

CART-GRAC

Contraception
Access
Research
Team



Groupe de
recherche sur
l'accessibilité à
la contraception

Developing a National Family Planning Primary Healthcare Research Program

**Opportunities and Priorities
Identified Through Stakeholder
and Expert Consultations**

Fall 2011



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

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Executive Summary

To develop a foundation for a national family planning research network, a core research team conducted several initiatives throughout the fall of 2011. Meetings with health system decision makers in public health and health services delivery from government, public and not-for-profit sectors across the nation were carried out to capture perceived gaps and opportunities as seen by knowledge users. As well, key informant interviews, and surveys among national organizations representing vulnerable populations and those representing health care professionals were conducted, and used to inform discussions at planning meetings with nationally representative health professionals and interdisciplinary academic researchers. Innovative models and important gaps emerging from each of these activities have been used to identify priorities for a programmatic community-based primary healthcare family planning research and researcher training agenda that could advance access to optimal contraception and abortion knowledge and services.

The aim of this work is to improve the health of Canadian women and families by reducing unintended pregnancies and improving recognition of optimal pregnancy timing, so that women are able to achieve the healthiest pregnancies. Our goal is to undertake primary healthcare family planning research that will lead to improvements in **equitable access** to high quality family planning knowledge, services and methods, particularly among vulnerable women and families throughout Canada.

Initiatives described here include:

- National mixed methods surveys of stakeholders and primary healthcare clinicians
- Expert Interviews with key stakeholders
- A “Network Launch” consultation forum with Clinical Service providers
- A planning meeting with key decision makers and interdisciplinary academic researchers to establish research program priorities

This report will largely detail the latter of these activities, with findings from the former activities provided in the appendices.

On October 25, 2011, the CART-GRAC Contraception Access Research Team / Groupe de Recherche sur l'Accessibilité à la Contraception convened the *Setting National Family Planning Health Service Goals* core planning meeting to guide Canada's first national family planning research collaboration.

More than two dozen health policy leaders, hospital administrators, health economists, social scientists, population health experts, computer scientists, primary care health professionals, community group representatives and interdisciplinary researchers from across Canada came together in Toronto, Canada to review results from surveys, expert interviews and consultations. This meeting fostered a sharing of ideas, identification of priorities, and agreement on best approaches for a robust program of national family planning research.

Six themes emerged from the day's discussions with allied priority issues and ideas for the CART-GRAC core team to consider when focusing their efforts as the initiative moves forward. (See chart, next page.)

The CART-GRAC core research team will use the themes and ideas generated by these stakeholder and expert consultation initiatives, and the information from the mixed methods studies (appended) to inform development of an innovative programmatic approach to research and a researcher training program.

The CART-GRAC initiative heralds a bold new frontier for family planning research and collaboration in Canada. It marks the first-ever national network of interdisciplinary, cross-sectorial, interprofessional family planning researchers and stakeholders working in concert with public health and health system delivery leaders to share ideas and lead innovation for the benefit of Canadian women and families.

CART-GRAC Summary Themes

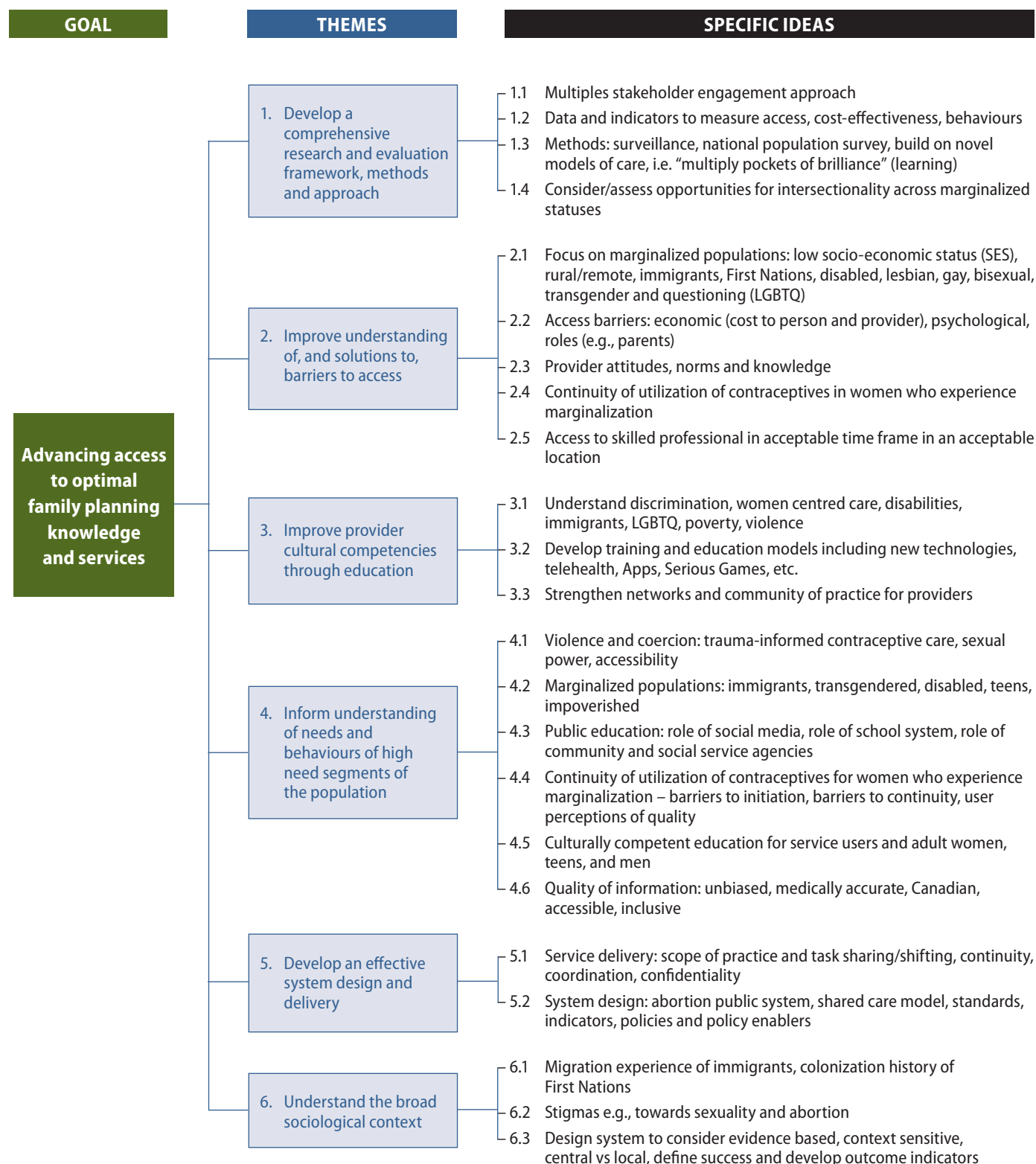


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- University of British Columbia (UBC), Department of Family Practice
- BC Women's Hospital and Health Centre (BC Women's)
- The GRAND (Graphics, Animation and New Media) NSERC funded Network of Centers of Excellence
- Women's College Hospital, Toronto, Ontario
- Institut national de santé publique du Québec (INSPQ)
- University of Toronto

CART-GRAC team leads Dr. Wendy Norman and Dr. Sheila Dunn, and with the expert advice and collaboration of Dr. Edith Guilbert of the INSPQ, extend their thanks to the following individuals for their assistance:

- Janet Brown (Facilitator)
- Penelope Hutchison (Writer)
- Jessica Ferne (Note-Taker)
- Jane Gautier (Arrangements for Stakeholder Interviews)

Most importantly, CART-GRAC wishes to thank the policy makers, health system leaders, health care providers, administrators, computer scientists, researchers and others who attended the October 25, 2011 planning session, and the October 23 network launch session and the hundreds of health professionals, advocates, national representative organization leaders and citizens across the country who contributed their experiences and opinions in the stakeholder surveys. Their energy, enthusiasm and thoughtful, considered suggestions have provided the foundational elements on which to build the first national Canadian family planning research collaboration.

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Setting Priorities for a National Research Program

More than 25 stakeholders from across Canada came together in Toronto, Canada on October 25, 2011, to establish key priorities for an inaugural national family planning research team. The Contraception Access Research Team (CART)/Groupe de Recherche sur L'Accessibilite a la Contraception (GRAC) planning meeting saw health policy leaders, health system decision makers, health economists, human-computer interaction scientists, community group representatives, primary care health professionals and interdisciplinary researchers evaluate broad stakeholder input from surveys and interviews, and bring forward their best ideas to establish priorities.

(See Appendices A and B for the day's agenda and a list of participants and participant organizations.)

Session objectives were to:

- Understand the current state of family planning challenges in Canada, and exchange ideas on mechanisms to address these.
- Discuss successful models of family planning health services, and potential innovations that could be shared between provinces to enhance community-based primary healthcare access and knowledge translation nationally.
- Explore optimal team, collaborator and network composition considering public, private, not-for-profit and academic sectors; key knowledge users and health policy decision makers; a broad range of health, social science and communication disciplines; and including representation from among marginalized and vulnerable populations.
- Discuss how family planning research may inform government health care decision makers, facilitate knowledge translation and enhance uptake of research findings into a post research phase.

The first half of the day gave participants an overview of current family planning gaps and opportunities – moving from global family planning needs to the state of Canadian family planning health services research, to a summary of consultations with key national stakeholders on facilitators and barriers to effective contraception and abortion access.

The facilitated afternoon sessions synthesized ideas gleaned from the morning and participant experience and perspectives to identify key priorities for research themes to advance access to optimal family planning knowledge and services.

The goal for these activities is to set the foundation for a new national community-based primary health care (CBPHC) family planning research team. The priorities identified will be used by the CART-GRAC team to develop a programmatic research and researcher training agenda that will improve equitable access to optimal family planning knowledge and services and thus realize:

- A reduction in unintended pregnancies
- Improved awareness of optimal fertility timing leading to...
- Improved health for Canadian women and their families.

CART-GRAC's **AIM** is to reduce unintended pregnancies and increase awareness of optimal pregnancy timing and thus improve health, particularly among vulnerable groups of Canadian women and their families.

Our **GOAL** is to undertake primary healthcare family planning research that will lead to improvements in **equitable access** to high quality family planning knowledge, services and methods, particularly among vulnerable women and families throughout Canada.

1. Understanding Family Planning Gaps and Opportunities

A. Forming a Canadian Contraception Access Research Network

Dr. Wendy Norman, a CART-GRAC Team Leader, and community-based primary healthcare clinician scientist, explained the rationale for the formation of a national family planning research team, collaboration and network.

Challenges facing contraception and abortion primary health care services in Canada are national in scope. Current disparities in access to services disproportionately affect marginalized and vulnerable populations. While innovative research is occurring in some provinces and successful innovative family planning service models do exist, little evaluation, knowledge translation and

sharing is occurring between jurisdictions. A coordinated, collaborative approach has the potential to innovate and improve access to knowledge and services and thus to reduce unintended pregnancies nationwide.

CART-GRAC's objectives are to:

- Build a capable, collaborative interdisciplinary, cross-sectorial national family planning research team, collaboration and network;
- Develop a plan for a national research and researcher training program that will produce innovative, high quality family planning primary healthcare research in Canada;

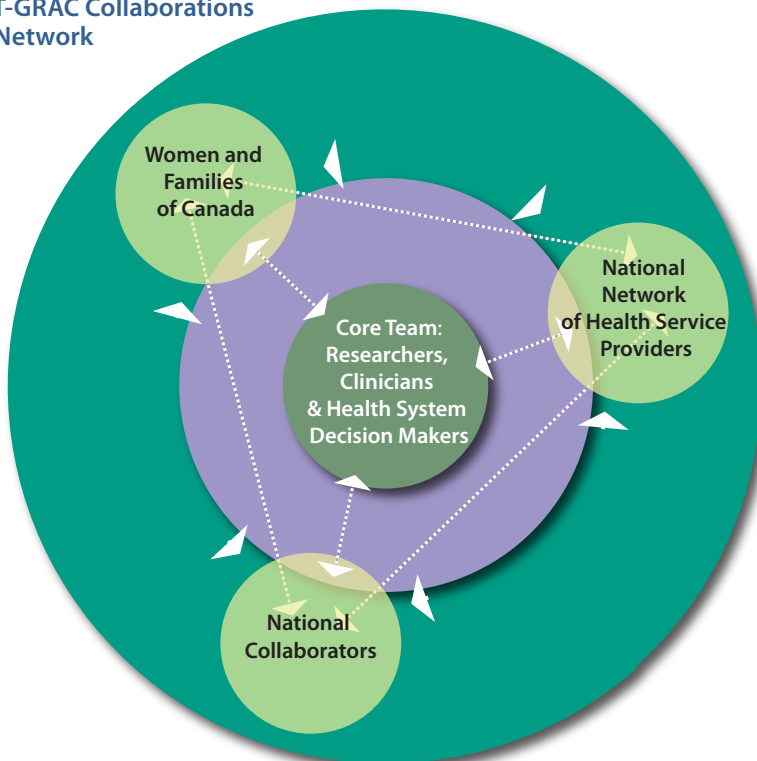
CART-GRAC envisions:

- a core team of 10-12 interdisciplinary researchers and key knowledge users from both public health and health services (i.e. leading health systems decision makers),
- collaborating with a wide range of national interdisciplinary researchers, knowledge users and communications experts
- consulting with an advisory panel including representatives of vulnerable populations of women, of health service providers, and interested national stakeholders.

Core-Team Vision:

This model will optimize dissemination of CART-GRAC research findings and implementation of evidence-based practices into better community-based primary health care for women and families of Canada.

CART-GRAC Collaborations and Network



(See Core Team Ideal Components, right: blue fields are direct knowledge users and health policy leaders, red fields represent interdisciplinary researchers and health service professionals with the green field of trainees and Junior researchers.)

The current opportunity to realize this vision is offered within a 2012 CIHR grant competition to improve access to community-based primary health care (CBPHC) for vulnerable populations. Many populations experience significant disparities in access to knowledge and services supporting family planning (e.g., those in rural/remote locations; of First Nations, Inuit or Metis heritage; of low socio-economic status; youth; new immigrants and populations with mental health and addictions challenges).

The CIHR award funding the CART-GRAC planning activities detailed in this report was provided to support an application for this five-year CBPHC Team Grant.

Additional intents of the CIHR grant are to promote researcher capacity building, to create the next generation of researchers across Canada; and to increase the utilization of research evidence amongst primary health care system decision makers.

B. Meeting Global Family Planning Needs

Dr. Dorothy Shaw, Vice President, Medical Affairs for BC Women's Hospital & Health Centre, 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 the global family planning environment and its parallels to the Canadian experience, especially amongst marginalized and vulnerable populations.

Core Team Ideal Components



Half the world's population is under 25 years of age, most living in developing countries, yet their reproductive and health needs seem to have been forgotten. Of the 200 million pregnancies resulting every year, roughly 80 million are unwanted, resulting in 20 million induced abortions and close to 50,000 deaths from unsafe abortions. Evidence suggests high maternal, perinatal and neonatal morbidity and mortality rates are associated with inadequate and poor quality health services, legal barriers, lack of political will, underfunding, as well as poverty and lack of education, among other challenges.

There are significant efforts underway to tackle global family planning challenges. The United Nation's Millennium Development Goal 5 focuses on improving maternal health. The targets are by 2015 to:

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.

Dr. Dorothy Shaw

A key take-home message from Dr. Shaw was that ultimately, investing in family planning makes good economic sense. Every dollar spent on family planning saves at least \$4 dollars that would have been spent treating complications arising from unplanned pregnancies.

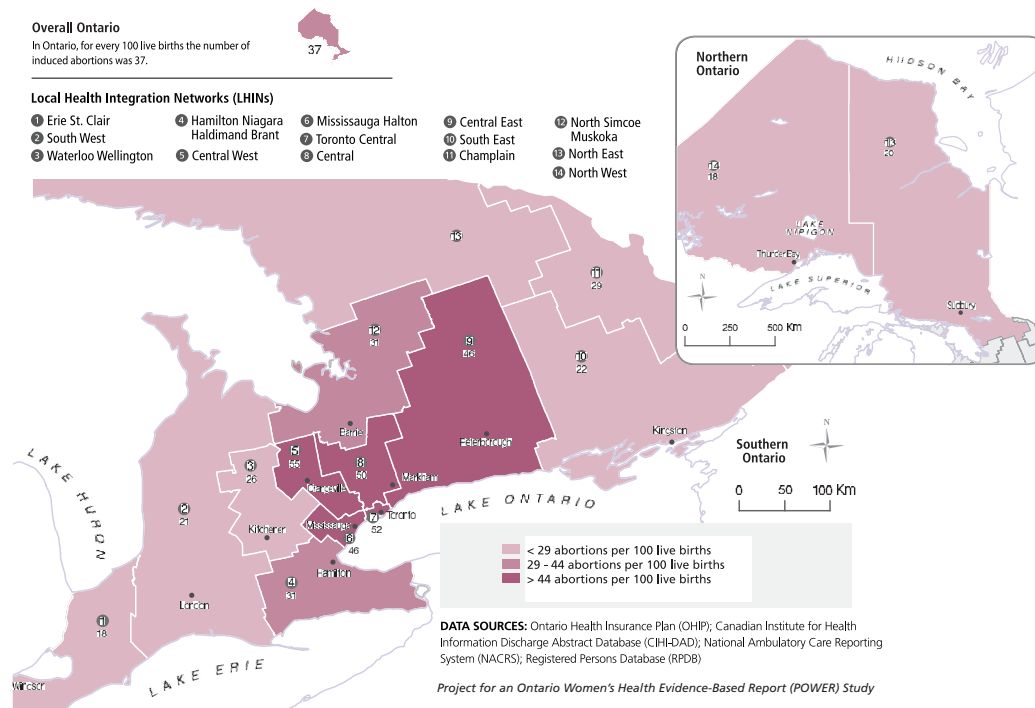
1. Reduce maternal mortality ratios by three quarters.
2. Achieve universal access to reproductive health.

There are many parallels in terms of our work on national family planning issues to the global setting, for example in some of our marginalized and vulnerable populations the age demographics nearly reflect that in the developing world, access issues in Canada among those in northern and rural communities, among Aboriginal and immigrant populations and with those with mental health and substance use challenges are significant, and the shortage of health

human resources is as relevant here as it is in developing countries. Ideas like task-shifting and sharing are already leading to better contraception access for women in developing countries and have been shown to be safe and effective in isolated developed world and even some Canadian trials.

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Age-standardized induced abortion rate by health region (LHIN), 2007 (per 100 women aged 15-49)



CART GRAC Timeline	March 2011-February 2012	September-December 2011	October 22-25, 2011
	<ul style="list-style-type: none"> Interviews with Key Stakeholders: Decision Makers in Public Health and Health Services Planning 	<ul style="list-style-type: none"> National Stakeholder Survey Examining access and quality issues Interviews with Key Stakeholders: National Organizations Representing vulnerable groups and those representing healthcare professionals 	<ul style="list-style-type: none"> Clinician and Social Scientist Input The North American Forum on Family Planning: CART-GRAC held a first national Canadian family planning research network meeting Key Informants Research Priorities Planning Meeting National family planning stakeholder meeting

C. National Scan: Examples of Canadian Family Planning Research

Highlights from recent innovative research from Ontario, Quebec and British Columbia set the context for exploring current gaps and opportunities for the development of a national contraception and abortion research agenda, and highlight opportunities to share current province-specific successful models between jurisdictions.

Ontario

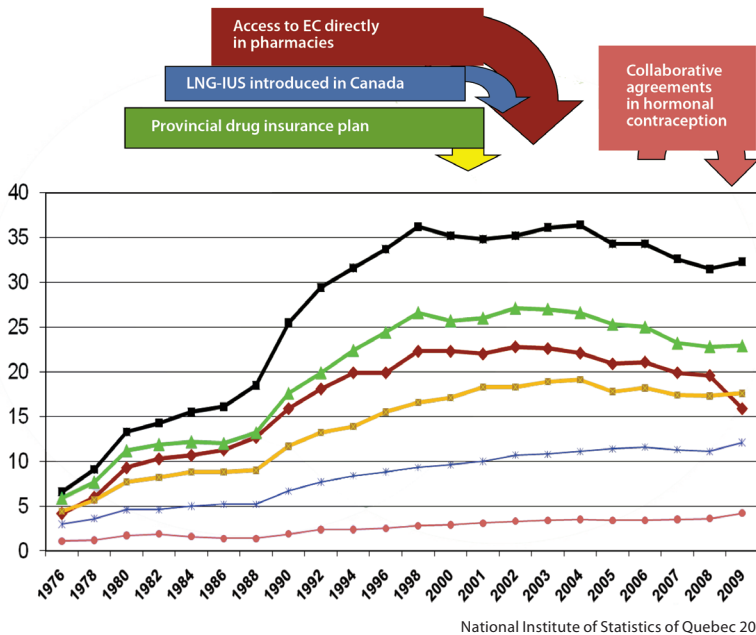
The Ontario POWER study, funded by ECHO¹, utilized large administrative datasets to examine population-based trends in abortion trends, teen pregnancy and intrauterine device (IUD) insertion rates. Dr. Sheila Dunn, a CART-GRAC Team Leader, said having access to Ontario’s robust databases allowed researchers to link socio-economic status, education and geographic regions. This enabled conclusions to be drawn about health equity with findings persuasive enough to encourage changes in health policy and practice.

POWER study highlights include:

- Women living in the poorest

1 ECHO is an agency of the Ontario Ministry of Health and Long-Term Care.

Abortion rates in Quebec, per age groups 1995-2008



neighbourhoods had abortion rates two times higher than those living in more affluent neighbourhoods.

- Urban women had abortion rates twice that of their rural counterparts.
- Teens in the lowest income brackets have birth rates six times higher than upper income women.
- Improved IUD insertion rates were driven by gynecologists, not family physicians.

Dr. Dunn noted a number of questions arising from the POWER study for further investigation, including:

2012	May 2012	October 2012
<ul style="list-style-type: none">• Operating Grants to begin National Research– Applications for research funding planned for spring-summer-fall 2012	<ul style="list-style-type: none">• CIHR CBPHC Team Grant, Letter of Intent due	<ul style="list-style-type: none">• CIHR CBPHC Team Grant Application due (if invited)

1. Are lower abortion rates in some areas due to socio-cultural influences, better contraception or decreased access to abortion?
2. What factors affect high pregnancy and abortion rates in poorer teens?
3. What physician characteristics are associated with providing IUD insertion in family practice?

Quebec

Dr. Edith Guilbert, a Clinician Scientist and medical advisor in the L'Institut national de santé publique du Québec (INSPQ), summarized the evolution of Quebec's 2007 collaborative agreement in hormonal contraception. This novel task-shifting model allows women to access prescription contraception through a nurse and a pharmacist rather than requiring a physician consultation.

Working with the Colleges of physicians, nurses and pharmacists, a model was developed to allow nurses to prescribe hormonal contraception to women for a six-month period. Task-shifting enabled nurses to evaluate patients,

counsel, and provide a particular form similar to a prescription women could take to their local pharmacy to get hormonal contraception (pill, patch, etc.). The agreement was supported by a web-based nursing training program offering nurses university credit for completion. Dr. Guilbert noted further research is necessary to understand the factors influencing nurses prescribing contraception and a larger study is being launched to examine this question.

- IUD use in Quebec is 10% compared to the rest of Canada at 2%, which is thought to be due to provincial policies to subsidize contraception cost.

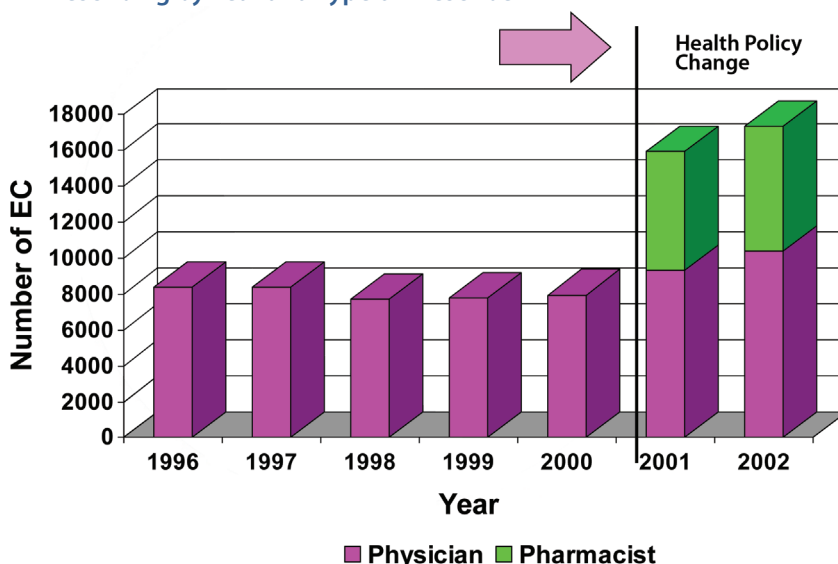
British Columbia

In 2000, British Columbia became the first jurisdiction in North America to allow pharmacists to prescribe emergency contraception (EC). Dr. Judith Soon presented findings from pharmacoepidemiologic research using population-based administrative data to track EC and contraception utilization rates.

Highlights from the youth sexual health research team studies included:

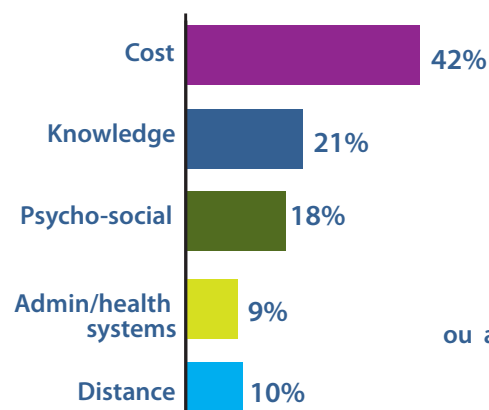
- Prior to 2000, there were approximately 8,000 prescriptions annually from physicians for EC. That rate essentially doubled in one year with the task-sharing change in health policy allowing pharmacists to prescribe approximately 7,000 EC per year.
- Teen pregnancy rates are much higher and contraception utilization rates much lower in northern British Columbia and among those with lower socio-economic status indicators.
- EC use in northern British Columbia is lower compared to the Lower Mainland despite higher demonstrated need.

Pattern of Emergency Contraception (EC), Prescribing by Year and Type of Prescriber

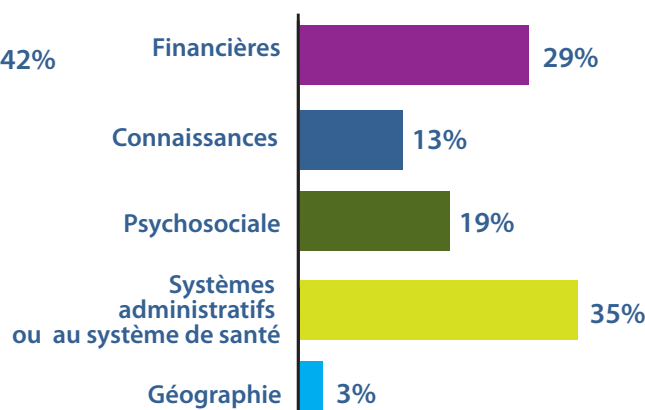


Soon JA, Levine M, Osmond BL, Ensom MHH, Fielding DW. Effects of Making Emergency Contraception Available without a Physicians's Prescription: A Population-based Study. CMAJ 2005;172(7): 878-833.

Barriers to Access



Difficultés d'accessibilité



National surveys in English were predominantly answered by health service providers from provinces other than Quebec, While the French versions were answered almost exclusively by those from Quebec. (For full survey results see Appendix C.)

- Approximately 81% of all abortion services in British Columbia are concentrated in the Lower Mainland.
- Ethnographic research in two northern British Columbia communities has suggested that among sexually active youth, five times more used male condoms only than birth control pills or no contraceptive method.

British Columbia's Contraception and Abortion Research Team (CART) has developed a provincially-based network of health care decision makers, health service professionals, researchers, and health policy leaders undertaking health services research including community-based health demonstration projects. Similar to the CART-GRAC national initiative, the aim is to reduce unintended pregnancies and improve access to contraception in British Columbia.

D. Stakeholder Scan

The team leads shared preliminary results from the CART-GRAC Canadian Contraception Access Survey (CCAS) and from consultations with collaborators, service providers, and advocates for vulnerable groups nationwide. (For final results, see appendix C.)

Most notable was the dramatic difference in the results between French-speaking respondents who were almost exclusively Quebec-based, who largely indicated successful achievement of equitable access to family planning knowledge, services and methods throughout Quebec, and those from the rest of Canada indicating wide gaps and inequities relating to access.

Approximately 89% of respondents from predominantly English speaking provinces felt the marginalized or vulnerable groups of women they served have disproportionately more difficulty in accessing contraceptive services compared to 44% among French-speaking respondents, almost exclusively Quebecois. The biggest barriers for English Canada were cost and knowledge while French-speaking respondents highlighted administrative and health system barriers, noting the dearth of primary care

“There are youth in need of quality contraceptive care but youth are not always an identified vulnerable group category. We need to show how youth are not being served and don’t have an identified primary care physician.”

Dr. Dorothy Shaw

physicians in Quebec (1 in 3 Quebecers has no access to a primary care physician).

Major cost barriers were the initial cost for IUDs (59%) and transportation (54%) for English respondents. Surprisingly, French respondents also highlighted the cost of the method (31%) as a major barrier, noting an issue with the provincial drug insurance plan in the case of women under 25 years of age living at home and thus on their parents’ provincial drug insurance plan. This situation precludes confidentiality, as contraceptive prescriptions are noted on the plan of the parents.

Psycho-social barriers resonated across both groups with “embarrassment/fear about obtaining” (English 70%; French 41%) and “negative attitudes toward certain contraceptives” (English 63%; French 41%) as the two main barriers to accessing contraception.

For quality of contraceptive care, 57% of English respondents compared to 21% of French stated that marginalized and vulnerable groups of women (including those of young age) are disproportionally receiving lower quality of contraceptive care.

For both English and French respondents, poor client-provider relationships and limited contraception choices (*ie., “It’s the pill or nothing.”*) were the main barriers to high quality contraception care.

Access to abortion was a critical issue with 66% of English respondents knowing women who disproportionally have more difficulty accessing abortion services compared to only 10% in Quebec. It was noted that in English Canada, most medical or surgical abortions services are concentrated in urban centres and hampered by a slow referral system. In Quebec, every health area has an abortion provider compared to the rest of Canada where groups with the highest needs (e.g., remote) have no local provision at all for abortion.

Discussion

The initial survey results fomented much discussion about the differences between the Quebec health services delivery model and family planning services in the rest of the country, and which successes could potentially be shared across jurisdictions. Excellent access to provincial health administrative data in Ontario was seen as a potential strength to improve understanding and targeting of programming, as was the seamless collaboration in British Columbia between health system leaders, researchers and family planning health services. Participants actively explored opportunities for further study, challenges and potential solutions.

Top 3 Groups Receiving Lower Quality of Contraceptive Care

ENGLISH RESPONDENTS	FRENCH RESPONDENTS
18% Low socio-economic status	16% Under 18 years of age
14% Living in northern & remote areas	13% Coping with mental illness
13% First Nations/Aboriginals	22% Low socio-economic status

Success Factors of Quebec Model

Dr. Edith Guilbert noted that “access trumps everything” in Quebec. While there is a lack of primary care physicians, overall Quebec has been successful in improving access to contraception and abortion services based on 3 key factors:

1. Subsidised contraception provision (low cost or free for all methods)
2. Task-sharing agreement to allow access to prescription contraceptives through nurses and pharmacists
3. Direct pharmacy access to emergency contraception

Role of Education

The Quebec model utilizes nurses in schools to increase access to contraception among youth. Participants noted a large variation in the level of nurse involvement in schools across the rest of Canada, with sexual health education varying widely in terms of quantity, quality, timing with respect to student grade, and frequency. In terms of strategies for programmatic research, reaching youth through schools was thought to be out of scope of what could be accomplished through the national collaboration within the first five-year plan.

Measuring Reproductive Care

An influential survey of the Centers for Disease Control in the United States (The National Survey of Family Growth-NSFG) has collected information about determinants of sexuality, pregnancy outcomes, and access to contraception and abortion services since 1973. The NSFG provides a rich resource of data to guide health policy decision makers and service providers. More than twelve other developed countries have similar surveys to guide family planning policy-making and service delivery. Canada has no mechanism to collect such information on population needs or to understand our unique factors underlying disparities in access. **Participants including decision-makers present highlighted the need to develop a Canadian national family growth survey to collect Canadian-context data on trends and disparities in determinants of births and pregnancy rates, as an essential foundation to inform policy and health services planning.**

Participants including decision-makers present highlighted the need to develop a Canadian national family growth survey to collect Canadian-context data on trends and disparities in determinants of births and pregnancy rates, as an essential foundation to inform policy and health services planning.

2. Setting Priorities, Building Solutions

“We need to spread the learning. It’s about multiplying pockets of brilliance.”

Pat Campbell,
CEO, ECHO

After a morning of information gathering, the Nominal Group technique interactive afternoon sessions gave participants an opportunity to share their expertise and perspectives, with an aim to:

- Prioritize key unmet needs/problems into potential research themes
- Develop five to six research themes based on potential systematic changes, innovative solutions and data/research requirements.

Participants began with a 15-minute individual exercise to reflect on their key issues and what they felt were unmet needs to advance family planning health services delivery. Next stakeholders moved into groups of two to three to share their reflections and find commonalities. Discussion proliferated as the smaller groups joined together into four large groups to synthesize and prioritize key themes and issues. The day ended with an engaging forum where participants determined six theme areas for concentration by the CART-GRAC national collaboration.

The work undertaken by stakeholders at the planning session marked an integral part of the process to assist CART-GRAC team leads to define a clear, coherent national research program and develop a coordinated national research team.

A. Summary Themes

Six clear themes emerged from the robust group and forum discussions with specific ideas on how they could be utilized to support the overarching goal of advancing Canadian women’s access to optimal family planning knowledge and services. While many issues cut across themes, there was general agreement that the final six highlighted the key areas for CART-GRAC concentration.

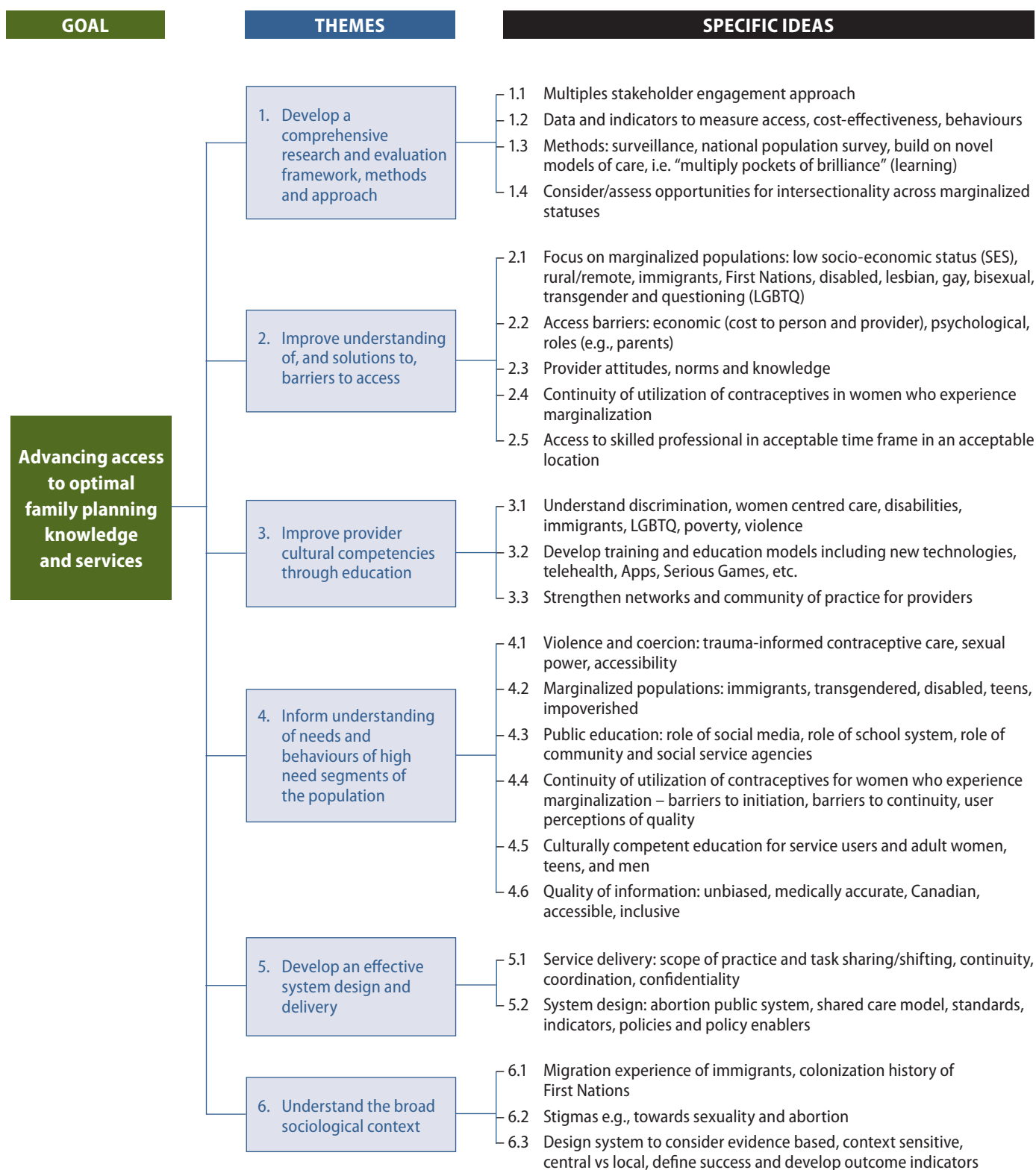
1. Develop a Comprehensive Research and Evaluation Framework, Methods and Approach

Participants noted the need for Canadian-based data that is accessible and inclusive. Suggestions included the creation of effective surveillance mechanisms to track indicators such as access, barriers, cost, sexual health behaviours and knowledge users and the determinants of health contributing to trends and disparities. Critical to this will be the tracking of subgroups to gain a deeper understanding of the issues facing marginalized populations. Such data is also vital to informing the business case for family planning health services and health policy.

Engaging a broad base of stakeholders from within the vulnerable populations any research might investigate was cited as vital to creating context-sensitive and community-relevant research projects. “We need to know who are the community stakeholders. Youth and marginalized groups need to be part of these discussions.”

Research approaches need to be intersectional, recognizing that contraception and abortion issues are cross-cutting. This includes

CART-GRAC Summary Themes



Participants suggest one of our objectives would be to see access to service for the person in need, by an available skilled professional, within an acceptable time frame, in an acceptable location.

across population groups and across issues such as violence, coercion, geography and other factors.

Knowledge translation was highlighted as vital to any comprehensive research and evaluation framework. Efforts should focus on spreading new knowledge and best practices: both those already successful within a province or provinces, and new models arising from the research of our team.

CART-GRAC will aim to systematically identify, share knowledge between jurisdictions, and uniformly evaluate models of care to facilitate national implementation of optimal community-based primary health care family planning knowledge, services and methods.

2. Improve Understanding of, and Solutions to, Barriers to Access

Access was a critical priority for all participants with many barriers to obtaining quality, timely, contraception and abortion services noted including cost, geography, attitudes, knowledge and continuity of care.

Some stakeholders called for free and/or affordable contraception, especially for highly effective methods such as IUDs and hormonal contraception options. Others stressed the need to look at the role of parent and provider attitudes and knowledge as facilitators or barriers to family planning services. “We need to consider – why do women start and then stop using contraceptives? Use this as a starting point to broadening our understanding of how to improve access.”

Another common element was the **need to ensure the equitable distribution of services** to address access for rural, northern and Aboriginal communities, especially around abortion services which, outside of Quebec, are concentrated in southern urban settings.

“Improving knowledge and uptake of forgettable contraception, such as IUDs where contraception is excellent independent of daily or episodic user input, can help address many of the common barriers to achieving continuous effective contraception.”

3. Improve Provider Cultural Competencies through Education

This theme focused on health care provider knowledge, training and attitudes and how they influence access to contraception and abortion services. Much discussion focused on the need to learn more about, and learn how to best address, provider attitudes and practices.

Another suggestion to improve vulnerable and marginalized women’s experiences of family planning services was the provision of “cultural humility” training to health care providers to better respond to women’s needs. Broad cultural competency has the potential to support better care for women with different abilities, languages and ensure care is women-centered. New technologies offer diverse opportunities for provider education such as the use of online games and curricula to enhance provider access to training. The members of GRAND (a NSERC network of Centers of Excellence in graphics, animation and design including university computer science faculty across Canada) had several excellent suggestions for improved, modern knowledge translation for both health service providers and patients, using web-based platforms independent of location.

Many participants suggested the CART-GRAC network should expand beyond the health sector to include social scientists and other “people who contribute” to our knowledge. Suggestions included training social science researchers from the fields of law, politics, economics and other social science fields to support a new generation

We need to improve evidence-based knowledge among health service providers, not only related to modern family planning methods, but also sensitivity and awareness of the cultural and social context among specific populations.

of family planning researchers. This could help strengthen the CART-GRAC network and communities of practice for providers. **CART-GRAC meeting participants called for research to find methods to support improved access to high quality contraception and abortion services through better provider education.**

4. Inform Understanding of Needs and Behaviours of Marginalized and Vulnerable Segments of the Population

The population theme centered on relations between individuals, populations and sub-populations and the context from which people and groups seek family planning care.

Violence and coercion was a focal issue for participants, noting women who've experienced relationship violence have different experiences of access to care. Clinicians need to be aware and sensitive to this history by providing "trauma-informed sexual care." Underpinning this issue was a call to educate youth about egalitarian sexual relationships as a means of primary prevention. Participants further expanded on this theme by highlighting the need for culturally sensitive to recognize the historical and/or systemic barriers to contraception access many marginalized groups face, such as First Nations and Aboriginal peoples.

The role of public education, whether at the individual, sub-population or population level, was deemed vital to improving Canadian family planning outcomes. The role of social media, the school system, communities and social services agencies were just a few sectors mentioned by participants as viaducts for effective information and knowledge transfer. The quality of that information and education was noted as important to improving awareness of options and access to contraception

and abortion services. "We need unbiased, not pharmaceutical funded, Canadian-based, accessible, inclusive education," said one participant

5. Develop Effective System Design and Delivery

Key issues for effective nationwide family planning systems were the need for integrated shared models of care, effective policies, sustainable resources and accountability through robust surveillance and monitoring.

Task-sharing was a top priority for participants, pointing to shared care models, where integration and coordination between allied health providers supported by effective referral systems, can improve access to family planning services. Many noted successes in Quebec and in developing countries where the scope of services provided by nurses and midwives and other allied health professionals has expanded in several instances to allow provision of contraception and abortion services.

Effective family planning systems are also built on having access to robust data and surveillance tools. "We need indicators to identify what the problems are, what we do, and how do we do it to improve the management of the system", said a stakeholder. Indicators are required to improve the understanding of not just users knowledge and behaviours but to measure cost effectiveness and access.

Participants talked about a need for common standards and indicators that communities have to meet supported by a continuing feedback loop of data for communities to maintain the process. Many noted that the foundation of any effective family planning system is the provision of adequate resources and infrastructure to sustain and improve services.

What about the guys?
We need best practices in teaching and engaging men in contraception planning, in the surveillance of men's involvement in contraception engagement.

"We need to look beyond physicians for the provision of contraception and abortion services. Throughout the world, family planning services are provided safely by midwives, nurses, and pharmacists. Could we be looking at models like this?"

Dr. Wendy Norman

"Stigma is something we need to address directly and continually."

Dr. Wendy Norman

"We need indicators to identify what the problems are, what we do, and how do we do it to improve the management of the system", said a stakeholder.

"We have achieved the most success where initiatives are context-based and context sensitive."

*Pat Campbell,
CEO, ECHO*

The stigma towards sexuality and abortion was deemed a critical cross-cutting contextual issue.

6. Understand the Broad Sociological Context

The theme of context centered on the need to take into account the current environment, from politics to culture to socio-economic factors, in which populations, sub-populations and family planning services exist.

Stakeholders highlighted the importance of the context informing the system. This included incorporating sociological and socio-cultural aspects, to the need to reduce disparities among marginalized populations, to understanding how power dynamics and historical factors (e.g., colonization of First Nations peoples) impacts a sub-population group's access to and experience of contraception and abortion care.

Effective services need to exist in a framework that is evidence based and context sensitive for each community and population group. One stakeholder described this as taking critical elements of a program and working with a community to design appropriate services based on their individual resources, challenges and opportunities.

From the stigma abortion providers face to the stigma around openly discussing sexuality as a healthy aspect of peoples lives, participants saw it as necessity to address stigma in its broadest sense and at all levels.

"What about happiness as an outcome measure? You may have an unplanned pregnancy but you may in the long run be happy. My perception of what would be the final indicator is happiness in reproductive health."

B. Approach to the Research Program

As the CART-GRAC team leads and core research team move forward with development of a proposal to CIHR to fund a national family planning research program, one of the challenges is determining whether the approach should be one of depth or breadth. CART-GRAC team leads asked participants for opinions garnering these suggestions:

- **Go for Breadth** – Focus on an integrated program of research, 2-4 key strains or issues rather than 1 question.
- **Emphasize the Team Approach** – Demonstrate the creation of a new network of collaborators utilizing this grant as seed funding that will launch multiple other projects nationwide.
- **Highlight Knowledge Development and Translation** – Focus on the educational, training and knowledge transfer elements within and beyond the network.

C. Pathways to Progress

Reflecting on the day's work as the planning session came to a close, participants offered their thoughts and advice on the team work ahead and the building of a national collaboration in family planning.

1. Be Strategic

"People who work in women's health are passionate about what we do... it's one of our strengths, and we need to draw on that intelligence. But we also need to think about how to interact with the bigger systems, like tri-council agencies, to ensure we get funding to do the work we want to do."

"We need to speak the language that best speaks to our peer reviewers. Innovation is important as is the notion of task-sharing but we must also have excellent science and good methodology to hold it all together."

2. Make the Business Case

"We need to make the business case. We need to be better at articulating and differentiating the Canadian context compared to the international situation, especially among our marginalized groups."

"The dollar issue is important. In reproductive health, especially among vulnerable populations, the strategic point is that we are working to save dollars amongst a difficult to serve population. This needs to be central to the business case with a dollar figure attached."

3. Engage Broad Stakeholder Base

"Value the engagement of the community in the development process."

"Invite other groups across Canada into this discussion. Create a bigger, more robust network. Keep the momentum going."

"Recognize we are asking for public money and the edge we have is our network, and how in the end we'll go public with our findings and make it available to other researchers."

4. Next Steps

The CART-GRAC core team is gathering information and ideas collected at the planning session as well as from other consultative initiatives to organize thematic priorities for a clear, achievable national research and researcher training program on access to high quality family planning.

The October 25, 2011 national planning session was vital to identify priorities, suggest solutions and pinpoint knowledge needed to support resolutions. The critical input provided by stakeholders will inform the setting of a five-year research and researcher training program with integrated knowledge translation.

This initiative heralds a bold new frontier for family planning in Canada as the first-ever national network of family planning stakeholders working in concert and sharing ideas for the benefit of Canadian women and families.

Comments, ideas and suggestions can be directed to the CART-GRAC team at:

CART-GRAC@exchange.ubc.ca
Tel: 1.877.9CART90
(1.877.922.7890)
www.CART-GRAC.ca

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Appendices

Appendix A: Core Research Team Planning Meeting Agenda

MORNING	UNDERSTANDING FAMILY PLANNING GAPS & OPPORTUNITIES	
8:00 – 8:30	REGISTRATION, BREAKFAST BUFFET	
8:30 – 9:15	Welcome and Overview	Drs. Norman (BC), Dunn (ON) and Guilbert (QC)
9:15 – 9:35	Meeting Global Family Planning Needs	Dr. Dorothy Shaw
9:35 – 10:15	National Scan: State of Canadian Family planning research – examples from British Columbia, Ontario and Quebec of research related to access, service delivery and population based outcomes; Group discussion	Team Leads; Group
10:15 – 10:30	NUTRITION AND NETWORKING BREAK	
10:30 – 12:00	Stakeholder Scan – Summary from consultations with collaborators, service providers, advocates for vulnerable groups, and the Canadian Contraception Access Survey	Team Leads; Group
12:00 – 13:00	LUNCH	
AFTERNOON	SETTING PRIORITIES, BUILDING SOLUTIONS	
13:00 – 13:15	Welcome and review agenda for afternoon	Janet Brown
13:15 – 14:30	Nominal Group Process: Prioritize 5-6 research themes	Group
14:30 – 14:50	NUTRITION AND NETWORKING BREAK	
14:50 – 15:00	Introduce the Knowledge Cafe	Group
15:00 – 16:00	Knowledge Café (A)	Group
16:00 – 16:30	Knowledge Café (B)	Group
16:30 – 17:00	Check out; closing remarks	Group; Team Leads

Appendix B: CART-GRAC Conference Participants

October 25, 2011, Toronto, Ontario

Invitees by Category, Name, Province, Expertise, Affiliated Organization

CONFERENCE ORGANIZERS

Wendy V. Norman, British Columbia and Team Lead,
Clinician-Researcher, family physician,
University of British Columbia

Sheila Dunn, Ontario Lead,
Clinician-Researcher, family physician, University of Toronto

Edith Guilbert, Quebec Lead
Clinician-Researcher, family physician,
Institut national de santé publique du Québec

Judith Soon, British Columbia,
Research Coordinator, Pharmacy liaison,
Contraception researcher University of British Columbia

HEALTH SERVICE DECISION-MAKERS

Perry Kendall, British Columbia and Team Knowledge User
lead, Provincial Medical Officer of Health,
BC Ministry of Health

Pat Campbell, Ontario Knowledge User, Lead,
Executive Director, Echo, Echo: Improving Women's
Health in Ontario

Julie Soucy, Quebec Knowledge User Lead,
Head of Surveillance in Health Promotion and Prevention
at the Direction of Public Health of the Ministry,
Ministère de la Santé et des Services Sociaux du Québec

Isabelle Cote, Quebec,
Coordinator, Family Planning and Abortion Services,
Ministère de la Santé et des Services Sociaux du Québec

Jan Christilaw, British Columbia,
President, BC Women's Hospital & Health Centre

Paul Hassellback, British Columbia,
Medical Health Officer, Vancouver Island Health Authority

Rita Shahin, Ontario,
Associate Medical Officer of Health, Toronto Public Health

RESEARCHERS AND HEALTH SERVICE PROVIDERS

Amélie Blanchet-Garneau, Québec,
Nurse clinician/researcher in immigrant health,
Université de Montréal

Stirling Bryan, British Columbia,
Health economic researcher, University of British Columbia

Jocelyn Downie, Nova Scotia,
Women's reproductive health and intersection of law,
ethics and health care (LLB/LLM), Dalhousie University

Lorraine Ferris, Ontario,
Medico-legal-ethics-policy researcher related to women's
health services, University of Toronto

Angel Foster, Ontario
Mixed-methods researcher into women's reproductive
health, University of Ottawa

Jean-Yves Frappier, Quebec,
Pediatric clinician/researcher in adolescent sexual health
and abuse, Université de Montréal

Janusz Kaczorowski, Quebec,
Medical sociologist focusing on primary care and health
services research, Université de Montréal

Bill Kapralos, Ontario,
Computer Science and Engineering researcher,
Serious Games Development, University of Ontario Institute
of Technology

Mona Loutfy, Ontario,
Clinician/researcher specializing in women,
HIV and reproductive health, University of Toronto
(Women's College)

Lisa McCarthy, Ontario,
Pharmacist clinician/researcher in primary care,
Women's College Hospital

Patricia McNiven, Ontario,
Midwifery clinician/researcher, McMaster University

Rahim Moineddin, Ontario,
Bio-statistician researcher, University of Toronto

Regina-Marie Renner, British Columbia,
Obstetrics/Gynecology clinician/researcher in family
planning, University of British Columbia

Elizabeth Saewyc, British Columbia,
Vulnerable Youth Behaviour researcher, University
of British Columbia

Jean Shoveller, British Columbia,
Social contexts of youth sexual health inequities researcher
University of British Columbia

Eleni Stroulia, Alberta,
Computer Science researcher, Virtual Reality Education
tools (PhD), University of Alberta

LEADERSHIP IN ORGANIZATIONS REPRESENTING WOMEN'S HEALTH

Marie-Noelle Caron, Quebec,
Public Health Advisor, Commission de la santé et
des services sociaux des premières nations du Québec
et Labrador

Geri Bailey, Ontario,
Manager, Health Policy and Programs, Pauktuutit
Inuit Women of Canada

Ainsley Jenicek, Quebec,
Communications specialist, Fédération du Québec pour
le planning des naissances

Lola Mc Namara, Quebec,
Nurse in charge, Le Comité québécois de vigilance
sur l'avortement

Dorothy Shaw, British Columbia,
Past President, FIGO, Vice President, Medical Affairs,
BC Women's Hospital & Health Centre

REGRETS FROM:

Paul Hasselback, Perry Kendall, Julie Soucy, Rahim
Moineddin, Amanda Black, Geri Bailey, Jocelyn Downie and
Mona Loutfy (Logan Kennedy attending on her behalf).

Appendix C: Stakeholder Scan

1. National Stakeholder and Expert Interviews

Actionable Themes from CART-GRAC Stakeholder Consultations

These themes emerged from analysis of the interviews between CART-GRAC leaders and executive directors or other leading professionals among key 14 national organizations relevant to family planning health services.

Theme 1: Priorities in developing educational initiatives to facilitate use of highly effective methods of contraception among vulnerable populations

What are the priorities in developing educational initiatives for the public, health care providers and decision-makers to increase knowledge and favorable opinions about use of highly effective methods of contraception for vulnerable populations?

- Enhance and publicize availability of accurate online and social media contraception and sexual health resources for the public
- Develop standardized interdisciplinary Canada-wide undergraduate and continuing professional education training in family planning, including surgical and medical abortion, that is case-based, culturally sensitive and includes new contraceptive methods
- Demonstrate the benefit of IUD insertion training programs for health care professionals (e.g., physicians, nurse practitioners, nurses, midwives) practicing in underserved areas
- Provide Community Health Representatives among Aboriginal communities with advanced training and resources related to family planning
- Emphasize the importance of preventing Sexually Transmitted Infections (STIs) through the use of contraceptives and barrier methods to protect future fertility
- Encourage the provision of ongoing sex education early and throughout high school
- Proactively plan for the release of mifepristone in Canada and facilitate training of allied health professionals to provide this agent in underserved areas

Theme 2: Recommendations to facilitate task-sharing of family planning services for vulnerable populations

What health system changes are necessary to facilitate the training, certification and employment of allied healthcare professionals able to directly provide family planning services in distant, rural or urban areas where these services are lacking?

- Propose expanded interdisciplinary use of telehealth facilities for family planning service consultations to facilitate access in underserved regions
- Utilize telephone consultations among allied healthcare professionals (nurses, pharmacists, midwives) to obtain authorization for contraception
- Explore the interest of Colleges of allied health professionals and their members across Canada to facilitate the direct confidential provision of contraception
- Express support for the provision of family planning information and contraceptives in secondary schools, colleges and universities

Theme 3: Requirements needed to sustain integrated accessible family planning services

What is required to develop and sustain a fully integrated accessible system of family planning services available for vulnerable populations?

What challenges does your organization face when advocating for improved family planning services for vulnerable populations?

- Advocate for expanded access to a full range of family planning contraceptive options for Aboriginal women, with a minimum of Non-Insured Health Benefits paperwork
- Replicate successful programs such as the BC Pregnancy Options Service in other jurisdictions to enable patient referral to rural providers for timely access to abortions
- Recognize and support the role of family physicians in providing care to vulnerable populations

- Support the desirability of multiple access points to the health care system to meet a range of patient-centred needs for family planning services

Theme 4:
Expectations for equitable and affordable access to family planning methods

What changes in health care policy and financing are necessary to facilitate low-cost long acting reversible methods of contraception?

What changes in health care policy and financing are necessary to facilitate access to all contraceptive methods to First Nations and immigrant populations?

- Leverage a national voice for family planning services to improve access to equitable and affordable family planning services for Aboriginals across Canada
- Enhance funding for family planning health service programs for vulnerable and marginalized women to enable provision of free contraceptives, especially the long acting reversible contraceptive methods
- Investigate the development of a cohesive and consistent reimbursement mechanism for family planning methods among third party payers and government plans
- Provide decision-makers with the outcomes of cost-effectiveness family planning research
- Share “best practices” of successful family planning programs to enable tailored and targeted expansion into other jurisdictions; similarly, share findings of unsuccessful programs so that scarce resources are not unnecessarily expended
- Publicize the Non-Insured Health Benefits program to allied health professionals to minimize the unnecessary demand for payment of services that are reimbursable
- Recognize the importance of coverage for transportation/accommodation/meals and a support person for rural and remote women needing to travel extended distances to urban settings to access abortion services
- Discuss with Health Canada and the Public Health Agency of Canada the desirability of providing their high quality sexual health kits to communities north of 60° as well as those south of 60° N.

Theme 5:
Enhancing consistency of high quality family planning services across Canada

What changes are necessary to improve quality of care in family planning all across the country?

- Understand and support the need for culturally sensitive, tailored and targeted family planning initiatives in remote and northern communities, through the conduct of needs assessments utilizing traditional processes
- Expand the ability of allied health care professionals to appropriately counsel patients, and where necessary triage and refer patients for health care services such as STIs and contraception
- Encourage interdisciplinary training early in undergraduate health care professional training programs to facilitate collaboration and team work
- Publicize standardized protocols with simple checklists for providing family planning services to primary care providers and allied health professionals
- Promote the expectation that basic family planning knowledge and skills such as IUD insertion should be incorporated into the education of medical residents and other appropriate allied health professionals (e.g., midwives, nurse practitioners)

2. Clinician and Social Scientist Collaborators

National CART-GRAC Network foundation meeting within the North American Forum on Family Planning, October 23, 2011

This workshop is an example of several CART-GRAC has held at significant national and international meetings of family planning clinicians, clinician researchers and social scientists. The session was fully subscribed by enthusiastic English and French speaking attendees (extra chairs were brought in for those standing at the back early in the session) and more than 30 people enlisted to join the CART-GRAC network.

“CART-GRAC Canada: Forming a Canadian Contraception & Abortion Research Team and Network”

This bilingual session welcomed interested contraception and abortion focused Social Scientists and Clinician Researchers from North America, and throughout the world, with a particular focus on those currently or planning to undertake research in Canada. Brief presentations by CART-GRAC leaders were followed by open dialogue with workshop participants exploring and developing appropriate themes, collaborations and strategies to inform the CART-GRAC research program agenda.

We propose to compare and contrast provincial experience aiming to bring knowledge of the most effective policies and programs to all provinces.

Objectives for the session included:

1. Understand the current state of contraception and abortion research in Canada;
2. Discuss possible methods to support research between and within provinces where a national research collaboration will be able to enhance effectiveness and knowledge translation;
3. Form an understanding of potential upcoming research grant opportunities, that may be suitable to support inter-provincial primary healthcare research collaboration;
4. Be able to describe and understand issue specific information on addressing common national contraception and abortion challenges;

5. Understand a Community-Based Primary Healthcare Research Team model, engaging government and appropriate knowledge users and health system decision makers in development of effective contraception and abortion research questions, to better facilitate knowledge translation and program continuation into a post research phase.

The session was enthusiastically attended by an international group of Francophone and Anglophone social scientist and clinician researchers, and research trainees, actively engaging in the exploration of potential collaborations and potential project ideas for CART-GRAC's network.

Session Leaders:

Dr. Wendy V. Norman, Clinical Professor, UBC, Vancouver, BC. (lead)

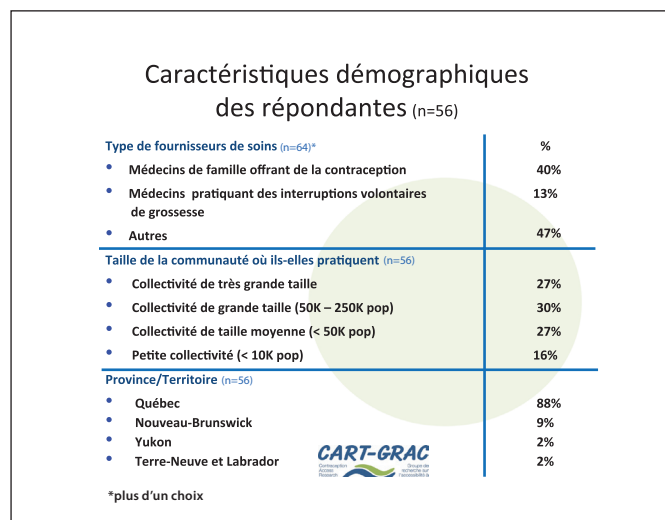
Dr. Edith Guilbert, Professor, Laval University, Quebec City, Quebec

Dr. Sheila Dunn, Associate Professor, University of Toronto, Toronto, Ontario

Dr. Judith Soon, Assistant Professor, University of British Columbia, Vancouver, BC



As the answers for most Access and Quality of Service questions varied significantly between Quebec Francophone respondents, and those of all other Canadian regions (responding in English), we will show side by side the French vs English responses to selected questions.



Groups of Women Served

(n=150)

	%
Low socioeconomic status (SES)	94%
Under 19 years of age	89%
Coping with mental illness	81%
Coping with substance abuse issues	79%
First Nations/Aboriginals	70%
Living in housing projects	61%
Without medical insurance	61%
New immigrants/refugees	60%
With disabilities	59%
Sex trade workers	47%
Homeless	47%
Living in northern and remote areas	29%



Groupes de femmes vulnérables rencontrées par les fournisseurs de soins...

(n=56)

	%
Faible statut socio-économique	79%
Moins de 19 ans	91%
Ayant des problèmes de santé mentale	55%
Toxicomanes	45%
Première Nations/Autochtones	21%
Vivant dans des logements subventionnés	23%
Non couvertes par une assurance santé	45%
Nouvelles immigrantes et réfugiées	30%
Handicapées	18%
Travailleuses du sexe	14%
Sans abri	9%
Habitant les régions nordiques ou éloignées	7%

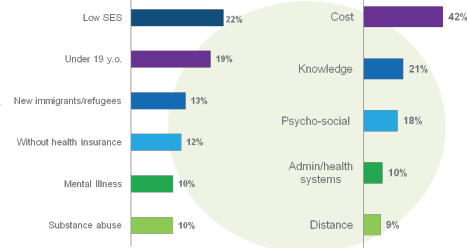


Access to Contraceptive Services

Groups of Affected Women (n=348)*

Barriers to Access (n=122)

83% of respondents stated that the women they served have disproportionately more difficulty in accessing contraceptive services



* Could select up to 3 choices

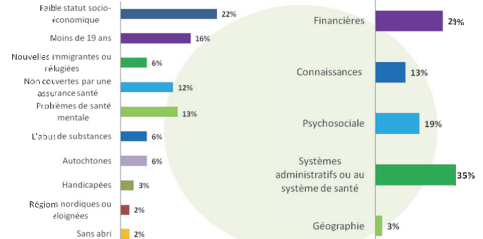


Accès aux services contraceptifs

Groupe de femmes vulnérables affectées (n=95)*

Difficultés d'accessibilité (n=31)

55% des répondants rapportaient que ces groupes de femmes éprouvaient des difficultés marquées à avoir accès à la contraception



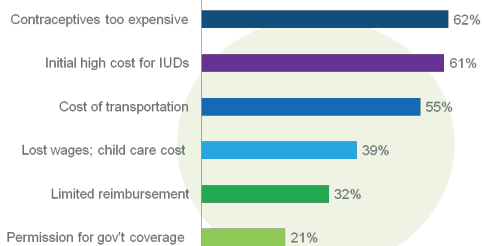
*Pouvaient sélectionner jusqu'à 3 choix



Access to Contraceptive Services

Cost/Financial Barriers

(n=150)



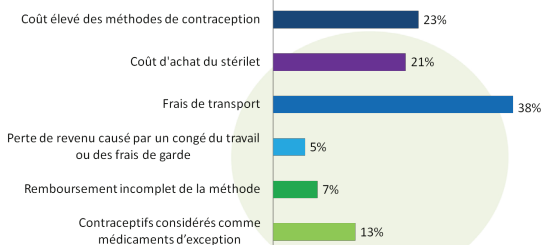
"Contraceptives for women should be fully covered under our basic provincial health care plan."
"The working poor woman balks at the price of contraception."



Accès aux services contraceptifs

DIFFICULTÉS FINANCIÈRES

(n=56)



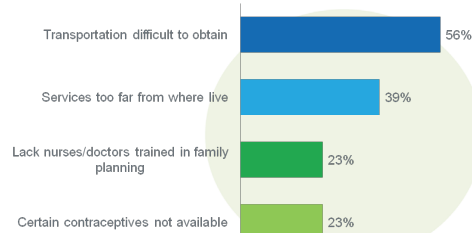
"Si les parents ont une assurance privée, les frais de contraception des ados apparaissent sur le rapport mensuel envoyé aux parents."

"Si les ados ne veulent pas que leurs parents soient au courant, elles doivent payer et n'ont pas d'argent."



Access to Contraceptive Services Geography/Distance Barriers

(n=150)

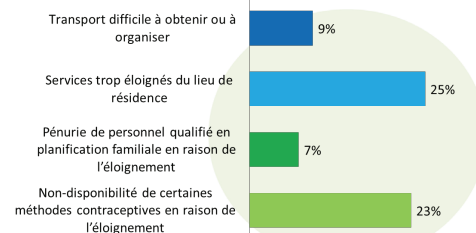


"Confidentiality concerns in small town"; "Interpreters only available in some clinics".
"The few stores get closed on weekends".



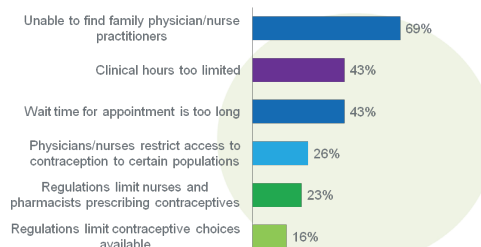
Accès aux services contraceptifs DIFFICULTÉS GÉOGRAPHIQUES

(n=56)



Access to Contraceptive Services Administrative/Health Systems Barriers

(n=150)

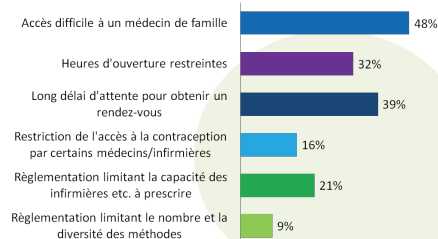


"Many clinics are not accepting new patients [so] women cannot book pap smears or contraceptive prescriptions"



Accès aux services contraceptifs DIFFICULTÉS LIÉS AUX SYSTÈMES ADMINISTRATIFS

(n=56)

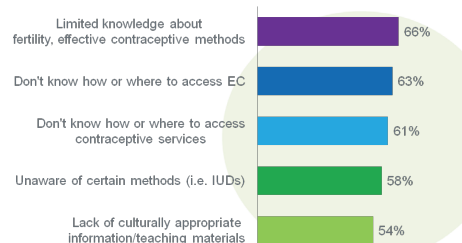


"La majorité des femmes sont incapables de trouver un médecin."
"L'initiation de la contraception par l'infirmière scolaire a beaucoup facilité l'accessibilité."



Access to Contraceptive Services Knowledge Barriers

(n=150)

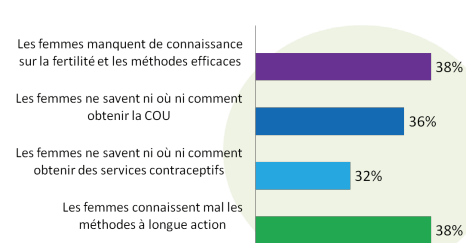


"Women believe the myths." "Fears based on false information."
"Other countries have special family planning clinics, which are free, run by female staff, and provide free contraceptives, PAPS, pregnancy testing."



Accès aux services contraceptifs MANQUE DE CONNAISSANCES

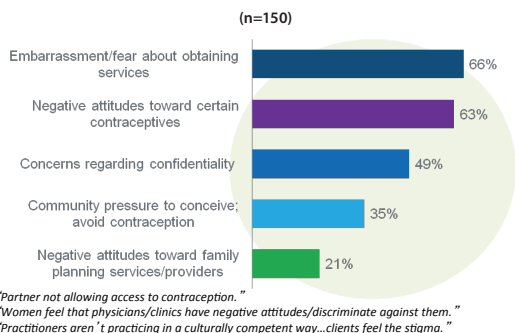
(n=56)



"Manque de connaissances pour les ados."

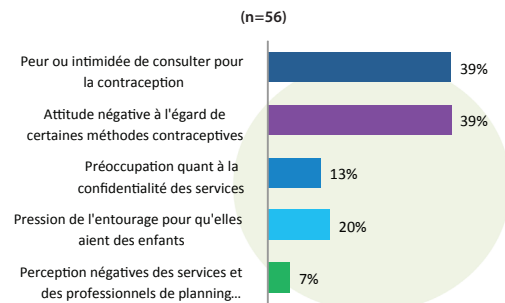


Access to Contraceptive Services Psycho-social Barriers



CART-GRAC
 Centre de planification et de santé
 Réseau de planification et de santé
 Réseau de planification et de santé

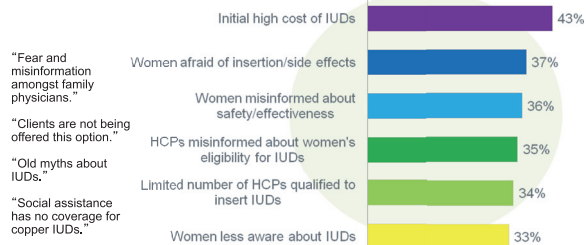
Accès aux services contraceptifs DIFFICULTÉS DE NATURE PSYCHO-SOCIALE



CART-GRAC
 Centre de planification et de santé
 Réseau de planification et de santé
 Réseau de planification et de santé

Restriction to IUD Use (n=150)

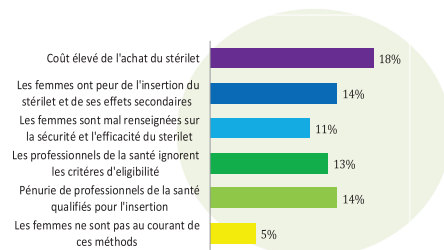
50% of respondents stated that IUDs have been restricted or less offered to women as a contraceptive option



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 Réseau de planification et de santé
 Réseau de planification et de santé

Restriction de l'accès au stérilet (n=56)

27% des répondants affirment que l'accès au stérilet est limité et qu'il est moins souvent proposé comme méthode contraceptive



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 Réseau de planification et de santé
 Réseau de planification et de santé

Quality of Contraceptive Care (n=148)

58% of respondents stated that certain groups of women are disproportionately **receiving lower quality of care**

Most affected groups include women: (n=230)*

- Low SES (17%)
- Under 19 y.o. (16%)
- First Nations/Aboriginals (12%)
- Coping with mental illness (11%)
- Living in Northern and remote areas (9%)
- New immigrants/refugees (9%)
- Substance abuse (8%)

* Respondents chose up to 3 groups (by order of importance)

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 Réseau de planification et de santé
 Réseau de planification et de santé

Qualité des soins en contraception (n=56)

30% des répondants affirment que certains groupes de femmes ont déjà eu accès à des services de contraception de **piètre qualité**

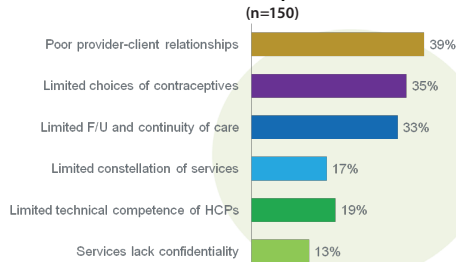
Les groupes les plus affectés sont les femmes: (n=41)*

- présentant des problèmes de santé mentale (20%)
- de faible statut socioéconomique (15%)
- de moins de 19 ans (12%)
- des Premières Nations/Autochtones (10%)
- nouvelles immigrantes ou réfugiées (7%)
- toxicomanes (7%)
- habitant dans des régions nordiques ou éloignées (2%)

* Les répondants pouvaient choisir jusqu'à 3 groupes par ordre d'importance

CART-GRAC
 Centre de planification et de santé
 Réseau de planification et de santé
 Réseau de planification et de santé

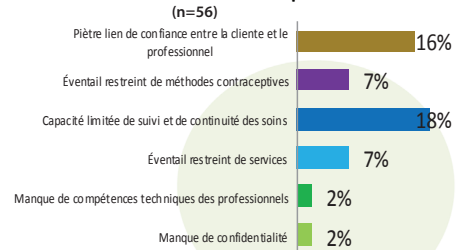
Barriers to High Quality Contraceptive Care



"Family physician unwilling to prescribe."; "Going to a walk-in clinic for sexual health services is far from ideal."; "It is extremely difficult for low income women to obtain; partly due to cost, and partly due to lack of privacy in our medical system."



Difficultés d'accessibilité à des soins de haute qualité

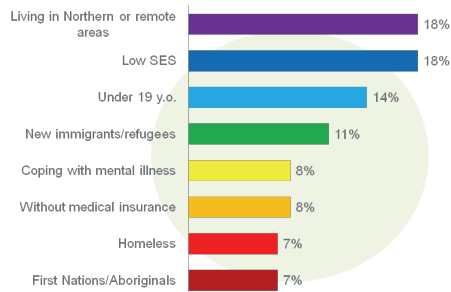


"Pas de relance chez les adolescentes absentes aux rendez-vous de suivi. Plusieurs arrêtent leur contraception car elles ont annulé leur rendez-vous et leur prescription est échue - risque de grossesse +++. "
"En région éloignée, les femmes doivent se présenter à l'urgence lorsqu'elles n'ont pas de médecin traitant. L'accueil qu'on leur réserve est peu agréable."



Access to Abortion Services

Groups of affected women (n=244) *
64% of respondents are aware of certain groups of women who have disproportionately more difficulty accessing abortion services (n=150)

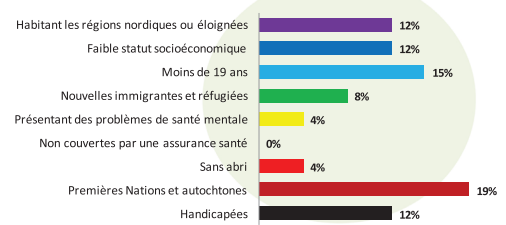


* Could select up to 3 choices



Accès aux services d'interruption volontaires de grossesse

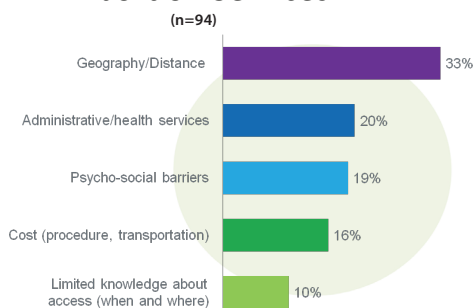
(n=26)*
20% des répondants affirment qu'elles ont observé un ou des groupes de femmes avant des difficultés marquées d'accès à des services d'IVG (n=56)



* Pourrait faire jusqu'à trois choix

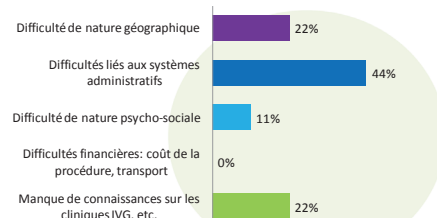


Barriers to Accessing Abortion Services

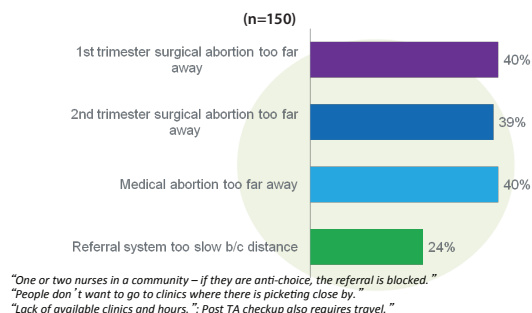


Difficultés d'accès aux services d'IVG

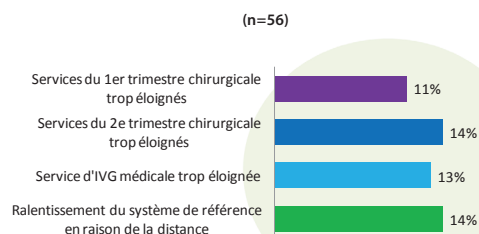
(n=9)



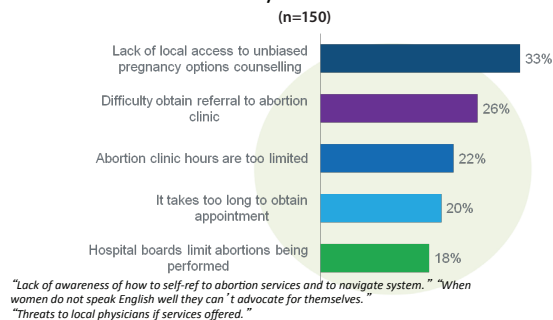
Accessing Abortion Services Geography/Distance barriers



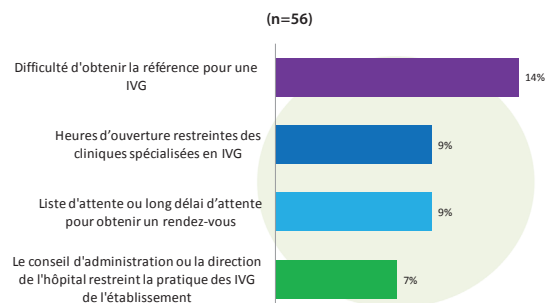
Accès aux services d'IVG DIFFICULTÉS D'ORDRE GÉOGRAPHIQUE



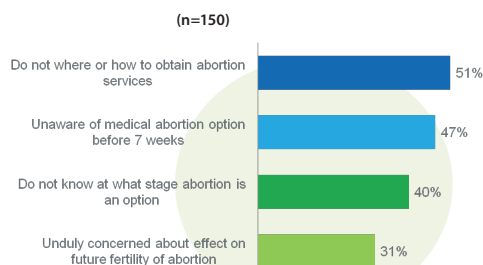
Accessing Abortion Services Administrative/Health Services barriers



Accès aux services d'IVG DIFFICULTÉS LIÉS AUX SYSTÈMES ADMINISTRATIFS



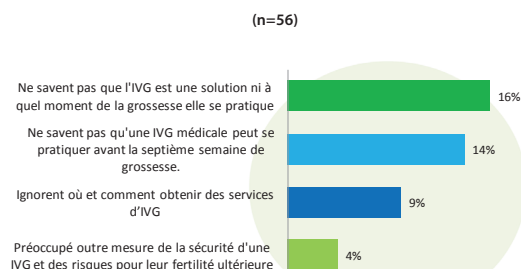
Accessing Abortion Services Knowledge barriers



"Unaware cost is covered by Medicare."; *Medical abortion is generally not available."* *"A political group in geographic region actively provides mis-information on abortion."*

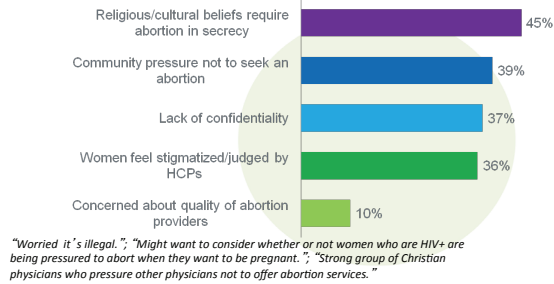


Accès aux services d'IVG MANQUE DE CONNAISSANCES



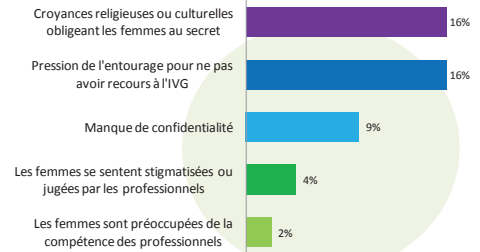
Accessing Abortion Services Psycho-social barriers

(n=150)



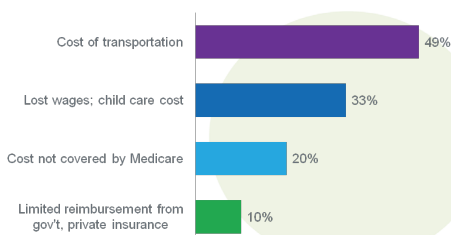
Accès aux services d'IVG DIFFICULTÉS D'ORDRE PSYCHO-SOCIAL

(n=56)



Accessing Abortion Services Cost/Financial Barriers

(n=150)

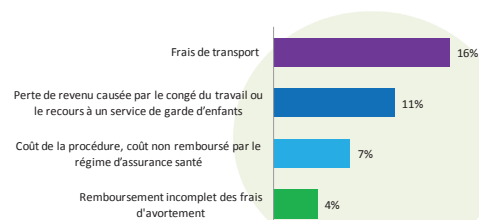


"The provinces by not including abortion in reciprocal payment agreements are contravening the Canada Health Act, as well as compromising the constitutional rights of women."



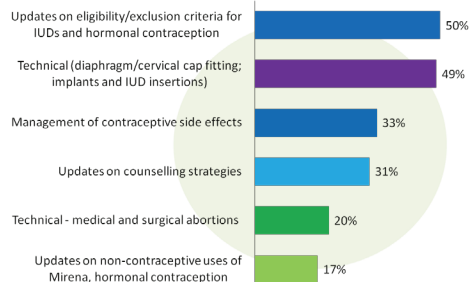
Accès aux services d'IVG DIFFICULTÉS FINANCIÈRES

(n=56)



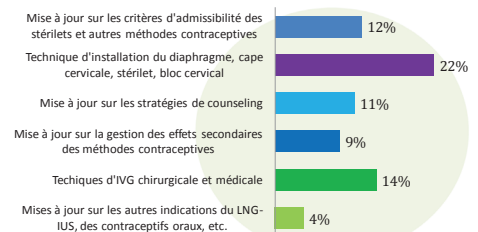
Further Training/CE Sought by Service Providers

(n=150)



Formation ou perfectionnement demandé par les fournisseurs de soins

(n=56)



Comments....

- “Client-centred and holistic models of care have been the most successful in reaching and connecting with women from marginalized communities.”
- “Bring medical services to community centres where marginalized women may access.”
- “I would like to see female-staffed family planning clinics for women to attend; free of charge, with all contraceptives being covered under our basic provincial medical service plans.”
- “You need to look at HIV primary care physicians who are quite successful in helping women who know their HIV status, plan and time their pregnancies...they are a good role model.”



Commentaires....

- “Suivi de près, relance téléphonique pour suivi et lors d’ absences aux rendez-vous. Disponibilités de rendez-vous rapide pour ado qui a besoin de contraception et est à risque +++. Échantillons de diverses méthodes remis aux ados lorsqu’ elles n’ ont pas d’ argent.”
- “ Accessibilité à tous.”
- “Accès à la clinique jeunesse. Disponibilité de plusieurs collègues dans le suivi en matière de planning.”



Comments....

- “More on-going anti-oppression training for service providers to strengthen competencies in working with diverse, under-served and vulnerable communities.”
- “Every contraceptive method should be free for any woman in Canada who would choose to use one.”
- “Recently, we have had both research and education programs offering free copper and Mirena IUDs to women in BC seen at the time of an abortion. This appears to have helped many women avoid a future abortion; our wait list for abortions have diminished significantly.”



Commentaires....

- Clinique de planning offrant la gamme complète des moyens de contraception, y compris l’ IVG jusqu’ à 15 semaines de grossesse dans le système public.”
- “Assurance médicament couvre les stérilets.”
- “L’ accès via le CLSC de la région, les plages horaires privilégiées en échographie au CH de la région et des médecins consciencieux et humain qui respectent, tout en éduquant les femmes qui traversent ce parcours de vie.”



Comments....

- “We know from Ontario research that condom machines in high schools significantly reduce pregnancy and thus abortion. But many places remain remote and far from places to buy condoms etc.”
- “A travelling clinic to remote areas for contraceptive services.”
- “Ask physicians who provide contraception to patients to mention that ‘If the method fails, we can talk about your options...’ to indicate he/she would provide information about abortion care if required.”



Commentaires....

- “Distribution gratuite de la COU dans les écoles et CLSC, adoption de l’ OC de CH.”
- “Mesures financières d’ aide au transport et accompagnement ainsi qu’ enseignement auprès des professionnels.”
- “Disponibilité de l’ infirmière en planning et la facilité pour entrer en contact avec elle.”



Appendix D: Collaboration with GRAND

(An NSERC funded Network of Centers of Excellence in Graphics, Animation and New Media)

Report to the GRAND PEAKS Committee

**Re: The Planning Meeting of the Contraception
Access Research Team, October 25, 2011**

**From: Eleni Stroulia, PNI (HLTHSIM, MEOW),
Bill Kapralos, CNI (DIGLT)**

On Tuesday, October 25, 2011, Drs. Kapralos (DIGLT) and Stroulia (HLTHSIM, MEOW) participated in The Planning Meeting of the Contraception Access Research Team, organized by Drs. Wendy Norman (UBC), Edith Guilbert (INSPQ), and Sheila Dunn (Women's College Hospital, Ontario). The purpose of the meeting was to bring together clinicians, care providers, social workers, decisions makers and technologists, interested in putting together a grant application to CIHR in April 2012, for a long-term program to improve the health of marginalized and vulnerable women and their families, through improved access to high-quality family-planning knowledge and services.

As GRAND researchers, our objective was (a) to identify opportunities for collaboration between the GRAND community and the network that Drs. Norman, Guilbert and Dunn putting together, and, to the extent possible, (b) to formulate ideas for specific research projects to be pursued in the context of their grant proposal or other proposals.

At this point, we see the following project ideas:

1. Developing virtual-patient simulations to train care providers from diverse disciplines, including family medicine, nursing and pharmacy, in advising patients on their reproductive health issues. This activity would rely on our HLTHSIM/DIGLT platforms to help with the training of these professionals in the current context of "task sharing" (a term reflecting the re-negotiation of the scope of services potentially delivered by each discipline).
2. Developing serious games to educate the general public about reproductive-health issues and available services, with a special focus to youth who are particularly engaged in gaming. Such a project would again rely on our HLTHSIM/DIGLT platforms and tools.
3. Developing instruments and platforms to collect and analyze data about the current state of the public's reproductive-health knowledge, practices and use of services. The instruments would be "open" and could be adopted by interested agencies to collect data across Canada, across demographics, and across socio-economic status. This data could further be linked with other open-data (building on current open-data and linked-data initiatives) to investigate questions around the relative needs across Canada and potential impact of specific initiatives. This project could potentially involve GRAND researchers interested in social studies (NAVEL), information dissemination (NEWS) and information search strategies (NGAIA).
4. Developing a new type of collaboratory platform (akin to the GRAND Forum) to support the formation and sustainability of this community.



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