Mitigating (Mis)Conceptions: 
Expanding Contraceptive Choice and Access in the Yukon

by
Taryn Leah Ann Turner
B.A. Honours (International Development and Politics), Trent University, 2010

Capstone Submitted in Partial Fulfillment of the
Requirements for the Degree of
Master of Public Policy

in the
School of Public Policy
Faculty of Arts and Social Sciences

© Taryn Leah Ann Turner 2014
SIMON FRASER UNIVERSITY
Spring 2014

All rights reserved.
However, in accordance with the Copyright Act of Canada, this work may be reproduced, without authorization, under the conditions for “Fair Dealing.” Therefore, limited reproduction of this work for the purposes of private study, research, criticism, review and news reporting is likely to be in accordance with the law, particularly if cited appropriately.
Approval

Name: Taryn Leah Ann Turner
Degree: Master of Public Policy
Title: Mitigating (Mis)Conceptions: Expanding Contraceptive Choice and Access in the Yukon

Examinig Committee: Chair: Dominique Gross
Professor, School of Public Policy, SFU

Olena Hankivsky
Senior Supervisor
Professor

Judith Sixsmith
Supervisor
Professor

Nicole Berry
External Examiner
Associate Professor
Faculty of Health Sciences, SFU

Date Defended: March 14, 2014
Partial Copyright Licence

The author, whose copyright is declared on the title page of this work, has granted to Simon Fraser University the non-exclusive, royalty-free right to include a digital copy of this thesis, project or extended essay[es] and associated supplemental files ("Work") (title[s] below) in Summit, the Institutional Research Repository at SFU. SFU may also make copies of the Work for purposes of a scholarly or research nature; for users of the SFU Library; or in response to a request from another library, or educational institution, on SFU’s own behalf or for one of its users. Distribution may be in any form.

The author has further agreed that SFU may keep more than one copy of the Work for purposes of back-up and security; and that SFU may, without changing the content, translate, if technically possible, the Work to any medium or format for the purpose of preserving the Work and facilitating the exercise of SFU’s rights under this licence.

It is understood that copying, publication, or public performance of the Work for commercial purposes shall not be allowed without the author’s written permission.

While granting the above uses to SFU, the author retains copyright ownership and moral rights in the Work, and may deal with the copyright in the Work in any way consistent with the terms of this licence, including the right to change the Work for subsequent purposes, including editing and publishing the Work in whole or in part, and licensing the content to other parties as the author may desire.

The author represents and warrants that he/she has the right to grant the rights contained in this licence and that the Work does not, to the best of the author’s knowledge, infringe upon anyone’s copyright. The author has obtained written copyright permission, where required, for the use of any third-party copyrighted material contained in the Work. The author represents and warrants that the Work is his/her own original work and that he/she has not previously assigned or relinquished the rights conferred in this licence.

Simon Fraser University Library
Burnaby, British Columbia, Canada

revised Fall 2013
Ethics Statement

The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

a. human research ethics approval from the Simon Fraser University Office of Research Ethics,

or

b. advance approval of the animal care protocol from the University Animal Care Committee of Simon Fraser University;

or has conducted the research

c. as a co-investigator, collaborator or research assistant in a research project approved in advance,

or

d. as a member of a course approved in advance for minimal risk human research, by the Office of Research Ethics.

A copy of the approval letter has been filed at the Theses Office of the University Library at the time of submission of this thesis or project.

The original application for approval and letter of approval are filed with the relevant offices. Inquiries may be directed to those authorities.

Simon Fraser University Library
Burnaby, British Columbia, Canada

update Spring 2010
Abstract

High rates of unintended pregnancy risk undermining women’s sexual and reproductive health rights in the Yukon. This ongoing issue can be ameliorated through convenient access to highly effective contraceptive methods and related contraceptive care.

117 Yukon women of reproductive age (19-49) participated in a study designed to explore the current status of unintended pregnancy and contraceptive access in the territory. The study identifies three main barriers to access: limited constellation of authorized contraceptive providers, underutilization of contraceptive counselling to promote consistent use of effective contraception, and constraints of method cost on affordability.

This study identifies cost-effective policy responses to improve contraceptive access and care in the Yukon: expanding the role of pharmacists and nurse practitioners as key providers of contraceptive care, offering opportunities for professional training in contraceptive counselling and practice, extending services through an integrated after-hours sexual health clinic, and subsidizing the cost of contraception.

Keywords: Unintended pregnancy; contraception; sexual and reproductive health; northern, rural, and remote health; Yukon; cost-effectiveness evaluation
For my mum, Gail – 

to whom I owe the best that I am and ever will be.
Acknowledgements

With respect to this capstone, there is no short supply of people to whom I am indebted.

First, this research was only made possible through the generous and gracious support of the Yukon women’s community. Working alongside these dedicated women in their tireless quest for justice and equality has been one of the most formative and fulfilling experiences of my life. A special thanks to Natalka (for planting the seed and bringing me North), Julianna (for your endless enthusiasm and support), Linnea (for laying the groundwork), and to all the other incredible women who helped set this project in motion.

I would also like to sincerely thank those who participated in the surveys and otherwise supported the research. On the Yukon side, a particular thank you to Karen Archbell, Shauna Demers, Josianne Gauthier, Elyse Kornhauser, Michelle McHardy, Cathy Stannard, Jan Stick, Emily Wale, and Sherri Wright. On the “outside,” a heartfelt thanks to Dr. Wendy Norman and Dr. Nicole Berry for sharing their insight, knowledge, and expertise on this topic, and to Dr. Olena Hankivsky for her clarity, guidance, and encouragement.

Finally, I have only been able to come this far with the help and support of those around me. While there are too many people to account for here, each has made me aspire to be a better and more courageous person – an invaluable gift. A special thank you to the wonderful and inspirational cohort with whom I was fortunate enough to spend the past two years. And last but certainly not least, everlasting gratitude to my beloved family.
Table of Contents

Approval........................................................................................................................... ii
Partial Copyright Licence .................................................................................................. iii
Ethics Statement ................................................................................................................ iv
Abstract.......................................................................................................................... v
Dedication......................................................................................................................... vi
Acknowledgements ......................................................................................................... vii
Table of Contents ........................................................................................................... viii
List of Tables .................................................................................................................. x
List of Figures ................................................................................................................ x
List of Acronyms ............................................................................................................ xi
Executive Summary ........................................................................................................ xii

Chapter 1. Introduction ................................................................................................... 1
  1.1. Policy Problem ........................................................................................................ 3

Chapter 2. Background to the Policy Problem ............................................................... 4
  2.1. The Right to Reproductive Health ........................................................................... 4
  2.2. Unintended Pregnancy and Contraception .......................................................... 4
  2.3. Access to Contraception in Canada ....................................................................... 6
  2.4. Access to Contraception in Yukon ....................................................................... 8
    2.4.1. Organization and Regulation of Health Care in Yukon .................................. 9
    2.4.2. Availability of Contraception in Yukon ......................................................... 10
    2.4.3. Accommodation of Contraception in Yukon ............................................... 12
    2.4.4. Accessibility of Contraception in Yukon ...................................................... 13
    2.4.5. Affordability of Contraception in Yukon ..................................................... 14
    2.4.6. Acceptability of Contraception in Yukon .................................................... 15

Chapter 3. Methodology ................................................................................................. 17
  3.1. Data Collection ....................................................................................................... 17
  3.2. Data Analysis ......................................................................................................... 19

Chapter 4. Key Findings of the Yukon Service User Survey ........................................... 20
  4.1. Respondent Demographics ................................................................................... 21
  4.2. Contraceptive Care ............................................................................................... 21
    4.2.1. Health Site and Provider .............................................................................. 21
    4.2.2. Patient-Centered Care and Contraceptive Counselling ................................. 23
    4.2.3. Privacy and Confidentiality ......................................................................... 25
  4.3. Contraceptive Methods ......................................................................................... 27
    4.3.1. Method Selection, Perceptions, and Use ...................................................... 27
    4.3.2. Method Payment and Coverage ................................................................... 31
    4.3.3. Method Switching and Discontinuation ...................................................... 33
  4.4. Unintended Pregnancy ......................................................................................... 35
List of Tables

Table 1. Efficacy of Contraceptive Methods in Preventing Pregnancy ........................................ 5
Table 2. Social and Economic Benefits Associated with Contraception ................................ 7
Table 3 Structure of Service User Survey .............................................................................. 20
Table 4 Key Demographics of Survey Respondents and Yukon Women .............................. 22
Table 5 Contraceptive Care Responses .................................................................................. 26
Table 6 Contraception Method Responses ............................................................................. 34
Table 7 Unintended Pregnancy Outcome Responses ............................................................. 38
Table 8 Evaluative Criteria and Measures ............................................................................. 53
Table 9 Summary of Criteria and Measures Evaluation (not weighted) ............................... 58
Table 10 Summary of Criteria and Measures Evaluation (Equity & Efficiency x 2) .............. 58
Table 11 Cost of Unintended Pregnancy Outcomes in Yukon for 2011-2012 ...................... 72
Table 12 Estimated Cost-Savings of Increasing Contraception Use in Yukon ...................... 74

List of Figures

Figure 1. Disagreement with Key Indicators of Patient-Centered Care (Site and Provider Activities) .................................................................................................................. 24
Figure 2. Disagreement with Key Indicators of Patient-Centered Contraceptive Care (Site and Provider Knowledge & Awareness) ......................................................... 24
Figure 3 Disagreement Among Method Perception, Selection, and Satisfaction ............... 29
Figure 4 Current Method Choice and Desire to Switch to a Covered Method ..................... 32
# List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEDAW</td>
<td>Convention for the Elimination of All Forms of Discrimination Against Women</td>
</tr>
<tr>
<td>CHA</td>
<td>Canada Health Act</td>
</tr>
<tr>
<td>HSS</td>
<td>Yukon Health and Social Services</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine Device</td>
</tr>
<tr>
<td>IUS</td>
<td>Intrauterine System</td>
</tr>
<tr>
<td>LARC</td>
<td>Long-Acting Reversible Contraception</td>
</tr>
<tr>
<td>NAPRA</td>
<td>National Association of Pharmacy Regulatory Authorities</td>
</tr>
<tr>
<td>NIHB</td>
<td>Non-Insured health benefits</td>
</tr>
<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td>SARC</td>
<td>Short-Acting Reversible Contraception</td>
</tr>
<tr>
<td>SOGC</td>
<td>Society of Obstetricians and Gynaecologists of Canada</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>YPA</td>
<td>Yukon Pharmacists Association</td>
</tr>
<tr>
<td>YRNA</td>
<td>Yukon Registered Nurses Association</td>
</tr>
</tbody>
</table>
Executive Summary

Internationally, it is widely recognized that women have a right to reproductive health, and that a key component of exercising this right is access to contraception. This is because access to contraception enables women to determine the timing, spacing, and size of their desired families. In fact, global studies suggest that secure access to, and effective use of, modern contraception can avert up to two-thirds of unintended pregnancy.

In Canada, women’s access to health care differs within and between regions. Specifically, women in remote and northern communities do not share equally in access to health services, and thus to contraceptive care and the benefits flowing from fully realized reproductive rights. By extension, remote and northern women may also be at higher risk of unintended pregnancy.

This study explores the availability and quality of contraceptive care in remote and northern Yukon, and women’s experiences in accessing this care. Specifically, it investigates (a) whether and the extent to which expanding contraceptive choice and access in Yukon will mitigate the incidence of unintended pregnancy in the territory, and (b) whether this reduction and related cost-savings will yield the significance to warrant government intervention.

A mixed methods research framework guides the investigation, and is comprised of an environmental scan, cross-jurisdictional literature review, complementary service user and service provider surveys, semi-structured interviews with six key informants, and a benefit-cost evaluation. Throughout this framework, contraceptive care is considered in relation to five tenets of access: availability, accommodation, accessibility, affordability, and acceptability.

Three key findings from the research are highlighted, as follows. First, access to contraception is constrained by the limited constellation of authorized contraception prescribers, a barrier that is exacerbated by the high rate of unattached patients without a regular physician. Second, patient-centered contraceptive counselling appears to be
an underutilized strategy for identifying the best contraceptive methods to suit individual needs and preferences, as well as to promote the consistent use of more effective contraceptive methods. Third, affordability appears to be a barrier for some women. For instance, method cost has an observable inverse relationship with the selection and adherence of effective contraceptives, and thus a negative impact on the accessibility and quality of contraceptive care.

Based on the above findings, four policy responses are identified and evaluated against criteria of equity, efficiency, and feasibility. This evaluation reveals that each response will be effective in expanding contraceptive choice and access in the Yukon. Moreover, by reducing the rate of unintended pregnancy, each policy is also projected to yield cost-savings to government. In light of these significant benefits accruing to women and the government, a three-stage policy approach is recommended:

In the short-term, specialized training for nurse practitioners will enable qualified providers to realize their full scope of practice in the area of sexual and reproductive health care. In the medium-term, pharmacy access to contraception will empower pharmacists with an expanded scope of practice in a manner befitting their education and training. Also in the medium-term, and depending on the unmet demand for care, an after-hours integrated sexual and reproductive health clinic can offer a one-stop-shop for contraception, options counselling, and education. Finally, in the long-term, universal access will ensure full coverage of all forms of contraception for Yukon residents.

By taking a multi-step approach, this suite of policy recommendations will help identify and attenuate potential barriers posed by implementation complexity or the need to build public and government consensus around the proposed policies.

This study is the first of its kind in the Yukon. While further research is needed on sexual and reproductive health and contraceptive care in the territory, this study makes an important contribution to bringing the needs and experiences of northern and remote women to bear on public policy and decision-making. In doing so, it makes the sexual and reproductive health care needs of these women more visible, both in the Yukon and beyond.
Chapter 1. Introduction

Although 80 percent of Canadian women use some method of contraception to keep from becoming pregnant, an estimated 40 percent of all pregnancies in Canada are unintended (University of Ottawa, 2014). Unintended pregnancy refers to both mistimed pregnancy, wherein a woman becomes pregnant at an earlier time than originally desired, and unwanted pregnancy, wherein a woman has no plans or desire to become pregnant. In general, there are two main outcomes of unintended pregnancy: live birth or abortion.¹ Half of all unintended pregnancies are carried to term, while the remainder is terminated through induced abortion (ibid). Each of these outcomes carries high costs for both individual women and public health and social systems (Sonfield et al, 2013; Population Council, 2012; Sonfield, 2011).

Although there is no published data on the rate of unintended live births in Canada, there are national statistics on the abortion rate that can be used as a proxy to indicate the overall incidence of unintended pregnancy.² In Canada, the abortion rate is 14.1 abortions per 1000 live births. Yukon, the westernmost territory, has an abortion rate higher than the general population, at 19.1 abortions per 1000 live births (CIHI, 2011; Statistics Canada, 2005).

While this high abortion rate could indicate that Yukon has a higher prevalence of unintended pregnancy than Canada, it could also simply indicate that the territory has a

¹ Miscarriage and ectopic pregnancy are two other pregnancy outcomes, but are excluded from this analysis due to low prevalence rates. Ectopic pregnancy has an incidence rate of ~1%. Early miscarriage up to 12 weeks has an incidence rate of ~16%; late miscarriage between 12 and 20 weeks of pregnancy has an incidence rate of ~1%. It may be important to note that fetal loss is greater than what is indicated by these “clinical” miscarriage estimates, as the majority of miscarriages occur within the first three weeks of conception when women may not know they are pregnant. For instance, fetal loss estimates range from 31% to 89% (Nepomnaschy et al, 2006). However, given the lack of data on early fetal loss with respect to unintended pregnancy and the low prevalence of clinical miscarriages, this study focuses on live births and abortion.

² This generalization may overlook termination due to considerations of maternal or fetal health.
better system for reporting abortions procured by Yukon residents. This lack of certainty reflects the lack of data on women’s sexual and reproductive health in Canada. Specifically, the most comprehensive studies on contraceptive use among Canadian women were undertaken in 2002 and 2006, respectively (Fisher et al, 2004; Black et al, 2009). Neither study published findings specific to the experiences of rural, remote, or northern women, who typically face limited access to reproductive health services, and by extension, contraceptive care and abortion (Sutherns et al, 2005).

The purpose of this study is to improve the health and lives of Yukon women by bridging an important gap in knowledge between the existing research on the accessibility of reproductive health services in Yukon, and the experience of women in accessing this care. Specifically, this is the first study to investigate the availability and quality of contraceptive care in Yukon, and women’s experiences in accessing this care. Previous research on health care in northern, rural, and remote communities (Sutherns et al, 2005) and sexual health education in Yukon (Rudachykh, 2013) has indicated a need for this type of evidence-based and community-centered research in the development of locally appropriate health care policies and decision-making processes.

The investigation is five-fold. First, national and international literature is used to identify critical dimensions of unintended pregnancy as it relates to both public health and reproductive rights. Second, data collected from complementary surveys of Yukon contraceptive users and service providers is analyzed to determine whether and to what extent the current constellation of sexual and reproductive health services adequately and appropriately responds to women’s contraceptive needs. Third, four policy options are identified and drawn from national and international best practices in sexual and reproductive health care delivery. Fourth, each policy option is rated against a comprehensive evaluation framework to assess its relative effectiveness in expanding contraceptive choice and access in a manner that is equitable, efficient, and feasible.

3 For the purposes of this study, contraceptive care refers to: method choice, related clinical procedures of method administration, contraceptive counselling, follow-up, and abortion. While abortion is not a pre-emptive form of contraception, it may be accessed as a form of retroactive contraception for women experiencing method failure or lack of access to preventative methods. Contraception and abortion are both essential factors supporting women’s reproductive rights (Cook and Dickens, 2003 & 2009).
within the context of the Yukon health care system. Finally, and based on this evaluation, the study suggests next steps for the effective implementation of the recommended policy options, and concludes with a brief discussion of the limitations of this study, as well as areas for future research.

1.1. Policy Problem

Yukon has a high abortion rate that indicates a high rate of unintended pregnancy, and by extension, unmet need for contraception. However, the paucity of research on women’s access to and use of contraception makes it difficult to determine which health intervention is best suited for tackling the issue of unintended pregnancy in the territory. As such, data must be collected and analyzed to determine whether or to what extent the constellation of health services in Yukon adequately responds to women’s contraceptive needs. Given the high public costs of unintended pregnancy and competing demands on limited government resources, a cost-effectiveness evaluation is also needed to determine whether Yukon should allocate its scarce resources toward resolving the issue of unintended pregnancy in the territory. Put simply, research is needed to evaluate whether and the extent to which increasing contraceptive choice and access in Yukon will mitigate the incidence of unintended pregnancy in the territory, and then determine whether this reduction and related cost-savings will yield the significance to warrant government intervention. In doing so, this study seeks to show that reproductive rights, as indicated by unintended pregnancy and women’s access to contraceptive care, is a public health issue that carries potential costs and cost-savings. Thus, for reasons of equity, public health, and efficiency, these issues fall under the purview of the Yukon government.
Chapter 2.  Background to the Policy Problem

2.1.  The Right to Reproductive Health

The Beijing Platform situates women’s control over reproductive health within the context of inalienable human rights (Cook and Dickens, 2009), while the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW) prohibits any form of discrimination that would impede a women’s ability to control her own fertility or access reproductive health services (Cook, 1993). Canada, as a signatory of CEDAW, is beholden to take active and progressive steps to ensure safe provision and effective usage of reproductive education and contraception. This commitment includes the allocation of resources necessary to ensure women realize their right to “be informed and to have access to the safe, effective, affordable and acceptable methods of family planning of their choice” (WHO, 2001), and the option of safe abortion in the case of unwanted pregnancy (Cook and Dickens, 2003). Though this convention is legally binding under international law, it requires ongoing support from present governments to ensure effective implementation, and may therefore be subject to shifting priorities.

2.2.  Unintended Pregnancy and Contraception

According to the World Health Organization an estimated 123 million women intend and succeed in becoming pregnant each year, while an additional 87 million women experience an unintended pregnancy (WHO, 2005). These 87 million women are an important indicator that reproductive rights are not universally enjoyed.
Table 1. Efficacy of Contraceptive Methods in Preventing Pregnancy

<table>
<thead>
<tr>
<th>Traditional Methods</th>
<th>Short-Acting Non-Hormonal</th>
<th>Short-Acting Hormonal</th>
<th>Long-Acting Reversible</th>
<th>Permanent Sterilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withdrawal</td>
<td>Cervical cap</td>
<td>Oral pill</td>
<td>IUD (Copper T)</td>
<td>Vasectomy</td>
</tr>
<tr>
<td>Periodic abstinence</td>
<td>Spermicide</td>
<td>Plan “B” pill</td>
<td>IUS (Mirena)</td>
<td>Tubal ligation</td>
</tr>
<tr>
<td></td>
<td>Sponge</td>
<td>Vaginal ring</td>
<td>Transdermal patch</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diaphragm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male condom</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female condom</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Global studies suggest that an estimated two-thirds of unintended pregnancy can be averted by addressing the twin hurdles of “unmet need” for contraception: the lack of access to a full range of safe and effective modern contraception methods, and the ineffective use of these methods (Singh and Darroch, 2012; The Population Council, 2012). It is therefore critical women maintain access to a full range of contraceptive methods over the course of their reproductive lifecycle, particularly during times of changing contraceptive needs when they are at most risk of unintended pregnancy (ibid). As this full range varies in efficacy in preventing pregnancy (Table 1), several countries and jurisdictions emphasize the need for improved access and use of long acting reversible contraception (LARC) (Wellings et al, 2013; Norman et al, 2013; Singh and Darroch, 2012).  

It is important to note that the focus of this study is solely women’s use and access to contraception. This is due to two considerations: First, the two male options of contraception are included in this analysis; to investigate the development of additional male methods (such as male LARCs) is beyond the scope of this investigation. Second, as only women are able to become pregnant, and as the current array of methods places the financial and health-related burden of contraception largely on their shoulders (Campo-Engelstein, 2012), it is essential that women’s concerns of access be prioritized for this initial investigation. While this framing may reproduce a problematic framework that undermines the ideas of shared contraceptive responsibility and male reproductive autonomy (ibid), for reasons of pragmatism and limited resources, a more comprehensive perspective on contraceptive use and is left to future studies.
2.3. Access to Contraception in Canada

Access to contraception is an integral component of women’s reproductive rights. By mitigating unintended pregnancy, it is also key to manifold social and economic benefits to both women and society as a whole (Table 2). To the extent that policies and programs can ensure access to the most effective methods of contraception, and the extent that these methods enable women to plan whether or when to have children, Canadian women and society will enjoy a variety of social and economic benefits\(^5\). It is essential, however, to recognize that these benefits are not shared equally among women, both within and between regions (Sonfield et al., 2013; Singh and Darroch, 2012).

This variance has two interrelated causes. First, “Canadian women” are not an uniform entity with homogenous sexual and reproductive health needs; their access to contraception is influenced by multiple identities and social locations such as age, gender identity and expression, language, class, ability, sexual orientation, ethnicity, culture, and geography (Dolan and Thien, 2008; Armstrong et al., 2003; Reid, 2002). Second, accessing timely, appropriate, and high quality reproductive health care is intimately related to these multiple and overlapping dimensions of health. For instance, women in rural, remote, or northern communities experience more limited access to primary health services and poorer health outcomes than either rural men or urban women\(^6\) (Sutherns et al., 2005). Yet even within this rural grouping, certain subsets of women face even more limited access and correspondingly poorer health. For example, in rural regions with Aboriginal populations, health care services must be sensitive to the needs and historical experiences of rural Aboriginal women, who are more likely than their non-Aboriginal counterparts to live in socio-economically disadvantaged communities, experience limited access to health services, face racist and discriminatory

---

5 Contraception has multiple positive and negative side effects on reproductive and overall health; these differential impacts are not taken into account in this analysis.

6 Health Canada defines rural and remote as communities that are home to less than ten thousand residents, and are removed from urban services and resources. By this definition, Whitehorse is the only non-rural community in Yukon.
policies, and be subjected to an overarching lack of respect and cultural safety (Browne et al, 2000; Armstrong et al, 2003; Aboriginal Health Initiatives Sub-Committee, 2011).

Table 2. Social and Economic Benefits Associated with Contraception

<table>
<thead>
<tr>
<th>Reduced Risk of Unintended Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women's Health (b)</td>
</tr>
<tr>
<td>• Improved maternal morbidity and maternal health outcomes</td>
</tr>
<tr>
<td>Women's Mental Health and Happiness (a)</td>
</tr>
<tr>
<td>• Determine timing, spacing, and size of desired family</td>
</tr>
<tr>
<td>• Freedom and ability to pursue an education and/or career of choice</td>
</tr>
<tr>
<td>• Lessens risk of depression and anxiety during pregnancy</td>
</tr>
<tr>
<td>Women's Economic Stability (a)</td>
</tr>
<tr>
<td>• Increased earning power(^7)</td>
</tr>
<tr>
<td>• Employment in short- and long- term</td>
</tr>
<tr>
<td>Women's Family (b)(c)</td>
</tr>
<tr>
<td>• Improved health and well-being</td>
</tr>
<tr>
<td>• Greater economic stability for their family</td>
</tr>
</tbody>
</table>

(a) Sonfield et al, 2013; (b) Population Council, 2012; (c) Singh and Darroch, 2012

Taken together, it is clear that access to contraception and the benefits flowing from fully realized reproductive rights are not shared equally by women in rural, remote, and northern communities, and that Aboriginal women are likely disproportionally impacted by this inequity. By extension, this means that these women may also be at higher risk of unintended pregnancy than their urban or non-Aboriginal peers. It is for reasons such as this that Health Canada requires gender-based analysis of health care policies; though such undertakings rarely influence policy (Office of the Auditor General, 2009). As such, this complexity may be better addressed through targeted research and

\(^7\) When a woman has a child, her earnings can decrease in the short and long-term. This is known as a “family gap.” Delaying the first birth until the late 20s or 30s can help to mitigate the family gap (a).
the development of a national sexual health care strategy, such as can be found in the United Kingdom (Wellings, 2013).

2.4. Access to Contraception in Yukon

Major national and territorial consultations that have previously assessed the status of Yukon health care and service delivery have taken a narrow definition of “access.” For instance, both the 2002 Commission on the Future of Health Care in Canada and 2008 Yukon Health Care Review viewed access in the important yet limited terms of wait-times for appointments, tests, and surgery. This definition neither fully reflects the health care needs of Yukoners, nor their diverse relationships to health care in a largely rural, remote, and northern region.

Instead, access to health care is better considered in relation to the public policy goal of ensuring equitable access to quality health care, a principle to which the CHA and Yukon Health Act both aspire. Specifically, Penchansky and Thomas’ framework of access outlined in their article, “Concept of Access: Definition and Relationship to Consumer Satisfaction” is supplemented by Bertrand et al.’s “Access, Quality of Care and Medical Barriers in Family Planning Programs” to evaluate the accessibility of SRH services and contraception in the Yukon (Norman WV, unpublished).

The main strength of this approach is that it fosters a more nuanced understanding of access as the sum of the availability, accommodation, accessibility, affordability, and acceptability of reproductive health services and contraception in the territory. These five tenets of access are elucidated in the remainder of this chapter, following a brief overview of the organization and regulation of health care in Yukon. The data presented in this section is gathered from three main sources: publicly available documents, key informant interviews, and findings of the Yukon service provider survey. It is noteworthy that this study offers a unique and tailored review of sexual and reproductive services that provides a deeper analysis of “access” than would be offered through other Yukon health care reviews.
2.4.1. Organization and Regulation of Health Care in Yukon

Yukon territory has a population of 35,503, spread over a landmass of 483,610 km². The capital city of Whitehorse is home to three quarters of the population, while the towns of Dawson City and Watson Lake have populations of roughly 2000 residents. The remaining thirteen communities have populations ranging from approximately 50 to 800 people. One quarter of the Yukon population self-identify as Aboriginal.8

Government services are provided through the Government of Yukon, Government of Canada, fourteen Yukon First Nations governments9, and municipalities. In 2011, the federal government extended Territorial Health System Sustainability Initiative until March 31, 2014. This funding provides Yukon with 13 million to help offset the challenges and higher per capita costs associated with delivering community health care in the north (Health Canada, 2010). However, rising pressures on Yukon health care will render this federal funding insufficient to recompense the future demands of a growing population (Yukon Health Care Review, 2008). For this reason, finding cost-effective healthcare programs and policies is a strategic territorial goal (Government of Yukon, 2009). Moreover, twin Auditor General reports on the Yukon Department of Health & Social Services (HSS) and Yukon Hospital Corporation (YHC) underscore this need to more appropriately assess, plan for, and meet the health needs of Yukoners in a suitably cost-effective manner (2011; 2013).

Delivery of Yukon health care is governed by several pieces of legislation, including the Yukon Health Act, Hospital Act, Health Professions Act, Medical Professions Act, Pharmacists Act, Licensed Practical Nurses and Registered Nurses Profession Acts.

Medical and related service delivery expenses are defined in Yukon Drug Formulary, Yukon Payment Schedule, and Travel for Medical Treatment Act, while Yukon health insurance plans are regulated through Yukon Health Care Insurance Plan.

---

8 All statistics in this section sourced from Yukon Bureau of Statistics (www.eco.gov.yk.ca/stats/).
9 Eleven First Nations have finalized land claims and are implementing or have implemented self-government agreements, which includes the transfer of certain health services to First Nations.
and Yukon Hospital Insurance Services Plan. Yukon is awaiting new health privacy regulations through its proposed Bill No. 61 Health Information Privacy and Management Act.

Yukon acute health services are delivered through Whitehorse General Hospital and overseen by the Yukon Hospital Corporation’s Board of Directors; service delivery is administered through the Department of Health & Social Services (HSS). The Yukon Medical Association, Yukon Medical Council, Yukon Registered Nurses Association, and Yukon Pharmacists Association are the professional associations working to recruit, retain, and regulate physicians, nurses, and pharmacists practicing in the territory.

2.4.2. Availability of Contraception in Yukon

Availability of contraceptive care relates to “the relationship of the volume and type of existing services and resources to the clients’ volume and types of needs,” and can refer to the adequate supply of health care facilities, providers, or specialized health programs or services (Penchansky, 1981, p.128).

Health Care Facilities:

Acute care in Yukon is provided by Whitehorse General Hospital. Two new hospitals in Dawson City and Watson Lake were behind schedule and over budget, but opened their doors by the end of 2013.

Primary and preventative health services are provided through fourteen community health centers, which are staffed by nurses and auxiliary receptionists and janitorial staff. Nurses provide medical care through daily clinics, and are available on-call for emergency health services 24 hours a day, seven days a week. Most communities do not have resident physicians, but rather have physicians that visit the health centers at prearranged times, such as once every two weeks.

Health Care Providers:

Health care professionals working in rural and remote communities face challenges in the form of isolation, travel, weather, higher per capita health provision,
and lack of professional anonymity (Curran et al, 2004; CMA, 2000). Yukon is facing a shortage of both physicians and nurses, despite ongoing recruitment efforts with generous benefit programs. Although there is no data with regard to the physician shortage, it is estimated that 10 to 15 percent of residents do not have a family physician (Eggertson, 2013). Whitehorse residents may use a medical walk-in clinic on Saturdays and Sundays or the General Hospital's emergency room. No Yukon family physicians are currently accepting new patients. 

In October 2013, Yukon became the last jurisdiction in the country to legislate nurse practitioners when the Nurse Practitioners Amendment Regulations was passed in an Order-in-Council (194). While only one registered nurse practitioner has received a license to date, a broader recruitment process is currently underway (Government of Yukon news release #12-209). Until this time, Yukon had two regulated groups of nurses: Registered Nurses (RNs) and Licensed Practical Nurses (LPNs), opting for an expanded scope of practice for RNs serving rural communities. Nurse practitioners can order diagnostic tests, diagnose diseases, and prescribe drugs in addition to those duties performed by RNs and LPNs (CNO, 2011).

Specialized Services – Pregnancy, Abortion, and Contraception

Yukon women seeking reproductive health services have limited options. The Yukon Women’s Clinic at Whitehorse General Hospital offers maternity services for women without a family physician. Neither the Dawson City nor Watson Lake Hospitals will be equipped to offer maternity care. Insertion of IUD, cervical cancer screening, and referrals for abortion are not currently offered at the Women’s Clinic due to funding and staffing pressures (Yukon News, 2013). Women requiring gynaecological services but lacking a family physician must therefore seek care at the walk-in clinic or emergency department at Whitehorse General.

10 This information was obtained from Yukon Health and Social Services phone directory that provides monthly updates on which physicians are taking new patients (867-393-6980) as of December 2013. Note that the Yukon Medical Association expects four new doctors to begin taking patients in 2014 (CBC News, 2013).

11 The information in this section is supplemented by Yukon HSS handout Birth Control Methods and e-HealthGuide: http://www.ykhealthguide.org/community/whitehorse_services/abortion).
Women seeking an abortion are constrained by departmental policy and physicians qualified or willing to perform the procedure. Referrals must be obtained through a family physician or rural licensed practical nurse. Women without a physician must visit the walk-in clinic or emergency department to schedule an appointment with a physician to receive a referral. Medical abortions are not widely available, and there is only one therapeutic abortion provider serving the territory.

The availability of certain contraceptive methods is dependent on women’s access to a family physician. For instance, women require a doctor’s prescription for birth control pills, transdermal patches, vaginal rings, contraceptive injections, IUDs, and diaphragms. Alternatively, emergency contraceptive pills (morning after pills) are available without prescription at multiple locations in Whitehorse, and through the community health centres in rural Yukon.

2.4.3. Accommodation of Contraception in Yukon

Accommodation of contraceptive care refers to a “relationship between the manner in which the supply of resources are organized to accept clients,” and includes both administrative dimensions such as hours of operation or appointment systems, and medical dimensions, including telehealth services, medical regulations, and provider qualifications (Penchansky, 1981, p.128; Bertrand, 1995).

*Hours of Operation:*

Where and when reproductive health and contraceptive services are available, they are limited to primarily weekday and daytime clinics, appointments, or other hours of operation. However, 86 percent of Yukon females have fulltime employment, and an additional 9 percent work part time (Yukon Bureau of Statistics, 2012). This means women must arrange time off work or childcare for appointments with their family physician or community health nurse, even if just to fill a prescription. Women who rely on walk-in clinics or the emergency department may be further inconvenienced by long and unpredictable wait times.
**Telehealth Services:**

Yukon Health & Social Services operates two phone lines that provide confidential and free health information. Yukon HealthLine offers direct contact to a registered nurse 24 hours a day, seven days a week. YK Style offers sexual health information from 9:00am until 9:00pm on weekdays. While this telehealth service has potential to reduce emergency room visits or after-hour calls to the community health nurses, the care it provides is limited to information rather than service-based health care.

**Regulation of Prescribing Authority:**

Physicians are the gatekeepers to prescription contraception in the Yukon. Pharmacists are not able to prescribe contraception, and are instead a secondary provider that is responsible for providing method-specific instructions.

As NPs can order diagnostic tests, make diagnoses, and prescribe drugs, the recent regulation of NPs in Yukon may augment accommodation by expanding the number of providers licensed to prescribe contraception.

**2.4.4. Accessibility of Contraception in Yukon**

Accessibility of contraceptive care relates to “the relationship between the location of supply and the location of clients,” and refers to transportation resources, travel time, distance, and price or costs associated with travel arrangements (Penchansky, 1981, p.128). In general, it requires that contraceptive services be located at points where women can access them with an “acceptable level of effort” (Bertrand, 1995).

**Geographic Distance from Urban Care:**

The majority of Yukon women live in and around Whitehorse, where the majority of contraceptive services and the entirety of abortion services are provided. However, the community spatial index reveals that rural women must travel by highway from 54 to 536 kilometers should they require or desire urban service (Government of Yukon,
The northernmost community of Old Crow is fly-in only. Further aggravating these geographical issues is the inadequacy of some rural health centre services. Centralization of health care in Whitehorse has created a systemic barrier to care that disproportionately impacts rural women and especially vulnerable subsets of rural women (ibid).

Location of Abortion Services:12

Abortion services require a dating ultrasound, which is only offered in Whitehorse.

Abortions up to 12 weeks are performed as day surgery at the Whitehorse General Hospital, and may take four days including pre- and post-op care. After 12 weeks, women are sent to Vancouver, Edmonton, or Calgary. Travel costs for rural women seeking an abortion in Whitehorse are covered under valid Yukon medical coverage, as are travel costs incurred by women seeking care outside the territory. Status First Nations women may arrange travel subsidies through Non-Insured Health Benefits.

2.4.5. Affordability of Contraception in Yukon

Affordability of contraceptive care refers to “the relationship of prices of services …to the clients’ income, ability to pay, and existing health insurance,” and clients’ perception of the worth of such services relative to the total cost (Penchansky, 1981, p.128). Put differently, affordability is a matter of economic accessibility and the extent to which women are not deterred from seeking care due to cost of reaching or obtaining care (Bertrand, 1995).

Economic Accessibility

Yukon women experience higher incidences of poverty and economic insecurity due to the high cost of living and job insecurity characterizing rural, remote, or northern

12 Information supplemented by www.ykhealthguide.org/community/whitehorseservices/abortion.
communities (Women’s Directorate, 2013; Northern Secretariat, n.d). The escalating costs of prescription drugs and the limited coverage of contraception by employee health benefits may thus adversely impact contraceptive use by Yukon women (Armstrong et al, 2003). In particular, three-quarters of lone parent families that have annual incomes of less than $30,000 are headed by a female parent (Government of Yukon, 2012). Similarly, First Nations women, who are more likely to experience poverty and unemployment, may be deterred from accessing contraceptive care due to the wait-times associated with reimbursement for travel costs from Non-Insured Health Benefits (YSWC, 2012).

2.4.6. Acceptability of Contraception in Yukon

Acceptability of contraceptive care relates to “the relationship of clients' attitudes about personal and practice characteristics of providers to the actual characteristics of existing providers, as well as to provider attitudes about acceptable personal characteristics of clients” (Penchansky, 1981, p.129).

Anonymity and Confidentiality:

Lack of anonymity pervades health care interactions in both Whitehorse and rural Yukon communities, due to small population sizes and services relying on face-to-face relationships. Concerns have been raised in several communities regarding stigma, provider bias, and lack of confidentiality in the delivery of reproductive health services (Rudachyk, 2013). These issues may deter or otherwise adversely affect women’s willingness to access contraceptive services.

Perception of Providers:

When women must fight to simply gain access to health care services due to scarcity of qualified health professionals or having to travel great distances, they may not be able to see their preferred provider. For instance, while some women prefer to have a female physician, the persisting shortage of family physicians in Yukon may leave women feeling fortunate enough to simply find a physician. Similarly, women who rely on
walk-in clinics or the emergency room for contraceptive care may not have any choice in the characteristics of their provider, or in the duration of consultation.

Taken together, these five tenets of access reveal systemic and structural barriers to accessing contraceptive care in the Yukon. However, it does not evaluate the ways in which these barriers impact women’s satisfaction, contraception use, or unintended pregnancy. To fill this gap, further research is conducted through a survey of service users and providers in the territory. The findings are presented below, in Chapter Four.
Chapter 3. Methodology

This study received minimal risk approval from the SFU Office of Research Ethics on November 20, 2013. The primary purpose of the study is to better understand what is needed to expand access to contraceptive care. A mixed methods framework was employed due to its noted benefits for primary health care research; namely that it unites the layers of nuance and depth found in qualitative design with the statistical reliability of quantitative methods (Borkan, 2004).

This framework was operationalized in two major phases: a data collection phase with three related research components, and a data analysis phase with two related components:

3.1. Data Collection

Literature Review: A literature review of sexual and reproductive health (SRH), contraception, and unintended pregnancy was conducted. This review included peer-reviewed academic articles, research studies, program reports, and local, national, and international materials. Identified topics include: best practices in contraceptive care, clinical standards and national guidelines in contraceptive provision, models of health care delivery, and cost-effectiveness evaluations. This preliminary research phase was conducted through the SFU Library research engine and publicly accessible materials published online.

Surveys on Yukon Access to Contraception: In order to investigate the status of contraceptive care in Yukon, complementary “service user” and “service provider” surveys were designed. For the former, eligible respondents were women of reproductive age (19-50 years old) who either had a valid Yukon Health Care card or had seen a Yukon health provider in the six months preceding their participation in the
survey. In the latter, eligible respondents were those medical and nonmedical professionals who had provided contraceptive services in Yukon for at least six months preceding completion of the survey. Major references used for the design of these studies are: the “Canadian Contraception Study” survey tool (1993, 1995, 1998, 2002) provided by co-author Dr. William Fisher of University of Western Ontario; and the “Canadian Contraception Access Survey” findings published in 2011 by the Contraception Access Research Team (CART), and incorporated with permission of CART team lead Dr. Wendy Norman. Data collection took place between December 9, 2012 and January 20, 2014. Collection was non-random, as survey participants were recruited through email notifications of the study. These emails were distributed through public email listings and organizational list-serves, and contained a link to the secure WebSurvey instrument. This link was also shared through the Facebook pages of relevant Yukon groups and organizations. Paper copies of the surveys were mailed to three non-profit or educational organizations in Whitehorse, and to 10 medical clinics in Whitehorse, Dawson City, and Watson Lake. Of 121 completed service user surveys, 117 fit the required criteria for inclusion, while all 11 health providers also fit the eligibility criteria for inclusion. Responses were anonymous, and all written comments were anonymized and coded.

The survey design was thus a non-random convenience sample, as women self-selected to participate. Under such circumstances, it is possible that women with strongly positive or negative opinions about contraception access were more likely to respond. Additional limitations to data collection are that the survey was only offered in English, and youth under 19 years of age were not eligible to participate.

Key Informant Interviews: Semi-structured phone interviews were conducted with six representatives of Yukon Health & Social Services, Yukon Official Opposition Caucus Office, and Yukon Pharmacists Association (YPA), between January 28 and February 19, 2014. Interview questions were derived from service user and provider survey results, as well as international assessment tools and project evaluation reports on sexual and reproductive health services and contraceptive provision.
3.2. Data Analysis

Survey Data Analysis: Data collected from the service user and provider surveys was entered into SPSS, a statistical software package, to evaluate using frequency tables, graphs, and cross-tabulation tables. This statistical analysis highlighted key themes and patterns in survey respondent data, which were then compared against national and international research findings to identify areas of similarities and divergence. Write-in responses were coded and analyzed thematically.

Key Informant Interviews: The data gathered in key informant interviews was used to fill in background information gaps, provide local context, and identify, develop, and evaluate the recommended policy options.

Cost-effectiveness Evaluation: Survey data was used to develop a cost-effectiveness evaluation framework built in Microsoft Excel. Specifically, these survey responses were used to develop a cost-effectiveness evaluation of contraception method use, as well as an evaluation model to compare public provision of contraception against unintended pregnancy outcomes.
Chapter 4. Key Findings of the Yukon Service User Survey

In order to gain a more nuanced understanding of the ways in which women access and use contraception in Yukon, as well as their experiences when accessing related care, a service user survey was distributed online and by mail. Eligibility was limited to adult respondents age 19-49, who are of reproductive age and therefore at risk of unintended pregnancy. Due to financial constraints and distance, the survey was put online. In an effort to also reach women without easy access to computers, copies of the survey were sent to three community and educational organizations that deliver service to women. The survey collected data on respondent demographics, women’s satisfaction and perceptions of key variables associated with contraceptive care and their current method, and data on incidence of unintended pregnancy (Table 3).

Table 3 Structure of Service User Survey

<table>
<thead>
<tr>
<th>Types of Question</th>
<th>Demographics</th>
<th>Contraceptive Care</th>
<th>Contraceptive Methods</th>
<th>Unintended Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age, Ethnicity, Education, Employment, Income, Population, Transportation</td>
<td>Health Care Site &amp; Provider Patient-Centered Care &amp; Counselling Privacy &amp; Confidentiality</td>
<td>Method Perceptions, Choice, and Use Method Payment and Coverage Method Switching and Discontinuation</td>
<td>Pregnancy Outcomes Key Demographic Indicators</td>
</tr>
</tbody>
</table>
4.1. Respondent Demographics

Given the sample size (n=117), the demographic composition of survey respondents does not fully reflect the eligible population and may not be generalized to the entire population of Yukon females age 19-49 (95% CL; 9.04 CI). A comparative analysis of key demographic indicators with federal and territorial statistics reveals that survey respondents skew young, educated, White, mid-income, childless, and “urban.” Table 4 provides a synopsis of these differences.

4.2. Contraceptive Care

Contraceptive care questions gathered information and opinions on three major and interrelated care areas: health care site and primary provider; patient-centered care and contraceptive counselling; and privacy and confidentiality. Table 5 summarizes survey responses to these questions.

4.2.1. Health Site and Provider

The majority of respondents primarily access health care through medical and walk-in clinics (66%), and cite family or clinic physicians as their primary provider (85%) for contraceptive health care. This emphasis on physician-based care is unsurprising given the prescribing requirements inherent to hormonal SARCs (with the exception of emergency contraception), and the insertion or procedural requirements for both LARC and permanent methods. Despite the role of physicians as primary providers of contraceptive methods, it is noteworthy that about 40% of respondents appear to be unattached, seeking care through emergency or walk-in clinic doctors, nurses, or even pharmacists. In terms of quality of contraceptive care, respondents that access medical clinics and family physicians report higher levels of overall satisfaction with both their current contraceptive method and overall contraceptive care (~76-80%). While those respondents that access walk-in clinics, the emergency room, and clinic physicians also enjoy high levels of satisfaction with their current method (73-78%), they are far less likely to be satisfied with their overall contraceptive care (38-54%). Respondents that access community health centre are even less likely to be satisfied with their current me-
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Category</th>
<th>Survey n(%)</th>
<th>Yukon (%)</th>
<th>Diff. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age*</td>
<td>19-24</td>
<td>18 (15%)</td>
<td>15%</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>25-29</td>
<td>40 (34%)</td>
<td>19%</td>
<td>+15</td>
</tr>
<tr>
<td></td>
<td>30-34</td>
<td>32 (27%)</td>
<td>17%</td>
<td>+10</td>
</tr>
<tr>
<td></td>
<td>35-39</td>
<td>17 (15%)</td>
<td>16%</td>
<td>–1</td>
</tr>
<tr>
<td></td>
<td>40-44</td>
<td>7 (6%)</td>
<td>17%</td>
<td>–9</td>
</tr>
<tr>
<td></td>
<td>45-49</td>
<td>3 (3%)</td>
<td>16%</td>
<td>–13</td>
</tr>
<tr>
<td>Education</td>
<td>High school</td>
<td>6 (5%)</td>
<td>20%</td>
<td>–15</td>
</tr>
<tr>
<td></td>
<td>Some college or university</td>
<td>21 (18%)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>College/university</td>
<td>88 (75%)</td>
<td>65%</td>
<td>+10</td>
</tr>
<tr>
<td>Ethnicity**</td>
<td>White</td>
<td>111 (80%)</td>
<td>71%</td>
<td>+9</td>
</tr>
<tr>
<td></td>
<td>Aboriginal</td>
<td>18 (13%)</td>
<td>23%</td>
<td>–10</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>9 (7%)</td>
<td>6%</td>
<td>+1</td>
</tr>
<tr>
<td>Annual Household</td>
<td>&lt; $20 000</td>
<td>9 (8%)</td>
<td>14%</td>
<td>–6</td>
</tr>
<tr>
<td>Income</td>
<td>$20 000 - $39 999</td>
<td>23 (20%)</td>
<td>18%</td>
<td>+2</td>
</tr>
<tr>
<td></td>
<td>$40 000 - $59 999</td>
<td>28 (24%)</td>
<td>17%</td>
<td>+7</td>
</tr>
<tr>
<td></td>
<td>$60 000 - $79 999</td>
<td>27 (23%)</td>
<td>14%</td>
<td>+9</td>
</tr>
<tr>
<td></td>
<td>$80 000 - $99 999</td>
<td>8 (7%)</td>
<td>12%</td>
<td>–5</td>
</tr>
<tr>
<td></td>
<td>&gt;$100 000</td>
<td>22 (19%)</td>
<td>24%</td>
<td>–5</td>
</tr>
<tr>
<td>Children</td>
<td>None</td>
<td>91 (78%)</td>
<td>43%</td>
<td>+35</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>8 (7%)</td>
<td>26%</td>
<td>–19</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>11 (9%)</td>
<td>22%</td>
<td>–13</td>
</tr>
<tr>
<td></td>
<td>3+</td>
<td>6 (6%)</td>
<td>9%</td>
<td>–3</td>
</tr>
<tr>
<td>Employment***</td>
<td>Full-time</td>
<td>78 (67%)</td>
<td>70%</td>
<td>–3</td>
</tr>
<tr>
<td></td>
<td>Part-time</td>
<td>23 (20%)</td>
<td>11%</td>
<td>+9</td>
</tr>
<tr>
<td></td>
<td>Not employed</td>
<td>15 (13%)</td>
<td>19%</td>
<td>–6</td>
</tr>
<tr>
<td>Location</td>
<td>Population &gt;1500</td>
<td>95 (81%)</td>
<td>82%</td>
<td>–1</td>
</tr>
<tr>
<td></td>
<td>Population &lt; 1500</td>
<td>5 (4%)</td>
<td>18%</td>
<td>–14</td>
</tr>
<tr>
<td></td>
<td>Outside Yukon</td>
<td>17 (15%)</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

a. Includes frequencies for survey responses with cell numbers of 5 or greater
b. *Indicates that respondents were able to select multiple self-identifiers.
c. ** Indicates gender-specific Yukon statistics
d. *** Indicates gender-specific Yukon statistics, but for women age 25-54
thod (58%) contraceptive care (50%), and are also more likely to have experienced an unintended pregnancy (42%). Women who cite nurses as a primary provider indicate the lowest overall satisfaction with their current method (50%) and contraceptive care (36%); this may denote insufficient education, skills training or authority to provide contraception among Yukon nurses.

4.2.2. Patient-Centered Care and Contraceptive Counselling

Patient-Centered Care

Patient-centered health care is associated with higher-quality care, both patient and provider satisfaction rates, and can even foster health improvement by enabling the patient to take an active and informed role in their own healthcare and management (CMA General Council, 2009; Coulter & Ellins, 2006). Though the majority of women respondents indicate receiving many elements of overall patient-centered care, such agreement varies across several indicators and access points. In terms of indicators, respondents generally agree their primary providers treat them with respect (84%), but are less inclined to agree that they were listened to, given accurate and unbiased information, or received sufficient time or attention (67-69%). In regard to points of access, Figure 1 highlights walk-in clinics and clinic physicians as those access points with the lowest level of agreement on indicators of overall patient-centered care (at least 20% strong disagreement or disagreement). Key indicators of patient-centered contraceptive care reveal weaker agreement (43-68%) among women than overall patient-centered care, especially for those accessing walk-in clinics, or seeing clinic physicians and nurses. This deviation is evident when comparing Figure 1 with Figure 2, the prevalence of at least 20% disagreement across contraceptive care indicators.

Patient-Centered Counselling

Studies additionally show that patient-centered contraceptive counselling can have a statistically significant impact on women’s knowledge, perceptions, and increased use of contraception (Nobili et al, 2007; Brown et al, 2011). Yet, the efficaciousness and quality of this counselling may be diminished if inconsistent across health care providers, if providers have low and / or inaccurate knowledge of health care
Figure 1. Disagreement with Key Indicators of Patient-Centered Care (Site and Provider Activities)

Figure 2. Disagreement with Key Indicators of Patient-Centered Contraceptive Care (Site and Provider Knowledge & Awareness)
providers, if providers have low and/or inaccurate knowledge of contraceptives, if there is limited continuity of care, or if women are dissatisfied with their providers (Dehlendorf et al, 2009; Barot, 2008). Yet inconsistency is what is revealed among survey respondents, with just 70% having spoken to their primary provider about contraception in the 12-months prior the study. Of those 70%, less than half report receiving up-to-date information on a range of contraceptives, or clear instructions on method use. While 61% received counsel on the benefits and risks of different methods, only 27% were given information on the costs of these methods.

Women accessing family physicians and nurses are more likely to have spoken with their provider about contraception (76% and 71%), as are those accessing a medical clinic, emergency room, or community health centre (73-78%). While counselling is not associated with higher method satisfaction in this study, respondents reporting counselling are more satisfied with their contraceptive care (72%) and less likely to have had an unintended pregnancy (22%) than those who do not (37% and 29%). It is therefore evident that not all respondents enjoy the same access to contraceptive counselling, and therefore access to contraceptive care and lower risk of pregnancy.

4.2.3. Privacy and Confidentiality

Confidentiality is a highly valued component of health care. In smaller communities, and for patients accessing sexual and reproductive health services, it may be of even greater importance due to perceived or actual lack of anonymity and privacy. A U.K. study reports that patients of a sexual health clinic are most concerned about disclosure when accessing care, while an Opt BC report suggests that confidentiality concerns can cause women to seek substandard or unsafe reproductive care (Sauer et al, 2013; Opt BC, 2010). Survey respondents corroborate these findings, with 78% agreeing with the statement, “accessing contraception in small communities can be difficult because a person’s lack of anonymity may interfere with their privacy.” It is interesting to note that women accessing care through community health centres or pharmacies are the least likely to agree with this statement, despite being located in smaller communities and public spaces. Similarly, and also contrary to hypothesized
results, satisfaction with contraceptive care is higher among women who agree with the above statement (62%) than those who do not think confidentiality is a concern (26%). Likewise, unintended pregnancy is lower among those women that perceive confidential-

Table 5 Contraceptive Care Responses

<table>
<thead>
<tr>
<th>Health Care Site</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical clinic</td>
<td>85 (48%)</td>
</tr>
<tr>
<td>Walk-in clinic</td>
<td>32 (18%)</td>
</tr>
<tr>
<td>Emergency room</td>
<td>26 (15%)</td>
</tr>
<tr>
<td>Community health centre</td>
<td>12 (7%)</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>13 (7%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Provider</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family physician</td>
<td>73 (54%)</td>
</tr>
<tr>
<td>Clinic physician</td>
<td>42 (31%)</td>
</tr>
<tr>
<td>Nurse</td>
<td>14 (10%)</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>3 (2%)</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>3 (2%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient-Centered Care</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treated patient with respect</td>
<td>94 (84%)</td>
</tr>
<tr>
<td>Believed what the patient said</td>
<td>94 (81%)</td>
</tr>
<tr>
<td>Involved patient in decision-making</td>
<td>87 (76%)</td>
</tr>
<tr>
<td>Sensitive to patient’s preferences</td>
<td>83 (71%)</td>
</tr>
<tr>
<td>Gave desired time and attention</td>
<td>81 (69%)</td>
</tr>
<tr>
<td>Listened to and understood issues</td>
<td>78 (67%)</td>
</tr>
<tr>
<td>Gave accurate and unbiased info</td>
<td>80 (69%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contraceptive Care</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comfortable talking about SRH</td>
<td>77 (66%)</td>
</tr>
<tr>
<td>Cares about finding best method</td>
<td>59 (52%)</td>
</tr>
<tr>
<td>Listens to and respect needs</td>
<td>80 (68%)</td>
</tr>
<tr>
<td>Aware of future pregnancy plans</td>
<td>49 (43%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contraceptive Counselling*</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spoke to provider in last 12 months</td>
<td>82 (70%)</td>
</tr>
<tr>
<td>Initiated discussion</td>
<td>36 (44%)</td>
</tr>
<tr>
<td>Up-to-date info on range of methods</td>
<td>36 (44%)</td>
</tr>
<tr>
<td>Benefits &amp; risks of different methods</td>
<td>50 (61%)</td>
</tr>
<tr>
<td>Clear instructions on method use</td>
<td>37 (45%)</td>
</tr>
<tr>
<td>Discussed costs of different methods</td>
<td>22 (27%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Privacy Issues</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of anonymity make accessing contraception difficult</td>
<td>91 (78%)</td>
</tr>
</tbody>
</table>
ility to be a barrier when accessing contraception (22%) than those who do not (31%). It can therefore be suggested that privacy may be a preference rather than an overriding concern for many respondents accessing contraceptive care.

4.3. Contraceptive Methods

Contraceptive method questions gathered information and opinions on three major interrelated areas: contraceptive method perception, choice, and use; payment and coverage; and method switching or discontinuation. Table 6 provides a synopsis of survey responses to these questions.

4.3.1. Method Selection, Perceptions, and Use

Selecting a contraceptive method is a function of multiple factors or considerations, including perceptions of contraception, knowledge or favourability of methods, and the compatibility of a chosen method with personal preferences and lifestyle needs. Disagreement between method choice, reasons for method selection, and adherence may account for some of the discrepancy between women’s desire to avoid present or future pregnancy and actual contraceptive practice (Lamvu et al, 2006; Brown et al, 2011).

Method Selection

Survey respondents were able to select multiple contraceptive methods to account for those using several different methods to meet their contraceptive needs. Though the male condom is the most commonly reported method (29%), it is likely that not all women use it as their primary method. Similar to the findings of a 2006 Canadian study, withdrawal (16%) and birth control pills (12%) are the next most frequently reported methods. Combined, LARC use comes second only to condoms use, with as many as 1 in 5 respondents report using LARCs (11% IUS; 9% IUD). This is in stark contrast to the 2006 study, when the IUS was just recently available to Canada and only 2% of respondents reported using it. Similarly, a 2002 Canadian contraceptive study reports just 3% of respondents using IUDs. As there is no recent evidence to indicate
whether this higher prevalence of IUS and IUD is more common today than a decade ago, it is not yet known whether this study has yielded uncommon results. In either case, it represents an interesting development in the use of highly effective contraceptive methods. Rounding out the most common major methods are vasectomy, natural family planning, and the hormonal contraceptive ring, at about 5% each.

Across major methods, women’s satisfaction with their current method is positively related to its efficaciousness in preventing pregnancy. Vasectomy and LARCs enjoy the highest rates of satisfaction at 88% and 100%, while SARC methods such as the birth control pill and ring have slightly lower satisfaction rates of 85% and 83%. By comparison, traditional methods including condoms, natural family planning, and withdrawal have lower satisfaction rates of 66%, 63%, and 59%. These less effective methods were also those most commonly used by women before their last unintended pregnancy (38% withdrawal; 26% condoms).

Method Perceptions

Respondents were able to select up to three reasons for choosing their current method. The top seven reasons can be delineated into three overarching categories: effectiveness, lifestyle, and physical considerations. It is important to note the latter two categories do not relate to the primary function of contraceptives in preventing pregnancy, but rather to secondary considerations that reflect personal preferences and values. For example, while the largest amount of respondents cite effectiveness as a main reason for their current contraceptive choice (17%), many also selected a method based on lifestyle considerations – convenience (12%), ease of use (11%), and menstrual regulation (5%); or physical considerations – non-hormonal (10%), lack of side effects (8%), and ability to become pregnant in the future (5%). Noteworthy differences between these findings and those of a 2010 U.S. study on contraception perceptions and method choice is the comparatively minor role that cost (3%) and provider recommendations (4%) play in respondents’ method choice (Brown et al, 2011). The latter difference may be of particular importance given the statistically significant impact discussions with health providers have on method selection, and therefore on increasing the compatibility between reasons for using contraception and actual method
choice - an important factor in method adherence (Bitzer et al, 2012; Lamvu et al, 2006; Brown et al, 2011).

Certainly, there is some amount of disagreement between respondents' perceived favourability of different contraceptive methods and their current method choice. For instance, although withdrawal meets all lifestyle and physical considerations except for menstrual regulation and is the second most popular method among respondents, it also has the lowest favourability rating of all major methods (19%). This broad disagreement between method perception and selection is reflected in lower levels of satisfaction among withdrawal users. In contrast, the agreement between those respondents that value effectiveness as a reason for selecting their current method and the high levels of favourability for more effective LARC and SARC methods (53-57%) is reflected in higher method satisfaction among users of these methods. This association between method perception, selection, and satisfaction is summarized within Figure 3.

![Figure 3 Disagreement Among Method Perception, Selection, and Satisfaction](image)

a. Favourability adjusted to remove those who had not heard of the method
Method Use

Three-quarters of survey respondents both desire to avoid a present pregnancy and do not plan to have a child in the next two years. Virtually all respondents (97%) are favourable of contraception as good protection against pregnancy; yet only 89% use some form of contraception. This apparent discrepancy between the desire to avoid pregnancy and actual contraceptive use means that about 1 in 10 of the respondents who are having sex are not using contraception. Of those women reporting use, only 64% always use their chosen method. Issues of method failure aside, this means that approximately 40% of survey respondents are at high risk of unintended pregnancy. Among women with inconsistent method use, 19% usually and 10% sometimes use contraception, while 7% rarely or never use contraception. This use profile is similar to that of a 2009 Canadian study which found 65% of survey respondents always used contraception and 20% usually or sometimes used some form of contraception (Black et al, 2009). While the non-use rate of 15% found in this 2009 study is higher than what is found here, it is also higher than the 9% rate of non-use found in an earlier 2002 Canadian contraception study (Black et al, 2009).

Women that report using LARC and SARC methods are those most likely to always use contraception, although inconsistent use (sometimes, rarely, never) is higher for women using the pill (10%) and vaginal ring (33%) than for IUS or IUD users (6%). Respondents using traditional contraception such as condoms or withdrawal are the least likely to always use contraception (60% and 22%) and are similarly most likely to report inconsistent use (14% and 37%). Method satisfaction is more likely among those who always use contraception (71%), and unintended pregnancy is less likely (17%). In contrast, method satisfaction is less prevalent among women reporting inconsistent use (16%), whereas unintended pregnancy is more than twice as likely (40%).

There are myriad reasons for patterns of contraceptive use, from changes in sexual activity, relationship status, or overall health to shifting pregnancy intentions. With the data available, the former is not verifiable. However, the trends do indicate that pregnancy intentions do not account for the total variation in method use. If it were the case, higher rates of satisfaction and lower rates of unintended pregnancy would be expected among those reporting inconsistent use, as users’ method or adherence would
be aligned with their pregnancy intentions. Based on the survey results, two patterns emerge. First, some variability in adherence may be attributed to differing pregnancy intentions: about three-quarters of respondents that do not want to become pregnant now or in two years’ time are more likely to always use contraception than the one-third of respondents with ambiguous or favourable pregnancy intentions, both now and in the future. Second, perceptions of method effectiveness appear to impact adherence: 97% of women who always use contraception perceive their current method to be effective in preventing pregnancy, in contrast to the 65% of inconsistent method users. In either case, it is clear that at least some respondents with no desire to become pregnant are using insufficiently effective method, and are using these methods inconsistently.

4.3.2. Method Payment and Coverage

Contraception is not covered under Canadian public health insurance. In Yukon, the Department of Health & Social Services provides condoms through an assortment of clinics, community centres, and public events. Emergency contraception is available free of charge at the Victoria Faulkner Women’s Centre in Whitehorse, and a specific formulary of approved contraception is available to status Aboriginal women under the federal Non-Insured Health Benefit plan. Beyond these instances, women secure contraception through out-of-pocket payments, private insurance, or a combination thereof. Among those respondents using contraception 40% pay out-of-pocket, 17% share the expense with their partner or family (this does not specify the proportion covered by out-of-pocket or insurance plans), and 5% are entirely covered through a partner or family. Another 18% have co-payment plans where they share the cost with an insurance plan, and the rest have coverage through private insurance plans (8%) or NIHB (10%). This means as few as 1 in 5 women may have full coverage for their contraceptive health care needs, though even then what methods are covered may not be best suited to a woman’s lifestyle or personal preferences.

Women who pay for contraception out-of-pocket are most likely to be satisfied with their current method of contraception (87%), followed by those with full and partial coverage under an insurance plan (~70% each). These three groups also report low rates of unintended pregnancy, from 20-24% of respondents. Among those women that
share payment with their partner or family, dissatisfaction is over twice as high than among other payment groups (26%), and the rate of unintended pregnancy is higher than average (33%). Interestingly, women covered through NIHB report the highest likelihood of being satisfied with their current method (91%), as well as of having experienced an unintended pregnancy (36%).

To better determine whether and the extent to which payment may have an impact on method choice, efficacy, and satisfaction, survey respondents were asked if they would switch to a different method of contraception if it were covered under health insurance. While most women stated they would keep their current method (77%), a quarter said they would switch to a similarly expensive method of contraception that is now covered (1%) or a more expensive method of contraception that better meets their needs (22%). This need may be related to both efficacy and lifestyle or personal preferences, as women who express a desire to switch to another method are less likely to perceive their current method as effective (74%) than women who would keep their method (89%). Women who would switch to another method are also much more likely to be dissatisfied with their current method (44%) than the respondents who would keep their current method (4%). This may be a significant finding, as it suggests that cost is a barrier keeping at least some women from using more effective contraceptive methods,

![Figure 4 Current Method Choice and Desire to Switch to a Covered Method](image-url)
and certainly from ones that better suit their overall contraceptive health needs. As uninsured women are less likely to switch to a different method than those with insurance, these women may also be more likely to remain with a contraceptive method that does not meet their needs (Barot, 2008). If so, this would help to explain why those respondents who would switch methods report higher rates of unintended pregnancy (36%) than their survey counterparts for whom cost may not be a constraint (20%). Overall, these trends echo the results of two different U.S. studies which found the following: if cost barriers are removed, respondents with a desire to switch methods are twice as likely to use less effective contraceptives than those who would not switch, and are also more likely to choose an effective, long-acting method than in the general population (Sonfield, 2011).

4.3.3. Method Switching and Discontinuation

Women’s satisfaction with their current contraceptive method is important for consistent method use patterns and method continuation. While a degree of method switching is a normal part of finding the most suitable option to meet changing contraceptive needs over a reproductive lifetime, it can also be associated with delayed continuation in the subsequent contraceptive method (Barot, 2008; McEneaney and Hong, 2009). Method dissatisfaction can also account for method switching in as many as a quarter of women each year, with twice as many switching to less effective contraceptives than those who would not switch, and non-use than to more effective contraceptives (Barot, 2008). The survey results echo this literature, with 26% of women reporting switching methods over the 12-months preceding the study. Of these women, only a small minority (17%) switched twice. Women who switched methods in the past year are less likely than those who did not switch to be satisfied with their current method (63% vs. 82%), while those who switched twice are the least likely to be satisfied (40%). Birth control (41%), condoms (21%), and the contraceptive ring (8%) are the three most common methods that women report discontinuing in the last year. In keeping with the literature, women that switched methods are more likely to use withdrawal (47%) and condoms (43%) than the total respondent population. However, it is also noteworthy that women who switched methods are slightly more likely to use IUDs (17%).
When asked to explain why they switched methods, women were most likely to reference physical concerns as the motivating reason for discontinuing, especially due to side effects or a desire to use non-hormonal contraception. Lifestyle concerns were the second most likely reason, particularly around method adherence issues, a preference for more convenience, or changing sexual activity (relationship status or number of sexual partners). Effectiveness was the next most commonly cited issue, framed as both a desire to move away from ineffective methods, and towards more effective methods. Frequent reference was made to the IUD as a recommended and desired method, due to its convenience and long-term effectiveness. Woven within these broader categories were comments about changing contraceptive needs and method failure, as well as three core barriers: cost, access to providers, and getting or refilling prescriptions.

Table 6 Contraception Method Responses

| Pregnancy Intentions | n (%)
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not want to become pregnant now</td>
<td>88 (75%)</td>
</tr>
<tr>
<td>Doesn't plan to have child in next 2 years</td>
<td>88 (75%)</td>
</tr>
</tbody>
</table>

| Perception of Contraception | n (%)
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree or Agree</td>
<td></td>
</tr>
<tr>
<td>Good protection against pregnancy</td>
<td>94 (97%)</td>
</tr>
<tr>
<td>Expensive</td>
<td>66 (56%)</td>
</tr>
<tr>
<td>Convenient to use</td>
<td>66 (56%)</td>
</tr>
<tr>
<td>Sexual partner supports using</td>
<td>98 (85%)</td>
</tr>
<tr>
<td>Embarrassing to request or purchase</td>
<td>39 (33%)</td>
</tr>
<tr>
<td>Disrupts “the mood.”</td>
<td>24 (21%)</td>
</tr>
</tbody>
</table>

| Frequency of Use | n (%)
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>75 (64%)</td>
</tr>
<tr>
<td>Usually</td>
<td>22 (19%)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>12 (10%)</td>
</tr>
<tr>
<td>Rarely</td>
<td>3 (3%)</td>
</tr>
<tr>
<td>Never</td>
<td>5 (4%)</td>
</tr>
</tbody>
</table>

| Main Reasons for Non-Use | n (%)
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Carried away in the moment</td>
<td>17 (35%)</td>
</tr>
<tr>
<td>Dislikes using contraception</td>
<td>9 (18%)</td>
</tr>
<tr>
<td>Recent or desired pregnancy</td>
<td>7 (6%)</td>
</tr>
</tbody>
</table>

| Major Current Methods | n (%)
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom (male)</td>
<td>49 (29%)</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>27 (16%)</td>
</tr>
<tr>
<td>Birth Control Pill</td>
<td>20 (12%)</td>
</tr>
<tr>
<td>Intrauterine System (IUS)</td>
<td>18 (11%)</td>
</tr>
<tr>
<td>Intrauterine Device (IUD)</td>
<td>16 (9%)</td>
</tr>
<tr>
<td>Natural Family Planning</td>
<td>8 (5%)</td>
</tr>
</tbody>
</table>
### Top Reasons for Using Current Method

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness</td>
<td>54 (17%)</td>
</tr>
<tr>
<td>Convenience</td>
<td>39 (12%)</td>
</tr>
<tr>
<td>Non-hormonal</td>
<td>33 (10%)</td>
</tr>
<tr>
<td>Easy to use</td>
<td>34 (11%)</td>
</tr>
<tr>
<td>No side effects</td>
<td>26 (8%)</td>
</tr>
<tr>
<td>Menstrual regulation</td>
<td>16 (5%)</td>
</tr>
<tr>
<td>Ability of future pregnancy</td>
<td>16 (5%)</td>
</tr>
</tbody>
</table>

### Payment Method

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Pocket</td>
<td>46 (40%)</td>
</tr>
<tr>
<td>Co-payment</td>
<td>21 (18%)</td>
</tr>
<tr>
<td>Shared with partner/family</td>
<td>19 (17%)</td>
</tr>
<tr>
<td>NIH</td>
<td>11 (10%)</td>
</tr>
<tr>
<td>Private insurance</td>
<td>10 (8%)</td>
</tr>
<tr>
<td>Partner/family</td>
<td>6 (5%)</td>
</tr>
</tbody>
</table>

### Coverage

<table>
<thead>
<tr>
<th>Approach</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keep current method</td>
<td>89 (77%)</td>
</tr>
<tr>
<td>Switch to more expensive method that better meets needs</td>
<td>25 (22%)</td>
</tr>
</tbody>
</table>

### Switched Last 12 Months

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>30 (26%)</td>
</tr>
<tr>
<td>Once</td>
<td>27 (23%)</td>
</tr>
<tr>
<td>Twice</td>
<td>5 (4%)</td>
</tr>
</tbody>
</table>

### Main Discontinued Methods

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Control Pills</td>
<td>11 (41%)</td>
</tr>
<tr>
<td>Condom</td>
<td>7 (21%)</td>
</tr>
<tr>
<td>Birth Control Ring</td>
<td>5 (8%)</td>
</tr>
<tr>
<td>Intrauterine system (IUS)</td>
<td>4 (4%)</td>
</tr>
</tbody>
</table>

### 4.4. Unintended Pregnancy

Unintended pregnancy questions gathered information on pregnancy intentions and outcomes, as well as women’s experience accessing abortion care. Key demographic variables were also included to determine how contraceptive care, method use, and unintended pregnancy vary across different groups of respondents. Table 7 offers a summary of unintended pregnancy outcomes.
4.4.1. **Unintended Pregnancy Outcomes**

Of 117 survey respondents, 28 report having experienced an unintended pregnancy in the five-year period preceding the study. This means 24%, or about 1 in 5, women became pregnant without an active plan or intention of becoming pregnant. Of those women, 57% always or usually used contraception at the time of pregnancy. Three-quarters report having had one unplanned pregnancy, while the remaining quarter report two. When asked if they had wanted to wait until later to become pregnant, 80% said yes. This suggests that the majority of unplanned pregnancies were mistimed. When asked about the pregnancy outcome of their most recent unplanned pregnancy, 54% of women reported an abortion, 11% miscarried, and 39% had a live birth and kept the child. These pregnancy outcomes are in line with general trends for unintended pregnancy, where half of all pregnancies are aborted or carried to term in somewhat equal measure (University of Ottawa, 2014). Among the 15 respondents that had an abortion, 13 underwent surgical abortions in the capital of Whitehorse, and 2 more had medical abortions. Half of women seeking abortion had to travel to another city or community for the procedure, and 5 had to see more than one service provider to get a referral for the abortion. Two-thirds of respondents had to wait more than two weeks to get a referral for abortion and/or between the referral and the procedure itself. In two-thirds of cases, women were offered information about different contraceptive methods, and about half felt supported by their health care provider. Roughly half of all those who had an abortion also felt supported by their social network. These results indicate barriers to accessing abortion close to home and in a timely manner, an issue that could be addressed by improving referral systems, increasing medical abortion availability, or offering abortions in local ambulatory care and community medical centres (Guthrie, 2010; Erdman et al, 2008; Norman et al, 2013).

4.4.2. **Key Indicators and Unintended Pregnancy**

Unintended pregnancy is a complex issue with a network of interrelated influencing factors and indicators. The survey is not amenable to a regression, and instead relies on thematic analysis using cross-tabs. It is therefore critical to note that these “sets” of women are not mutually exclusive, but rather share multiple or
overlapping sets of identities that all influence experiences of access and quality of care. With this in mind, the following are some key themes identified in the survey findings:

Ethnicity: Respondents were allowed to pick multiple self-identifiers to denote their ethnicity. Women that self-identify as Aboriginal (First Nations, Metis, or Inuk) are more likely to have experienced an unintended pregnancy (39%) than women that self-identify as White (23%). Aboriginal respondents were also less likely than their White counterparts to be satisfied with their current contraceptive method (61% vs. 78%) and contraceptive care (39% vs. 65%).

Age: Women age 30-39 are more likely (27%) to have had an unintended pregnancy than those ages 19-29 (22%) or 40-49 (20%). The highest incidence was among 19-24 (33%) and 35-39 (35%) year-old respondents. Satisfaction with current method increases with age, as 31% of those in their 20s, 43% in their 30s, and 70% in their 40s report being very satisfied with their current method. Reported method choice does not appear to vary with age, with the exception of female sterilization. Overall satisfaction with contraceptive care also increases with age, with 57% of those in their 20s being very satisfied, in contrast to 80% of those in their 40s.

Income: The incidence of unintended pregnancy does change significantly above and below median Yukon income. This may be due to the mitigating effect of low-income women with less than $20,000 household income, who have the lowest rate at 11%; those with annual incomes of $20-40,000 have the highest rate at 30%. Income does however appear to have a positive relationship on satisfaction with current method. For instance, reports of very satisfied increase by an average of 8-10% from a low of 28% among respondents with annual household income below $40,000, to a high of 59% among those with incomes above $100,000. This may be explained by the fact that the former income group is less likely to report using the more expensive LARC methods and more likely to use condoms and withdrawal. Finally, women are more likely to be very satisfied with contraceptive care above the median income (31%) than below (13%), and those with incomes above $100,000 are most likely to report being satisfied (59%). Recalling that women who identify lack of coverage as a barrier to a method meeting their needs are more likely to have had an unplanned pregnancy, it is
reasonable to suggest that affordability of contraception and care is an important consideration among survey respondents.

Employment: Respondents that work full-time are less than twice as likely to report an unplanned pregnancy than those that work part-time (18% versus 39%). Those who work part-time are more likely to be very dissatisfied or dissatisfied with their current method (22%) than their full-time counterparts (9%), although those who work full-time are more likely to be dissatisfied with their contraceptive care (16%) than those working part-time (9%). This may be due to the affordability of desired methods: only 15% of women working full-time would switch to a more expensive method, compared to 41% of those working part-time. Hormonal birth control use is higher among those working full-time, possibly due to employee insurance plans, while withdrawal is nearly twice as high among those working part-time.

Table 7 Unintended Pregnancy Outcome Responses

<table>
<thead>
<tr>
<th>Frequency</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unintended Pregnancy in last 5 years</td>
<td>28 (24%)</td>
</tr>
<tr>
<td>Once</td>
<td>21 (75%)</td>
</tr>
<tr>
<td>Two</td>
<td>8 (25%)</td>
</tr>
<tr>
<td>Unintended Pregnancy Mistimed</td>
<td>22 (79%)</td>
</tr>
<tr>
<td>Unwanted</td>
<td>6 (21%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pregnancy Outcomes</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td>15 (54%)</td>
</tr>
<tr>
<td>Kept baby</td>
<td>11 (39%)</td>
</tr>
<tr>
<td>Miscarriage</td>
<td>3 (11%)</td>
</tr>
</tbody>
</table>

Transportation: Use of different transportation methods can be a function of many different motivations: distance, income, convenience, or ecological considerations. However, in the absence of a geographical analysis, transportation will be taken as the proxy indicator for distance and accessibility. For instance, as respondents that walk as their primary mode of transportation report the lowest rate of unintended pregnancy (13%), it could be inferred that they live in an area with readily available services, including health care. Women that primarily drive a car report the average rate of
unintended pregnancy (24%), while those that rely on the bus report higher than average rates (38%). Perhaps unsurprisingly, dissatisfaction with both current method and contraceptive care is highest among transit users at 38%, and negligible among drivers and walkers.

4.5. Limitations of the Study

These survey findings have four main limitations, which should be addressed with further targeted or comprehensive research:

First, although the entirety of the Yukon is northern and remote, only communities outside of Whitehorse are considered rural, as they are home to fewer than 10,000 residents and are removed from urban services and resources. For this reason, and due to the low response rate among rural respondents, the preceding study findings did not provide a breakdown of contraceptive care in urban and rural communities. Although it appears only five rural respondents completed the survey, this number may underestimate the number of respondents that lived or sought care in the rural communities over the past year. To ensure the experiences of rural women are not misrepresented, this study uses the lower rural response estimate.

Second, this study is focused specifically on the relationship between contraception and unintended pregnancy. As such, the investigation does not sufficiently address issues or experiences of access and care among diverse sets of individuals across the spectrums of gender identity, sexual orientation, biological sex, and gender expression. In addition, the limitation of eligibility to self-identified women may overlook pre-operative trans-men who are at risk of unintended pregnancy.

13 Specifically, of those respondents that report living in a different Yukon community in the year preceding the study (n=73), 16% report that they resided in a community with a population below 1500 people. This rate is in line with the 2006 Yukon Mobility and Migration census report that shows Yukon to have a 17% migration rate, with one-third of migration occurring intra-territorially. Though this means up to 15% of respondents may identify as rural residents, it is unknown what proportion of contraceptive care was accessed in a previous or current community.
Third, the study was furthermore limited to adult respondents. Unintended youth pregnancy is generally higher than that of adults, a trend that may have different influencing factors and therefore, required responses (Wellings et al, 2013; Guttmacher Institute, 2013).

Fourth, using satisfaction and perception as key indicators for quality in health care has some potential limitations: it is subjective, hard to measure, and may be prone to “courtesy bias” (Williams et al, 2000). This can be rectified in future surveys by using a validated survey tool.

4.6. Summary of Key Findings

Despite the above limitations, this survey makes an important contribution to research on the current status of contraceptive care in the Yukon, and on reproductive health more broadly.

The survey findings indicate that access to effective and high-quality contraceptive care varies across different key indicators and among different respondent groups, and that these differences are associated with unintended pregnancy. Specifically, three main themes can be identified, as follows:

• Availability of contraception is constrained by the limited constellation of authorized contraception providers, a barrier that is exacerbated by high rates of unattached respondents without a regular physician;

• Patient-centered contraceptive counselling appears to be an underutilized strategy to identify the best contraceptive methods to suit individual needs and preferences, as well as to promote the consistent use of more effective contraceptive methods; and

• Affordability appears to be a barrier for some respondents: method cost has an observable inverse relationship with selection and adherence to effective
contraceptives, and thus a negative impact on the accessibility and quality of contraceptive care.

As evidenced throughout the findings, these survey results both reflect and deviate from those found in national and international literature. Of particular importance is the findings related to unintended pregnancy. In particular, one quarter of the study respondents report having experienced an unintended pregnancy in the past five years. This finding reflects rates of 28% and 27% found in two previous Canadian studies (Fisher et al, 2004; Black et al, 2009). However, the demographic breakdown of this survey reflects a profile of low-risk for unintended pregnancy. For instance, research indicates that higher-income, white, and college- or university-educated women have rates of unintended pregnancy of less than half the national average in the United States (Guttmacher Institute, 2013). This indicates that the findings of this survey may underestimate the actual incidence of unintended pregnancy, and thus access to contraceptive choice and care.
Chapter 5. Discussion of Policy Alternatives

Unintended pregnancy is not a public health issue unique to Yukon or even Canada. International and national efforts to improve women's access to contraceptive care, or to sexual and reproductive health services more broadly, range from community based education to institutionalized national sexual health policies. Though varied in expression, these efforts reflect a movement toward “contraceptive convenience; to better integrate contraception into the everyday lives of women and to simplify women’s access to it” (Barot, 2008). The precepts of contraceptive convenience are manifest in a shared recognition that current models of contraception provision are unduly constraining women’s access in three central ways: failing to reflect medical and scientific advancements, relying on physicians as de facto “gatekeepers” of care, and failing to recognize women as responsible, competent decision makers in their own health care (Barot, 2008).

Although these initiatives offer best practices and lessons learned in reforming and transforming contraceptive care, the solutions are based primarily on urban issues rather than rural problems of access. As rural, remote, and northern women can be largely invisible within the literature on health needs, policies, and decision-making processes, these practices offer “urban solutions” that cannot be transposed directly on the Yukon context (Sutherns et al, 2005). For these reasons, the central dicta featured in these initiatives are employed in relation to the findings of this Yukon contraception study, and areas of similarity or difference are noted to ensure a robust comparison of alternatives.

The remainder of this chapter focuses on four recommended policy options that can mitigate barriers to contraception and thereby advance the agenda of contraceptive convenience in the Yukon. These options are based on information gathered in the
Yukon contraception surveys, key informant interviews, and a literature review of best practices in SRH care and access.

5.1. Nurse Practitioner Specialized Training

Nurse Practitioners (NPs) are governed by the Registered Nurses Profession Act and receive their license through the Yukon Registered Nurses Association (YRNA) that regulates nursing practice in the territory. The Order in Council permitting licensure of NPs was passed in October 2013, although the attendant professional regulations and recruitment strategy have yet to be made public. It is thus an opportune time to integrate sexual and reproductive health strategies into the NP regulations and suite of services to be delivered by incumbent NPs. Specifically, the legislation enables the prescribing authority required for contraceptive provision, as well as the abilities to perform IUD/IUS insertion and medical abortion, namely by enabling the diagnoses, screening, and testing for conditions, and performing “other procedures authorized by regulations.” In other Canadian and international jurisdictions, procedures also include the independent preparation, dispensation, or sale of prescription drugs by qualified nurses (Health Force Ontario, 2014). Evidence indicates that NP quality of care is higher or comparable to physicians with respect to patient outcomes, time spent in medical investigation, and overall patient satisfaction (Horrocks et al, 2002; Sangster-Gormley, 2012).

In order to fully realize the critical role of Nurse Practitioners in contraceptive care, counselling, and education, the following five steps can be taken to make sexual and reproductive health management a strategic goal:

First, ensure NP regulations facilitate provision of contraceptive management and medical abortion as needed. The Yukon survey findings indicate that nurses are an underutilized point of access for health and contraceptive care. Meanwhile, studies increasingly recognize NPs as unique healthcare providers that can simultaneously expand access to contraception, mitigate unintended pregnancy, and reduce health care costs (McEneaney and Hong, 2009). As NPs are widely demonstrated to address service gaps to underserved populations such as unattached patients, rural and remote
regions, and vulnerable or marginalized populations, they are a much-needed addition to the SRH care team (Gardner and Gardner, 2005; Offredy, 2000).

Second, develop, adapt, or deliver continuing education in specialized contraceptive training and decision support tools, as follows:

**Contraceptive management:** Canadian NPs are highly educated; the educational standard is a Master’s degree through an accredited graduate program. As such, minimal training is needed to ensure that all NPs have specialized training and skills in contraceptive management. Yukon College has educational agreements with secondary institutions in B.C. and Alberta, thus two training programs are identified as possible partnerships: BC Institute of Technology offers a 6-week online course in partnership with Options for Sexual Health on “Contraceptive Management in Reproductive Health” and the Alberta Society for the Promotion of Sexual Health offers 2-week online modules including one on “Birth Control Updates.”

**LARC insertion and removal:** The Yukon survey findings reveal that LARC use is on the rise, with many women indicating an interest or preference to switch to an IUD/IUS. However, service user and provider respondents indicate that some physicians are unfavourable or uncomfortable with providing these methods. U.K. and U.S. studies highlight the role of NPs in filling this service gap, and indicate an observed and positive association between practicum training in IUD insertion, greater and more accurate knowledge of patient eligibility and IUD risk profile, and a higher likelihood of routine counselling on IUD (Trouton, 2012; Harper et al, 2013). As such, it is recommended Yukon NPs undertake practicum training through, for example, 1-hour workshop or 4-hour clinicals, with attention given to nurses’ perceptions of risk areas such as failure of insertion, early expulsion, perforation, or eligibility of nulliparous women.

**Abortion:** The survey findings and key informant interviews each reveal barriers to abortion referrals and procedures, and low prevalence of medical abortions. This trend is not unique to Yukon, but rather is evident in northern and rural BC as well.

14 Medical abortion refers to a non-surgical abortion induced by pharmaceutical drugs.
(Dressler et al., 2013). In US, England, Scotland, and Sweden, NPs or their European equivalents have varying licensure and training in medical and early surgical abortions (Berer, 2008; Kishen and Stedman, 2010). This practice has been linked with improved access to early medical abortions, and an increasing frequency of medical abortions relative to surgical procedures (Berer, 2009; Kishen and Stedman, 2010). It is therefore recommended that Yukon NPs are able to make referrals for surgical abortion, and/or administer medical abortion. Steps such as self-referral may be considered to overcome a limited availability of dating ultrasounds reported by rural Yukon service providers (Guthrie, 2010).

Third, require at least one member of the YRNA Nurse Practitioner Advisory Committee to have specialized training or otherwise sufficient experience to support best practices in sexual and reproductive health strategic planning, management, and evaluation. Although on a different scale, this oversight is observed to have a benefit on certification and training in the U.K (Kishen and Stedman, 2010).

Fourth, develop a recruitment and mentorship strategy to supports NP community based research, opportunities for ongoing professional development, and the long-term sustainability of trained staff; a best practice that has seen higher retention of NPs in rural Australia (Gardner and Gardner, 2005). For example, cover the training costs of continuing education, and ensure a distribution of NPs in the communities to hazard against professional isolation or burnout.

Fifth, consider placing an NP on rotation in Many River’s Outreach Van to provide contraceptive care to marginalized populations in Whitehorse, as service provider survey respondents indicate that women who are homeless, substance users, and/or have mental health issues face the greatest barriers in accessing these services.

5.2. Pharmacy Access to Contraception

Yukon pharmacists are governed by the Pharmacists Act, which is overseen by both the Department of Health & Social Services and Department of Community Services. The Yukon Pharmacists Association, a voluntary professional association
comprised of 28 pharmacists practicing in the territory, offers additional oversight. In February 2014, the Association entered into collaboration with the government to review and update the Pharmacists Act, which does not presently support an expanded scope of practice for pharmacists practicing in Yukon. For instance, s.9 of the Act prohibits the provision of drugs without “written prescriptions signed by a medical practitioner,” a stipulation that can inhibit continuity of care and method adherence by precluding even emergency refills of contraception. YPA President Josianne Gauthier states that desirable amendments to the Act would enable pharmacists to fulfill their full scope of practice, as well as increase access to clinical pharmacists in rural communities.

In order to expand the clinical role and presence of Yukon pharmacists as qualified contraceptive providers integral to contraceptive care in the territory, the following six steps can be taken:

First, amend the Pharmacists Act to enable clinical pharmacists to initiate, modify, refill, and monitor prescription contraceptives, as well as refer for LARC and other sexual and reproductive health services. The Yukon survey findings indicate that pharmacists are an underutilized point of access for health and contraceptive care. Meanwhile, studies in the United Kingdom, United States, and Canada suggest that pharmacists are clinically competent and achieve comparable clinical outcomes to physicians when independently providing hormonal contraception or administering injectable contraceptives, and are also capable of referring women to sexual health or medical clinics for LARC methods (Parsons et al, 2013; NHS South East London, 2012).

Second, develop, adapt, or deliver a university-accredited course on clinical delivery of contraceptive services, to be completed via Yukon College or distance learning modules, and which requires the completion of clinical placement under supervision of a sexual health provider experienced in contraceptive counselling. Although the Yukon survey did not collect data on women’s perceptions of provider qualifications or training, the wider literature suggests that pharmacists are perceived as being qualified to provide contraceptive services among service users, physicians, and the pharmacist profession itself (Rafie, 2012; Landau, 2006; CART, unpublished). Several studies further suggest that this medical and patient acceptability is contingent
upon adequate medical screening and training. For instance, in a U.K. pharmacy access pilot, participating pharmacists were required to complete a 15-credit MSc module and 20-hour clinical placement under supervision of a physician or qualified nurse trained in SRH before taking part in the study (Parsons et al, 2012; NHS South East London, 2012).

Third, adopt the National Association of Pharmacy Regulatory Authorities resource for pharmacy operators, “Facilities, Equipment, Supplies, Workflow and Facility Re-Design” to ensure clinical standards of care are met on-site, such as private or semi-private counselling areas. Presently, not all Yukon pharmacies are equipped with an appropriate counselling area (Gauthier, February 2014). However, both the Yukon and international studies have found patient privacy to be of significant importance, including for women accessing community pharmacies in low population areas (Parsons et al, 2012).

Fourth, establish a pharmacy practice regulatory mechanism to ensure that clinical guidelines and criteria for contraception use are followed, including: WHO Medical Eligibility Criteria for Contraceptive Use, SOGC clinical guidelines on contraception, and the National Association of Pharmacy Regulatory Authority (NAPRA) guidelines on emergency contraception as a Schedule III drug. Some Yukon pharmacies fail to adhere to national guidelines on emergency contraception provision (Gauthier, February 2014) despite Community Services re-joining NAPRA as a full contributing member (Information Bulletin, July 2011). This divergence may undermine public or medical confidence in the clinical standards and clinical outcomes of pharmacy access that is enjoyed in other jurisdictions (Whelan et al, 2013; Gale and Watson, 2011; Bissel and Anderson, 2003).

Fifth, establish a reimbursement schedule for initial prescriptions, renewal, changes in dosage or directions for use, and medication therapy review or consultation with patients. Though not addressed in the Yukon survey or key informant interviews, the inclusion of a fee schedule to compensate the provision of clinical services under an expanded scope of practice emerges as an essential practice in the literature (Gale and Watson, 2011; Soon et al, 2004).
Sixth, design an incentive program to support clinical pharmacist recruitment in the rural communities. Yukon is unique from jurisdictions encountered in the literature review insofar as the totality of clinical pharmacists and commercial pharmacies are located in Whitehorse. While Dawson City and Watson Lake have “rural pharmacist” physicians that can prescribe, dispense, and sell contraception, this policy is inferior to hiring trained pharmacists for three main reasons: rural pharmacists’ care may be limited by conflicts of interest, method bias, or by risks to patient safety when the ordering physician is not fully informed on possible medication interactions, contraindications, or duplication of treatment. (Gauthier, February 2014) Subsequently, these providers may not be well suited for the pharmacy access scheme, and clinical pharmacists are needed to fill this service gap.

5.3. After-Hours Integrated Sexual Health Clinic

BC Options for Sexual Health is an organization of independent sexual health clinics that receives the largest share of its funding from the provincial government Health Services Authority, in addition to income taken in for contraceptive sales or services, including education or professional programming (Opt BC, 2013). Planned Parenthood is the U.S. equivalent of Options, and also receives its funding from a combination of government health services grant and reimbursements, and its own health services revenue (Planned Parenthood, 2013). Notably, Planned Parenthood receives a quarter of its funding from private contributions and bequests, likely due to the lack of universal health coverage in the U.S. that makes accessing health services markedly more difficult for certain women (ibid). Both have non-profit status, and a volunteer Board of Directors governs Options BC. In the survey of Yukon health providers, common and favourable mention was made regarding an integrated sexual health clinic that would serve as a “one-stop-shop” of contraception, options counselling, and education. This favourability is likely linked to reports of fragmented service provision among Communicable Diseases Centres, the Yukon Women’s Clinic, and limited access to family and walk-in physicians that can have “limited technical competence” in contraceptive care.
In order to support holistic and accessible contraceptive care in Whitehorse, the five following steps can be taken:

First, convene a Steering Committee to agree upon the structural framework of the clinic and produce a terms of reference or collaborative agreement to oversee clinic implementation and ensure continued integration of services. Committee members may represent Health & Social Services, Yukon Community Services, Ta’an Kwach’an Council and Kwanlin Dun First Nation, Yukon Medical Association, Yukon Registered Nurses Association, Yukon Pharmacists Association, and community organizations such as Blood Ties Four Directions Centre and Yukon women’s groups. Formalized agreements and collaboration with key community stakeholders are best practices in interagency service delivery; by managing expectations and establishing a sense of shared accountability, these organizing tools support initiative sustainability (Turner et al, 2013).

Second, staff the clinic with one or both a physician and licensed practical nurse (or nurse practitioner) trained in sexual and reproductive health, in addition to an office administrative assistant. SRH services span the spectrum of preventative healthcare, from cancer screening to STI testing, contraception provision, pregnancy options counselling, and abortion services. This co-location of service provision is a form of integrated, patient-centered health provision that is associated with improved health outcomes for patients that otherwise lack access to primary health care, and feature safe prescribing practices among clinic practitioners (Black, 2013).

Third, provide services in a discrete yet central location to ensure accessibility; and locate services in an existing facility to minimize costs. For example, Pine Medical Clinic, Horwoods Mall Medical Clinic, or Whitehorse Medical Centre may vary in terms of client capacity and privacy, but are all centrally located. Confidentiality and privacy are health service qualities that are highly valued among Yukon respondents and patients in several international studies. As studies reveal perceptions of stigma to be higher among women seeking contraception from an integrated SRH clinic than those accessing a family planning clinic, privacy should be priority when selecting the service location (Sauer et al, 2013).
Fourth, offer after-hours clinic services and/or weekend clinics, as demand requires. For instance, begin by offering a weekly clinic from 5-8pm. Although similar services to those of the clinic may be available elsewhere and at other times, research in B.C. indicates that even in settings where the Health Authority, physicians, or SRH clinics concurrently prescribe contraception, the limited availability of health care services dominated any potential duplication of services (Cook et al, 2006).

Fifth, organize the clinic to accept both walk-in patients and appointments that can be made in advance by phone or email. While neither the literature review nor the survey findings reveal this arrangement to be a best practice, it was observed to be commonplace in an environmental scan of Opt BC and Planned Parenthood clinics serving communities with populations approximating that of Whitehorse.

5.4. Universal Access to Contraception

Yukon has demonstrated its commitment to publicly funding sexual health through STI condom campaigns and provision of emergency contraception. However, these are less effective methods with specific regard to preventing pregnancy. By funding more effective contraception the Yukon government can deepen its commitment to sexual health in the territory. Service providers that took part in this study widely considered cost to be a barrier facing Yukon women seeking high-quality contraceptive services, and made repeat calls for free contraception for women. Although these requests do not specify how to fund contraception, respondents acknowledged that medical insurance coverage is not sufficient for all women, a finding that is further supported by the distribution of payment methods reported by service user survey respondents. Recommendations for full or partial Yukon government coverage of contraceptives were also put forth in a Symposium on Women’s Reproductive Health attended by rural and urban health service providers, health care professionals, and community workers (YSWC, 2012).

These local calls for publicly provided contraception are supported on a national and international level in two chief ways. First, cost-effectiveness studies reveal that promoting long-acting reversible contraception results in cost-savings to the medical
system and public sector at large (Sonfield, 2004; Sonfield, 2011; Mavranezouli, 2009; Frost et al, 2008; Pilgrim et al, 2010). Second, evaluations of public provision schemes repeatedly demonstrate that increased access to contraception yields cost-savings related to averted unintended pregnancy that greatly outweighs the initial costs of provision. For instance, cost-benefit ratios of 1:7 to 1:90 in per-dollar downstream savings in medical system, public health, and social services expenditures have been estimated in California, Sweden, and United Kingdom (Opt BC, 2010; Mavranezouli, 2009).

In order to ensure universal access to effective contraception in Yukon, four steps can be taken to remove cost barriers:

First, collaborate with the Yukon Formulary Working Group to include prescription contraceptives in the Yukon Drug Programs Formulary as a “Y” drug, with full coverage for all residents with a valid Health Care Card. This recommendation is in line with multiple European countries that provide publicly funded contraception to all citizens in either full or partially subsidized form, including the United Kingdom, France, the Netherlands, Belgium, and Denmark, among others. Although coverage varies from 20% of oral contraceptives in Belgium to 100% coverage for prescribed contraceptives in the U.K, this universal access scheme will maximize public equity while minimizing government administration overhead (Centre for Reproductive Rights; Opt BC, 2010).

Second, ensure full coverage for prescription contraceptives is available to newly immigrated women, in partnership with Yukon HSS and Department of Advanced Education. Lack of health coverage for newly arrived women was identified in the service provider survey findings, and is widely reported across Canada (Shoveller et al, 2007; Oxman-Martinez et al, 2005). Providing contraceptive coverage to recent immigrants waiting to qualify for Yukon Health Care will bridge an important yet oft overlooked gap in health service delivery.

Third, coordinate ordering and purchasing through Yukon Hospital Corporation in order to take advantage of bulk purchasing power. The challenges of providing high quality health services for a relatively small tax base is widely noted in Yukon (Yukon Health Care Review, 2008); this recommendation provides a strategy for increasing
access to care while procuring contraception at lower costs than on a per-pharmacy basis (Opt BC, 2010).

Fourth, identify contraception as a priority for joint purchasing initiatives through the Western Premiers’ Conference. This recommendation is a long-term strategy for mitigating up-front public expenditures on contraception provision, and aligns with Yukon’s Memorandum of Understanding on reducing pharmaceutical prices through joint purchasing initiatives with the Western provinces (Health Council of Canada, 2013). Each of the last two policy recommendations echo broader arguments either against the inefficiencies of multi-payer financing, or for the lower pharmaceutical costs associated with single-payer financing schemes (Blomquist, 2012; Morgan et al, 2013; Gagnon, 2010).
Chapter 6. Policy Objectives

6.1. Policy Objectives and Criteria

The preceding section of this study identifies four policy alternatives that the Yukon may consider for expanding access to high-quality contraception and related care in the territory. In order to assess the extent to which each alternative meets this chief purpose, the following evaluation criteria measure the ability of each option to meet three overarching policy objectives: equity, efficiency, and feasibility.

Table 8 Evaluative Criteria and Measures

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Definition</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity</td>
<td>The extent to which the policy expands the availability, accommodation, accessibility, affordability, and acceptability of contraceptive services</td>
<td>High&lt;br&gt;Medium&lt;br&gt;Low</td>
</tr>
<tr>
<td>Efficiency</td>
<td>The extent to which the policy reduces government net spending</td>
<td>High&lt;br&gt;Medium&lt;br&gt;Low</td>
</tr>
<tr>
<td>Feasibility</td>
<td>The likelihood that the policy will garner government support by addressing its strategic priorities, and stakeholder support such as medical professionals and the women’s community.</td>
<td>High&lt;br&gt;Medium&lt;br&gt;Low</td>
</tr>
</tbody>
</table>
6.1.1. Equity

For reasons demonstrated throughout this study, equity is of central concern when discussing sexual and reproductive health. Women are simultaneously more likely to use sexual and reproductive health services and face barriers in accessing this health care than their male counterparts. As demonstrated throughout this study, women are not a homogenous entity with identical relationships to the health care system. Rather, access and quality of care is experienced differentially among intersecting “social locations,” including rurality, remoteness, ethnicity, and class. The extent to which each policy alternative supports equity is therefore of paramount concern to its ultimate efficacy. To gauge this efficacy, five tenets of access form the evaluative criteria, as follows:

**Availability:** The extent to which the policy expands the volume and type of existing services and resources, as measured by new points of access, services, and provider qualifications.

**Accommodation:** The extent to which the policy improves the organization of care, as measured by hours of operation, appointment systems, and referral systems.

**Accessibility:** The extent to which the policy improves the location of services, as measured by the relative allocation of new services among geographical regions.

**Affordability:** The extent to which the policy improves the economic accessibility of contraceptive care, as measured by the reduced economic burden of contraception.

**Acceptability:** The extent to which the policy addresses perceived areas of priority, as measured by patient anonymity/confidentiality and duration of consultations.

6.1.2. Efficiency

The need for cost-effective health interventions within a context of rising budgetary pressures and increasing health system costs is clearly identified by the study, and is furthermore reiterated in the Auditor General Report on Yukon Health
Services and Program in 2011. The purpose of this efficiency objective is to evaluate the extent to which policy alternatives can expand access to contraceptive care along the following criteria:

Cost-effectiveness: The extent to which the policy increases or reduces government net spending within the overall Health & Social Services budget, as measured by benefits yielded (averted unintended pregnancy) less the costs incurred (overhead, training, or supply costs) as a result of expanding contraceptive services.

6.1.3. Feasibility

Feasibility refers to the social, political, and economic climate within which the issue of contraceptive care is located, and seeks to evaluate the extent to which the values or priorities of this climate favour different policy alternatives. This compatibility is critical both with respect to the structures and institutions governing contraceptive care, and to the adjudication of key stakeholders or decision-makers. As such, three key criteria are employed to evaluate the feasibility of expanding contraceptive care and access in the Yukon, as follows:

Integration: The extent to which the policy meets goals of health promotion and education established within the Yukon Health Care Review (2008), and as measured by the integration of contraception into overall SRH services.

Management and Implementation: The extent to which the policy options meets the priorities of sustainability and accountability set out in the 2008 Health Care Review and 2011 AG Report, and as measured by needs-based assessment, service design and delivery, and evaluation mechanisms.

3rd Party Acceptance: The extent to which political or public opposition will support or oppose the policy option, as measured by inferred or stated positions based on current policy, press releases or statements, and key stakeholder interviews.
Chapter 7. Analysis of Policy Options

7.1. Policy Evaluation

Throughout the first three components of the study design, best practices to ensure access to high-quality contraceptive care are identified, compared against trends in the provision of contraception services in Yukon, and evaluated to determine their relative cost effectiveness. Through this process, four policy options are identified.

The final component of the study is the development of a comprehensive evaluation framework by which to assess the relative effectiveness, relevance, and expense of these policy options within the context of the Yukon health care system.

This framework is comprised of 9 criteria that evaluate the degree to which each proposed policy option might improve women’s access to contraceptive care, and 18 quantitative and qualitative measures that evaluate the degree to which each criterion is being met (See Appendix A for the full summary list). While some criteria have multiple measures and others have just one, these diverse measures are standardized by scoring or ranking each out of three possible points. This enables comparison among criteria by designating each a high (3), medium (2), or low (1) score.

These criteria and measures are drawn from the literature review, survey findings, and informant interviews. Particular emphasis was given to the Yukon Government Department of Health & Social Services priorities as identified in the 2008 Health Care Review, recommendations advanced in the 2011 Auditor General’s report on HSS, and the Yukon Government’s 2012 Social Inclusion and Poverty Reduction Strategy. This framework enables an objective comparison and evaluation of the policy options in line with the priorities established by survey respondents, the Yukon Government, and Office of the Auditor General.
Nurse practitioner training is the policy option that receives the highest score when measured against this evaluation framework, while pharmacy access and SRH clinic tie for second place (Table 9). As a non-service based policy, universal access to contraception is excluded from this portion of the analysis, but evaluated using a cost-effectiveness framework below (Section 7.6.2). A sensitivity analysis was also conducted to determine whether or not the weighting of certain priorities could lead to different policy outcomes (Table 10). For instance, double weighting was applied to public equity and government efficiency criteria. In neither case did this adversely impact nurse practitioner training. However, double weighting of government efficiency did result in pharmacy access outranking the after-hours SRH clinic. This ranking highlights the relative favourability of NP training as a policy response, though further discussion is needed to determine whether and to what extent the other three options may still complement or enhance this option. This discussion is provided as follows:

7.2. Policy Recommendations

Based on the charts above, it is clear that nurse practitioner training dominates both pharmacy access and an after-hours SRH clinic in areas of public equity, government efficiency, and overall feasibility. Meanwhile, pharmacy access will outrank an after-hours clinic when government efficiency or public equity is prioritized. Given these outcomes, it can be concluded that nurse practitioner training may be most effective for addressing issues of contraception access and thus unintended pregnancy in the Yukon context, followed by pharmacy access, and then an after-hours clinic. As such, this study makes the following recommendations to address the policy problem:

Each policy presented in this analysis is based on best practices with demonstrable efficacy in expanding contraceptive choice and access, and thus averting unintended pregnancy and health system costs. In light of this efficacy, a three-stage approach is offered for consideration to the Yukon Department of Health and Social Services. By taking a multi-step approach, this suite of policy recommendations will help identify and attenuate potential barriers posed by implementation complexity, or the need to build public and government consensus around the proposed policy options.
Table 9 Summary of Criteria and Measures Evaluation (not weighted)

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Pharmacy Access</th>
<th>NP Training</th>
<th>After-hours Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
</tr>
<tr>
<td>Accommodation</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Accessibility</td>
<td>Medium</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Affordability</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Acceptability</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
</tr>
<tr>
<td>Cost-effective</td>
<td>Medium</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Integration</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Management &amp; Implementation</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>3rd Party Acceptance</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
</tr>
<tr>
<td>Total (/27)</td>
<td>17</td>
<td>22</td>
<td>17</td>
</tr>
</tbody>
</table>

Table 10 Summary of Criteria and Measures Evaluation (Equity & Efficiency x 2)

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Pharmacy Access</th>
<th>NP Training</th>
<th>After-hours Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
</tr>
<tr>
<td>Accommodation</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Accessibility</td>
<td>Medium</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Affordability</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Acceptability</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
</tr>
<tr>
<td>Cost-effective</td>
<td>Medium</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Integration</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Management &amp; Implementation</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>3rd Party Acceptance</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
</tr>
<tr>
<td>Total (/45)</td>
<td>30</td>
<td>37</td>
<td>26</td>
</tr>
</tbody>
</table>

First, the pressing need for improved access to contraception indicated within this study requires an immediate policy response. In the short-term, it is essential that the forthcoming regulations on Yukon nurse practitioners appropriately regulates and
funds the training of these providers. As nurse practitioners already have the advanced training and skillset required to successfully complete required training, and as institutions such as BC Institute of Technology provide ongoing certification courses, this option supports a swift, cost-effective, and easily implemented policy response unlikely to face opposition from government or 3rd party stakeholders.

Second, it is important to recognize that the complex issue of contraceptive access and unintended pregnancy may not be resolved with a single strategy. Rather, it is possible to develop a comprehensive and strategic policy response. To that end, a pilot pharmacy access scheme is recommended as a medium-term policy response. As the Pharmacist Act does not presently support an expanded scope of practice for pharmacists practicing in the territory, and as negotiations on amending the Act are currently underway, it is expected that implementation will face delay. However, it is noteworthy that such a delay may benefit the feasibility of the pilot, by providing initiative stakeholders more time to build public or medical awareness, confidence, and support around pharmacy access to contraception. An additional benefit of the pilot program is that it will enable responsive and evidence-based evaluation of the policy option to ensure maximum quality and efficacy.

Third, while the after-hours integrated sexual health clinic is a feasible option that will be easy to implement, it ranked lowest of the three service-based policy options. In addition, it requires the highest government resources in both up-front time and ongoing operational costs, with unknown impact on public uptake of the service. For these reasons, it is recommended that the clinic option be reevaluated following the impact evaluations of the nurse practitioner and pharmacy access schemes.

Fourth, universal access to contraception is recommended as a long-term response. This option is the only alternative to directly address the barrier that method costs pose to access, and may have the most demonstrable impact on government savings by increasing access to more effective contraception methods. Despite such benefits, introducing this option as a long-term response has two benefits. First, this option is the most likely of all policy responses to suffer from contention and low government or public support. Delaying introduction until cost savings from reduced
unintended pregnancies are evidenced will bolster feasibility. Second, although this option could stand alone, it will be even more effective if free contraception is accessed through a qualified provider offering patient-centered contraceptive counselling. As such, this option may be better served if introduced after NP and before or after pharmacists’ training.

The remainder of this chapter provides further discussion on the extent to which each policy option addresses the issues of contraceptive access and care in Yukon, as indicated by the evaluation framework delineated above. This discussion is laid out with reference to the recommended multi-step approach, beginning with nurse practitioner training, and concluding with an analysis of the universal access policy.

7.3. Analysis of Specialized Nurse Practitioner Training

Framing Assumptions

Two assumptions are made for the purpose of this analysis: 25 nurse practitioners from 13 rural community health centres and 10 urban facilities will partake in the training program, and training expenditures will reflect course fees of BC Institute of Technology’s online contraceptive management course for RNs.

7.3.1. Equity

Availability: Ensuring Yukon nurse practitioner regulations enable NPs to prescribe, dispense, and sell prescription contraceptive methods, insert IUD/IUS, and provide medical abortions will empower these medical professionals to provide health care that is commensurate with their education and qualifications. However, as women’s sexual and reproductive health content may vary among educational programs, it is advisable that specialized training in contraception be available to NPs practicing in Yukon. To be sure, other NP studies have referenced “diffusion of innovation” theory to underscore the importance of investing in new clinical practices (Berwick, 2003). Education is one such form of investment, and will carry high returns in two key ways. First, NPs are primary health providers that offer both preventative health and treatment.
For this reason, NPs will come into contact with various patients for reasons other than their contraceptive needs. By investing in contraceptive training and management, these NPs will have the skill and confidence required to integrate contraceptive care into daily health provision, potentially reaching individuals who would not otherwise be offered or seek out this care. To this end, NP training is unique among other options, and may offer contraceptive access to a broader range of women. Second, there are several studies that suggest NPs without SRH training are both more likely to have misconceptions about LARC eligibility and risk, and less likely to offer and provide these more effective methods (Trouton, 2012; Harper et al, 2013). By offering continuous opportunities for specialized, experiential skill training, this option concurrently broadens the constellation of contraceptive providers while also supporting wider availability and use of LARCs.

Accommodation: Although NPs typically have more flexible schedules than doctors or pharmacists and are more likely to provide in-home care; these strong indicators of accommodation will be constrained if NPs work in community health centres and physician or walk-in clinics. Specifically, NP service provision in healthcare facilities will be limited by a near universal prevalence of weekday hours of operation among such locations, and by the existing walk-in or appointment structure. However, NPs are able to provide services that pharmacists cannot, including LARC insertions and medical abortion. This will support streamlined and same day service provision, an important consideration in ensuring contraceptive convenience.

Accessibility: A major strength of this policy option is the broad distribution of newly trained providers and attendant services across the territory. NPs have been widely successful in addressing service gaps in rural and remote areas, and in working with underserved populations that typically have higher rates of method discontinuation and method failure (Harper et al, 2013). As such, NPs will engender more equitable, accessible, and higher quality of care in rural communities. However, retention may require certain incentives, in terms of remuneration, professional development, and research or mentorship opportunities. Similarly, NPs working in Whitehorse may be able to better provide services to marginalized or vulnerable populations, including those who are street involved, substance users, or have precarious housing status.
Affordability: This option will have no discernable impact on affordability, although it is noteworthy that regulations prohibit NPs from profiting from prescription drug sales, a convention that will hazard against marking up contraception prices.

Acceptability: Although NPs located in physician offices or community health centres may not be able to offer the same levels of privacy as those able to make home visits, this limitation is offset by the length of time that NPs are able to dedicate to patients. Specifically, a 2006 Ontario primary health care nurse practitioner study indicates that NPs spend an average of 30 minutes with patients (Donald et al, 2010), though an earlier U.S. study sets this time at 19 minutes (Mendenhall, 1980). In either case, NPs offer the longest estimate for patient consultation among all options, a feature that will support patient centered contraceptive care, counselling, and higher levels of method efficacy and satisfaction.

7.3.2. Efficiency

Cost-Effectiveness: NP training will cost the government an estimated $12,500 in up-front training for 25 NPs, and $1,000 thereafter for two additional NPs annually. As NPs are salaried government or private health care providers that are already being recruited to provide a range of services in the territory, these training expenditures are the sole outlays required by the government. Should the recruitment not yield as many workers as required to meet the assumptions of this analysis, either efficiency or availability and accessibility will be negatively impacted. However, if this number proves accurate, NPs will provide a cost-effective means for raising the accessibility and quality of contraceptive care in the Yukon, while simultaneously reducing costs.

7.3.3. Feasibility

Integration: NPs are qualified to provide health promotion services, STI/HIV testing, cervical cancer screening, and pregnancy options counselling. Some NPs can also be effective in identifying or supporting women that experience sexualized violence or gender based violence – both of which are associated with higher risk of unintended pregnancy and poorer health outcomes (Planned Parenthood, 2012; Pallitto, 2005). As
such, NPs are well positioned to support integrated SRH services, and offer comprehensive sexual education programs to the public if the opportunity should arise.

Management & Implementation: By codifying an expanded role for NPs in provision of contraception and related care in Yukon, NP legislation and regulations will help support initiative accountability and sustainability. Similarly, the Yukon Registered Nurses Association can encourage, monitor, and evaluate knowledge and adherence to clinical practice guidelines and standards. While NPs are in an excellent position to collect data related to contraception use, unmet contraceptive need, and general trends across demographic groups, there is currently insufficient data management or data sharing processes to fully realize this capacity. Should data sharing progress, NPs will be key allies in the development of a needs-based, responsive SRH strategy.

3rd Party Acceptance: The YRNA is likely to have high levels of support for this policy option, as it will enable NPs to exercise their full scope of practice in matters of SRH, as well as provide funded opportunities of professional development. YPA president Josianne Gauthier also indicates that pharmacists support the advancement of NPs as key partners in integrated health care teams. While physicians may perceive NPs as potential competition to their fee-for-service profession, the relief NPs will bring to a health system facing an ongoing physician shortage will likely overshadow any proclivity toward “turf wars” (DiCenso et al, 2005).

7.4. Analysis of Pharmacy Access to Contraception

Framing Assumptions

Three assumptions are made for the purpose of this analysis: 19 pharmacists from 6 commercial pharmacies will partake in the pharmacy access program; accreditation courses are funded by the Yukon government at a rate of $1365 per pharmacist; and one additional pharmacist will be funded for accreditation annually.
7.4.1. Equity

Availability: Amending the Yukon Pharmacists Act will permit pharmacists to fulfill an expanded scope of practice more befitting to their level of education and training. In so doing, this option will expand the available constellation of qualified providers and increase access for “unattached” patients that are currently face barriers to both prescription contraceptive methods and related counselling. As pharmacies offer all but IUD/IUS insertion and permanent contraceptive procedures, this policy will also widen access to a range of contraception methods. In order to maximize the benefits of this option it is essential that pharmacists undergo accreditation in contraception provision. Such training has two main strengths: First, Yukon pharmacists hail from jurisdictions across the country and may have incongruent technical or experiential knowledge. Uniform training will harmonize knowledge and equitable public access to accurate information. Second, university-accredited courses support high-quality contraceptive care comparable to other primary care providers. The recruitment of pharmacies and their attendant pharmacists will ensure continuous public access to trained staff, even in the context of changing work schedules or sick leave.

Accommodation: Pharmacy access to contraception scores highest among the policy options in respect to accommodation due to its three key advantages as a point of access. First, pharmacy hours of operation provides access on weekday evenings, weekends, and even holidays, when physician offices or clinics are generally closed. Second, access to a pharmacist requires neither an appointment nor a long wait, and instead offers drop-in service provision that will be more convenient for some women. Third, this expanded access will relieve pressures on physician office and emergency rooms to refill prescriptions; thereby streamlining services and further reducing overall wait times.

Accessibility: One limitation of this option is that the allocation of new services will not be geographically equitable, but rather concentrated primarily in Whitehorse. If the rural incentive program is adopted, this limitation can be redressed as services are extended to more rural and remote areas. Due to the unknown costs and public acceptance of this initiative, rural clinics are not considered in this analysis.
Affordability: This option is unlikely to have a discernible impact on affordability so long as legislative safeguards preclude conflicts of interests wherein pharmacists or rural clinical pharmacists may benefit financially from the sale of prescription drugs they provide. Such safeguards are particularly needed in a territory that permits up to 30% mark-ups on pharmaceutical drug pricing (Government of Yukon, 2008).

Acceptability: Pharmacy access supports privacy to the extent that pharmacies are a multiple purpose venue that are frequented for an assortment of reasons. So long as appropriate structural provisions are in place to support patient privacy, this option will provide a familiar point of access that is acceptable to patients. Having multiple sites offering pharmacy access is an important factor in ensuring patient privacy, as it provides alternate points of access for women that perceive a lack of anonymity to be a barrier to care. Finally, pharmacy access pilots in U.K. furthermore indicate that community pharmacists are able to provide longer consultations than in a physician setting; range: 13-21 minutes; average: 19 minutes. (Parsons et al, 2013).

7.4.2. Efficiency

Cost-Effectiveness: Pharmacy access will incur approximately $26,000 in government expenditures on up-front training costs. Pharmacists’ subsequent expanded scope of practice must be appropriately reimbursed through a fee schedule. For instance, B.C. reimbursement ranges from $10 for prescription adaptations to $60 for “medication review” (BC Pharmaceutical Services Division, 2011). A study on pharmacy access to contraception in U.K. notes pharmacy consultation fees are lower than those seen in both family physician offices and SRH clinics. Ultimately, this policy option will incur an up-front training cost that is higher than for nurse practitioners. Yet, community pharmacists are ultimately private sector workers that offer lower-cost alternatives to ongoing services than publicly funded physician fees or public nurse practitioner wages. A potential constraint on long-term cost-effectiveness is limited retention of trained pharmacists. However, as there is no publicly available data on the turnover rate for this profession in Yukon, the constraint is considered null for the purpose of this analysis.
7.4.3. Feasibility

Integration: To the extent that signposting is fostered among health care providers, and to the extent that pharmacists have sufficient knowledge of local SRH services, pharmacy access to contraception will support integrated SRH strategies.

Management & Implementation: Facilitating pharmacy access through legislation is a key component in ensuring initiative accountability. Likewise, the Yukon Pharmacist Association will be a key player in monitoring and evaluating initiative adherence to appropriate clinical practice guidelines and standards. While current infrastructure includes computer programs to review medication profiles or flag drug interactions, it does not support e-pharmacy or e-prescribing services found in other jurisdiction. However, the pending implementation of a territorial drug management system will help facilitate the data collection required to track contraceptive use and trends, and support the ongoing development of an evidence-based, responsive SRH strategy.

3rd Party Acceptance: The Yukon Pharmacists Association will be firmly onside with this policy option, due to the expanded scope of practice and enhanced status of the profession. Individual pharmacists are also likely to support the initiative as it offers an opportunity to fulfill professional requirements for ongoing training without any great personal financial cost. Potential resistance from nurses or physicians may be overcome with the knowledge that pharmacists receive university accreditation in contraception provision, as well as increased interaction as referral systems are put in place and increasingly utilized. Public acceptance has been demonstrated through ongoing uptake of emergency contraception pills in a pharmacy setting, as well as in existing pharmacy access programs.

7.5. Analysis of an After-Hours Integrated Sexual Health Clinic

Framing Assumptions

Three assumptions are made for the purpose of analysis: the clinic will be staffed by one physician, nurse practitioner, and administrative assistant; the clinic will offer a
full range of contraceptives for purchase on-site; and that the government will fund the clinic by subsidizing the rent of the hosting site and hourly wages of health staff.

7.5.1. Equity

Availability: An after-hours integrated sexual health clinic will not greatly improve availability beyond what services can be offered independently by physicians and nurse practitioners. However, by bringing these providers together for the purpose of providing integrated sexual health, this policy option provides a high-value point of access for dedicated contraceptive care.

Accommodation: As the clinic is essentially a one-stop-shop for contraceptive care, it supports the tenet of contraceptive convenience by offering direct access to a range of methods, services, and supplies for purchase. Convenience will also be supported should the clinic offer a combination of walk-in and appointment services. The main constraint of this option is its limited hours of operation. While the clinic will extend contraceptive services into the early evening hours, doing so once or twice per week means that it scored lower than both pharmacy access and NP training.

Accessibility: Having the sexual health clinic based in downtown Whitehorse has the benefit of being generally accessible to the majority of Yukon residents. However, it does not address the reality of underserved rural populations. To the extent that the clinic will provide a high-quality alternative of care for rural women who travel into Whitehorse, it may have some benefits for women from the communities. In general, however, the clinic ranks lower than pharmacy access and NP training.

Affordability: Opt BC and Planned Parenthood clinics offer subsidized contraception to patients. Should this clinic offer a similar service; it would have a positive impact on increasing the affordability of contraception for women. However, as the funding for such subsidies are limited, this may mean only some methods would receive this benefit as opposed to the full range of available methods.

Acceptability: Some women may prefer to visit a dedicated sexual health centre due to perceptions about provider qualifications, the likelihood of receiving unbiased or
non-judgmental care, or the quality of care in a clinical setting. For this analysis, the ranking for acceptability cannot reasonably measure or account for these variables. The central benefit of this option is the estimated length of consultations reported in other U.S. and U.K. sexual health clinics, from 21-23 minutes (MacKay and Cole, 1996; NICE, 2011). Although this is longer than that found under a pharmacy access scheme, it is shorter than the NP initiative. By contrast, a limitation of this option is that sexual health clinics provide moderate privacy in a small town, even when located in a multipurpose or discrete location, as those accessing the service may encounter others with whom they are acquainted. Though this may not be an overriding concern for all women, it could be a deterrent for some. As such, conducting a focus group with women in the community may help determine the priorities and preferences of the target population, particularly with regard to where, when, and by whom services are offered.

7.5.2. Efficiency

Cost-Effectiveness: An after-hours sexual health clinic offers more opportunities for cost-effective service delivery than will be found for a stand-alone clinic. Certainly, repurposing or sharing clinical space with a practice that already covers overhead costs is a pragmatic alternative. Unless an agreement is negotiated wherein access to the site is volunteered, the government can offer to subsidize the overhead costs of the practice in question. The following assumptions can be made to estimate the value of this subsidy: overhead costs are 26% of physicians’ annual salary, average annual salary for Yukon physicians is $317 000, and average hourly wages for NPs is 46$ per hour in Canada (Yukon News, 2013; Globe and Mail, 2013; Mathai, 2012). Based on these assumptions, if services are offered once per week in four hours time slots, the annual funding is an estimated $8232 for the overhead cost and $7968 for clinic staff. Supposing potential variation in clinic staff (e.g. NP-led clinic) and overhead costs (e.g. the hosting practice negotiates a higher subsidy of 15%), the annual costs of the clinic can range from $11,000 to $22,500. In either case, the clinic will likely require more government funding than either of the first two options.
7.5.3. Feasibility

Integration: Being a one-stop-shop for sexual health care, the after-hours clinic is a source of increased service integration, particularly as the physician and NP on-site will be specialists in the field.

Management & Implementation: As an unlegislated initiative that is not regulated or otherwise formally overseen by a health authority, the after-hours clinic may not be publicly accountable to the same degree as the first policy alternatives. However, an interagency governing body such as a steering committee (short-term) and board of directors (long-run) will be effective mechanism for ensuring transparency and high quality service delivery and evaluation. This interagency collaboration can also help foster relationships among various health and community stakeholders, which may, in turn, engender increased data sharing and the development of needs-based policy responses to contraceptive needs and unintended pregnancy in the territory.

3rd Party Acceptance: Support for an after-hours clinic in Whitehorse will likely gain high acceptance among the medical community and public at large, largely due to its potential to relieve pressure on current medical services. Indeed, a dedicated sexual health clinic appeared to be top of mind for many respondents in each study survey, when respondents were asked about either their experiences accessing health care, or about how to improve access to contraceptive care in the territory. Should a clinic be supported as a viable policy alternative by the government, it is noteworthy that a need for ongoing funding is a critical feature of success in other jurisdictions.

7.6. Analysis of Universal Access to Contraception

7.6.1. Equity

As roundly established in the literature and survey findings, contraceptive access is adversely impacted by cost. By removing the economic burden that is borne in full or part by the majority of women, publicly funded contraceptives will support both the affordability and economic accessibility of contraception. This public provision of
contraception must be universal in both range and scope. First, funding only part of the full range of contraceptive methods would unduly constrain another tenet of access: that of availability. Second, universal access to contraception overcomes the observed inequities in access among groups of women that are differentiated on the basis of their relationship to income, employment, or existing health insurance.

7.6.2. **Efficiency**

Publicly funded contraception has a demonstrably positive impact on the efficiency policy objective. In order to fully understand the value or significance of this policy for the Yukon government, the following model estimates the potential cost savings generated by universal access to contraception. The model employs survey findings to approximate method use and unintended pregnancy outcomes in Yukon, and cost data are sourced from CIHI and Yukon HSS records as required.

**Step One: Identifying Pregnancy Outcomes in Yukon**

According to Statistics Canada, in 2012-2013 there were 440 live births in Yukon. In the most recently available CIHI data from 2011, there were 155 induced abortions, with an additional 23 procedures performed outside of the territory. The prevalence of unintended pregnancy based on method choice is calculated using the unintended pregnancy rate and distribution of method use found in the study survey, in addition to “typical use” failure rates reported in the Yukon HSS brochure titled, Birth Control Methods. For instance, of 618 total conceptions, an estimated 148 are unintended (see Table 11).  

**Step Two: Identifying and Estimating Costs of Unintended Pregnancy in Yukon**

This analysis estimates the direct medical costs incurred by women experiencing an unintended pregnancy in the Yukon under a universal access scheme. Direct medical costs

---

16 This estimation may significantly underestimate the incidence of unintended pregnancy in Yukon. First, the total number of estimated unintended pregnancies is lower than reported abortions. Second, if roughly equal numbers of unintended pregnancy result in abortion and live birth, as many as 356 of the total 618 reported conceptions could be unintended (58%).
costs are therefore the sum of method provision and maternal pregnancy outcomes. In the former, average method values are estimated from costs identified in manuals published by women’s health organization. In the latter, the average costs of unintended pregnancy outcomes are derived from CIHI data on live hospital birth and induced abortion. Both the survey results and literature indicate that about half of all unintended conceptions result in equal numbers of abortion and live birth.

**Live Births**

In Canada, an average 1 in 10 dollars spent on hospital care goes towards obstetrical care, with 0.60 going towards maternal inpatients and 0.4 towards newborns (CIHI, 2006). Adjusting 2002-2003 physician-payment data collected by CIHI for inflation, the average annual cost per maternal patient for in-patient obstetrical care is $3621. While CIHI does not provide an average cost estimate for hospital care of newborns, it can be calculated by finding the difference between total obstetrical and maternal costs, or $2414 (CIHI, 2006).\(^{17}\)

**Induced Abortion**

CIHI does not provide average patient costs for therapeutic abortions in Yukon. Nor does it estimate the incidence of abortions beyond 12-weeks gestation that require insured health coverage for travel to southern facilities to obtain the procedure. As such, three assumptions are made to estimate the value of abortion in Yukon: costs for in-hospital induced abortion is conservatively estimated to be $1000; estimates suggest that 90% of all abortions take place within the first 12 weeks of pregnancy; and low-estimate return airfare to Vancouver ($600) will serve as a proxy for travel costs incurred for the remaining 10% of abortions obtained out-of-territory.\(^{18}\) Costs of ectopic pregnancy and miscarriage are excluded due to a low combined incidence of less than three percent.

---

\(^{17}\) Nearly all live births in Yukon are delivered in Whitehorse General Hospital.

\(^{18}\) Note that the 2011 CIHI data indicates that 13% of abortions were obtained out-of-territory.
Table 11 Cost of Unintended Pregnancy Outcomes in Yukon for 2011-2012

<table>
<thead>
<tr>
<th></th>
<th>Number of Cases</th>
<th>Average Cost per Case</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion cost pre-12 weeks (0.9 of total)</td>
<td>67</td>
<td>$1000</td>
<td>$67 000</td>
</tr>
<tr>
<td>Abortion cost post-12 weeks (0.1 of total)</td>
<td>7</td>
<td>$1000 + $600 travel = $1600</td>
<td>$11 200</td>
</tr>
<tr>
<td>Cost of live births (maternal + newborn)</td>
<td>74</td>
<td>$3621+ $2414 = $6 035</td>
<td>$446 590</td>
</tr>
<tr>
<td>Total</td>
<td>148</td>
<td>$3546</td>
<td>$524 790</td>
</tr>
</tbody>
</table>

Step Three: Estimating Cost-Effectiveness and Assessing Against Sensitivity Analyses

Based on the estimated average costs of live birth and abortion outcomes associated with unintended pregnancy in Yukon, a base case scenario is established wherein an annual cost of $524,790, or per-case cost of $3546, is incurred by Yukon health care system. Assuming a time horizon of ten years and standard discount rate of 3%, this base case has a net present value (NPV) of $5.8 million dollars in health care costs.

Total NPV of Unintended Pregnancy Medical Costs = $5 772 690

This base case can be compared against three alternative contraceptive scenarios, as suggested by the survey findings and literature.

Scenario One: Following the removal of financial barriers to LARC methods, the first scenario estimates the uptake IUD/IUS use among Yukon women. As 25% of survey respondents reported they would switch to a different method if it was covered, and two-thirds of women in a 2012 study state a preference to switch to IUD, the uptake of IUD/IUS is estimated to be 17%. Under this formula, contraception provision will cost the government $14,740 annually. Assuming the reduction in other method use is equal,
a total 42 unintended pregnancies are averted, resulting in a cost savings of $148,932 (a cost-benefit ratio of $1 to $10). In other words, increasing LARC use by 17% will generate net benefits of an estimated $134,192 annually (averted medical costs less public expenditures on contraception). This means the NPV of health care costs is $3.7 million dollars, or that increasing LARC use yields $1.3 million in benefits over a ten-year time horizon.

Scenario Two: In order to account for the pregnancy intentions of Yukon women, the second scenario applies a higher discount rate of 5% to reflect the high incidence of mistimed pregnancy reported in the survey. Under this scenario, costs are deferred to a future time when some women will have a child at the time of their choosing. In the scenario, some 80% of those who experienced a mistimed pregnancy in the past five years reported a mistimed pregnancy. Under this scenario, the total NPV cost is $3.4 million, and $1.2 million in benefits are realized over a ten-year time horizon.

Scenario Three: In order to account for the possibility of method discontinuation and evaluate the extent to which method switching impacts public expenditure on LARC methods, the time horizon is shortened from ten years, to two years. As IUD/IUS has high up-front costs, a ten-year time horizon allows the full benefit of LARC coverage to be realized. By reducing the time horizon and retaining the discount rate of 5%, it is possible to suggest the impact of early method discontinuation for the purposes of having a child in the next two years, as 25% of survey respondents indicated. In the end, this means the NPV of health care costs is $2 million, and that roughly $700,000 is yielded in benefits.

In each of the three scenarios above, it is clear that public provision of contraception will reduce the direct medical costs incurred by unintended pregnancy, even when a higher discount rate and shorter time horizon are used. This means that net benefits accrue to government even if it funds more expensive LARC contraceptive methods, even if some averted unintended pregnancies are mistimed and the cost is deferred to some future time, and even if women switch methods before the net benefits are fully realized. Certainly, one key limitation of this policy is the possibility of frequent method switching and attendant rise in public expenditures. Although women may be
more likely to switch methods under a universal access scheme, this might have more to
do with the barriers cost pose to consistent use of effective methods than a sense of
social license. Specifically, women who are dissatisfied with a method may try several
different methods before finding one that suits their needs, but will also be more likely to
find and consistently use a more effective and satisfactory method.

Recalling that conservative cost estimates are used in this analysis, that no direct
or indirect non-health expenditures related to unintended pregnancies are included as
cost savings, and that the actual unintended pregnancy rate is likely higher than that
used here, it is reasonable to assert that public provision of contraception will yield net
benefits and cost-savings higher than those suggested here. In short, the benefits of
publicly providing contraception will easily outweigh the initial costs of coverage.

Table 12 Estimated Cost-Savings of Increasing Contraception Use in Yukon

<table>
<thead>
<tr>
<th></th>
<th>Base Case</th>
<th>Scenario 1</th>
<th>Scenario 2</th>
<th>Scenario 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>42 averted</td>
<td>1 278 876</td>
<td>1 170 387</td>
<td>715 173</td>
</tr>
<tr>
<td></td>
<td>3% discount</td>
<td>(-) 3 772 478</td>
<td>(-) 3 406 692</td>
<td>(-) 2 081 682</td>
</tr>
<tr>
<td></td>
<td>10 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NPV Benefits</td>
<td>--</td>
<td>2 493 602</td>
<td>2 236 305</td>
<td>1 366 509</td>
</tr>
<tr>
<td>(-) NPV Costs</td>
<td>n/a</td>
<td>(-) 3 279 088</td>
<td>3 536 385</td>
<td>4 406 181</td>
</tr>
<tr>
<td>NPV Cost-Savings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NPV Costs</td>
<td>5 772 690</td>
<td>3 279 088</td>
<td>3 536 385</td>
<td>4 406 181</td>
</tr>
</tbody>
</table>

7.6.3. Feasibility

Integration: Universal access to contraception may encourage women that
express a desire to switch to more effective methods to seek contraceptive care or
counselling where they may not have done so before. This option will support integration
to the extent that new or targeted contact with health care providers increases knowledge or access to additional sexual and reproductive health services.

Management & Implementation: Some research suggests that the difference between free and low-cost contraception may have limited impact on contraceptive use. That said; the administrative complexity required to manage a subsidy policy might incur more government resources than simply providing universal access. Meanwhile, the bulk purchasing of contraception will require government resources, but should be easily streamlined into existing processes at Whitehorse General Hospital.

3rd Party Acceptance: Service providers and users survey respondents indicate wide support for free contraception as a key factor in improving access to contraceptives in Yukon. Similar support was shown at a Reproductive Health Options Symposium hosted in Whitehorse in 2012 that was attended by both urban and rural non-profit, government, and community workers (YSWC, 2012). Although the positions of Yukon doctors and nurses is not known, it can be assumed that doctors will support free access, due to the 2011 Canadian Medical Association resolution to this effect. Overall, third party acceptance will likely be at moderate or high for this policy alternative. The greatest resistance can be expected to come from government, due to the limited application of free contraception in Canada.
Chapter 8. Conclusion

First and foremost, this study is a preliminary investigation into the causes and rate of unintended pregnancy in Yukon. Specifically, this study investigates the potential relationship between unintended pregnancy, availability or quality of contraceptive care, and women’s experiences in accessing this care. It is the first study of this kind in the Yukon; though research remains limited on the issue of contraception access across the country, and particularly among rural, remote, or northern communities. As such, this study is not only an important contribution to the limited literature on women’s health in northern Canada, but will also help bring Yukon women’s health needs to bear on national and territorial discussions of health care policy, programs, and services where they have long been invisible, or subject to imported solutions from southern jurisdictions. To this end, the study is a first step towards developing responsive and evidence-based policy solutions that will improve the health and lives of Yukon women.

The research findings indicate a relationship between access to contraception and unintended pregnancy in Yukon, as was indicated by the high rate of abortion in the territory. More specifically, the research demonstrates that access and use of contraception depends on three key, interrelated factors: availability of authorized contraception providers, effective contraceptive counselling, and the affordability of contraception. Best practices on sexual and reproductive healthcare delivery, which speak to these three priority areas of access, are both identified and evaluated to determine their suitability within the Yukon context.

This study furthermore demonstrates that increased access to contraception will result in cost-savings to the government that far exceeds any expenditure incurred through provision of expanded health care services or contraception. As this savings flows from the reduced rate in unintended pregnancy, it is clear that access to choice
and high-quality contraceptive care carries significant benefits for both women and government, and therefore warrants effective government intervention.

The proposed recommendations offer effective strategies for expanding access to contraception in Yukon. At the heart of this strategy is an expanded constellation of healthcare providers trained in patient-centered contraceptive care and counselling, and with the authority to mitigate unmet need for contraception in the territory. In line with these priorities, the recommended short-term policy option is that nurse practitioners be provided with the specialized training and prescribing authority to independently offer, administer, and manage contraception and related services. In the medium and long-term, strategies of pharmacy access, after-hours sexual health clinics, and universal access are additionally recommended. As Yukon government is both the key player and source of expert knowledge for the implementation of these recommendations, it is essential that appropriate representatives of Health & Social Services, Community Services, and Insured Services be engaged and consulted in the early days of future strategies to enact or amend said recommendations.

These strategies will require further evidence-based research on contraception access and care in the rural communities, and among vulnerable and marginalized populations. Government collaboration with professional associations, relevant community and non-governmental organizations, and research organizations\(^\text{19}\) will help ensure that both this research and subsequent health services are community-centered and responsive to the needs of the population. This collaboration may be well served by observing best practices in interagency partnerships, such as early engagement, co-design, and local solutions for local issues. Early engagement is an opportunity for government to identify, understand, and maximize collective community strength and knowledge; this practice increases community uptake of initiatives, and fosters the development of accessible, responsive, and culturally appropriate and sustainable services. Co-design is a strengths-based approach that marries community priorities with formal government processes, ensuring that each partner, regardless of size, is

\(^{19}\) For example, the Contraceptive Access Research Team based in B.C. and associated with UBC and Women’s Health Research Institute is currently conducting research on community-based primary health care and contraceptive access in Canada.
able to contribute according to their capacity and skill; this practice harmonizes diverse priorities and supports partners in developing projects that enjoy higher levels of credibility, stakeholder buy-in, and participant satisfaction. Finally, local solutions to local issues ensures locally specific needs, strengths, and practices are recognized; by engaging with promising or innovative local practices or practitioners, this policy increases organizational and community capacity, supports partnerships based on mutual respect, and results in client-centered services (Turner et al, 2013).

In order to support public and government knowledge and awareness of this need for further research and interagency collaboration, the findings of this study will be disseminated in the form of a full report and two-to-three page policy brief to Yukon Health & Social Services, professional medical associations, Yukon College, and the Yukon Women’s Coalition, an association of territorial women’s organizations.

By framing the issue of unintended pregnancy within the lens of reproductive rights, evidence-based research, and cost-effectiveness evaluation, this study seeks to show that reproductive rights, as indicated by unintended pregnancy and women’s access to contraception care, is a matter of public health. As such, it carries with it potential costs and cost-savings for the government. Thus, for reasons of equity, public health, and efficiency, the onus for addressing both unintended pregnancy and access to contraception lies with the Yukon government. This study identifies short and long-term policy responses the government may use in undertaking this process.
References


CIHI. Giving Birth in Canada: the costs. February 2006: Canadian Institute for Health Information.


Curran, et al. Strengthening the Medical Workforce In Rural Canada. June 2004: Faculty of Medicine Memorial University of Newfoundland.


Government of Yukon. Payment Schedule for Yukon. April 2011: Insured Health Services


Northern Secretariat of the BC Centre for Women’s Health. The Determinants of Women’s Health in Northern Rural and Remote Regions: Examples and Recommendations from Northern British Columbia. UNBC: http://www.unbc.ca/assets/northern_fire/WmNorth.PDF


Pilgrim, et al. Modelling the cost-effectiveness of interventions to encourage young people, especially socially disadvantaged young people, to use contraceptives and contraceptive services. April 2010: University of Sheffield School of Health and Related Research.


Trouton, K. “How can we increase IUD insertion by primary care providers?” European Journal of Contraception and Reproductive Health Care 17 (2012), S104.


## Appendix A.

### Summary List of Criteria and Measures

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Definition</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equity</strong></td>
<td>The extent to which the policy expands the availability, accommodation, accessibility, affordability, and acceptability of contraceptive services</td>
<td>▪ Number of new medical and non-medical facilities providing contraceptive services&lt;br&gt;▪ Number of new contraceptive services provided&lt;br&gt;▪ Hours of operation&lt;br&gt;▪ Requires an appointment for initial visit&lt;br&gt;▪ Number and location of visits/referrals required for the desired method or procedure&lt;br&gt;▪ Average distance/time required to reach points of access&lt;br&gt;▪ Economic burden of contraception&lt;br&gt;▪ Patient anonymity&lt;br&gt;▪ Average duration of consultation with patients.&lt;br&gt;▪ Integration with other SRH services.&lt;br&gt;▪ Opportunities for public education.&lt;br&gt;▪ Allocation of new services in rural and remote communities</td>
</tr>
<tr>
<td><strong>Efficiency</strong></td>
<td>The extent to which the policy reduces government net spending</td>
<td>▪ Government spending (benefits of averted procedures less the incremental costs of staff and services)</td>
</tr>
<tr>
<td><strong>Feasibility</strong></td>
<td>The likelihood that the policy will garner government support by addressing its strategic priorities, and stakeholder support such as medical professionals and the women's community.</td>
<td>▪ Mechanisms to ensure accountability&lt;br&gt;▪ Supports data collection&lt;br&gt;▪ Collaboration with groups supporting women’s health initiatives or promoting the accessibility of all forms of contraception and services&lt;br&gt;▪ Regulatory and evaluation framework&lt;br&gt;▪ Stakeholder positions</td>
</tr>
</tbody>
</table>
Appendix B.

Service User Survey

Consent Form for Service Users
Title of study: Women’s Access to Contraceptive Services in Yukon

Who is conducting the study?

This study is being conducted under the auspices of Simon Fraser University. The application number of the study is 2013s0709.

Principal Investigator
Taryn Turner
School of Public Policy
Contact: [Contact Information]

Faculty Supervisor
Olena Hankivsky
School of Public Policy
Contact: [Contact Information]

Why are we doing this study?

I am a Yukon resident completing my master’s degree at the School of Public Policy at Simon Fraser University. As part of my degree requirements, I am undertaking a research project on the current status of women’s reproductive health in the Yukon, and specifically on how to improve Yukon women’s access to contraceptive care. This study is being conducted under the auspices of Simon Fraser University.

What are the benefits of participating in this study?

This survey will collect data on your experiences and opinions of these services, and is the first contemporary study of its kind in the territory. Your responses will be an important resource for deepening the quality of this study. While your participation in the study may not benefit you directly, others may benefit in the future from what is learned in this study.

Your participation is voluntary

Your participation is voluntary. You have the right to refuse to participate and your refusal to participate will not have any adverse effects on your person. If you decide to take part in the survey, you may still choose to withdraw at any time without any negative consequences, and any completed responses will be destroyed. The survey will take approximately 10-15 minutes to complete. Survey respondents will not be paid for their participation.

How will your privacy be maintained?

Your confidentiality will be respected. Your name, contact information, or identifiers will not be collected. This means all responses are anonymous and will be reported only in combination with many other respondents. All survey data will be saved on a USB and stored in a locked filing cabinet at Simon Fraser University School of Public Policy until two years after the study when all data will be destroyed.

Version: October 11, 2013
Is there any way being in this study could be bad for you?

Some questions in this survey may seem sensitive or personal. There is a small risk that these questions may generate feelings of embarrassment or discomfort. You do not have to answer any question if you do not want to.

What will happen with the survey results?

The results of this study will be reported in a graduate thesis and the main findings may be published in academic journal articles or presented at conferences. You may request a copy of the final report from the Principal Investigator [Redacted].

Who can you contact if you have questions or concerns about the study?

If you have any questions about this survey or research, please contact principal investigator Taryn Turner [Redacted] or faculty supervisor Olena Hankivsky [Redacted]. If you have any concerns about your rights as a study participant or your experience while participating in this survey, you may contact Dr. Dina Shafey, Associate Director, Office of Research Ethics [Redacted].

Participant Consent

Participating in this survey is entirely up to you. You have the right to refuse to take part in this survey. If you decide to participate, you may choose to stop the survey at any time without giving a reason and without any negative impact on you.

By checking the box “You have read the consent form and wish to take the survey,” you are indicating that you consent to participate in this study.

☐ You have read the consent form and wish to take the survey.
Yukon Women's Reproductive Health Care
Service User Survey

This survey is gathering data on the current status of women's reproductive health in the Yukon, and specifically on how to improve women's access to contraceptive care. This survey will take approximately 10-15 minutes to complete, and will ask questions about your experiences and opinions of these services.

If you have any questions about this survey or research, please contact the principal investigator, Taryn Turner [contact information], or faculty supervisor Olena Hankivsky [contact information].

Thank you in advance, your time is sincerely appreciated!

Definitions: Contraception, also known as birth control, is a method or device used to prevent a pregnancy. Abortion is the willful termination of a pregnancy.

Screener Questions:

QA. This survey is collecting data related to the pregnancy intentions of females. For the purpose of the survey, female refers to individuals who can become pregnant.

Do you identify as...

☐ Male
☐ Female

QB. In what year were you born? _________

QC. Do you have a valid Yukon Health Care card, or have you seen a Yukon health care provider in the last twelve months?

☐ Yes
☐ No

This survey is for Yukon women age 19-50 only. Thank you for your interest!
Reproductive health is just one part of a woman’s health. First, let’s talk about your overall health care experience as a Yukon woman.

Q1. Over the last 12 months, where did you usually go for health care services?

☐ Medical clinic
☐ Walk-in clinic
☐ School counselor
☐ Emergency room
☐ College/university clinic
☐ Community health centre
☐ Pharmacy
☐ Other (please specify): ______________________

Q2. During this time, who was your primary health care provider? Primary means the individual you spoke with most often.

☐ Family doctor
☐ Clinic physician
☐ Counselor
☐ Nurse
☐ Midwife
☐ OB/GYN
☐ Pharmacist

Q3. Overall, do you think that your primary health care provider did the following? Please circle the number that best reflects your opinion of the care you received.

1 = Strongly Agree
2 = Agree
3 = Neither Agree nor Disagree
4 = Disagree
5 = Strongly Disagree

<table>
<thead>
<tr>
<th>Service</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treated you with respect</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Believed you when you told him or her something</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involved you in decision-making about your health care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was sensitive to your lifestyle, needs, and preferences</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gave you the time and attention that you desire</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listened to and understood issues important to you</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provided you with accurate and unbiased information</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Version: October 11, 2013
Q4. In general, are you satisfied with the health care you have received?

☐ Very satisfied
☐ Satisfied
☐ Neutral
☐ Dissatisfied
☐ Very dissatisfied

Contraception is an important topic when discussing women’s reproductive health. Let’s explore some general ideas about different methods of contraception.

Q5. To what extent do you agree or disagree with the following statements about contraception:

1 = Strongly Agree
2 = Agree
3 = Neither Agree nor Disagree
4 = Disagree
5 = Strongly Disagree

Contraception...

Offers good protection against pregnancy 1 2 3 4 5
Is expensive 1 2 3 4 5
Is convenient to use 1 2 3 4 5
Disrupts the “mood” during sexual activities 1 2 3 4 5
Is something your sexual partner supports using 1 2 3 4 5
Can be embarrassing to ask for and/or purchase 1 2 3 4 5

Version: October 11, 2013
Q6. Based on what you know about different methods of contraception, would you say you have a favourable or unfavourable opinion of the following methods, where:

1=Very favourable  
2=Favourable  
3=Neutral  
4=Unfavourable  
5=Very unfavourable  
N/A= Have not heard of this method.

<table>
<thead>
<tr>
<th>Method</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Barrier Contraceptive (Lea’s Shields®)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Birth control patch</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Birth control pill</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Birth control ring (NuvaRing®)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Cervical cap</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Condom (male)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Condom (female)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Contraceptive sponge</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Emergency contraception (Plan B®)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Female sterilization (tubal ligation)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Intrauterine Device (ParaGard®)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Intrauterine System (Mirena®)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Injectable contraceptive (Depo Provera®)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Male sterilization (vasectomy)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Natural family planning</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Spermicide</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Please provide some comments to explain your ranking (optional):

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Version: October 11, 2013
Some women discuss contraception options with their health care provider. Here are a few questions about your overall experience discussing contraception with your health care provider.

Q7. Have you and your primary health care provider discussed contraception in the last 12 months?

☐ Yes
☐ No (skip to Q9)

Q8. During that discussion, did your primary health care provider do the following? Please either circle “Y” for Yes or circle “N” for No.

Y/N Ask you if you wanted information about contraception
Y/N Give you up-to-date information on a range of contraceptive methods
Y/N Talk about the benefits and risks of different contraceptive methods
Y/N Provide clear instructions on how to correctly use specific methods
Y/N Discuss the costs of different methods

Q9. To what extent do you agree or disagree with the following statements?

1 = Strongly Agree
2 = Agree
3 = Neither Agree nor Disagree
4 = Disagree
5 = Strongly Disagree

Your primary health care provider...

Seems uncomfortable talking about sexual and reproductive health
Cares about finding the contraception method that works best for you
Does not listen to your needs or treat you with respect
Is aware of your future plans to get pregnant or not
Shows no interest in your sexual partner’s attitudes to contraception
Sets a follow-up appointment if you start a new contraception method

Q10. In the last 12 months, have you ever been refused contraception?

☐ Yes
☐ No

If yes, what was the reason you were given for this refusal (optional):  

Version: October 11, 2013
Q11. In the last 12 months, have you been discouraged from using the contraceptive method that you wanted to use and/or requested to use?

☐ Yes
☐ No

If yes, what was the reason you were given for this discouragement (optional):

________________________________________________________________________________

________________________________________________________________________________

Q12. In this question, you will be asked to read two different arguments. After you have read both, please check the box beside the argument you most strongly agree with.

Argument 1:
Some people say that accessing contraception in small communities can be difficult because a person’s lack of anonymity may interfere with their privacy.

☐ I most strongly agree with Argument 1.

Argument 2:
Other people say that accessing contraception in small communities is not difficult because a person’s lack of anonymity does not interfere with their privacy.

☐ I most strongly agree with Argument 2.

Q13. In general, are you satisfied with the contraceptive care you have received from your primary health care provider?

☐ Very satisfied
☐ Satisfied
☐ Neutral
☐ Dissatisfied
☐ Very dissatisfied

Please provide some comments to explain your ranking (optional):

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Version: October 11, 2013
Let’s talk a little bit about your personal experience with contraception. Keep in mind that women may use contraception for non-contraceptive benefits and/or to prevent pregnancy.

Q14. Have you had sexual intercourse within the last 12 months?
   - Yes
   - No (skip to Q18)

Q15. During this time, did you use some form of contraception?
   - Yes
   - No (skip to Q17)

Q16. In general, how often did you use contraception?
   - Rarely
   - Sometimes
   - Usually
   - Always

Q17. Which statement best describes why you did not use contraception? Select one.
   - I am pregnant
   - I am trying to become pregnant
   - I don’t mind becoming pregnant
   - I have just had a baby
   - I don’t believe in using birth control
   - I am not currently having sex
   - I am not currently having sex that can get me pregnant
   - I am infertile
   - I don’t like using birth control
   - My partner or family will not let me use contraception
   - I couldn’t access contraception
   - I got carried away in the moment
   - I don’t know
   - I always used contraception
   - Other (please specify): _______________________

Version: October 11, 2013
Part of understanding your contraceptive choices involves discussing your feelings about pregnancy. In this next section, we will explore some of the reasons you may have chosen your current method of contraception.

Q18. To what extent do you agree or disagree with the following statement:

“It is important that I do not become pregnant right now.”

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Q19. Of the following, which is your current method of contraception?

- Abstinence
- Barrier Contraceptive (Lea’s Shield®)
- Birth control patch
- Birth control pill
- Birth control ring (NuvaRing®)
- Cervical cap
- Condom (male)
- Condom (female)
- Contraceptive sponge
- Diaphragm
- Emergency contraception (Plan B ® or “morning after pill”)
- Female sterilization (tubal ligation)
- Intrauterine Device (ParaGard® IUD)
- Intrauterine System (Mirena®)
- Injectable contraceptive (Depo Provera®)
- Male sterilization (vasectomy)
- Natural family planning
- Spermicide
- Withdrawal

Version: October 11, 2013
Q20. Why did you choose this particular method? Please rank the top three reasons for your decision, with 1 being the most important reason.

- Acne
- Menstrual suppression
- Effectiveness
- Inexpensive
- Convenience
- Little or no pain
- Does not interfere with sexual activity
- Ability to become pregnant in the future
- Easy to use
- Non-hormonal
- Does not require a prescription
- Protection against STIs/HIV
- Little or no side effects
- Recommended by health care provider
- Recommended by friends or family
- Partner wanted to use it
- Flexibility
- Permanence
- Other (please specify): _______________________

Q21. Did you switch to your current method of contraception from another method in the last 12 months? Note: “if you switched to a different brand of the same method (e.g. switching from Yaz birth control pills to Alesse birth control pills), answer “no.”

☐ Yes
☐ No (skip to Q24)

Q22. How many times have you switched primary methods in the last 12 months?

☐ Once
☐ Twice
☐ Three or more times

What was the last method you used before switching to your current method?

☐ Abstinence
☐ Barrier Contraceptive (Lea’s Shield®)
☐ Birth control patch
☐ Birth control pill
☐ Birth control ring (NuvaRing®)
☐ Cervical cap
☐ Condom (male)

Version: October 11, 2013
☐ Condom (female)
☐ Contraceptive sponge
☐ Diaphragm
☐ Emergency contraception (Plan B® or “morning after pill”)
☐ Female sterilization (tubal ligation)
☐ Intrauterine Device (ParaGard® IUD)
☐ Intrauterine System (Mirena®)
☐ Injectable contraceptive (Depo Provera®)
☐ Male sterilization (vasectomy)
☐ Natural family planning
☐ Spermicide
☐ Withdrawal

Q23. Why did you decide to switch away from your last method of contraception? Please give up to three reasons for your decision, with 1 being the most important reason.

1. ________________________________
2. ________________________________
3. ________________________________

Q24. Overall, how would you rate the effectiveness of your current method in preventing pregnancy?

☐ Very effective
☐ Effective
☐ Neither effective nor ineffective
☐ Ineffective
☐ Very ineffective

Q25. In general, how satisfied are you with the method you are currently using?

☐ Very satisfied
☐ Satisfied
☐ Neutral
☐ Dissatisfied
☐ Very dissatisfied

Please provide some comments to explain your answer (optional):

_________________________________________________________________
_________________________________________________________________

Version: October 11, 2013
Just a few more questions...

Q26. Which of the following best describes how you pay for contraception?

☐ You pay the costs yourself
☐ Your partner or family pays for the costs
☐ You share the costs with your partner or a family member
☐ The cost is covered by a private insurance plan
☐ You have a co-payment plan: you pay part and insurance pays part
☐ The cost is covered by Non-Insured Health Benefits
☐ You cannot afford contraception right now

Q27. Suppose that you no longer have to pay for contraception because the costs are covered by your health care insurance.

Would you...

☐ Keep using your current method of contraception
☐ Switch to a similarly expensive method that is now covered
☐ Switch to a more expensive method that better meets your needs

Q28. Have you had an unplanned pregnancy in the last 5 years?

☐ Yes
☑ No (skip to question 33)

If yes: how many unplanned pregnancies have you had in the last 5 years?

☐ 1
☐ 2
☐ 3
☐ 4 or more

Q29. Think back to the time of your last unplanned pregnancy. Please either circle “Y” for Yes or circle “N” for No.

Y/N Did you want to wait until later to become pregnant?
Y/N Did you want to have any (more) children at all?

Q30. Were you using contraception around the time that you became pregnant?

☐ Never
☐ Rarely
☐ Sometimes
☐ Usually

Version: October 11, 2013
Q31. What was the outcome of your last unplanned pregnancy?

☐ Abortion
☐ Miscarriage
☐ Adoption
☐ Kept the baby

Q32. If you had an abortion in the last 5 years, please answer whether or not you:
Check all that apply.

☐ Had a medical abortion
☐ Had a surgical abortion in Whitehorse
☐ Had a surgical abortion in another city
☐ Had to travel to another community for the abortion
☐ Had to see more than 1 service provider to get a referral for abortion
☐ Had to wait more than 2 weeks to get a referral for the abortion
☐ Had to wait more than 2 weeks between the referral and the abortion
☐ Were offered free pre- and/or post-abortion counselling
☐ Were offered information about different contraceptive methods
☐ Felt supported by your health care provider
☐ Felt supported by your social and/or family network

Finally, in order to better understand women’s access to contraception and abortion services in the Yukon, I would like to ask you a few questions about your background.

Q33. What is the highest level of education that you have completed?

☐ Some grade school (K-7)
☐ Some high school (8-12)
☐ High school graduate
☐ Some college or university
☐ College/university graduate or beyond

Q34. In which language(s) are you most comfortable having a conversation?

☐ Athapaskan (Gwich’in, Hän, Upper Tanana, Northern Tutchone, Southern Tutchone, Kaska, Tahltan)
☐ English
☐ Cantonese
☐ French
☐ German
☐ Inuktitut

Version: October 11, 2013
Q39. Do you plan to have a child in the next two years?

☐ Yes
☐ No

Q40. Are you employed outside of your home?

☐ Yes
☐ No (Skip to Q42)

Q41. If you work outside of the home, do you work:

☐ Part-time
☐ Full-time

Q42. Approximately how large is the community where you currently live?

☐ Fewer than 300 people
☐ Between 300 and 600 people
☐ Between 600 and 1500 people
☐ More than 1500 people

Q43. Have you lived in a different community in the last 12 months?

☐ Yes
☐ No (Skip to Q45)

Q44. How large was the community (or communities) where you lived in the last 12 months? Check all that apply:

☐ Fewer than 300 people
☐ Between 300 and 600 people
☐ Between 600 and 1500 people
☐ More than 1500 people

Q45. What is your primary form of transportation?

☐ Walking
☐ Car
☐ Bus
☐ Handy-Bus
☐ Taxi
☐ Family/partner/friends
☐ Seasonal transportation (e.g. bikes, boats, snowmobiles)
☐ Other (please specify): __________________________

Thank you very much for your participation! Your time and insight is appreciated!
Appendix C.

Service Provider Survey

Consent Form for Service Providers
Title of study: Women's Access to Contraceptive Services in Yukon

Who is conducting the study?

This study is being conducted under the auspices of Simon Fraser University School of Public Policy. The application number of the study is 2013s0709.

Principal Investigator
Taryn Turner
School of Public Policy
Contact: [REDACTED]

Faculty Supervisor
Olena Hankivsky
School of Public Policy
Contact: [REDACTED]

Why are we doing this study?

I am a Yukon resident completing my master’s degree at the School of Public Policy at Simon Fraser University. As part of my degree requirements, I am undertaking a research project on the current status of women’s reproductive health in the Yukon, and specifically on how to improve Yukon women's access to contraceptive care.

What are the benefits of participating in this study?

This survey will collect data on your experiences and opinions of these services, and is the first contemporary study of its kind in the territory. Your responses will be an important resource for deepening the quality of this study. While your participation in the study may not benefit you directly, others may benefit in the future from what is learned in this study.

Your participation is voluntary

Your participation is voluntary. You have the right to refuse to participate and your refusal to participate will not have any adverse effects on your person, employment, or evaluation of your organization. If you decide to participate, you may still choose to withdraw your participation at any time without any negative consequences, and any completed questions will be destroyed. The survey will take approximately 10-15 minutes. Survey respondents will not be paid for their participation.

How will your privacy be maintained?

Your confidentiality will be respected. Your name, contact information, or identifiers will not be collected. This means all responses are anonymous and will be reported only in combination with many other respondents. All survey data will be saved on a USB and stored in a locked filing cabinet at Simon Fraser University School of Public Policy until two years after the study when all data will be destroyed.

Version: October 11, 2013
Is there any way being in this study could be bad for you?

There is little risk that anything in this study that could harm you or be bad for you. Some questions in the survey may seem sensitive or personal and you do not have to answer any question if you do not want to.

If you have any questions about sexual health, call these free sexual health lines:

**Yukon HealthLine**: free, confidential health information. Speak with a registered nurse anytime night or day. Dial 811.

**Yukon Style**: free, confidential sexual health information line. Open Mon-Fri from 9am until 9pm. Call 1-877-YK STYLE (1-877-957-8953).

What will happen with the survey results?

The results of this study will be reported in a graduate thesis and the main findings may be published in academic journal articles or presented at conferences. You may request a copy of the final report from the Principal Investigator [redacted].

Who can you contact if you have questions or concerns about the study?

If you have any questions about this survey or research, please contact principal investigator Taryn Turner [redacted] or faculty supervisor Olena Hankivskyi [redacted]. If you have any concerns about your rights as a study participant or your experience while participating in this survey, you may contact Dr. Dina Shafee, Associate Director, Office of Research Ethics [redacted].

Participant Consent

Participating in this survey is entirely up to you. You have the right to refuse to take part in this survey. If you decide to participate, you may choose to stop the survey at any time without giving a reason and without any negative impact on you.

By checking the box “You have read the consent form and wish to take the survey,” you are indicating that you consent to participate in this study.

☐ You have read the consent form and wish to take the survey.

Version: October 11, 2013
Yukon Women’s Reproductive Health Care
Service Provider Survey

This survey is gathering data on the current status of women's reproductive health in the Yukon, and specifically on how to improve women's access to contraceptive care. This survey will take approximately 10-15 minutes to complete, and will ask questions about your experiences and opinions of these services.

If you have any questions about this survey or research, please contact the principal investigator, Taryn Turner [redacted], or faculty supervisor Olena Hankivsky [redacted].

Thank you in advance, your time is sincerely appreciated!

Screener Question:

A. Have you been providing health care or related services in the Yukon for at least 6 months?

   Yes
   No

This survey is for service providers who have been working in the Yukon for at least 6 months. Thank you for your interest!
There are several different points of contact for women seeking reproductive health care. First, let’s talk about where your work fits into the Yukon health care system.

Q1. Please select your place(s) of employment over the last 12 months:

☐ Medical clinic  
☐ Walk-in clinic  
☐ Education facility  
☐ Emergency room  
☐ College/university clinic  
☐ Community health centre  
☐ Pharmacy  
☐ Other

Q2. Please select your current career field:

☐ Family physician  
☐ Clinic physician  
☐ Community worker  
☐ Counselor  
☐ Nurse  
☐ Midwife  
☐ OB/GYN  
☐ Pharmacist  
☐ Social worker

Q3. For how many years have you been working in this career field?

☐ 0-5 years  
☐ 6-10 years  
☐ 11-15 years  
☐ 16-20 years  
☐ 21-25 years  
☐ 26-30 years  
☐ 31-35 years  
☐ 36-40 years  
☐ 41 or more years

Q4. On average, what percentage of your daily workload involves providing services related to family planning? Write an “x” on the line.

<table>
<thead>
<tr>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
<th>70%</th>
<th>80%</th>
<th>90%</th>
<th>100%</th>
</tr>
</thead>
</table>

Version: October 11, 2013
Q5. Do you provide contraception, contraceptive care, or contraceptive counselling to Yukon women?

☐ Yes
☐ No

Q6. Do you have formal training and education in family planning services?

☐ Yes
☐ No

Contraception is a health care field that is constantly changing and evolving. Here are a few questions about your overall awareness and experience providing contraception to women in the territory.

Q7. On a scale of 1-10, how knowledgeable do you feel about the following methods of contraception, with 10 being the most knowledgeable?

<table>
<thead>
<tr>
<th>Method</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barrier Contraceptive (Lea’s Shields®)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth control patch</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth control pill</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth control ring (NuvaRing®)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical cap</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom (male)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom (female)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptive sponge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diaphragm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency contraception (Plan B®)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female sterilization (tubal ligation)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrauterine Device (ParaGard®)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrauterine System (Mirena®, DepoProvera®)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injectable contraceptive (Depo Provera®)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male sterilization (vasectomy)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natural family planning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spermicide</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Version: October 11, 2013
Q8. Based on what you know about different methods of contraception, would you say you have a favourable or unfavourable opinion of the following methods, where:

1=Very favourable
2=Favourable
3=Neutral
4=Unfavourable
5=Very unfavourable
N/A= Have not heard of this method.

<table>
<thead>
<tr>
<th>Method</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinence</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Barrier Contraceptive (Lea’s Shield®)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Birth control patch</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Birth control pill</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Birth control ring (NuvaRings®)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Cervical cap</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Condom (male)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Condom (female)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Contraceptive sponge</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Emergency contraception (Plan B®)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Female sterilization (tubal ligation)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Intrauterine Device (ParaGard®)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Intrauterine System (Mirena®)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Injectable contraceptive (Depo Provera®)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Male sterilization (vasectomy)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Natural family planning</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Spermicide</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Please provide some comments to explain your ranking (optional):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Version: October 11, 2013
Q9. Which of the following types of contraceptive services do you provide? Check all that apply.

☐ Print/media information about contraception
☐ Verbal information about contraception
☐ Discuss the benefits and risks of different methods of contraception
☐ Discuss the costs of different methods of contraception
☐ Clear instructions on how to correctly use specific methods
☐ Contraceptive prescriptions
☐ Print/media information about pregnancy options
☐ Verbal information about pregnancy options
☐ Ask about the woman’s future plans to get pregnant or not
☐ Discuss the woman’s lifestyle and needs
☐ Discuss the woman’s preferences for different contraception methods
☐ Discuss the woman’s sexual partners’ preferences for contraception
☐ Follow-up with women after starting a new method of contraception
☐ Information on which contraceptives protect against STIs
☐ None of the above

Q10. On average, how often do you provide these contraceptive services?

☐ Multiple times a day
☐ Once a day
☐ Every couple of days
☐ Once a week
☐ Less than once a week
☐ Never

Q11. Have you refused contraception to one or more women in the last 12 months?

☐ Yes
☐ No

If yes, what was the context for this decision (optional):

__________________________________________________________________________

Q12. Have you refused to provide the specific contraceptive method requested by one or more women in the last 12 months?

☐ Yes
☐ No

If yes, what was the context for this decision (optional):

__________________________________________________________________________

Version: October 11, 2013
Q13. On average, how often do you provide services to women experiencing an unplanned pregnancy?

☐ Multiple times a week
☐ Once a week
☐ Every couple of weeks
☐ Once a month
☐ Less than once a month
☐ Never

Q14. Does your place of employment provide referrals to abortion services?

☐ Yes
☐ No (skip to Q17)

Q15. In your capacity at work, do you provide women with referrals to abortion services?

☐ Yes
☐ No (skip to Q17)

Q16. Approximately how many referrals for abortion have you made in the last 6 months?

☐ 1-5
☐ 6-10
☐ 11-15
☐ 16-20
☐ 20 or more

Q17. Do you give women the name of a health care provider that is able to provide her with a referral for abortion?

☐ Yes
☐ No

Version: October 11, 2013
Q18. In your opinion, what are the 5 most important barriers to accessing abortion services facing Yukon women? Please rank by order of importance, with 1 being the most important barrier.

___ 1st trimester surgical abortion is too far from home
___ 2nd trimester surgical abortion is too far from home
___ Costs of transportation, lost wages, and/or childcare
___ Unable to arrange for transportation, time off work, and/or childcare
___ Difficulty obtaining abortion referral
___ Lack of confidentiality
___ Lack of unbiased pregnancy options counselling
___ Long wait times for obtaining an appointment
___ Medical abortions not offered
___ Women do not know how or where to obtain an abortion
___ Women feel stigmatized or judged by health care provider
___ Women feel stigmatized or judged by family, friends, or partner
___ Women do not recognize the pregnancy in time
___ Other (please specify): _________________________

Please provide some comments to illuminate your ranking (optional):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Version: October 11, 2013
Part of understanding your experiences providing reproductive health care services to women in Yukon is looking at the broader health care system you are working within. In this next section, we will explore some of the barriers women may face in accessing these services.

Q19. In your opinion, what are the most important barriers that Yukon women face when seeking access to contraceptive services? Please rank by order of importance, with 1 being most important.

___ Cost/financial barriers (e.g. transportation, childcare, lost wages, insurance, price of contraception, etc.)

___ Geographical barriers (e.g. local availability of contraceptives, location of services, trained providers, transportation, weather/road conditions, etc.)

___ Administrative barriers (e.g. clinic hours, wait times, prescribing authority, discrimination, unable to find provider, etc.)

___ Knowledge barriers (e.g. how or where to access services, culturally appropriate care, efficacy and/or compliance issues, unaware of certain methods, etc.)

___ Social barriers (e.g. confidentiality, embarrassment, fear, negative attitude, partner/familial pressure, etc.)

Please provide some comments to illuminate your ranking. For example, why did you select these barriers? What are some specific areas or issues of concern within each type of barrier?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Version: October 11, 2013
Q20. In your opinion, what are the 3 most important barriers Yukon women face in receiving high-quality contraceptive services? Rank by order of importance, with 1 being the most important barrier.

[Ranking options]

Comments: -

Q21. In your opinion, which of the following groups of women receive lower quality of care than other women in the Yukon? Rank by order of prevalence, with 1 being the most prevalent.

[Ranking options]

Other (please specify): ________________________________

Version: October 11, 2013
Q22. In general, how satisfied or dissatisfied are you with the quality of contraceptive care available to women in the Yukon?

☐ Very satisfied
☐ Satisfied
☐ Neutral
☐ Dissatisfied
☐ Very dissatisfied

Please provide some comments to explain your ranking (optional):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Q23. Which of the following areas would improve the quality of contraceptive health care for all women in the Yukon? Check all that apply.

☐ Additional administrative/government support for health care providers
☐ Cultural training around women’s reproductive health
☐ Technical training on contraceptive methods (e.g. IUD, diaphragm fitting)
☐ Technical training for medical/surgical abortions
☐ Training in patient-centered care
☐ Updates on contraceptive methods
☐ Updates on contraceptive counselling strategies
☐ Updates on eligibility and exclusion criteria for different contraceptives
☐ Updates on management of contraception side effects
☐ Updates on pregnancy options counselling

Q24. In what other ways may contraceptive and abortion services in the Yukon be improved?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Version: October 11, 2013
Finally, I would like to ask you a few questions about your personal background.

Q25. Do you identify as...

- Male
- Female

Q26. In what year were you born? ________

Q27. In which language(s) are you most comfortable having a conversation?

- Athapaskan (Gwich’in, Hän, Upper Tanana, Northern Tutchone, Southern Tutchone, Kaska, Tahltan)
- English
- Cantonese
- French
- German
- Inuktitut
- Mandarin
- Spanish
- Tagalog
- Tlingit
- Other (please specify): ________________________

Q28. How large is the community where you currently work?

- Fewer than 300 people
- Between 300 and 600 people
- Between 600 and 1500 people
- More than 1500 people

Q29. Have you worked in a different community in the last 12 months?

- Yes
- No (Skip to end)

Q30. How large was the community (or communities) where you worked in the last 12 months? Check all that apply:

- Fewer than 300 people
- Between 300 and 600 people
- Between 600 and 1500 people
- More than 1500 people

Thank you very much for your participation! Your time and insight is appreciated!

Version: October 11, 2013
Appendix D.

Key Informant Interview Questions

**Key Stakeholder Interviews**

**Preliminary Questions:**

What is your educational or work background? How did you come to occupy this specific work position? How long have you been working in this position? Etc.

**Reproductive Health Policy and Planning**

1. In your opinion, is there a sexual and reproductive health (SRH) strategy or policy in Yukon?

2. Who are the major stakeholders in developing and delivery of SRH services in Yukon? Are you aware of any coordination or collaboration between government departments or other organizations to design, provide, or evaluate these services?

**Perceptions of Abortion and Unintended Pregnancy**

3. In your opinion, are unintended pregnancy and/or abortion important issues in Yukon?

**Availability & Accessibility of Contraceptive Services**

4. What do you think of the availability and accessibility of contraception methods and/or services in Yukon?

5. Is there sufficient availability of trained contraceptive providers?

6. What do you think would be the most effective approach to improving access to contraceptive services and care, given the capacity of the service delivery system?

**Quality of Contraceptive Services**

7. What do you think of the quality of contraceptive services in the Yukon?

8. What do you think is the most effective approach to improving this quality?

**Service Management, Evaluation, and Accountability**
9. Does the Yukon health service delivery system have the capacity to identify, monitor, and evaluate women’s contraceptive needs, service utilization, and/or pregnancy outcomes?

10. Is there a clear process of decision-making and accountability measures in the management of contraceptive services?

Resource Allocation and Service Costs

11. Is the cost of new or improved contraceptive services affordable within the limits of existing resources?

Wrap-Up:

12. Is there anything else you would like to talk about that we haven’t covered?