Provision of care to diverse populations: results from the 2019 Canadian Abortion Provider Survey

The WHO highlighted the importance of providing culturally safe, high-quality healthcare,[1] emphasising that services should be welcoming to diverse populations, including "youth and people from sexual and gender minorities, people living with disabilities, and all groups in vulnerable and marginalised situations".

We conducted the 2019 Canadian Abortion Provider Survey (CAPS), collecting demographics, clinical abortion practices, and stigma experiences of providers.[2 3] In this research letter we present how abortion providers cared for diverse populations and the related training they had received.

Physicians, nurse practitioners and abortion service administrators who provided abortion care in 2019 were eligible to participate. To explore dimensions of care provided to diverse populations, we asked multiple-choice and open-ended questions, including: Do you provide abortion care to diverse patient populations (eg, cultural/ethnic origins, gender/identity, etc.)? Do you adjust your abortion care to diverse patient populations? Have you ever had specific training for providing abortion care to diverse populations during your education/professional training? We present descriptive statistics analysed with R Statistical Software. We conducted a reflexive thematic analysis of the open-ended responses and organised our results in an explanatory narrative.

Of the 500 respondents who completed the CAPS survey, 356 started the Diverse Populations section and we report on the results of this subsample. Respondents (n=356) represented every province and territory in Canada as well as urban (59.1%) and rural (40.9%) areas. The majority of respondents self-identified as women (83.5%), clinicians (92.1%) as opposed to administrators, and having less than 5 years' experience providing abortion care (65.6%).

While most clinicians reported they had not received specific training for providing care to diverse populations (91.2%), 91.8% indicated they provided care to diverse populations and almost half (47.0%) adjusted care to accommodate their patients' needs most or all of

Table 1 Qualitative analysis of responses to the 'Care for Diverse Populations' section of the 2019 Canadian Abortion Provider Survey

Theme	Subtheme	Sample quotation
Adjusting care to patient's religion and/or culture	–	"We serve an Indigenous population in Quebec and they occasionally request to take the fetal tissue home to bury which we will accommodate." 'Openness to particular requests around management of the products of conception; for the most part it's just openness to any cultural/religious/etc. preferences or practices the patient may bring up."
	Including culturally appropriate support people on the team	"Involvement of culturally appropriate support people (eg, Indigenous cultural navigator/Indigenous midwife), faith-based supports (priest, imam), provision of CuddleCot so that family can take baby home." "I always ensure I take the family situation into consideration as well as ensure that I'm able to ask about who their supports are. In some cases, family are unhelpful due to their religious beliefs and therefore I determine whether there are alternative supports for them."
Adjusting language and communication	–	"We care for a lot of international students in town for school - I find they often have very minimal understanding of contraceptive options so we have to take a lot of time to explain this to this population of patients. Sometimes a telephone translation service, or family member translating, is required for others." "I adjust amount and speed of information-sharing based on comprehension, language, education, cognitive status, mental health, expression of cultural ethical concerns." "Some patients request I use different terminology (ie, not refer to their situation as a 'pregnancy' or avoid the term 'fetus/baby') for personal reasons." "Using different documents/handouts (languages, pictographs, etc.)."
Providing gender-affirmative, trauma-informed care		"Always using gender-neutral language, trans-inclusive assessment of services." "Different terms to describe procedure/anatomy/contraception, use of preferred pronouns." "I think we try to use trauma-informed care. We have moved away from using words like relax and trying to let individuals drive their medication choices." "I discuss intimate partner violence and review how their partner feels/if they know and discuss safety if needed."
Shifting where and when services are provided	To make care more accessible	"I have some patients who live far away, so I adjust to more telephone follow-up and don't necessarily check serial hCG for those patients." "I work with nurses in remote First Nations communities via telehealth to increase access to abortion care." "…allow drop-ins and seeing people when they arrive, even if it's late/the wrong appointment day/time." "…may give them the option of taking medications in hospital versus at home if they live out in the communities that are far from the ER or have poor pain tolerance and require further care."
	To ensure communication and adherence	"For those with lower literacy or English language skills, I will definitely have them take the mifepristone on site. Sometimes, if I'm uncertain of their comprehension, I will have them take the misoprostol on site as well. I also follow them more closely with phone calls afterwards to ensure follow-up hCGs are done. I have created picture-rich infographics to facilitate understanding of the process." "I have a primarily First Nations patient base from fly-in communities. I do multiple in-person visits to ensure communication is clear and ensure medication is taken correctly as many of my patients have limited medical literacy. Our policy requires them to be near a hospital rather than returning to fly-in communities so we see them and do ultrasounds earlier to try to confirm they are safe to fly home prior to discharge."
Asking patients to share their preferences		"I ask about patient preferences, beliefs, so I can present all options and ensure the options they know are available are consistent with their belief systems." "Primarily, acknowledging the differences and asking the person to please feel comfortable correcting us if we make an error, and also asking them if there is anything we can do to make the situation more comfortable for them." "…abortion care for me is part of primary healthcare delivery, which by nature is client-specific and tailored to each individual's circumstances."

ER, emergency room; hCG, human chorionic gonadotropin.

the time. When asked which continuing training opportunities would be relevant in supporting care of diverse populations, the majority of respondents suggested web-based training (77.3%) followed by in-person training (34.1%).

Finally, participants who adjusted their care to diverse populations were given the option to provide an open-ended response to the question: Please explain how you adjust your abortion care (eg, to specific environment, specific personnel or specific training). Our analysis of the qualitative responses from 206 participants identified five core themes (italicised below), which we summarise with sample quotations in table 1. Participants *adjusted care to the patient's religion and/or culture*, for instance by being open to managing the products of conception and/or including culturally appropriate support people. *Adjusting language and communication* was a core strategy participants described, through translation services, shifting the amount and speed of information shared, and offering multilingual resources with visuals.

Some participants specified that they provided *gender-affirmative* and *trauma-informed* care[4] through use of gender-neutral language and trans-inclusive services. Other participants focused on *shifting when and where services are provided* including virtual health and flexible appointments. Others described relying on in-person care and closer follow-up when concerned about protocol adherence due to, for example, low literacy or English language skills. Finally, participants described offering personalised care by *asking patients to share their preferences*.

We identified a gap in Canada between recommendations to provide culturally safe healthcare and abortion provider-reported training opportunities to provide care to diverse populations. Most respondents reported never receiving specific training. Less than half of respondents consistently adjusted care to diverse populations, for example, by implementing trauma-informed, culturally safe and gender-affirmative practices. We were unable to assess the quality of these care practices. In order to improve and standardise provision of culturally safe care as an indicator of equitable access to high-quality abortion care, we found there is an urgent need to develop, implement and evaluate training materials specific to providing abortion care to diverse populations.

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