



**CFMS FEMC**  
Canadian Federation  
of Medical Students  
Fédération des étudiants et des  
étudiantes en médecine du Canada

# Universal Access to Contraception

CFMS National  
Day of Action



BACKGROUND DOCUMENT



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Canadian Federation  
of Medical Students

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étudiantes en médecine du Canada

**About Us:** The Canadian Federation of Medical Students (CFMS) is the national organization representing over 8,000 Canadian medical students from 15 medical schools across Canada. We represent medical students to the public, to the federal government, and to national and international medical organizations.

**Our Mission:** The Canadian Federation of Medical Students (CFMS) is the national voice of Canadian medical students. We connect, support, and represent our membership as they learn to serve patients and society.

**Our Vision:** Tomorrow's physicians leading for health today.

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## Introduction

In 2017, Canada took on a global leadership role by investing \$650 million over three years in funding for sexual health and reproductive health rights. A main component of this campaign included “investing in family planning and contraceptives”.<sup>(1)</sup> The Canadian Government reinforced their commitment to advancing gender equality in 2019 when they announced they would increase their funding to \$1.4 billion annually to “support women and girls’ health around the world”, by 2023.<sup>(2)</sup> \$700 million of this funding is to be applied specifically to sexual and reproductive health rights. Canada’s actions on the global stage to support sexual and reproductive health rights are commendable; however, Canada cannot lead by example or inspire other nations to embrace equality without first ensuring our own disparities have been addressed. Many Canadians lack basic pharmaceutical coverage for contraceptives, medications described by the WHO as “essential”.<sup>(3, 4)</sup> Before Canada can truly become an international champion for reproductive health rights, we must first ensure we have advocated and provided the basics for our own citizens.

Contraception is an essential component of healthcare that is often not included in private and provincial medical plans. Failure to provide access to contraception is a multifaceted issue that leads to increased unplanned pregnancy. Unplanned pregnancy ultimately results in direct healthcare losses up to \$320 million annually.<sup>(5)</sup> The costs associated with unplanned pregnancy cannot be quantified solely in dollars, as there can be significant emotional impact to the patient. The following excerpt is an adapted story from a real patient (Note: the case has been de-identified to protect patient confidentiality):

*Jane is a 16-year-old female living in rural Saskatchewan. She has discussed contraceptive options at length with her family physician and has decided on the hormonal IUD. She chose the hormonal IUD because it has the lowest failure rate of all available options, uses low levels of hormones, and does not require her to reliably take a contraceptive pill at the same time every day. Her local family physician does not feel comfortable inserting IUDs so Jane must make an appointment in Regina, which is four hours away. Besides the difficulties associated with the long distance to her appointment, the IUD costs \$350. Jane has some coverage through her parents’ private insurance plan, but the plan is not confidential so her parents will be aware of her decision to use contraception. Jane is currently in an abusive home situation, and having her parents discover her contraceptive use would likely result in physical violence. Thus, Jane decides to save up the \$350 to pay for the cost of the IUD through working at her part time job. This will take her approximately two months.*

The described situation highlights many issues within the current state of contraceptive access in Canada. Rural access, cost barriers, and confidentiality all play a large role in many Canadians being unable to access contraceptives. The following document describes the barriers to contraceptive access in Canada in detail and explains why providing nationally funded contraceptive access is an excellent method to honour the Canada Health Act’s tenants of universality and accessibility.

# Part I: Our Proposal

## **1.0 Our Asks**

1. Provide federally sponsored universal coverage of contraception, including the copper IUD, for all Canadians and include all contraceptive methods within the national Pharmacare plan;
2. Sponsor public education campaigns to endorse and circulate the Society of Obstetricians and Gynecologists of Canada information about contraceptive methods and use, and;
3. Implement a federally supported task-shifting model to include allied healthcare providers in contraceptive prescribing in all Canadian provinces and territories for improved access.

### *1.1 Federally Sponsored Universal Coverage of Contraception*

Contraception is an umbrella term referring to a range of methods used primarily to prevent pregnancy. Available options include the oral contraceptive pill (OCP), the transdermal patch, the vaginal ring, injectable progestins, and the hormonal and copper intrauterine devices (IUD). Different methods contain different medications, often the hormones estrogen and progesterone, or can be unmedicated, such as the copper IUD. Different formulations contain varying amounts of hormone resulting in unique side effect profiles. Each method has distinct specifications pertaining to frequency of use, route of use, and efficacy. Of note, all contraceptive methods are prone to usage error besides the IUD, which is inserted by a healthcare provider and remains effective for up to five years with no additional interventions. Error in contraceptive use can result in unplanned pregnancy which can cause significant emotional consequences and costs the Canadian healthcare system over \$320 million, annually. Besides preventing pregnancy, certain types of contraception have additional health benefits including prevention of several gynecological cancers and treating heavy or painful menstrual bleeding. The type of contraception suitable for a particular patient is highly individualized and cannot be optimized with a one-size-fits-all model.

Contraceptive coverage in Canada is currently determined by provincial, territorial and private healthcare plans. Current plans are very inconsistent in the extent of coverage and often do not cover the most effective options. IUDs are over 99% effective at preventing pregnancy but are often not covered due to the considerable initial cost, often around \$350. Additionally, current plans do not cover all available options, therefore limiting patients from receiving their preferred method of contraception. We propose a federally funded, universal coverage plan, including the oral contraceptive pill, the progestin only pill, the transdermal patch, the vaginal ring, progestin injections, the copper IUD, and the hormonal IUD, for all Canadians. This plan is cost-effective, beneficial to all Canadians, and can serve as an excellent first step to the national Pharmacare plan.

*“Cost is the most basic barrier. There are lots of other barriers, but it's also the one that we can get rid of right away.”*

— Dr Teale Bondaroff, co-founder and chair of Access BC *on barriers to accessing contraception in Canada*

*“There certainly are a lot of people [for whom] the upfront cost of an IUD is very prohibitive. But there are some people who make the argument... that we should be prescribing IUDs and consider them as first-line birth control. Would you prescribe an anti-hypertensive if you knew it was less effective than another one?”*

— Dr Megan Clark, Family Physician and Women’s Health Activist, Regina SK *on the current climate of contraceptive prescribing in Canada*

## *1.2 Public Contraceptive Education*

Informed consent is a core tenant of medical ethics. Patients are tasked with making decisions about their care and deserve to be fully informed of their options. However, misinformation is prevalent in the modern age and it can be difficult to discern the facts from fiction. There are a plethora of myths surrounding contraception that have become accepted by the general public and healthcare professionals, alike. To dispel these myths and educate Canadians about their contraceptive choices, we request a federally sponsored education campaign using evidence-based information, such as the resources provided by the Society of Obstetricians and Gynecologists of Canada (SOGC). This campaign would place these resources in the public eye to empower Canadians in their choices about contraception.

*“Patients are declining the most effective methods because of incorrect information/urban legends about risks and complications”*

— Dr Sally Mahood, Family Physician and Women’s Health Activist, Regina SK *on contraceptive myths and misinformation*

*“I think that the more opportunities you give physicians to actually use and prescribe contraceptive methods, the more physicians who [will] seem comfortable doing this. Not everybody will ever be comfortable but theoretically you would get more physicians [involved], because you just can't prescribe something that the patient can't afford.”*

— Dr Margaret Morris, Obstetrician and Gynecologist, Winnipeg MB *on physician experience with contraceptive counselling and prescribing.*

## *1.3 Task-Shifting for Improved Contraceptive Access*

A major barrier to accessing contraception is reasonable access to a healthcare provider with prescribing power. Canada is characterized by a sparse population distributed across a large land

mass; apart from those settled in our major cities, many Canadians are spread variably throughout rural and remote areas. These areas often do not have a residing physician and instead rely on allied healthcare providers such as nurse practitioners, registered nurses, pharmacists, and midwives. Task-shifting is a modification that allows allied healthcare practitioners to expand their scopes of practice to include roles that are not traditionally included in the practices of their urban counterparts. In this context, task-shifting would grant registered nurses, pharmacists, and midwives, once appropriately trained, the ability to counsel on and prescribe contraception, as well as insert and remove IUDs. We request that the federal government work intimately with all provinces and territories to emphasize a shared commitment to task-shifting in contraceptive care to ensure equitable access to contraception for all Canadians.

*“But now imagine you’re a woman living 150 kilometers outside of 100 Mile House ... You’re living out there and you have to go to the clinic to get an IUD ... So you have to hitchhike from your home to town to get to the clinic. Now, this is in Northern British Columbia. We’ve had a huge problem with missing and murdered Indigenous women. You’re putting your life on the line to hitchhike to a clinic ... Clinics are only open during normal business [hours], so you’re taking a day off work to go hitchhike into town and go to a clinic. To get a prescription, you go across town to the pharmacy ... But next you have to go and get your IUD inserted. It’s never the same day. You have another appointment a couple days later to get your IUD inserted.”*

— Dr. Teale Bondaroff, co-founder and chair of Access BC *on barriers to contraceptive access in rural and remote communities in Canada*

## Part II: The Current Situation

### **2.0 Introduction to Contraception**

A variety of contraceptive options is an essential component of a successful universal coverage plan. Contraception methods are chosen by patients in consultation with their physicians based on unique lifestyle and healthcare needs. Different methods of contraception have different success rates, side effect profiles, cost, requirements for administration, and contraindications. Considering these variables, a single contraceptive method is not appropriate for all Canadians.

#### *2.1 Hormonal Contraception*

Hormonal contraceptive methods include combined oral contraception (COC), progestin-only pills, hormonal intrauterine devices (IUD), vaginal rings, the transdermal patch, and progestin injections. These methods have a variety of administration frequency, from daily (contraceptive pill) to once every 3-5 years (IUD). It is important that a variety of hormonal options are available as some Canadians are unable to use estrogen-containing formulations.<sup>(6)</sup> Additionally, these methods of contraception can be used to treat heavy or irregular menstrual bleeding, acne, and menstrual pain.<sup>(7)</sup>

#### *2.2 Non-Hormonal Contraception*

Contraceptive methods without hormones, such as the Copper IUD, are essential to provide cost-free for those who are unable to use hormonal methods. This demographic includes individuals with certain genetic conditions, depression, hypertension, smoking, or those with active breast cancer.<sup>(8)</sup> Non-hormonal methods of contraception may also be chosen if the user wishes to avoid common side effects of hormonal contraception such as weight gain, depression, and breast tenderness.<sup>(6)</sup>

#### *2.3 Long-Acting, Reversible Contraception*

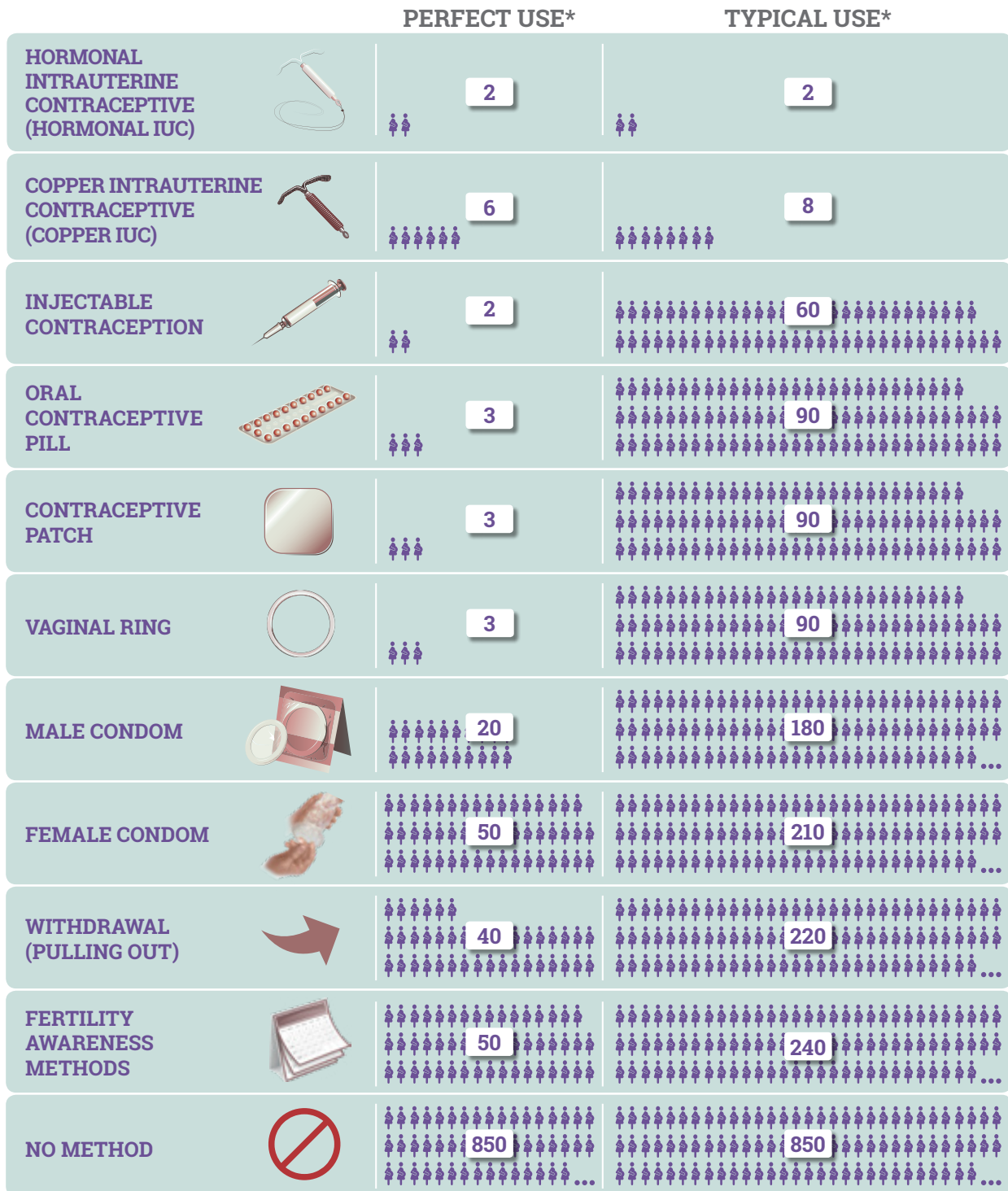
Long-acting reversible contraception (LARCs) encompasses the hormonal and copper IUDs. These methods are recommended for youth by the Canadian Pediatric Society due to ease of use. LARCs have infrequent administration which allow for better compliance. Additionally, the hormonal IUD has a significantly lower dose of hormone than oral contraceptive pills (OCP), as it releases hormones directly into the uterus instead of first requiring absorption through the gastrointestinal tract. Local hormone administration greatly decreases the number and severity of side effects an individual will experience. The hormonal IUD does not include estrogen so can be used safely in many individuals with contraindications to estrogen use. The CHOICE project in the United States studied the contraceptive choices participants made when given access to no-cost reversible contraception. The results of this study revealed that 75% of participants chose a LARC method when cost was eliminated.<sup>(9)</sup>



# HOW EFFECTIVE IS MY BIRTH CONTROL?

Relative efficacy of contraceptive options: perfect use vs. typical use<sup>1</sup>

 **Pregnancies for every 1,000 women during first year of use**



Adapted from the Canadian Contraception Consensus, 2015<sup>1</sup>

For the full list of contraception methods and their corresponding perfect use and typical use effectiveness, please visit [www.SexandU.ca](http://www.SexandU.ca)

\*The relative effectiveness of a birth control method is defined in two ways: actual effectiveness and theoretical effectiveness. Actual effectiveness refers to the "typical use" of a method, meaning how effective the method is during actual use (including inconsistent and incorrect use). Theoretical effectiveness refers to the "perfect use" of a method, which is defined by when the method is used correctly and consistently as directed.<sup>2</sup>

References: 1. Society of Obstetricians and Gynaecologists of Canada (SOGC). Canadian Contraception Consensus (Part 1 of 4). *J Obstet Gynaecol Can* 2015;37(10):936-42. 2. CDC: Centers for Disease Control and Prevention. Reproductive Health: Contraception. Available at: <https://www.cdc.gov/reproductivehealth/contraception/index.htm>

### **3.0 Health Benefits of Contraception**

A large and growing body of literature supports the many health benefits of contraceptive use: these include preventing several gynecological cancers, treating certain illnesses, and improving heavy menstrual bleeding and pain.<sup>(7)</sup> Furthermore, contraceptive use for pregnancy prevention alleviates unplanned pregnancy-related illness and death.<sup>(10)</sup>

#### *3.1 Benefits of Contraceptives for Menstruation and Pain Control*

Hormonal contraception is routinely used to treat multiple menstruation-related ailments including irregular cycles, heavy bleeding, and menstrual pain. Of note, more than half of oral contraceptive pill (OCP) prescriptions are given for indications other than pregnancy prevention. Of the 58% of people using OCP for additional non-contraceptive purposes, an estimated 31% use it for menstrual pain and cramps, 28% for menstrual cycle regulation, 14% for acne, and 4% for endometriosis.<sup>(11)</sup>

#### *3.2 Reduction of Cancer Risk with Contraceptive Use*

Consistent hormonal contraceptive use reduces the lifetime risk of developing certain gynecological cancers. Individuals who take a combination OCP (estrogen and progesterone) have a 50% reduced risk of developing uterine cancer. Cancer risk declines with length of OCP use, a benefit which continues after an individual stops using the OCP.<sup>(12)</sup> Combination OCPs also decreases the risk of ovarian cancer by 20% with every 5 years of use<sup>(12, 13)</sup> and reduce the risk of colorectal cancer.<sup>(8, 13)</sup>

#### *3.3 Contraceptives as Treatment for Disease*

Certain contraceptives are used for the treatment of polycystic ovarian syndrome (PCOS). PCOS is a common health condition affecting 10% of individuals of reproductive age.<sup>(14, 15)</sup> This condition often causes painful, irregular menses and increases the risk of infertility. Long term complications of the disease include type 2 diabetes and heart disease.<sup>(15)</sup> The standard treatment for PCOS includes the OCP, skin patch, vaginal ring, birth control injection, or the hormonal IUD.<sup>(14)</sup>

#### *3.4 Health Risks of Pregnancy*

Every pregnancy and delivery carries innate health risks: these include blood clots, anemia, organ-failure, seizures, high blood pressure, bleeding, infection, and death.<sup>(10)</sup> By electively preventing pregnancy in individuals at greater risk of complications, contraceptives can help mitigate these life-endangering risks.

## 4.0 Consequences of Unplanned Pregnancies

Unplanned pregnancies are associated with significant individual and societal consequences and affect a substantial portion of the Canadian population. Approximately 40% of pregnancies in Canada are unplanned, with over 39 000 unplanned pregnancies among adolescents aged 15 to 19, and 180 000 unplanned pregnancies among individuals aged 18 to 44 each year.<sup>(5)</sup>  
<sup>16)</sup> Unplanned pregnancy is associated with negative health consequences for the parent and baby, alters the life course of the family, and perpetuates the health disparities experienced by Canadians, particularly those who are already disadvantaged. Furthermore, research shows that approximately one in three women in Canada will have an abortion in their lifetime, which has associated health risks as well as emotional and social consequences.<sup>(17)</sup>

### 4.1 Health Consequences of Unplanned Pregnancies

A person's ability to choose if or when they become pregnant has a direct impact on their health and well-being. Innate health risks exist with every pregnancy and delivery, as discussed above, and this is further heightened in the case of unplanned pregnancies. People with an unplanned pregnancy are less likely to receive necessary nutrients, such as folic acid supplementation, and may expose their fetus to harmful substances such as tobacco, alcohol, and select medications. Unplanned pregnancy also precludes the opportunity to receive preconception care and decreases the duration of prenatal care, which limits opportunities to optimize the health of the parent and baby.<sup>(17-19)</sup> After delivery, unplanned pregnancies can have detrimental effects on the infant's life with increased rates of infant death, child abuse, and poor childhood development due to insufficient resources.<sup>(19, 20)</sup>

Experiencing any unplanned pregnancy can be traumatic, regardless of whether the pregnancy is terminated or carried to term.<sup>(21)</sup> Considering the option of pregnancy termination can be an emotionally difficult experience, and the procedure itself involves pain and significant expense.<sup>(22)</sup> While both surgical and medical abortions are very safe, they are medical procedures which carry innate risks. Furthermore, unplanned pregnancy is associated with significant increases in postpartum depression.<sup>(23)</sup>

The health consequences of unplanned pregnancies can place parents and their future children at a disadvantage for achieving their full health potential and contribute to the existing health inequities experienced by disadvantaged demographics in Canada.

### 4.2 Health Inequity and Unplanned Pregnancies

Unplanned pregnancy plays a major part in perpetuating the health disparities experienced among Canadians, yet this issue receives far less attention than is warranted. High rates of unplanned pregnancy, abortion, and unplanned birth contribute to the cycle of disadvantaged experiences by specific demographics such as immigrants, low-income individuals, and youth, when people are unable to modify their fertility as desired.<sup>(17)</sup> An unplanned pregnancy and birth can significantly alter the life course of adolescent parents; it can negatively impact their

opportunities to complete high school, graduate from college, secure meaningful employment with a living wage, and raise their children in a nurturing home within a safe community. Overall, adolescent parenting is associated with lower educational achievement, lower income, and an increased reliance on social support programs.<sup>(17, 22, 23)</sup>

Socioeconomic disparities have long been recognized to influence birth outcomes and pregnancy health risks. Individuals who are inadequately insured, have not completed postsecondary education, live below the poverty line, or are a visible minority already suffer disproportionately from mental illness, low rates of pregnancy detection and care, and adverse reproductive outcomes. Unplanned pregnancy further compounds the pre-existing disparities they experience.<sup>(24)</sup> For example, babies born to disadvantaged mothers have an increased risk of being born preterm or too small<sup>(19)</sup>, which are the leading causes of infant death.<sup>(20)</sup> Therefore, these marginalized populations who are already at a socioeconomic disadvantage in the context of parenting also suffer more severely from the health risks associated with unplanned pregnancy.

## **5.0 Coverage of Contraception**

### *5.1 Introduction to Current Levels of Coverage*

In Canada, the cost of contraceptives is the responsibility of the user or their private insurer instead of our healthcare system.<sup>(25)</sup> This contrasts with the current health policies in the United Kingdom, United States, Australia, New Zealand, and numerous European Union countries that provide universal subsidy for contraception.<sup>(26-28)</sup> No federally funded, universal plan covering all available contraceptives exists, as the Affordable Care Act stipulates within the United States, making contraceptive coverage patchy and sometimes non-existent.<sup>(29, 30)</sup> Provincial and territorial health care plans typically do not cover most drugs and devices, with some exceptions. Exceptions include those who are receiving social welfare benefits, receiving care within the hospital, or who qualify as youth or elderly persons<sup>(30)</sup>. Examples of these include Ontario's OHIP+ extended provincial coverage, which covers select oral contraceptive pills and the hormonal IUD for those 24 years and under, with OHIP coverage, or covered by a private plan.<sup>(31)</sup> In Quebec, people under age 18 whose parents are on RAMQ insurance and the provincial prescription drug plan may receive hormonal contraception such as OCPs at no cost.<sup>(32)</sup> Under the federal Non-Insured Health Benefits program, registered First Nations, Métis, and recognized Inuit persons are covered for most contraceptive options available in Canada.<sup>(25)</sup> However, coverage within these plans varies and does not provide people with an acceptable range of contraceptive options. The Canadian Agency for Drugs and Technology in Health's Common Drug Review program concluded that transdermal contraceptive patches and vaginal rings offer no additional advantage over oral contraceptives, resulting in these methods being variably covered.<sup>(33, 34)</sup> However, this review does not take into account patient preference, a factor that is very important in maintaining contraceptive adherence. Copper IUDs are not considered to be medications because they do not contain hormones and are often not covered under this pretense. Further, subdermal implants, which have been shown to have Tier I efficacy, are not available in Canada due to Health Canada restrictions

with clinical trial recency.<sup>(35)</sup> Subdermal implants have been available since 1998 and are currently used in 86 countries; pharmaceutical companies withdrew their applications to sell the subdermal implant in Canada because it was financially unfeasible for them to repeat their clinical trials to meet Health Canada restrictions.<sup>(36)</sup> The lack of access to an acceptable range of contraceptive choices creates an obstacle for those seeking appropriate methods to meet their individual and family reproductive goals within the context of their priorities, values, and culture.

## *5.2 Private Coverage*

Individuals may be covered under private pharmaceutical insurance plans through their employer or as the dependent of an employee with private coverage.<sup>(25)</sup> However, contraceptive coverage within private plans is inconsistent. For example, the Alberta School Employee Benefit Plan for teachers covers 100% of prescription contraceptives, but Canada Post's insurance plan outright excludes "contraceptive implants or appliances normally used for contraception whether or not prescribed for a medical reason", which excludes the IUD.<sup>(37, 38)</sup> Employers have the right to make the distinction between pharmaceuticals serving the purpose of prevention versus treatment, such as IUD or OCP use for pregnancy prevention in contrast to use for treatment of heavy menstrual bleeding. When covered, contraceptive options are often referred to as "preventatives" alongside items like elective vaccines, or else require a "prior approval" form signed by a physician to verify the use of the contraceptives for medical reasons.

## *5.3 Demographics Without Contraceptive Coverage*

A substantial proportion of the population does not have either private or public pharmaceutical insurance, subsequently forcing individuals to pay high up-front costs for contraceptives.<sup>(3)</sup> School-based services, government-run youth clinics, and nonprofit organizations that provide counselling, prescriptions, and low-cost or no-cost contraceptives have been implemented throughout Canada to counteract the financial burden that remains due to Canada's patchy contraceptive coverage. However, budgetary constraints create limited choice, and many of these programs cannot afford to provide the most effective contraceptives, such as the hormonal and copper IUDs.<sup>(29, 30)</sup> Ultimately, effective contraception is underutilized in Canada due to insufficient subsidies for contraceptive methods, narrow choice of contraceptive methods, and insurance plans whose stipulations are not consistent with the current standard of care.

## **6.0 Barriers to Contraceptive Care**

Cost has been identified as the single-most significant barrier to accessing contraception in Canada.<sup>(39, 40)</sup> Among Canadians, those with the lowest household incomes demonstrated lowest use of contraceptives<sup>(41)</sup>, were disproportionately affected by unplanned pregnancy, and had increased rates of pregnancy termination<sup>(17)</sup>. Youth have been found to experience disproportionate rates of the above as well; the evidence states that improved access to affordable contraceptives would decrease the number of youth at-risk for unplanned pregnancy<sup>(41)</sup>. A study

from Washington State University found that providing contraception at no cost reduced the overall number of unplanned pregnancies, leading to a decrease in pregnancy termination rates by 62 to 78% from the national average.<sup>(42)</sup>

Individuals with the lowest financial capacity to afford contraception are also the least likely to have private insurance coverage.<sup>(17)</sup> The rising cost of contraception is continually proven to be the primary barrier to access, particularly among individuals with low income. Even among those with private insurance, the degree of contraceptive coverage is variable. It is important to note that, for youth in particular, cost is a substantial barrier to accessing contraception due to significant up-front costs.<sup>(43, 44)</sup> Additionally, in order to remain anonymous, youth who are dependent on their parent's medical insurance must pay out-of-pocket for contraception, as their purchase will be available to those whom the insurance is under.<sup>(44, 45)</sup> Although various schools, clinics, and non-profit organizations offer contraceptives at little to no cost, they are financially constrained to a limited selection of contraceptive options with the most effective methods, IUDs, being infrequently offered.<sup>(46)</sup> A single IUD costs up to \$350 which is unaffordable for many adolescents. The cost of contraception is subsidized in Quebec, thus resulting in the lowest proportion of unmet contraceptive needs in Canada.<sup>(47)</sup>

## 7.0 Cost-Benefit Analysis

Providing universal access to contraception diminishes individual access barriers and results in significant cost savings for the healthcare system. The cost-savings from providing universal coverage of contraception stems from a reduction in both unplanned pregnancies and subsequent terminations. The direct costs of unplanned pregnancies amount to \$61 million for people aged 15-19 and \$320 million for people aged 20-29, annually.<sup>(6, 16)</sup> Specifically, annual costs secondary to contraception non-adherence comprise a significant proportion of total spending, at \$37 million and \$143 million among the two age groups, respectively.<sup>(6, 16)</sup> Improving access through universal coverage removes cost-associated barrier to contraceptive adherence and provides Canadians with the option to use LARC methods. LARC use markedly improves adherence through their aforementioned longstanding and low maintenance design.

Black et al. 2015 modelled the cost savings associated with switching to LARCs from other methods in individuals aged 20 to 29. The three scenarios modelled included changing to a LARC from OCP alone, from any short-acting method (OCP, patch, vaginal ring), and from short-acting methods or no method. Each scenario resulted in over \$34 million in cost-savings total. Importantly, each scenario achieved cost neutrality in 12 months. This model was repeated for adolescents aged 15 to 19, with at least \$3 million in savings for each scenario. Estimated cost neutrality occurred by 6.8 months in this demographic.<sup>(16)</sup>

Ames et al. (2012) conducted a Canadian retrospective cohort study to delineate systemic cost-savings through IUD use. The authors found that providing an IUD immediately following pregnancy termination compared to oral or injectable contraception was associated with healthcare savings of approximately \$242.97 per person by five years.<sup>(48)</sup> In concert with the aforementioned

CHOICE project which determined that 75% of participants chose a LARC method when cost was removed as a barrier,<sup>(9)</sup> these Canadian studies show the significant systemic savings that would result from universal coverage of contraception.

## **8.0 Task-Shifting for Contraceptive Care**

### *8.1 Defining Task-Shifting and its Role in Contraceptive Care*

Task-shifting is a process that delegates specific tasks from certain healthcare workers to other members of the healthcare team who hold different credentials.<sup>(49)</sup> In context, this encompasses expanding the scope of practice of allied healthcare workers such as registered nurses, pharmacists, and midwives to include contraceptive counselling, prescribing, and IUD insertion and removal. Task-shifting is an essential model in rural and remote areas to improve access in communities without a physician or telehealth capabilities.

World leaders in contraceptive care encourage the practice of task-shifting as the demand for care exceeds the current availability of providing healthcare professionals. The Society of Obstetrics and Gynecology (SOGC) 2015 Consensus states that it is both safe and feasible for allied health workers (midwives, registered nurses, and pharmacists) to provide contraceptive care, and call for healthcare jurisdictions to engage in task-shifting initiatives.<sup>(5)</sup> A 2017 WHO report echoed this sentiment by stating that nurses and midwives can safely and effectively provide education and counselling on contraceptives, prescribe contraceptives, and insert and remove IUDs. Furthermore, IUD insertion performance between physicians and nurses is equivalent with appropriate training.<sup>(50)</sup>

### *8.2 Benefits of Task-Shifting*

Task-shifting is an important part of improving contraceptive access through increasing the points of entry to care.<sup>(49)</sup> This model is a cost-effective solution to improving access and availability to contraception in Canada, as nearly all populated regions already have pharmacists and nurses who would be qualified to provide these services. Task-shifting is particularly beneficial for rural and remote communities which currently face greater challenges in accessing care.<sup>(49)</sup> Furthermore, distributing these tasks among various healthcare providers frees time for clinicians to employ more specialized skills towards the long waitlists of more medically complex patients. From a financial perspective, task-shifting is a safe and effective way to reduce the costs of family planning services by spending less on specialist services when the same tasks can be performed equally well by allied health professionals.<sup>(49)</sup>

### *8.3 The Current State of Contraceptive Prescribing in Canada*

In Canada, hormonal contraceptives can only be obtained through prescription from a physician, nurse practitioner, or midwife.<sup>(51-56)</sup> Based on provincial midwifery scope-of-practice documents, the only provinces and territories where midwives can prescribe and insert IUDs (with

additional training and authorization) are BC, Alberta, and the Northwest Territories.<sup>(53-56)</sup> According to Hulme et al.<sup>(17)</sup>, non-physician health care workers are underutilized in the Canadian healthcare system, making task-shifting an ideal avenue to maximize pre-existing healthcare infrastructure. Furthermore, allied healthcare professionals are open to increasing their scopes of practice and task-shifting agreements in contraceptive care. A 2015 BC survey found that over 80% of pharmacists representing every region of BC were interested in prescribing hormonal contraceptives if the appropriate legislation was in place.<sup>(51)</sup> Additionally, the College of Nurses of Ontario is currently advocating to allow registered nurses to prescribe contraceptives.<sup>(52)</sup>

#### *8.4 Success Stories of Task-Shifting in Canada*

Within Canada, Quebec has adopted a task-shifting policy for contraceptive care and their rates of unplanned pregnancy have decreased significantly since implementation.<sup>(57)</sup> Quebec's Bill 90 was passed in 2002 allowing task-shifting between different health-care professionals. In 2007, the Collaborative Agreement in Hormonal Contraception (CAHC) was implemented. This currently allows trained nurses and pharmacists to prescribe hormonal contraception for one year without a medical consultation. Furthermore, nurses and pharmacists can provide an initial IUD consultation and prescription before insertion by a physician or nurse practitioner. Since 2007, over 4000 nurses have been trained in hormonal contraception in Quebec using in-person and online methods.<sup>(57)</sup>

The outcomes of task-shifting in Quebec have been significant: Guilbert et al.<sup>(57)</sup> reported that abortion rates have decreased by 24% among people 15 to 19 years of age and 15% among people 20 to 24 years of age between 2004 and 2011. Further, the birth rate among teens 15 to 19 years of age has decreased by 15%.

In less than a decade, Quebec dramatically reduced abortion and adolescent birth rates using large-scale policy changes including task-shifting. This serves as a successful model for which the rest of Canada can follow suit. Task-shifting is safe, efficacious, and is recommended by international leaders in contraceptive care. Furthermore, Canada is the ideal setting to implement a task-shifting model given our geographically dispersed population. Lastly, the Canadian healthcare system currently has the human resources to implement task-shifting and the parties involved are interested in expanding their scope of practice. A federally supported task-shifting model would promptly increase access to contraception in the rural and remote regions of Canada while simultaneously assisting with problems intrinsic to the Canadians healthcare system, such as wait times.



## Part III: The Importance of Universal Access to Contraception

### **9.0 Health Equity and Universal Access to Contraception**

The World Health Organization (WHO) defines health equity as *every individual having a fair opportunity to attain their full health potential, and that no one should be disadvantaged from achieving this potential* because of their race, ethnicity, religion, gender, age, social class, socioeconomic status, sexual orientation, or other socially-determined circumstances.<sup>(58)</sup> In Canada, our universal healthcare system has allowed us to make significant strides towards achieving health equity amongst our population. Despite the advancements in our healthcare system since Medicare was introduced over 50 years ago, many barriers still exist which have prevented Canada from achieving true health equity. In an unequal system, vulnerable and at-risk populations feel the greatest impact from systemic change. Although universal access to contraceptives is not an all-encompassing solution to achieving health equity, it is a major step that will drastically improve the lives of Canadians and bring us all closer to optimal health.

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## Acknowledgements

We would like to thank the community leaders and health experts whose expertise and guidance helped shape the direction of this document. Without you, this would not have been possible

**Brianne Goertzen**, Provincial Director;  
Manitoba Health Coalition

**Dr. Farkad Balaya**, Obstetrician and  
Gynecologist; Montreal, Quebec

**Dr. Giosi Di Meglio**, Adolescent Medicine  
Specialist; Montreal Children's Hospital

**Dr. Maggie Morris**, Obstetrician and  
Gynecologist; Winnipeg, Manitoba

**Dr Megan Clark**, Family Physician;  
Regina, Saskatchewan

**Dr Sally Mahood**, Family Physician;  
Regina, Saskatchewan

**Dr Sarah Smith**, Obstetrician and Gynecologist;  
Regina, Saskatchewan

**Dr Teale Bondaroff**, Founder and Co-Chair;  
Access BC

We would also like to acknowledge the members of the Day of Action Research Committee for the tremendous amount of time and effort that you have dedicated to researching, compiling and writing this backgrounder.

**Amanda Mills**, Queen's University

**Nada El Tobgy**, University of Manitoba

**Jessica Froehlich**, University of Saskatchewan

**Seana Adams**, University of Toronto

**Sara Markovic**, University of Manitoba

**Xuan Zhao**, University of British Columbia

**Michael Teutenberg**, McMaster University

**Morgan Haines**, University of British Columbia

**Jobanjit Phulka**, University of British Columbia

**Saman Fouladirad**, University of British  
Columbia

With Deepest Appreciation and Gratitude,

Lara Witt  
CFMS National Office of Political Action

Helen Teklemariam  
CFMS Director of Government Affairs

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