

Contraception and Abortion in BC:

Experience Guiding Research Guiding Care

Report of Proceedings

April 28, 2011

Acknowledgements

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- Joan Geber (Executive Director, Women's Healthy Living Secretariat, MOH)
- Dr. Jan Christilaw (President, BC Women's)
- Dr. Perry Kendall, BC's Provincial Medical Officer of Health

- Dr. Dorothy Shaw (Professor, Obstetrics & Gynecology, UBC; past president FIGO)
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Above all, CART wishes to thank the 122 health care providers, front-line workers, administrators, researchers and others who attended the conference and provided critical input into the future direction of contraception and abortion health system improvement in British Columbia.



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Executive Summary

On April 28, 2011, the Contraception & Abortion Research Team (CART) and Options for Sexual Health (OPT), in collaboration with sponsoring organizations, brought together 122 health care providers, administrators, front-line staff and researchers to explore the barriers and facilitators for reducing unintended pregnancies by improving access to high quality contraception and abortion services in British Columbia.

The aim of the *Contraception & Abortion in B.C.: Experience Guiding Research, Guiding Care* conference was to solicit expert opinion and collaborative interprofessional input on priority issues to support the development of community-based health service demonstration projects, and the appropriate associated research, for health system improvement.

KEY THEMES

- > BC has a significant unmet need for contraception
- > Uneven distribution of access to services
- > Rural/urban disconnect (access, knowledge, training)
- > Challenges facing sub-populations (immigrants, Aboriginal women)
- > Gaps in knowledge and gaps in data are hindering progress

MAJOR BARRIERS	MAJOR FACILITATORS
Lack of knowledge (public, provider, decision-makers)	Education (patient, professional and decision-makers)
Cost of contraception	Free contraception
Distance & rural/urban service inequities	Increased funding Health professional education
Lack of effective data	Better data collection and reporting
Stigmatization & public/provider/decision-maker attitudes towards sexuality, contraception and abortion	Policy framework for sexual health
Lack of health professionals providing contraception and abortion services	Training for health professionals facilitating service provision: RN, NP, midwives, pharmacists, MDs

The morning plenary session speakers provided the international-to-local perspectives on the state of and issues surrounding contraception and abortion care. An audience 'speak-out' gave participants the opportunity to share their experiences and opinions regarding the key barriers and facilitators to good family planning care in the province.

During the afternoon workshops, participants gathered in small working groups to prioritize the issues and explore potential ideas for health systems improvement and potential associated research initiatives. CART proposes to apply for a CIHR "Partnerships in Health Systems Improvement" (PHSI) grant. This grant will support a demonstration project in 1-4 BC communities, and will include a rigorous evaluation component. CART leaders asked conference participants to determine key

components and themes for a demonstration health system improvement project aiming to reduce unintended pregnancies and improve access to high quality contraception and abortion services.

The CART conference marked the beginning of an ongoing engagement with stakeholders within the family planning community in BC. Participant input will assist in informing effective approaches to the development of health system improvement demonstration projects and associated evaluation research with the ultimate aim to reduce unintended pregnancies and improve access to high quality contraception and abortion services for all British Columbians.

KEY WORKING GROUP THEMES

Possibilities & Priorities:

1. **Knowledge Translation & Education:** Increase public and health professional education on the unmet need for contraception, highly effective contraceptive methods including the advantages of Long Acting Reversible Contraception (LARC); and abortion.
2. **Access:** Improve access to information, resources, services and contraceptives.
3. **Training:** Address lack of access in rural communities through contraception and abortion health professional training in multiple disciplines (midwives, nurse practitioners, pharmacists and physicians (both family physicians & Obstetricians/Gynecologists))
4. **Funding:** Remove financial barriers to contraception access

Critical Components

- > Collaboration & Partnerships
- > Community Engagement
- > Target 20-29 age group; underserved population groups
- > Tailor projects to needs of individual communities

Potential Stakeholder Roles:

- > Advocate
- > Researcher
- > Health system-health administration advisor
- > Service deliverer
- > Health Professional Educator/Resource

Experience Guiding Research, Guiding Care

On April 28, 2011, the Contraception & Abortion Research Team (CART) and Options for Sexual Health (OPT) brought together 122 health care providers, front-line workers, administrators, researchers and others from British Columbia's (BC) family planning, abortion and sexual health care sector. (See Appendices A and B for the day's agenda and participant affiliations.)

The goals of the *Contraception & Abortion in BC: Experience Guiding Research, Guiding Care* conference were to identify the important health services systems and barriers that need to be addressed; identify and describe what an appropriate system of services would look like; and describe and delineate the research required to get us there.

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

- Develop knowledge on recent best practices in contraception and abortion care.
- Identify gaps in knowledge and health system delivery of effective contraception and abortion service provision;
- Establish open multi-lateral working relationships between health system decision makers, front line clinicians, senior academic researchers, and researchers in training from private, public and non-profit sectors;
- Plan a Contraception and Abortion research agenda to address identified needs;

The morning plenary set the current context for abortion and contraception care, with a variety of speakers moving from an international to a local perspective. The afternoon workshop centered on interprofessional, inter-sectoral group discussions where participants shared their knowledge and explored possibilities for health systems improvement and associated evaluation research in this field.

Part 1: Plenary

Welcome

The conference began with a traditional First Nations welcome to this Territory by Gloria Nahanee of the Spritist Squamish Nation. Honouring the spirits of the eagle, killer whale, wolf and rabbit, participants enacted a brief dance of each animal, energizing the room and setting a positive tone for the day.

Dr. Jan Christilaw, President of BC Women's Hospital & Health Centre, then gave the official welcome and said her hope for the day was for all participants to leave with a better sense of how we can work together to improve abortion and contraception services in BC.

Dr. Wendy Norman, a CART leader, set the stage for the day's events. She said the goal of the conference was to improve contraception and abortion services in BC by looking at the current barriers and gaps in accessing services to inform the planning for health system improvement demonstration projects and evaluative research to make positive changes. Her desire for the day was to hear the stories of people working on the front lines and about the needs of women, and to use that information as key identifiers to make the services we bring to women and their families even better.

International & National Perspectives

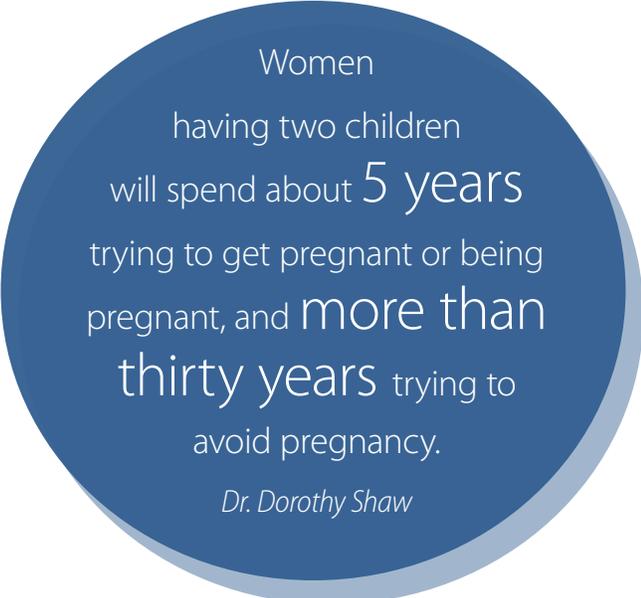
Three speakers set the international and national context for current state of unmet need for contraception.

Meeting the Needs of Family Planning Globally

Dr. Dorothy Shaw, immediate past president of the International Federation of Gynecology and Obstetrics (FIGO), and Canadian spokesperson for the Partnership for Maternal, Newborn and Child Health, talked about family planning globally and the lessons to be learned from the international experience.

Dr. Shaw noted that women having two children will spend about 5 years trying to get pregnant or being pregnant, and more than thirty years trying to avoid pregnancy. With typical contraceptive failure rates of 5% of users per year, more than 33 million among the 700 million women using contraception, experience an accidental or unintended pregnancy annually, with many of these ending in abortion. In terms of abortion, globally the lifetime average is about one abortion per woman.

She highlighted that among 180-210 million pregnancies worldwide every year, 80 million are unwanted, resulting in 50 million abortions and among the 22 million unsafe abortions: 47,000 subsequent deaths. Maternal conditions globally are the second leading cause of death among women, noting that unsafe sex and unmet need for contraception are the leading modifiable risk factors for death of reproductive age women in the world.



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Dr. Dorothy Shaw

Multiple factors affect women's access to health services which Dr. Shaw stated are as applicable in BC as they are worldwide, such as political will, legislation, geography, and culture. She noted there are inequities in terms of maternal health, maternal morbidity and access here in Canada as well, especially among First Nations and immigrant populations.

There is a global recommitment to family planning especially through the Global Strategy for Women's and Children's Health. The ultimate goal is to ensure access to universal reproductive health by 2015 [Millennium Development Goal 5B].

Canadian Legal, Political & Medical Barriers to Access to Abortion

Vicki Saporta, President and CEO of the National Abortion Federation (NAF), discussed the legal and political barriers to timely abortion care access in Canada. She began by noting how this CART conference marked the first meeting of its kind to discuss setting a research agenda for abortion and contraception.

Canada is one of only a few countries without a federal law restricting abortion however, there is inequitable access to abortion care in this country. In recent years the number of hospitals providing abortion care has decreased to 1 in 6 in Canada, with the majority of services provided by clinics and concentrated in urban areas. She noted that the potential introduction of mifepristone in Canada in the future could help support better access to abortion care for women in rural areas.

There are few opportunities for physicians and front-line workers to stay current on the latest trends and research on abortion care. NAF supports its members by publishing clinical policy guidelines, a clinical textbook, and hosts an annual meeting – some of the only places physicians can obtain continuing education in abortion care.

Vicki stated the need to continue to work to ensure all women have access to the highest quality of abortion care, to fight legal inequities and to ensure providers can include abortion care in their practice and ensure women can obtain care.

There is inequitable access to abortion care in Canada...with the majority of services provided by clinics and concentrated in urban areas.

Vicki Saporta

Challenges to Understanding Abortion: the Data collection and access issue in Canada and BC

Dawn Fowler, NAF's Canadian Director, gave an overview of the challenges around data collection and access to abortion in Canada. Statistics Canada first began collecting and reporting data on abortions in Canada in 1970. Budget cuts and changes in data collection since 1988 have resulted in uneven collection of data on abortion with missing information on well over 10% of provincial and national abortions.

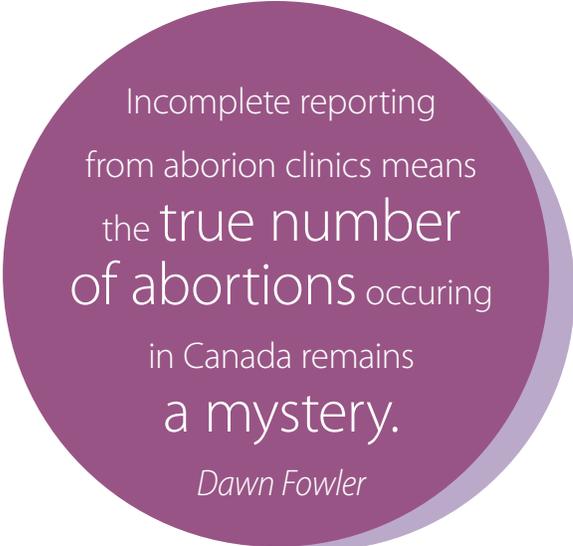
Today, data collection and reporting resides with the Canadian Institute for Health Information (CIHI). Most abortions in Canada now occur in clinics. While hospitals must report, there is incomplete reporting from clinics meaning that the true number of abortions occurring in Canada remains a mystery. The result is that we are unable to produce a basic statistical profile of abortion in Canada. The implications of this situation are that it is difficult to know if abortion is increasing or decreasing; it makes creating good public policy a challenge; and means benchmarking and supporting resource planning is difficult.

Panel Questions

The following highlight just a few of the numerous questions participants had for the speakers.

1. **How do we get government to make funding available for all abortion and contraceptive services – what would make sense financially and for women's health?**

Dr. Jan Christilaw noted that free contraception is one part of an effective solution and would result in significant costs savings however the problem is the initial outlay of funding. Dr. Dorothy Shaw said ministries of finance need to be accurately informed about the cost-effectiveness of family planning initiatives for them to be successfully adopted. She noted this is an area in which politicians often have little information or exposure to facts, and that we may have a role to provide this education.



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a mystery.

Dawn Fowler

2. **What would be most effective strategy to reduce unintended pregnancies in the developing world?**

Dr. Dorothy Shaw said a multi-pronged strategy is needed that includes education for women and girls along with access to free or reasonably priced contraception that reflects the surrounding economic conditions.

3. **What changes are happening around medication for abortion services and what are the challenges of making those changes?**

Vicki Saporta said NAF has considered advocating for mifepristone in Canada as a high priority among their activities. Mifepristone is the gold standard of medical abortion care and its availability in Canada is long overdue.

Ryan Foundation Keynote Address: Best Practices in Contraception & Abortion

Dr. Mark Nichols, MD, Professor and Division Head, General Gynecology and Obstetrics, Director of the Family Planning Fellowship at Oregon Health Sciences University (OHSU), and current President of the Society of Family Planning, gave the keynote address on the evidence regarding 'what works' for better family planning services. There are four sources of information on best practices:

- Cochrane reviews
- Society of Family Planning clinical guidelines
- NAF clinical guidelines
- High quality individual studies

In the US medical abortions are increasing (nearly half of all abortions under 9 weeks gestational age) while surgical abortions are on the decline. In terms of clinical complications, some amount of retained products was the most common complication for both medical and surgical abortion but the overall complication rate is under 0.5% of patients, demonstrating the overall safety of either abortion method.

Dr. Nichols reviewed research on the use of paracervical block, which for many years has been the standard of care for surgical abortion. The literature indicates the best paracervical block technique includes injecting and waiting 3 minutes prior to dilation; that deeper injection is better than shallow; and that a paracervical block reduces pain for both dilation and aspiration among patients undergoing surgical abortion.

He highlighted the underutilization of those contraceptives in the top tier of effectiveness: long acting reversible contraception (LARC) such as intrauterine devices (IUDs) and contraceptive implants. With typical intrauterine system failure rates of 0.3%, (compared to 5-8% for oral contraceptives for example) many more unintended pregnancies could be prevented using LARC methods. In reviewing studies on the cost-effectiveness of contraception methods, LARC methods such as intrauterine contraception are the most cost effective contraceptive options.

In the US a study showed that long acting reversible contraceptives, such as IUDs and implants, are cost effective, with \$7 saved for every dollar spent. Another study found that the cost of providing IUD immediately after delivery in a US hospital would result in the hospital losing 70 cents per dollar but would result in the State saving \$2.94 for every dollar spent. Dr. Nichols said the complex funding system for health care in the US prevents changes from being made but demonstrates the savings of immediate postpartum contraceptive provision.

Panel Questions

1. Do you have data comparing rates of complications from medical to surgical abortion?

No, we don't have data that compares the two but the message I would give is abortion is safe, and rates of infection or other complications are low for both. The experience in the US shows how abortion is a very safe procedure.

Long acting reversible contraceptives, such as IUDs and implants, are the most cost effective contraceptive methods...with studies supporting a health system savings of \$7 for every dollar spent.

Dr. Mark Nichols

2. There are challenges in providing medical abortions in rural areas as it is difficult to get women to follow up, can you comment?

Women know when they've completed their medication abortions after using mifepristone. They've bled, their nausea is gone; they don't feel pregnant anymore. In the US we want them to come back for follow up but in the developing world there is a move away from routine follow up visit because it's not often feasible. Dr. Norman also commented that in Canada we have only methotrexate available for medication abortion. Due to the teratogenicity of the agent we have a much higher responsibility to ensure follow up with every pregnant woman who has received this medication. There was general agreement that availability of mifepristone could greatly increase access and ease of medical abortion for Canada.

Access to Family Planning in BC

The second panel of the morning focused on the topic of access to family planning in British Columbia.

Aboriginal Women's Perspective

Lerinda Swain, Nurse and Program Coordinator for BC Women's Aboriginal Health Program, said it is important for providers to get to know the protocols when working in First Nations communities and with First Nations peoples. She said there are more than 203 bands in BC representing a diversity of populations. Approximately 74 % of those who identify as Aboriginal people (including non-status, Métis, First Nation, and Inuit) live off reserve, and 40% of the Aboriginal population in BC is under 25 years of age compared to 16% in the general population. Teen pregnancies remain four times higher among Aboriginal girls.

Aboriginal women view sexuality as a gift but community attitudes are highly influenced by individual Nations and beliefs. Abortion is a touchy subject, many communities don't recognize abortion however women traditionally had medicine plants for those who didn't want to have a pregnancy. The lack of communication within the community means that when Aboriginal women and girls want to travel to access an abortion, they are afraid to ask

their 'aunties' for help. Often young girls know they aren't ready but are pressured into having children by parents, partners, and the community. There are also restrictions to accessing contraception and it is important to look at how accessible the community is to services.

Due to the significant judgment placed on Aboriginal women, a big role for BC Women's Aboriginal Health Program is in teaching cultural competency and awareness.

Reaching Youth through Technology

Dr. Mark Gilbert, MD, leads the HIV and Sexually Transmitted Infections (STI) surveillance program at the BC Centre for Disease Control (BCCDC). He spoke about BCCDC's experiences reaching out to youth through social media avenues. Given that 66% of youth use social networking, it is imperative to deliver services online as a way to reduce barriers to sexual health care and reduce the overall burden of STI's in BC.

In focus groups, youth say they are looking for websites that offer clear concise reliable information from an official agency that looks and feels relevant. At inspot.org youth can send an anonymous e-card to a partner telling them they may have been exposed to an STI.

Dr. Gilbert also said models are being developed to deliver online STI testing. A client can go to a testing site, do the online assessment, print off a lab requisition and go to lab, then get the results online or over the phone where they would access a referral for treatment. Another example to reduce access barriers is the provision of online contraception (currently offered from one California based site) where an individual can request a contraceptive online and have it delivered to them.

As most youth use cell phones to access the internet, one organization, bedsider.org, will send individuals reminders to take their birth control or other contraceptive method through a phone application. Dr. Gilbert noted how these are great pilot programs but we don't fully understand their impact, benefits and/or challenges. He said this changing technology is not a revolution but a revelation and the health sector needs to catch up.

Trends in Abortion Access in BC

Dr. Wendy Norman, MD, Clinical Professor in the Department of Family Practice at the University of British Columbia, and a CART leader, provided an overview of the key trends in abortion access in BC. She stated abortion is a marker for an unmet need for contraception. In Canada there are approximately 100,000 abortions performed annually with rate in BC of 16 per 1,000 women of reproductive age (15-44) compared to a Canadian rate of 14 (2005).

While there has been a concerted effort to reduce teen pregnancy, resulting in rates dropping in this age bracket, the highest users of abortion services are in the 20-29 age groups. Many public health youth services are limited to women under 25 and some to those under 19, and therefore missing a large group of women who have a proven unmet need for contraception.

Dr. Norman said abortion is a commonly accessed reproductive service. 31% of Canadian women reaching age 45 in 2005 had at least one lifetime abortion, demonstrating the unmet need for contraception. She talked about how accessibility to abortion outside major urban areas is low, and noted how only 19% of abortions in BC are offered outside Vancouver, Victoria or Kelowna. In addition, there has been a 60% decline in the number of abortion providers between 1998 and 2010, and a further 10% drop in the number of abortion providers outside urban BC in 2010-11 alone, highlighting this as a call to start improving access to abortion in our community hospital system and to support training of rural health professionals would could provide abortion services closer to women's home communities.



31% of
Canadian women
currently starting menopause
have had an abortion

Wendy Norman

Audience Speak-Out: Barriers & Solutions to Accessing Contraception and Abortion Services

Following the panel discussion, participants were asked to reflect on what they heard, share their experiences and talk about the barriers to access and potential solutions. All panel speakers gathered at the front table to answer questions and facilitate discussion.

Policy Change

The discussion began with a question about what the one most important policy change that we should be focusing on, given all the options. Dr. Norman said we can learn from other jurisdictions in that taking one measure does not do justice to providing the best care. Free contraception is good but you need public health education on risks and benefits for women and updated education for health providers on highly effective contraceptive methods.

Barriers

Dr. Ellen Wiebe highlighted information from studies she'd conducted on what women who are having abortions in BC say they want. The number one issue was getting an abortion as soon as possible, with the number two priority being getting an appointment for an abortion – getting through to a human being on the telephone. Another study comparing the amount of time loss from work (disability) between women choosing a medical or a surgical abortion, found surgical abortions disabled women to a greater extent in terms of taking time off work/school or childcare duties due to length of the wait time before their actual abortion appointment. A final study asking about barriers to contraception access found that 25% of immigrant women had difficulty (and in general this difficulty was in access to knowledge about contraception and abortion services) compared to 15% of non immigrant women in Vancouver, among whom cost was found to be the main barrier.

Other providers discussed the challenges they faced trying to provide abortion care in small communities. One physician noted that unlike urban clinics where a variety

of staff provide comprehensive care, 'I do everything'. She described facing barriers such as funding, limitations on OR scheduling, and OR closures.

Another provider said she wanted to provide abortion care in an outpatient setting but was denied by the hospital, despite the fact that it is more cost-effective to provide the service in an ambulatory setting (for example with a nurse providing intravenous sedation support rather than an anesthesiologist), citing problems such as availability of trained nurses, and support staff.

Messaging

One physician suggested taking a more personal approach to getting the message across to government such as providing vignettes of individual patients impacted by poor access to abortion and contraception. Vicki Saporta noted a key part of NAF's work is to collect patient stories and support patients to speak about their experiences. "I have not seen anything more effective in changing minds than patient stories". Dr. Dorothy Shaw said it is also important to never make the assumption that government officials are well informed about family planning issues because that has not been her experience. Later, during the conference, other delegates noted that few politicians and health administrators hear the stories of women having difficulty accessing abortion and contraception care in BC. Front line care providers in BC should encourage women and families to bring their stories of difficulty accessing contraception and abortion care to the attention of government and our politicians.

Stigma & Sexuality

Participants made a number of comments about the stigma related to sexuality and our inability as a society to openly discuss issues of contraception and abortion. One administrator stated that politicians and administrators are not willing to engage in these conversations openly and the need to find other ways to move the agenda forward. Dr. Shaw noted how this is due to the fact that we don't talk about sex or sexuality in public.

Another participant, specializing in Adolescent Medicine, noted condom use should be an important component of all education messaging and not limited to discussion of sexually transmitted infection prevention, but should also

be highlighted in contraception education. Conference delegates supported this suggestion enthusiastically.

The development of a sexual health action framework for BC was highlighted as a progressive step being made by the Ministry of Health in collaboration with regional health authorities and BC Women's Hospital & Health Centre. The framework will include recommendations to improve sexual health and reduce disparities for all citizens.

Data Collection & Reporting

When asked what we can do to improve data collection and reporting in BC, Dawn Fowler suggested that all facilities need to report on their statistics using the same definitions of elements. There also needs to be a central collector and repository of information, with health authorities defining the data set and mechanisms for reporting.

BC Abortion Providers Survey

Preliminary results of a new survey, the BC Abortion Providers Survey (BCAPS), to better understand the challenges, service parameters and career intentions of physicians providing abortion service in BC, were highlighted by Drs. Jennifer Dressler and Nanamma Mauhgn, Family Practice Residents in the Rural Residency Program, Kelowna Site, UBC Department of Family Practice.

The preliminary results from 17 urban and rural physician respondents, collected just two hours prior, were highlighted. The survey will continue over the coming months and attempt to include every physician providing abortion services in BC.

Interestingly the early results showed a majority of the current physicians providing abortions had practiced for more than 25 years, supporting the observation that attrition in rural abortion providers may be due at least in part to retirement (without replacement).

CART Pre-Conference Survey

Results of the CART pre-conference survey were highlighted at the start of the afternoon health systems improvement planning session by facilitator Barbara Grantham.

The following results are inclusive of answers from all 52 respondents who took the survey. Many comments and elaborations for each question were submitted, and can be found in full in the appendix. (See *Appendix C for the complete survey results*).

Conference Survey Participant Demographics:

- 58% of participants work in a large urban setting, 23% in a community under 10,000 population.
- 54% are front line health professionals; 27% health service administrators; 23% physicians providing abortion services, and 15% university based researchers.

Top 3 Barriers to Delivering Effective Contraception:

1. Cost was chosen as one of the three factors for 29.4% of the responses (ie: by nearly every responder);
2. Public knowledge about effective methods 21.8%;
3. Public attitudes towards certain contraceptive methods 15.4%

Top 3 Barriers to Providing Abortion Services:

1. Lack of physician abortion providers 21.2% (again chosen by the majority of responders as one of their three choices)
2. Harassment/stigma from members of our community 15.7%
3. Access to operating room time 13.2%

Facilitators to Reducing Unintended & Unwanted Pregnancies:

(The following facilitators were each rated. The percentage indicates the proportion of respondents rating this factor "Very important")

1. Public Education about highly effective contraceptive methods 84.6%
2. Provision of free contraception for all women 71.2%
3. Health professional education program in family planning 63.5%

Facilitators to Improving Provision of Abortion Services:

(The following facilitators were each rated. The percentage indicates the proportion of respondents rating this factor "Very important")

1. Health administrator/health authority support to create or expand an abortion clinic 61.5%
2. Training programs to teach GPs to become abortion providers 55.8%
3. Training for Obstetricians/Gynecologists to become abortion providers 26.9%

Part II: Health Services Design & Research Planning Workshop

The conference shifted in the afternoon into a planning workshop for 65 designated interprofessional and inter-sectoral participants. The aim was to develop partnerships and explore ideas for health systems improvements (and rigorous evaluation) that could lead to a reduction in unintended pregnancies and improved access to highly effective contraception and abortion services.

Summary of Feedback

Conference facilitator Barbara Grantham summarized the morning's key themes to contextualize the afternoon's discussions. In addition, the full responses to the pre-conference survey, including all comments and suggestions, were provided to each discussion group.



MAJOR BARRIERS	MAJOR FACILITATORS
Knowledge	Education (public, professional and decision-makers)
Cost	Free contraception
Distance	Innovations in practice and care
Data	Better data collection and reporting
Stigmatization	Policy framework for sexual health

Partnership in Health Systems Improvement Grant: Vision

The CART leaders, Dr. Wendy Norman, Dr. Jean A. Shoveller, and Dr. Janusz Kaczorowski, reviewed the CIHR Partnerships in Health Systems Improvement (PHSI) grant guidelines and their project vision.

A PHSI grant provided funding to host this conference with the aim to bring together groups of front-line health workers, health service administrators and academic researchers to tackle complex problems at a systems level. The purpose of the grant is to support the development and implementation of demonstration projects at the community level. The grant is an opportunity to test a scale model for a redesign of the health system in terms of how contraception and abortion services are delivered in BC.

The \$400,000 available in grant funding from CIHR, along with support and in-kind donations from partner organizations, will support the team to design and implement a health system improvement demonstration project in possibly up to four BC communities. CART team members asked conference participants to help them determine the key components and themes for a demonstration project that would be scalable, cost effective, work in urban and rural areas and ultimately could make a difference to reduce unintended pregnancy and improve access to highly effective abortion and contraception services in BC.

CHAP Experience

Dr. Janusz Kaczorowski summarized the results of a community-based randomized cluster trial project in Ontario to improve cardiovascular health. The purpose was to draw important parallels regarding how to design, implement and evaluate community level intervention which can improve outcomes at the population level.

CHAP – Cardiovascular Health Awareness Program – started out as a series of pilots and community level demonstration projects, then progressed to a large randomized cluster design of all 39 Ontario communities with populations between ten and sixty thousand people. The project is a community-based program bringing together local family physicians, pharmacists, other health professionals, public health representatives, volunteers, and health and social service organizations to promote and actively participate

in the prevention and management of heart disease and stroke. The project included:

- Opportunities for multiple accurate blood pressure readings and the promotion of healthy eating, physical activity and smoking cessation.
- Invitations to older adults to measure their blood pressure in pharmacies and other familiar community settings, using an automated blood pressure measuring device with help from a trained volunteer.
- Ability of participants to take home a copy of their results and give their permission to have this health information shared with their family physician and pharmacist. This allows physicians and pharmacists to follow-up with their patients if required.
- Measurement of outcomes and effectiveness from population health administrative databases, facilitating community and professional engagement in the intervention.

CHAP acted as funding agency and solicited proposals from volunteer and community based organizations within the intervention communities on how they would collaborate and what activities they would undertake to improve cardiovascular (CV) health. Agencies in each of the 20 intervention communities selected received \$5,000 to lead mobilization activities around CVD awareness and health promotion utilizing volunteer peer health supporters, family physicians and pharmacists.

With a coordinated community intervention lasting only 10 weeks, the CHAP researchers were able to show a 9% reduction in hospital admissions for cardiovascular related events over the following year. In extrapolating CHAP's results population-wide, it was found that the program would result in 5,000 fewer annual CV hospital admissions in Ontario. Factors contributing to CHAP's success were:

- Working with and mobilizing local community organizations
- Guidance and support from CHAP team
- Focus on collaboration and multi-pronged approach

Further information on the CHAP project can be found at: www.chaprogram.ca

Working Group I & II: Possibilities for Program Design & Priority Setting

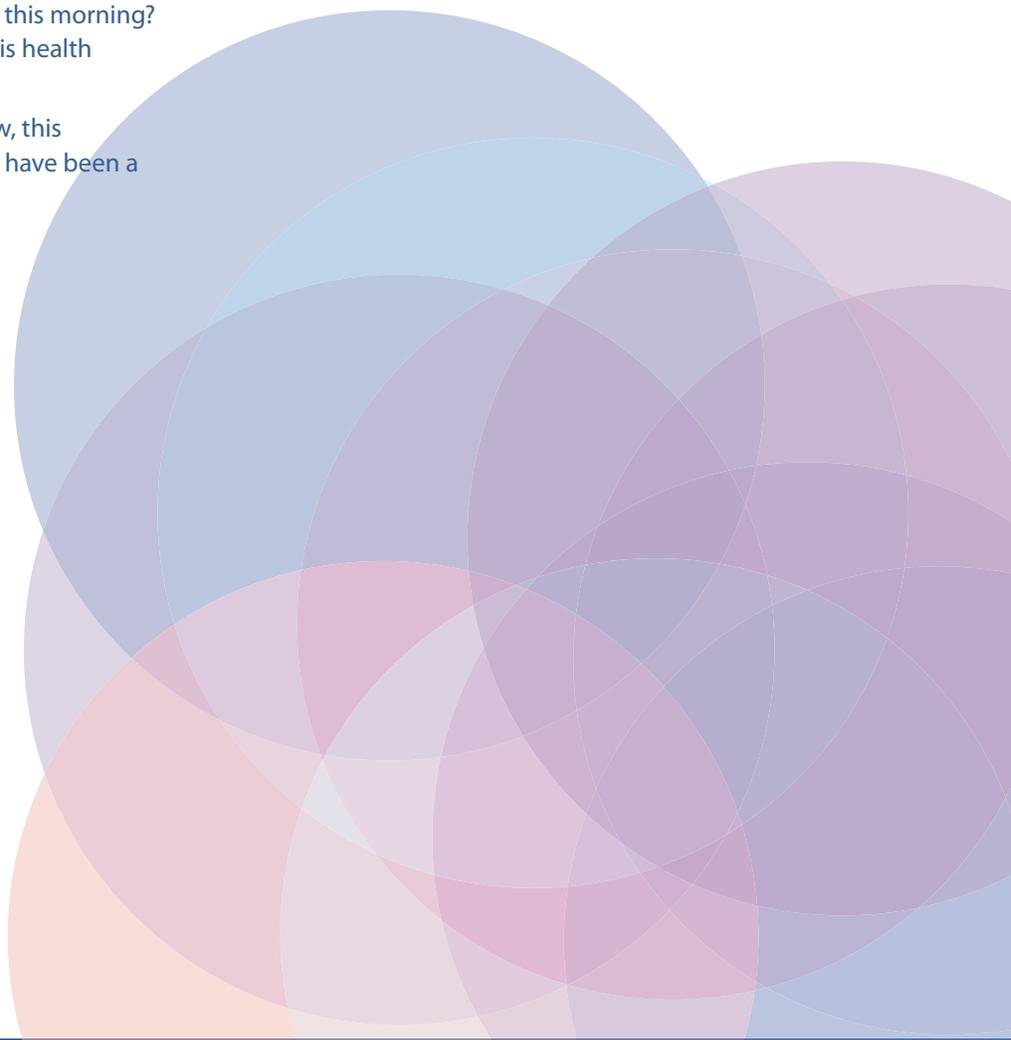
Participants spent the majority of the afternoon in working groups discussing the possibilities for health service demonstration project design and research to improve contraception and abortion services. Working groups were an interdisciplinary, inter-sectoral mix of health system administrators, front-line providers, researchers, representatives of community based organizations and others from each health authority region to support meaningful conversation.

The first working group session asked participants to answer the following questions:

1. What are the most important issues that need to be addressed:
2. What components of a health service will we need to address the gaps in service we identified this morning? What are the possibilities in designing this health service approach? What's our wish list?
3. From my perspective, five years from now, this demonstration health service project will have been a success if...

After an hour of robust discussion and a brief break, the working groups reconvened to prioritize the issues arising in their discussions. Groups structured their conversation by answering the following questions:

1. What are the priorities?
2. Why are they priorities?
3. How would you rank them? Are there important linkages between them?
4. One thing that will work is...
5. One thing that won't work is...



Plenary: Sharing & Setting Priorities

The conference returned to a plenary forum, with a representative from each working group summarizing their key issues and project possibilities, their priorities and the role they individually or as a group wanted to play as CART moves forward with its work.

GROUP 1

Possibilities & Priorities:

- Interventions aimed at populations in the 20-29 age group
- Target small and medium-sized communities around knowledge translation projects.
- Educational initiatives around contraception aimed at entire communities (patients, providers, general public) using innovative media (print, web, social network tools) that are professionally sourced, culturally appropriate and language accessible
- Training for nurse practitioners in contraception and abortion care
- Remove financial barriers to contraception access.
- Take a 4-pronged community-based research approach:
 1. One community is status quo
 2. One community receives the educational component for services providers and in schools
 3. One community has barriers to contraception access removed
 4. One community has barriers to both education and contraception removed.

What Won't Work

- Maintaining the status quo

Role:

- Advocate
- Researcher
- Advisory member
- Service deliverer

GROUP 2

Possibilities & Priorities:

1. Lack of public education on contraception and abortion, need to target education to underserved population groups.
2. Need for timely access to a range of services with evaluation pre and post-project.
3. Lack of abortion providers; urban/rural disconnect and lack of access to contraception and abortion services.
 - Public knowledge and access connected, focus on disseminating accurate information about different methods of contraception and abortion services through various youth-engaging media (online, social networking sites, cell phone); don't be dependent on school education
 - Expand OPT clinics around BC, utilize online drug ordering and pick up.
 - Success markers: wait times for abortion are less than 1 week.

What Will Work

- Knowledge component – critical to have community engagement as a starting point.

What Won't Work

- Having health system as the gatekeeper controlling services

Role:

- Advocate
- Researcher
- Advisory member
- Service deliverer

GROUP 3

Possibilities:

- Examined issue from an access lens: Access to education, care, timely service, geographic perspective, sub-population (youth and need for confidentiality)
- Issue of access to contraception and abortion key factors that could be improved upon.

Priorities:

1. Broad-based provider education for physicians, nurse practitioners, pharmacists and other allied care providers on contraception and abortion.
 2. Public education
- Key linkage for provider education is free contraception as a way to enhance quality of care and skills of providers.
 - Take a universal approach to free contraception implementation. Be mindful of unique needs of special populations so we don't enhance divisions between groups.
 - Initiatives need a supportive funding structure and take a comprehensive approach (fulsome analysis of any strategy)
 - Broad stakeholder engagement within each participating community
 - Utilize a community development approach with different community engagement processes
 - Demonstration project strategies must be universal and transferable, but ensure there is flexibility and sensibility to local context.

What Will Work

- Projects focused on the 'low hanging fruit' or easy wins – contraception and abortion access and provider education.
- Projects that are achievable, measurable, utilize existing data to support it, and have a comparison group.
- Focus on the success of a strategy to keep momentum going towards ultimate vision of good sexual health for all.

GROUP 4

Possibilities & Priorities:

- *Ultimate goal: Change public and health official attitudes.*
1. Education and transfer of knowledge that is scientifically based, supports transfer from professionals to patients and between professionals.
 2. Funding needs to be in place
 3. Access – need access to information, resources, services and birth control.
- To ensure effective implementation, need a strategic plan or map across the province to ensure collaboration and standards of practice in place.
 - Reduce redundancies and costs by examining overlaps in services (i.e. between what youth clinics and emergency rooms offer in small communities) to use resources more effectively and efficiently.

What Won't Work

- Lack of collaboration

Success in 5 Years Looks Like...

- Not having money does not prevent a patient from having access to timely care.
- Correct information is available to make informed decisions
- Providers don't have to hide, be afraid, abortion talked about as a normal medical service.

Pilot Project

- Education in schools (K-12) involving parents and well-trained professionals coming in.
- Community and health professional education (physicians, NP's, pharmacists) in targeted communities. Measure results at end (number of pregnancies and abortions, use of emergency contraception before and after study) to see if there's a difference between study and non-study communities.

GROUP 5

Success in 5 Years Looks Like...

- Every male and female who wants sexual health information can access it when they want; information is reliable
- People feel free to openly and safely discuss sexual health and abortion in their community.
- Every pregnancy is wanted.

Possibilities & Priorities

1. Sexual health education and knowledge translation for women and men around contraception across the lifespan.

- Need to combat stigma and shame around contraception and abortion
- Recognize rural/urban disparities. Projects should be tailored to needs of individual communities (not one size fits all), look at professional mixes and ensure health and social service providers have the same information (include addition and other professionals in education).
- Focus on privacy and confidentiality issues at an institutional level
- Strengthen data collection and reporting

GROUP 6

Possibilities & Priorities:

- Focus on health service perspective: Need for information-sharing, surveillance, and knowledge transfer to health professionals.
- Issue of lack of providers and access linked.
- Project 1: Develop an itinerant abortion team that would go out to different communities and provide services, provide training to health professionals to build community capacity.
- Project 2: Develop divisions within Family practice, stratify and incorporate contraception/abortion training/knowledge transfer.
- Project 3: New scope of practice for RN's in development provides opportunity to incorporate contraception/abortion training/knowledge transfer.
- Project 4: Changing scope of practice for pharmacists

to support enhanced over-the-counter dispensing of contraception.

- Project 5: Create a randomized controlled trial around free contraception in a few communities.

What Will Work

- Clear questions with a defined scope

What Won't Work

- Trying to accomplish too much

GROUP 7

Possibilities & Priorities:

1. Access, specifically the rural/urban divide and how rural access to contraception and abortion more difficult than in urban settings.
 - Project: Examine rural equity of access with equal focus on providers and women.
 - Provider side: Examine barriers in rural settings, isolation, lack of support, security concerns. Priority is creation of a network to champion recruitment, continuing education, development of a community of practice with a research arm, collaborative work. Ensure professional education and training available, provide training to NP's, midwives, nurse and relate that to expanding scopes of practice. Tie into current Rural GP Incentive Program.
 - Patient side: Our dream is to create a comprehensive women's all inclusive health service including public education and expanded suite of services. Focus on 20-29 age group and marginalized women (culture, language, poverty).
 - Use a community engagement model with partnerships between communities and providers and women.
 - Priority should be on network development and service provision.

Common Themes & Messages

Dr. Jean Shoveller summarized the themes and messages elicited through the working group discussions. She described participants as not only service providers, administrators, social workers, statisticians and front-line providers but as individuals who are clients and users of the system. “We’ve all been there and maybe we don’t want to be there again but be in a better place.”

Inequities in Access & Knowledge

One of the key overarching themes from the day was about the need to address inequities – across age groups, geography, cultural and gender divides and knowledge. The need to tackle issues of access and knowledge translation through education of providers, patients and the public were reiterated over and over again throughout the day.

Feasibility & Learnings

Dr. Shoveller expressed her appreciation for the generation of a highly feasible set of researchable questions and projects. She described them as ‘early wins’ which will help guide care, practice and result in some early learnings. She said we can learn about what it would take to change our system, to address cost as a barrier, and how that links up with use. We can also learn about what it takes to change the culture of our system, studying that process and linking access and cost and distribution, and linking it with a health budget and health issue, not a moral dilemma no one wants to talk about.

Partnerships

Every group talked about the importance of partnerships as model, across communities and with the communities we work in. Dr. Shoveller described the conference as a significant next step towards expanding and solidifying such partnerships.

Normalizing Needs

Other participants highlighted their take-away messages from the day’s discussions. One stakeholder noted “It’s about normalizing needs. We haven’t normalized the need for contraception, and for abortion where contraception fails, and we haven’t normalized sex education.”

Facilitator Barbara Grantham closed the day by summarizing the four themes she came away with from the day’s discussions:

- Overcoming Distances
- Getting better at Data
- Tackling system Disincentives
- Engaging Decision-makers

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. Dr. Wendy Norman described the work of the day as just the beginning of a continuous engagement with stakeholders within the family planning community in BC. She said everyone’s input was and will continue to be critical to the success of the Contraception and Abortion Research Team’s work and hoped participants would continue to be an ongoing voice in how projects move forward.

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 developing demonstration health system improvement projects, with appropriate evaluation research, that will address the CART aim to 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@cw.bc.ca

Appendices

Appendix A: Agenda

MORNING SESSION: PLENARY

- 7:30–8:00 am **Registration**
- 8:00–8:25 am **Welcome Plenary:**
Welcome to the Territory of the Spritist Squamish Nation
Gloria Nahanee
Welcome: Dr. Jan Christilaw, President BC Women’s Hospital and Health Centre
Experience Guiding Research Guiding Care:
Reducing Barriers to Contraception & Abortion Services in BC
Dr. Wendy V. Norman
- 8:20–9:15 am **Panel Session 1: The International and National Perspective**
Moderator: Dr. Wendy V. Norman
Meeting the Need for Family Planning Globally
Dr. Dorothy Shaw
Canadian Legal, Political and Medical Barriers to Access Timely High Quality Abortion Care
Vicki Saporta
Challenges to Understanding Abortion in Canada & BC:
The Data Collection and Access Issue
Dawn Fowler
Questions for panel
- 9:15-10:00 am **Ryan Foundation Keynote Address:**
Best Practices in Contraception & Abortion Care
Dr. Mark Nichols: Evidence on “What Works” for Better Family Planning Services
- 10:00 -10:20 am **BREAK:** Poster viewing session and networking
- 10:20–11:00 am **Panel Session 2: Focus on Access to Family Planning in BC**
Moderator: Jean A Shoveller
Aboriginal Women’s Perspective
Lerinda Swain
Reaching Youth Through Technology
Dr. Mark Gilbert
Trends in Abortion Access in BC
Dr. Wendy V. Norman
Questions for panel
- 11:00–11:50 am **The Audience Speaks: Barriers and Solutions to Accessing Contraception & Abortion Services**
Moderated panel with all speakers: Share your experience; submitted and live audience cases
Moderator: Barbara Grantham
- 11:50 am–12:10 pm **Survey Preview: BC Abortion Provider’s Survey, Preview of Early Results**
Drs. Jennifer Dressler and Nanamma Maughn
Plenary Summary and Plenary Closing Remarks
Dr. Wendy V. Norman

AFTERNOON SESSION: WORKSHOPS

Health Services Design and Research Planning Workshop

(for designated participants)

12:10–1:00 pm	LUNCH AND NETWORKING
1:00–1:20 pm	Workshop Welcome: Summary of Feedback from the Pre-Conference Survey and the Morning Barbara Grantham
1:20–1:30 pm	Partnership in Health Systems Improvements Grant: CART Team Leaders' Vision for the Project Dr. Wendy V. Norman, Dr. Jean A. Shoveller, Dr. Janusz Kaczorowski
1:30–1:50 pm	CHAP Experience: A Community-based Approach Dr. Janusz Kaczorowski
1:50–2:20 pm	Working Group A: Possibilities for Program Design & Research Approach
2:40–3:00 pm	NUTRITION BREAK: featuring scientific posters and networking
2:40 – 3:10 pm	Working Group B: Priority Setting for Action
3:10 – 4:10 pm	Workshop Plenary: Sharing and Setting Priorities for Programming with Integrated Research
4:10 – 4:20 pm	Workshop Closing Remarks CART team leaders

Appendix B: 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 a third 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 at least 6 community-based non-profit organizations
- Academic faculty and researchers from UBC, Kwantlen, and 3 research institutes.

The following sectors were represented (with many participants representing more than one sector):

Front-line health workers <i>(Including physicians providing abortions 17%)</i>	48%
Non-Profit Community organizations	41%
Academic Researchers	21%
Health Administrators, Students, CART staff, and Health professionals in Training	15%

Appendix C: Posters

The following posters were displayed throughout the conference:

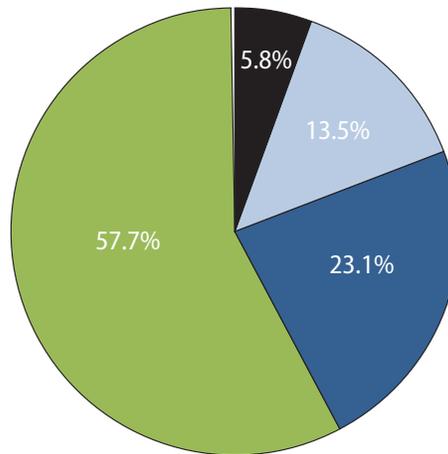
1. Ames CM, Norman WV.
Preventing Repeat Abortion: Is The Immediate Insertion of Intrauterine Devices Post-abortion a Cost-effective Option Associated With Fewer Repeat Abortions?
2. Bergunder J, Eccles L, Norman WV.
Women seeking abortion underreport gestational age by an average of one week based on last menstrual period compared to ultrasound dating.
3. Collins M, Holehouse R, Kaczorowski J.
Chlamydia Screening in an International Resort Community: A Pilot Outreach Program to Expand Access.
4. Dueck R, Hestrin B, Norman WV.
Provincial Pregnancy Options Telephone Referral Service: Ten year retrospective review.
5. Egan G, Soon JA, Levine M.
Impact of Physician Dispensing on Access to Emergency Contraception.
Alan C. Hayman Summer Student Research Poster Competition. Faculty of Pharmaceutical Sciences. Vancouver, BC. September 5, 2008.
6. Leung F, Jelescu A, Soon JA, Norman WV, Bacon A, Porter A, Li J, Cortina S, Nakamichi A, Kwok E, Foster S.
Development of Virtual Patients: A New Learning Strategy to Enhance the Pharmacy Family Planning Curriculum.
Alan Hayman Memorial Summer Student Research Poster Competition. Vancouver, BC. September 7, 2010.
7. Leung VWY, Soon JA, Marra CA, Lynd LD, Levine M.
History of regular hormonal contraceptive use among emergency contraceptive users in British Columbia. J Popul Ther Clin Pharmacol 2011;18:e200-1.
8. MacDonald K, Norman WV.
Better Contraceptive Choices: Immediate vs interval insertion of intrauterine contraception after second trimester abortion.
9. Norman WV, Dicus L, Lam M, Gurm B.
A multi-cultural contraception satisfaction questionnaire for use in studies of women following abortion.
10. Soon JA, Levine M, Schmidt T.
Use of Emergency Contraception in Women Presenting for Abortion in British Columbia: Differences and Similarities Across Major Language Groups.
Proceedings of the 2003 National Abortion Federation Annual Meeting. Seattle, WA. April 7, 2003.
11. Soon JA, Leung VWY, Levine M, Reade JA, Shoveller JA.
Utilization of Regular Contraception Among Rural Northern Youth in British Columbia: An Ethnographic Study.
J Popul Ther Clin Pharmacol 2011; 18(2):e212. [abstract]. Canadian Association for Population Therapeutics Annual Conference. Ottawa, April 17-19, 2011.
12. Teng F, Kwok E, Goldstein K, Cessford T, Ng C, Leslie J; Norman WV, Soon J, Malhotra U, Fitzsimmons B, Vedam S, Garrett B.
CARES: Computer-Assisted Reproductive health Education for Students.
13. Wiebe E, Kozoriz K, Lam J.
Cell Phones in Abortion Clinics: Exploring the Use, Benefits and Problems of Mobile Cellular Phones in Abortion Clinics.
14. Wiebe E, Byczko B, Johnson M.
Environmental Benefits of Manual Vacuum Aspiration.

Appendix D: Pre-Conference Survey

This report contains a detailed statistical analysis of the results to the survey titled CART pre-conference survey. The results analysis includes answers from all respondents who took the survey in the 7 day period from Wednesday, April 20, 2011 to Wednesday, April 27, 2011. 52 completed responses were received to the survey during this time.

1) I work in a setting described as a:

- Large Urban setting
- Large community (50,000 to 250,000)
- Medium sized community (under 50,000)
- Small community (under 10,000)



2) My role(s) include(s): (choose all that apply)



Other Responses:

- Interpretation
- Researcher at health authority (BCCDC)
- Medical Health Officer
- Advocate for women's health
- Community base researcher

3) What are the top 3 barriers to delivering effective contraception in your facility/community?



4) Please tell us about any other important barriers in your community to provision of effective contraception:

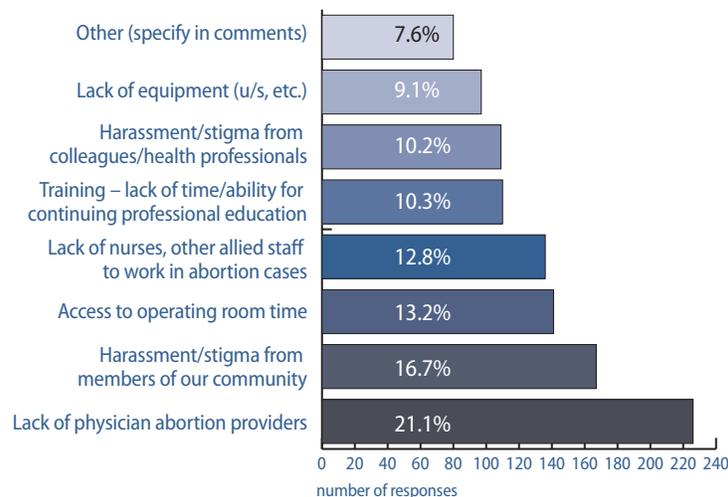
- > Lack of knowledge among the public and fellow health professionals about long acting reversible contraception and IUDs
- > I do not have enough experience
- > Myths such as IUDs inappropriate for using among those under 20 years
- > A reluctance in certain population groups to embrace contraception
- > Travel to Vancouver for procedures above 12 weeks (9 hour car journey), only 1 physician available in our town to perform TAs
- > Very low socioeconomic population equates to inability to pay for birth control, non-status individuals are limited to pay for birth control while their status First Nations friends pay nothing. Young girls are pressured very early to begin sexual relationships and have limited knowledge of effective birth control and STI prevention. Girls as young as 11 and 12 are afraid of

infection or have someone know they are taking the pill thus risk pregnancy and STI's due to the stigma of being labeled promiscuous. The educators within the primary and secondary schools are reluctant to provide sexual education to the younger youths in fear that "we are promoting early sexual activities". Condoms are not provided in the primary schools though some grade 6 & 7 girls' frequent public health for weekly pregnancy tests, plan B, and condoms.

- > No health centre at the university
- > It is a very small community. There is no such thing as confidentiality at the Dr's office, hospital settings. People are reluctant to access service due to perceived privacy issues and real privacy issues. Next town is 400 km away in one direction. Dr's are not up to date on current practices and reluctant to incorporate new information into their practice- despite numerous attempts.
- > We are in a children's setting
- > Community facility that makes it hard for young people to access service discreetly
- > N/A (I do not work in contraception service provision or research.)

- > Health authority attitude of risk avoidance, and the belief that contraception and abortion are controversial issues - therefore easiest solution is to avoid them.
- > OPT in PG provides services to youth under 25 years, and others have to go to the walk in clinic if they have no doctor.
- > Transportation issues for getting to clinics. Lack of physicians, many people in our community do not have a family physician and have to access walk in clinic to get their contraception.
- > Lack of good and sound sexual education program in the school system. Sexuality being a hidden topic not openly addressed at home, school, etc.
- > Many options are not suitable for clients. New contraceptive methods that do not involve hormones.
- > Availability of staff to administer
- > Religious beliefs
- > Health professionals need to build trusting relationships with young people who are leading high risk lifestyles- especially using alcohol and drugs to self medicate emotional pain. This requires time and dedication- more money needed for PHNs to help with and build relationships with students in schools around the issues of healthy sexuality
- > Time-- for providers and clients to get to real issues in sexuality - complexity of issues regarding sexuality - abortion misinformation and link to STI prevention
- > Inconvenience of accessing health care centres, and limited availability of family doctors.
- > Though in a large urban setting with a diversity of service providers available to most, we can still encounter outdated information among health care professionals, as well as the public, about contraceptive methods/use. As well, though contraception for youth can be fairly accessible, there is inequity in such access among sub-populations and, increasingly, cost is a barrier to adult women.
- > No youth clinic services. Limited hours of operation and cost for attendance at sexual health clinic.
- > Remote rural communities - travel to services
- > Cultural versus religion blending of the two also creates shaming and stigmas
- > Health care providers attitudes and occasional sabotage
- > Media involvement

5) Please rank in order, from #1 as most important, the following challenges or barriers to providing abortion services in your community?



6) Please tell us about any other important barriers faced by women in your community, or you in your professional role, preventing timely access to abortion services.

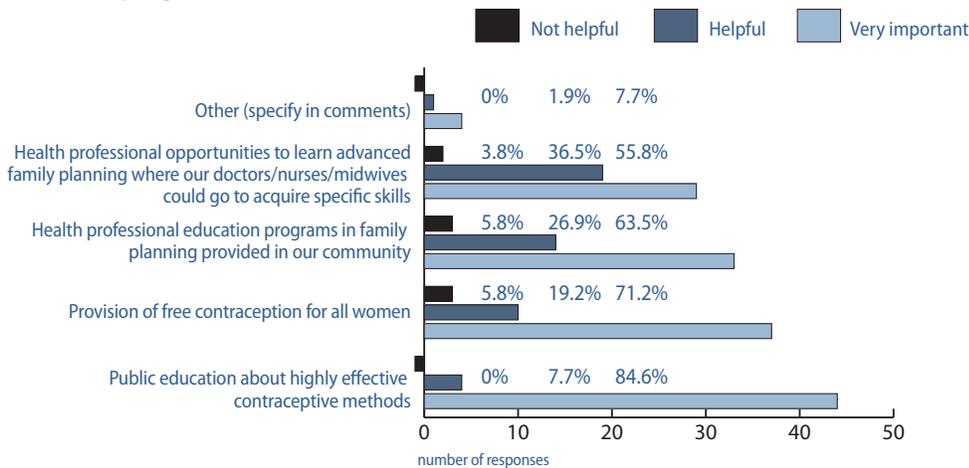
- > Lack of effective sex education within school district powerful and vocal position within the local churches against abortion, requiring women to have to leave the community for service provision.
- > There are few barriers, except that I am the sole provider of the service, and if I am out of town, there is no one who can/will step in. Some physicians are unwilling to refer patients for religious reasons...
- > Lack of resources
- > Politics around funding and health authorities. Funding for extra services in abortion clinics i.e. HIV testing, staff education Difficulty getting trained counsellors.
- > Language barrier and lack of knowledge of Canadian health care system (do not know where and how to access abortion service)
- > Lack of sufficient government funding
- > No routine u/s service within this community. Physicians do not have the training for u/s dating (frequent locums) Women must drive 120 km to the next community where the option of a medical abortion is provided if the woman is less than 7 weeks pregnant. All other pregnancies must be sent off island to Prince Rupert, Terrace or Vancouver which is costly and inconvenient.
- > People have to travel 400 km one way to the nearest abortion provider. If you are a teenager this means parents must be involved as it would be an overnight trip. Plus confidentiality issues in a small town and poor school age reproductive health teaching in schools.
- > Not in our setting at BCCH, but maybe an issue in BC Women's Hospital
- > Nearest provider is 2 hours away and due to high poverty, transportation is an issue
- > N/A (Not familiar with abortion services or research.)
- > Health authority perceptions.
- > If clients are unable to get services in PG due to no OR time or GP available, they must travel out of community to Quesnel & pay if overnight stay.
- > We have one physician in our community that provides abortion services. If that physician is not available then clients have to travel to another community and finances can be a barrier. Women on social assistance have huge loopholes to go through to get funding in place to travel. This is incredibly stressful for them.
- > Lots of referrals from other communities were the referral process takes a bit of time and also for woman to come and travel to caregiver providing the service not located in their community. US availability for dating, woman not always aware of LMP.
- > Physical environment/weather
- > Inadequate funding, no reciprocal billings with most other provinces
- > Access to abortion due to distance and cost to them incurred by travel.
- > Difficult access due to large distances to travel to obtain services
- > Need access to confidential services to assist with transportation and costs for people- especially if relatives work in the departments where they need to access service and funds
- > I now live in an urban environment with access but as a past provider with a high rural clientele- lack of confidential financial support for traveling and access to credible information in the early stages of an unintended pregnancy were huge barriers.
- > Patients feel that they cannot talk with their family physicians about this or ask for a referral due to the physician's personal opinion on abortion
- > Language and cultural barriers, and lack of knowledge of rights and services available in Canada.
- > In my particular community, stigma and negative attitudes prevail to limit access to needed termination services for later pregnancies. In the reality of having to deal with these limitations, women's choices are not honoured, additional barriers/harms are created and, at times, the ethical decision-making framework that we say we promote for patients in health care is not upheld.
- > Distance for travel to city where abortion services are available. Huge wait times if a woman is told by abortion clinic that she needs an abortion to confirm dates prior

to attendance at abortion clinic. There are no providers locally.

- > Parts of health authority have to travel distances to larger centre to access abortion services
- > Lack or cost of travel to access services
- > Lack of services in Fraser Health Authority Health care provider attitudes

- > Cost for travel out of their home communities.
- > Lack of access to contraception and abortion services/info in rural areas
- > Doctors that won't support women's choice
- > Patient Access to Abortion Services (i.e. Transportation)

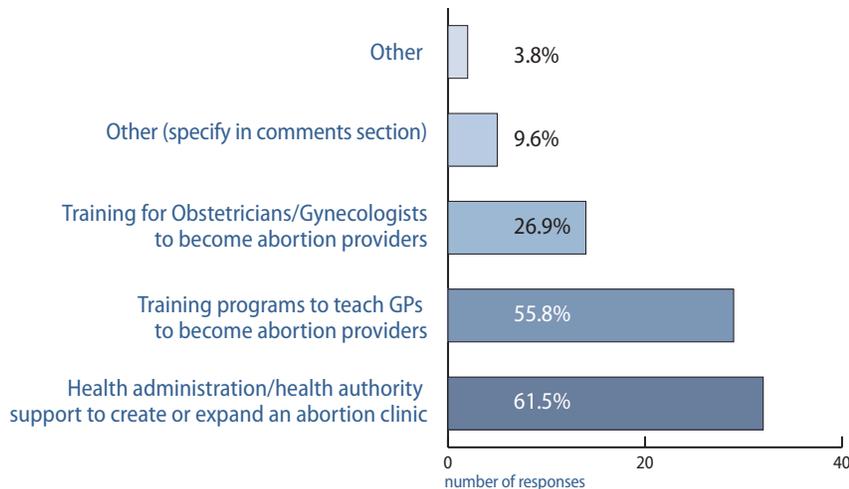
7) Please tell us about the probable importance of the following facilitators that could enable you/your facility/your community to reduce unintended and unwanted pregnancies?



Comment Responses:

- > Simply put, Mirena should be free for all women under 25, not just first nations.
- > Information provided in multiple languages
- > Enforcing stricter regulations for individuals who are breaching the age of consent for sexual activity such that older men who are engaging in sex with pre-adolescent girls are punished appropriately. Thereby supporting and sending a clear message.
- > Most of our clients are FN and so receive contraception free if status through DIA
- > Increased demonstration of public support for women's health issues
- > Include emergency contraception in the above. Also public education about sexuality
- > I think that we must recognize the complexity of sexual health issues, including contraceptive use, in the real lives of people e.g. the many factors that contribute to "risk-taking" (pregnancy, STI/HIV) like alcohol use, violence, poverty/self-efficacy.
- > Screening and brief interventions for problem alcohol use for youth and young adults, wherever they are, e.g. at sexual health clinic, at youth centres. Clinical impression is that most unprotected sex occurs due alcohol/ substance use.
- > Research to identify communities in which reproductive health services and education are deficient. Also, research to evaluate services and educational programs.

8) Please indicate which of the following facilitators would enable you/your facility/your community to improve your delivery of abortion services?



Other Responses:

- > Let people especially immigrants or international students know abortion in Canada is legal, safe and accessible, although not a big number, there are people have to fly to their home country to do an abortion due to the lack of knowledge.
- > Better funding for existing clinics
- > Support to create a health clinic
- > Dr's here reluctant to do training as are hospital nurses. The hospital here has not done ANY surgery other than c-section in years.
- > Use of misoprostol in clinics not restricted to physicians, with back up
- > Use of nurses and midwives as TA providers why are we only relying on MDs
- > Anesthetists who would be willing to provide services
- > I think that there is good momentum with training; health administration must step up to support abortion services & interested providers now, particularly in areas where gaps exist.
- > Exposure to abortion care services for health care providers who do not intend to provide but would refer for services

9) Please tell us anything else about barriers to effective, accessible contraception and abortion services in your community.

- > Women frequently discontinue contraception shortly after prescribed, due to side effects and compliance issues. Additional patient-specific counselling by a trained health professional during the first 3 months to teach medication management skills to the patient may reduce unintended pregnancies related to poor compliance.
- > Most young non native girls can not afford Mirena, the only effective way to provide contraception to teenagers. Our rate of unplanned pregnancies amongst our native population has dropped dramatically since Mirena arrived. We do also need better and more relevant sex-education at our local schools - this is done in a haphazard way. The abortion service functions well overall, with little harassment (except that my kids were kicked out of the local Roman Catholic private school because their father provided abortions!)
- > Able to meet the needs of marginalized populations (addictions, isolation of new immigrants, working mothers)
- > When I think of barriers to care. I think outside the lower mainland, there is not good knowledge of where services available. I understand this to be a matter of security for providers, but health authorities should advertise

where their abortion services can be obtained without identifying who the abortion providers are. We need to be more out there as far as advertising services.

- > Our university has no health clinic. Students/employees need to go to services in the health authority. Some do not want to access through their GP
- > Again we have an OPT clinic but it is under utilized due to lack of client knowledge of what is available, teaching in schools is almost non-existent, Dr's reluctant to provide services, and perceived and real confidentiality issues.
- > Transportation as noted previously
- > Inconsistent policies. Insufficient HA resources to support contraceptive services (and abortion services).
- > Age of OPT in PG, appointments available for OPT (only 21 as a one afternoon clinic)
- > Patient travel to care is another barrier. It is astounding to me that patients from Kamloops must travel 2.5 hours to Kelowna for care. There should be a requirement that all tertiary care hospitals within a health authority should have dedicated abortion care as part of complete reproductive care services.
- > Middle and high school outreach program to promote access to OPT and established Youth Clinics or to furnish contraception directly. Do schools still have nurses? If not, an RNP on site could be a valuable source of information and provider of contraception and information and referral for medical care.
- > Restrictions put on by the health authority of how many abortions can be done each year.

- > Just figuring out a new system to manage the new CRNBC guidelines on medication distribution
- > We have a very supportive GP – when she is away or ill we have no local service – too much depends on her- we are very thankful for her
- > Poverty, impact of hyper sexualization of girls and impact of parenting earlier than 30 plus years of age on young women and their children.
- > Fragmented services with hospitals and community based providers
- > I would like to see abortion care seen as a normalized part of women's care services with advertising in the same manner as other clinics. I just wish we did not have this security shadow hanging over us. I truly believe that younger generations do not attach the same stigma to this part of medicine that we ourselves do.
- > Cultural influences, inequities that women face.
- > Safety
- > There is currently a barrier to accessing data for research in the areas of contraception and abortion services.
- > I also wanted to express strongly my belief that contraception should be provided free of charge to anyone desiring it. I believe Holland and (one of the Scandinavian countries) have the lowest unplanned pregnancy rates in the world; they also provide free contraception to their citizens.



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