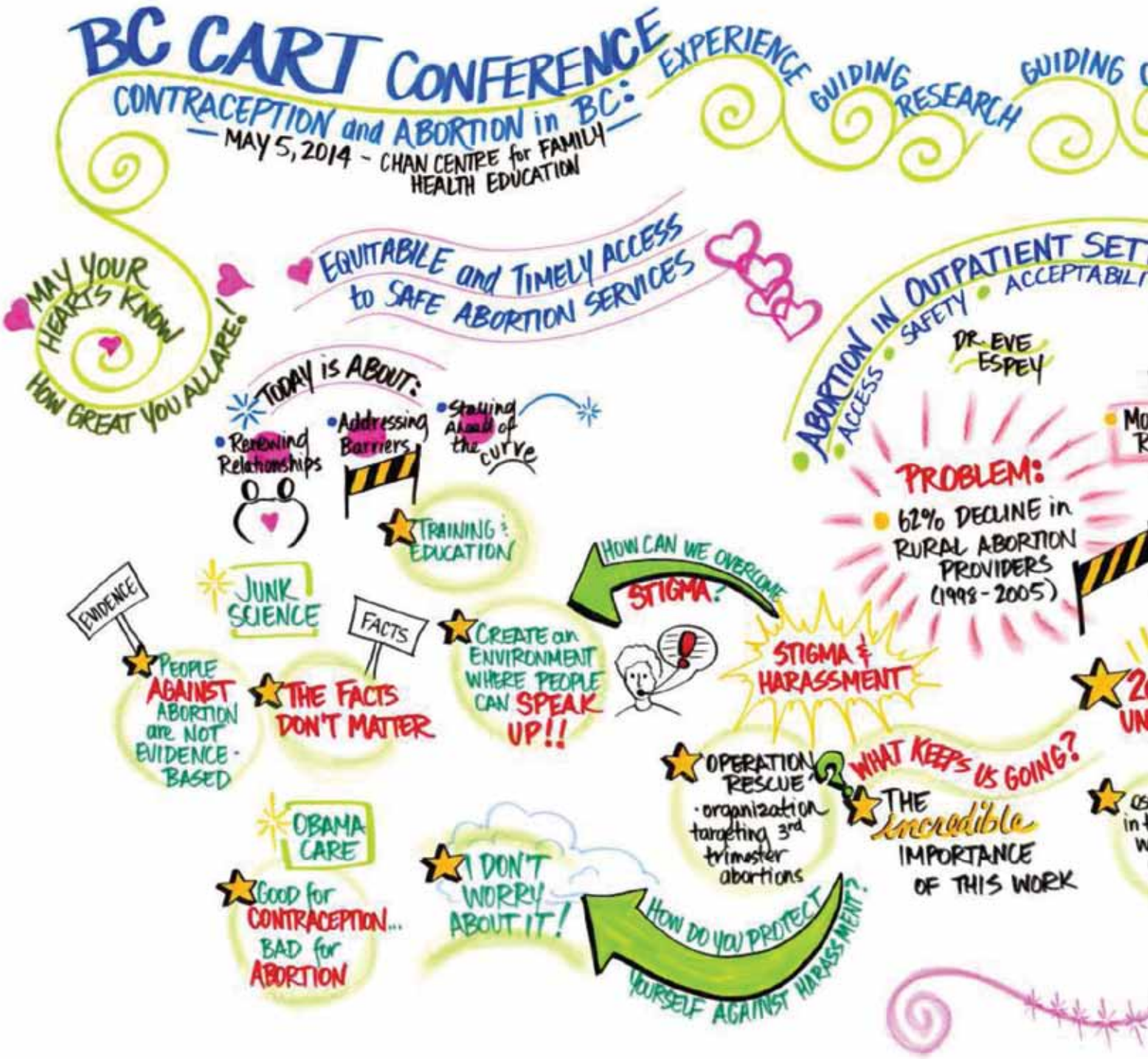
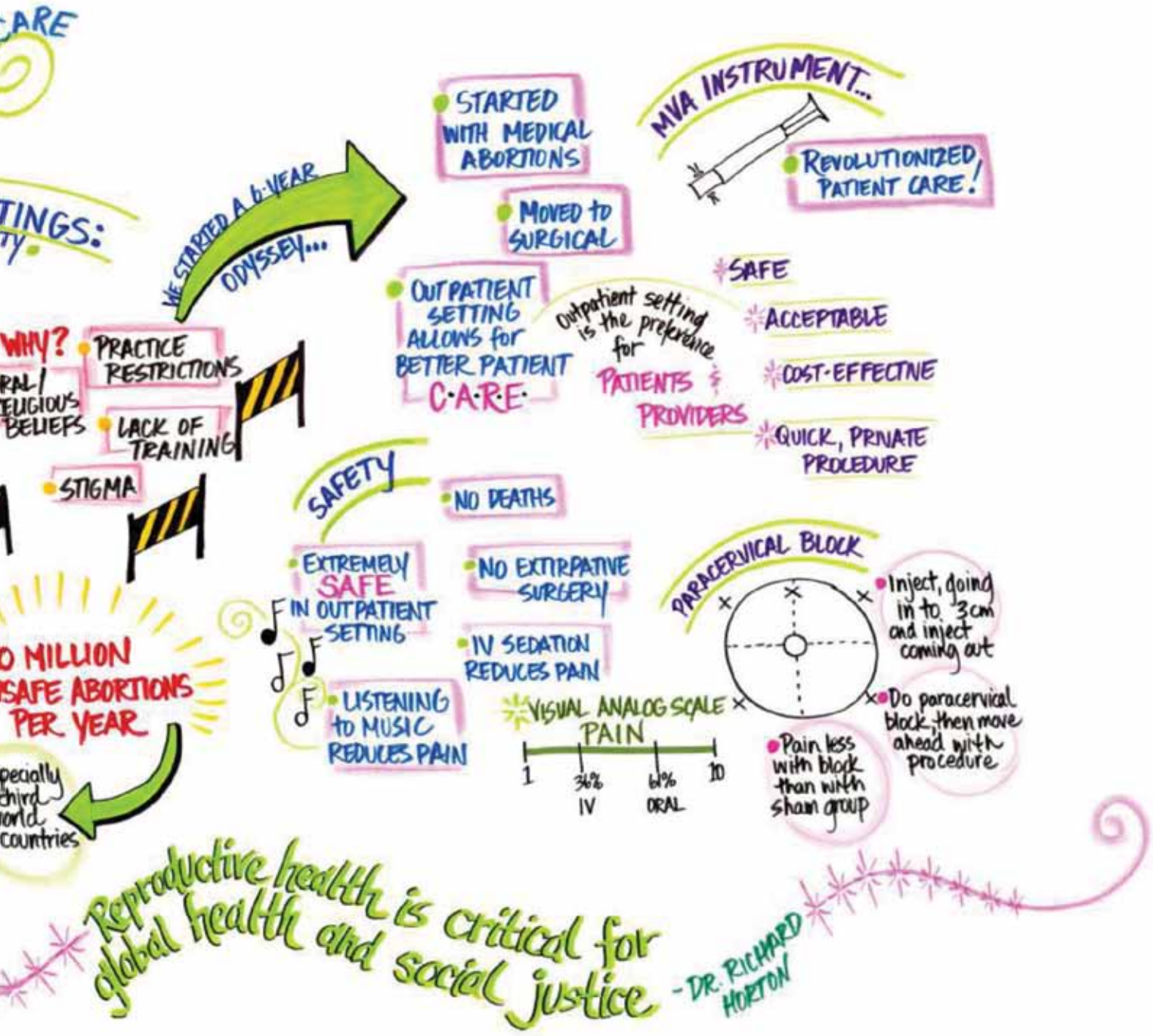
CART-GRAC
Contraception Access Research Team
Groupe de recherche sur l'accessibilité à la contraception

Contraception and Abortion in BC

Report of Proceedings, May 5, 2014


BC CART CONFERENCE
CONTRACEPTION and ABORTION in BC:
— MAY 5, 2014 - CHAN CENTRE for FAMILY HEALTH EDUCATION
EXPERIENCE
GUIDING
RESEARCH
GUIDING
MAY YOUR HEARTS KNOW HOW GREAT YOU ALL ARE!
EQUITABLE and TIMELY ACCESS to SAFE ABORTION SERVICES
ABORTION IN OUTPATIENT SET
ACCESS • SAFETY • ACCEPTABILI
DR. EVE ESPEY
TODAY is ABOUT:
• Renewing Relationships
• Addressing Barriers
• Staying Ahead of the curve
PROBLEM:
• 62% DECLINE in RURAL ABORTION PROVIDERS (1998-2005)
TRAINING & EDUCATION
HOW CAN WE OVERCOME STIGMA?
EVIDENCE
JUNK SCIENCE
FACTS
CREATE an ENVIRONMENT WHERE PEOPLE CAN SPEAK UP!!
STIGMA & HARASSMENT
PEOPLE AGAINST ABORTION are NOT EVIDENCE-BASED
THE FACTS DON'T MATTER
OPERATION RESCUE
· organization targeting 3rd trimester abortions
WHAT KEEPS US GOING?
THE Incredible IMPORTANCE OF THIS WORK
OBAMA CARE
Good for CONTRACEPTION... BAD for ABORTION
I DON'T WORRY ABOUT IT!
HOW DO YOU PROTECT YOURSELF AGAINST HARASSMENT?


CARE
TINGS:
WHY?
RAL/
ELIGIOUS
BELIEFS
PRACTICE RESTRICTIONS
LACK OF TRAINING
STIGMA
O MILLION
SAFE ABORTIONS
PER YEAR
pecially
hird
orld
countries
WE STARTED A 6-YEAR ODYSSEY...
STARTED WITH MEDICAL ABORTIONS
MOVED to SURGICAL
OUTPATIENT SETTING ALLOWS for BETTER PATIENT C·A·R·E·
MVA INSTRUMENT...
REVOLUTIONIZED PATIENT CARE!
Outpatient setting is the preference for PATIENTS & PROVIDERS
SAFE
ACCEPTABLE
COST-EFFECTIVE
QUICK, PRIVATE PROCEDURE
SAFETY
NO DEATHS
EXTREMELY SAFE IN OUTPATIENT SETTING
NO EXTIRPATIVE SURGERY!
IV SEDATION REDUCES PAIN
LISTENING to MUSIC REDUCES PAIN
PARACERVICAL BLOCK
Inject, going in to 3cm and inject coming out
Do paracervical block, then move ahead with procedure
Pain less with block than with sham group
VISUAL ANALOG SCALE
PAIN
1
3.6% IV
6.1% ORAL
10
Reproductive health is critical for global health and social justice
- DR. RICHARD HORTON

Acknowledgements

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

The Contraception Access Research Team-Groupe de recherche sur l'accessibilité à la contraception (CART-GRAC) would like to thank the following organizations for their sponsorship and support:

- BC Women's Hospital and Health Centre (BC Women's)
- Canadian Institutes of Health Research (CIHR)
- Options for Sexual Health BC (Opt BC)
- Rural Coordination Centre of BC (RCCbc)
- Ryan Residency Training Program in Family Planning
- The National Abortion Federation (NAF)
- University of British Columbia's Department of Obstetrics & Gynecology
- Michael Smith Foundation for Health Research (MSFHR)
- Women's Health Research Institute (WHRI)

The conference would not have been possible without the diligent efforts of the Organizing Committee, including CART-GRAC leads Dr Wendy Norman and Dr Perry Kendall, Provincial Health Officer, as well as Joan Geber, Executive Director, Healthy Populations and Well-Being Branch, Ministry of Health, Cheryl Davies Vice President, Ambulatory, BC Women's Hospital and Health Centre, and CART Team members.

We are very grateful for the support of our Opt partners: Jennifer Breakspear, Executive Director and her organizing team for their work.

Thank you to graphic illustrator, Lisa Edwards.

In addition we are greatly indebted to our tireless conference staff and our exceptional student volunteers.

Above all, CART wishes to thank the 84 policy makers, health care providers, front-line staff, hospital administrators, health authority leaders, students, patients, community organization representatives, and researchers who attended the conference and provided critical input into the future direction of abortion health system improvement in British Columbia.

Executive Summary

Purpose of the Conference

To address an urgent need for abortion services in rural British Columbia (BC), the Contraception Access Research Team-Groupe de recherche sur l'accessibilité à la contraception (CART-GRAC) convened policy makers, health care providers, patients, administrators, researchers and community organizations from family planning, abortion and sexual health care sectors for the third *Contraception & Abortion in BC: Experience Guiding Research Guiding Care* Conference.

The previous conference (April 2011) identified a rapid attrition of rural BC abortion services and launched research to understand the etiology, gaps and barriers. The aim of this 2014 conference was to disseminate, evaluate and incorporate research evidence into potential strategies for health service improvement in BC. The over-arching goal is improved health for women and families through equitable access to high quality abortion care.

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Morning Plenary

Delegates were welcomed to the morning plenary by Joan Geber, on behalf of Dr. Perry Kendal, Provincial Health Officer, Government of BC. Local, national and international speakers presented the latest evidence and best practices for abortion service delivery.

Afternoon Facilitated Working Groups

The afternoon workshop facilitated interprofessional, inter-sectoral group discussions where participants shared expertise and perspectives to develop and prioritize solutions to the identified abortion health services challenges. Specific action plans resulted, and five committed "Regional Implementation Teams" were formed.

Results

This conference is part of an ongoing engagement with stakeholders within the family planning community in BC. Participant input has informed innovative approaches to health system improvements and suggested areas for additional research. The ultimate aim is to equitably support British Columbians to time and space their pregnancies to meet their own reproductive and family health goals.

KEY PLENARY & DISCUSSION PANEL THEMES
Rapid attrition of rural abortion providers
Uneven distribution of access to services
Rural/urban disconnect (barriers, knowledge, training)
Unmet need for abortion services locally, nationally and globally
Gaps in data and community stigma hindering progress

MAJOR BARRIERS	MAJOR FACILITATORS
• Distance • Logistics	• Increase training and provision of medical abortions • Transition surgical abortion provision into ambulatory settings
• Lack of effective data collection and surveillance	• Data sharing and monitoring agreements engaging relevant provincial partners
• Stigmatization and public/provider attitudes toward abortion	• Increase awareness and dialogue on abortion and reproductive health
• Lack of rural health professionals providing abortion services	• Increased training and support for physician providers • Expand scope of practice for abortion service provision: training for NP, midwives

KEY WORKING GROUP THEMES | KEY CHANGE TOPICS
1. **Knowledge Translation and Education:** Increase health professional education on the unmet need for abortion and contraception services and associated costs.
2. **Access:** Improve access to information and services through region specific initiatives to support facilities and providers.
3. **Training:** Address health professional abortion and contraception training in multiple disciplines (midwives, nurse practitioners, pharmacists and MDs).
4. **Funding:** Examine potential cost-savings of 30% per procedure through delivery of surgical abortions of surgical abortions in ambulatory vs operating room settings.
5. **Support:** Improve support for rural providers (mentoring, centralized counselling services, locum program, Community of Practice).
6. **Monitoring and Surveillance:** Standardize data collection and surveillance through data sharing and monitoring agreements between organizations currently collecting abortion data.

CRITICAL COMPONENTS
• Collaboration and networking
• Reduce stigma and dispel myths
• Public campaigns and political advocacy
• Policy reform
• Cost-benefit analysis

Contents

Experience Guiding Research, Guiding Care

On May 5, 2014, the Contraception Access Research Team-Groupe de recherche sur l'accessibilité à la contraception (CART-GRAC) and Options for Sexual Health (Opt) brought together health care providers, patient representatives, front-line workers, administrators, policy makers, researchers and others from British Columbia's (BC) family planning, abortion and sexual health care sector for the third *Contraception & Abortion in BC: Experience Guiding Research, Guiding Care* Conference (CART Conference).

The rapid attrition of rural abortion services throughout BC, and a paucity of information on factors influencing rural abortion services were identified in the last conference (April 2011). This resulted in a mixed methods study, The BC Abortion Providers Survey (BCAPS). This study identified specific addressable challenges, gaps, and barriers, as well as highlighting local innovations and practical solutions that have been successful in BC rural communities (Appendix D).

The goals of the 2014 CART Conference were to facilitate the dissemination, evaluation and incorporation of the latest research evidence on abortion and family planning services into potential strategies for health service delivery in BC. The over-arching goal for this meeting was improved health for women and families through access to high quality family planning. Delegates, many of whom were participants in the 2011 meeting, brought together a wide range of perspectives from the private, public and not-for-profit sectors.

To achieve these goals, the day's work focused on four objectives:

1. **To engage interdisciplinary health professionals, policy-makers and patient-representatives in discussions on the most current national and international evidence for high quality abortion health service delivery.**
2. **Provide a forum for health professionals to network, learn of new opportunities, and build collaborations.**
3. **To disseminate the findings of the BC Abortion Providers Survey, and abortion provision in different contexts, that could inform decision making, clinical care, share best-practices and influence health system design.**
4. **Facilitate small-group discussions on the implications and opportunities within the research findings of the BC Abortion Providers Survey, and sharing of best-practices, supporting development of strategies for health system/health services improvements that will increase equitable access to, and quality of, family planning for BC women.**

Local, national and international speakers presenting the latest evidence on delivery of high quality abortion health services, including the results of the BCAPS research. The afternoon workshop centered on interprofessional, inter-sectoral group discussions where participants shared their knowledge and discussed potential solutions for priority challenges and gaps in contraception and abortion health services in BC.

Part I: Plenary

Welcome

The conference began with a traditional First Nations welcome to the Musqueam Traditional Territory by Elder Mary Charles, a Queen's Jubilee Medal recipient. Elder Charles led the participants in a prayer, asking for the creator to unite all participants physically, mentally and spiritually to lead the way for future generations and make this world a better place.

Joan Geber, Executive Director, Population Health & Well-being (including the Women's Health Directorate); Population and Public Health, BC Ministry of Health, offered greetings on behalf of Dr Perry Kendall, Provincial Health Officer, BC Ministry of Health. She referred to the Provincial Health Officer's Report, *The Health and Well-being of Women in British Columbia* released in 2011 which is a comprehensive appraisal of women's health in BC. This report outlines where further efforts are required and outlines 43 recommended actions, ten of which are related to reproductive care, including recommendations specific to abortion: "to ensure equitable and timely access to abortion services." She indicated that she was pleased the morning conference and the afternoon working groups were convened to help the Ministry address this recommendation.

Dr Jan Christilaw, President of BC Women's Hospital & Health Centre, gave a welcome on behalf of the hospital. She recognized that because of the work done in this room and by CART-GRAC, this conference represents a leading national initiative in research and planning around abortion and contraception access. She noted that BC Women's has a strong hub of leaders who are passionate about these issues and a network of dedicated individuals around BC who contribute to effective health improvements through delivery of high quality care. She emphasized that one of her hopes for the day was a renewal of some of those relationships so that we can work together to ensure better access to abortion and contraception services for all women in BC.

Dr Wendy Norman, Conference Chair, set the stage for the day's events. She said the goal of the conference was to improve contraception and abortion services in BC, especially rural areas, by looking at the results of the BC Abortion Providers Survey (BCAPS) and current research. She also introduced our graphic illustrator, Lisa Edwards, who captured a visual representation of presentations and discussion. Her illustrations from the day can be seen throughout this document.

Current Knowledge, BC Evidence and Best Practices

Several speakers set the context for current evidence on provision of high quality abortion health services locally, nationally and internationally.

RYAN FOUNDATION KEYNOTE ADDRESS

Abortion in Outpatient Settings: Access, Safety, Acceptability

Dr Eve Espey, Professor, Department of OB-GYN and Chief, Family Planning Division, University of New Mexico in Albuquerque, NM, gave the keynote address in which she discussed the barriers to abortion provision in a national and international context, and described her experience with, and the documented advantages of, providing abortion in outpatient settings.

> *No woman can call herself free who does not own and control her body. No woman can call herself free until she can choose consciously whether she will or will not be a mother.*
>
> *– Margaret Sanger*

Dr Espey noted similar rates of decline in rural abortion providers for Canada and the United States, as well as similar access barriers for women including the long distances many must travel to access care.

Dr Espey highlighted a 2011 New Mexico study[1] of family practice physicians and OB-GYNs comparing the number of abortion providers in 2001 (N=210) and 2008 (N=165). Similar rates among all clinicians for any providing abortion service in 2001 (11%) and 2008 (15%) were found. However, there was a significant decline in rural clinicians providing these services, dropping from 7% to 2% in the same interval. Despite the availability of mifepristone, the pill used for medical abortions, in the US since 2000, this study showed little increase in abortion access overall, and a significant decrease in rural abortion access.

The study also explored barriers to providing abortion services for OB-GYNs and family practice physicians, and Dr Espey noted the differences between the two disciplines. For OB-GYN's the main barriers reported were: personal moral or religious beliefs (50%); practice restrictions against abortion (36%); and office staff attitudes against abortion (35%). For family practice physicians, the most common barriers were: lack of training in abortion (70%); lack of training in ultrasound (60%); lack of ultrasound in office (55%); and practice restrictions against abortion (44%).

Improving training for family practice physicians on abortion provision is one potential strategy to improve abortion access for women. Abortion training for advanced practice clinicians, such as nurse practitioner, nurse midwives and physician assistants is another strategy to increase access. Dr Espey noted that some similar issues were reflected in the British Columbia Abortion Providers Survey[2] including professional isolation (i.e. stigma); logistics, such as lack of operating room (OR) time; and lack of replacement providers (see page 10 for more information).

Dr Espey then discussed the advantages of providing abortions in outpatient settings, by reflecting on the University of New Mexico Hospital (UNM) journey taken to introduce abortion services to the hospital, which included a series of educational, political, logistical and economic challenges. Today, the UNM Center for Reproductive Health (UNMCRH) is a 9000 square foot outpatient clinic that offers both medical and surgical abortion services, as well as other family planning services. The clinic also has a RYAN program and a Family Planning Fellowship.

In the US, like Canada, the majority of abortions are performed in outpatient clinics, 90% and 86%, respectively. Some of the advantages to offering abortion in such settings include: cost effectiveness (i.e. not requiring OR time or staff); reduction in complications (i.e. safety of analgesia over general anesthesia); flexibility (i.e. greater ease with patient scheduling); and the ability to offer better patient-centered care (i.e. increased privacy). Over a two-year period, Dr Espy noted that her clinic moved from performing 90% of miscarriage management and abortion procedures in the OR to 90% in the outpatient setting. Patient reported advantages include efficiency and privacy.

1 Espey, E., Eyman, C., Leeman, L., Ogburn, T., & North, M. (2010). Has mifepristone medical abortion expanded abortion access in New Mexico? A survey of Ob/Gyn and family medicine physicians. Contraception, 82(2), 206.

2 Norman, W. V., Soon, J. A., Maughn, N., Dressler, J., & Vitzthum, V. J. (2013). Barriers to Rural Induced Abortion Services in Canada: Findings of the British Columbia Abortion Providers Survey (BCAPS). *PLoS ONE*, *8*(6), e67023.

Research supports providing abortion care in outpatient settings. A retrospective study reviewed 170,000 outpatient 1st trimester abortion procedures confirming the safety of such settings, showing no deaths, no major surgery and very low rates of hospitalizations.[3] Dr Espy noted that studies show that the majority of patients choose outpatient settings to receive abortion care, if given a choice. Notably, the duration of procedures are almost 80% longer in the OR settings and the estimated costs are twice as high. Additional justification for delivering abortion care in outpatient settings includes the simple set up and cost-effectiveness of the equipment (i.e. Manual Vacuum Aspiration instrument).

Dr Espy concluded her speech by reflecting on the reasons that keep her fighting for improved access to abortion services. Despite harassment and stigma, her team are passionate to proving abortion services and training. Providing safe and legal abortion services in critical to reducing the number of maternal mortalities associated with unsafe abortions.

Abortion in the Global Context

Dr Dorothy Shaw, Clinical Professor, UBC and Vice President, Medical Affairs, BC Women's Hospital & Health Centre, gave an overview of global abortion access and provision. She noted that unsafe abortion is a public health problem primarily affecting poor women. While these global statistics are likely under reported, it is estimated that there are between 180-210 million pregnancies every year and 273,500 maternal deaths. Eighty percent of maternal deaths are due to obstetrical complications during child birth. However, the World Health Organization (WHO) estimates unsafe abortions account for 13% of all maternal mortality worldwide. That is, 47,000 of these maternal deaths are a result of unsafe abortion procedures and about 5 million women are hospitalized every year with complications of abortion. Additionally, 220 million women have unmet contraception needs.

The 1994 International Conference on Population and Development's (ICPD), Programme of Action (PoA) established a goal for all governments to "meet the family planning needs of their populations as soon as possible and should, in all cases by the year 2015." However, Dr Shaw stated that one of the major barriers to achieving this goal is the statement included in the PoA which indicates that "in **no** case should **abortion** be promoted as a **method of family planning.**"

Each year, nearly 20 million of the 42 million induced abortions are carried out using unsafe procedures. Dr Shaw noted that safe abortion access and contraception availability is correlated with maternal mortality rates. Twenty-six percent of women live in countries where abortion is generally prohibitive and these tend to have the highest rates of maternal mortality and lower rates of contraception prevalence.

Dr Shaw went on to debunk several myths that prevail around abortion and contraception. She noted that the idea that "abortion is rare" contributes to the stigma associated with this issue. However, statistics show 31% of Canadian women and 30% of Brazilian women ended at least one pregnancy in their life time. Religious countries do not have lower abortions rates. A study from Brazil, a highly Catholic country, showed a large portion of gynecologists would help a woman to access an abortion, or would access an abortion themselves.

Dr Shaw discussed numerous concerns related to unsafe abortion. Timely access to care for complications due to unsafe abortions is a serious concern. In Gabon, a study reviewing maternal deaths showed that women had to wait significantly longer to access care due to unsafe abortion complications, compared to women accessing care for other reasons. Persecution and imprisonment of women is also a concern. In El Salvador, abortion is not permissible under any circumstance, even to save the life of a woman. Women are jailed if they are found, or believed to have undertaken an induced abortion. Incomplete spontaneous abortion may be indistinguishable from induced abortion. The costs of unsafe abortions are also significant. In low and middle income countries (LMIC), up to 50% of hospital budgets allocated to obstetrics and gynecology are used to treat complications of unsafe abortions. Infant mortality is also related to pregnancy spacing and maternal mortality/ morbidity. Finally, there is growing evidence that, especially in adolescent girls, unintended pregnancy and unsafe abortion is associated with violence and sexual coercion.

The lowest abortion rates are found in countries with access to comprehensive sexuality education, contraceptive services and legal safe abortion. Legal reforms have occurred in several countries, including Nepal in 2002,

3 Hakim-Elahi E, Tovell HM, Burnhill Ms Complications of first-trimester abortion: a report of 170,000 cases. Obstet Gynecol. 1990;76(1):129–135

> *"…the idea that "abortion is rare" contributes to stigma associated with this issue. However, statistics show 31% of Canadian women and 30% of Brazilian women have at least one abortion in their life time."*
>
> *– Dr Dorothy Shaw*

which has seen a 50% reduction in maternal mortality. Other countries that have made legal reforms include: Columbia, Ethiopia, Sierra Leone, Kenya, Malawi, Mexico City, Mozambique, Nigeria and Uruguay.

Dr Shaw pointed to examples of progress, including the 2006 *International Federation of Gynecology and Obstetrics's Prevention of Unsafe Abortion Initiative*. Forty-six countries participated in this initiative which involved a situational analysis of induced and unsafe abortions and the implementation of a country-based plan of action. Finally, in March 2014, a meeting of political, health, and human rights leaders from over 30 countries resulted in *the Airlie Declaration for Safe Legal Abortion* which calls on governments to: "make safe legal abortion universally available and accessible to all women regardless of age, income, or where they live."

Unmet contraception needs are significant and directly impacts the rates and need for abortions. At least one in four women seeking to avoid pregnancy is not using an effective method of contraception. Women with unmet contraceptive needs account for 82% of all unintended pregnancies. Addressing the unmet need for contraceptive information and services would result in approximately 22 million fewer unplanned births, 25 million fewer induced abortions and 150,000 fewer maternal deaths each year.

Dr Shaw concluded her presentation with some thoughts on next steps including reducing stigma by being mindful of language (i.e. pro-choice vs. pro-abortion) and debunking the myth that abortion is rare. Seeking consensus, rather than continuing the polarizing rhetoric, and willingness to engage in difficult conversations are all strategies required to improve access to safe and legal abortion for all women.

Abortion in Canada: You are not Alone

Ms Dawn Fowler, Director, National Abortion Federation, Canada, gave an overview of how NAF, the professional association of abortion providers in Canada, the United States and Mexico, can assist rural providers and address some of the issues around stigma. Since 1977, NAF has ensured the safety and high quality of abortion practice with standards of care, protocols, quality improvement programs, and accredited continuing medical education for both surgical and medical abortions. NAF also aims to provide a scientific evidence base for good quality, safe abortion care. Several years ago the Canadian program was created to address specific issues and challenges of providing abortion care in this country. There are 28 NAF member facilities in Canada which provide approximately 80% of all abortions.

NAF's medical education activities include publishing the only clinical textbook on surgical and medical abortions; webinars; conferences and onsite trainings (CME credits). NAF also sets standards through their evidence-based *Clinical Policy Guidelines* which are reviewed and updated annually. Member facilities are visited on a regular basis by NAF's clinical services staff to verify that they comply with the guidelines. NAF collects statistics (i.e. complication statistics) to monitor performance and also develops public education campaigns to help reduce stigma and raise awareness around the issues of abortion.

NAF's *24-Hour Clinic Support Services* are available to members who may be the target of anti-choice violence or disruption. NAF can provide member agencies security assessments (on-site and in-home) and trainings. NAF also tracks violence and disruptive activities, and can help liaise with local, provincial and federal administrators and law agencies to reduce security concerns. NAF's Public Policy activities help to dispel myths and counter misinformation around the safety of abortion (e.g. press conferences and research briefs). NAF also meets with parliamentarians, members of provincial legislatures and colleges around legislation concerns and to continue to lobby for abortion rights and increased access. Finally, NAF can directly assist women through information pamphlets, their toll-free hotline (1-800-772-9100), multilingual website (www.prochoice.org), and the Canadian Patient Assistance Fund which can provide financial assistance for travel, birth control, and other related costs.

Medical Abortion: How to and What's New

Dr Ellen Wiebe, Clinical Professor, UBC, and director of the Willow Women's Clinic, provided an overview of innovative methods for the provision of medical abortions. Medical abortions, as provided in BC, are shown to be 98% effective when gestational age is less than seven weeks; and 85% for eight weeks or more.

There are several benefits to providing medical abortions, including timeliness and privacy of the procedure. Medical abortion, a non-invasive procedure, may allow abortion care to be more accessible, especially in rural and remote areas, and allow partner involvement if desired. Some of the drawbacks Dr Weibe outlined for providing medical abortions include the uncertain time line for completion, several visits required throughout the procedure, and the cost of medication. Women experience numerous side effects with medical abortions, including nausea (44%), chills (44%), diarrhea (26%), fever (21%), vomiting (17%) and pain. Additionally, surgical completion is required in 5-10% of cases – 2% require surgery due to continued pregnancy or excessive bleeding, while the rest account for women choosing surgery due to delayed completion. Women should be counselled on what to expect and be given anti-emetics and/or analgesics to manage side effects. Despite the uncertain timeline and side effects, 85% of women indicate that they would choose the same procedure again. The approval of mifepristone in Canada, is much anticipated, given the drug's quicker response, greater safety and fewer reported side effects than the only agent currently available in Canada, methotrexate (used in combination with misoprostol).

Dr Wiebe discussed basic requirements to provide medical abortions in a rural community. These include the ability to determine gestational age and confirm completion of the procedure (e.g. ultrasound; HCG). Physicians must also ensure patients are provided with counselling, including explanations of medications and side effects and the importance of follow up to assure completion. Physicians will also need access to Rh testing and suction aspiration procedures. Finally a 24/7 on-call service and patient follow up protocol is necessary.

Dr Weibe concluded by discussing the protocol for providing medical abortions which requires assessing for

(under seven weeks and no medical contraindications); obtaining informed consent (discuss efficacy, risks, side effects and patient agrees to surgical abortion if regimen fails). All patients are given methotrexate and misoprostol (various protocols were discussed). Follow up to ensure the pregnancy is terminated is extremely important for all patients due to the teratogenicity of both drugs.

Abortion service in BC: Findings from the British Columbia Abortion Providers' Survey

Dr Wendy Norman and Dr Jennifer Dressler provided an overview of the findings from the BC Abortion Providers Survey (BCAPS) study, as launched at the 2011 CART Conference. While BC abortion rates have remained largely unchanged from 1996 to 2005, there has been a 65% drop in provision of abortions in rural locations, and of rural abortion providers, during this time.

The BCAPS study aimed to quantify determinants for BC abortion providers, and facilitators and barriers to provision of care. Self-administered questionnaires, were distributed to all known BC abortion providers in 2011. Optional semi-structured interviews were conducted, transcribed and analyzed.

The BCAPS study found 50% of abortion providers were family physicians, and half overall were female. The three largest urban areas reported 91% of all abortion provision and 98% of second trimester services. Only 57% of reproductive age women reside in the associated regions. All rural providers performed surgical abortions within a hospital operating room, although three indicated the use of a hospital outpatient facility as well. In contrast, all of the urban facilities offered surgical abortions within an outpatient setting. Rural abortion services have more limited accessibility and lower gestational limits. While there were no personal experiences of harassment reported by rural providers, a small number of urban providers reported receiving threats to themselves or family, property vandalism, and trespassers at their home.

Overall, urban providers reported a supportive environment and few barriers to service provision. In contrast, rural providers reported significant barriers, many to do with logistics included: insufficient operating room time; high demand for services with no relief providers; professional isolation, and abortion cases being given low priority in the OR. Rural physicians also noted scheduling difficulties due to time spent on counseling and preparation, activities that are usually undertaken by allied professionals in urban clinics. Finally, rural physicians noted a concern about burn-out due to having no replacement providers available.

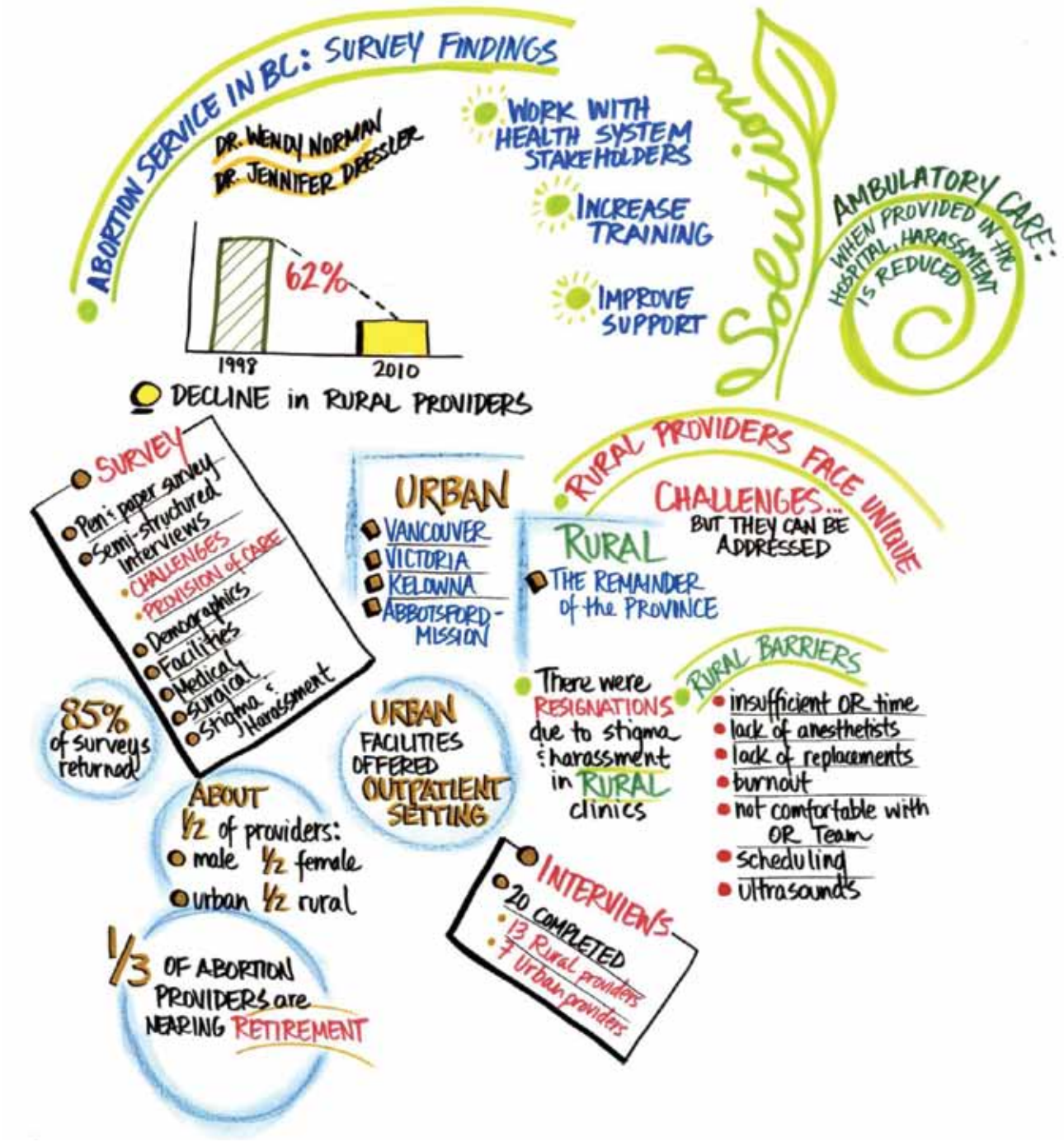
Concluding their presentation, Drs Dressler and Norman discussed potential next steps. They indicated that the largest common barrier reported for rural services are difficulties related to providing services within an OR. Performing abortion services in ambulatory settings could reduce many of these logistical barriers and result in cost savings. They also discussed the importance of improving professional support for rural abortion providers (e.g. practice support, consultation links, continuing professional education) and increasing training among family physicians and obstetrician gynecologists, particularly those planning to practice in rural areas. Finally, they pointed to the need to work with rural health system stakeholders to identify facilitators that will improve access and reduce costs for abortion services.

Lightning Presentations on BC Services, Organizations, and Opportunities

Short overviews on key initiatives, services and organizations supporting access to abortion services in BC were given by the following presenters:

BC Ministry of Health

Joan Geber, Executive Director, Population Health & Well-being (including the Women's Health Directorate); Population and Public Health, BC Ministry of Health, noted that the Ministry of Health released its directional document *Setting Priorities for the Health Care System* in February 2014. This document outlines eight priorities to support the health and well-being of BC citizens. The second priority in the document, *"implement targeted and effective primary prevention and health promotion through a coordinated delivery system,"* especially guides the work of the Healthy Development and Women's Health Directorate. As such, they work closely with BC Women's Hospital, the BC Centre of Excellence for Women's Health, the health authorities, including the First Nations Health Authority, non-profits, as well as with women's health researchers to improve the health for women and families in BC. One of their main priorities is to respond



to the Provincial Health Officer's Report, The Health and Well-being of Women in British Columbia released in 2011 which made 43 recommendations to support the health and well-being of women in BC. Ten of the recommendations are related to reproductive health. Ms Geber pointed to two recommendations that were of particular relevance to the CART audience: "*improve access to contraception, especially long –acting reversible contraception*"; and "*ensure equitable and timely access to abortion services.*" Ms Geber noted that she was pleased to be linking with Dr Norman and CART in the planning and implementation of initiatives, such as the provincial door-to-door Sexual Health Survey. This survey will, for the first time, collect comprehensive sexual health, contraception practices and social determinants of health information on a representative sample of British Columbians.

BC Women's Hospital & Health Centre

Cheryl Davies stated that BC Women's provides primary to tertiary care along the continuum of reproductive care services, including abortion care services. BC Women's CARE (Comprehensive Abortion and Reproductive Education) Program provides early surgical abortions as well as advanced terminations for fetal anomalies or critical maternal indications.

BC Women's employs a range of providers (e.g. general practitioners; OBGYNs, Maternal Fetal Medicine specialists) within an interdisciplinary approach to care which also includes nurses, counsellors, and support staff. BC Women's also hosts students across those disciplines with the aim of knowledge sharing and ensuring successors for future services. BC Women's offers the majority of abortion services in an ambulatory setting within the hospital, removed from acute care services. Ms Davies indicated that BC Women's was pleased to be part of a network of collaboration, professional support and knowledge sharing in BC (hospitals, community clinics, physicians and allied health professionals). This network of support is unique amongst abortion care services and is key to sustainability, good practices, and nurturing inspiration in this area of women's health. She noted that this work cannot be done in isolation, whether in rural or urban settings.

Ms Davies concluded by encouraging those providers who are seeking to start offering abortion services or feeling isolated, to make connections with other abortion care services, including BC Women's. BC Women's can help with advocacy efforts, policy development, and clinical case consultation. They can also assist with hospital based operations and logistics for providing abortion services, including identifying opportunities for offering services in an ambulatory setting (rather than operating room setting) within hospitals.

Options for Sexual Health

Jennifer Breakspear, Executive Director, stated that Options for Sexual Health (Opt), is Canada's largest non-profit provider of sexual health services through clinics, education programs, and their 1-800 Sex Sense hotline. There are 60 Opt clinics around BC, many of those operating in rural communities.

The three pillars of the organization are: clinical services, education and their toll-free information and referral line which serves the public, physicians, and allied health professionals. Ms Breakspear noted how proud she was of the expertise within the organization and the alliances between Opt and the network of abortion care providers throughout province. Opt also partners with researchers to investigate critical issues around abortion care. Ms Breakspear concluded by encouraging rural providers to connect with Opt to receive support for themselves, staff and patients.

Ryan Program: Training at BC Women's

Brian Fitzsimmons, MD, FRCSC, FACOG, Clinical Associate Professor, and Director of the Ryan Residency in Family Planning, Department of Obstetrics and Gynaecology at UBC, and the Medical Director; CARE Program, BC Women's Hospital & Health Centre discussed the Ryan Program. Six years ago The Ryan Program of Family Planning Training for Obstetrics and Gynecology Residents was started at BC Women's with its first cohort of residents graduating this year as OBGYNs. Dr Fitzsimmons noted that these graduates will hopefully meet some of the needs in abortion care provision around the province.

The Ryan Program also hopes to train more family practice physicians who are interested in providing abortion services. Dr Fitzsimmons encouraged anyone who is interested in getting training or updating to contact them. He noted the importance of training, research, education in the area of abortion provision. The Ryan Program works closely with CART, NAF, UBC and partner abortion clinics (Willow Women's Clinic, Elizabeth Bagshaw Women's Clinic, Everywoman's Health Centre, and Vancouver Island Women's Clinic) to help enhance training. Dr Fitzimmons pointed to the success of influencing the UBC Undergraduate training program to have more emphasis on family planning and contraception as one example of their contribution. Acknowledging tight resources everywhere,

Dr Fitzimmons emphasized the need to work together to increase training opportunities, and therefore improve access to abortion services for women in the province.

Rural Coordination Centre of BC

Leslie Carty, Executive Manager, presented on the Rural Coordination Centre of BC (RCCbc), which is funded by the Joint Standing Committee on Rural Issues (BC Ministry of Health and Doctors of BC), and works closely with the Department of Family Practice (UBC). The RCCbc seeks to improve rural health education and advocates for rural health in British Columbia. The RCCbc focuses on six pillars of interest which includes *identifying the needs of specific populations* (e.g. aboriginal, mental health, emergency services, and geriatric services); and *communication* (promoting ongoing discussion and networking of rural health care professionals on education and practice).

The RCCbc also engages in rural health services research, evaluation and quality improvement; recruitment and retention; and education and training. The RCCbc supports the Rural Education Action Plan (REAP) Program through UBC which provides funding for physicians to receive extra training and upgrade their skills. The RCCbc aims to support and foster networking amongst rural health care practitioners.

Women's Health Research Institute

Dr Kathryn Dewar, Research Director, gave an overview of the Women's Health Research Institute (WHRI) which supports and promotes women's health research across BC and networking between stakeholders. She indicated that WHRI is proud to be one of the supporters of the CART Team and of this Conference. The WHRI hosts monthly research rounds which showcase various topics on women's health research. The monthly rounds are CME accredited and can be broadcast to other health care sites across the province.

The WHRI also facilitates several research grant awards throughout the year, for example the Nelly Auersperg Award which supports preliminary studies in women's health research. Dr Dewar encouraged anyone who is interested in receiving updates to check out their website or sign up for their email distribution list.

There is no cost to join the WHRI. As a member, the WHRI can offer research facilitation services- support through all stages of the research process (data collection, grant applications and statistical analysis). The WHRI can also help to promote news and events to the women's health research community.

UBC Women's Health Family Physician Fellowship

Dr Wendy Norman explained that the UBC Enhanced Skills training through the Department of Family Practice offers funding for a tailored package in women's health issues (three months). This program can help with covering the costs of travel and training for family physicians interested in abortion care, family planning as well as other women's health areas (e.g. obstetrics, breast diagnostics, and HIV). She noted that supporting providers' education around the province is a top priority for the program.

Conference Partners, Audience Members

Dr Norman opened the floor to audience members for any updates on current initiatives and services. Dr Judith Soon, Assistant Professor, UBC Faculty of Pharmaceutical Sciences discussed a current research project, *Emergency Contraception IUDs: Pharmacist Provision Pilot Project*. Dr Soon noted recent increased interest in Copper-T intrauterine devices (Copper IUD) as an effective, form of emergency contraception. She noted that women coming into pharmacies, sexual assault programs, emergency departments, and Opt clinics could be provided with information about copper IUDs, if relevant. This study involves a free accredited training program for pharmacists in Vancouver and Victoria to provide eligible women with information about copper IUDs. Women who are interested are provided rapid access (within seven days, usually next day) for the copper IUD insertion at two clinics: Willow Women's Clinic (Vancouver) or the Vancouver Island Women's Clinic (Victoria). Some of the costs are covered by insurance companies and MSP will cover the cost of insertion.

Panel Questions

Concluding, all presenters from the morning gathered for a panel discussion. The following highlight just a few of the numerous questions posed by participants.

Are there any articles countering the myths associating abortions with breast cancer and/or mental health concerns?

Dawn Fowler noted that there is a vast amount of literature on this, and that NAF has a package available for providers on how to counter such myths, as well as information on the NAF website.

What is your opinion on the progress towards global abortion rights and access?

Dr Dorothy Shaw said there is uneven progress globally. While there has been definite progress in some countries, the opposition is very well organized. She gave the example of Kenya who changed their constitution to include legal access to abortion for specific indications, but then halted the process due to pressure from anti-choice organizations. However, she pointed to examples of great progress, such as Uruguay's harm reduction model which has been implemented in several other countries. She emphasized the importance of continuing to advocate for access to reliable, effective contraception, and safe abortions when it fails.

Why isn't contraception free?

Dr Norman acknowledged that health care resources are not always distributed in a way that seems equitable. In order to equitably plan and space pregnancies, women need access to high quality contraception services and to have contraception provided free. In order to present a business case to government that free contraception would be cost effective and improve equity, she noted a comprehensive sexual health survey using representative data from the province to determine the current burden to manage unintended pregnancies is needed. She indicated that CART, BC Women's and the Ministry of Health were working together collect this data.

It is estimated that 30% of women will have had an abortion by the end of their reproductive years, yet so many do not make this public. There may be an opportunity for mobilizing a huge number of change agents to advocate for better expenditures of health care dollars to support women in their reproductive years and to align services to where they are needed. How do you see facilitating a public discussion to support political will to make these kinds of change?

Dr Espey noted that the evidence is indeed there to support providing low or no cost contraception. It is a fact that spending money on contraception saves money. Dr Espy also noted that unfortunately, the facts don't matter for many conservative decision makers. It is important to get abortion out of the shadows and for women to start to speak up about their abortions. She noted the need to make it less taboo for women to speak about their abortions. Ms Fowler also pointed to the need to educate the public on abortion and normalize it as a part of reproductive health.

In BC where abortion is legal, there is stigma about providing this service. Many physicians who are willing to provide abortion care are reluctant because of the fear of stigma. How can we change this?

Dr Espey noted that the need to create a supportive environment where physicians and staff are empowered to speak up and say "yes I would be willing to do this and I believe in the importance to provide safe abortion care." Values clarification is also important. Bringing together people who support abortion provision to discuss the issues and build networks of support, will reduce feelings of isolation. Dr Espey also noted the importance of champions in this area, as well as continued efforts to increase

training, research and education. Government support is also key to reducing the stigma associated with abortion.

Given the lack of abortion providers in rural and remote locations, are midwives being trained in abortion care?

Dr Shaw indicated that at the latest International Confederation of Midwives general assembly a policy statement was passed that stated "midwives could, should and would be trained to provide abortion care." Dr Shaw noted that midwives are in the position to see the consequences of unsafe abortion but generally are not in the position to assist. Although many countries are adopting this, there are still some barriers including current abortion providers being hesitant to facilitate this transition and hand over this responsibility to midwives in rural and remote locations. She stated that "we are making progress and I'm optimistic that we can utilize midwives to help deliver these services over time." She also noted that research has shown the efficacy and safety of midwifery and nurse practitioner management of abortion, especially medical abortions. Legislation and political will are the main barriers.

Does NAF provide a mentoring program for physicians that are now trained, but are uncertain on how to manage the dialogue and security concerns related to providing these services in their communities?

Ms Fowler confirmed that NAF does have such a program. She noted that they try to provide mentoring support in two ways. First they link new physicians up with seasoned abortion care providers who are fairly local. They also have people in the NAF office who can support them in navigating questions- how to dialogue and when to walk away from certain questions. NAF is also willing to send people into a facility to spend time with new physicians to help problem solve and provide mentorship.

What would you say to physicians who are reluctant to provide medical abortions in their community because of concerns about complications?

Dr Wiebe simply responded that if physicians can manage a miscarriage in their community, they can manage a medical abortion.

While I agree that ambulatory settings would be ideal for abortion provision, in most rural hospitals, the operating room is about the only facility suitable, because there are no ambulatory care facilities. We know that we do not need to put women to sleep in order to use that space and perform the procedure. How can we get education to the operating room staff about not requiring general anesthesia for all patients?

Dr Norman noted that some of the larger rural centres where abortion care is being provided in operating rooms, are running some ambulatory clinics within the hospital (e.g. colposcopy or colonoscopy clinics). These clinics have the space, training and staff to potentially also offer abortion services. Dawn Fowler, also noted it is very important to have staff working in abortion care by choice when providing these services in hospital. A more women-centred and supportive environment can be offered when staff is working there by choice, rather than scheduled to be there.

Given that one of the main barriers noted by the rural providers was the time allocated to counselling, and how burn out is an issue, is there any consideration for providing that counselling centrally, perhaps by Skype or phone?

Dr Norman referred to the Provincial Pregnancy Options Service line, which was developed by BC Women's Hospital and the Ministry of Health, and staffed with counsellors who can provide counselling and information about regional services Dr Norman stated that she believed there is an opportunity the potential of investing in a central service which could better support many of the rural providers, giving information about the procedure and providing remote counselling to patients. She noted that Options for Sexual Health has also been a partner in providing counseling locally and centrally through their hotline and clinics.


INTERACTIVE AUDIENCE-PANEL DISCUSSION
PROGRESS...
IS HAPPENING, BUT IT IS UNEVEN
Opposition is well-organized
We still have WORK to DO
WE MUST COMMUNICATE & DEVELOP SUPPORT NETWORKS
NDS:
NEW DRUG SUBMISSION
HEALTH CANADA is DOING THEIR DUE DILIGENCE
PINE FREE CLINIC CLOSING
HAs DECIDE WHAT STAYS OPEN and WHAT CLOSES (ADM & DM Level Decisions)
CONTRACEPTION
WHY IS IT NOT FREE IN CANADA?
We need to do a SURVEY to determine COSTS of UNINTENDED PREGNANCIES
VARIABLE HEALTH PLAN COVERAGE
PUBLIC HEALTH LENS
HOW CAN THE DISCUSSION BE FACILITATED TO ENHANCE POLITICAL WILL?
Speaking about abortion is TABOO
People who are not being IMPACTED by STIGMA are IN A BETTER POSITION to SPEAK OUT
MYTHS:
Public perception is that ABORTION is RARE
WE NEED TO TALK ABOUT IT & NORMALIZE ABORTION

Part II: Development of Proposed Solutions

The conference shifted in the afternoon to a planning workshop for designated interprofessional and inter-sectoral stakeholders. The aim was to use the information presented in the morning and participants' expertise to explore of ways of collectively planning and strategizing to improve support for rural abortion services and the provision of services closer to home for women in BC.

Presentation of Innovative Solutions in BC Communities

Dr Norman began the afternoon by reading two write-in testimonies that were sent in by physicians working in northern BC communities, and discussing the challenges they have experienced in offering abortion services in their rural setting. The physicians noted being overwhelmed with the workload and struggling to continue providing abortion services with such tight resources. The lack of relief for rural providers and patient travel issues were noted as major barriers. Both physicians noted the need to explore new models of care to ensure the abortion and family planning needs of rural women are met.

The audience then heard, via video conference, about two services in BC that had moved their abortion provision out of the OR and into ambulatory settings within their hospital. Presenters discussed the impact this shift had on their hospital, staff and feedback from patients.

Women's Services Clinic – Kelowna

Bev Sieker, Health Services Director, Kelowna General Hospital, noted that the Women's Services Clinic, was established at the hospital in 2000. The clinic was originally funded to provide 650 procedures a year and provide services up to 12 weeks gestation. The weekly clinic is located within the acute care facility, but in an area that is separated from patient wards. Staffing includes a unit clerk (three-day/week) to book appointments and support the running of clinic. The clinic is also staffed with four registered nurses who rotate through counseling, pre-post procedure care, and providing support during the procedure, with one licenced practical nurse and one Sterile Processing Technician.

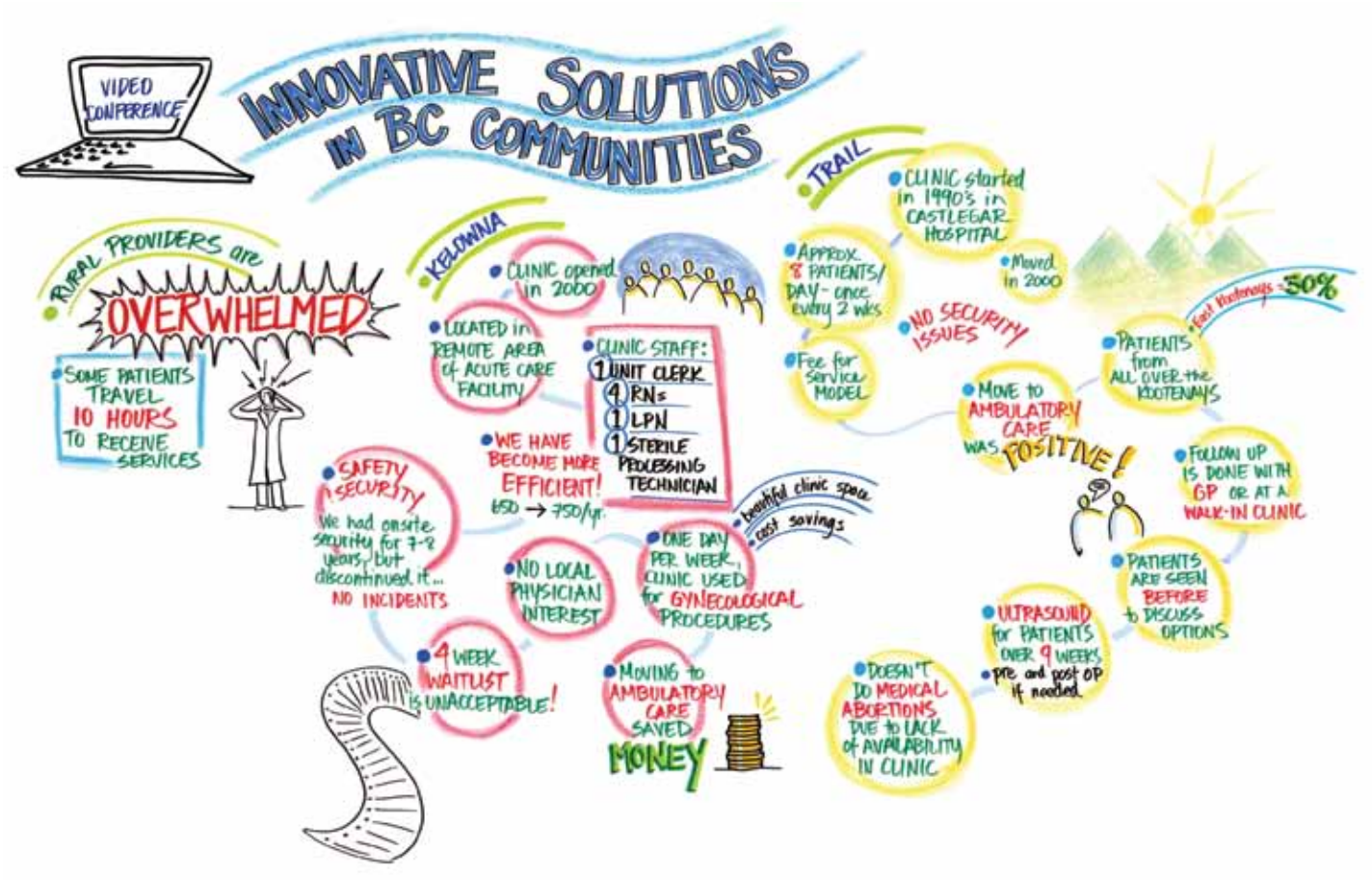
While the funding and staffing model has stayed the same, efficiency continues to increase, with 750 abortion procedures performed in 2013-2014. Ms Sieker noted that the long wait list, an average of four weeks, is a major barrier to meeting the needs of women in the Okanagan and beyond. They continue to advocate for additional resources to run more clinics per week. In terms of safety and security, the clinic has the recommended control features and access restrictions, but does not require security presence at the clinic. There have been no security incidents in 14 years. They have seen a savings of between $300-$350 per case by moving the procedures out of the operating room (avg $830/case), and into this ambulatory care setting (average $520/case). Since Fall 2009, the hospital has also been able to use the clinic space one day a week to perform gynecological procedures, moving them out of the operating room. This has seen similar savings per case. The patient and physician response to providing abortion procedures in the clinic space has been overwhelmingly positive, with a concomitant decrease in stigma for the abortion service, as all women's services are now offered in the same "Women's Services Clinic".

Kootenay Boundary Regional Hospital, Trail

Cindy Ferguson, Manger of Surgical Services and Ambulatory Care, Kootenay Boundary Regional (KBR) Hospital and a local physician in the region discussed their ambulatory abortion clinic. The program originated in 1990s at Castlegar Hospital and was moved to the KBR Hospital in 2002. Abortion services were moved out of the OR and into an ambulatory setting two years ago. Her clinic noted almost identical savings per procedure as noted by the Kelowna service. Ambulatory staff (one RN, one LPN, and one clerk) are used to run the bi-weekly clinic which utilizes the surgical day care centre. While most staff have no concerns working in the clinic, Ms Ferguson noted that she allows staff to opt out of working there if they choose. On average, between six to ten patients are seen per clinic. The clinic sees patients from across the Kootenays.

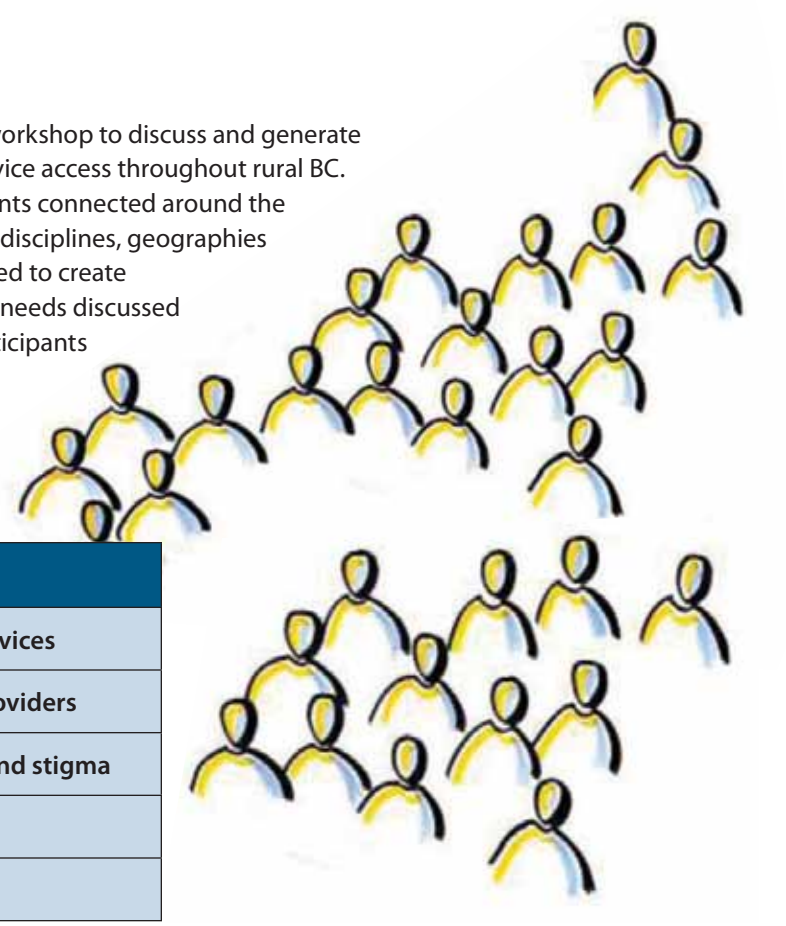
Ultrasounds are performed in the clinic on the day of the procedure when needed. The move from the OR to the ambulatory setting was a positive move for the patients, allowing for a much more relaxed atmosphere. Ms Ferguson noted that the KBR clinic also has no onsite security during the day, and has never encountered a security issue.

The physician noted that one of the challenges to running this clinic is that there are not funding for abortion provision, therefore only staffing and infrastructure funding comes from the hospital budget and the only physician payment is fee-for-service. Unlike other centres, there are no counsellors to provide support and counselling to patients. This responsibility falls on the physician who sees patients outside clinic the day before (pre-operative intake, counseling, consent etc). Follow up is done with the patient's GP, at an Opt Clinic, or a walk-in clinic. However, the physician noted that some GPs refuse to provide care to abortion patients. The clinic does not provide medical abortions, because the sole physician is not readily available for the volume of follow up and on-call services as required for methotrexate medical abortions. The physician reported that it would be ideal if more GPs in the area provided medical abortions and thus the KB hospital service would surgical abortions as a backup. Being the only provider of abortion services, the physician noted potential issues of burn out due to her need to be on-call at all times, although she is rarely called off hours, and to a sense that it is hard to be away from the community as there is no one to undertake the service in her absence.



Summary of Feedback

The rest of the afternoon was spent in a facilitated workshop to discuss and generate ideas on how to improve family planning health service access throughout rural BC. Facilitator, Jen Reed-Lewis recognized that participants connected around the content presented in the morning through different disciplines, geographies and perspectives. The afternoon session was intended to create coordinated action to mitigate the gaps and service needs discussed in the morning sessions. Ms Reed-Lewis, invited participants to reflect on the content and issues they want to coordinate around and to drive that to action.



KEY THEMES
BC has a significant unmet need for abortion services
Uneven distribution of access to services and providers
Rural providers facing major logistical barriers and stigma
Medical abortions are underutilized
Gaps in knowledge and data hindering progress

MAJOR BARRIERS	MAJOR FACILITATORS
Provider relief and succession	Training and Education
Cost and logistics	Innovations in practice and care
Lack of data	Better data collection and reporting
Stigmatization	Advocacy and dispelling myths
Distance	Rural provider support and counseling

Open Space Dialogue Session: Generating Solutions and Recommendations

Ms Reed-Lewis lead participants through an Open Space dialogue process which aimed to generate list of key change topics and move participants through three conversation rounds to focus the discussion on solutions and recommendations.

First participants were asked to respond to a focused question to generate change topics: "If we are going to provide safe, high quality abortion support in rural communities, we really need to focus our efforts on..."

Participants were asked to shout out response and then write it down on a piece of paper and post it on a whiteboard for everyone to see. After generating a robust list of change topics, participants were lead through three rounds of discussion in small working groups to further explore the change topics. Working groups were an interdisciplinary, inter-sectoral mix of health system administrators, front-line providers, researchers, representatives of community based organizations and others from each health authority region to support meaningful conversation. Groups structured their conversation by answering the following questions:

1. What are we doing well?

2. What are the barriers? What can we improve on?

3. What's one recommendation?

Round A

Change Topic	What are we doing well?	What are the barriers? What can we improve on?	What's one recommendation?
1. Increase medical student interest	– Medical School curriculum and Problem Based learning covers abortion	– More hands on learning – Include a mandatory ½ day rotation – Increase awareness of GPs as abortion providers	– Increase focus on abortion during family residency training in rural areas
2. Increase training opportunities for rural GPs	– REAP funding	– Give priority to physicians with a practice location • Flexibility in schedule and duration • Peer mentoring • Distance education • Geographic support communities	– Provide more flexible abortion training with priority given to practicing physicians
3. Systematic monitoring and surveillance	– Individual clinics get their own data to use for planning and monitoring	– Consistent standardized collection and consolidation of data used for planning and monitoring – Data sharing agreements – Relax the interpretation of Freedom of Information Act (FOI) with respect to abortion data between institutions	– Pull together a broad based working group to develop a system of data collection, monitoring and surveillance (clinicians, policy, FOI, researchers, etc)
4. Make health authorities responsible for providing abortion services	– Most HAs are offering some ambulatory care – Collaboration between CART and Ministry of Health	– Better compliance with SOGC standards – Improved funding levels for Opt Clinics – HAs making access to abortion a priority	– Inter-collaborative conversation needed • Where is the best place to provide services? • Look at Quebec model • Discuss pay per performance – Give incentive to hospitals and administrators
5. Provider retention	– There are some dedicated and inspired providers	– Fee codes – Recruitment in rural communities for abortion training	– Funding and support should be more reflective of the work done by abortion providers (Surgical TAs) – A rural abortion provider locum pool is needed – A community of practice for providers could be supportive and helpful
6. Explicit mentoring support	– Assume mentoring integrated with skills training – Ryan Fellowship working for GYN residents – NAF monitoring support	– More access to training for family physicians – Formalized training system – Use connections from the training process to maintain support network	– Training to include more than skill development as well as follow up support

Round B

Change Topic	What are we doing well?	What are the barriers? What can we improve on?	What's one recommendation?
1. Improve grassroots local advocacy and support	– There are Opt Clinics, women's organizations and NAF involvement in some communities	– Make grassroots support more effective – Identify champions – Use less obvious networks to make abortion issue more explicit – Sustaining existing surgical services	– Develop a way to leverage existing supportive community groups to facilitate grassroots support and advocacy
2. Examine the scope of practice for interdisciplinary teams (e.g. nurse practitioners, midwives)	– NPs have a fairly large scope now – Midwifery more interested in contraception issues – Pharmacists have great expertise about contraception and abortion – Good resources for resource-limited communities	– More choice in providers for women – More scope in practice for other providers; including counselling – Prototype for doula care	– Diversify the level of support for, and team members to support, abortion care providers – Expand beyond physicians (but first focus on contraception) • NP pilot project • Pharmacists
3. Patient counseling support for rural providers	– Sharing information between clinics	– Standardizing documents between all clinics/ providers – Access to resources in other languages	– Central bank of guidelines and patient information • Easy access • Clear owner for updates • Access to remote counselling (Opt hotline, etc). – Would BC Women's consider a central counselling services?
4. Eradicate stigma and isolation	– NAF ads/ anti–stigma campaigns – Talking about it; normalizing the experience – Being explicit about being pro-choice	– Public education and patient education – Get education system on board – Hold teachers and schools accountable to deliver on mandated learning outcomes	– Broad reaching public education campaign (using social media) to get people to understand that abortion is safe, legal and normal
5. College eliminate 14 week TA restriction for General Practitioners	– Recognizing that all other provinces have no such limitations – CollegePSBC has recognized that there are gaps, and no formalities required, so they may be amendable to change	– Changing attitudes in the hospitals for second trimester abortions – Training should be recognized by skills and competency, not professional designation – Training currently is signed by but there is no formal "form" or training list of competencies	– While training criteria should be set, the designation GP/OB/GYN should now be removed. Timing may be optimal now
6. Provider Engagement and Competency	– RCC/ REAP funding – NAF Conference and CART Conference	– A system of connecting new providers with experienced, local mentors – Connecting providers with NAF and other organizations to support them – Organizational system of notifying providers about updated training/ CMEs etc – Establish a discussion network	– Proactive system for contacting and connecting abortion providers regarding training opportunities and support
7. Peer Support and Counselling	– Counselling services offered by providers and allied health team – Pregnancy Options and Opt phone lines	– Better engagement of women with abortion history to provide support to current patients – Normalization and de-stigmatization of abortion – Educational resources to support counsellors	– A pilot project "The Book Club" e.g. Choices Study. Providers as coordinator/liaisons to start conversation about supporting the next generation of women. Help connect and support women with similar experiences

Round C

Change Topic	What are we doing well?	What are the barriers? What can we improve on?	What's one recommendation?
1. Strategies to move procedures out of the OR and into ambulatory setting	– Cost argument – Kelowna data may work for some settings to keep on OR slate	– Educate Anesthesiologist that standby or IV sedation = same fee code as general anesthesia – General anesthetic not best practice - local anesthesia is safer – Early Pregnancy Loss Clinics could be incorporated – Location - ER or ambulatory procedure room	– Advocate for standards to include alternatives to general anesthesia – Undertake and publish research in BC on various funding models, costs and outcomes
2. Mobilize the public to recognize abortion as a public health issue	– Mobilize the public to recognize abortion as a public health issue	– We are funding the procedure – Need to talk about abortion more – More 'story-telling' – Look at the social costs of unwanted children – Need politicians to embrace the issue	– Public media campaign with charismatic spokesperson • Gain widespread support • De-stigmatize • Acknowledge abortion as a common practice of women
3. Streamline and standardize accreditation and regulation for abortion car	– Keeping patients safe – Clinics are working together and coming from evidence based approach to problem solving	– Collaboration with other institutions – Encouraging evidence based consistent standards	– Encourage setting appropriate standards that are applied *consistently* through an integrated single accreditation
4. Prevention of unintended pregnancy, through better sexual health and contraception education	– Sexual health education is embedded into mandated curriculum – We have 60 Opt clinics (but need more)	– Standardize delivery of sexual health education and make sure that it is delivered – Community physicians delivery of sexual health info (e.g. Oregon's 1 Key Question Program)	– Standardize sexual health and family planning education for all
5. Develop regional centres for abortion care	– Kelowna is a 'go to' facility for the Interior region	– Develop related and similar services (e.g fertility, D&C) to use the same type of facility – Use population data and geography to determine most effective location	– Use the model of Kelowna clinic to develop in four areas of province – make these services more integrated and "program-based
6. Free contraception for all	– Opt clinics - in public health offices offer inexpensive contraception – Only four clinics able to insert IUDs – NIHB program	– Insurance companies should be required to cover contraception – Government funded contraception – CADTH current recommendations are efficacy not effectiveness based and a change here could go a long way to supporting government and private insurance subsidy to contraception	– Compile and present evidence to support providing contraception to all women – Present a business case to CADTH to consider changing their current perspective and recommendations with regard to contraceptives.
7. Vacation relief for rural providers and staff	– Providers empathetic - would be willing to help if they could	– Increase the number of abortion clinic days/week • Both items require funding!	– Rural providers locum resource with funding for travel, accommodation, premiums

In addition to the above change topics generated and explored in working group discussions, the following issues were also brought up in the initial brainstorming session:

1. Policy Reform – allow portability of medical insurance coverage for abortion between provinces
2. Improvements in MSP funding for rural providers who don't have counsellors or access to counselling services
3. Support and infrastructure for abortion services from hospitals

Action Planning: Sharing and Setting Priorities

The afternoon concluded with participants breaking into their respective geographic, health authority groups ("Regional Implementation Teams" to engage in action planning. Participants reviewed the change topics and recommendations generated throughout the afternoon, and in like groups, chose one theme for which to develop an initial action plan.

The participants then gathered as a large group, with a representative from each working group summarizing the key issues, priorities and benefits of their action plans.

Group 1: Interior Health

What is your 'aim'?

- Initiate an abortion clinic in Cranbrook supported by established clinics
- Benefits to rural women
- Increase access to service
- Decrease travel
- High level plans
- Establish meeting with stakeholders to discuss needs and logistics
  - Logistics. Staff, Equipment, MDR
  - Space
  - Who are our clients? Who does the prep and follow up? Education
  - What next?

Who's involved?

- Trail – administrator and physician
- Cranbrook – two administrators and two physicians
- Support: three other IHA group members

How will you know the plans are addressing the aim?

- Regular clinic? – every two weeks
- Clients from East Kootenays and Kootenay Boundary having quality abortion services in Cranbrook.

Group 2: Island Health

What is your 'aim'?

- Focus on training for medical abortions
- Involve providers from multiple disciplines (i.e. NP in Port Hardy)
- Increase exposure during family residence

Benefits to rural women

- Reduced travel for procedures

High level plans

- Include training in family practice residency
  - exposure more important than gaining competency
- Collect data to support feasibility of this plan

Who's involved?

- UBC Family Residency program
- Island Health Providers

How will you know the plans are addressing the aim?

- Collect data on medical abortions provided
- Collect data on complications (i.e. lost to follow-up)

Group 3: Northern Health

What is your 'aim'?

- We will approach Northern Medical Program and Prince George Family Practice Residency Program to provide the following:
  - Skills on counselling for options in pregnancy
  - Skills on medical and surgical abortions
  - Explore women's health clinic in Prince George Opt clinic in PG currently only serves women up to 26 years of age)

Benefits to rural women

- Accessibility and sustainability

High level plans

- We already see and train medical students and residents – just need to incorporate this into the training

Who's involved?

- Physician providers from: Prince George, Smithers, Dawson Creek

How will you know the plans are addressing the aim?

- Decreased referrals for TA locally and to C.A.R.E.

Group 4: Vancouver Coastal & Fraser Health

What is your 'aim'?

- Change public opinion with respect to the value (financial and otherwise) of free contraception

Benefits to rural women

- Cost is a big barrier to accessing contraception.
- Contraception is highly useful for rural women who have more complications in accessing abortions.

High level plans

- Evidence to support free contraception
  - Opt has compiled reports in the past
  - More research about rural access to contraception
  - More research about Canadian context
- Evidence won't necessarily be adequate – often the evidence already exists, but for ideological reasons, there are still barriers.
- Bring the issue of abortion and contraception to people's 'radars'.
  - More forums, networking between organizations (Opt, NAF) and the hospitals and health authorities
  - Increased webcasting and webinars

Who's involved?

- Epidemiologists
- Government
- Researchers
- Advocates
- Canadian experts

How will you know the plans are addressing the aim?

- When contraception is free!
- Hopefully abortion rates will go down and rural women will have less hardships in accessing abortion.

Group 5: Provincial Services & Government

What is your 'aim'?

- Build business case for sharing, surveillance and monitoring of abortion data.

Benefits to rural women

- Increased access to abortions locally.
- Decreased travel and associated costs.

High level plans

- Determine current resources and who is providing services.
- Pull together data from health authorities, Opt, BC Women's, Perinatal Services BC (PSBC) and NAF.
- Use the Hospital Services Review as a hook to justify the service plan.

Who's involved?

- Pull together a taskforce that includes:
  - Data people
  - FOI people
  - Opt
  - PHSA
  - RCCBC
  - CART
  - Pharmacy (Judith)
  - NAF (Dawn)

How will you know the plans are addressing the aim?

- The data is collected and then the plan is developed.

Next Steps

As the conference came to a close, there was confidence and commitment on the part of participants to remain engaged in the CART process and their individual advocacy efforts. Dr Wendy Norman described the work of the day as just the beginning of a continuous engagement with stakeholders within the abortion and family planning community in BC. Ms Reed-Lewis expressed her hope that participants can continue to advocate and share information about what was presented and discussed today.

The next steps for the CART process are to review the conference proceedings and the input and actions prioritized by participants. This will enable the team to determine the most effective approach to working towards the CART aim of reduce unintended pregnancies and improve access to highly effective contraception and abortion services in BC.

Further comments ideas and suggestions can be directed to the CART team at: Cart.grac@ubc.ca or visit our web site: www.cart-grac@ubc.ca


ABORTION IN THE GLOBAL CONTEXT
DR. DOROTHY SHAW
THIS PROBLEM
IS HIGHLY SOLVABLE!
ICPD PoA CAIRO
Governments should be responsible for family planning
5 MILLION
WOMEN each YEAR are HOSPITALIZED with COMPLICATIONS from ABORTION
ROMANIA
Maternal mortality rates soared when contraception and abortion were made illegal
MAJOR INITIATIVES
INTERNATIONAL DAY of ACTION for REDUCTION of ABORTION
PREVENTION of UNSAFE ABORTION PROJECT
URUGUAY HARM REDUCTION MODEL
Access to information
Ultrasound
AIRLIE DECLARATION
PREVENTION
WHO HAS DECISION-MAKING POWER in SEX & CONTRACEPTION?
ABORTION IS NOT RARE!
RELIGIOUS COUNTRIES DO NOT HAVE a LOWER RATE of ABORTION
UNMET CONTRACEPTIVE NEED GLOBALLY is SIGNIFICANT
PROBLEM:
DELAY IN PROVIDING CARE for COMPLICATIONS from ABORTION
El Salvador:
WOMEN are WRONGFULLY IMPRISIONED for SPONTANEOUS MISCARRIAGES
Restricting ACCESS to CONTRACEPTION and ABORTION increases MATERNAL MORTALITY RATES
13%
OF MATERNAL MORTALITY IS DUE to UNSAFE ABORTION
PROGRESS
ACCESS to CONTRACEPTION
EDUCATION & ACCESS to INFORMATION
LEGAL REFORM for REPRODUCTIVE HEALTH & RIGHTS
2011-2013 in the USA:
200 provisions reduced access to ABORTION
CALIFORNIA approved provision by mid-level providers

Appendix A: Agenda

MORNING — **CURRENT KNOWLEDGE, BC EVIDENCE & BEST PRACTICES**

Participants: **Open invitation for all family planning clinicians, service providers and regional administrators, researchers, patient group representatives, and trainees**

8:00–8:10 **First Nations Welcome Ceremony**

First Nations Elders

8:10–8:25 **Welcome and Overview**

Dr Perry Kendall, Provincial Health Officer, BC Ministry of Health;
Dr Jan Christilaw, President, BC Women's Hospital and Health Centre;
Dr Wendy V. Norman, Conference Chair

8:25–8:30 **Introduction of the Ryan Program International Speaker**

Dr Brian Fitzsimmons, Assistant Professor, and Director,
Ryan Program in Family Planning, Dept of Obstetrics & Gynecology, UBC;
Medical Director, CARE Program, BC Women's Hospital

8:30–9:10 **KEYNOTE ADDRESS: Abortion in Outpatient Settings: Access, Safety, Acceptability**

Dr Eve Espey, Professor, Department of OB-GYN
Chief, Family Planning Division, University of New Mexico, Albuquerque, NM

09:10–09:30 **Abortion in the Global Context**

Dr Dorothy Shaw, Clinical Professor, UBC, Vice President, Medical Affairs,
BC Women's Hospital, Vancouver, BC

09:30–09:50 **Abortion in Canada: You Are Not Alone**

Ms Dawn Fowler, Director, National Abortion Federation, Canada

09:50–10:10 **NUTRITION AND NETWORKING BREAK – POSTER VIEWING SESSION**

10:10–10:30 **Medical Abortion – How To and What's New**

Dr Ellen Wiebe, Clinical Professor, UBC

10:30–10:50 **Abortion Service in BC: Findings from the British Columbia Abortion Providers' Survey**

Dr Wendy Norman, Assistant Professor, UBC
Dr Jennifer Dressler

10:50–11:10 **2-minute Lightning Presentations on BC Services, Organizations, Opportunities**

BC Ministry of Health – *Joan Geber;*
BC Women's Hospital & Health Centre – *Cheryl Davies;*
Options for Sexual Health – *Jennifer Breakspear;*
Ryan Program: Training at BC Women's – *Dr Brian Fitzsimmons;*
Rural Coordination Centre of BC – *Dr Kirstie Overhill;*
Women's Health Research Institute – *Dr Kathryn Dewar;*
UBC Women's Health Family Physician Fellowship – *Dr Wendy Norman, Conference Partners, Audience Members*

11:10–11:50	**Interactive Audience-Panel Discussion:** – Audience Submissions of Comments, Reaction, Questions – Ideas to Address Identified Challenges/Opportunities *All Speakers, Moderator and Audience Members*
11:50–12:00	**Conference Summary and Morning Session Closing Remarks** *Dr Dorothy Shaw* *Dr Wendy Norman*

AFTERNOON BY INVITATION ONLY

AFTERNOON	**DEVELOPMENT OF PROPOSED SOLUTIONS**
Participants	**Invited Knowledge User leaders, Health System Decision-Makers, Patients, Rural physicians, Researchers and Trainees**
12:00–12:30	**INTER-SECTORAL, INTERDISCIPLINARY LUNCH**
12:30–13:00 (DURING LUNCH)	**Presentation of Innovative Solutions in BC Communities** *Providers from several BC communities*
13:00–14:30	**Creating Change Conversation Rounds** – Change Topics generated by participants, choose 3 topics for 3 conversation rounds – Open Space Technique *Facilitator*
14:30–14:45	**NUTRITION AND NETWORKING BREAK** – Gallery walk on Themes
14:45–15:30	**Issue to Action** – In like groups, choose a theme to act on and within sphere of control identify improvement areas to take on *Facilitator*
15:30–16:15	**Report Outs** *Facilitator*
16:15–16:45	**Meeting Summary, Next Steps** – *Conference Chair*
16:45–17:00	**Closing Ceremony**

Appendix B: Speaker Bios

Dr Jan Christilaw

Dr Jan Christilaw is President of BC Women's Hospital & Health Centre (BC Women's) and a leader in Canada and internationally in ensuring women have access to high quality reproductive health care. She is a Clinical Professor in the Department of Obstetrics-Gynecology, holds a Masters of Health Science; is a Past-President of the Society of Obstetrician-Gynecologists of Canada; a Co-Chair of the Women's Health Task Force, a member of the JOGC Editorial Board, and past chair of the SOGC Ethics Committee. Jan's recent Awards include: the Federation of Medical Women of Canada Reproductive Health Award, and the Queen Elizabeth II Diamond Jubilee Medal.

Cheryl Davies

Cheryl is currently the Vice-President, Patient Care Services at BC Women's. She has over 20 years experience in women's health as a nurse, educator and executive leader, in both community and hospital settings, and is a former Executive Director of the Elizabeth Bagshaw Women's Clinic. A lifelong volunteer, she is currently a Board Director with Health for Humanity.

Dr Kathryn Dewar

Dr Kathryn Dewar is the Research Program Manager at Women's Health Research Institute, BC Women's Hospital & Health Centre. She collaborate with clinicians, residents and hospital staff to develop and implement research projects within the clinical programs of BC Women's Hospital.

Dr Jennifer Dressler

Dr Jennifer Dressler is a rural family physician living in Grand Forks and working in and around the West Kootenay/Boundary region. She graduated from the Okanagan Rural Family Medicine Program, during which she was a co-investigator in the BCAPS study. She is returning to UBC to complete additional training in obstetrics and women's health.

Dr Eve Espey

Dr Eve Espey, MD MPH is Professor and Chair of the Department of Obstetrics and Gynecology, and Family Planning fellowship director at the University of New Mexico. She is President-elect of the Society of Family Planning, the Medical Advisory Committee Chair for the National Campaign to Prevent Teen and Unplanned Pregnancy and Chair of the American College of OB-GYN's Committee on Underserved Women. She has numerous publications in the area of family planning and medical education and has presented locally, regionally and nationally on these topics.

Dr Brian Fitzsimmons

Brian Fitzsimmons, MD, FRCSC, FACOG is a Clinical Associate Professor, and Director of the Ryan Residency in Family Planning, in the Department of Obstetrics and Gynaecology at UBC, and the Medical Director of the CARE (Comprehensive Abortion and Reproductive Education) Program at BC Women's Hospital and Health Centre.

Dawn Fowler

Dawn Fowler is the Canadian Director for the National Abortion Federation. Previously, she worked at Health Canada as Chief of Reproductive and Child Health and coordinated the development of Canada's Perinatal Surveillance System which she insisted include abortion. She has also been a consultant with WHO – EURO Office and worked on reproductive health and quality assurance issues in the newly independent states of the former Soviet Union. Dawn organized the opening of Vancouver Island women's Clinic in British Columbia and managed the facility for four years before taking her current position at NAF.

Joan Geber

Joan Geber has worked in government since 2004. She is currently the Executive Director of the Population Health and Well-being Branch at the Ministry of Health. Within that Branch she provides leadership for two Directorates: the Healthy Development and Women's Health Directorate, and most recently, the Seniors' Health Promotion Directorate. Her responsibilities include development of policy and initiatives related to health promotion and prevention in the areas of women's, maternal and children's health, and seniors' health and well-being. Additionally, she supports the federal-provincial-territorial status of women table. She holds a Masters of Public Administration, a Bachelor of Nursing, and a Psychiatric Nursing diploma.

Dr Perry Kendall

Dr Perry Kendall has been British Columbia's Provincial Health Officer since 1999. As senior medical health officer for the province, he is responsible for advising the minister and senior members of the ministry on health issues in BC and on the need for legislation, policies and practices; monitoring the health of the people of B.C.; providing information and analyses on health issues; and, reporting to the public on health issues or on the need for legislation or a change of policy or practice respecting health. In 2011, Dr Kendall published the report on the Health and Wellbeing of Women in British Columbia.

Dr Wendy Norman (Conference Chair)

Dr Wendy V. Norman has been a family physician since 1985, and has been an abortion provider since 1991. She is an Assistant Professor, and Director, Clinician Scholars Program and Family Practice Research Training in the Department of Family Practice at UBC, and a Scholar of the Michael Smith Foundation for Health Research.

Norman's research program seeks to improve family planning access, quality of care, and health policy. She founded and co-leads the national collaboration: Canadian Contraception Access Research Team/Groupe de recherche sur l'accessibilité à la contraception. www.cart-grac.ca

Dr Dorothy Shaw

Dorothy Shaw, (MBChB, FRCSC, FRCOG, CEC, CCPE) is the Vice President, Medical Affairs for British Columbia's Women's Hospital & Health Centre, responsible for quality and safety in patient care using patient-centred, cost-effective approaches. She is a Clinical Professor in the Departments of Obstetrics and Gynaecology and Medical Genetics in the Faculty of Medicine at the University of British Columbia (UBC). Dr Shaw is Past President of the Society of Obstetricians and Gynaecologists of Canada (1991-1992) and was the first woman President of FIGO from 2006-2009. She currently chairs the Canadian Network for Maternal, Newborn and Child Health.

She is recognized for her contributions to the health and rights of women in Canada and globally and has received several highly prestigious awards in Canada and around the world.

Dr Ellen Wiebe

Dr Ellen Wiebe is a Clinical Professor in the Department of Family Practice at the University of British Columbia. After 30 years of full-service family practice, she now restricts her practice to women's health. She is the Medical Director of Willow Women's Clinic in Vancouver providing medical abortions and contraception. Her research interests include abortion and contraception.

Facilitator: Jen Reed-Lewis

Ms Jen Reed-Lewis has a MA in leadership training and is a seasoned leadership and organization development consultant, with 20 years experience as a catalyst and facilitator.

Appendix C: Participant Sectors

Conference participants included representatives from all CART partner organizations, and from the Northern, Interior, Vancouver Island, Vancouver Coastal and Provincial Health Services health authority regions of British Columbia.

Participants represented

- Health professionals and staff from all BC abortion clinics
- More than half of BC's rural physician abortion providers
- Front line health professional and administrative staff from public health and Options for Sexual Health contraception and sexual health clinics throughout BC
- BC Women's Hospital leadership and staff
- BC Ministry of Health and Provincial and health authority regional medical officers of health
- Regional hospital administrators
- Members of community-based non-profit organizations
- Academic faculty and researchers.

Appendix D: Abstracts

Abstracts of the articles of research on which this conference is based

Norman WV.
Abortion In British Columbia: Trends Over 10 Years Compared To Canada Contraception 2011, 84 (3), 316

University of British Columbia, Vancouver, British Columbia, Canada

Objectives: To determine trends and distribution in Canadian and British Columbia (BC) abortion services from 1995 to 2005.

Methods: We performed a secondary analysis of published data and data available through the BC Pregnancy Options Services database. We measured age-specific population trends and trends for abortion rates and service location in Canada and BC, and trends for the number of BC physicians performing abortions.

Results: While Canadian abortion rates declined 12% from 1995 to 2005,BC rates have remained largely unchanged (0.6% decline overall, 9% in highest risk group). Age-specific population shifts do not explain the trends nor the difference between Canada and BC. In both jurisdictions, a trend towards abortion provision in purpose-specific clinics prevails. In BC, 81% of abortions are now provided within clinics located in large urban centers, almost exclusively in Vancouver and Victoria. Since 1995, BC has experienced an estimated decline in the number of abortion providers offering services at hospitals outside the clinic system of upwards of 60%, and a 65% decline in the number of abortions provided in such hospitals.

Conclusions: BC abortion rates are not following Canadian declining trends and are increasingly available only in clinics located in large population centers. Accessibility for women in rural and remote locations has declined 65% from 1995 to 2005.

WV Norman, JA Soon, N Maughn, J Dressler.
Barriers to Rural Induced Abortion Services in Canada: Findings of the British Columbia Abortion Providers Survey (BCAPS). PloS one 8 (6), e67023

Background: Rural induced abortion service has declined in Canada. Factors influencing abortion provision by rural physicians are unknown. This study assessed distribution, practice and experiences among rural compared to urban abortion providers in the Canadian province of British Columbia (BC).

Methods: We used mixed methods to assess physicians on the BC registry of abortion providers. In 2011 we distributed a previously-published questionnaire, and conducted semi-structured interviews.

Results: Surveys were returned by 39/46 (85%) of BC abortion providers. Half were family physicians, within both rural and urban cohorts. One-quarter (17/67) of rural hospitals offer abortion service. Medical abortions comprised 14.7% of total reported abortions. The three largest urban areas reported 90% of all abortions, although only 57% of reproductive age women reside in the associated health authority regions. Each rural physician provided on average 76 (SD 52) abortions annually, including 35 (SD 30) medical abortions. Rural physicians provided surgical abortions in operating rooms, often using general anaesthesia, while urban physicians provided the same services primarily in ambulatory settings using local anaesthesia. Rural providers reported health system barriers, particularly relating to operating room logistics. Urban providers reported occasional anonymous harassment and violence.

Interpretation: Medical abortions represented 15% of all BC abortions, a larger proportion than previously reported (under 4%) for Canada. Rural physicians describe addressable barriers to service provision that may explain the declining accessibility of rural abortion services. Moving rural surgical abortions out of operating rooms and into local ambulatory care settings has the potential to improve care and costs, while reducing logistical challenges facing rural physicians.

J Dressler, N Maughn, JA Soon, WV Norman. The Perspective of Rural Physicians Providing Abortion in Canada: Qualitative Findings of the BC Abortion Providers Survey (BCAPS). PloS one 8 (6), e67070

Background: An increasing proportion of Canadian induced abortions are performed in large urban areas. For unknown reasons the number of rural abortion providers in Canadian provinces, such as British Columbia (BC), has declined substantially. This study explored the experiences of BC rural and urban physicians providing abortion services.

Methods: The mixed methods BC Abortion Providers Survey employed self-administered questionnaires, distributed to all known current and some past BC abortion providers in 2011. The optional semi-structured interviews are the focus of this analysis. Interview questions probed the experiences, facilitators and challenges faced by abortion providers, and their future intentions. Interviews were transcribed and analyzed using cross-case and thematic analysis.

Results: Twenty interviews were completed and transcribed, representing 13/27 (48.1%) rural abortion providers, and 7/19 (36.8%) of urban providers in BC. Emerging themes differed between urban and rural providers. Most urban providers worked within clinics and reported a supportive environment. Rural physicians, all providing surgical abortions within hospitals, reported challenging barriers to provision including operating room scheduling, anesthetist and nursing logistical issues, high demand for services, professional isolation, and scarcity of replacement abortion providers. Many rural providers identified a need to 'fly under the radar' in their small community.

Interpretation: This first study of experiences among rural and urban abortion providers in Canada identifies addressable challenges faced by rural physicians. Rural providers expressed a need for increased support from hospital administration and policy. Further challenges identified include a desire for continuing professional education opportunities, and for available replacement providers.


ABORTION IN CANADA: You are NOT ALONE
DAWN FOWLER
NAF GOAL:
ABORTION
SAFETY
NAF - CANADIAN ROOTS
Canadian Programs
Members across the country
Support
NAF: Professional Association of Abortion Providers
CLINICAL TEXTBOOK
SURGICAL & MEDICAL ABORTIONS
SOON TO BE IN SPANISH
WEBINARS
ON-SITE TRAININGS
CONFERENCES
Clinical Policy Guidelines
QUALITY ASSURANCE MONITORING
WE ARE ALWAYS THERE for YOU
CALL US!
WE WILL COME to YOU!
SAFETY and SECURITY
assessments (facility & home)
lobbying
AWARENESS
PUBLIC POLICY
dispelling MYTHS
press conferences
legislation
meet with colleges
NAF HOTLINE & PATIENT ASSISTANCE
MEMBERS-ONLY WEBSITE
WE WANT TO BRING YOU TO A LEVEL OF COMFORT IN PROVIDING ABORTION CARE
MEDICAL ABORTION: How To and What's New
DR. ELLEN WIEBE
MEDICAL ABORTION
PROS
Early
Private
Natural
Foster
CONS
Uncertainty of Timing
Pain/Bleeding
5-10% surgical complications
WHY? WOMEN CHOOSE IT!
PROTOCOLS:
DIFFERENCES IN SIDE EFFECTS
ASSESSING for COMPLETION
FOLLOW UP to ENSURE that an ABNORMAL BABY is NOT BORN!
GESTATIONAL AGE
IMPACTS the EFFECTIVENESS
MANAGING SIDE EFFECTS
THERE ARE LOTS!
LET THEM KNOW WHAT TO EXPECT
MEDICAL HISTORY
HISTORY
RH
WHAT'S NEXT?
SAFER!
FASTER!
MANAGING DELAYED RXNS
OPTIONS: surgery, More Miso, Wait & see
COUNSELING
OPTIONS
INFORMED CONSENT
CONTRACEPTION
RESOURCES
National Abortion Federation
WILLOWCLINIC.CA
SOGC 2013 Guidelines
MEDICAL ABORTIONS by SKYPE
COURIER MEDICATION
SUPPORT VIA SKYPE
METHOTREXATE & MISOPROSTOL
SAFE for BREAST-FEEDING


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


CIHR IRSC
Canadian Institutes of Health Research
Instituts de recherche en santé du Canada


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


Opt
Options for
Sexual Health


Rural Coordination
Centre of BC
Enhancing rural health through
education and advocacy
RCC BC


naf
NATIONAL
ABORTION
FEDERATION


RYAN
RESIDENCY
TRAINING PROGRAM