abortion care
https://pubmed.ncbi.nlm.nih.gov/36369652/

Barriers and enablers to nurse practitioner implementation of medication abortion in Canada
https://pubmed.ncbi.nlm.nih.gov/36701296/

Abortion for incarcerated people

Martha Paynter, RN, PhD, Dalhousie University

Access to abortion for incarcerated people is under-researched. In this rapid-fire research update, Martha Paynter described the protocol for a study, which will investigate the access to abortion barriers for incarcerated people. A disproportionate number of incarcerated people are Indigenous, Black, and lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual (LGBTQ+.) This study will be the first in Canada to engage patients, care providers, and staff to investigate this topic.

She shared the steps in the study protocol. First she aims to synthesize literature and Canadian prison policies regarding abortion care.

Next, she will conduct structured qualitative interviews to understand the abortion access experiences of people who have experienced incarceration in BC,

Questions will explore how incarcerated women receive information about pregnancy options, pathways to seeking care, care experiences, unmet needs, and recommendations for patient-centred care. She will also interview care providers and prison staff.

This study has the potential to improve access to appropriate reproductive health services for incarcerated people seeking abortion care. The novel approach will be valuable for examining other areas of healthcare delivery with incarcerated people and set the stage for Canada-wide investigation of abortion access for incarcerated people.

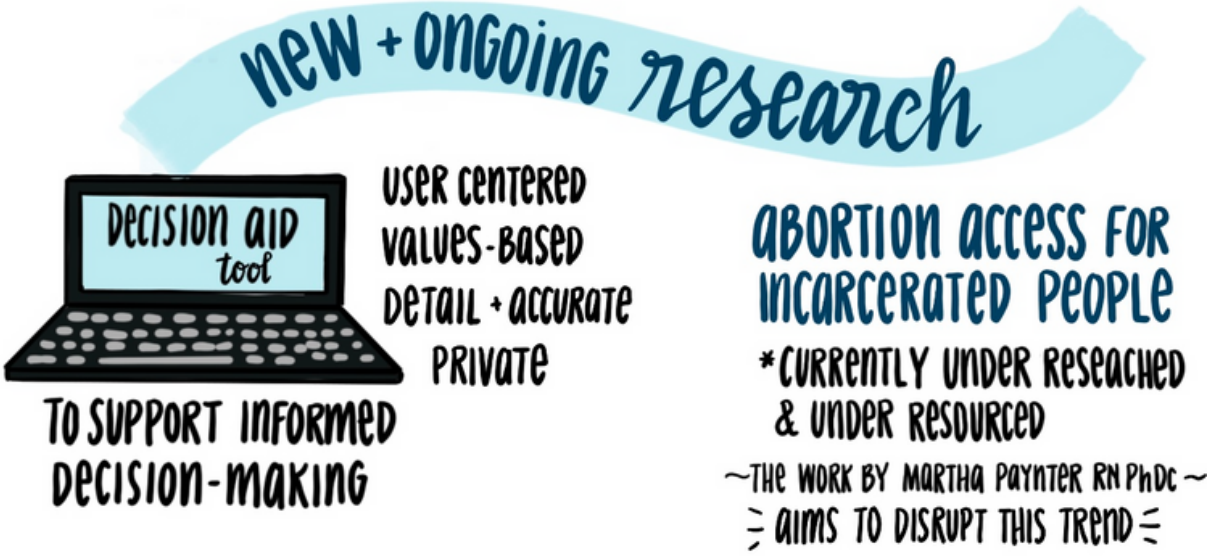
Method of abortion – a decision aid to support patient choice

Kate Wahl, MSc, PhD Student
Sarah Munro, PhD

CART researchers have developed a patient decision aid that will support people seeking abortion care. Kate Wahl described the development process and how it can be used to improve care pathways.

The development of the patient decision aid followed 3 phases – prototyping, pilot testing of a paper-based version, and pilot testing of an online version. The study had a user-centred design method. It involved members of the public and abortion providers in the design process. The content of the patient decision aid was based on SOGC best practice guidelines and review from an expert panel.

This tool is being tested in a randomized control trial led by Dr. Melissa Brooks at Dalhousie University. The trial will examine whether the patient decision aid affects decision quality and satisfaction, and the results will be shared at the next meeting.



Questions and Discussion

Moderator
Dr. Astrid Christofferson-Deb, BC Children's Hospital Medical Director, Population and Global Health, BC Women's Hospital and Health Centre

Question 1

How is the quality of care met through nurse practitioners and telemedicine?

Responses

R1: Patient perspective information on telemedicine in Canada is not available yet. Internationally, we know that telemedicine makes services accessible but people may still need in-person care. A hybrid model of care may be ideal.

R2: Patient privacy and accessibility to technology could be issues. It is critical to allow patient choice. Telemedicine for patients whose first language is not English or French is a challenge where a three-way phone call with a translator may be necessary.

Question 2

Can we advance access to abortion through midwifery?

Responses

R1: International literature is available on safety around midwives' scope of practice for contraception and abortion care.

R2: One of the largest issues is that when people are choosing to have an abortion, midwives are not included in the care pathway. It is important to explore a framework where midwives are involved in care.

Regional Group Breakout Discussions

Fraser Health

- Expanding pharmacists' scope of practice in the Fraser Health region to allow pharmacists to prescribe contraception has the potential to increase access in smaller communities.
- It is important for clinicians to provide comprehensive care wherever possible. It makes a difference to patients.
- CART could support knowledge translation by synthesizing evidence on pharmacist prescribing and sharing that knowledge with provincial stakeholders.

Interior Health

- Creating a safe place for patients is vital for quality care. Some examples of creating safe spaces for Indigenous clients include ensuring they have access to Elder support and/or matriarchs and having a supportive attitude
- What does good abortion care look like? Accessible, judgment-free, good follow-up, includes mental health and physical recovery, clients do not feel pressured to take contraceptives, informed consent, and respect client's autonomy.
- Options for Sexual Health shared that the most difficult part for clients is knowing when to come to the Options clinics. Clinicians do not always know to refer patients to Options, so most people hear about it through word of mouth.
- There are plenty of barriers to accessibility: having limited access to culturally safe services, physical barriers and travel needed to get services, as well as the cost associated with that travel, time off work, lack of transportation, resistance from a healthcare provider and/or other members of the healthcare team.

Island Health

- Where are services available across the region? Nanaimo provides a full range of abortion care; Campbell River serves the north of the Island; Port Hardy has access to first-trimester medical abortion. However there is a need to offer improved access to care, for instance surgical services in ambulatory care across the region.

- There is importance of providing care close to where patients live to minimize travel. This is an especially important consideration for LARC, as it can be difficult for clients to discontinue if they live in remote regions.

- Urgent and primary care centres are often not recognized as an access point for LARC and abortion by Island Health.

- On the topic of financial barriers, some First Nations clients may have financial support from their Band Council to pay for travel and housing, while others do not. There is an opportunity to bridge funding baps, for instance through abortion funds.

- There are challenges around referrals. If abortion providers were to advertise their services this would increase referrals; however, there is a concern about harassment.

Northern Health

- What are the opportunities to involve midwives in family planning care? At present, abortion provision is not within midwifery scope of practice, while postpartum contraception is.

- Access to surgical abortion in the northwest cluster in BC is limited to Prince George (one exception is a provider in Haida Gwaii), where it is available up to 14 weeks gestational age. After that, clients have to travel to Vancouver. There is limited interest in Prince George to expand abortion services beyond 14 weeks.

- There are challenges in identifying abortion providers in the north. There is heavy reliance on the CARE program for referral, which protects provider information out of safety concerns.

- Sex Sense, operated by Options, also keeps a list of abortion providers. Providers are encouraged to call and register themselves.

- In the north, challenges to access also include not having Options clinics in smaller communities, staff shortages during holidays, and not having a primary care provider. Improving the collaboration between nurses, family physicians and social workers can help overcome that.

- The Northern Health bus as an opportunity to make abortion care accessible.

Provincial Health Services Authority

- There is a lack of data available on where people can access 2nd-trimester abortion. It is important to work with partners to address data gaps and build a responsive health system that provides timely access.

- Young people are often afraid to seek family planning care and lack information on the logistics of where and when to go. Attendees shared that they have noticed a demographic shift since the pandemic began with an increase in clients who are international students.

- It is important to dismantle the perception that losing a child through abortion is different from losing a child through stillbirth. Some abortions happen in wanted pregnancies, too.

- There is potential to reduce the shame attached to abortion. When talking about abortion, listeners must listen with an open heart and kindness.

- There is not enough support for emotional or spiritual needs before and after abortion, in particular for Indigenous clients. There is an opportunity to create an Aunties group to call upon, comprising people of the same heritage to provide support for those in need.

Vancouver Coastal Health

- Interpreter services are necessary for supporting clients who do not speak English or French as their first language. Interpreter services cost upwards of $200 per hour, and if the client does not show up for the appointment, the interpreter fee must be paid by the provider.

- Billing issues exist when providing abortion care, including for clients that reside in the Fraser Health region but access surgical abortion in other regions.

- It is important to consider history of sexual trauma and sexual violence for the client seeking abortion care. If a client is referred from one place to another, it is important to ensure that the client does not have to re-share their story. Similarly, it is important to consider what is shared with partners when following up with clients.


EXPLORE THE POSSIBILITY OF ESTABLISHING A
PROVINCE-WIDE 24/7 SUPPORT TEAM
TO ENSURE CONTINUITY OF CARE
FUND + SUPPORT
KNOWLEDGE TRANSLATION INITIATIVES
UPDATE EXISTING RESOURCES ON AN ONGOING BASIS
Did you Know?
INFO!
TRUE, CONSISTENT MULTI-DISCIPLINARY COLLABORATIONS
OPPORTUNITIES
ONGOING ANALYSIS
INTERSECTIONAL DATA TO UNDERSTAND NEEDS & BARRIERS
AUNTIES CIRCLE
GRIEF SUPPORT & SPACES FOR HEALING & CELEBRATION TOO

Meeting Summary and Next Steps

Dr. Sarah Munro invited participants to the share key takeaways from the regional breakout sessions in the plenary. Below is a summary of the discussion:

Addressing stigma
There is a perception that losing a child through medical abortion is different from miscarriage. This idea, and the stigma attached, must be dismantled to provide more support for the grief and trauma regarding child loss.

Identifying data for second trimester abortion
There is a gap in the data available on abortion care, specifically on who is accessing second-trimester abortion. There may be intersectional barriers to access that impact certain populations and delay their access to first-trimester abortion.

Gaps in the number and type of professionals
The number of professionals involved in abortion and contraception does not match patient demand for care. The limited number of professionals is due to a range of accreditation issues, lack of equipment required to provide abortion care, and lack of translators.

Decentralizing care
Attendees brainstormed an opportunity to decentralize care using a national abortion hotline and providing training for the staff at Sex Sense (program by Options for Sexual Health) to address abortion related queries.

A potential solution to challenges identified included utilizing the The Rapid Access to Consultative Expertise (RACE) line. The RACE line could be expanded to cater to contraception and abortion as many of the questions that are addressed by RACE are related to those topics.

Forming call groups for rural providers
Often, rural physicians must support their patients by being on-call around the clock to prevent them from travelling long distances or to an unsupportive clinician for post-abortion care. A potential solution could be forming an on-call network of physicians to respond to patient questions.

Access to midwives and nurse-practitioners
In Northern Health, attendees identified a need for comprehensive reproductive care and increased access to surgical abortion. Midwives could fill some of the gaps around contraception access, for postpartum contraception in particular.

Additionally, Nurse Practitioners are credible resources for abortion care. Contraception and abortion care resources should use multidisciplinary language that includes a range of providers.


PHARMACISTS
WE AIM TO CREATE & SUPPORT MORE
collaborative & multidisciplinary APPROACHES
MIDWIVES
REGISTERED NURSES
Rx
MEDICAL PRACTITIONERS
ENHANCED SCOPE OF SERVICE PROVISION
Taking advantage of their unique position & unique relationship to those seeking care to increase capacity & help close existing care gaps.

Appendix

Meeting Agenda

7TH BC Women's - CART – OPTIONS Provincial Meeting

CONTRACEPTION & ABORTION IN BC: EXPERIENCE GUIDING RESEARCH GUIDING CARE

AGENDA
March 4, 2022, 08:00-16:30 PT
Virtual event

Co-Chairs: Sarah Munro and Cheryl Davies

MORNING	**Access to Contraception for all – Implementation in BC**	
Time	*Activity*	*Speakers*
8:00 - 8:15	Land Acknowledgement	Cheryl Davies
	Welcome from First Nations Elder	Dr. Roberta Price Elder Glida Morgan
8:15-8:30	Welcome from CART, BC Women's Hospital, and Provincial Leaders	Sarah Munro Cheryl Davies Natasha Prodan-Bhalla Michelle Fortin
8:30 - 8:45	Attaining equitable access and expanding contraceptive options for all in BC *Update from the BC Ministry of Health*	Erin Price
8:45 – 9:00	Strategies to support consent, culturally safe and trauma-informed care and access to contraception	Unjali Malhotra
9:00 – 9:15	Audience Discussion in Plenary	
9:15 - 9:45	Contraception Practice Updates • Etonogestrel contraceptive implant • Nurse scope of practice • Pharmacist scope of practice	*Moderator: Madeleine Ennis* Renée Hall Ali Fuchshuber Enav Zusman
9:45 – 10:00	Nutrition and Networking Break	
10:00-11:00	Panel: Improving access and integrated care for underserved populations • 2SLGBTQIA+ • Immigrant and newcomer youth • Indigenous clients	*Moderator: Danette Jubinville* Travis Salway Zeba Khan Miranda Kelly Jessy Dame Keisha Charnley Olivia Louie
11:00 – 11:15	Q&A	
11:15 - 11:30	Options for Sexual Health: Our Journey to Maintain Access	Blanka Jurenka
11:30 – 12:15	Breakout Discussion Groups *What are the contraception access gaps for underserved populations and their health care providers?*	
12:15 - 12:30	Audience Discussion in Plenary	
12:30 - 13:15	Lunch	

Updated: March 2, 2022

AFTERNOON	Abortion Care: Optimizing and Advancing Access	
Time	*Activity*	*Speakers*
13:15 - 13:20	Introduction to afternoon sessions	
13:20 - 13:40	Abortion access for Indigenous clients	Sarah Munro Danette Jubinville Renée Monchalin
13:40 – 14:00	Abortion Practice Updates • Abortion emerging best practices • Telemedicine • CAPS workforce results in BC	Madeleine Ennis Regina Renner Pallavi Sriram
14:00 – 14:15	State of the Science: Mifepristone in Canada since 2017	Kim McGrail
14:15 – 14:35	Rapid Fire Research Updates • Impact of COVID-19 on access to abortion care • Mifepristone provision by NPs • Abortion for incarcerated people • Method of abortion patient decision aid	Madeleine Ennis Andrea Carson Martha Paynter Kate Wahl
14:35 – 14:50	Q&A	
14:50 – 15:00	Nutrition Break	
15:00 - 15:45	Breakout Discussion Groups *What are the abortion access gaps by region?*	
15:45 - 16:15	Audience Discussion in Plenary	
16:15 - 16:30	Meeting Summary and Closing	

Updated: March 2, 2022

Appendix

Speaker Bios

Dr. Elder Roberta Price, Coast Salish Snuneymuxw and Cowichan Nation

Elder Roberta Price is from the Coast Salish Snuneymuxw and Cowichan Nation. For over 30 years, Elder Roberta Price has actively shared her leadership, wisdom, and teachings at UBC and throughout the Lower Mainland to assist both Indigenous and non-Indigenous community members to achieve improved outcomes in health care. She has been instrumental in helping to create shared spaces for both Indigenous and Western approaches to healing and health. Her ongoing involvement and leadership in research projects have been key to the continued work of decolonizing health care and creating cultural safety and equity for Indigenous patients. She holds an honorary doctorate from the University of British Columbia.

Elder Glida Morgan, Tla'amin First Nation

Elder Glida Morgan is from the Tla'amin First Nation. Elder Glida is determined to bring healing light to our Indigenous People in her role as a front-line worker on Vancouver's Downtown East Side in the areas of Family Violence, Mental Wellness and Women's Health. Elder Glida has explored ways in which culture can be integrated into the health care plans for Indigenous people. Performing at community events across the lower mainland; Elder Glida is involved in a group who provides medicine in the form of songs for patients in palliative care through singing and drumming traditional songs.

Natasha Prodan Bhalla

Natasha Prodan Bhalla is the new Vice President (VP) of Professional Practice, Quality and Safety, and Chief Nursing Executive at Provincial Health Services Authority (PHSA) and the Chief Nursing Officer Advisor to the Ministry of Health. Previous to these roles she was the NP Lead in PHSA. She holds a Bachelor of Science in Nursing (BScN) from the University of Western Ontario, MN/NP from the University of Toronto, and 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 continues to work part-time in the Women's Health Centre and her current focus is women's health which includes reproductive and sexual health care for women with disabilities and heart disease. She is adjunct faculty at both UBC and the University of Victoria. She is passionate about being a NP and the contribution nursing can make as leaders to improve the health care system.

Erin Price Lindstrom

Erin Price Lindstrom is the Acting Director of Women's, Maternal, and Early Childhood Health at the BC Ministry of Health. Her team of passionate and deeply committed staff work together and cross-ministry on a range of health system policy initiatives focused on advancing health equity and improving health and wellness for women, perinatal families, and young children in BC. Prior to joining the Ministry in 2020, Erin provided clinical care for families as a Registered Midwife in several urban, rural, and rural-remote communities around the province since 2007, including most recently on Salt Spring Island. Erin is weeks away from completing a Master's Degree in Health Leadership through Royal Roads University, with a focus on policy innovation in the health sector. She continues to enjoy the pace of island living with her husband and four children.

Unjali Malhotra

Unjali Malhotra is the Medical Officer for Women's Health and completed her residency in Winnipeg, Manitoba, where she created and completed a women's health residency program after family residency. Dr. Malhotra is the founder of the UBC Women's Health Residency Program (for training family doctors in advanced women's health skills for delivery in rural and remote communities). She is the outgoing Medical Director of Options for Sexual Health BC (five years) and the outgoing Chair of the Society of Obstetricians and Gynaecologists of Canada's Canadian Foundation for Women's Health (two years). She also previously served on the Board

of the Federation for Medical Women. She is an author and speaker for Continuing Medical Education both provincially and nationally. In her various roles, Malhotra has co-created provincial programs that are focused on advocacy, community support, and education as much as clinical services.

Ali Fuchshuber

Ali Fuchschuber has recently graduated from her dual Masters degree at UBC where she focused her research on certified nursing scope of practice and women's health. Currently, she works as a STI/HIV Nurse Educator at the BC Centre for Disease Control (BCCDC). Ali's career goal is to work at a policy level to increase equitable access to contraception, abortion, and sexual health services for people living in British Columbia, especially for underserved populations.

Renee Hall

Renee Hall is a Clinical Associate Professor at UBC who has been working in the area of family planning in Vancouver for 20 years. She is the lead on the UBC long acting reversible contraceptive insertion training program. Dr. Hall is the medical director at Kelowna General Hospital's Women's Services clinic and works at the CARE program at BC Women's Hospital, Every Womans Health Center, Elizabeth Bagshaw Clinic and Willow Clinic.

Enav Zusman

Enav Zusman is a PhD student in the Department of Obstetrics and Gynaecology at the The University of British Columbia (UBC) who has been working with CART since 2019. Passionate about women's health, Enav's research interests include pharmacoepidemiology, perinatal epidemiology, reproductive health, and mental health during and after pregnancy. Prior to commencing her PhD studies, Enav obtained a Doctor of Pharmacy (PharmD) and MSc in Experimental Medicine from UBC and a Bachelor of Science (BSc) in Medical Sciences from Tel Aviv University (Israel).

As a pharmacist, Enav plans to combine her clinical knowledge and experience with her research work to better support medication safety and effectiveness during pregnancy to improve patient care. Enav's doctoral research is supported by a Killam Doctoral Scholarship.

Miranda Kelly

Miranda Kelly is Stó:lō and was raised in her home community of Soowahlie First Nation (near Chilliwack, BC). She has ties to Cowichan, Snuneymuxw, and Sumas First Nations through her Dad's side, and mixed Russian, Scottish and Welch ancestry on her Mom's side. Since 2007, she has held positions in Indigenous health research, planning, policy, education, engagement, and community care. Her love for supporting Indigenous women and families grew from her own experience of becoming a parent. After the birth of her second child, she was called to birth work. She practiced as a full spectrum doula with the ekw'i7tl Indigenous doula collective and served primarily Indigenous families in the Metro Vancouver area. Since February of 2021, Miranda has been humbled to hold the role of Director, Indigenous Women and Family Health with Vancouver Coastal Health.

Travis Salway

Travis Salway is a social epidemiologist who works to understand and improve the health of Two-Spirit, transgender, and queer populations. Dr. Salway is an Assistant Professor in the Faculty of Health Sciences at Simon Fraser University (SFU), an Affiliated Researcher at the BC Centre for Disease Control, and a Research Scientist at the Centre for Gender and Sexual Health Equity.

Zeba Khan

Zeba Khan is a graduate student researcher and a Mitacs fellow at the The University of British Columbia. As a newcomer to Canada herself, Zeba is interested in understanding how underserved groups, particularly newcomers and immigrants access healthcare in BC. She is a board member for

Options for Sexual Health and is embedded in the Centre for Health Evaluation and Outcome Sciences (CHEOS) team.

Blanka Jurenka

Blanka Jurenka was born in Prague, and was raised in Winnipeg. Blanka studied French literature and theatre, at UBC, and, after working for a few years in the theater scene, she returned to UBC for sciences. She feels lucky to have studied two very different fields. Dr. Jurenka graduated from UBC medical school in 1997, and from Family Practice Residency in 1999. She has worked in Youth Clinics and with the Sexual Assault Service since she began practice, and at Options, as a medical director, since March 2020.

Cheryl Davies

Cheryl Davies is the Chief Operating Officer of BC Women's Hospital + Health Centre, one of the largest maternity hospitals in Canada and the only facility in BC with a dedicated mandate of advancing the health of women, newborns and their families. Cheryl has over 30 years' experience in women's health as a nurse, educator and senior leader, in both community and hospital settings. She is a passionate advocate for gender equity and decolonizing our health system with Indigenous partners and people with lived and living experience for better health outcomes, access and experiences across the continuum of care.

Sarah Munro

Dr. Munro (she/her) is a settler researcher and Assistant Professor in the UBC Department of Obstetrics and Gynaecology. She is also a Scientist and Knowledge Translation Program Head with the Centre for Health Evaluation Outcome Sciences. As a member of the Contraception and Abortion Research Team, she uses knowledge translation and implementation science to bridge gaps in access to contraception and abortion care. Her research is supported by the Canadian Institutes of Health Research and Michael Smith Health Research BC.

Contraception and Abortion Research Team

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Contraception and Abortion Research Team
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