Sexual and Reproductive Health Toolkit

An introduction

Dr. Sadaf Faisal, Ph,D, B,Pharm, BCGP

Tomilola Grant, MPH, B.Pharm

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Canadian Pharmacists Association
Association des pharmaciens du Canada

Disclosures

- Partnership and funding

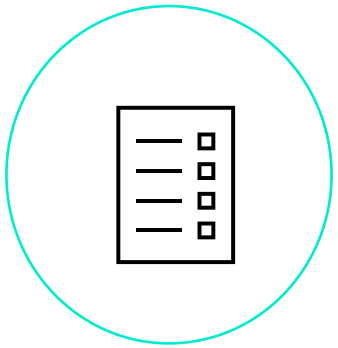
Financial contribution:

Health Canada | Santé Canada

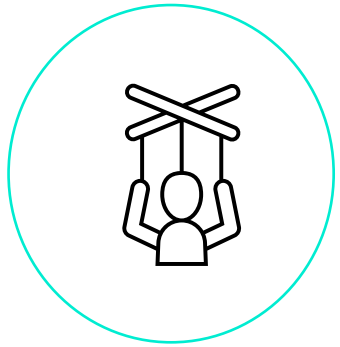
Agenda

Background

Development of toolkit



Components of toolkit



Use of toolkit

Poll 1

How confident are you in your ability to dispense the medications to end a pregnancy?

1 = Not at all confident

2 = Not confident

3 = Unsure

4 = Confident

5 = Very Confident

Background

In developed countries, 257 million women are not using safe methods of contraception

Worldwide

- 40% unintended pregnancies
- 50% of unplanned pregnancies result in abortion
- 45% of abortions performed are unsafe
- 7 million hospitalization annually and contributing to 5 to 13% of all maternal deaths.

Canada

- 34–40% unintended pregnancies
- 60% of unintended pregnancies end in abortion

Government of Canada: Sexual and reproductive health and rights. https://www.international.gc.ca/world-monde/issues_development-enjeux_developpement/global_health-sante_mondiale/reproductive-reproductifs.aspx?lang=eng
Sedgh G, Singh S, Hussain R. Stud Fam Plann. 2014;45(3):301-314.

Background

Abortion in Canada

1

Decriminalized in Canada in 1969

2

Insured health service

3

Jurisdictional and regional disparities to access

4

Barriers for marginalized populations

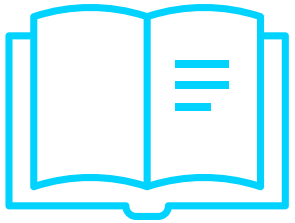
Action Canada for Sexual Health and Rights. Universal Periodic Review of Canada. Joint Stakeholders Report. Nov 2023,

Role of Pharmacists

- 11,000 pharmacies across Canada
- Majority of Canadians live within 5 km of a pharmacy
- 8 provinces now allow pharmacists to prescribe hormonal contraception
- Pharmacists can prescribe, educate and counsel.

How was the toolkit developed?

Research and Information Gathering



Comprehensive Literature Review	Focused on equity gaps and socio-economic barriers related to medication abortion
Environmental Scan	Identified existing resources available for both pharmacists and patients, pinpointing areas where gaps in information and support are prevalent

Real-World Insight

Focus Group Discussions with

- ***BIPOC Individuals***
  - To understand safe and stigma free environment

- ***Pharmacists across the country***
  - To explore the barriers and facilitators to provide medication abortion and contraception services at the pharmacy

Focus group discussions – End users

"One of the challenges one would consider is having people guilt trip you. You go to the pharmacy to get some contraceptive or the abortion pill, you get people looking at you, and they're making you feel you are doing something terrible"

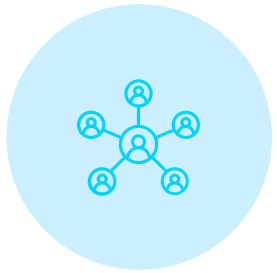
Participant (age: 25-34)

Focus group discussions - Pharmacists

"Most of the populations that are coming to you or requesting a medication abortion, they don't really know where to go. They're not really aware of who to see, whether or what, how this whole process happens, what to look for."

Expert Review

Lessons learned from the project



Engagement phase

Pharmacist preferred tools

Type of language

Socio-economic factors

Purpose and Scope

Scope of the Toolkit

Resources	• Medication abortion • Contraception
Audience	• Pharmacists • Patients
Language	• English • French

Purpose(s) of the Toolkit

Support for daily practice

Counselling & education

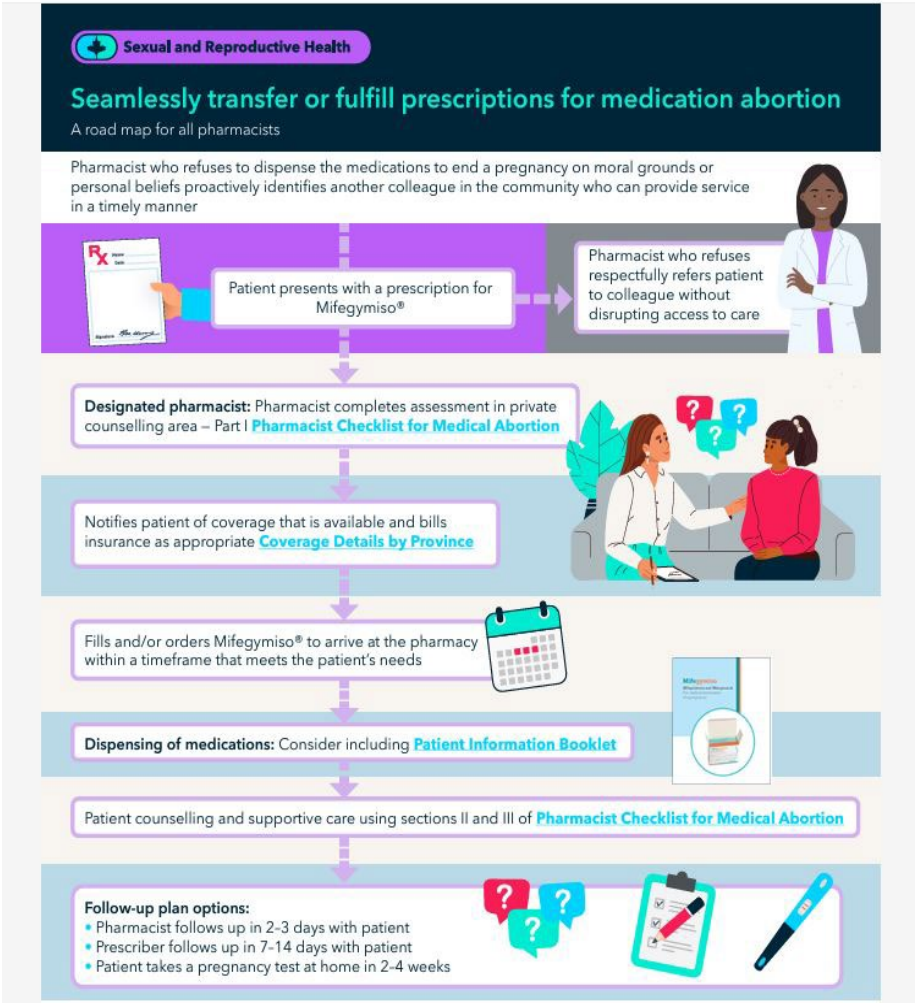
Documentation templates

Overview of the tools

Where can I find the toolkit?

www.pharmacists.ca/advocacy/practice-development-resources/sexual-and-reproductive-health/

Pharmacist tools: Medication abortion



- Algorithm – A roadmap for all pharmacists

Pharmacist tools: Medication abortion

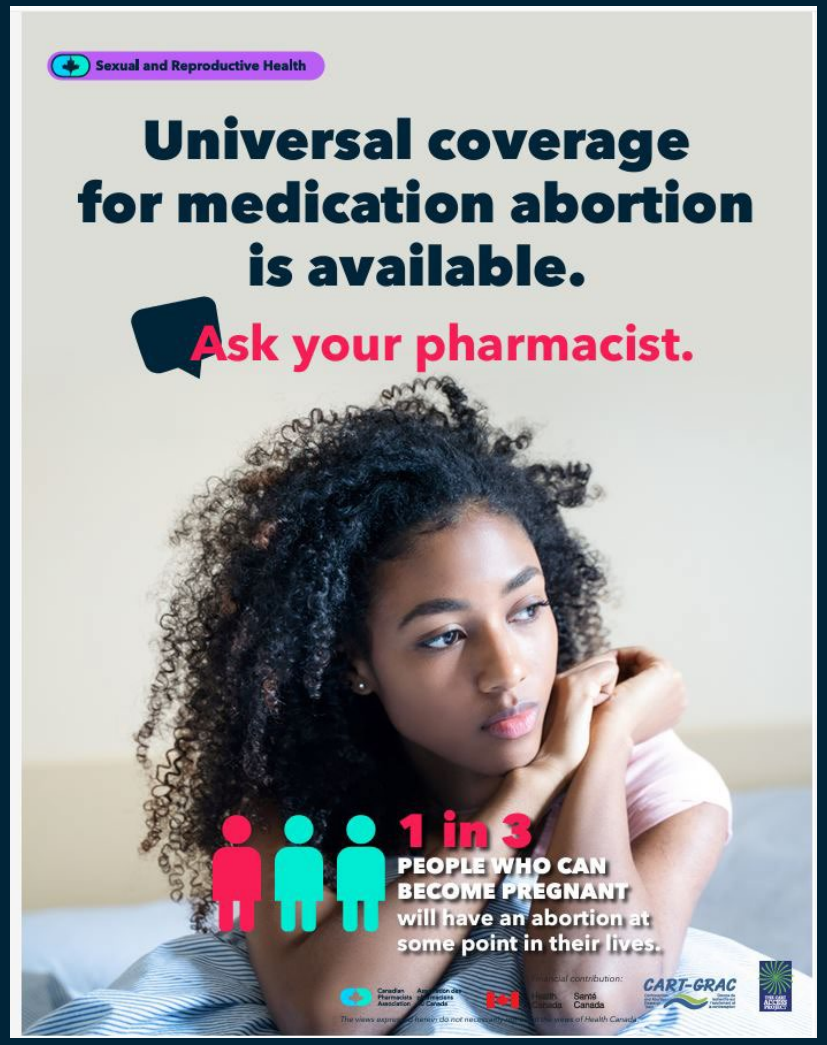
- Infographic – myths and facts

Poll 2

True or false: The cost for Mifegymiso (mifepristone and misoprostol combination) is covered by all provinces and territories for individuals possessing valid health insurance from the province or territory in which they reside.

- **True**
- **False**

Pharmacist tools: Medication abortion



Posters

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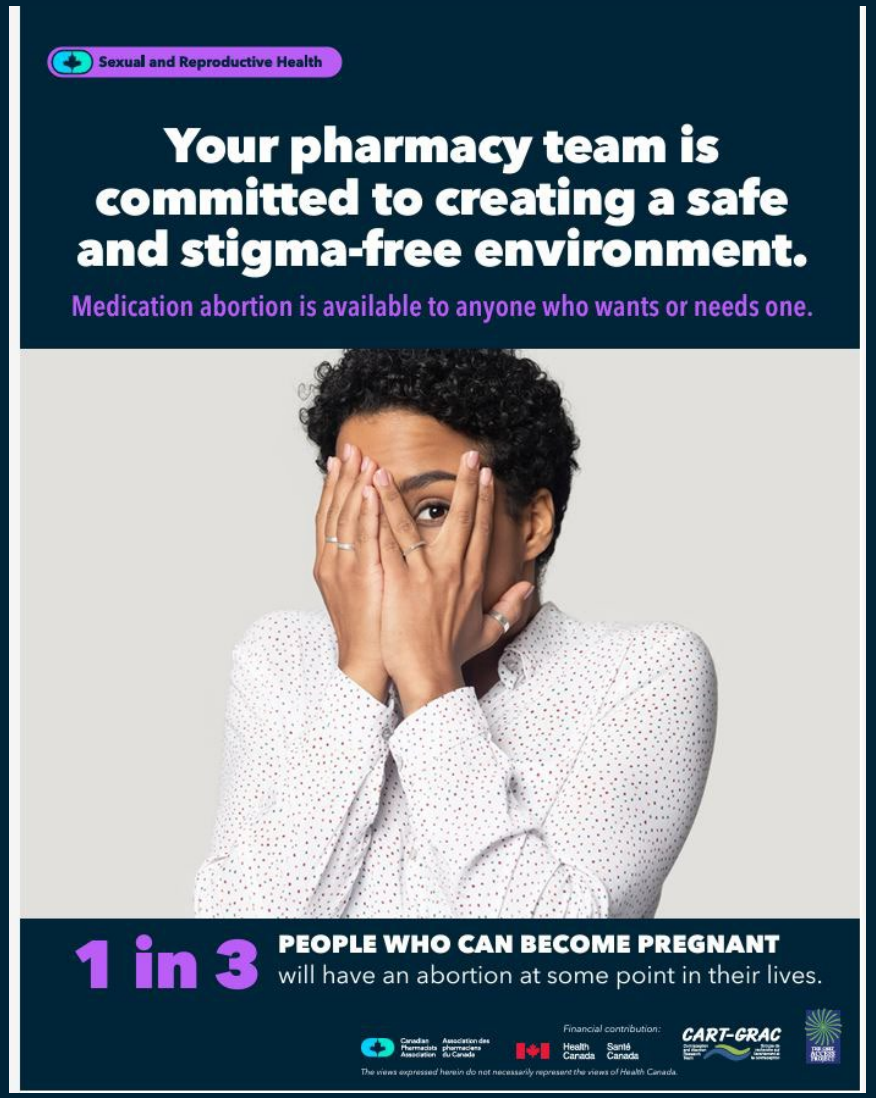
Pharmacist tools: Medication abortion

Posters

Pharmacist tools: Medication abortion

Posters

Pharmacist tools: Medication abortion

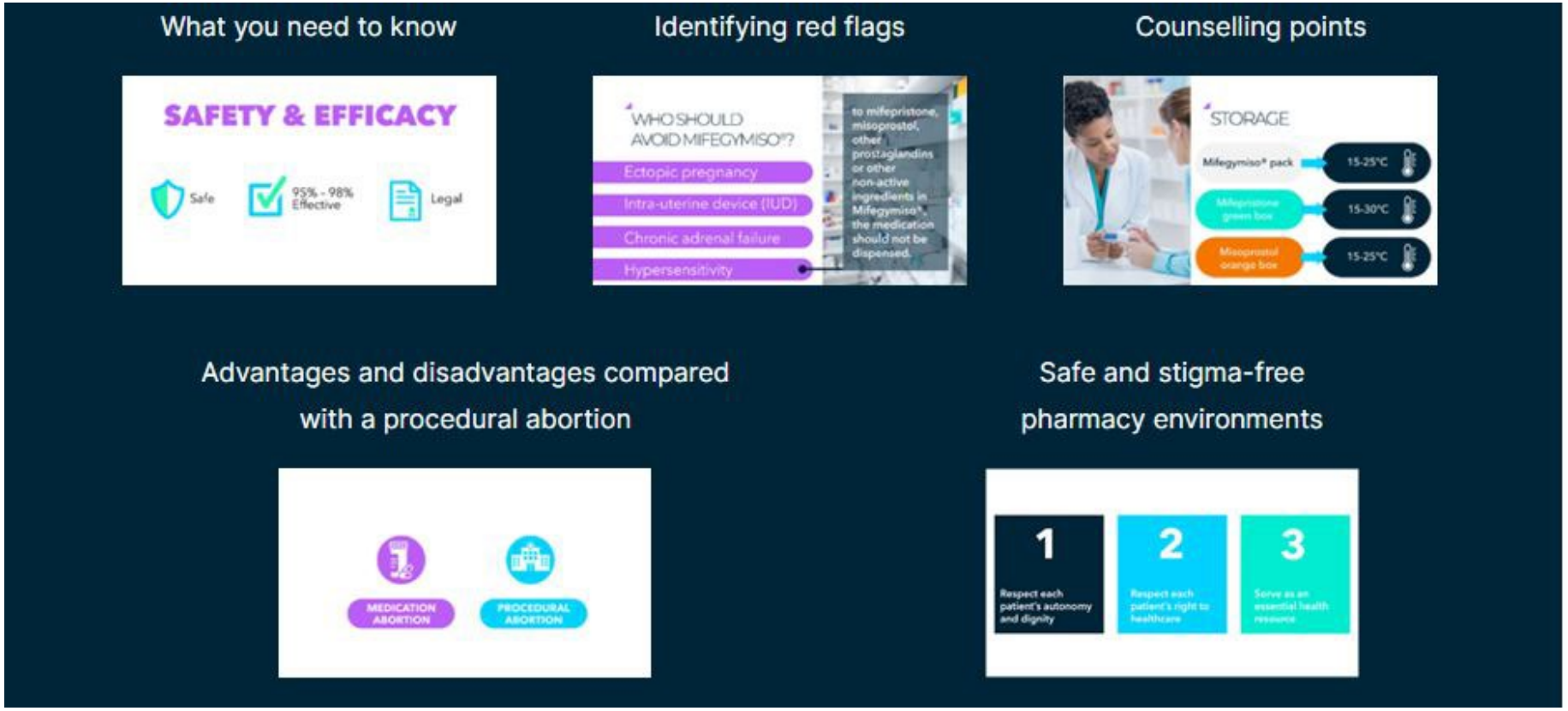


Posters

Canadian Pharmacists Association | Association des pharmaciens du Canada

Pharmacist tools: Medication abortion

- Micro-learning videos



Pharmacists Tools: Medication abortion

- Recorded webinar

Pharmacist tools: Contraception

- Choosing tool

Sexual and Reproductive Health

Prescribing or counselling on contraception

Important Factors to Consider

This tool is designed to be used to help patients understand the options available for pregnancy prevention. When selecting a suitable contraceptive, certain factors are important to consider.

OPTION	EFFECTIVENESS[1]	CHANGES TO MENSTRUAL BLEEDING	FREQUENCY OF USE[2]	HORMONE CONTENT	PRIVACY	METHOD OF USE
Levonorgestrel (LNG)-IUS	99 out of 100	Spotting, lighter or no periods	Up to 8 years	Progestin	Partner(s) may be aware	Placed inside uterus by a health-care provider
Copper IUD	99 out of 100	Heavier or longer periods for the first 3–6 months	Up to 3–10 years	No hormone	Partner(s) may be aware	
Implant	99 out of 100	Spotting, lighter or no periods	Up to 3 years	Progestin	Discreet[3]	Placed in upper arm by a health-care provider
DMPA injection	97 out of 100	Spotting, lighter or no periods	Every 3 months	Progestin	Very discreet	IM injection in the deltoid or gluteal muscle by a health-care provider
Combined oral contraceptive	91 out of 100	Spotting for the first few months; periods may become lighter	Daily at the same time	Estrogen & progestin	May be visible	Oral use
Progestin-only pill	91 out of 100			Progestin		Oral use
Patch	91 out of 100		Weekly	Estrogen & progestin	Discreet	Apply to skin
Vaginal ring	91 out of 100		Monthly		Partner(s) may be aware	Insert in vagina
Internal condom	79 out of 100	No effect	Every time	No hormone	Not discreet	Insert in vagina
External condom	87 out of 100					Put over penis
Diaphragm with spermicide	88 out of 100				Mostly discreet	Insert in vagina
Sponge with spermicide (no previous vaginal birth)	88 out of 100					
Sponge with spermicide (after vaginal birth)	76 out of 100					
Spermicide alone	72 out of 100					
Cervical cap (no previous vaginal birth)	84 out of 100					Insert in vagina and push back until cap covers cervix
Cervical cap (after vaginal birth)	68 out of 100					

DMPA: depo medroxyprogesterone acetate IM: intramuscular IUD: intrauterine device LNG-IUS: levonorgestrel-releasing intrauterine system

Pharmacist tools: Contraception

- Getting started with contraception services

Sexual and Reproductive Health

Getting started with contraception services

Step 1 **Ensure privacy and confidentiality.**

Step 2 **Complete patient assessment** (Patient assessment form).
Patient demographics, medical history, menstrual history, social history, possibility of pregnancy, future pregnancy intention, contraceptive experiences, preferences.
Blood pressure check. Refer if long-acting reversible contraceptives are selected or any contraindications exist.

Step 3 **Collaborate with patient to select the most appropriate method based on assessment.**
Provide all options that can be used safely, discuss possible side effects and appropriate use of the options provided (Important factors to consider), discuss dual-method (hormonal + barrier) use based on planned start date (Contraceptive start methods).

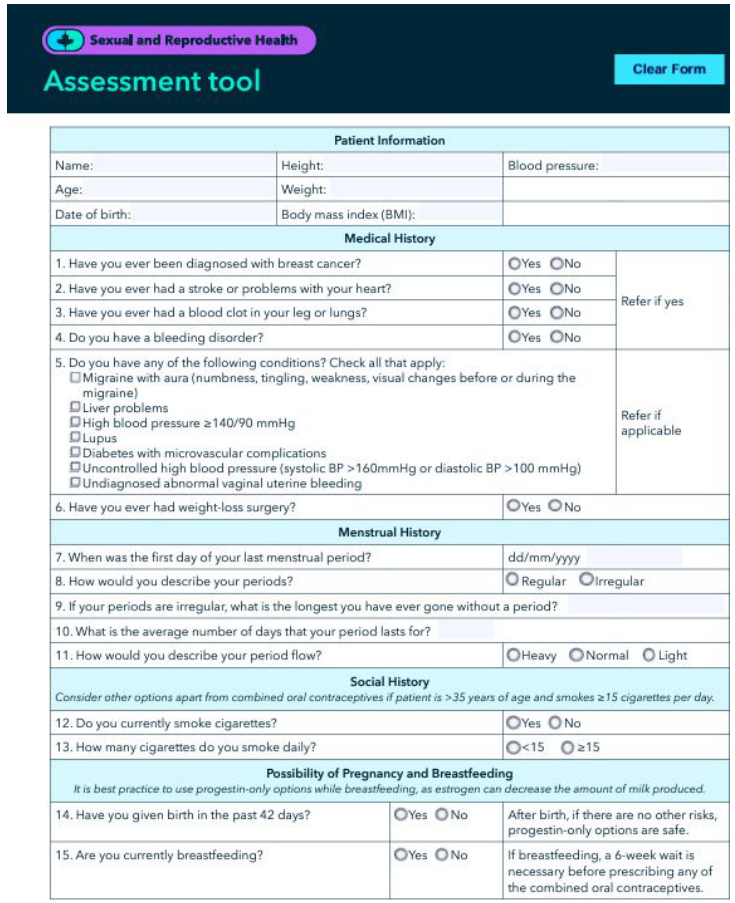
Step 4 **Screen for drug interactions.**
If combined hormonal contraception is an option, check for clinically significant drug interactions.

Step 5 **Provide the method selected by patient.**
Counsel on correct use and confirm understanding. Set up follow-up plan and possible start date (Contraceptive start methods) and suggest setting up a phone reminder to improve adherence. The follow-up plan should include subsequent blood pressure checks and refills if necessary.

Step 6 **Document and notify.**
Document and keep a record of all patient visits and notify all health-care providers.

Pharmacist tools : Contraception

- Assessment tool



Sexual and Reproductive Health

Assessment tool

Clear Form

Patient Information		
Name:	Height:	Blood pressure:
Age:	Weight:	
Date of birth:	Body mass index (BMI):	

Medical History		
1. Have you ever been diagnosed with breast cancer?	○Yes ○No	Refer if yes
2. Have you ever had a stroke or problems with your heart?	○Yes ○No	
3. Have you ever had a blood clot in your leg or lungs?	○Yes ○No	
4. Do you have a bleeding disorder?	○Yes ○No	
5. Do you have any of the following conditions? Check all that apply: ☐Migraine with aura (numbness, tingling, weakness, visual changes before or during the migraine) ☐Liver problems ☐High blood pressure ≥140/90 mmHg ☐Lupus ☐Diabetes with microvascular complications ☐Uncontrolled high blood pressure (systolic BP >160mmHg or diastolic BP >100 mmHg) ☐Undiagnosed abnormal vaginal uterine bleeding		Refer if applicable
6. Have you ever had weight-loss surgery?	○Yes ○No	

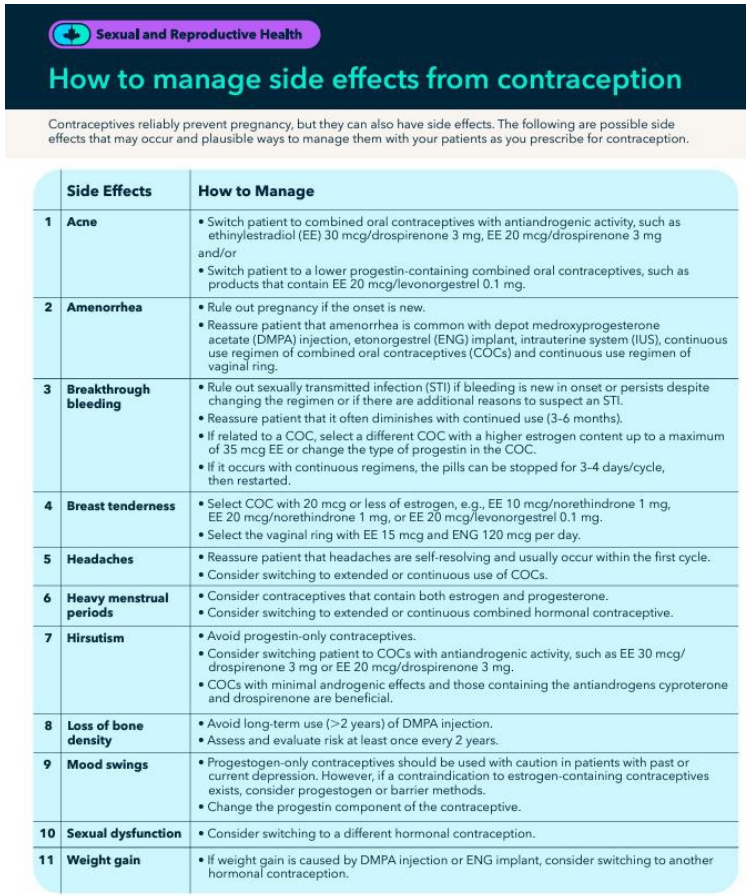
Menstrual History	
7. When was the first day of your last menstrual period?	dd/mm/yyyy
8. How would you describe your periods?	○Regular ○Irregular
9. If your periods are irregular, what is the longest you have ever gone without a period?	
10. What is the average number of days that your period lasts for?	
11. How would you describe your period flow?	○Heavy ○Normal ○Light

Social History *Consider other options apart from combined oral contraceptives if patient is >35 years of age and smokes ≥15 cigarettes per day.*	
12. Do you currently smoke cigarettes?	○Yes ○No
13. How many cigarettes do you smoke daily?	○<15 ○≥15

Possibility of Pregnancy and Breastfeeding *It is best practice to use progestin-only options while breastfeeding, as estrogen can decrease the amount of milk produced.*		
14. Have you given birth in the past 42 days?	○Yes ○No	After birth, if there are no other risks, progestin-only options are safe.
15. Are you currently breastfeeding?	○Yes ○No	If breastfeeding, a 6-week wait is necessary before prescribing any of the combined oral contraceptives.

Pharmacist tools: Contraception

- How to manage side effects



Sexual and Reproductive Health

How to manage side effects from contraception

Contraceptives reliably prevent pregnancy, but they can also have side effects. The following are possible side effects that may occur and plausible ways to manage them with your patients as you prescribe for contraception.

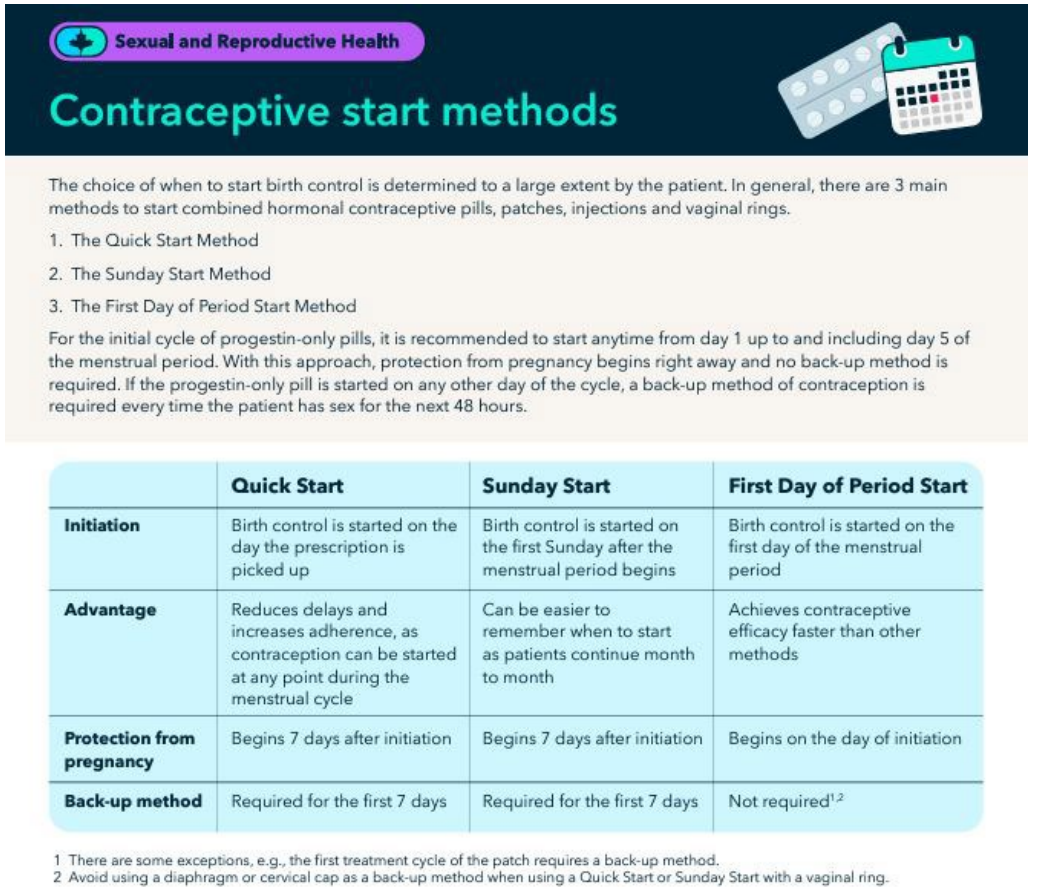
	Side Effects	How to Manage
1	**Acne**	• Switch patient to combined oral contraceptives with antiandrogenic activity, such as ethinylestradiol (EE) 30 mcg/drospirenone 3 mg, EE 20 mcg/drospirenone 3 mg and/or • Switch patient to a lower progestin-containing combined oral contraceptives, such as products that contain EE 20 mcg/levonorgestrel 0.1 mg.
2	**Amenorrhea**	• Rule out pregnancy if the onset is new. • Reassure patient that amenorrhea is common with depot medroxyprogesterone acetate (DMPA) injection, etonorgestrel (ENG) implant, intrauterine system (IUS), continuous use regimen of combined oral contraceptives (COCs) and continuous use regimen of vaginal ring.
3	**Breakthrough bleeding**	• Rule out sexually transmitted infection (STI) if bleeding is new in onset or persists despite changing the regimen or if there are additional reasons to suspect an STI. • Reassure patient that it often diminishes with continued use (3–6 months). • If related to a COC, select a different COC with a higher estrogen content up to a maximum of 35 mcg EE or change the type of progestin in the COC. • If it occurs with continuous regimens, the pills can be stopped for 3–4 days/cycle, then restarted.
4	**Breast tenderness**	• Select COC with 20 mcg or less of estrogen, e.g., EE 10 mcg/norethindrone 1 mg, EE 20 mcg/norethindrone 1 mg, or EE 20 mcg/levonorgestrel 0.1 mg. • Select the vaginal ring with EE 15 mcg and ENG 120 mcg per day.
5	**Headaches**	• Reassure patient that headaches are self-resolving and usually occur within the first cycle. • Consider switching to extended or continuous use of COCs.
6	**Heavy menstrual periods**	• Consider contraceptives that contain both estrogen and progesterone. • Consider switching to extended or continuous combined hormonal contraceptive.
7	**Hirsutism**	• Avoid progestin-only contraceptives. • Consider switching patient to COCs with antiandrogenic activity, such as EE 30 mcg/drospirenone 3 mg or EE 20 mcg/drospirenone 3 mg. • COCs with minimal androgenic effects and those containing the antiandrogens cyproterone and drospirenone are beneficial.
8	**Loss of bone density**	• Avoid long-term use (>2 years) of DMPA injection. • Assess and evaluate risk at least once every 2 years.
9	**Mood swings**	• Progestogen-only contraceptives should be used with caution in patients with past or current depression. However, if a contraindication to estrogen-containing contraceptives exists, consider progestogen or barrier methods. • Change the progestin component of the contraceptive.
10	**Sexual dysfunction**	• Consider switching to a different hormonal contraception.
11	**Weight gain**	• If weight gain is caused by DMPA injection or ENG implant, consider switching to another hormonal contraception.

Pharmacist tools : Contraception

- How to manage missed doses
  - Vaginal ring
  - Patch
  - Progestin-only pill
  - Combined hormonal contraceptive pill
  - Injection

Pharmacist tools: Contraception

- Start methods
  - Quick start
  - Sunday start
  - First day of period start



Sexual and Reproductive Health

Contraceptive start methods

The choice of when to start birth control is determined to a large extent by the patient. In general, there are 3 main methods to start combined hormonal contraceptive pills, patches, injections and vaginal rings.

1. The Quick Start Method
2. The Sunday Start Method
3. The First Day of Period Start Method

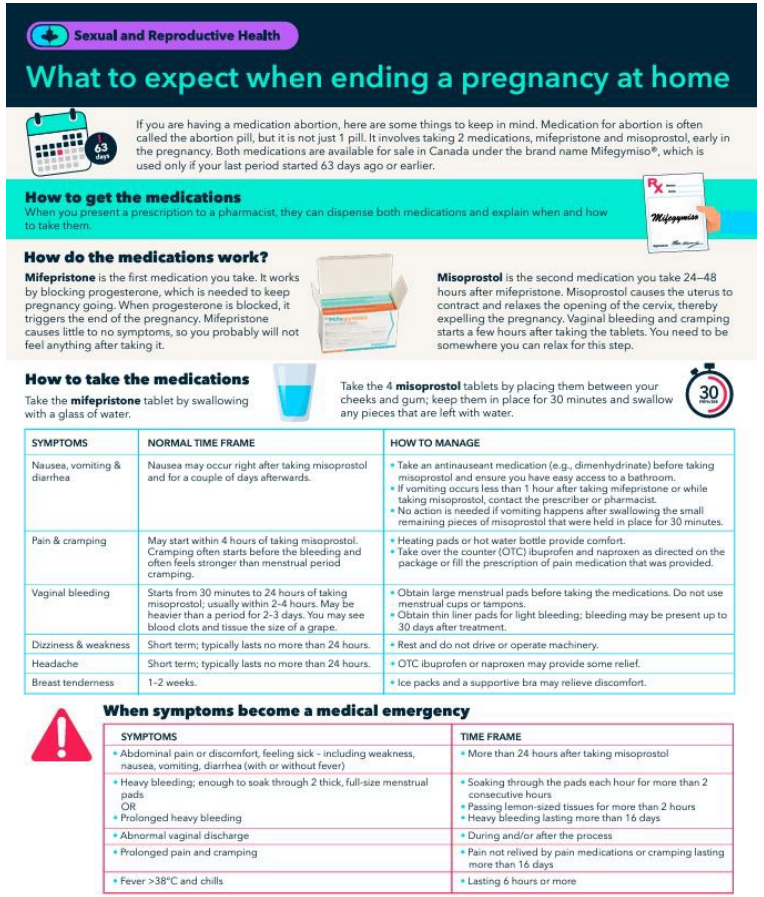
For the initial cycle of progestin-only pills, it is recommended to start anytime from day 1 up to and including day 5 of the menstrual period. With this approach, protection from pregnancy begins right away and no back-up method is required. If the progestin-only pill is started on any other day of the cycle, a back-up method of contraception is required every time the patient has sex for the next 48 hours.

	Quick Start	Sunday Start	First Day of Period Start
Initiation	Birth control is started on the day the prescription is picked up	Birth control is started on the first Sunday after the menstrual period begins	Birth control is started on the first day of the menstrual period
Advantage	Reduces delays and increases adherence, as contraception can be started at any point during the menstrual cycle	Can be easier to remember when to start as patients continue month to month	Achieves contraceptive efficacy faster than other methods
Protection from pregnancy	Begins 7 days after initiation	Begins 7 days after initiation	Begins on the day of initiation
Back-up method	Required for the first 7 days	Required for the first 7 days	Not required[1,2]

1 There are some exceptions, e.g., the first treatment cycle of the patch requires a back-up method.
2 Avoid using a diaphragm or cervical cap as a back-up method when using a Quick Start or Sunday Start with a vaginal ring.

Patient tools : Medication abortion

- What to expect when ending a pregnancy at home



Sexual and Reproductive Health

What to expect when ending a pregnancy at home

If you are having a medication abortion, here are some things to keep in mind. Medication for abortion is often called the abortion pill, but it is not just 1 pill. It involves taking 2 medications, mifepristone and misoprostol, early in the pregnancy. Both medications are available for sale in Canada under the brand name Mifegymiso®, which is used only if your last period started 63 days ago or earlier.

How to get the medications

When you present a prescription to a pharmacist, they can dispense both medications and explain when and how to take them.

How do the medications work?

Mifepristone is the first medication you take. It works by blocking progesterone, which is needed to keep pregnancy going. When progesterone is blocked, it triggers the end of the pregnancy. Mifepristone causes little to no symptoms, so you probably will not feel anything after taking it.

Misoprostol is the second medication you take 24–48 hours after mifepristone. Misoprostol causes the uterus to contract and relaxes the opening of the cervix, thereby expelling the pregnancy. Vaginal bleeding and cramping starts a few hours after taking the tablets. You need to be somewhere you can relax for this step.

How to take the medications

Take the **mifepristone** tablet by swallowing with a glass of water.

Take the 4 **misoprostol** tablets by placing them between your cheeks and gum; keep them in place for 30 minutes and swallow any pieces that are left with water.

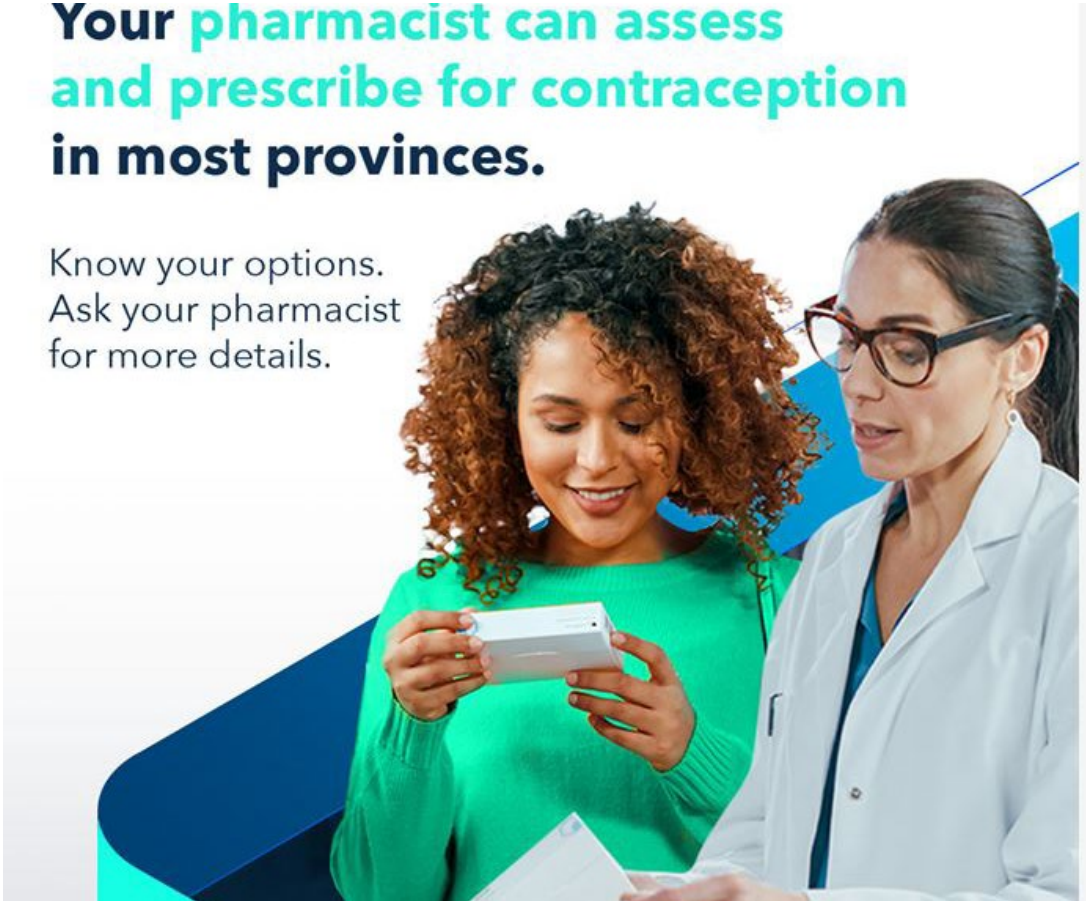
SYMPTOMS	NORMAL TIME FRAME	HOW TO MANAGE
Nausea, vomiting & diarrhea	Nausea may occur right after taking misoprostol and for a couple of days afterwards.	• Take an antinauseant medication (e.g., dimenhydrinate) before taking misoprostol and ensure you have easy access to a bathroom. • If vomiting occurs less than 1 hour after taking mifepristone or while taking misoprostol, contact the prescriber or pharmacist. • No action is needed if vomiting happens after swallowing the small remaining pieces of misoprostol that were held in place for 30 minutes.
Pain & cramping	May start within 4 hours of taking misoprostol. Cramping often starts before the bleeding and often feels stronger than menstrual period cramping.	• Heating pads or hot water bottle provide comfort. • Take over the counter (OTC) ibuprofen and naproxen as directed on the package or fill the prescription of pain medication that was provided.
Vaginal bleeding	Starts from 30 minutes to 24 hours of taking misoprostol; usually within 2-4 hours. May be heavier than a period for 2-3 days. You may see blood clots and tissue the size of a grape.	• Obtain large menstrual pads before taking the medications. Do not use menstrual cups or tampons. • Obtain thin liner pads for light bleeding; bleeding may be present up to 30 days after treatment.
Dizziness & weakness	Short term; typically lasts no more than 24 hours.	• Rest and do not drive or operate machinery.
Headache	Short term; typically lasts no more than 24 hours.	• OTC ibuprofen or naproxen may provide some relief.
Breast tenderness	1–2 weeks.	• Ice packs and a supportive bra may relieve discomfort.

When symptoms become a medical emergency

SYMPTOMS	TIME FRAME
• Abdominal pain or discomfort, feeling sick – including weakness, nausea, vomiting, diarrhea (with or without fever)	• More than 24 hours after taking misoprostol
• Heavy bleeding; enough to soak through 2 thick, full-size menstrual pads OR • Prolonged heavy bleeding	• Soaking through the pads each hour for more than 2 consecutive hours • Passing lemon-sized tissues for more than 2 hours • Heavy bleeding lasting more than 16 days
• Abnormal vaginal discharge	• During and/or after the process
• Prolonged pain and cramping	• Pain not relived by pain medications or cramping lasting more than 16 days
• Fever >38°C and chills	• Lasting 6 hours or more

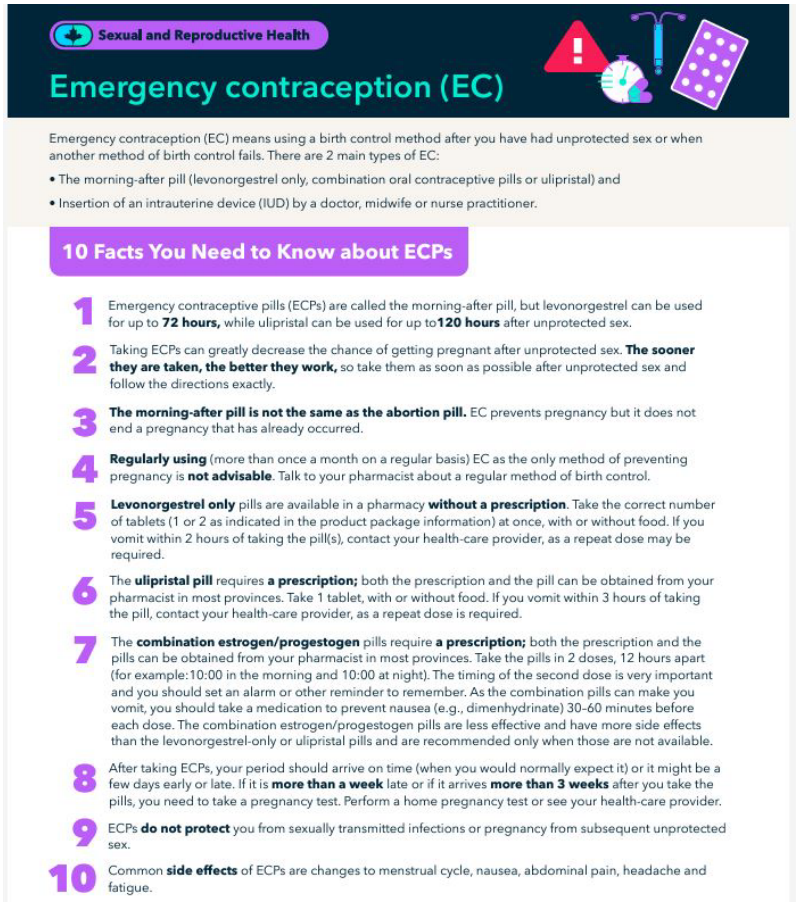
Patient tools: Contraception

- Poster



Patient tools: Contraception

- 10 facts you need to know about Emergency Contraceptive Pills (ECPs)



Sexual and Reproductive Health

Emergency contraception (EC)

Emergency contraception (EC) means using a birth control method after you have had unprotected sex or when another method of birth control fails. There are 2 main types of EC:

- The morning-after pill (levonorgestrel only, combination oral contraceptive pills or ulipristal) and
- Insertion of an intrauterine device (IUD) by a doctor, midwife or nurse practitioner.

10 Facts You Need to Know about ECPs

1. Emergency contraceptive pills (ECPs) are called the morning-after pill, but levonorgestrel can be used for up to **72 hours,** while ulipristal can be used for up to **120 hours** after unprotected sex.
2. Taking ECPs can greatly decrease the chance of getting pregnant after unprotected sex. **The sooner they are taken, the better they work,** so take them as soon as possible after unprotected sex and follow the directions exactly.
3. **The morning-after pill is not the same as the abortion pill.** EC prevents pregnancy but it does not end a pregnancy that has already occurred.
4. **Regularly using** (more than once a month on a regular basis) EC as the only method of preventing pregnancy is **not advisable**. Talk to your pharmacist about a regular method of birth control.
5. **Levonorgestrel only** pills are available in a pharmacy **without a prescription**. Take the correct number of tablets (1 or 2 as indicated in the product package information) at once, with or without food. If you vomit within 2 hours of taking the pill(s), contact your health-care provider, as a repeat dose may be required.
6. The **ulipristal pill** requires **a prescription;** both the prescription and the pill can be obtained from your pharmacist in most provinces. Take 1 tablet, with or without food. If you vomit within 3 hours of taking the pill, contact your health-care provider, as a repeat dose is required.
7. The **combination estrogen/progestogen** pills require **a prescription;** both the prescription and the pills can be obtained from your pharmacist in most provinces. Take the pills in 2 doses, 12 hours apart (for example: 10:00 in the morning and 10:00 at night). The timing of the second dose is very important and you should set an alarm or other reminder to remember. As the combination pills can make you vomit, you should take a medication to prevent nausea (e.g., dimenhydrinate) 30–60 minutes before each dose. The combination estrogen/progestogen pills are less effective and have more side effects than the levonorgestrel-only or ulipristal pills and are recommended only when those are not available.
8. After taking ECPs, your period should arrive on time (when you would normally expect it) or it might be a few days early or late. If it is **more than a week** late or if it arrives **more than 3 weeks** after you take the pills, you need to take a pregnancy test. Perform a home pregnancy test or see your health-care provider.
9. ECPs **do not protect** you from sexually transmitted infections or pregnancy from subsequent unprotected sex.
10. Common **side effects** of ECPs are changes to menstrual cycle, nausea, abdominal pain, headache and fatigue.

Poll 3

After viewing the SRH toolkit, how confident are you in your ability to dispense the medications to end a pregnancy?

1 = Not at all confident

2 = Not confident

3 = Unsure

4 = Confident

5 = Very Confident

Case Studies

Case 1: Emily

A 30-year-old woman who walks into your pharmacy seeking information about **medication abortion**. She recently discovered that she is **pregnant** and is considering **medication abortion** as a safe and private alternative to a procedural abortion. She heard that it is very painful and she is seeking guidance on the **process, potential side effects, and how would you as a pharmacist** can support her through this decision.

Case 1: Emily

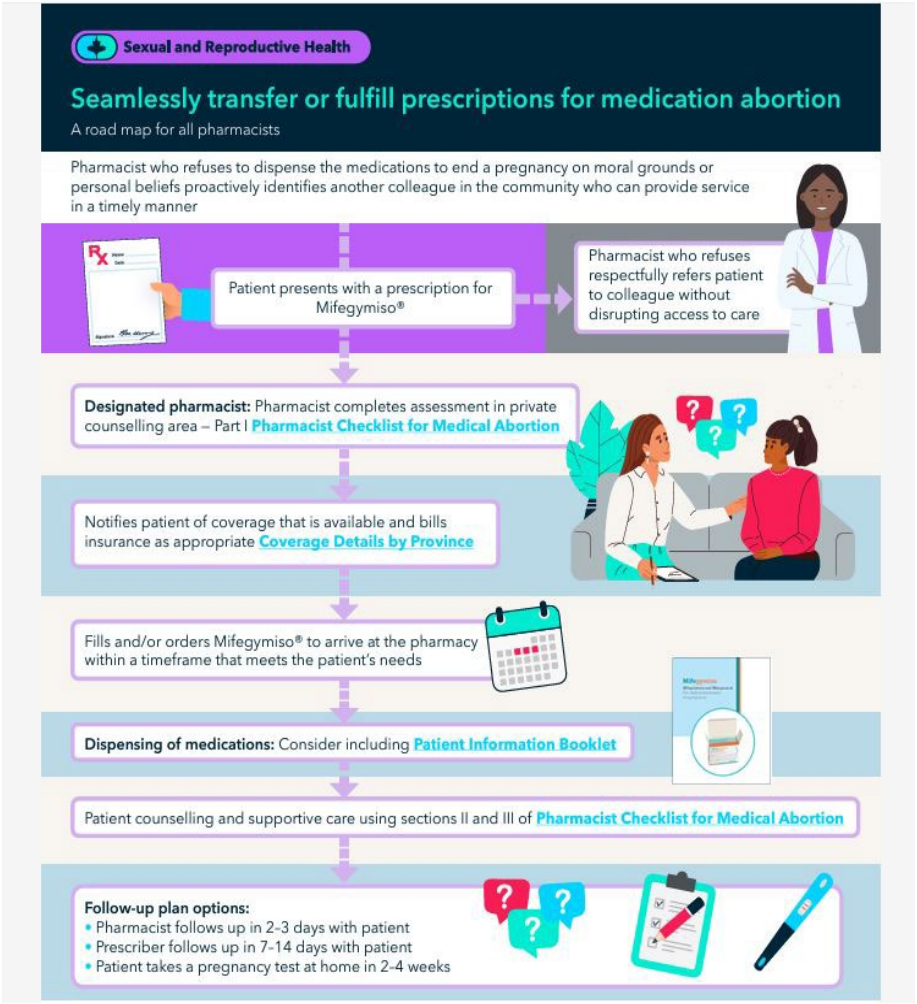
Tools:

- Debunking medication abortion myths
- A roadmap for pharmacists
- Micro-learning videos – Safety and efficacy, reflags and counselling points
- Patient resources: what to expect when ending a pregnancy at home

Case 2: Priyanka

- A 25-year-old woman who walks into her local pharmacy **seeking information and access to medications to end a pregnancy**. Through a consultation with her primary health-care provider, Priyanka has made the decision to end her pregnancy through medication abortion and has a prescription for the medications. She arrives at the pharmacy, expecting to have the prescription filled promptly, **dispensing the medications conflicts with the personal and moral beliefs of Sarah**, who is the pharmacist on duty.
- Recognizing the importance of providing timely and compassionate care, Sarah is faced with an ethical dilemma.

Case 2: Priyanka



Tools:

- A road map for pharmacists

Case 3: Charlie

- A 28-year-old woman who visits her local pharmacy seeking guidance on sexual and reproductive health. She is currently in a committed relationship and is interested in **exploring contraception options** that align with her lifestyle and health needs. Charlie is generally healthy, with no significant medical history. She has been using condoms as her primary form of contraception but is interested in exploring alternative methods that may offer increased convenience and effectiveness. Charlie has heard about various contraceptive options but is unsure about **which one would be the best fit for her.** She is also **worried about the side effects.**

Case 3: Charlie

Tools:

- Choosing tool
- Contraceptive start method
- How to manage side effects

Thank you

Canadian Pharmacists Association
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