TOWARDS A NURSE-LED MODEL OF CARE FOR MEDICATION ABORTION PROVISION IN REGIONAL AND RURAL VICTORIA

by

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MD, MPH

Submitted in fulfilment of the requirements for the degree of

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Deakin University

September 2018
I am the author of the thesis entitled

Towards a nurse-led model of care for medication abortion provision in regional and rural Victoria

submitted for the degree of Doctor of Philosophy

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This thesis is dedicated to my beloved father Prof. Dr. Michel Mandel

(1926 – 2017)
ACKNOWLEDGEMENTS

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# LIST OF ACRONYMS AND ABBREVIATIONS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACHPR</td>
<td>African Commission on Human and Peoples’ Rights</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AMA</td>
<td>Australian Medical Association</td>
</tr>
<tr>
<td>ANMF</td>
<td>Australian Nursing and Midwifery Federation</td>
</tr>
<tr>
<td>Anti-D</td>
<td>Anti-Rhesus (D) immunoglobulin</td>
</tr>
<tr>
<td>ARIA</td>
<td>Accessibility/Remoteness Index of Australia</td>
</tr>
<tr>
<td>ASGS</td>
<td>Australian Statistical Geography Standard</td>
</tr>
<tr>
<td>CERSH</td>
<td>Centre for Excellence in Rural Sexual Health</td>
</tr>
<tr>
<td>CRR</td>
<td>Center for Reproductive Rights</td>
</tr>
<tr>
<td>DHHS</td>
<td>Department of Health and Human Services</td>
</tr>
<tr>
<td>GCCSA</td>
<td>Greater Capital City Statistical Areas</td>
</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
</tr>
<tr>
<td>hCG</td>
<td>Human chorionic gonadotropin</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>IQR</td>
<td>Inter-quartile range</td>
</tr>
<tr>
<td>KW</td>
<td>Kruskal-Wallis H-test</td>
</tr>
<tr>
<td>MA</td>
<td>Medication abortion</td>
</tr>
<tr>
<td>MBS</td>
<td>Medicare Benefits Schedule</td>
</tr>
<tr>
<td>MDA</td>
<td>Medical Directory of Australia</td>
</tr>
<tr>
<td>MS</td>
<td>Marie Stopes</td>
</tr>
<tr>
<td>MTOP</td>
<td>Medical termination of pregnancy</td>
</tr>
<tr>
<td>MWU</td>
<td>Mann Whitney U test</td>
</tr>
<tr>
<td>NHSD</td>
<td>National Health Service Directory</td>
</tr>
<tr>
<td>NMBA</td>
<td>Nursing and Midwifery Board of Australia</td>
</tr>
<tr>
<td>Pap test</td>
<td>Papanicolaou cervical screening test</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PHCN</td>
<td>Primary health care nurse</td>
</tr>
<tr>
<td>PLSC</td>
<td>Plain Language Statement and Consent</td>
</tr>
</tbody>
</table>
PNIP  Practice Nurse Incentive Program
RACGP  The Royal Australian college of General Practitioners
RANZCOG  The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RCN  The Royal College of Nursing
RCOG  The Royal College of Obstetricians and Gynaecologists
Rh-negative  Rhesus-negative
RWAV  Rural Workforce Agency Victoria
TGA  Therapeutic Goods Administration
UK  United Kingdom
UN  United Nations
US  United States
VIC  Victoria
VLRC  Victorian Law Reform Commission
WHO  World Health Organization
ABSTRACT

In the case of an unwanted pregnancy, access to abortion services should be easily available, regardless of a woman’s residence, age, socio-economic status, or cultural and religious background. Nevertheless, in Victoria, one of the three Australian jurisdictions where abortion is legalised, abortion provision is mostly confined to major cities and remains sparse in regional and rural areas. While the medication abortion method has the potential to expand the pool of abortion providers in underserved regions, the uptake among general practices in Victoria remains low. A key strategy to improve abortion access is to increase the involvement of primary health care nurses in the medication abortion provision process, an approach that is already successfully and effectively implemented in many countries all over the world.

The aim of this study was to develop a nurse-led model of care for medication abortion provision in the primary health care setting of regional and rural Victoria to improve abortion access. Additionally, the study explored the current and potential future involvement of general practitioners and primary health care nurses in regional and rural Victoria in the delivery of medication abortion services, as well as the factors that might hinder or enable medication abortion provision uptake or implementation of the nurse-led model.

The study used a mixed-method approach consisting of two separate but interconnected studies. The first study used a cross-sectional survey design. A convenience sample participated, consisting of 69 general practitioners and primary health care nurses from regional and rural Victoria. For the second study, the Delphi technique was used and a total of 24 experts took part in three iterative survey rounds.

While only a small percentage (11%) of the surveyed participants were currently involved in medication abortion provision, there was quite a high overall interest (61%) in receiving medication abortion training. Participants, however, perceived a range of barriers for medication abortion provision uptake, such as a lack of training opportunities, a lack of supportive systems,
uncooperative colleagues, legal uncertainties and social stigma. The Delphi findings showed great support for nurse-led medication abortion provision and data analysis led to the formation of three nurse-led models. The first and preferable model is a fully autonomous nurse-led model. However, due to federal government restrictions on abortion medication prescriptions, the health care system, and the lack of financial remuneration for nurse-led medication abortion provision, the extent of the primary health care nurse’s involvement in medication abortion provision is currently limited. Therefore, a second, legally feasible, nurse-led medication abortion model was constructed. The third included model can be used by primary health care nurses in situations when a non-supportive general practitioner is present.

The proposed models can inform and guide key players who want to become involved with nurse-led medication abortion provision. However, the study identified that a lack of training opportunities and support services, as well as the influence of stigma, can deter the implementation of nurse-led medication abortion provision model. Further, there is an urgent need for general and specialised education on medication abortion provision and for an independent reimbursement of primary health care nurses’ medication abortion-related activities. Finally, to implement a fully autonomous nurse-led model, prescription rights policy review is required as well as a health care reform to end current health care system rebate constraints.

This study provides insight into the current roles of general practitioners and primary health care nurses from regional and rural Victoria in medication abortion provision and their perceived barriers for medication abortion provision uptake. Further, the study findings suggest that in the legal and social climate of Victoria, implementation of a nurse-led model of medication abortion provision is feasible. However, to facilitate this process, the perceived lack of medication abortion awareness, knowledge and training needs to be addressed to ensure that abortion access for regional- and rural-residing women will be improved.
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Throughout history, women all over the world, regardless of their origin, religion or cultural background, have used induced abortions as a solution for unwanted pregnancies. Currently, the most prominent reason for unintended pregnancies is contraception failure, mainly caused by incorrect use or the unmet need for family planning (Sitruk-Ware, Nath & Mishell 2013; World Health Organization (WHO) 2012). Thus, despite the progress in effective and safe contraceptive methods, unintended pregnancies remain unavoidable and induced abortions will continue to be practised (Cohen 2012; Sitruk-Ware, Nath & Mishell 2013). An induced abortion, further referred to as ‘abortion’, is the termination of a pregnancy with the use of surgical methods (such as vacuum aspiration and dilatation and evacuation) or pharmacological drugs (Family Planning NSW 2013).

Over the years, abortions have proven to be very safe and effective medical procedures when performed by skilled providers with correct medical techniques or pharmaceutical regimens (WHO 2012). Nevertheless, access to safe abortion services is often restricted, either legally or because of a lack of service providers, which can result in unsafely performed procedures that pose a serious risk to women’s physical health (WHO 2012). Although nearly all (97%) unsafe abortions and related complications occur in developing countries, access to abortion in Australia is certainly not without barriers (de Moel-Mandel & Shelley 2017; Ganatra et al. 2017; Kumar et al. 2004; WHO 2012). The termination of a pregnancy is still a criminal act in most Australian jurisdictions (see section 1.4.1) and abortion provision is particularly sparse in regional and rural communities, owing to the ongoing perception of abortion as an extremely controversial procedure, which makes physicians reluctant to become involved (de Moel-Mandel & Shelley 2017; Shah & Ahman 2009). While a range of developed countries have addressed provider-shortage problems by using primary health care nurses (PHCNs) for the delivery of medication abortion (MA)
services, this evidence-based practice is not yet integrated in Australia’s general practices (WHO 2015b).

This chapter provides the context for the current study. The first section gives an overview from a global perspective of the history, safety, efficacy and legality of induced surgical and MAs. The second section recognises access to safe abortion services as a reproductive and human health right, while the third section introduces Saurman’s Theory of Access framework as the tool that was used to guide the study’s research process. Next, abortion access in Australia is examined, followed by the situation in Victoria, as this state was chosen as the setting of the study. Section 1.5 proposes nurse-led MA provision as an approach to increasing abortion access in Victoria’s regional and rural areas. Finally, in the last section, an outline of all chapters in this thesis is presented.

1.1 ABORTION – THE GLOBAL CONTEXT

Globally, approximately 41 percent of all pregnancies are unintended, and around half of these unintended pregnancies will end in an abortion, resulting in approximately 56 million abortions each year (Ganatra et al. 2017; Sedgh, Singh & Hussain 2014; WHO 2012). While abortions have been practised throughout history, it was only since countries started to legalise abortion that procedures became more safe and effective (Joffe 2009). Yet, currently, due to the worldwide variety in abortion legality and social, cultural and religious beliefs, unsafe abortions persist, resulting in maternal morbidity and mortality (Culwell & Gerdts 2014; WHO 2012). In this section, these aspects will be further explored.

1.1.1 The history of abortion procedures

While the ethics of abortion have been questioned since Greek and Roman times, the acceptability of abortions only became an issue in the nineteenth century because of the rising knowledge about foetal development and medical advances (Baird & Porter 2010). Constraints on abortion were introduced not only to protect women from the often-fatal practices of
abortionists, but also to protect foetal life and punish women for the sin of terminating a pregnancy (Berer 2017). This further led, through a succession of laws, to the criminalisation of abortion, which was first enacted in the United Kingdom (UK) with the Offences Against the Person Act 1861 (Baird & Porter 2010). Soon, other countries, such as Japan and the United States (US) followed, and by the end of the Second World War, abortion became a highly-restricted procedure all over the world (Baird & Porter 2010; Finer & Fine 2013). Around the 1950s, a gradual global trend of the relaxation of these legal restrictions began in Central and Eastern Europe, and around 1985, most industrialised countries had liberalised their abortion laws (Finer & Fine 2013).

Alongside the relaxing abortion laws, procedures to end unwanted pregnancies also evolved. The more invasive surgical ‘dilatation and curettage’ and ‘dilatation and evacuation’ methods were replaced by the manual or electric vacuum aspiration technique for pregnancies up to 12 weeks. These advanced procedures proved to be very safe, with less than 0.1 percent of women requiring hospitalisation due to serious complications, and a case–fatality rate of 0.1 per 100,000 interventions before nine weeks of pregnancy, or 0.7 per 100,000 interventions overall (Sedgh et al. 2016; WHO 2012). Further, the often ineffective and dangerous use of chemical and herbal compounds to induce abortions, described in many historic manuscripts, became abandoned when the strong abortive effect of prostaglandins was discovered in the 1970s (Fiala & Gemzel-Danielsson 2006; Santow 1998). Misoprostol, initially used for the treatment and prevention of peptic ulcer disease, became the prostaglandin of choice because it was inexpensive, had few side-effects and proved to function orally as well as via oral mucosa (Gomperts 2014; Schaff 2010). This discovery led to an evolution of MA regimens.

1.1.2 Advancements in effective, efficient and safe MA regimens

In 1982, French scientists discovered that the addition of the anti-progestogen mifepristone, also known as RU486, potentiated the abortion effect of misoprostol and further reduced most common side-effects (Fiala & Gemzel-
Chapter 1 | Introduction

Danielsson 2006). Over time, a variety of dosages, routes and timing of administration were trialled. Current evidence-based guidelines recommend, for pregnancies in the first 63 days of gestation, the use of mifepristone 200 mg orally followed within 36–48 hours by misoprostol 800 mcg taken buccally, a regimen that has proven to be as effective as surgical abortions (Chen & Creinin 2015; Goldstone, Walker & Hawtin 2017; Raymond et al. 2013; The Royal Australian and New Zealand College of Obstetricians and Gynaecologists 2016 (RANZCOG); WHO 2012).

Abortions induced with medication are not only very effective, but also efficient and one of the safest procedures in contemporary medicine. Chen and Creinin (2015, p. 17) defined an efficient MA as one ‘in which the pregnancy was expelled from the uterus without need for surgical evacuation’. Three large studies (Chen & Creinin 2015; Goldstone, Michelson & Williamson 2012; Goldstone, Walker & Hawtin 2017) investigated the efficiency and safety of MA procedures for pregnancies less than nine weeks’ gestation, using the evidence-based regimen. The most recent of the three studies, an observational cohort study of 15,008 women, showed a success rate of 95.2 percent (Goldstone, Walker & Hawtin 2017). This study, conducted at Australian Marie Stopes International clinics, had similar findings to Chen and Creinin’s (2015) systematic review, and Goldstone, Michelson and Williamson’s (2012) observational study of 13,345 women, which reported success rates of 96.7% and 96.5%, respectively. Abortion method failure not only includes incomplete abortions, which can be managed medically or require a surgical intervention, but also ongoing pregnancies. The rate of ongoing viable pregnancies after the MA procedure was almost identical for all three studies (0.6–0.8%), and occurred more often in parous women, older women with previous abortions, and more gestationally advanced pregnancies (The Royal College of Obstetricians and Gynaecologists (RCOG) 2011).

The side-effects of an MA procedure are comparable to a spontaneous abortion, which is defined as the loss of a pregnancy without outside intervention before 20 weeks' gestation, when the embryo or foetus is not
capable of surviving independently (WHO 2012). Side-effects include uterine cramping and bleeding for the duration of, on average, nine days, as well as nausea, vomiting, diarrhoea, headache and dizziness (WHO 2012). Serious side-effects not related to method failure, on the other hand, such as infections or severe bleeding requiring transfusion, were rare (see Table 1.1).

### Table 1.1 Method failure and serious side-effects of MA (≤ 63 days)

<table>
<thead>
<tr>
<th>Study</th>
<th>Efficiency rate (%)</th>
<th>Incomplete abortion requiring surgical intervention (%)</th>
<th>Continuing viable pregnancy (%)</th>
<th>Infection (%)</th>
<th>Bleeding requiring transfusion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goldstone, Walker &amp; Hawtin (2017)</td>
<td>95.2</td>
<td>4.8</td>
<td>0.8</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Chen &amp; Creinin (2015)</td>
<td>96.7</td>
<td>Not provided</td>
<td>0.8</td>
<td>0.01-0.5</td>
<td>0.03-0.6</td>
</tr>
<tr>
<td>Goldstone, Michelson &amp; Williamson (2012)</td>
<td>96.5</td>
<td>2.9</td>
<td>0.6</td>
<td>0.2</td>
<td>0.08</td>
</tr>
</tbody>
</table>

Note: Studies with up to 70 days’ gestation are included.

Ectopic pregnancies, where the fertilised egg nestles outside the endometrial layer of the uterus, are a significant cause of morbidity and mortality in women of reproductive age (Rana et al. 2013; Shannon et al. 2004). While MA regimens do not terminate ectopic pregnancies, pre-abortion screening methods that include bimanual examination, last menstrual period dating, serum pregnancy test measurements (human chorionic gonadotropin (β-hCG)) and/or vaginal ultrasonography, do reduce after-treatment diagnosis (Shannon et al. 2004). Ectopic pregnancy rates after MA procedures range between 0.007% and 0.03%, which are very low compared to the overall worldwide incidence of ectopic pregnancies (1-2%) (Cleland et al. 2013; Gaudu, Crost & Esterle 2013; Orazulike & Konje 2013; Shannon et al. 2004). The diagnosis of ectopic pregnancies in early pregnancies, however, still poses considerable challenges, as ultrasonography is often non-diagnostic (Lichtenberg & Paul 2013; Shannon et al. 2004).
Since its introduction, the use of mifepristone for early MA has increased exponentially and MA is currently provided in more than 60 countries worldwide (Jones et al. 2017). In the US in 2014, for example, approximately 45 percent of abortions up to nine weeks’ gestation were medication procedures, while in England and Wales in 2016, this proportion was as high as 62 percent (Department of Health 2017a; Jones & Jerman 2017). Nevertheless, despite the availability of efficient and safe abortion options for women with an unwanted pregnancy, still 45 percent of all abortions worldwide are performed unsafe, due to restrictive abortion laws (Ganatra et al. 2017).

1.1.3 The relationship between restrictive abortion laws and unsafe abortions

While over the years most Westernised countries adopted relatively tolerant abortion laws, almost all developing countries in Africa, Latin America, the Middle East and Southern Asia still vastly restrict abortions (Theodorou & Sandstrom 2015). Data shows that 26 percent of all countries worldwide only allow abortions as a solution to save the woman’s life, and that in countries such as El Salvador, Nicaragua, Dominican Republic, Malta and Vatican City, abortion is illegal in all circumstances (Theodorou & Sandstrom 2015). In 2017, this total ban on abortion was eased in Chile, with the introduction of a new law that allows abortions when the life of the pregnant woman is at risk, in the case of rape, or if the foetus is not viable (Vivanco & Undurraga 2017).

Despite common assumption, restrictive laws do not prevent women from having an abortion (WHO 2012). Women still pursue abortion services, which are consequentially often performed in clandestine and unsafe circumstances (WHO 2012). Worldwide every year, about 25.1 million abortions are performed unsafely, resulting in the death of at least 47,000 women and another five million women who will end up with a permanent disability (Ganatra et al. 2017; WHO 2012). Therefore, it is of the utmost importance that abortions are decriminalised, safe and accessible, and that abortion laws and policies need to protect a woman’s health and her human rights (Sedgh et al. 2017).
2016; WHO 2012). It has been demonstrated that the implementation of a human rights-based approach will not only reduce abortion numbers but also maternal mortality and morbidity caused by unsafe abortions (Shaw 2010).

1.2 ABORTION, A REPRODUCTIVE AND HUMAN HEALTH RIGHT

The right to access safe abortion care and a woman’s freedom to make decisions on the number, spacing and timing of children are incorporated in international human rights treaties and global consensus declarations (WHO 2012). The first Universal Declaration of Human Rights, which acknowledged the dignity and human rights of every human being, emerged in 1948 with the formation of the United Nations as a reaction to the atrocities of the Second World War (Shaw 2010). Over the years, global consensus declarations on human rights, which include the rights to life, liberty, health, privacy and non-discrimination, were progressively recognised in international treaties and conventions, and endorsed in the constitutions and laws of most countries (WHO, 2012). Reproductive rights, positioned as a subsection of human rights, were first defined and accepted in 1994 at the International Conference on Population and Development (ICPD) in Cairo, Egypt (United Nations (UN) 1994). The reproductive rights’ focus moved away from population control through fertility regulation towards a rights-based approach to protect sexual and reproductive health (Campo 2013). Reproductive rights became recognised as ‘the basic right of all couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so’ (UN 1994, para 7.3). Although the ICPD report specified that governments needed to ‘deal with the health impact of unsafe abortion as a major public health concern’, abortion prevention was given a much higher priority (UN 1994, para 8.25). The ICPD agreement further stated that in the case of an unwanted pregnancy, women should have access to trustworthy information, counselling and medical support, as well as post-abortion care and family planning services to avoid repeat unplanned pregnancies (UN 1994). In addition, it was
determined that in states where abortion was legal, abortion provision should be safe (UN 1994). However, the ICPD ‘Programme of Action’ did not identify the need for states to legalise abortion, despite the fact that legalisation has proven to be crucial for the reduction of unsafe abortions (Fine, Mayall & Sepúlveda 2017).

The last few decades witnessed dramatic health problems related to human sexuality and sexual behaviour, such as sexually transmitted infections, the HIV pandemic, unsafe abortions and sexual violence (WHO 2015c). Together with an increased understanding of discrimination and inequality related to sexual and reproductive health, which includes abortion, these changes led to the construction of a range of sexual health promoting human rights standards, which were made operational through laws and policies at state levels (WHO 2015c). National laws thus determine the framework for sexual health-related policies, programs and services, and they can either protect human rights, or generate restrictions (WHO 2015c).

The strong correlation between the legality of abortion and safe abortion provision, as discussed in Section 1.1, and the recognition of unsafe abortion as a major public health problem, resulted in an increase in human rights advocacy for abortion, with law reform supported as a public health intervention (Erdman 2014; Zampas & Gher 2008). A key development after the ICPD report was the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (the Maputo Protocol) (African Commission on Human and Peoples’ Rights (ACHPR) 2003). This protocol, adopted by the African Union in 2003, warrants women’s right to health, including sexual and reproductive health, and it recognises ‘abortion, under certain conditions, as a women’s human right, which they should enjoy without restriction or fear of being prosecuted’ (ACHPR 2003, p. 2). While the treaty only involved the African continent, elsewhere other regional human rights bodies also began to address abortion as a human rights imperative (Zampas & Gher 2008). In 2008, for example, the Parliamentary Assembly of the Council of Europe approved a report that encouraged its 47 representing countries to decriminalise abortion
and guarantee a woman’s right to access safe and legal abortion (Fine, Mayall & Sepúlveda 2017). Further, in 2016, the United Nations Committee on Economic, Social and Cultural Rights explicitly included the right to abortion in the right to reproductive health, and acknowledged that access to safe and legal abortion services is a fundamental component of the right to achieve the highest standard of health (Sifris & Belton 2017).

Over the years, the principles of reproductive rights became rooted in a constellation of international human rights standards (Center for Reproductive Rights (CRR) 2010). The principles not only support the view for abortion on request, but they also suggest that any restriction on the access to safe abortion is an obstruction of a woman’s human rights (CRR 2010; Zampas & Gher 2008). Although to date these standards are certainly not acknowledged by all international treaty-monitoring bodies, they can be used by abortion advocates to improve women’s full reproductive autonomy (Fine, Mayall & Sepúlveda 2017; Zampas & Gher 2008). The endorsement of International Human Rights treaties in Australia is outlined in Section 1.4.

The following section uses a theory of access framework to discuss the right to have access to health care services, including safe abortion services.

**1.3 DIMENSIONS OF ACCESS TO HEALTH CARE SERVICES**

Access to health care, including the provision of abortions, is considered to be a human right and implies an adequate supply of health services available when wanted or needed (Gulliford et al. 2002; Russell et al. 2013; WHO 2015a). Access to health care is of particular concern for people living in regional and rural areas, where socio-economic disadvantages, travel distances and workforce shortages can contribute to poorer health outcomes for the population concerned (Saurman 2016; Wakerman et al. 2008).

The term ‘access’, however, was not well-defined until 1981 when Penchansky and Thomas (1981, p. 139) conceptualised access as a measure of ‘the fit between characteristics of providers and health services, and
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characteristics and expectations of clients’. In other words, access is influenced by the features of health care resources and their potential consumers (Levesque, Harris & Russell 2013). Penchansky and Thomas (1981) proposed a classification of the concept of access by dividing access into five distinct but interconnected dimensions:

1. **Availability** – the volume and types of health care services in relation to the health care needs of the population.
2. **Accessibility** – the location of health care services and the ease and capacity with which the population can reach the service.
3. **Acceptability** – the populations’ attitudes about the expected characteristics of the health care provider in relation to the actual provider’s characteristics, and vice versa.
4. **Affordability** – the ability of the population to pay for the health care service.
5. **Adequacy** – the ways in which health care services are organised in relation to the population’s perception of the ability to contact or reach the service when required.

It was proposed that to deliver effective health care services, access must be assessed on each of the defined dimensions, with none of the dimensions being sufficient in its own right (Gulliford et al. 2002).

Over the years, a multitude of studies interpreted access to health care in a variety of ways. Access dimensions were left out, labelled differently, or they were combined, depending on the context and the type of health problem addressed (Levesque, Harris & Russell 2013; Obrist et al. 2007). Margolis et al. (1995), for instance, only used three dimensions of access (structural, financial and personal) to describe the access barriers to health care for socially disadvantaged children in the US. Peters et al. (2008), on the other hand, used four dimensions of access (geographic accessibility, availability, financial accessibility and acceptability) for their framework, to describe health service access inequalities in low- and middle-income countries. Their framework considered each access dimension to have a supply and demand factor. Jacobs
et al. (2011) described a similar classification in their proposed framework that was applied in low-income Asian countries. They (2011, p. 290) defined supply-side factors as ‘aspects inherent to the health system that hinder service uptake by individuals, households or the community’, and demand-side factors as aspects that effect ‘the ability to use health services at individual, household or community level’. Jacobs et al.’s (2011, p. 291) classification is reproduced and presented in Table 1.2. The classification shows an almost equal distribution of access factors between the supply-side and demand-side, except for the availability dimension. To ensure equitable access to health care services, both sides of each dimension need to be addressed by researchers and policy makers (Russell et al. 2013). Despite the geographical focus on Asia, the framework by Jacobs et al. (2011) is applicable to the Australian context, as access barriers are fairly similar globally, and framework adjustments are mainly required for local socio-economic and cultural characteristics.

Table 1.2 Supply-side and demand-side factors across four dimensions of health services access

<table>
<thead>
<tr>
<th>Dimension of access</th>
<th>Supply-side factors</th>
<th>Demand-side factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessibility</td>
<td>Service location</td>
<td>Indirect costs to household (transport)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Means of transport available</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Information on health care services/providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Education</td>
</tr>
<tr>
<td>Availability</td>
<td>Unqualified health workers, staff absenteeism, opening hours</td>
<td>Waiting time</td>
</tr>
<tr>
<td></td>
<td>Motivation of staff</td>
<td>Drugs and other consumables</td>
</tr>
<tr>
<td></td>
<td>Non-integration of health services</td>
<td>Waiting time</td>
</tr>
<tr>
<td></td>
<td>Lack of opportunity</td>
<td>Late or no referral</td>
</tr>
<tr>
<td>Affordability</td>
<td>Costs and prices of services</td>
<td>Household resources and willingness to pay</td>
</tr>
<tr>
<td></td>
<td>Private–public dual practices</td>
<td>Opportunity costs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cash flow within society</td>
</tr>
<tr>
<td>Acceptability</td>
<td>Complexity of billing system</td>
<td>Households’ expectations</td>
</tr>
<tr>
<td></td>
<td>Inability for patients to know prices beforehand</td>
<td>Low self-esteem / assertiveness</td>
</tr>
<tr>
<td></td>
<td>Staff interpersonal skills</td>
<td>Community and cultural preferences</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stigma</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of health awareness</td>
</tr>
</tbody>
</table>

Source: Reproduced from Jacobs et al. (2011, p. 291).
Another modification of Penchansky and Thomas’ (1981) approach was applied by Saurman (2016), who supplemented Penchansky and Thomas’ five dimensions with a sixth ‘awareness for access’ dimension. The need for awareness as an additional access dimension was recognised during the evaluation of an emergency tele-psychiatry program that provided access to specialist emergency mental health care in rural and remote communities across western New South Wales, Australia (Saurman 2016). Saurman (2016) argued that for a health care service to be effective, users as well as providers need to know that it exists. Awareness through effective communication and information provision was recognised as particularly important in rural and remote communities, which are often affected by population mobility and health workforce instability (Saurman 2016). The importance of this dimension was also recognised by Russell et al. (2013), who included awareness in their framework for policy makers, to be used to improve the access to health care of Australia’s rural and remote population. Given the setting and the focus of the current study, Saurman’s (2016, p. 37) Theory of Access framework (reproduced in Table 1.3) was adopted as a practical tool to guide the research process and to address the abortion access and uptake barriers in regional and rural Victoria that emerged from the key research questions.

The next section first outlines the endorsement of International Human Rights treaties in Australia and how these treaties are integrated through legislation into Australia’s domestic law. The section then discusses surgical and medication abortion access and provision in Australia, and specifically access in the state of Victoria.
Table 1.3 Access to health care framework

<table>
<thead>
<tr>
<th>Dimensions of access</th>
<th>Definition</th>
<th>Dimension components and examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessibility</td>
<td>Location</td>
<td>An accessible service is within reasonable proximity to the consumer in terms of time and distance</td>
</tr>
<tr>
<td>Availability</td>
<td>Supply and demand</td>
<td>An available service has sufficient services and resources to meet the volume and needs of the consumers and communities served</td>
</tr>
<tr>
<td>Acceptability</td>
<td>Consumer perception</td>
<td>An acceptable service responds to the attitude of the provider and the consumer regarding characteristics of the service and social or cultural concerns. For instance, a patient’s wish to see a female doctor may determine whether a service is considered acceptable or not</td>
</tr>
<tr>
<td>Affordability</td>
<td>Financial and incidental costs</td>
<td>Affordable services examine the direct costs for both the service provider and the consumer</td>
</tr>
<tr>
<td>Adequacy</td>
<td>Organisation</td>
<td>An adequate service is well organised to accept clients, and clients are able to use the services. Considerations of adequacy include hours of operation (after-hour services), referral or appointment systems, and facility infrastructures (wheelchair access)</td>
</tr>
<tr>
<td>Awareness</td>
<td>Communication and information</td>
<td>A service maintains awareness through effective communication and information strategies with relevant users (physicians, nurses, patients, the broader community), including consideration of context and health literacy</td>
</tr>
</tbody>
</table>

Source: The dimensions of access (Saurman 2016, p. 37).

1.4 ABORTION ACCESS IN AUSTRALIA

Abortion access in Australia is complex, as there is no national abortion legislation, rather the legality of abortion is a matter for the states and territories. Further, abortion is currently legalised in five jurisdictions and still considered a crime in South Australia, Western Australia and New South Wales (de Moel-Mandel & Shelley 2017). This section explores current abortion legislation in Australia and describes the estimated incidence of abortions. Then, the postponed introduction of mifepristone in Australia is explained, and finally,
a description is provided of the current abortion access situation in Victoria, the setting of this study.

1.4.1 The legal barriers to abortion access in Australia

Australia has endorsed most of the International Human Rights treaties, which include the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child, and the Convention on the Elimination of All Forms of Discrimination against Women (which specifically asserts the reproductive rights of women) (Attorney-General’s Department 2018). However, not all the treaties’ terms are integrated through legislation into Australia’s domestic law (Sifris & Belton 2017). According to the obligations grounded in these international legal standards on human rights, specifically in the field of reproductive rights, abortions in Australia should be legally obtainable on request, or on broad social and economic grounds, and abortion services should be easily accessible and available (CRR 2004; 2013). The current Australian abortion legislation, however, is incapable of achieving this goal. The law that regulates abortion practice in Australia derives from the English Offences against the Person Act 1861, and is not regulated at the federal level, but separately controlled by each of the six states and two territories (Costa et al. 2015). From the early 1970s, surgical abortions became somewhat more liberally available, as jurisdictions started to make their own different reforms and amendments to this criminal act (Baird 2015). Nevertheless, despite reform legislation and an expansion of some of the circumstances under which abortion can be lawfully performed, abortion is currently only decriminalised in five jurisdictions (the Australian Capital Territory, Tasmania, Victoria, Northern Territory and recently (2018) Queensland) and is still defined in the criminal law in South Australia, Western Australia, and New South Wales (Termination of Pregnancy Bill 2018 (Qld) ; Costa et al. 2015; de Moel-Mandel & Shelley 2017). Table 1.4 provides an overview of Australia’s different laws and regulations and the circumstances that allow an abortion in each jurisdiction.
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### Table 1.4 Current abortion laws in Australian states and territories

<table>
<thead>
<tr>
<th>Jurisdiction* (population ×10^6)</th>
<th>Name of law</th>
<th>Reform legislationb</th>
<th>Abortion legalised</th>
<th>Abortion legal on request</th>
<th>Abortion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital Territory (0.41)</td>
<td>Medical Practitioners (Maternal Health) Act 2002 Health (Improving Abortion Access) Legislation Amendment Bill 2018</td>
<td>-</td>
<td>2002</td>
<td>Yes</td>
<td>An abortion is managed like any other medical procedure An abortion may only be carried out by a registered medical practitioner</td>
</tr>
<tr>
<td>Victoria (6.32)</td>
<td>Abortion Law Reform Act 2008</td>
<td>-</td>
<td>2008</td>
<td>&lt;24 weeks</td>
<td>≥24 weeks: approval required of second doctor that abortion is in woman’s best interest</td>
</tr>
<tr>
<td>Tasmania (0.52)</td>
<td>Reproductive Health (Access to Terminations) Act 2013</td>
<td>-</td>
<td>2013</td>
<td>≤16 weeks</td>
<td>&gt;16 weeks: approval required of second doctor that abortion is in woman’s best interest</td>
</tr>
<tr>
<td>Northern Territory (0.25)</td>
<td>Termination of Pregnancy Law Reform Act 2017</td>
<td>-</td>
<td>2017</td>
<td>&lt;23 weeks</td>
<td>≤14 weeks: if qualified doctor agrees that a woman’s physical, mental or social health is endangered, 14-23 weeks: if consulted second doctor considers an immediate physical, mental or social maternal health risk</td>
</tr>
<tr>
<td>South Australia (1.72)</td>
<td>Criminal Law Consolidation Act 1935 Amended in 1969</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>&lt;28 weeks: abortion is permitted after approval of two medical practitioners on maternal and foetal health grounds. Pregnant woman must have been resident in South Australia for at least 2 months Abortions can only take place in hospitals</td>
</tr>
<tr>
<td>Western Australia (2.58)</td>
<td>Criminal Code 1913 and Health Act 1911 Amendment Act 1998 Termination of Pregnancy Law Reform Act 2017</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Abortion for a woman &lt;16 years requires parental or legal guardian consent &lt;20 weeks: justified only on serious maternal or foetal medical grounds ≥20 weeks: permission required from minimum two doctors from minister-appointed panel and performed in selected facility</td>
</tr>
<tr>
<td>Queensland (4.93)</td>
<td>Termination of Pregnancy Bill 2018</td>
<td>-</td>
<td>2018</td>
<td>≤22 weeks</td>
<td>Abortion available upon request. &gt;22 weeks: consultation second doctor required</td>
</tr>
<tr>
<td>New South Wales (7.86)</td>
<td>Crimes Act 1900</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Allowed in case of severe danger to maternal physical or mental health including economic and social issues</td>
</tr>
</tbody>
</table>

**Notes:**
- Australia’s estimated resident population at 30 June 2017 was 24,598,900 people (Australian Bureau of Statistics 2017).
- Despite reform legislation, abortion is still defined in the criminal law in South Australia, Western Australia, and New South Wales.
- Doctors must refer women in the case of conscientious objection to non-objectors.
1.4.2 Abortion incidence in Australia

Despite abortion not being decriminalised across all Australian states and territories, it is estimated that approximately 40 to 50 percent of all pregnancies in Australia are unplanned and that about half of the women with an unplanned pregnancy will decide to have an abortion (Family Planning NSW 2013; Rowe et al. 2016). Further, about one in three women will have an abortion during their life, with most (90%-92%) performed in the first 11-14 weeks of gestation (Hutchinson, Joyce & Cheong 2013; Scheil et al. 2017; Victorian Law Reform Commission (VLRC) 2008). Unfortunately, up-to-date, reliable national estimates of annual abortion numbers are difficult to determine, as each jurisdiction has its own abortion-reporting mechanism, and only South Australia and Western Australia routinely collect and publish abortion statistics (Chan & Sage 2005). The latest national incidence study dates from 2005, and conservatively estimated a total number of 84,460 (surgical and medical) terminations performed in 2003, equating to an abortion rate of 19.7 per 1,000 women aged 15-44 (Chan & Sage 2005). This estimate was calculated using Medicare\textsuperscript{1} data and private health insurance claims (for privately insured women), as well as public hospital morbidity data. More recent state specific data suggest total abortion rates of 13.5 per 1,000 women aged 15-44 in South Australia in 2015 and 16.4 per 1,000 women aged 15-44 in Western Australia in 2012 (Hutchinson, Joyce & Cheong 2013; Scheil et al. 2017). The rates in both South Australia and Western Australia have dropped since 2003, from 16.7 to 13.5 and from 18.6 to 16.4 for every 1,000 women, respectively. Further, when South Australia’s data is extrapolated nationally, the number of abortions (surgical and medical) in 2015 is approximated to be 65,000 (Branley & Scott 2017). Additionally, the Medicare Benefits Schedule\textsuperscript{2} (MBS) item most commonly used for surgical abortions indicates 47,683 abortions were performed in 2016 (Department of Human Services 2018). Taken together, this data suggest that total abortion

\textsuperscript{1} Medicare is Australia’s national health care scheme that provides eligible citizens’ access to a range of health services at reduced or no cost, as well as free treatment in public hospitals (Department of Human Services 2017b).

\textsuperscript{2} The MBS lists all Medicare services subsidised by the Australian Government.
rates have decreased since 2003 (Branley & Scott 2017). The following section discusses the introduction and evolution of MA provision in Australia.

1.4.3 Medication abortion provision in Australia

MA has only been widely available in Australia since 2012. While there is a paucity of data available on current national MA provision, the most recent data from Western Australia (2010-2012) and South Australia (2015) show that 11.1 percent and 29.5 percent, respectively, of all performed abortions (as discussed in section 1.4.2) were induced with medication (Hutchinson, Joyce & Cheong 2013; Scheil et al. 2017). Yet, Dawson et al. (2016) reported that despite the recognised multiple advantages of MA, specifically regarding administration and privacy, service provision remains limited.

Before the official registration of mifepristone in Australia, early abortions were sometimes performed with misoprostol in combination with methotrexate, a chemotherapy agent that affects rapidly dividing cells, and is generally used for the treatment of psoriasis and cancer (de Costa et al. 2007). Neither drugs were licensed for abortions, and thus used ‘off-label’, which is common medical practice, recognised by the Therapeutic Goods Administration (TGA) (de Costa & de Costa 2006). This regimen, however, was less effective and had more side-effects when compared with the currently used combination of mifepristone-misoprostol (de Costa et al. 2007).

Trials with the mifepristone and misoprostol combination in Australia were initiated and approved in 1994 by the TGA in collaboration with the World Health Organisation (WHO) (Baird 2015; Petersen 2010). The trials, however, triggered a range of anti-abortion responses, and in 1996, the Federal Liberal–National Coalition Government of Australia, led by Prime Minister John Howard, agreed to amend the Therapeutic Goods Act 1989 to get anti-abortion senator Harradine’s support for the partial privatisation of the government-owned telecommunications company, Telstra. This amendment to the Therapeutic Goods Act 1989 included provisions that unintended pregnancy could not be induced with medications, restricting access to MA.

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3 Australia’s regulatory agency that oversees the use of medications in Australia.
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Goods Act resulted in a ban on the importation and the use of mifepristone (O’Rourke, Belton & Mulligan 2016; Petersen 2010). For the next 10 years, the Therapeutic Goods Amendment Act 1996, known as the ‘Harradine Amendment’, provided the Federal Health Minister with the right to veto the import applications for mifepristone, thus disallowing the women of Australia the choice of a safe alternative to surgical abortion (Petersen 2010). In 2006, however, after persistent lobbying by reproductive health groups and four female Federal parliamentarians, the Harradine Amendment was overturned and the new bill gave the TGA the power of approval (de Costa et al. 2007; O’Rourke, Belton & Mulligan 2016). Strict regulations remained, resulting in only a slow increase of mifepristone use, but over time, authorised prescribers moved from being solely gynaecologists to general and sexual health practitioners, and private abortion providers such as Marie Stopes International Australia (hereafter called Marie Stopes) (de Costa 2012). In order to improve mifepristone’s accessibility, MS Health, a subsidiary of Marie Stopes, successfully applied in August 2012 to the TGA for the import and distribution of mifepristone in Australia (Baird 2015; O’Rourke, Belton & Mulligan 2016; TGA 2012). One costly condition was that MS Health was required to develop a risk management program, consisting of a web-based register, the provision of mandatory online training, and a 24-hour telephone advice service for women (O’Rourke, Belton & Mulligan 2016). Further, the TGA mandated prescribing medical practitioners and dispensing pharmacists to register with the MS Prescribing Program (O’Rourke, Belton & Mulligan 2016). Seven months later, when mifepristone and misoprostol became listed under the Pharmaceutical Benefits Scheme (PBS)4, purchase costs considerably reduced (Baird 2015).

TGA registration was initially obtained for mifepristone 200 mg and misoprostol 800 mcg (four 200 mcg tablets) for abortions up to 49 days’ gestation, but in 2015 an extension was approved for gestations up to 63 days (Baird 2015). The combination of mifepristone, taken orally at a clinic, and

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4 The Pharmaceutical Benefits Scheme works in conjunction with Medicare and subsidises the cost of a range of prescribed medicines (Department of Human Services 2017b).
misoprostol, taken buccally 36-48 hours later at home, has been endorsed by
The Royal Australian and New Zealand College of Obstetricians Gynaecologists
(RANZCOG) (2016) since 2013 and, according to a large study by Goldstone,
Walker and Hawtin (2017), with 15,008 women attending Marie Stopes clinics in
Australia, has proven to be an efficient and safe choice for abortions within the
nine weeks’ gestational limit.

Currently, mifepristone can be sold and used all over Australia, but within
the legal context of the different state and territory laws, as discussed in Section
1.4.1. In most parts of Queensland, for instance, where a new legislation for MA
was included within the Criminal Code in 2009, it is not easy to access abortion
services due to the lack of clear legal precedents, which make physicians, nurses
and women reluctant to become involved (de Costa 2012). Local requirements
also determine where and by whom the drugs can be dispensed. For example,
abortion laws in South Australia limit the provision of MA to hospitals, which
excludes home use of misoprostol and may thus restrict abortion access to
women living in rural and remote areas (Belton et al. 2016; de Moel-Mandel &
Shelley 2017).

The next section will discuss the legality of abortion and access to
abortion services in the Victorian context.

1.4.4 The Victorian context

In Victoria before 2008, the Crimes Act 1958 was in operation, which
made the provision of abortions an indictable offence, with the judiciary to
decide if the reason for an abortion was deemed lawful or unlawful (VLRC 2008).
From 1969, Victorian abortion law was based on the Supreme Court ruling of
Justice Menhennitt in the case of R v Davidson. The Menhennitt ruling
considered abortion lawful when the act was:

necessary to preserve the woman from a serious danger to her life or her
physical or mental health (not being merely the normal dangers of pregnancy
and childbirth) which the continuation of the pregnancy would entail; and in the
circumstances not out of proportion to the danger to be averted. (VLRC 2008, p. 19).

Nearly 40 years later, in 2008, Victoria legalised abortion, with the passing of the Abortion Law Reform Bill 2008 (Vic). This Act (Abortion Law Reform Act 2008 (Vic)) allows any woman in Victoria to have a surgical or medication abortion up to 24 weeks’ gestation, when performed by a registered medical practitioner. A late-term abortion, post 24 weeks, can only be performed when a qualified physician—defined as a person licensed to practice medicine—after consultation with another physician believes the abortion is appropriate in regard to ‘all relevant medical circumstances and the woman’s current and future physical, psychological and social circumstances’ (Abortion Law Reform Act 2008 (Vic), p. 4). Included in the new Act is also a regulation regarding conscientious objection, which is defined by Zampas and Andion-Ibanez (2012, p. 232) as ‘the refusal to participate in an activity that is considered incompatible with somebody’s religious, moral, philosophical or ethical beliefs’. Whereas in the rest of Australia, except Tasmania (Reproductive Health (Access to Terminations) Bill 2013 (Tas)), health professionals have the right to invoke conscientious objection to abortion, health practitioners with conscientious objection in Victoria and Tasmania, while not required to participate in elective abortion procedures, are obliged to notify women about their beliefs and to refer them to providers without conscientious objection (Abortion Law Reform Act 2008 (Vic)). For medication-induced terminations of pregnancies up to 24 weeks, the Victorian Act states that registered pharmacists or registered nurses authorised under the Drugs, Poisons and Controlled Substances Act 1981, may dispense or administer the abortifacient drugs prescribed by a medical practitioner (Abortion Law Reform Act 2008 (Vic)).

Even though abortion provision in Victoria is legal, abortion access is still compromised due to a range of non-legal factors, such as a lack of providers, privacy concerns or fear of stigma, which reflect a reluctance of society as well as government towards the provision of abortion services (International Planned Parenthood Federation 2008). Abortion access barriers, together with
unintended pregnancies, were identified by the Victorian Women’s Health Services (2015) as an immediate concern for the health of Victorian women. Their ‘Priorities for Victorian Women’s Health 2015–2019’ report (2015) showed the need for the State Government to develop and implement a sexual and reproductive health strategy to support women’s right to health via the provision of safe, legal and accessible abortion service provision. Chapter Two discusses the non-legal abortion access barriers in more depth.

1.5 A NURSE-LED MA PROVISION MODEL AS A SOLUTION TO IMPROVE ABORTION ACCESS IN REGIONAL AND RURAL VICTORIA

The diversities in legal restrictions in Australia, and the resulting uncertainties about the boundaries of the law, together with social, economic and health system influences, can affect the willingness of doctors to provide abortion services (Culwell & Hurwitz 2013; de Costa et al. 2015; de Moel-Mandel & Shelley 2017). Provision is mostly confined to private clinics in metropolitan areas, and consequently, abortion access for women living in Australia’s rural and remote areas is highly restricted (Doran & Hornibrook 2016).

The existing inequities in abortion access across Australia may be improved by an increased use of medication, rather than surgical methods for induced abortions (de Costa 2005). MA is particularly suitable to be delivered at the primary care level, as no specific surgical facilities, instruments or a full range of staff are required (Finer & Wei 2009; Hwang et al. 2005; WHO 2012). General practitioners (GPs) in regional and rural areas are specifically well placed for MA provision, as they already provide most sexual and reproductive health consultations due to a lack of local family planning services (Lorch et al. 2015). While the involvement of GPs in abortion service provision has the potential to considerable improve abortion access to women residing in underserved regions, their uptake of MA provision remains low, and very little is known about the underlying factors that determine a GP’s decision to become a provider (Dawson et al. 2017; Grossman & Goldstone 2015; Newton et al. 2016a).
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An acceptable and achievable approach for the delivery of safe MA care in the primary health care sector, is the practice of task shifting and task sharing (WHO 2015b). Task shifting and sharing addresses the shortage of physicians and the time-intensive aspect of the MA process by increasing the tasks of associate health workers in the MA provision process (WHO 2015b). This public health strategy is currently applied in a number of countries, including the US, France, Great Britain and Sweden, and may be a solution for the presently low provision of MA in Australian general practice (Berer 2009; Jackson 2011). When appropriately trained, PHCNs have been proven to provide MA services as safe and effective as physicians (Warriner et al. 2011).

Australian PHCNs currently already play an important role in the delivery of PHC services to women of reproductive age, including health promotion, illness prevention and health maintenance (Australian Nursing and Midwifery Federation (ANMF) 2011). According to local practice needs, PHCN involvement in MA provision may vary, and can include counselling, referral provision, MA management as well as the delivery of follow-up care (Advancing New Standards in Reproductive Health 2015; Kishen & Stedman 2010; Newton et al. 2016a). A nurse-led MA provision model would be particularly ideal for the outpatient setting in Australia’s regional and rural areas, as the average number of GPs per 1,000 population is relatively lower, and the average number of PHCNs per 1,000 population is considerably higher when compared to metropolitan areas (Department of Health and Human Services (DHHS) 2015a). Further, in Victoria, abortion is legalised and PHCNs are allowed to be involved in the prevention and management of unintended pregnancies, which includes MA provision (ANMF 2011; 2014; VLRC 2008).

While data is available on the implementation and the clinical outcome of one nurse-led MA service at a sexual health clinic in Wodonga, Victoria, (Tomnay et al. 2018), nothing is known about the barriers and facilitators to the implementation of extended PHCN roles in MA provision. To achieve equitable abortion access across Victoria, more innovative models of service delivery are
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needed. This study, therefore, aimed to explore the feasibility of a nurse-led model of MA provision in the PHC setting of regional and rural Victoria.

1.6 OVERVIEW OF THE THESIS

This thesis is structured into nine chapters. In this first chapter, the context of the study has been presented together with a proposed solution to improve abortion access in regional and rural Victoria. In addition, the choice of Saurman’s (2016) dimensions of access as the guiding framework for this research was articulated. Chapter Two provides a review of the available literature. Abortion access barriers in Australia’s regional and rural areas are discussed by emphasising the importance of MA service provision in the PHC sector, and existing models of nurse-led care are examined together with two approaches currently used in Australia to improve abortion access in regional and rural areas. In Chapter Three, an overview of the study methodology is provided along with contextual detail of the setting for this study (i.e., the state of Victoria). Chapter Four details the methods of the cross-sectional study and Chapter Six describes the Delphi study. These chapters explain the study design, sampling and recruitment methods, instrument development, data collection and data analysis. The findings of the cross-sectional study and the Delphi study are described in Chapter Five and Seven, respectively. Chapter Eight discusses the main findings of the study in relation to the available literature, the three proposed nurse-led models of care for MA provision, as well as the study strengths and limitations. Finally, Chapter Nine presents the study conclusion and provides implications and recommendations for practice, policy and future research.
Chapter Two first gives a review of the available evidence on the range of non-legal factors that currently hinder access to abortion services in Australia. These factors are divided and discussed into the different dimensions of Saurman’s (2016) access to health care framework (see section 1.3). Next, a review is provided of the gradual recognition of PHC as the centre of effective and sustainable health care systems globally, as well as in the Australian context. The use of nurse-led models of care is outlined as an essential strategy for the improvement of PHC infrastructure, and some examples of Australian nurse-led models are provided. To increase safe abortion access in Australia’s regional and rural areas, different options of nurse-led MA models are explored, particularly of models that are compatible with the requirements of Victoria. The chapter finishes with an overview of two innovative approaches of MA provision that are currently employed in Australia.

2.1 ACCESS BARRIERS TO ABORTION SERVICES IN AUSTRALIA

Populations should be able to access adequate and appropriate health care services when required (Russell et al. 2013; WHO 2015a). It has been recognised, however, that people living in regional and rural areas specifically encounter access barriers to health care, due to socio-economic disadvantages, travel distances and workforce shortages, which can contribute to poorer health outcomes for the population concerned (Saurman 2016; Wakerman et al. 2008). In Australia, the National Health and Hospital Commission’s Report (2009) and the National Primary Health Care Strategic Framework (Australian Government 2013) both identify equitable access to PHC services for all Australians as a priority area for action. Currently, approximately 29 percent of Victoria’s regional population encounter considerably reduced access to PHC providers
and health services, including abortion provision (Australian Institute of Health and Welfare (AIHW) 2016a).

Apart from the legal factors that can hinder access to abortion services, as previously discussed in Section 1.4.1, there are also a range of non-legal factors that can hinder abortion access, which include the shortage of abortion providers, abortion costs, confidentiality and stigma (Doran & Hornibrook 2014; 2016; Rice 2008; VLRC 2008). These non-legal barriers to abortion access can be categorised into the six access dimensions of Saurman’s access to health care framework (2016) (see section 1.3), which include availability, accessibility, acceptability, affordability, adequacy and awareness. These dimensions will be discussed in the following four sections. The access dimensions of accessibility, availability and adequacy are presented together, due to their interrelatedness.

### 2.1.1 Availability, accessibility, and adequacy

Availability, accessibility and adequacy are three interconnected access dimensions that relate to logistical factors that can hinder access to abortion services and providers in regional and rural areas, including travel-related logistical problems and limited clinic options. It is widely acknowledged that the availability of abortion services in the regional and rural areas of developed countries around the world, including Canada, the US and New Zealand, is limited (Jones & Jerman 2013; Norman et al. 2013; Silva & McNeill 2008). While a similar situation exists in Australia’s regional and rural areas, the available Australian research on family planning access is sparse (Doran & Hornibrook 2014; Kruss & Gridley 2014; Nickson, Smith & Shelley 2006). The lack of access to safe abortion services is linked with the recognised shortage of trained abortion providers, which is globally one of the most critical barriers for regional and rural women accessing safe abortion services, and particularly for women who are socially or economically disadvantaged (de Moel-Mandel & Shelley 2017; WHO 2015b). De Costa, Douglas and Black (2013) suggested that the low number of abortion providers in New South Wales and Queensland is partly the result of the existing legal ambiguities, which may make doctors reluctant to become
involved. Nevertheless, in Victoria, where the influence of legal ambiguities is not applicable since law reform in 2008, the number of abortion providers has not increased and, therefore, access to abortion provision has not improved (Keogh et al. 2016). Besides in Tasmania that recently closed its sole abortion clinic, forcing women to travel interstate, most Australian abortion clinics remain located in the metropolitan centres of each jurisdiction (Burgess 2018; Children by Choice 2018b). In Western Australia, for example, nearly all abortions are performed in private clinics around the capital city, Perth, and less than five percent of abortions take place in rural public hospitals (Hutchinson, Joyce & Cheong 2013). A similar situation exists in Victoria, where all abortion services are located in and around Melbourne, with the exception of two MA providing sexual health clinics in Wangaratta and Wodonga, two cities in the north-east of Victoria (Better Health Channel 2018; Gateway Health 2018b). The lack of available regional and rural abortion providers, and the consequential diminished accessibility of abortion services, was reported by the participants of six Australian studies (Doran & Hornibrook 2014; Hulme-Chambers et al. 2018; Kruss & Gridley 2014; Quine et al. 2003; Shankar et al. 2017; Victoria’s Regional Women’s Health Services 2012). The qualitative study by Quine et al. (2003), for instance, explored the rural-urban differences among adolescents in the accessibility of health services in New South Wales. The rural youth reported that accessing health services was a major problem because of the distance and the limitations in public transport. Additionally, Kruss and Grimley (2014), who interviewed 11 professionals, acknowledged an overall lack of women’s health and family planning services in Victoria’s rural areas.

The lack of trained abortion providers can potentially improve by shifting MA provision into the PHC setting. However, despite the relative ease to obtain abortion medication, the simple mode of administration and the overall acceptance of MA among providers and the public, service provision remains limited (Dawson et al. 2016; Hulme-Chambers et al. 2018). Before 2015, the narrow window of up to 49 days’ gestation may have been difficult to adhere to regarding timely appointments with physicians and services (Grossman &
Goldstone 2015). Further, GPs interested in MA provision were obliged by medical indemnity insurance providers to obtain the same level of coverage as surgical abortion providers, which involved very high costs (Grossman & Goldstone 2015). While time limits and insurers policies, two significant barriers to providing MA, have changed, and the number of certified prescribers has grown since 2015, MA service provision is still mainly provided in the private health sector in major cities, significantly increasing the costs involved with the service (Grossman & Goldstone 2015).

2.1.2 Affordability

Abortion costs vary considerably. Fee-free or low-cost treatments only apply for procedures undertaken in public hospitals, or for MA procedures provided by the two bulk-billed Gateway Health clinics in Wangaratta and Wodonga, Victoria (AIHW 2016b; Gateway Health 2018b). Nearly all abortions in Australia, however, except in South Australia and the Northern Territory, are provided in private clinics, as public hospitals mainly terminate pregnancies in the case of a foetal abnormality (Belton 2018; de Costa et al. 2015). Considering the fact that only approximately 50 percent of the population has some form of private hospital insurance cover, abortions can, therefore, be expensive, with prices up to $800 AUD for first trimester procedures (Children by Choice 2018a). Additional influential factors for the affordability of abortion procedures are the extra costs involved in obtaining an abortion, which are specifically relevant to women residing in regional and rural locations (Nickson, Smith & Shelley 2006). Travel costs, overnight accommodation and the prolonged time spent away from home, with subsequent absence from work or study, as well as the possible necessity for child care, were all recognised in Australian studies as indirect expenses that increased the overall costs of the abortion procedure (Doran & Hornibrook 2016; Hulme-Chambers et al. 2018; Nickson, Smith & Shelley 2006; Rice 2008; Shankar et al. 2017). Extra out-of-pocket expenses were reported by 41 percent of the 2,326 women undergoing an abortion in one of Marie Stope’s clinics in Australia, with a median amount of $150 AUD (Shankar et al. 2017).


### 2.1.3 Acceptability

The acceptability of abortions can be considered from a supply-side perspective (the provider and the health system) as well as from a demand-side perspective (the consumer). Both sides, however, are highly influenced by the fact that, independent of legalisation, abortions remain highly stigmatised procedures, which are still censured politically, religiously, or otherwise (Grimes et al. 2006). Lipp (2011) acknowledged that abortion stigma can never be fully eradicated, because of religious, ethical and personal principles. Abortion stigma is defined by Kumar, Hessini and Mitchell (2009, p. 628) as ‘a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood’. Kumar et al. (2004) blame the impact of stigma on state and societal control over abortion, fed by religious beliefs and ethical views, as the reason why a procedure as common and safe as abortion is still silenced and ignored. They argued that women who seek abortions are commonly perceived as a threat to existing gender norms and control over female sexuality, as they inadvertently defy three common assumptions about the ideal conduct of women: sexual behaviour solely for reproduction; motherhood; and protection of the vulnerable.

From a supply-side perspective, it has been argued that abortion stigma, associated with the procedure as well as the provider, could be the main reason for the failure to incorporate abortion provision into hospitals and general practice (Sheriff 2009). This position was confirmed by Freedman et al. (2010), who interviewed obstetrician-gynaecologists in the US who had undergone abortion training, about barriers experienced when wanting to implement abortion provision in their practice. All interviewees agreed that abortion stigma and ideological disagreement were the main barriers responsible for practice restrictions and collegial pressure.

Related to the influence of stigma on abortion access is the practice of conscientious objection, or the refusal to participate in an activity that is considered incompatible with somebody’s religious, moral, philosophical or
ethical beliefs (Zampas & Andion-Ibanez 2012). Conscientious objection to abortion provision can result in a refusal to provide information, to refer or to offer post-abortion support (O'Rourke, De Crespigny & Pyman 2012). Conscientious objection seems to be increasing worldwide, with percentages of physicians who refuse to perform abortions ranging from 10 percent (in the UK) to 70 percent (in Italy) (Chavkin, Leitman & Polin 2013). A survey conducted by de Costa, Russell and Carrette (2010) gained insight into the views and practices of Australian gynaecologists and obstetricians regarding abortion. Findings revealed that most respondents supported the availability of abortion in Australia. Only 15 percent of responders indicated being totally against abortions, although the quality of the data may be affected by the relatively small proportion of respondents (49%) as well as by the questionable representativeness of the sample due to the controversial topic (de Costa, Russell & Carrette 2010). Health professionals in Australia have the right to invoke conscientious objection, except in Victoria (Abortion Law Reform Act 2008 (Vic)) and Tasmania (Reproductive Health (Access to Terminations) Bill 2013 (Tas)), where health practitioners with conscientious objection to abortion need to notify women about their beliefs and refer them to providers without conscientious objection. The conscientious objection clause, however, still incites harsh responses from religious organisations that declare the obligation to refer an attack on the freedom of religious beliefs and conscience (O'Rourke, De Crespigny & Pyman 2012).

From a demand-side perspective, studies have shown that abortion stigma can negatively influence a woman’s social, psychological and physical behaviour (Major et al. 2009). Major et al. (2009), therefore, contended that perceived social stigma has more effect on a woman’s mental health than the procedure itself. All participants in a qualitative study in the UK (Astbury-Ward, Parry & Carnwell 2012) perceived their abortions as socially unacceptable and they feared being judged and negatively labelled. The women, therefore, decided to keep their abortion a secret from others, while additionally some experienced self-blame and self-stigmatisation (Astbury-Ward, Parry & Carnwell
A study by Women’s Health Victoria determined that abortion stigmatisation is the main reason that women living in rural and regional areas often prefer to travel to metropolitan areas to ensure confidentiality and privacy (Rice 2008). Quine et al. (2003) reported that teenage pregnancy was mainly recognised as a major health problem in the rural areas of New South Wales, with concerns about confidentiality and visibility as a barrier for obtaining contraceptives or seeking an abortion.

Abortion stigma not only marginalises providers and users, but it can also encourage harassment and violence, which may, in turn, dissuade health professionals from abortion provision (Martin et al. 2014). In the US, and particularly in the Midwest and the South, most (84%) abortion-providing facilities experienced at least one form of anti-abortion harassment, such as picketing or harassing phone calls, and sometimes also more serious attacks, including bombings, vandalism and arson (Jerman & Jones 2014). Several US studies have researched the impact of anti-abortion harassment on abortion-seeking women and abortion providers. Doan (2007), for instance, reported that anti-abortion harassment could potentially result in a delay in the abortion procedure and a decrease in the number of abortion providers, and additionally can cause a range of psychological responses in women. The effect of harassment on women’s emotional response to abortion was also examined by Foster, Dobkin and Upadhyay (2013). They found that levels of distress were higher in women who were stopped by the anti-abortion protestors, who were spoken to, as well as by women who reported having had difficulties with their abortion decision.

It is, however, questionable if all these study results are applicable to Australia, where, with the exception of the 2001 murder of a clinic security guard in Melbourne, harassment experience has been fairly moderate (Sifris 2013). Nevertheless, Tasmania (Reproductive Health (Access to Terminations) Bill 2013 (Tas)), the Australian Capital Territory (Health (Patient Privacy) Amendment Bill 2015 (Act)), Victoria (Public Health and Wellbeing Amendment (Safe Access) Bill 2015 (Vic)), and just recently New South Wales (SBS News 2018), all established
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legislation for safe access zones around abortion clinics to prevent protesters from harassing women.

2.1.4 Awareness

Abortion access can also be hindered by a lack of awareness, which, just as with the acceptability of abortions (see section 2.1.3), applies to the supply-side as well as the demand-side of abortion care. For example, a provider or service needs to be aware of the local context and target population to deliver suitable and effective services (Saurman 2016). Awareness of the service, on the other hand, is required for potential users when they want to be able to access and utilise the service (Saurman 2016). Evidence shows that awareness is one of the main factors that ensures the provision of safe and accessible abortions for women, and is particularly important for users with low levels of health knowledge and/or low familiarity with local availability of health services (Phillips et al. 2012; Russell et al. 2013).

Newton et al. (2016b) suggest that Victorian women, particularly those residing in regional areas, have low levels of awareness of MA as an alternative to surgical abortion. Further, they found that women in regional areas often do not expect to be able to access MA in their own community. A study by Phillips et al. (2012) among tertiary students in Far North Queensland also revealed that more than half of the students were not aware that first-term abortions were provided in metropolitan Cairns. Even though abortion is only lawful in Queensland when there is serious danger to the woman’s physical or mental health, a 2013 government guideline (Queensland Clinical Guidelines 2013) recognises that medical practitioners may consider social and economic factors impacting on the woman’s life and health. However, despite the presence of expensive abortion providing private surgeries in the main cities, abortion access in the public sector or through GPs remains very restricted (Children by Choice 2016). Low awareness as a barrier for abortion access was also reported by Grindlay, Lane and Grossman (2013) in their evaluation of the provision of MA via telemedicine in Planned Parenthood clinics in Iowa, US. Their report showed
that awareness of the telemedicine service was low in the community and that women needed to be better informed about the availability of the local service.

Solutions to overcome most of the mentioned non-legal access barriers to abortion services will be now be discussed, highlighting the importance of health service provision in the PHC sector, together with the potential role of the PHC setting in MA provision.

2.2 PRIMARY HEALTH CARE: THE CENTRE OF AUSTRALIA’S HEALTH SYSTEM

Primary health care (PHC) brings ‘promotion and prevention, cure and care together in a safe, effective and socially productive way at the interface between the population and the health system’ (WHO 2008, p. 41). Health systems are defined by WHO (2000, p. 5) as all the organisations, institutions and resources whose ‘primary purpose is to promote, restore or maintain health’. Health systems include the consultations of regular medical professionals, the actions of alternative health providers, all medication use, health care delivered at home, as well as all public health and health promotion interventions (WHO 2000). Health systems are expected to improve the overall health of the population and offer protection against the financial cost of ill health (WHO 2000).

While people have been protecting their health and treating diseases for thousands of years, a distinct health care system reform only emerged after the Second World War (Cutler 2001). In 1978, WHO and United Nations Children’s Fund (UNICEF) prepared, as a joint initiative, the Alma Ata Declaration (WHO 1978a), a ground-breaking document in the global development of PHC (Chiarella 2008; WHO 2000). The declaration, which was unanimously adopted by all WHO member countries, including Australia, essentially recognised PHC as a strategy to achieve the social and political goal of ‘Health for All’ (WHO 2000). The Alma Ata conference confirmed the unacceptability of the global inequality in health status, with health—defined as ‘a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity’—
declared as a fundamental human right (WHO 1978b, p. 1). In the decades following the Alma Ata Declaration, however, countries failed to implement comprehensive PHC (Gauld et al. 2012). To reach ‘health for all’ required a reorientation of health systems and a re-strengthening of the PHC movement, which was documented in WHO’s ‘Primary Health Care: now more than ever’ report (2008).

The health care system of Australia consists of a mix of public and private health services, and is based on the principle that all citizens and permanent residents have the right to equal health care access (Willis, Reynolds & Keleher 2016). One of the driving forces of this system is Medicare, Australian’s public health insurance system (Willis, Reynolds & Keleher 2016). Despite some of its flaws, this health care system provides very good health outcomes, and contributes to male and female life expectancies that are among the highest in the world (Willis, Reynolds & Keleher 2016). However, it should be noted that the system is also responsible for the gap in the estimated life expectancy of Australia’s Indigenous population, which is approximately 10 years lower than the life expectancy of non-Indigenous residents (AIHW 2014).

Up until 2008, Australia’s health system was predominantly focused on hospitals and the provision of acute care, but, with the ageing population and the increasing rates of non-communicable diseases and health workforce shortages, the health system and health care resources had come under pressure (Doggett 2007; Willis, Reynolds & Keleher 2016). In her paper for the Centre of Policy Development, Doggett (2007) recognised the values of the Alma Ata Declaration (WHO 1978b) by emphasising that health systems needed to focus on primary care as opposed to tertiary (hospital) care to achieve better health outcomes for less money. Doggett (2007) advocated for PHC reform, a strategy that would improve the health of Australia’s population and assure a sustainable health system for the future. The National Health and Hospitals Reform Commission’s report (2009) and the Department of Health and Ageing’s First National Primary Health Care Strategy (2010a) also acknowledged the importance of equitable access to PHC. Community-based PHC became
identified as ‘the frontline’ of the health care system for most citizens, and usually involves the first contact of individuals with health care services, such as health promotion, prevention and screening, and disease treatment and management (Department of Health 2013). Currently, approximately 30 percent ($35 billion AUD) of the total government health expenditure in Australia is spent on PHC, compared with approximately 41 percent ($47 billion AUD) spent on public hospital services (AIHW 2017).

Most PHC services are provided through GPs, but providers also include nurses, midwives, pharmacists, dentists, and allied and Aboriginal health professionals, who can deliver PHC in a community-based setting or in the home (Department of Health 2013). The First National Primary Health Care Strategy (Department of Health and Ageing 2010a) was the policy driver for the abolition of Divisions of General Practice, which coordinated PHC services offered by GPs since 1992, and the formation of 61 Medicare Locals in 2012, with the intention to reduce service fragmentation and improve local community-level PHC services (Willis, Reynolds & Keleher 2016). Three years later, however, Medicare Locals were replaced, under the new government, by 31 Primary Health Networks, to provide and organise the infrastructure required to support general practice, including practice nurses (Lane et al. 2017). The strategy (Department of Health and Ageing 2010a), however, mainly focused on GPs providing selective PHC in the private sector, which consists of interventions for disease treatment and management. There was no mention of comprehensive services, which are based not only on health but also on social needs, and include approaches to address health inequities (Willis, Reynolds & Keleher 2016). The strategy also failed to address community and women’s health services, even though they are recognised to have their place in the PHC system (Willis, Reynolds & Keleher 2016).

The importance of PHC for women’s health was recognised in three policy documents that were published in addition to the above-mentioned documents that only focused on PHC in general. The first document was the National Women’s Health Policy 2010. This policy was built upon the foundations
of Australia’s National Policy on Women’s Health in 1989 that led to the adoption of priority women’s health issues in women’s health programs that were firmly founded on the social model of health (Bennett 2009). The National Women’s Health Policy 2010 continued to shape an environment that ensured the health and wellbeing of all Australian women (Department of Health and Ageing 2010b). The policy identified six key health areas for action, with one specifically addressing sexual and reproductive health (Department of Health and Ageing 2010b). The second document was the position paper Women and Sexual and Reproductive Health, published by the Australian Women’s Health Network (2012). This paper advocates that all women, including those residing in regional, rural and remote areas, should have appropriate access to affordable and comprehensive sexual and reproductive health care. The paper specifies seven key areas for women’s health needs, with two of the areas addressing abortions:

- Developing women’s health literacy through information transparency about pregnancy termination services; and
- Increasing reproductive choice including equality in access to legal termination services.

The most recent document, published by the Victorian Government (Department of Health and Human Services 2017), recognises access to sexual and reproductive health services as a fundamental right for every woman. The document ‘Women’s sexual and reproductive health strategy - Key priorities 2017–2020’ specifically focuses on increasing access to MA in regional and rural Victoria through innovative PHC models, ensuring that women have access to health services as close to where they live as possible (Department of Health and Human Services 2017).

Critical to PHC reform, however, is the improvement of the PHC infrastructure to enhance the quality and accessibility of PHC services, including MA provision (Department of Health and Ageing 2010a). Infrastructure improvement requires the development of new models of care for service delivery, which should be multidimensional, collaborative and transdisciplinary
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(Davidson et al. 2006; Department of Health and Ageing 2010a). Davidson (2006, p. 49) defines a model of care as ‘an overarching design for the provision of a particular type of health care service that is shaped by a theoretical basis, evidence-based practice and defined standards’. A well-defined model of care can clarify the work of involved health professionals, enabling them to achieve their shared goals and evaluate outcomes (Davidson et al. 2006).

In the following sections, nurse-led models of care are introduced as a different approach for the delivery of PHC services. Section 2.3 outlines the current role of nurses in the PHC setting of Australian general practice. Next, in Section 2.4, different variations of nurse-led models of care in the Australian context are reviewed, and Section 2.5 considers the potential of nurse-led models of care for the provision of MA.

2.3 THE ROLE OF NURSES IN AUSTRALIAN GENERAL PRACTICE

In Australia, GPs are usually the first contact people have with the health care system in the case of a health problem (Britt et al. 2014). Around 85 percent of Australians visit a GP each year and, as previously mentioned, the PHC setting is especially well equipped for the implementation of screening, disease prevention and chronic disease management programs (Britt et al. 2014; Halcomb et al. 2008a). However, the recommended preventative care that addresses lifestyle risk factors, especially for patients with socio-economically and socio-demographic disadvantaged backgrounds, is often inadequate due to a range of organisational and structural factors (Harris et al. 2013). Hoare, Mills and Francis (2011) contend that Australian GPs are often not able to manage the huge and diverse range of care that is required for their patients, and that practice nurses in general practices are underused. In the UK, on the other hand, nearly all chronic conditions are almost fully managed by nurses, which allows GPs to have more time for patients with more complicated medical conditions (Hoare, Mills & Francis 2011). Deployment of nurses is especially important in Australia’s regional and rural areas where the total number of nurses remains
fairly constant compared to other health care professionals, whose numbers reduce with remoteness (Sullivan, Francis & Hegney 2008). Further, the average length of stay of GPs in regional and rural practice is significantly less than for doctors practicing in metropolitan areas, and has slowly declined over the years to 7.2 years in 2016 (Li et al. 2014; Rural Health Workforce Australia 2017).

In contrast, over the last few decades, the number of nurses working in Australian general practice has steadily increased (Australian Medicare Local Alliance 2012). It was estimated that in 2012 approximately 63 percent of all general practices employed one or more nurses, compared to 40 percent in 2003, and that this increase is ongoing (Australian Medicare Local Alliance 2012; Halcomb et al. 2014). Nurses who work in general practice are most commonly either ‘enrolled nurses’, trained for 12 to 18 months at certificate or diploma level, or ‘registered nurses’, a three-year tertiary level degree, but less often nurse practitioners, who have a more extended level of training, or midwives (Australian Medicare Local Alliance 2012; Jacob, Sellick & McKenna 2012). In Australian general practice, registered nurses and enrolled nurses work side by side. A registered nurse is required to supervise the enrolled nurse’s practice, regardless of whether a GP is present (ANMF 2014). A registered nurse is defined as being ‘responsible and accountable for their own practice, and as such does not require supervision or provide care for and on behalf of other health care professionals’ (ANMF 2011, p. 2). Patient care is provided by nurses in collaboration with GPs and other health care professionals (ANMF 2011). For the purpose of this thesis, the overarching term ‘primary health care nurse’ (PCHN) will be used when referring to nurses working in any PHC setting, including general practices, community, domiciliary, educational, occupational and other informal settings (Australian Primary Health Care Nurses Association 2015). Additionally, the title of ‘practice nurse’ will be used for nurses who only work in general practice clinics.

Over the years, the workforce size as well as the role of the Australian general practice nurse gradually evolved, facilitated by a range of government funded incentive programs (Department of Health 2012b; Jolly 2007). In 2001,
the government initiated the ‘Nursing in General Practice Initiative’, to encourage growth in the number of practice nurses and improve access to primary care services, particularly for practices located in rural and remote settings (Joyce & Piterman 2011; Price 2007). The initiative also aimed to improve the prevention and management of chronic diseases and to contribute to quality, evidence-based practice and learning systems for practice nurses (Joyce & Piterman 2011; Price 2007). As a result, GPs were able to claim specific practice nurse activities, like Papanicolaou (Pap) smears (cervix cytology), immunisations, wound management, antenatal check-ups and chronic disease care plans, via the MBS (Halcomb et al. 2008b; Joyce & Piterman 2011). While the initiative resulted in a substantial increase in general practice nurses, it also appeared to restrict the practice nurse’s scope of practice to the MBS-defined services, as well as their autonomy, as they were often just regarded as income-generating employees (Joyce & Piterman 2011; Parker, Walker & Hegarty 2010; Price 2007). Further government support to encourage the employment of nurses was provided with the ‘Practice Nurse Incentive Program’ (PNIP), which was introduced in 2012 (Department of Human Services 2017d). This program aimed to simplify the previous funding arrangement of individual task-based billing by offering general practices a single quarterly incentive payment, with an additional rural loading of up to 50 percent. The new funding covers a range of nurse services, independent of Medicare item numbers, to meet the individual needs of work environments, decrease the workload of GPs, and to enable practice nurses to work to the full extent of their scope of practice (Lane et al. 2017; McKenna et al. 2015). In addition to the PNIP, the ‘Practice Incentives Program’ (PIP) aims to support GPs with extra incentives for activities that involve asthma, diabetes, sexual health care and cervical screening for under-screened women (Department of Human Services 2017c). Although practice nurses, under the new PNIP scheme, can no longer individually claim a cervical screening via the MBS, a short GP consult after the test will still trigger an incentive payment (Department of Human Services 2017c). There is, however, no PIP available for MA provision.
Australia's PHC policy necessitates the establishment of productive relationships between nurses, GPs and other health care providers (Adrian 2009). International and national studies acknowledge that the involvement of PHCNs in care functions will improve accessibility, costs, patient satisfaction, the adherence to evidence-based professional guidelines and the overall health status of patients (Chiarella 2008; Eley et al. 2013; Hoare, Mills & Francis 2011; Parker, Walker & Hegarty 2010). PHC models of care, however, require more than multidisciplinary and inter-professional collaboration, as the needs of the individual, as opposed to the professional, indicate which health professional is required and when it is required (Chiarella 2008). The transdisciplinary approach allows for greater effectiveness, efficiency and access to PHC provision, in particular for patients with chronic and complex conditions (Adrian 2009; Davidson et al. 2006). Nurses have proven to be capable of making autonomous decisions, and to deliver effective and equitable PHC services (Adrian 2009). Therefore, moving towards nurse-led models, especially in service-poor areas, can be an essential public health strategy that ensures an optimisation of the health workforce, improve health outcomes, is cost effective, and increase access to PHC services (Adrian 2009; Wakerman et al. 2008; WHO 2015b).

2.4 NURSE-LED MODELS OF CARE IN THE AUSTRALIAN CONTEXT

The ageing population and the continuing trend to shift care from hospitals to PHC services require a more effective use of the PHC nursing workforce. PHCNs are capable to provide a range of essential PHC services, including direct patient care, health promotion, chronic disease management and health assessments (Howe 2016). Therefore, one efficient way to improve health outcomes is through the development of nurse-led clinics. A review by Richardson et al. (1998), covering 17 studies from the US, Canada and the UK, suggests that between 25 percent and 70 percent of the work that is undertaken by physicians could be carried out by nurses. The international and national literature describe a multitude of variations in nurse-led models of care (Keleher
et al. 2007; Laurant et al. 2004). The two most commonly used models of practice are the ‘substitution model’, in which the practice nurse takes on a delegated part of a GP task, and the ‘collaborative model’, where the practice nurse is an autonomous provider of an aspect of patient care (Keleher et al. 2007). It is still unclear which one of the models is the most appropriate for practice nurses in Australia, as practice-nurse roles have varied extensively, ranging from traditional assistance and task delegation through to autonomous practice in disciplines, such as chronic disease management and preventive care (Keleher et al. 2007).

However, despite the internationally recognised success of nurse-led models, the up-take of advanced roles by practice nurses in Australia is low, and currently the majority of practice nurses are still only involved in procedural activities, like injections, wound dressing and check-ups (Britt et al. 2014). Role development is impeded by a lack of clear career pathways, restricted possibilities for specialised education programs and a perceived lack of collaboration with GPs (Halcomb et al. 2014). Lane et al. (2017) argued that to overcome some of these barriers, ongoing support, such as educational, network building and advocacy initiatives is required from a range of stakeholder organisations, and PHC organisations in particular.

Nevertheless, there have been some nurse-led initiatives, in which practice nurses provide specialist roles in chronic diseases and women’s health care (Britt et al. 2014; Eley et al. 2013; Porritt 2007). One example is the delivery of Pap tests by nurses. Nurses have been identified to improve access to cervical screening as well as the overall number of women participating (Holmes, Mills & Chamberlain-Salaun 2014; Mills et al. 2012; Tomnay et al. 2018). Data on nurse-provided Pap tests, however, are currently only routinely available in Victoria. While the practice nurse role in the Victorian Cervical Screening Program is undeniably very important, especially in regional and rural areas, most screening in Victoria is still provided by doctors, possibly because of inadequate remuneration fees and the existing traditional hierarchical paradigm between GPs and practice nurses (Holmes, Mills & Chamberlain-Salaun 2014; Mills et al.
2012; Nguyen & Ang 2014). In the UK, on the other hand, where nurses have been involved in cervical screening since the 1970s, almost 90 percent of all practice nurses are currently accredited cervical screeners and responsible for approximately 75 percent of the tests conducted in general practices (Greenfield, Stilwell & Drury 1987; Holmes, Mills & Chamberlain-Salaun 2014).

Overall, in order to cope with the growing burden of chronic and complex diseases and the ageing population, general practices must consider new styles of patient care delivery with a renegotiating of the traditional doctor-nurse distribution of labour. The demand and supply gap of health service provision is especially noticeable in regional and rural communities, with the shortage of health care providers for the delivery of induced abortions as a typical example (Wakerman et al. 2008). Access barriers to safe abortion services in regional and rural areas could be addressed by introducing a nurse-led model of care for MA provision.

2.5 NURSE-LED MODELS FOR THE PROVISION OF MEDICATION ABORTION

In this section, models of nurse-led MA provision are discussed, starting with the rationale for the use of the models in regional and rural settings and including examples of the different levels of care. Next, the current service delivery requirements for MA provision in Australia will be explained, and finally, the potential of a full-service nurse-led MA model in Victoria is discussed.

2.5.1 The different levels of care in nurse-led MA models

As mentioned before, the lack of skilled abortion providers is globally one of the most critical barriers for women accessing safe abortion services (WHO 2015b). This lack of skilled abortion providers is caused by a shortage in abortion training, stigma and a range of other barriers that are associated with the provision of abortion care (Whaley & Betstadt 2016). Further, the geographical spread of the skilled health workforce is in most countries favoured towards
metropolitan areas and/or the private sector, which disproportionally affects women living in rural areas and those that are socially or economically disadvantaged (WHO 2015b). A similar situation exists in Australia (de Moel-Mandel & Shelley 2017). Moving beyond specialist physicians and allowing other health workers to be involved with abortion provision could potentially increase and improve access to health care, especially for people with difficulty accessing traditional services (McKenna et al. 2015; WHO 2015b). This shift also provides women with choice and flexibility, which is indispensable to their reproductive autonomy and, thus, to their overall welfare (Sorhaindo & Morris 2016). As nurses play an important role in the provision of PHC services for women of reproductive age, their involvement has become a key strategy to improve access to safe abortion (Jackson 2011).

The use of abortion drugs instead of surgical methods has the potential, in low- and high-resource settings, to expand the pool of abortion service providers, in particular at primary care level (Finer & Wei 2009; Hwang et al. 2005). The provision of MA by mid-level providers (such as nurses and midwives), discussed in Section 1.5, has been endorsed by WHO (2012) since 2003, and is currently applied in a number of countries all over the world (Berer 2009; Jackson 2011). Evidence shows that trained health workers can provide early MA and associated tasks as effectively, safely and satisfactorily as physicians, and women do not need to travel long distances to abortion clinics (Barnard et al. 2015; WHO 2015b). Additionally, potential harassment, more easily encountered when entering specialised abortion clinics, would be minimised (Kishen & Stedman, 2010; Yarnall et al., 2009).

Abortion care tasks, provided by PHCNs or midwives, vary from country to country, depending on local legal requirements, and range from managing aspects of the MA procedure under supervision of a physician, to functioning autonomously (Yarnall, Swica & Winikoff 2009). At full-service institutions, the physician is often only present in a consultatory or supervisory role and to prescribe the required drugs (Kishen & Stedman 2010; Yarnall, Swica & Winikoff 2009). In the UK, for example, most MA units are run by PHCNs. PHCNs are,
however, not permitted to sign authorisation forms or prescribe abortion medication, and the physician thus remains responsible for the care of the woman (Kishen & Stedman 2010). A termination of pregnancy framework was published by the UK Royal College of Nursing (RCN) to guide nurses in this procedure and to help them develop their roles (RCN 2017). Currently, nurse practitioners, practice nurses, physician’s assistants or midwives routinely manage most aspects of the MA process in 14 US states, Sweden, France, Denmark, South Africa, China, India, Vietnam, Cambodia, Tunisia, Bangladesh, Cambodia, Nepal and Mozambique (Berer 2009; Jackson 2011; Kishen & Stedman 2010; Kopp Kallner et al. 2014; Warriner et al. 2011; Yarnall, Swica & Winikoff 2009). Guidelines for MA provision vary per country. The following section discusses the service delivery requirements for MA provision in Australia.

**2.5.2 Service delivery requirements for MA provision in Australia**

Service delivery requirements for MA provision in Australia are guided by a selection of statements issued by the RANZCOG (2016). The statements indicate that prescribing practitioners are responsible for the entire process, from medication administration to the follow-up procedures, which include management of complications, although they acknowledged that some of the care could be delivered by other qualified health care providers or services. The report (RANZCOG 2016) further agreed that for abortions less than 63 days’ gestation, misoprostol could safely be self-administered at home in settings with easily accessible emergency care, and in the presence of an accompanying person to assist and access support if required. The RANZCOG (2016) also provides guiding statements specific for the MA process, prior to and after the procedure (Table 2.1).
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Table 2.1 Guidelines for the MA procedure

<table>
<thead>
<tr>
<th>Prior to the MA procedure</th>
<th>After the MA procedure</th>
</tr>
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<tbody>
<tr>
<td>Provide women with accurate information and counselling, if required</td>
<td>Give information on what to expect, and the follow-up requirements</td>
</tr>
<tr>
<td>Assess case history and undertake physical examination</td>
<td>Provide instructions on how to access advice and help in the case of an emergency</td>
</tr>
<tr>
<td>Assess co-morbidities and contraindications to medication</td>
<td>Ensure completion of the abortion by clinical assessment, and hCG estimations and/or</td>
</tr>
<tr>
<td></td>
<td>ultrasound examination on indication</td>
</tr>
<tr>
<td>Confirm gestation and exclude ectopic pregnancy with the mandatory use of ultrasound</td>
<td>Confirm effective use of contraception of choice</td>
</tr>
<tr>
<td>examination</td>
<td></td>
</tr>
<tr>
<td>Assess blood group and Rhesus status</td>
<td></td>
</tr>
<tr>
<td>Consider screening for sexually transmitted diseases and/or antibiotic prophylaxis</td>
<td></td>
</tr>
<tr>
<td>Decide on future contraception and arrange for implementation</td>
<td></td>
</tr>
<tr>
<td>Provide written information about treatment and follow-up care</td>
<td></td>
</tr>
<tr>
<td>Obtain written consent</td>
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</tr>
</tbody>
</table>

Source: The use of mifepristone for medical termination of pregnancy (RANZCOG 2016).

Some of these recommendations, however, may limit the use of MA services, especially for women residing in low resource settings in Australia, and can increase the costs involved with the procedure. One example is the RANZCOG (2016) requirement for routine pre-abortion ultrasound scans. Although ultrasounds have shown to improve gestational dating in early pregnancies, the guideline on ‘The Care of Women Requesting Induced Abortion’ of the RCOG (2011), and a review by Kaneshiro et al. (2011), both advise to use ultrasounds only when women are not sure of the date of their last menstrual period, or when deviant dates or an ectopic pregnancy are suspected (see section 1.1.2). The available evidence thus suggests that a lack of ultrasound facilities should not hinder MA provision.

Currently in Australia, two or more visits to the health facility are usually required for the MA process; however, a single consultation for women who live long distances from a clinic can be offered (Goldstone, Walker & Hawthin 2017; Hulme-Chambers et al. 2018). The requirement for multiple visits adds additional
time and cost burdens for women, and health care providers have reported this requirement as a barrier for MA provision up-take and continuation (Blum et al. 2012; Jackson et al. 2012). Therefore, if a single visit can be offered to women who live long distances away, then that barrier to MA provision up-take would be removed. Jackson et al. (2012) hypothesised if women are able to accurately self-assess a complete abortion, the elimination of the follow-up visit can increase abortion access, and costs will be reduced. They argued, however, that an objective method for the assessment of abortion completion, such as sonography or serum hCG, is required as symptoms can only moderately predict MA failure. This proposed method is endorsed by the RCOG (2011) that recommends that for most women, follow-up with telephonic clinical assessment, together with an urine or serum pregnancy test is sufficient.

In regard to the RANZCOG’s (2016) advice to offer (self-collected) chlamydia screening and antibiotic prophylaxis, the literature identified differing positions. The RCOG (2011), for instance, advises screening of all women for Chlamydia Trachomatis, and if indicated for other sexually transmitted diseases, while WHO (2012) advises that without any clinical signs of an infection, the abortion should not be postponed while waiting for the test results. The RCOG (2011) also recommends use of antibiotic prophylaxis against chlamydia and anaerobe infections in MA. WHO (2012), as well as the American College of Obstetricians and Gynecologists (Creinin & Grossman 2014), on the other hand, do not require this use without any clinical infection signs, as they proclaim that the risk of an intrauterine infection after MA is very low.

Another recommendation under debate is the prophylactic, post-MA administration of anti-Rhesus (D) immunoglobulin (anti-D) to Rhesus-negative (Rh-negative) women to ensure protection from immunisation against Rh-positive blood. When a Rh-negative woman is pregnant with an Rh-positive foetus, she can develop antibodies, which may, in a subsequent pregnancy with a Rh-positive foetus, destruct this foetus’ red cells, causing foetal morbidity or even mortality (Fiala, Fux & Gemzell Danielsson 2003). Prophylactic immunisation to the D-antigen has proven to be very effective in women with
miscarriages, surgical abortions and ectopic pregnancies (Jabara & Barnhart 2003). While currently most countries, such as the UK (RCOG 2011), the US (Creinin & Grossman 2014) and Australia (RANZCOG 2016), recommend passive immunisation of all Rh-negative women within 72 hours after a first trimester MA, there is still no conclusive evidence-based support for this treatment (Fiala, Fux & Gemzell Danielsson 2003; Raymond et al. 2015). Therefore, WHO (2012) acknowledged the risk for Rh-sensitisation in pregnancies up to 63 days’ gestation to be very low and that an Rh-status test and anti-D prophylaxis are not required if Rh-immunoglobulin is not easily available.

With these guidelines and recommendations in mind, the following section will discuss the possibility of a full-service nurse-led model of MA in Victoria.

2.5.3 The potential for a full-service nurse-led model of MA provision in Victoria

The extension of nurse involvement in the provision of MA varies across Australia according to jurisdictional legal requirements and regulations. Within the context of Victoria, however, there is scope for the development and implementation of a full-service nurse-led MA model. Qualified registered nurses in Victoria are, since 2008, entitled by law to administer or supply mifepristone for pregnancies up to 24 weeks (although the TGA (2014) restricts the use of MA in PHC settings to gestations up to 63 days) and certified physicians, while still required for the prescription of mifepristone, do not need to be present when women take the pills (Abortion Law Reform Act 2008 (Vic); Grossman & Goldstone 2015; RANZCOG 2016). The current legislative climate of Victoria thus provides a perfect setting for nurse-led MA provision in regional and rural areas, although a range of political and economic barriers still restricts the full expression of nurses’ scope of practice, which encompasses the prevention and management of unintended pregnancies, including MA (ANMF 2011; 2014; Scanlon et al. 2015). Barriers include factors such as responsibility, trust, accountability and costs (Jakimowicz, Williams & Stankiewicz 2017).
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The actual scope of practice of PHCNs, however, includes all the essential clinical competencies required to provide MA with mifepristone and misoprostol (ANMF 2011). The available evidence demonstrates that properly trained practice nurses can expand their scope of practice to independently provide and manage safe and effective early MA, without direct supervision from a physician (WHO 2015b). Nurse involvement has the potential to expand safe abortion access at many levels and can include counselling, referral provision and MA management, as well as the delivery of the follow-up care (Advancing New Standards in Reproductive Health 2015; Kishen & Stedman 2010). Further, nurses are able to recognise and manage complications, and they can provide post-abortion contraception (WHO 2015b). Full-service MA provision by PHCNs in Victoria can, therefore, include the tasks presented in Table 2.2. However, in the hypothetical case of full-service MA provision, the local physician would still be required for pathology referrals and drug prescription.

The next section discusses two currently used approaches to improve the access of MA provision in the regional and rural areas of Victoria.
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**Table 2.2** Full-service tasks of PHCNs in MA provision

<table>
<thead>
<tr>
<th>Full-service tasks of PHCNs in MA provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of independent pre-abortion pregnancy counselling and accurate information</td>
</tr>
<tr>
<td>Conduct of a medical and physical assessment, including estimation of gestational age</td>
</tr>
<tr>
<td>Ruling out contra-indications and co-morbidities</td>
</tr>
<tr>
<td>Diagnosis and dating of pregnancy (with ultrasound)</td>
</tr>
<tr>
<td>Screening for ectopic pregnancy</td>
</tr>
<tr>
<td>Assessment of blood group and Rhesus status</td>
</tr>
<tr>
<td>Discussion of available abortion methods and services, and the respective potential complications</td>
</tr>
<tr>
<td>Obtaining consent required for the chosen procedure</td>
</tr>
<tr>
<td>Planning future contraceptive needs and decision of commencement date</td>
</tr>
<tr>
<td>Testing for sexually transmitted diseases, treatment and partner notification (if required)</td>
</tr>
<tr>
<td>Arranging appropriate and prompt referral to other services when required</td>
</tr>
<tr>
<td>Administration of mifepristone</td>
</tr>
<tr>
<td>Providing instructions for self-administration of misoprostol at home and management of side-effects</td>
</tr>
<tr>
<td>Provision of written information leaflets about treatment, complications, how to access help in an emergency, and the follow-up process</td>
</tr>
<tr>
<td>Assessing completion of abortion process (depending on local protocols: either clinically, with an hCG test and/or with ultrasound)</td>
</tr>
<tr>
<td>Provision of Anti-D IgG to non-sensitised RhD negative women</td>
</tr>
<tr>
<td>Ongoing support when required</td>
</tr>
</tbody>
</table>

Source: The RCN (2017) and the RANZCOG (2016).

### 2.6 TWO INNOVATIVE, ALTERNATIVE APPROACHES TO MA PROVISION IN AUSTRALIA

Currently in Australia, most medication abortions are still provided via costly, private and mainly metropolitan-located services (Black & Bateson 2017). Public service provision remains poor, especially outside metropolitan locations, and, despite the support and interest for MA provision in general practice, only a small number of GPs are certified prescribers (Dawson et al. 2017; Grossman & Goldstone 2015; Shankar et al. 2017). In the years following the legal availability of MA in Australia, two innovative approaches were introduced to improve MA access for women residing in regional and rural locations.
The first approach was initiated in 2014 by Gateway Health, a public sector PHC service provider in North East Victoria. Gateway Health offers MA via their sexual health clinic, using a nurse-led model of care with GP support (Hulme-Chambers et al. 2018). As patients at the clinic are bulk-billed, women are only required to pay for the price of the ultrasound and PBS prescription, thus keeping the out-of-pocket costs for the procedure low (Hulme-Chambers et al. 2018). Women are, in general, required to visit the clinic twice; however, in the case of long travel distances or for pregnancies nearing the 63 days’ gestation limit, a one-appointment-only procedure can be considered (Hulme-Chambers et al. 2018). After the second visit, women bring their prescription to the local pharmacy, where the mifepristone medication is taken under the observation of the pharmacist (Tomnay et al. 2018). The second phase of the two-step medication regimen is to be taken at home and is followed by a repeat pregnancy test and telephone follow-up (Tomnay et al. 2018). Hulme-Chambers et al. (2018) interviewed a self-selected sample of 18 women who had previously visited the clinic for an MA. Most women had contacted their local GP first and were then referred to Gateway Health, with travel distances to the clinic varying from five to 234 kilometres. Approximately one-third of the contacted GPs did not refer the women correctly or willingly to the MA provider. Further, about half the women reported the compulsory ultrasound to be a negative, stigmatising experience. All women, though, had a very positive, non-judgmental and informative experience with the clinic nurses (Hulme-Chambers et al. 2018).

Overall, Hulme-Chambers et al. (2018) demonstrated that the Gateway Health model provides affordable and acceptable MA services, but they concluded that indirect costs, due to long travel, and experienced stigma from local GPs, pharmacists and sonographers, required an increase in MA providers in regional and rural areas.

The second innovative approach in Australia was introduced in 2015, with the utilisation of telemedicine for the service provision of MA. Telemedicine, or telehealth, delivers health care services with the use of information and communication technology, to provide patient care at a
distance when specialist care is limited (Grossman et al. 2011). Globally, the use of telemedicine has expanded enormously in many areas of medicine, and can range from electronic communications between provider and patient to revolutionary, remotely controlled medical procedures (Boonstra 2013). MA early in the pregnancy is an ideal fit for telemedicine as contraindications can be easily assessed with an interview, pathology tests or physical examinations are not explicitly required, and abortion completion can be evaluated using hCG tests or ultrasonography (Raymond, Chong & Hyland 2016). Through self-administration of the medication at home, this approach will remove the need for patients to travel to a clinic and, thus, improve access to abortion services (Raymond, Chong & Hyland 2016).

Telemedicine MA provision can be delivered via three different models. The ‘clinic-to-clinic model’ was initiated in 2008 by the reproductive health care services network Planned Parenthood of the Heartland in Iowa, one of several states in the US that require physicians to dispense the MA drugs (Finer & Wei 2009; Grossman et al. 2011). As Planned Parenthood physicians usually operate near large-volume surgical abortion centres, the model enabled MA provision in remote clinics that stock mifepristone but do not have a physician on-site (Wiebe & Grossman 2014). At these clinics, a trained staff member counsels, screens and provides information to the abortion requesting woman, and organises laboratory tests and an ultrasound. The results are reviewed by a physician off-site, and if clinical criteria are met, a video teleconference is organised to discuss the procedure, after which the clinic will be authorised to dispense the medication under video surveillance (Wiebe & Grossman 2014). Two weeks later, the woman is required to return for a follow-up consultation with the staff member. A similar model has been used since 2011 at several remote clinics in Alaska (Grindlay & Grossman 2017). The Iowa method proved to be as safe and effective as in-person provision, with similar odds of having an adverse event, although study results were limited by the low response rate (35%) of contacted emergency departments (Grindlay, Lane & Grossman 2013; Grossman & Grindlay 2017). Nearly all (94%) women were satisfied with the
service, mainly because of the relatively quick process before the start of the actual procedure, and because they could obtain the abortion close to home (Grossman & Grindlay 2017). About 25 percent of the women, however, indicated that they would have preferred to be in the room together with the physician (Grossman & Grindlay 2017).

The second telemedicine model is the ‘clinic-to-woman-at-home’ approach, which is offered at an abortion clinic in Vancouver, Canada, for women who reside in the licensed province of British Columbia but live more than a two-hour drive from the abortion-providing clinic (Wiebe 2017). The women have a Skype video-conference with the abortion provider from home, and are directed to a local facility for laboratory tests and, if required, an ultrasound. If they are deemed eligible, a prescription for the abortifacients is faxed to a local pharmacy, or mailed directly to the woman, and the outcome of the procedure is monitored via a follow-up consultation by Skype a few weeks later (Wiebe & Grossman 2014). This model is currently also employed in a research project for women residing in the US states of Hawaii, Oregon, Washington and Maine (Gynuity 2017). According to Wiebe (cited in Raymond, Chong & Hyland 2016, p. 585), no serious complications were reported for the 33 women provided with MA.

The third model uses a ‘direct-to-woman’ approach and is similar to the ‘clinic-to-woman-at-home’ method. This approach is used by the website organisation ‘Women on Web’ (2017) that refers women who are eligible and live in a country where access to safe abortion is restricted, to a licensed doctor who can deliver the abortion pills (Wiebe & Grossman 2014). When an abortion via ‘Women on Web’ is not a possibility, the website (2017) provides information on alternative ways to obtain the medication and how to self-apply a safe abortion for pregnancies up to 12 weeks’ gestation with misoprostol only. The self-management of abortion, in which women obtain the drugs from informal routes, such as pharmacies, drug sellers or online services, and subsequently self-manage the abortion process, is a trend that has become increasingly common and feasible in settings with legal and/or non-legal abortion access.
barriers (Kapp et al. 2018). Aiken et al. (2017) analysed data of 1,023 women from the Republic and Northern Ireland, where abortion laws, until recently, were very restrictive, who underwent a MA with pills obtained online via Women on Web. Approximately 95 percent of the abortions were effective, comparable to in-person provision. The prevalence of adverse events was low (3%), and all women sought medical attention when necessary, as advised (Aiken et al. 2017). One limitation of the study was the reliance on women’s self-reporting, which can be subject to recall or social desirability bias. Further, it was not possible to obtain definite gestational age of the pregnancies at the time of the abortions, as some women might have been more weeks pregnant than they were willing to reveal, or there could have been delays in the taking of the pills (Aiken et al. 2017). Similarly, self-managed abortions are progressively used by women in the US because of of restrictive state-level legislations, long-distance travel to clinics, a lack of information, or a need for privacy (Aiken et al. 2018). Alternatively, ‘Women on Waves’ (2017), a ‘Women on Web’ related, Dutch-registered organisation, provides email support and advice for women in situations where safe abortions are not available. Women on Waves can bring women from countries where abortions are illegal, such as Mexico and Guatemala, on ships outside the country’s 12-mile radius territorial waters, where it is legal under the Dutch law to provide MA (Women on Waves 2017). A more recent initiative of Women on Waves is the provision of abortion pills with the help of drones, as was done in Poland and Northern Ireland with drones flying from Germany and the Republic of Ireland, respectively (O’Rourke, Belton & Mulligan 2016; Women on Waves 2017).

Overall, all telemedicine studies (Aiken et al. 2017; Grindlay & Grossman 2017; Grindlay, Lane & Grossman 2013; Grossman & Grindlay 2017; Raymond, Chong & Hyland 2016) showed that telemedicine provision of MA, irrespective of the method used, seemed to be as effective and safe when compared to in-person provision. Telemedicine is, therefore, recognised as ‘a reasonable alternative for those who may not otherwise have access to safe, high quality and effective abortion care’ (Gill & Norman 2018, p. 3).
Telemedicine was introduced to Australia in 1929 with the pedal radio network of the Australian Aerial Medical Service, which was later to be renamed the Royal Flying Doctor Service (Australian College of Rural and Remote Medicine 2012). This service expanded with trials of video communications in the 1970s to video consultation services to rural areas in the 1990s. With the spread of broadband, starting around 2005, connection costs were reduced, and the telehealth network increased rapidly (Australian College of Rural and Remote Medicine 2012). Nowadays, Medicare rebates and financial incentives are available for a range of online consultations across a range of medical specialties (Australian College of Rural and Remote Medicine 2012). Since 2015, telemedicine for MA abortions in Australia has been available through the Tabbot Foundation, Marie Stopes and Cairns Doctors (Belton 2017). Each deliver MA services, via the direct-to-woman model, in all Australian jurisdictions except for South Australia, where abortions need to be performed in a hospital. Due to a similar legislation, which was only amended in September 2018, women residing in the Australian Capital Territory needed to travel to Queanbeyan, a town in New South Wales located at the territory’s eastern border, to collect and take the medications (The Tabbot Foundation 2018). In addition, regulations in the Northern Territory, Queensland, Western Australia and New South Wales restrict telemedicine use to women who live within two hours’ drive from a medical facility that needs to be contacted for emergency care provision (The Tabbot Foundation 2018). Services from all three telemedicine providers are similar, and include the screening of women via a telephone consultation with a licensed physician, and ultrasound and pathology test arrangements at a convenient location (Belton 2017). If the woman is found eligible, all required medication and corresponding instructions are mailed to her directly (Belton 2017; The Tabbot Foundation 2018). Abortion success is confirmed using serum hCG testing. The cost of an MA is lowest via the Tabbot Foundation, which charges $250 AUD, excluding services provided by diagnostic providers or procedures required to treat complications or failed terminations (The Tabbot Foundation 2018).
An independent evaluation of the Tabbot telehealth service was presented by Belton (2017) at the Australasian HIV/AIDS Conference in Canberra. The service was found to be a safe, acceptable and effective choice for the delivery of MA. Data, however, showed that approximately 25 percent of women decided not to proceed with the abortion. No additional information was provided about the reasons behind these decisions. Further, of the 717 women in the study, only 15 percent were from outer regional areas, including less than two percent from remote areas. Therefore, study results mainly relate to women from major cities and inner regional areas, and it is questionable if they can be extrapolated for telemedicine provision in the regional and rural locations of Victoria, where self-management of the procedure can be more challenging due to socio-economic disadvantages and local privacy and stigma issues (Saurman 2016; Wakerman et al. 2008).

Both the Gateway Health model and the use of telemedicine for MA provision appear to have benefits and limitations. Gateway Health is regionally located and offers MA at a much more affordable price than private providers (Hulme-Chambers et al. 2018). However, the involvement and influence of GPs not connected with Gateway’s clinic, together with some reported long travel distances, demonstrate a need for a greater number of regional and rural providers in order to improve overall MA access and reduce indirect costs. Telemedicine, in particular when offered via the Tabbot Foundation, is relatively affordable. In addition, women who used this service reported fewer delays in obtaining the MA compared to in-person provision, and experienced more privacy, with less stigma and less travel time involved (Belton 2017; Grindlay & Grossman 2017; Grindlay, Lane & Grossman 2013). However, telemedicine does not provide a direct woman/doctor interaction, a shortcoming mentioned by 25 percent of telemedicine users in Iowa, US (Grossman & Grindlay 2017). In-person interaction is specifically required for women who are not able to independently interpret the provided instructions correctly, for instance because of low education, when English is not the first language, and for women who are less confident about self-managing abortion
at home (Aiken et al. 2017; Grindlay & Grossman 2017). Grindlay and Grossman (2017) also expressed concerns about the use of telemedicine for hearing-impaired women and those who are very emotional or unsure about their decision.

The limitations of the two currently used approaches of MA provision show that an additional, more comprehensive model of MA provision is required in Victoria to complement the existing models. A nurse-led model of MA provision in Victoria’s regional and rural areas would be able to deliver MA at a personal level and closer to women’s homes. Additionally, local PHC provision would allow providers to build valuable relationships with other local health professionals, required for pathology assessments and for emergency care, which would improve service access and reduce stigma. Further, it is hypothesised that locally provided MA and associated support will potentially improve post-abortion contraception follow-up and positively influence contraception adherence.

2.7 A NURSE-LED MODEL OF MA CARE FOR THE PHC SETTING OF REGIONAL AND RURAL VICTORIA

In a highly developed country such as Australia, safe abortions should be legally obtainable on request, or for a wide range of social and economic reasons, and abortion services should be easily accessible and available (CRR, 2004; WHO, 2012). However, until now, even in liberal Victoria, this aim has not been achieved. The current logistic and ethical barriers necessitate an alternative solution for the shortage in abortion provision, especially in regional and rural areas (Rice 2008).

The two MA provision approaches, as discussed in Section 2.6, namely regional public PHC sector provision and telemedicine, are currently employed in Victoria, yet both have their limitations. International evidence has consistently demonstrated the substantial contribution of skilled PHCNs to the accessibility of safe, first-trimester abortion care (Kishen & Stedman 2010). The inclusion of PHCNs in the MA provision process, and the development of a nurse-led MA
model of care, will not only define and enhance the role of the PHCN and advocate for policy change, but may ultimately improve abortion access in regional and rural areas of Victoria, the setting of this study. While it seems likely that there is potential for a nurse-led model, there is no literature available on the current role and/or involvement of PHCNs in the provision of MA in Victoria, and up until now, only a few studies have explored the uptake of MA provision among GPs. To address these gaps, this study aimed to assess, via a cross-sectional study, current MA practice among GPs and PHCNs in regional and rural Victoria, prevailing MA knowledge and overall abortion views, and intentions of becoming a future MA provider. Further, the study aimed, via the Delphi method, to explore the possibility of a nurse-led model of care for MA provision that could be widely applied in the PHC setting of regional and rural Victoria.
CHAPTER 3
STUDY CONTEXT

This chapter provides a brief overview of the context of the study. The chapter starts with stating the overall aim and research questions, and follows with a discussion of the methodological approach. Then, the geographical boundaries of the regional and rural areas of Victoria, the setting of the study, are described, and finally, the ethical considerations of this research are detailed.

3.1 AIM AND RESEARCH QUESTIONS

The aim of this study was to develop a nurse-led model of care for MA provision in the primary health care setting of regional and rural Victoria to improve abortion access. The research was guided by the following research questions and corresponding objectives:

1. What are the current and potential future roles of GPs and PHCNs in regional and rural Victoria in the delivery of medication abortion services?
   - Establish the current role of GPs and PHCNs in regional and rural Victoria in the provision of MA.
   - Understand the overall attitude of GPs and PHCNs in regional and rural Victoria towards abortion.
   - Identify the familiarity of GPs and PHCNs in regional and rural Victoria with MA.
   - Assess Victoria’s regional and rural GPs’ and PHCNs’ interest in MA provision.
   - Identify the anticipated and perceived challenges of MA provision by GPs and PHCNs in regional and rural Victoria.
   - Identify the scope of practice of a range of health practitioners for MA provision.
2. What would a nurse-led model of care for MA provision in regional and rural Victoria look like?
   • Develop recommendations and guidelines for the development of a nurse-led model of care for MA provision in regional and rural Victoria
   • Identify what a nurse-led model of care for MA provision in regional and rural Victoria looks like.

3. What are the anticipated barriers and solutions to the implementation of a nurse-led model of care for MA provision in the PHC setting of regional and rural Victoria?
   • Communicate opinions about the factors that can hinder or facilitate the implementation of a nurse-led model of care for MA provision in the PHC setting of regional and rural Victoria.
   • Collect recommendations of what needs to be done to overcome the barriers for implementation of a nurse-led model of care for MA provision in the PHC setting of regional and rural Victoria.

In order to answer these research questions, two separate but interconnected sequential studies were undertaken. First, a cross-sectional study, followed by a Delphi study. The purpose of the cross-sectional study was to answer research question one. The second study used the Delphi technique to explore research questions two and three, and to reach consensus about the feasibility of a nurse-led MA model. Data collection and analysis procedures are reported separately for each study, which is typical for a sequential mixed-method study (Creswell 2009).

The quantitative dominant cross-sectional study surveyed personal beliefs and attitudes of GPs and PHCNs in regional and rural Victoria on MA, current and potential future MA provision and the anticipated barriers and solutions of MA provision. Qualitative questions were incorporated in the questionnaire to get a better understanding of the findings (Creswell 2009). Chapter Four describes the methods for the cross-sectional study.

The Delphi study used a mixed-methods approach, which is a useful way to collect a variety of data to address complex social and health problems that
cannot be adequately dealt with when using a single method approach (Creswell 2009). In addition, mixed-method approaches offer a deeper and more comprehensive understanding of the research problem and increase validity and credibility of results (Creswell 2009; Greene, Benjamin & Goodyear 2001). The study employed a ‘sequential exploratory strategy’, one of the six classification types of mixed methods that are described by Creswell (2009, p. 214), with qualitative data (open-ended questions) collected in the first round, followed by two rounds of quantitative data collection (Creswell 2009). For some of the quantitative data collection, however, a ‘concurrent embedded strategy’ was applied, meaning that qualitative questions were added to expand and clarify the findings (Creswell 2009). Chapter Six details the Delphi methods adopted for this study.

The integration of both studies occurred after analysis in Chapter Eight, the discussion chapter. Here, the cross-sectional study findings and the findings of the Delphi study are combined and discussed together, within the context of the existing research literature.

### 3.2 THE STUDY SETTING

Victoria is geographically the second-smallest state in Australia but has the second largest population of about 6.32 million people, of which 23 percent live outside Greater Melbourne (Australian Bureau of Statistics 2018). The state is divided into nine regions: four metropolitan and five regional/rural regions (ABS 2015). The regional and rural areas of Victoria, as defined by the DHHS (2012a), are Barwon South West, Grampians, Loddon Mallee, Hume and Gippsland (see Figure 3.1). These regions were the setting of this study.
The geographic boundaries of these regions, however, vary, depending on what they are used for, including policy development, census collection, or the description of metropolitan/rural differences regarding employment and education (The National Rural Health Alliance 2018). While over the years, several geographical classification systems have been developed to define regional, rural and remoteness boundaries, the following two systems currently lead Australia’s rural health policy.

The Accessibility/Remoteness Index of Australia (ARIA) was created in 1998 and is currently maintained by the Hugo Centre for Migration and Population Research, University of Adelaide (2017). ARIA provides a measure of the road distance residents of non-metropolitan Australia have to travel in order to gain access to the nearest service centre, which can be a large city or small town (Hugo Centre for Migration and Population Research 2017). The longer the road distance, the more remote the individual resides from accessible services (National Centre for Social Applications of Geographical Information Systems 2008). One of the most widely used versions of ARIA is ARIA+, which is expressed in scores that range from 0 (high accessibility) to 15 (high remoteness). Scores are classified into remoteness areas categories (see Table 3.1) (Queensland Government Statistician’s Office 2017). The ARIA+ method thus uses a pure
Chapter 3 | Study context

geographical approach and does not include socio-economic factors, urban/rural aspects or population size in the calculation (Hugo Centre for Migration and Population Research 2017).

Table 3.1 Remoteness areas categories ARIA+

<table>
<thead>
<tr>
<th>Remoteness area</th>
<th>ARIA+ score</th>
<th>Accessibility to goods, services and opportunities for social interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Cities</td>
<td>0 ≤ 0.20</td>
<td>Relatively unrestricted</td>
</tr>
<tr>
<td>Inner Regional</td>
<td>0.21 - 2.40</td>
<td>Some restrictions</td>
</tr>
<tr>
<td>Outer Regional</td>
<td>2.41 - 5.92</td>
<td>Significantly restricted</td>
</tr>
<tr>
<td>Remote</td>
<td>5.93 - 10.53</td>
<td>Very restricted</td>
</tr>
<tr>
<td>Very Remote</td>
<td>10.54 - 15</td>
<td>Almost none</td>
</tr>
</tbody>
</table>


The second geographical classification system, the Australian Statistical Geography Standard (ASGS), has been used by the ABS (2014) since 2011. The ASGS provides a more comprehensive framework, where remoteness categories, defined with ARIA+ (Hugo Centre for Migration and Population Research 2017), are represented by population characteristics and environmental survey data (ABS 2014). Part of the ASGS is the concept of Greater Capital City Statistical Areas (GCCSAs), which represent the socio-economic extent of each of the eight Australian capital cities and satellite urban centres (ABS 2014). All the areas that are not part of GCCSAs are defined as ‘Rest of State Regions’ (ABS 2014). Melbourne’s Greater Capital City boundaries are shown in Figure 3.2.
The GCCSA classification system provides a practical geographic distinction between metropolitan and non-metropolitan areas, and this research has therefore adopted this classification. For the clarity of this thesis, ‘Greater Melbourne’ will be referred to as ‘metropolitan Melbourne’, and the ‘Rest of State Regions’ will be referred to as Victoria’s ‘regional and rural areas’.

### 3.3 ETHICAL CONSIDERATIONS

The cross-sectional study and the Delphi study were approved by the Deakin University Human Research Ethics Committee (DUHREC 2015-313 and DUHREC 2015-314). Although there was no specific risk involved in study participation, especially since partaking was entirely voluntary and, thus, only participants with an interest in the subject would choose to do so, the sensitive research topic could elicit a fear of social stigmatisation and negative judgement. Further, it should be noted that even though, in theory, a Delphi study would
allow a diverse group of specialists to anonymously express their views without any restrictions, peer pressure or influence from expert dominance, it is acknowledged that most panel members of expert groups often know each other. The arising ‘quasi-anonymity’ could make participants feel pressured to conform to the group's view, resulting in either adapting or abandoning the process (Hsu & Sandford 2007; Keeney, Hasson & McKenna 2011).

Therefore, the principal ethical issue of both studies was to acknowledge and ensure data security, and the privacy and confidentiality of the participants. All participants were informed, via the Plain Language Statement and Consent form (PLSC), that participation was voluntary and confidential, that participants could skip questions that made them feel uncomfortable, and that withdrawal was possible at any time until the ‘submit’ button was pressed, which implied consent. Further, it was explained that all identifying information was removed from data upon receipt, linked to each panellist’s unique ID code, and stored in separate databases. Responses were, therefore, fully anonymous and could not be directly linked to any of the participants. A prize was offered for GPs participating in the cross-sectional study, which required participants to provide their name and contact details if they wished to enter the draw. Details of eligible participants were separated from their responses and entered in a Microsoft Excel (2013) spreadsheet, which allowed for random selection of a winner. The winner of the $500 AUD travel voucher was notified by email. ID codes of the Delphi panellists were re-matched with corresponding email addresses for the second and third round questionnaire, as the Delphi process requires that the researcher can link back responses to individual panel members.

All data were handled and processed according to the rules of the National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council 2007), meaning that data were safely stored on a password-protected University server or in a locked cabinet, and that back-up USBs as well as any written paper copies were put in a locked filing cabinet, only accessible by the researchers. After the completion of the study, all digital data
were transferred to a USB, which will be, together with paper documents, securely stored within Deakin University for at least five years after the last publication.
CHAPTER 4
CROSS-SECTIONAL STUDY METHODS

In this chapter, the methods of the cross-sectional study will be described, including the study design, sampling and recruitment, instrument development, data collection and data analysis.

4.1 STUDY DESIGN

This study employed a cross-sectional study design to answer research question one: What are the current and potential future roles of GPs and PHCNs in regional and rural Victoria in the delivery of MA services? This design was chosen as the most suitable approach to obtain a quantitative description of the attitudes, opinions and behaviours of the study’s target population (GPs and PHCNs) in a short period of time (Creswell 2009). Further, cross-sectional studies are simple to execute, quick and relatively cheap (Webb & Bain 2011). Drawbacks of cross-sectional studies, however, are that the findings will only reflect a snapshot in time, and that they are prone to non-response bias, owing to high non-response rates (Sedgwick 2014; Webb & Bain 2011). Outcomes of this study will, therefore, not necessarily provide a true reflection of the sample population. These advantages and disadvantages are further discussed in the following sections.

4.2 SAMPLING AND RECRUITMENT

Multiple sampling and recruitment strategies were used in this study to obtain a sample from the target population: all nurses and GPs working in the PHC setting of regional and rural Victoria. The two groups are discussed separately.
4.2.1 Primary Health Care Nurses

The first target population of interest consisted of all nurses currently registered with the Nursing and Midwifery Board of Australia (NMBA) who work in the PHC setting of regional and rural Victoria. This group comprises enrolled nurses, registered nurses and nurse practitioners who work in general practice, community health service, education and sexual health clinics. While there are no accurate data available on the number of nurses, a 2012 report estimated that of the 2,425 practice nurses working in Victoria, approximately 45 percent (1,090) are employed outside major cities (Australian Medicare Local Alliance 2012).

The absence of a sampling frame required convenience sampling, a non-probability sampling technique whereby participants are selected in the most convenient way (Blair & Blair 2015). This technique has shown to be fast, easy and economical (Babbie 2010). The sample generated with convenience sampling, however, is vulnerable to selection bias (Babbie 2010). It can lead to an under-representation of certain groups within the sample, like those who are not in contact with any of the recruiting organisations or have no Internet access (Bethlehem 2010). Further, just as in probability sampling approaches, participation bias is an issue, because it is up to potential respondents to decide if they want to participate (Bethlehem 2010). Although this self-selection factor cannot be influenced, the choice to approach a broad and diverse group of organisations can reduce under-coverage (Bethlehem 2010). Overall, however, it cannot be assured that the sample obtained in this way will be a representation of the target population (Babbie 2010).

For non-probability samples, it is not possible to pre-assign a sample size or to obtain a random sample (Blair & Blair 2015). Consequently, an informal approach needs to be considered to yield a representative cross-section of the target group. One often-used method to obtain a sample size estimate is the use of a sample number that is typical for similar research in the field (Blair & Blair 2015). Research showed sample sizes in similar Australian studies ranged from 100 to 300; however, because of the contentious subject, lower responses were
to be expected (Australian General Practice Network 2009; Joyce & Piterman 2011; Merrick et al. 2012). To recruit the PHCN participants, the study used a multifaceted approach, consisting of convenience sampling and snowball sampling techniques (Babbie 2010).

For the convenience sampling method, a total of 27 professional nursing organisations, regional Primary Health networks and women’s health services, as well as a range of other key organisations with a focus on regional health, were approached as they were identified as suitable sources for nurse recruitment. Additionally, a publically accessible Facebook page, named ‘Medication abortion access in regional Victoria’, was established to promote the study. Facebook is known to be an effective recruitment tool as it enables organisations to “share” and “like” the page (Kapp, Peters & Oliver 2013). A convenience sample was also obtained from the publicly accessible National Health Services Directory (NHSD 2017), an online joint initiative of Australia’s federal government and the governments of all states and territories, which allowed potential participants to be approached directly instead of via third parties. The directory was explored for regional and rural general and primary care practices with a specific interest in sexual or women’s health and who employed practice nurses. To increase the chance of recruiting nurses, GP practice selection was restricted to relatively large (consisting of, approximately, more than six GPs) practices, as they appear to employ relatively more nurses. This search resulted in a list of 164 practices.

Eighteen of the 27 approached organisations promoted the study on their website, in their newsletter, mail-outs or on social media. Over the next four months, ongoing contact with the organisations that agreed to promote the study resulted in up to three published reminders and/or re-invitations to participate. The Facebook page included a short invitation letter, pinned to the top of the page, and an embedded link to the online questionnaire. To increase page engagement, the content of the page was updated on a regular base, for example with reminders and encouragements.

The PHCNs nurses working in the selected sample of 164 practices received an invitation letter by mail or email, depending on the contact
information provided in the NHSD. A reminder was sent four weeks after the initial invitation to all participating practices, as, due to the anonymous nature of the online questionnaire, it was not possible to identify who had participated. Depending on the medium that was used, the invitation either included an embedded link to the online questionnaire, or it directed the reader to a webpage that provided the same embedded link. All potential participants were additionally encouraged to forward the study information to eligible colleagues, thus creating a snowball effect (Babbie 2010).

4.2.2 General Practitioners

All qualified GPs who were actively practicing in the non-metropolitan areas of Victoria, as defined in Section 3.2, were eligible to be included in the cross-sectional study. According to data from the Rural Workforce Agency Victoria (RWAV) (2016) there were 1,861 GPs located in areas outside major cities. A probability sampling technique was used with the help of the Medical Directory of Australia (MDA), which is the leading online medical database for searching and locating doctors and health facilities nationwide, endorsed by the Australian Medical Association (AMA) (2017). The use of the directory allowed for contacting potential participants directly and is, therefore, less reliant on practice gatekeepers, like practice managers and practice assistants. The MDA subscription, however, did not permit for the compilation and use of a mailing list. Therefore, the contact details of all GPs that, according to the MDA, worked at that time in the PHC system of non-metropolitan Victoria, were looked up, one by one, on screen. Their names were then manually entered in a temporary file, producing a sampling frame of 1568 GPs. It was suspected that this number differed from the 1,861 GPs documented by the RWAV because of potential variations in the classification of geographic boundaries of regional/rural regions, and because not all GPs are registered with the MDA.

Using STATA (StataCorp 2015), a sample of 309 GPs, identified by their MDA identification number and corresponding name, was randomly selected from the sampling frame. The sample size required was calculated based on a 95
percent confidence interval and a five percent margin of error (Creative Research Systems 2012; O'Leary 2004). Of the selected sample, 22 GPs were either not found or they did not work in general practice, and two GPs were removed because their practice towns were not classified as a non-metropolitan area. To replete the loss of these 24 GPs, an additional random sample of 41 GPs was taken to provide for doubles and other exclusions. After screening, five names of this sample were indeed duplicates and, therefore, removed. A systematic sampling approach was then used, as this was the easiest and quickest way to obtain the desired sample size (Creswell 2009). Every fifth GP on the list was chosen until the 24 additional GPs were acquired to complete the sample. Contact details of the 309 GPs were then obtained from the National Health Service directory (2017), a database of Australian health and related services, and the White Pages, and used to compile a mailing list.

Additionally, as the initial response of the GPs to the online questionnaire was low, a non-probability, purposive snowball sampling method was employed to recruit more non-metropolitan GPs with the required specifications. A contact person of Deakin University’s regional/rural clinical schools was asked to introduce the study to GPs associated with these schools by sending them (non-personalised) invitation letters.

While it is widely acknowledged that primary care research is important for recommending clinical practice and to develop necessary evidence, GP recruitment for studies, and particularly for surveys, has proven to be challenging (Pit, Vo & Pyakurel 2014; Zwar et al. 2006). As the validity of survey results dependents on a sufficient number of responses, a variety of strategies have been developed to increase response rates, most of them consistent with the principles of Dillman’s Total Design Approach (Dillman, Smyth & Christian 2014). This approach emphases five elements in survey design and administration: inclusion of monetary incentives; a respondent-friendly survey layout; a multitude of reminders; enclosure of a stamped return envelope; and personalisation of the questionnaire. Four of Dillman’s strategies were employed in this study, as the enclosure of a stamped envelope was not required because
an online questionnaire was used for data collection. All GP participants completing the questionnaire by the stated deadline were offered the opportunity to enter a random prize draw for a $500 AUD weekend away voucher (Dillman, Smyth & Christian 2014; McLaren & Shelley 2000). Further, the mailed invitation letter sent to the 309 eligible GPs was personally addressed. All invitation letters, including the ones sent to GPs recruited via purposive snowball sampling, described the aim and purpose of the overall study and included a link to the questionnaire. The questionnaire was administered via the online survey tool Qualtrics (2015), which creates respondent-friendly and easy-to-use questionnaire layouts. Upon opening the questionnaire link, potential participants were first guided to the PLSC form (Appendix A), after which they were required to click the text that outlined that they had read the statement, understood their rights as a participant, and that they wished to continue. Two reminders were sent with two months’ interval each.

### 4.3 INSTRUMENT DEVELOPMENT

No existing instruments were available to determine the current and potential future roles of GPs and PHCNs in regional and rural Victoria in the delivery of MA services. Therefore, a new instrument was constructed drawing on the items of two existing questionnaires and the development of new items. Items were drawn from the Californian questionnaire by Hwang et al. (2005), who surveyed advanced practice clinicians, consisting of nurse practitioners, physician assistants and certified nurse-midwives, about their clinical experience with MA, personal beliefs and attitudes, clinical practices, possible interests in MA provision and their perceived barriers to providing such care. Their instrument, consisting of 22 items, was modelled, after extensive feedback and pilot-testing, on earlier questionnaires (McKee & Adams 1994). Additionally, items were drawn from a research instrument that was previously used in the US in 1997 and 2008 and in Canada in 2011 and 2013 to establish the practices and opinions of abortion providers (Lichtenberg, Paul & Jones 2001; Norman et al.
The newly developed instrument was modified according to each health provider group, with differences that mainly related to items that asked about occupation description, and the involvement with MA provision. The questionnaires consisted of five sections: socio-demographic characteristics; clinical experience; MA knowledge and involvement; personal beliefs and attitudes regarding abortion; and potential interest in MA provision. Items were mainly presented in multiple-choice, matrix, checkbox and Likert-scale format, and included a specification option, where appropriate, that allowed participants to write down additional responses to avoid the exclusion of significant data (Babbie 2010). Additionally, text boxes were employed to obtain numerical data regarding the age of participants, the number of years working in clinical practice, the year of commencing MA provision, and the numbers of provided MA.

The socio-demographic characteristics, the first section of the instrument, included items about gender, age, years of practice, part-time versus full-time work and current occupation/registration. They were based upon items used in similar studies (Hwang et al. 2005; Lichtenberg, Paul & Jones 2001; McKee & Adams 1994; Norman et al. 2013; Wiegerinck et al. 2008). Items regarding country of qualification and practice structure were only included for GPs, as not deemed relevant for PHCNs.

The four remaining sections of the questionnaire consisted of 24 items (the GP version) and 23 items (the PHCN version). The first section related to the clinical experience of the participants and consisted of items that measured the percentage of work time spent providing care to women of reproductive age, practice experience with women with unintended pregnancies, and the inclusion of abortion counselling and/or abortion referrals in consultations. All items were based on Hwang et al.’s (2005) instrument; however, wording was modified to reflect the Australian context.
The next section measured participants’ knowledge and involvement with MA and consisted of 12 (GPs) and 10 (PHCNs) items. Two items determined participants’ familiarity with MA. They were derived from Hwang et al.’s (2005) questionnaire. However, the phrase medication abortion was used instead of medical abortion. The next six (GPs) versus three (PHCNs) items related to personal and/or practice involvement with MA provision and estimated MA numbers. These items were also adapted from Hwang et al.’s (2005) questionnaire, but modified to reflect both target populations in the current Australian context. The last four (GPs) and five (PHCNs) items of this section were only applicable to current MA providers or to participants working in MA providing practices. These items included travel distance of abortion-requesting women to the clinic, encountered problems related to the MA provision process, encountered harassment, as well as disclosure issues regarding participants’ work environments. The items relating to travel distance and potential problems encountered in the MA provision process were based on the literature review (de Moel-Mandel & Shelley 2017; Hwang et al. 2005; Lichtenberg, Paul & Jones 2001; McKee & Adams 1994; Nickson, Smith & Shelley 2006; Norman et al. 2013; Wiegerinck et al. 2008). The final two multiple-option items were adapted and modified for the Australian context from the Lichtenberg, Paul and Jones (2001) questionnaire. The items enquired about encountered harassment and challenges of MA providers as well as disclosure issues regarding their work environment.

The four items that were part of the third section concerned participants’ personal beliefs and attitudes regarding (medication) abortion. Three items were drawn from Hwang et al.’s (2005) questionnaire. Extra response options, however, were added to the item that explored a range of health practitioners and their potential scope of practice regarding MA provision, to relate all options to the Australian context. The fourth item asked about circumstances that the participants believed justified abortions, with the answer choices reflecting the discourse that can be found in the current Australian literature (de Costa et al. 2015).
In the final section, three items were included that explored participants’ interest in MA training and potential barriers for MA provision uptake. After the first item enquired about the interest in MA training, the next two items asked non-MA providing participants to identify reasons for never wanting to provide or assist with MA and to identify reasons for not providing or assisting with MA, even though willing. Again, these items were derived from Hwang et al.’s (2005) questionnaire, with response options modified or added to reflect uptake barriers in the current Australian literature (de Moel-Mandel & Shelley 2017; Newton et al. 2016a). Participants were asked to mark all relevant choices for not or never wanting to provide or assist with MA from the checkbox list of potential responses. To finish, the GP questionnaire asked if participants wanted to enter the prize draw, and both questionnaires included an open invitation for the Delphi study at the end.

The GP and PHCN questionnaires were subsequently pre-tested and pilot-tested to identify problems related to language, relevance to the Australian context, size, flow and format of the questionnaires, browser compatibility and analysis methods (Radhakrishna 2007). First, a pre-test was conducted to assess the clarity and accuracy of the questionnaire instructions and to receive feedback on questionnaire design, language and technical aspects (Dillman, Smyth & Christian 2014). The pre-test procedure ensured that the questionnaires would function as consistent research tools to reduce both sampling (for example due to non-response) and non-sampling errors (like question misunderstandings or skip pattern problems) (Grimm 2010; Ruel, Wagner III & Gillespie 2016). A pre-test invitation email was sent out to a convenience sample of 17 friends and colleagues, which allowed for evaluations from people with a variety of backgrounds and knowledge (Dillman, Smyth & Christian 2014). The invitation explained, in short, the purpose of the pre-test and the approximate time it would take to complete the questionnaire items and feedback form. The questionnaires and feedback forms were returned within a week by 12 participants, a response rate of 70 percent. The feedback responses included problems regarding the flow and accessibility of the questionnaires, as
well as some typographical errors and language issues. Changes regarding the survey flow were made, and items were revised and reworded to improve the understanding of what was being asked and to enable satisfactory responses.

Following these amendments, the revised versions of the questionnaires were piloted among a convenience sample of the target population, which consisted of GPs and PHCNs working in metropolitan Melbourne. The pilot tested the whole research procedure, including the recruitment process, data collection and data analysis, in order to identify whether the proposed questionnaires would be suitable for the actual study and if they would be able to generate significant data that, after analysis, were able to answer the research questions (Ruel, Wagner III & Gillespie 2016). For logistic reasons, participants were sought in the direct neighbourhood of Deakin University. Thirteen local medical centres were contacted. An invitation to participate in the pilot questionnaires, with an explanation of the purpose of the pilot procedure and a link to the questionnaire, was either sent to the centres by email, via the centre’s website, or delivered in person. Additionally, a personal invitation email was sent to five GPs based at the medical centre at Deakin’s campus in Burwood (Melbourne). The GPs were encouraged to pass on the invitation to colleagues and practice nurses.

A few days after delivery, all practices, except for the Deakin practice, were contacted by phone to ensure that the invitations were received and distributed to potential participants. A reminder email was sent two weeks later to the Deakin GPs. From the 14 approached centres, which all together comprised approximately 100 GPs and around 20 practice nurses, only six questionnaires were returned. Three of them originated from GPs and three from nurses. It was hypothesised that the low response rate could be attributed to the role of practice managers, who appeared to be the person in control of the distribution of the questionnaires. On top of that, some practice managers explained that the distribution of questionnaires first required approval by the board of directors.
The feedback responses and suggestions resulted in the rewording and revision of two items (Rattray 2007). The item that asked about abortion counselling was reworded due to ambiguity, and an extra response option (‘I would not feel comfortable personally being involved’) was added to the item that enquired about reasons for not providing MA even though willing. Further, one item was added to the socio-demographic characteristics section of the PHCN questionnaire, to assess the highest qualification obtained. In addition, a problem with the sequence of the displayed questions was solved. Copies of the final versions of the PHCN and GP questionnaire are included in Appendix B and C, respectively.

4.4 DATA COLLECTION

An online, self-administered questionnaire was chosen as the method of data collection, because online questionnaires provide time-convenience for the participants in regards to answering the questions and they are environmentally friendly (Bourque 2004; Monroe & Adams 2012). Additionally, they are low in costs, easy to implement, and they have convenient built-in features for usage and data analysis (Bourque 2004; Dillman, Smyth & Christian 2014; Monroe & Adams 2012). Online questionnaires also remove a major possible cause of social desirability bias, as their (relative) anonymity can yield more comprehensive and candid answers on a sensitive topic like abortion (Bourque 2004; Brace 2013). Even though the use of standardised questions provides significant strength in regards to the measurements, they can also weaken the design as they provide less room for creative answers, and the initial questions cannot be changed during the study period (Babbie 2010; Schutt 2015). Debate around response rates to online questionnaires in comparison to mail or phone questionnaires is ongoing. Some studies (Dillman, Smyth & Christian 2014; Scott et al. 2011; Shih & Fan 2008) point out that online questionnaires have lower response rates than mail or phone questionnaires, while other studies (Ansolabehere & Schaffner 2014; Cobanoglu, Moreo & Warde 2001) provide evidence that online questionnaires produce comparable or even better response rates. The use of
online questionnaires for the participants recruited via Deakin University’s regional/rural clinical schools, however, hinders a personalised approach with options for reminders, as access depends on the link forwarded via a third party (Dillman, Smyth & Christian 2014). It should be noted, though, that this disadvantage is caused by the recruitment approach rather than the data collection method and it would also have been the case with a paper based questionnaire.

All data was collected between March and September 2016, using Qualtrics (2015), an online survey administering tool that can build surveys to conduct survey research, distribute surveys and analyse responses. An important feature of the program is that it can export data directly into statistical software programs, such as Excel and SPSS.

4.5 DATA MANAGEMENT AND ANALYSIS

All data from completed questionnaires were imported from Qualtrics into Microsoft Excel (2013), checked for errors and cleaned by removing all metadata, such as response submission dates, IP addresses, as well as any embedded data. As all Qualtrics data were exported in text format, data were recoded into numeric values. For example, Yes or No answers were recoded with 1 and 2, respectively, and Likert answers that involved ‘strongly disagree’ to ‘strongly agree’ were recoded into the numeric values 1-5. In addition, all statements in the matrix questions were divided in SPSS into separate variables and the scale answer options were assigned with appropriate values. The matrix question, for example, that asked participants if they hide the fact that they work in an MA-providing clinic from a range of people, was divided in SPSS into five single variables, which represented: hiding from spouse or partner; children; parents; friends; and/or neighbours. For each variable, the answer options ‘yes’, ‘no’ and ‘not applicable’, were recoded into the values 1, 2 and 3. Continuous data depicting ‘age’ and ‘years in practice’ were converted into three and four groups of ordinal categorical data, respectively.
After all data were checked, cleaned and manipulated, they were exported into IBM SPSS Statistics for Windows (Ver. 23, Armonk, NY: IBM Corp) for analysis. Descriptive statistics were used to examine the participants’ socio-demographic characteristics, clinical experience, MA knowledge and involvement, personal beliefs and attitudes regarding abortion, and potential interest in MA provision of the whole cohort and of GPs and PHCNs separately. Further analysis was done to assess potential statistically significant differences in the responses of the GPs and PHCNs. Similarly, differences were assessed between the sample GP characteristics and the characteristics of the regional GP workforce of Victoria (RWAV 2016). The Pearson chi square test ($\chi^2$), or Fisher’s Exact Test for small samples, was used to examine differences between sample GPs and regional GPs, and GPs and PHCNs for binary variables, for example: do you see women with unintended pregnancies as part of your practice, have you ever referred women for abortions, and I would support my colleagues in providing abortions (du Prel et al. 2010; Kroonenberg & Verbeek 2018). The non-parametric Mann Whitney U test (MWU) was performed to analyse differences between the GPs and the PHCNs for the ordinal scaled variables, such as Likert scale questions (du Prel et al. 2010). A characteristic of the Mann Whitney U test is that it can be used on small samples (du Prel et al. 2010).

Pearson’s chi square test ($\chi^2$), or the Fisher exact test for small samples, was also used to examine possible statistically significant differences between the GPs and PHCNs for the items that asked for reasons for never and not wanting to provide or assist with MA training. The item that related to the scope of practice of health care practitioners for MA provision was analysed with the Mann Whitney U test, because the answers were provided in an ordinal scale. For all tests a p-value less than 0.05 was used as a cut-off point for statistical significance (du Prel et al. 2010).

Thematic analysis was undertaken on the qualitative data obtained from the items that included a specification option. This qualitative data analysis technique is described by Braun and Clarke (2006, p. 79) as ‘a method for identifying, analysing and reporting patterns (themes) within data’. Thematic
analysis has proven to be a reliable research tool that can provide a rich-detailed interpretation of the data without the requirement of theoretical knowledge (Braun & Clarke 2006). Data were read and coded for additional themes. All transcripts were anonymised and assigned with a unique identification code which indicated profession (GP or PHCN) and participant number. Transcripts that provide further explanation or deepen the understanding of the presented data are used in Chapter Five to strengthen the study’s findings. Responses are attributed to the participants via the unique code assigned, which is denoted in brackets.

This chapter has described the methods for the cross-sectional study. The next chapter presents the findings of study.
CHAPTER 5
CROSS-SECTIONAL STUDY FINDINGS

This chapter presents the findings from the cross-sectional study with a sample of PHCNs and GPs working in the regional and rural areas of Victoria. The results are presented in four sections. The first section describes the socio-demographic characteristics of the participants. The second section aims to identify the current status of MA provision in regional and rural Victoria. It includes participants’ current role in MA provision, MA knowledge, their views on abortion, and their interest in becoming a MA provider. This section additionally explores the problems experienced by MA providers in regards to MA provision. The third section describes the perceived personal and logistical barriers for the uptake of MA provision, and the final section presents participants’ views on the scope of practice of a range of health practitioners for MA provision.

5.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS

A total of 69 participants, 39 GPs and 30 PHCNs completed the online questionnaire. The GPs’ response rate from the selected sample was 11 percent. The characteristics of the participants are presented in Table 5.1. Most PHCN participants (96.6%; n=28) were female, while in the GP group the female (53.8%; n=21) to male (46.2%; n=18) distribution was similar. According to data from regional Victoria, the actual percentage of male GPs in 2016 was 59.0 percent, which is 12.8 percentage points higher than the percentage of GP participants in this study (Rural Workforce Agency Victoria (RWAV) 2016). However, this difference was not statistically significant ($\chi^2 = 2.6; \text{ df} = 1; \ p = 0.14$). More than half (53.6%; n=37) of the participants were aged between 45 and 59 years. Each professional group had a mean sample age of 49 years, which was also similar to the overall mean age of regional GPs (B. Metherall, Data/Business Analyst, RWAV, email, 9 June 2017). The older age of the participants reflected the number of years the participants had worked in
general or clinical practice. More than half of the GPs (59.4%; n=22), compared with 48.1 percent (n=13) of PHCNs, had worked for more than 15 years in a clinical setting (MWU = 447.5; p = 0.46). Over two-thirds (64.1%; n=25) of the GPs worked full-time, which is congruent with RWAV (2016) findings, but statistically significantly higher than the 33.3 percent (n=10) of full-time working PHCN participants ($\chi^2 = 6.4; \text{df} = 1; p = 0.015$). Statistically significantly more GPs (64.1%; n=25) than PHCNs (34.5%; n=10; MWU = 380.5; p = 0.012) spent less than a third of their work time providing care to women of reproductive age.

The majority (82.1%; n=32) of the GP participants were qualified in Australia, which is statistically significantly higher than the overall 50 percent of Australian trained GPs currently practicing in regional and rural Victoria ($\chi^2 = 15.7; \text{df} = 1; p<0.001$) (RWAV2016).
## Table 5.1 Characteristics of the participants (n=69: GPs=39, PHCNs=30)¹ and comparable regional GP data (n=1861)

<table>
<thead>
<tr>
<th></th>
<th>Overall % (n)</th>
<th>Regional GPs² % (n)</th>
<th>GPs % (n)</th>
<th>PHCNs % (n)</th>
<th>GPs versus PHCNs χ² (df) / MWU⁴</th>
<th>p value</th>
<th>GPs sample versus regional GPs χ² (df)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (n=68)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>27.9 (19)</td>
<td>59 (1098)</td>
<td>46.2 (18)</td>
<td>3.4 (1)</td>
<td>15.1² (1)</td>
<td>&lt;0.001</td>
<td>2.6 (1)</td>
<td>0.14</td>
</tr>
<tr>
<td>Female</td>
<td>72.1 (49)</td>
<td>40.9 (763)</td>
<td>53.8 (21)</td>
<td>96.6 (28)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-44</td>
<td>30.4 (21)</td>
<td>38.5 (15)</td>
<td>20 (6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45-59</td>
<td>53.6 (37)</td>
<td>38.5 (15)</td>
<td>73.3 (22)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 60</td>
<td>15.9 (11)</td>
<td>23.1 (9)</td>
<td>6.7 (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean rank</td>
<td>34.4</td>
<td>35.8</td>
<td></td>
<td></td>
<td>561.0⁴</td>
<td>0.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean age (years)</td>
<td>49.2</td>
<td>49.1</td>
<td>49.4</td>
<td>48.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years in clinical practice (n=64)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 5</td>
<td>12.5 (8)</td>
<td>8.1 (3)</td>
<td>18.5 (5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-14</td>
<td>32.8 (21)</td>
<td>32.4 (12)</td>
<td>33.3 (9)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-24</td>
<td>21.9 (14)</td>
<td>27.0 (10)</td>
<td>14.8 (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 25</td>
<td>32.8 (21)</td>
<td>32.4 (12)</td>
<td>33.3 (9)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean rank</td>
<td>33.9</td>
<td>30.6</td>
<td></td>
<td>447.5⁴</td>
<td>0.46</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>50.7 (35)</td>
<td>61 (1135)</td>
<td>64.1 (25)</td>
<td>33.3 (10)</td>
<td>6.4³ (1)</td>
<td>0.015</td>
<td>0.2 (1)</td>
<td>0.74</td>
</tr>
<tr>
<td>Part-time</td>
<td>49.3 (34)</td>
<td>39 (726)</td>
<td>35.9 (14)</td>
<td>66.7 (20)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of qualification</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>50 (931)</td>
<td>82.1 (32)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15.7 (1)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Other</td>
<td>50 (931)</td>
<td>17.9 (7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide care women 13-44 years (n=68)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-33%</td>
<td>51.5 (35)</td>
<td>64.1 (25)</td>
<td>34.5 (10)</td>
<td>380.5⁴</td>
<td>0.012</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33-100%</td>
<td>48.5 (33)</td>
<td>35.9 (14)</td>
<td>65.5 (19)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: 1 Due to missing data, the number of participants is not the same for all variables; 2 Where possible, data is compared to information on the regional workforce of Victoria (RWAV 2016); 3 Chi-square test, including degrees of freedom; 4 Mann-Whitney U test statistic.
5.2 THE CURRENT STATUS OF MA PROVISION IN REGIONAL AND RURAL VICTORIA

The findings presented in this section aim to identify the current status of MA provision in regional and rural Victoria. First, participants’ clinical experience with women presenting with unplanned pregnancies is described, followed by participants’ knowledge of and involvement with MA provision. Next, the participants’ views on abortion and interest in becoming a MA provider are described as well as encountered problems with MA provision.

5.2.1 Clinical experience with unplanned pregnancies, MA familiarity, MA involvement and interest in MA training

All GPs (100%; n=39) and 86.7 percent (n=26) of the PHCNs reported that they were consulted by women with unintended pregnancies as part of their practice ($\chi^2 = 3.3; \text{df} = 1; p = 0.032$). Statistically significantly more GPs (94.9%; n=37) than PHCNs (53.8%; n=14; $\chi^2 = 15.5; \text{df} = 1; p < 0.001$) included abortion counselling in their consultations with women experiencing an unplanned pregnancy. In this study, counselling was defined as providing information and assisting with the decision-making process of the unplanned pregnancy. Further, all GP participants (100%; n=39), compared with almost half (46.7%; n=14) of the PHCNs, referred women requesting an abortion to abortion providers ($\chi^2 = 27.1; \text{df} = 1; p < 0.001$). Referral was either local (26.4% overall; n=14), to metropolitan Melbourne (20.8% overall; n=11), or to both local and metropolitan providers (37.7% overall; n=20). In addition, 15.1 percent (n=8) of all participants reported that they referred in a different way, for example because their practice was involved in MA provision (see Table 5.2).

Familiarity with MA was assessed, as well as personal MA involvement. Only 17.9 percent of both GPs (n=7) and PHCNs (n=5) reported that they were ‘very familiar’ with MA and the procedures involved in the MA process (Table 5.2). Five (20.0%) GPs reported they were directly involved in MA provision (see Table 5.2), and two (7.1%) PHCNs indicated to be a current MA provider when they were asked if they liked to be trained to provide MA (Table 5.3). One GP...
and three PHCNs did not provide MA themselves but worked in a practice where other practitioners provide the service. Of the seven (11.1%) participants who were currently MA providers, three started MA provision in 2015, two in 2014, and two did not specify. Only six participants provided data on the total number of MA performed (either personally or in their practice). GPs reported between 15 and 150 MA, while PHCNs reported between 10 and 100 MA performed in 2015.

Table 5.2 Clinical experience with unplanned pregnancies, MA familiarity and MA involvement (n=69: GPs=39, PHCNs=30)

<table>
<thead>
<tr>
<th>Do you see women with unintended pregnancies as part of your practice?</th>
<th>Overall % (n)</th>
<th>GPs % (n)</th>
<th>PHCNs % (n)</th>
<th>GPs versus PHCNs $\chi^2$ (df) / MWU$^3$</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>94.2 (65)</td>
<td>100 (39)</td>
<td>86.7 (26)</td>
<td>3.3$^2$ (1)</td>
<td>0.032$^4$</td>
</tr>
<tr>
<td>No</td>
<td>5.8 (4)</td>
<td>0 (0)</td>
<td>13.3 (4)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you include abortion counselling in your consultation? (n=65)</th>
<th>Overall % (n)</th>
<th>GPs % (n)</th>
<th>PHCNs % (n)</th>
<th>GPs versus PHCNs $\chi^2$ (df) / MWU$^3$</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>78.5 (51)</td>
<td>94.9 (37)</td>
<td>53.8 (14)</td>
<td>15.5$^2$ (1)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>No</td>
<td>21.5 (14)</td>
<td>5.1 (2)</td>
<td>46.2 (12)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have you ever referred women for abortions?</th>
<th>Overall % (n)</th>
<th>GPs % (n)</th>
<th>PHCNs % (n)</th>
<th>GPs versus PHCNs $\chi^2$ (df) / MWU$^3$</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>76.8 (53)</td>
<td>100 (39)</td>
<td>46.7 (14)</td>
<td>27.1$^2$ (1)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>No</td>
<td>23.2 (16)</td>
<td>0 (0)</td>
<td>53.3 (16)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If yes, where did you refer to? (n=53)</th>
<th>Overall % (n)</th>
<th>GPs % (n)</th>
<th>PHCNs % (n)</th>
<th>GPs versus PHCNs $\chi^2$ (df) / MWU$^3$</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>To a local abortion provider</td>
<td>26.4 (14)</td>
<td>23.1 (9)</td>
<td>26.4 (5)</td>
<td>4.5$^2$ (3)</td>
<td>0.21$^4$</td>
</tr>
<tr>
<td>To Melbourne</td>
<td>20.8 (11)</td>
<td>23.1 (9)</td>
<td>14.3 (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To both</td>
<td>37.7 (20)</td>
<td>43.6 (17)</td>
<td>21.4 (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>15.1 (8)</td>
<td>10.3 (4)</td>
<td>26.4 (4)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How familiar are you with MA? (n=67)</th>
<th>Overall % (n)</th>
<th>GPs % (n)</th>
<th>PHCNs % (n)</th>
<th>GPs versus PHCNs $\chi^2$ (df) / MWU$^3$</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not very familiar</td>
<td>23.9 (16)</td>
<td>17.9 (7)</td>
<td>32.1 (9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somewhat familiar</td>
<td>58.2 (39)</td>
<td>64.1 (25)</td>
<td>50.0 (14)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very familiar</td>
<td>17.9 (12)</td>
<td>17.9 (7)</td>
<td>17.9 (5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean rank</td>
<td>35.6</td>
<td>31.7</td>
<td>482.0$^3$</td>
<td>0.36</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you provide MA? (n=25)</th>
<th>Overall % (n)</th>
<th>GPs % (n)</th>
<th>PHCNs % (n)</th>
<th>GPs versus PHCNs $\chi^2$ (df) / MWU$^3$</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>20.0 (5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>80.0 (20)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Does your practice provide MA? (n=65)</th>
<th>Overall % (n)</th>
<th>GPs % (n)</th>
<th>PHCNs % (n)</th>
<th>GPs versus PHCNs $\chi^2$ (df) / MWU$^3$</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>15.9 (10)</td>
<td>13.9 (5)</td>
<td>18.5 (5)</td>
<td>2.4$^2$ (1)</td>
<td>0.56$^4$</td>
</tr>
<tr>
<td>No</td>
<td>84.1 (53)</td>
<td>86.1 (31)</td>
<td>81.5 (22)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: 1 Due to missing data, the number of participants is not the same for all variables; 2 Chi-square test, including degrees of freedom; 3 Mann-Whitney U test; 4 p-value of the Fisher exact test.
Ten (90.9%) of the 11 participants that were either directly, or via their practice, involved in MA provision, supplied information about the estimated distance MA requesting women had to travel to reach their clinic. Figure 5.1 shows that on average 76.7 percent of abortion-requesting women lived within 25 km of the MA-providing clinic, 14.0 percent of the women needed to travel between 25 and 50 km, and 5.4 percent travelled between 50 and 100 km. About four percent of abortion-requesting women had to travel more than 100 km.

Figure 5.1 The mean distance participants involved with MA provision indicated women had to travel to reach their clinic

5.2.2 Views on abortion and interest in becoming an MA provider

Seventy-eight percent (n=50) of the participants agreed with the statement that surgical and medication abortions should be ‘legal in all circumstances’. There was no difference in opinion between the GPs (71.4%; n=25) and the PHCNs (86.2%; n=25; \( \chi^2 = 2.0; \) df = 1; \( p = 0.23 \)) regarding the legality of abortions (see Table 5.3). Further, there was an overall substantial interest among participants who were not yet MA providers to receive MA training to manage unintended pregnancies. This interest, however, was statistically significantly higher among PHCNS (76.9%; n=20; \( \chi^2 = 5.3; \) df = 2; \( p = \)
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0.03) than among GPs (46.7%; n=14). Most GPs (97.1%; n=33) and PHCNs
(96.6%; n=28) also indicated to support a colleague in providing abortions.

Table 5.3 Participants’ view on abortion, their interest in receiving MA training and their
support for abortion providing colleagues

<table>
<thead>
<tr>
<th></th>
<th>Overall % (n)</th>
<th>GP % (n)</th>
<th>PHCN % (n)</th>
<th>GPs versus PHCNs χ² (df)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical and medication abortions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>should be (n=64):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal under any circumstances</td>
<td>78.1 (50)</td>
<td>71.4 (25)</td>
<td>86.2 (25)</td>
<td>2.0² (1)</td>
<td>0.23</td>
</tr>
<tr>
<td>Legal under certain circumstances</td>
<td>21.9 (14)</td>
<td>28.6 (10)</td>
<td>13.8 (4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illegal in all circumstances</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you interested in MA training?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=63)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Already providing</td>
<td>11.1 (7)</td>
<td>14.3 (5)</td>
<td>7.1 (2)</td>
<td>6.0² (2)</td>
<td>0.051³</td>
</tr>
<tr>
<td>Yes</td>
<td>54.0 (34)</td>
<td>40.0 (14)</td>
<td>71.4 (20)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>34.9 (22)</td>
<td>45.7 (16)</td>
<td>21.4 (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest in MA training among those</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>not yet providing (n=56)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>60.7 (34)</td>
<td>46.7 (14)</td>
<td>76.9 (20)</td>
<td>5.3³ (2)</td>
<td>0.03</td>
</tr>
<tr>
<td>No</td>
<td>39.3 (22)</td>
<td>53.3 (16)</td>
<td>23.1 (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would support my colleagues in</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>providing abortions (n=63)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>96.8 (61)</td>
<td>97.1 (33)</td>
<td>96.6 (28)</td>
<td>0.0² (1)</td>
<td>1.0³</td>
</tr>
<tr>
<td>No</td>
<td>3.2 (2)</td>
<td>2.9 (1)</td>
<td>3.4 (1)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: 1 Due to missing data, the number of participants is not the same for all variables; 2 Chi-
square test, including degrees of freedom. 3 p-value of the Fisher exact test.

The majority of participants (81.1%; n=50) indicated that abortions
should be legal in all circumstances. Of the 14 (21.9%) participants who found
abortions only justifiable ‘under certain circumstances’, all disapproved of
gender-selection abortions, but approved of abortion after rape or incest, the
detection of a foetal abnormality or a pregnancy that is life threatening (see
Figure 5.2). Further, among these 14 participants, all (n=4) PHCNs and all but one
GP (90%; n=9) agreed that abortion should be available for pregnancies up to 12
weeks’ gestation (see Figure 5.2).
**Figure 5.2** Circumstances that justify an abortion (for participants that justify abortion only ‘under certain circumstances’) (n=14).

The most commonly reported reason among non-providing participants for *never* wanting to provide or assist with MA was the concern about the need for surgical back-up in case of complications (see Table 5.4). This concern was statistically significantly higher among PHCNs (33.3%; n=9) than among GPs (9.4%; n=3; $\chi^2 = 5.2; df = 1; p = 0.03$). The main other reason for GPs *never* wanting to provide MA was the lack of support from colleagues (9.4%; n=3). For PHCNS, the main other reason was ‘too many legal restrictions’ (14.8%; n=4).
### Table 5.4 Reasons for never wanting to provide or assist with MA (n=62: GPs=34, PHCNs=28)\(^1\,^2\)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Overall % (n)</th>
<th>GPs % (n)</th>
<th>PHCNs % (n)</th>
<th>GPs versus PHCNs (\chi^2) (df)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am morally/ethically opposed</td>
<td>1.7 (1)</td>
<td>3.1 (1)</td>
<td>0 (0)</td>
<td>0.9 (1)</td>
<td>1.04</td>
</tr>
<tr>
<td>There is no need for more abortion providers</td>
<td>5.1 (3)</td>
<td>6.3 (2)</td>
<td>3.7 (1)</td>
<td>0.2 (1)</td>
<td>1.04</td>
</tr>
<tr>
<td>Anti-abortion harassment</td>
<td>1.7 (1)</td>
<td>0 (0)</td>
<td>3.7 (1)</td>
<td>1.2 (1)</td>
<td>0.46</td>
</tr>
<tr>
<td>Too many legal restrictions</td>
<td>8.5 (5)</td>
<td>3.1 (1)</td>
<td>14.8 (4)</td>
<td>2.6 (1)</td>
<td>0.17</td>
</tr>
<tr>
<td>I worry about the need for surgical back-up</td>
<td>20.3 (12)</td>
<td>9.4 (3)</td>
<td>33.3 (9)</td>
<td>5.2 (1)</td>
<td>0.03</td>
</tr>
<tr>
<td>My colleagues would not be supportive</td>
<td>5.1 (3)</td>
<td>9.4 (3)</td>
<td>0 (0)</td>
<td>2.7 (1)</td>
<td>0.24</td>
</tr>
<tr>
<td>My community would not be supportive</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>My friends and family would not be supportive</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Financially unviable</td>
<td>-</td>
<td>6.3 (2)</td>
<td>n/a</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Notes: 1 Participants already providing MA were excluded from answering the item; 2 Percentages do not add up to 100% as more than one answer could be provided; 3 Chi-square test, including degrees of freedom; 4 p-value of the Fisher exact test.

The qualitative data analysis of the data obtained from the specification option box did discover some additional reasons for why participants never wanted to provide MA. Some participants stated they did not feel comfortable being personally involved in MA services, even though they were not against abortion practices:

*I am not opposed to abortion and believe all women should have the right to choose, and I am happy to work where abortion can be organized or patient referred to someone who can help, but I personally don’t wish to be involved* (PHCN8).

One GP did not see the need to become an MA provider because of locally easily accessible services:

*Where I work we can refer patients to an unwanted pregnancy clinic at the local hospital* (GP22).
Another GP saw their part-time work as a barrier for MA provision:

*As I work part-time I would not be available to deal with any complications that might arise that needed urgent medical intervention and at this point I am uncertain if my colleagues would be happy to be involved* (GP16).

In addition, one PHCN considered MA to be a medical procedure:

*I feel this is a medical procedure and thus a doctor should be involved. Would support the patient in decision making and after care* (PHCN2).

In regards to the concerns expressed for the need of surgical back-up in case of complications, one PHCN commented:

*Although surgical back up may be an issue in some areas I do not see how this differs from a spontaneous abortion. I have seen shock and pain occur from this due to retained products being stuck in the cervix. It was fairly easy for the GP to remove these prior to transfer to hospital* (PHCN28).

5.2.3 Problems experienced when providing MA

Participants who indicated current involvement with MA provision, either directly or via their practice, were asked to specify if they had experienced any problems related to this service. None of the participants reported they had experienced acts of harassment and/or stigma issues related MA provision. Further, none of the GPs felt the need to be secretive about their work or work environment in relation to MA provision, towards their partner, children, parents, friends or neighbours. However, one PHCN reported feeling the need to hide the fact that she works in a clinic that provides abortion from at least one good friend and a neighbour. One GP indicated a lack of a 24-hour contact advice service to be a problem. Another GP who worked in an MA-providing clinic stated that their practice had encountered problems with the access to surgical back-up in the case of complications. No other problems were reported.
5.3 PERSONAL AND LOGISTICAL BARRIERS TO BECOMING AN MA PROVIDER

To investigate personal and logistical barriers to providing or assisting with MA, non-providing participants were asked to indicate all factors, applicable to their personal situation, that contribute to their decision to not become an MA provider even though willing (see Table 5.5). A lack of training opportunities was reported by nearly half of the participants as the most common reason for not providing MA (45.2%; n= 28). Statistically significantly more PHCNs (64.3%; n=18) than GPs (29.4%; n=10; \(\chi^2 = 7.5; df = 1; p = 0.01\)) indicated the lack of training as an up-take barrier. About one-third (37.1%; n=23) of the participants stated a reason for not providing MA was their lack of familiarity regarding the legal restrictions related to the MA process. PHCNs (64.3%; n=18) were statistically significantly more concerned about the legal restrictions involved with MA provision than GPs (14.7%; n=5; \(\chi^2 = 16.2; df = 1; p<0.001\)).

In regards to the follow-up phase after the MA procedure, nearly one-third (30.6%; n=18) of the participants reported concern about the absence of surgical back-up when MA complications arise (GPs 20.6%; n=7; PHCNs 42.9%; n=12; \(\chi^2 = 3.6; df = 1; p = 0.1\)). Further, about one-quarter (27.4%; n=17) of the participants were concerned there would be no physician available for back-up in the case of questions or complications after the MA procedure (GPs 17.6%; n=6; PHCNs 39.3%; n=11; \(\chi^2 = 3.6; df = 1; p = 0.09\)). Finally, participants (22.6%; n=14) also indicated a lack of a 24-hour contact advice services to be an MA up-take barrier (GPs 23.5%; n=8; PHCNs 21.4%; n=6; \(\chi^2 = 0.04; df = 1; p = 1.0\)).

In addition, participants reported local logistical issues as reasons for not providing MA services (see Table 5.5). A lack of access to ultrasound required for pregnancy dating and the exclusion of ectopic pregnancies, was deemed as an MA up-take barrier by 24.2 percent (n=15) of the participants. This barrier was statistically significantly more often reported by PHCNs (39.3%; n=11) than GPs (11.8%; n=4; \(\chi^2 = 6.3; df = 1; p = 0.02\)). Further, approximately 13 percent (n=8) of the participants stated that MA provision was not permitted by the facility where they worked (GPs 8.8%; n=3; PHCNs 17.9%; n=5; \(\chi^2 = 1.1; df = 1; p = 0.5\)).
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Other reported barriers were unsupportive colleagues (GPs 11.8%; n=4; PHCNs 3.6%; n=1; χ² = 1.4; df = 1; p = 0.4) and the unwillingness of the local pharmacist to supply mifepristone (GPs 0%; n=0; PHCNs 7.1%; n=2; χ² = 2.5; df = 1; p = 0.2).

Feeling uncomfortable being personally involved in MA provision was reported by approximately 10 percent (n=6) of the participants (GPs 5.9%; n=2; PHCNs 14.3%; n=4; χ² = 1.2; df = 1; p = 0.4) (see Table 5.5). Of particular note is the small number of participants who reported fear of anti-abortion harassment as a barrier for not providing MA (GPs 2.9%; n=1; PHCNs 10.7%; n=3; χ² = 1.5; df = 1; p = 0.3). Only two (5.9%) GPs mentioned MA provision being financially unviable.
### Table 5.5 Reasons for not providing or assisting with MA even though willing (n=62: GPs=34, PHCNs=28)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Overall % (n)</th>
<th>GPs % (n)</th>
<th>PHCN % (n)</th>
<th>GPs versus PHCNs $\chi^2$ (df)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>No training opportunities</td>
<td>45.2 (28)</td>
<td>29.4 (10)</td>
<td>64.3 (18)</td>
<td>7.5 (1)</td>
<td>0.01</td>
</tr>
<tr>
<td>Unsure of legal restrictions</td>
<td>37.1 (23)</td>
<td>14.7 (5)</td>
<td>64.3 (18)</td>
<td>16.2 (1)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Follow-up concerns</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No access to surgical back-up in case of complications</td>
<td>30.6 (19)</td>
<td>20.6 (7)</td>
<td>42.9 (12)</td>
<td>3.6 (1)</td>
<td>0.1</td>
</tr>
<tr>
<td>No physicians for back-up</td>
<td>27.4 (17)</td>
<td>17.6 (6)</td>
<td>39.3 (11)</td>
<td>3.6 (1)</td>
<td>0.09</td>
</tr>
<tr>
<td>Lack of 24-hour contact advice</td>
<td>22.6 (14)</td>
<td>23.5 (8)</td>
<td>21.4 (6)</td>
<td>0.04 (1)</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Local logistical problems</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No access to ultrasound</td>
<td>24.2 (15)</td>
<td>11.8 (4)</td>
<td>39.3 (11)</td>
<td>6.3 (1)</td>
<td>0.02</td>
</tr>
<tr>
<td>The facility where I work does not permit it</td>
<td>12.9 (8)</td>
<td>8.8 (3)</td>
<td>17.9 (5)</td>
<td>1.1 (1)</td>
<td>0.5^4</td>
</tr>
<tr>
<td>My colleagues would not be supportive</td>
<td>8.1 (5)</td>
<td>11.8 (4)</td>
<td>3.6 (1)</td>
<td>1.4 (1)</td>
<td>0.4^4</td>
</tr>
<tr>
<td>Unwillingness of local pharmacist to supply MA</td>
<td>3.2 (2)</td>
<td>0 (0)</td>
<td>7.1 (2)</td>
<td>2.5 (1)</td>
<td>0.2^4</td>
</tr>
<tr>
<td><strong>Personal issues</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would not feel comfortable being personally involved</td>
<td>9.7 (6)</td>
<td>5.9 (2)</td>
<td>14.3 (4)</td>
<td>1.2 (1)</td>
<td>0.4^4</td>
</tr>
<tr>
<td>Fear of anti-abortion harassment</td>
<td>6.5 (4)</td>
<td>2.9 (1)</td>
<td>10.7 (3)</td>
<td>1.5 (1)</td>
<td>0.3^4</td>
</tr>
<tr>
<td>My community would not be supportive (fear of stigmatisation)</td>
<td>3.2 (2)</td>
<td>2.9 (1)</td>
<td>3.6 (1)</td>
<td>0.02 (1)</td>
<td>1.0^4</td>
</tr>
<tr>
<td>My friends and family would not be supportive</td>
<td>1.6 (1)</td>
<td>0 (0)</td>
<td>3.6 (1)</td>
<td>1.2 (1)</td>
<td>0.5^4</td>
</tr>
<tr>
<td>Financially unviable (GPs only)</td>
<td>-</td>
<td>5.9 (2)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Notes: 1 Percentages do not add up to 100% as more than one answer could be provided; 3 Chi-square test, including degrees of freedom; 4 p-value of the Fisher exact test.

The qualitative data analysis of the data obtained from the specification option box revealed some additional reasons for participants not wanting to provide MA even though willing. One reason provided was the local low demand for MA provision, illustrated in the following quotes:

*My practice is small and the number of requests I encounter is insignificant. I do not intend embarking on further training for a skill I will rarely, if ever need to use* (GP25).
In my community, the safest and easily accessible option is through specialist gynaecologist... I believe they should provide the treatment (GP28).

Reasons also included the mandatory requirement for medical practitioners of passing the online training module to be able to provide MA (see section 1.4.3):

I attempted the on-line training a few years ago. I didn’t pass the final exam! ... I didn’t go back to study harder for 2 reasons- 1- I don’t have the time to do this!! 2 - I work in a small community the numbers of unwanted pregnancies are very low ... Took about 6 hours of my precious time. They should change the training!!!! I am more than happy to provide the service (GP18).

PHCNs highlighted specific barriers they perceived they would encounter when wanting to become involved with MA provision. Those barriers included an anticipated oppositional stance of involved professional organisations:

The AMA [Australian Medical Association] will prevent any nurse involvement in advanced practice wherever possible and the nurses’ board will not be much better (PHCN28).

Further, a comment was made about the role of Marie Stopes in regards to their online MA training module, which is only available to prescribing physicians (MS Health 2017):

Marie Stope only trains medical officers and makes MS2step available for their use (PHCN25).

5.4 SCOPE OF PRACTICE FOR MA PROVISION

In order to assess participants’ views on the scope of practice of a range of health care practitioners for MA provision, participants were asked to indicate which practitioners they believed were permitted to provide MA services (see Table 5.6). All agreed that the provision of MA falls within the scope of practice of obstetricians and gynaecologists. Most GPs (83.8%; n=31) and PHCNs (96.6%;
n=28) also recognised the GP as a potential MA provider. While more PHCNs (62.1%; n=18) than GPs (45.9%; n=17) agreed that MA could be provided by rural endorsed nurses, this difference was not statistically significant (MWU test=456; p=0.3). In addition, most GPs (81.1%; n=30) and PHCNs (72.4%; n=21) disagreed with enrolled nurses becoming MA providers.

PHCNs (79.3%; n=23), however, were statistically significantly more likely than GPs (32.4%; n=12; MWU test=243.5; p<0.001) to agree that MA provision falls within the scope of practice of nurse practitioners. Similarly, more PHCNs (44.8%; n=13) than GPs (10.8%; n=4; MWU test=318.5; p=0.02) agreed that MA provision falls within the scope of practice of registered nurses or midwives (PHCNs 65.5%; n=19; GPs 21.6%; n=8; MWU test=288.5; p=0.001).

### Table 5.6 Participants’ views around the scope of practice for MA provision of a range of health care practitioners (GPs: n=37; PHCNs: n=29)

<table>
<thead>
<tr>
<th>Health Care Practitioner</th>
<th>GPs versus PHCNs</th>
<th>MWU</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrician/Gynaecologist</td>
<td></td>
<td>499.5</td>
<td>0.1</td>
</tr>
<tr>
<td>GP</td>
<td>0</td>
<td>0</td>
<td>100 (37)</td>
</tr>
<tr>
<td>PHCN</td>
<td>6.9 (2)</td>
<td>0</td>
<td>93.1 (27)</td>
</tr>
<tr>
<td>General practitioner</td>
<td></td>
<td>467.5</td>
<td>0.1</td>
</tr>
<tr>
<td>GP</td>
<td>2.7 (1)</td>
<td>13.5 (5)</td>
<td>83.8 (31)</td>
</tr>
<tr>
<td>PHCN</td>
<td>0</td>
<td>3.4 (1)</td>
<td>96.6 (28)</td>
</tr>
<tr>
<td>Nurse practitioner</td>
<td></td>
<td>243.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>GP</td>
<td>48.6 (18)</td>
<td>18.9 (7)</td>
<td>32.4 (12)</td>
</tr>
<tr>
<td>PHCN</td>
<td>3.4 (1)</td>
<td>17.2 (5)</td>
<td>79.3 (23)</td>
</tr>
<tr>
<td>Rural endorsed nurse</td>
<td></td>
<td>456</td>
<td>0.3</td>
</tr>
<tr>
<td>GP</td>
<td>21.6 (8)</td>
<td>32.4 (12)</td>
<td>45.9 (17)</td>
</tr>
<tr>
<td>PHCN</td>
<td>17.2 (5)</td>
<td>20.7 (6)</td>
<td>62.1 (18)</td>
</tr>
<tr>
<td>Registered nurse</td>
<td></td>
<td>318.5</td>
<td>0.02</td>
</tr>
<tr>
<td>GP</td>
<td>62.2 (23)</td>
<td>27.0 (10)</td>
<td>10.8 (4)</td>
</tr>
<tr>
<td>PHCN</td>
<td>31.0 (9)</td>
<td>24.1 (7)</td>
<td>44.8 (13)</td>
</tr>
<tr>
<td>Enrolled nurse</td>
<td></td>
<td>467</td>
<td>0.3</td>
</tr>
<tr>
<td>GP</td>
<td>81.1 (30)</td>
<td>18.9 (7)</td>
<td>0</td>
</tr>
<tr>
<td>PHCN</td>
<td>72.4 (21)</td>
<td>13.8 (4)</td>
<td>21.6 (8)</td>
</tr>
<tr>
<td>Midwife</td>
<td></td>
<td>288.5</td>
<td>0.001</td>
</tr>
<tr>
<td>GP</td>
<td>45.9 (17)</td>
<td>32.4 (12)</td>
<td>21.6 (8)</td>
</tr>
<tr>
<td>PHCN</td>
<td>17.2 (5)</td>
<td>17.2 (5)</td>
<td>65.5 (19)</td>
</tr>
</tbody>
</table>

Notes: 1 Mann-Whitney U test statistic.
This chapter has described the findings from the cross-sectional study. Although most participants reported they are consulted by women with unintended pregnancies and they include abortion counselling in their consultation, the familiarity with MA provision was limited. Additionally, only seven (10.1%) (five GPs and two PHCNs) of the total sample of 69 participants indicated they were currently MA providers. A high level of interest was expressed in receiving MA training, especially among PHCNs. However, the findings also showed a wide range of personal and logistical barriers to MA provision, with distinct differences in perceived barriers between the two participant groups. Further, PHCNs and GPs differed in their opinion about the potential of MA provision by nurse practitioners, registered nurses and midwives. The differences are to be further discussed in Chapter Eight. The following two chapters present the methods and the findings of the Delphi study.
CHAPTER 6
DELPHI STUDY METHODS

A Delphi study was conducted to explore research questions two and three: what would a nurse-led model of care for MA provision in regional and rural Victoria look like, and what are the anticipated barriers and solutions to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria?

The chapter starts by describing and explaining the rationale for the use of the Delphi technique. Next, the panel sampling and recruitment methods are discussed, followed by a detailed description of the instrument development and data collection methods for each round. Lastly, the data management and analysis procedures employed in this study are explained.

6.1 STUDY DESIGN

The Delphi method is a strategy dating from the 1950s that uses the knowledge and experience of experts to reach consensus about a practical problem (Bleijenbergh, Korzilius & Verschuren 2011). The method can be used as a predicting or decision-aiding instrument applied to program planning or model construction, since it can gather knowledge about not yet identified data (Linstone & Turoff 2002; Skulmoski, Hartman & Krahn 2007). The original format, known as the Classical Delphi, was developed by the RAND corporation for the US Air Force to forecast technological and social developments (Dalkey 1969; Keeney, Hasson & McKenna 2011).

Generally, the classical format consists of a group communication process that aims to achieve expert consensus by using a minimum of two successive rounds of questionnaires (Hsu & Sandford 2007). The first round collects qualitative data and the subsequent rounds collect quantitative data (Keeney, Hasson & McKenna 2006). Each round is analysed and the results are anonymously reported back to the panel, which helps the panellists to
reconsider their initial opinions in later iterations, until full consensus is reached (Boulkedid et al. 2011; Linstone & Turoff 2002; Skulmoski, Hartman & Krahn 2007). The technique has three important features (Dalkey 1969). The first feature is the anonymity of the experts who participate in the study. Disadvantages associated with other group communication methods, such as manipulation or intimidation to approve a particular standpoint, are thus reduced (Hsu & Sandford 2007). The second feature relates to the controlled feedback of the results of the previous round, which reduces tangential and excessive communications, and the final feature is the use of statistical group response, such as agreement percentages, the spread of the responses and the overall group median rating, which aims to minimise group pressure toward conformity (Hsu & Sandford 2007).

From the late-1960s, the Delphi method became increasingly accepted and used within health care research. In the absence of globally approved guidelines, a large range of different formats emerged. Examples include the ‘modified Delphi’, which involves face-to-face interviews or a focus group for the first round, the ‘policy Delphi’, used in policy development, the ‘real-time Delphi’, a shorter, more efficient method, and the e-Delphi, which is carried out online (Gordon & Pease 2006; Keeney, Hasson & McKenna 2011).

There is, however, still debate over the ideal design of the Delphi technique (Goluchowicz & Blind 2011). This applies specifically to the following four Delphi characteristics: the optimal number of rounds; the optimal type of feedback; the selection of experts; and the sufficient level of agreement.

While the number of Delphi rounds can vary from two to 10, studies show that judgmental accuracy improved the most between the first and second round (Goluchowicz & Blind 2011). Therefore, most Delphi studies only require three iterations, even though in theory the iterative process of the Delphi method can be repeated continuously until consensus is reached (Hsu & Sandford 2007). The use of too many rounds, however, has been shown to cause participant fatigue resulting in lower response rates (Boulkedid et al. 2011;
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Skulmoski, Hartman & Krahn 2007). The number of rounds used in this study was three, and this choice is discussed in Section 6.1.1.

There is no documented consensus regarding the optimal feedback method delivered to panellists between each round. Feedback can either be provided as ‘statistical’ feedback (of median values and range of estimates) or ‘reasons’ feedback (involving arguments from the Delphi panellists along with their numerical estimates) (Goluchowicz & Blind 2011; Rowe, Wright & McColl 2005). Additionally, Rowe, Wright and McColl (2005) take into consideration the influence of the iteration process itself, which allows panellists, even without feedback, to reconsider their earlier responses. It has also been emphasised that a change in judgement of a panel member should be caused by new information only and not by conformity pressure (Goluchowicz & Blind 2011). Section 6.1.1 reports the feedback method used in this study.

The use of an expert panel is a fundamental feature of the Delphi method. It is suggested that a panel should reflect all stakeholders concerned with the study results, as they all have a different position on the subject matter (Boulkedid et al. 2011). The debate regarding the selection of experts is further discussed in Section 6.2.

Although a Delphi study aims to obtain consensus, the literature does not offer exact requirements about what is a sufficient level of agreement among participants (Powell 2003). Some studies pre-define consensus at a certain minimal percentage of agreement, ranging from 51 percent to 100 percent, while others derive consensus levels after data analysis or completely fail to mention them (Keeney, Hasson & McKenna 2011; Powell 2003). It has also been suggested to seek consensus in the stability of participants’ responses during a series of Delphi rounds (Keeney, Hasson & McKenna 2011). Stability of responses is defined as ‘the consistency of responses between successive rounds of a study’ (Dajani, Sincoff & Talley 1979, p. 84) and occurs when the response-category frequencies of two different Delphi rounds show to be not significantly different from each other. The pre-defined 75 percent level, however, is the most commonly used and recommended level in a wide range of Delphi studies,
and has been adopted for the current study (Hewitt & Cappiello 2015; Keeney, Hasson & McKenna 2011; von der Gracht 2012). Regardless of the method and agreement levels used for obtaining consensus, it is important to note that final consensus depends on the specific group of panellists, which means that results are not generalisable, and that they do not automatically imply the correct way to go (Clayton 1997).

Besides methodological ambiguities like the lack of universal guidelines on formats and consensus levels, the Delphi method also lacks any original support in a theoretical foundation (Gordon & Pease 2006; Hewitt & Cappiello 2015; Keeney, Hasson & McKenna 2011; Powell 2003). It is presumed that the absence of a theoretical underpinning, which provides guidance on how the study needs to be conducted and is essential to research integrity, originates from the fact that the Delphi method was developed in an era when science ruled over philosophy (Guzys et al. 2015). There is, therefore, an ongoing and unresolved debate in the literature about the Delphi’s epistemological stance and most Delphi studies are unclear about which theoretical framework criteria should be applied (Keeney, Hasson & McKenna 2011; Powell 2003). This was confirmed by Guzuys et al. (2015), who utilised a scoping review method to identify the methodological underpinnings used in Delphi research. They found that many researchers did not include a methodological rationale of their work, either because of indifference or uncertainty.

As the classical Delphi method consists of the collection of qualitative data followed by a structured process with quantitatively described results, it is difficult to place the method in a specific methodological category (Sekayi & Kennedy 2017). Because of the inclusion of a qualitative as well as a quantitative approach, it is juxtaposed between interpretative and positivist (scientific) paradigms (Hasson & Keeney 2011; Keeney, Hasson & McKenna 2011). The main argument against the positivist paradigm is that the technique is intended to share expertise in order to develop consensus and that it is not a scientific method that creates new knowledge (Hasson & Keeney 2011; Powell 2003). On the other hand, there is a discussion around the positioning of the Delphi
method within the interpretive paradigm, which considers the nature of the method to be subjective and qualitative (Keeney, Hasson & McKenna 2011). Some researchers, however, suggest the interpretive paradigm, and specifically social constructivism, to be particularly suited to the Delphi, due to the iterative feedback nature of the Delphi method that results in the construction of a consensus (Keeney, Hasson & McKenna 2011). Day and Bobeva (2005), on the other hand, argued to apply both qualitative and quantitative standpoints, or, as the technique develops quantitative data through qualitative methods, to give it a ‘hybrid’ epistemological status (Critcher & Gladstone 1998).

Mitroff and Turoff (2002) examined what the epistemologies of Western philosophers like Locke, Leibniz, Kant, Hegel and Singer could offer for insights into the Delphi process. They contended that while the original Delphi is closely aligned with the Lockean inquiry systems approach, which aimed to reach for consensus with the use of an informed group with a similar background of knowledge, nowadays more and more studies are using the Kantian approach that allows ‘many informed individuals in different disciplines or specialties to contribute information or judgments to a problem area which is much broader in scope than the knowledge that any one of the individuals possess’ (Mitroff & Turoff 2002, p. 27). The Kantian inquiry system is unambiguously goal-oriented and it aims to present an array of alternative models for the issue in question to acquire a comprehensive overview (Mitroff & Turoff 2002). The theoretical approaches used in this study are discussed in the next section.

6.1.1 The design used in this study

The Delphi method was well suited for this study because it allowed for the collection of opinions of a broad range of geographically spread-out professionals, without the need for face-to-face contact (McIlrath et al. 2010; Snyder-Halpern, Thompson & Schaffer 2000). All features of the Classical Delphi were utilised in the current study. First, all identities and responses of the experts remained anonymous throughout the Delphi process. This allowed the diverse group of specialists to express their views without any restrictions, peer-
pressure or influence from expert dominance (Hsu & Sandford 2007). Identities were only known by the researcher. Second, it was decided to adopt a mixed-method approach through three rounds of questionnaires, in order to expand the scope of the study and improve its analytical power (Sandelowski 2000). Three rounds are most commonly used in Delphi studies and often successfully lead to full consensus (Hsu & Sandford 2007). Further, a limited number of rounds maximises continuity of expert participation (Landeta 2006).

Round One employed a qualitative design in order to solicit extensive expert opinions on the issue (Clibbens, Walters & Baird 2012; Hasson, Keeney & McKenna 2000). This acquired a broader set of responses as compared with the use of more focused and structured questions. The disadvantage, however, is the more time-consuming analysis (Skulmoski, Hartman & Krahn 2007). The two subsequent rounds used a quantitative design to establish consensual opinions. Further details about the data collection instruments are provided in Section 6.3. Finally, following the recommendations of Keeney, Hasson and McKenna (2006), this study provided feedback to the panel of experts between the rounds in a ‘reasons’ form, that included arguments from the Delphi panellists along with their numerical estimates (Goluchowicz & Blind 2011; Rowe, Wright & McColl 2005) (see section 6.3.3). The statements generated from the collected data of the first-round questionnaire created the qualitative feedback, and the statistical summaries of the mutual opinions obtained in the subsequent rounds generated the numerical feedback. Simple numerical feedback, in the form of a measure of central tendency and (dis)agreement percentages, was favoured (Greatorex & Dexter 2000).

The Delphi study was administered online, as opposed to the pen-and-paper method. An e-Delphi approach was chosen, because online Delphi questionnaires are increasingly used among populations, such as health professionals, who regularly use Internet (Gill et al. 2013). Further, the method is recognised to be environmentally friendly, cost-effective, time-efficient and it facilitates direct import of data into analysis software (Gill et al. 2013).
As discussed in Section 6.1, it was pre-determined that consensus for the current study was reached when at least 75 percent of the panellists either ‘agreed’ or ‘strongly agreed’ with a statement and, additionally, if the spread of the scores in the distribution (interquartile range) was equal or less than one (Keeney, Hasson & McKenna 2011). Moderate consensus was set at 60-74 percent, and no consensus was defined for all statements with less than 60 percent of agreement.

This study positioned the used Delphi technique within the hybrid epistemological stance, not only because it used qualitative as well as quantitative data, but also because it acknowledged the position of Blass (cited in Keeney, Hasson & McKenna 2011, p. 19), who claimed that Delphi methodologies should not be positioned in one single paradigm (Critcher & Gladstone 1998). Further, the Delphi method adopted for this study was Kantian, as a mix of experts from a range of disciplines, each with a different perspective on the topic, were asked to express all their opinions and views about the proposed problem and possible solutions (Mitroff & Turoff 2002). A Kantian inquiry system, as explained by Mitroff and Turoff (2002), best suits problems that are essentially poorly structured and have a much broader scope than the problem knowledge that any one of the individuals possesses, whereas a Lockean inquiry system is more suited to well-structured problems that already have a certain degree of consensus.

6.2 PANEL SAMPLING AND RECRUITMENT

There is no agreement regarding the ideal sample size of panellists for a Delphi study (Hsu & Sandford 2007). The literature identifies a variety of sample sizes, ranging from as low as 10 (for groups with a homogeneous background), to more than 50 (Hsu & Sandford 2007). A sample size that is too small can result in non-representative conclusions, while a sample size that is too large will complicate the management and data analysis process (Hsu & Sandford 2007; Skulmoski, Hartman & Krahn 2007). Ideally, a Delphi panel needs to reflect a full range of professionals in order to capture all their opinions, which would enrich
the study’s results and enhance its credibility (Boulkedid et al. 2011). Additionally, a panel should include laypeople, with relevant expertise by virtue of their experience (Rowe & Wright 2011). According to Skulmoski, Hartman and Krahn (2007, p. 10), Delphi panellists should meet four ‘expertise’ criteria: 1) knowledge and experience with the issues under investigation; 2) capacity and willingness to participate; 3) sufficient time to participate in the Delphi; and 4) effective communication skills.

In this study, panellists were required to meet the four ‘expertise’ criteria, and were considered to be an expert if they belonged to one of the following groups:

- **Experts by profession:**
  - General practitioners from regional and rural Victoria and gynaecologists/obstetricians from Victoria, already involved or interested to become involved in the provision of MA.
  - Clinicians involved in sexual and reproductive health or abortion reform activities working in academia, education or policy development.
  - Clinicians involved in the professional bodies responsible for the different aspects of the nursing profession, such as nursing colleges and associations, regulatory authorities and unions. Additionally, this group includes those that work at management level within organisations like women's health, community health services, sexual health centres, family planning, pregnancy counselling services and private abortion clinics.
  - Nurses or midwives working in the primary health care setting of regional and rural areas of Victoria (general practice or community settings).

- **Experts by experience:**
  - Professionals who have an interest in, experience with, or are an advocate for induced abortions.
  - Women with experience with, or who are an advocate for, induced abortions.
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Non-probability, purposive and convenience sampling techniques were used for the establishment of the panel, including the snowball sampling technique. PHCNs, GPs and other clinicians actively working in MA, were located via an Internet search. A literature search for peer-reviewed publications and organisational reports of nurse-led models and/or abortion reform activities in Victoria identified professionals working in academia, politics or for women’s health organisations. Additionally, websites were explored for the identification of leaders of professional or government groups or organisations involved in nurse education, registration or reform. This search resulted in a total of 45 potential professional panel members in addition to the 22 GPs and 15 PHCNs from the cross-sectional study who expressed their interest in participating in the Delphi study. Of the identified 45 potential panel members, nine were clinicians and an additional 36 worked in universities, for professional organisations or in politics. Therefore, the total number of potential panel members invited to participate was 82. All these experts by profession were contacted directly via their available email or mail address (see Appendix D for a copy of the invitation letter).

Additionally, 22 organisations, such as professional nursing organisations, women’s health agencies and Primary Health Networks in regional and rural Victoria, were approached and asked to publish the study invitation for the professional experts by experience on their website, Facebook page or in their newsletter. The contact letter and the study invitation explained the purpose and structure of the study and the anticipated amount of time and effort that was to be expected from participation. In addition, the invitation requested to be forwarded to eligible colleagues (snowball sampling).

The other group of experts by experience, consisting of women with experience with, or who are an advocate for, induced abortions, were recruited with the help of a flyer that was circulated via the regional and rural Women’s Health Victoria agencies (see Appendix E for a copy of the flyer). Some of the approached agencies also published the invitation in their newsletter or on their Facebook page.
6.3 INSTRUMENT DEVELOPMENT AND DATA COLLECTION

The following sections describe the development of the instrument for each Delphi round and the corresponding data collection method. As explained in Section 6.1.4, the study used a Kantian approach with a ‘hybrid’ epistemological framework over three rounds of web-based questionnaires (Critcher & Gladstone 1998; Mitroff & Turoff 2002). Round One employed a qualitative design, consisting of demographic and open-ended questions. The answers to the open-ended questions were transformed into statements. The two subsequent rounds used a quantitative design to establish consensual opinions. Feedback was required after each round. Statements that had not achieved the pre-set consensus levels of 75 percent (and an IQR ≤ 1) were sent back to the panel for reconsideration. This process is depicted in Figure 6.1 and is detailed in the following sections.

Figure 6.1 The Delphi process

6.3.1 Round One

The instrument for Round One comprised of two parts. The first part collected socio-demographic data on contact details (name, work title, email
address and phone number), gender, age, country of origin, geographical work location, work title, current occupation, main activity in current job, years of experience in this role and their interest in the study. Obtaining this data allowed for clustering of the responses of the different expert groups and allowed for matching respondents data across rounds, and for sending follow-up rounds to panellists, including statistical feedback (Mead & Moseley 2001a). The items were developed by the researcher, informed by a literature review on demographic questionnaires in similar studies, and limited to ones directly relevant to the purpose of the study (Kotowski 2015; Lane et al. 2017; McKenna et al. 2015).

The second part of the instrument consisted of seven open-ended questions, typical for the first round of a Delphi process (Hsu & Sandford 2007). These open-ended questions were designed to directly address the second and third research questions of the study. Panellists’ responses depend on the exact wording of the questions, which is vulnerable to researcher bias and to errors in comprehension (Mead & Moseley 2001b). A strong instrument design is therefore essential to the success of the study and vital for replicability (Mead & Moseley 2001b). To minimise researcher bias and comprehension errors, a pre-test was undertaken to test the Round One instrument, the choice of the web-based survey tool Qualtrics (2015) and associated analysis (Clibbens, Walters & Baird 2012). It has been argued that the complexity of managing pre-tests and a full study simultaneously can result in considerable intervals between rounds and, therefore, participant attrition (Clibbens, Walters & Baird 2012). For this reason, most researchers only pre-test their first round (Clibbens, Walters & Baird 2012). This procedure was adopted in this study. The instruments of Round Two and Three were only checked for wording, flow, grammatical errors and technical problems by a few known contacts of the researcher.

For the pre-test of the instrument, an invitation letter was sent to a convenience sample of 25 experts. All experts were connected to Deakin University, Melbourne, and had a similar professional or interest background as the intended panel members. The pre-test asked participants to provide
feedback, via a short questionnaire, on the language and phrasing of the PLSC, the demographic and open-ended questions, and on potential ambiguities in the questions. Further, feedback was sought on the instructions provided; for example, if they were easy to follow, and if participants encountered any technical problems (Clibbens, Walters & Baird 2012). Feedback was specifically requested regarding the wording of the seven open-ended questions, as correct wording was crucial to the outcome of the study. Seven people participated. Five were ‘experts by profession’, and two panellists were classified as ‘experts by experience’.

The feedback resulted in the correction of typographical errors and a rephrasing of some of the Round One questions to clarify intended meaning. Additionally, the question: ‘What do you think needs to be done to improve this role of general practitioners/the primary health care nurse?’ (in the provision of early MA in regional/rural Victoria) was changed into: ‘How do you think the role of general practitioners/primary health care nurses in the provision of MA could be improved?’ Further, feedback from an ‘expert by experience’ resulted in the inclusion of an explanation of the term ‘MA’ in the instrument.

The final Round One instrument included the following open-ended questions:

1. What do you think is the current role of general practitioners and primary health care nurses in the provision of early medication abortion in regional/rural Victoria?
2. How do you think the role of general practitioners in the provision of medication abortion could be improved?
3. How do you think the role of primary health care nurses in the provision of medication abortion could be improved?
4. What factors facilitate or hinder regional and rural primary health care nurses when they are or want to be involved in the delivery of medication abortion services in regional/rural Victoria?
5. What do you believe are solutions or recommendations to improve primary health nurse participation in the provision of medication abortion in regional/rural Victoria?

6. What obstacles can potentially prevent these improvements?

7. How do you think the obstacles of question six can be addressed?

The full instrument is provided in Appendix F.

Data were collected online using Qualtrics (2015). A link to the Round One instrument was included in the invitation letter or flyer. This link directed potential panellists to the PLSC, which provided information about the study’s background, the Delphi procedure, confidentiality and privacy guidelines, the contact details of the researcher and a consent statement (Boulkedid et al. 2011). Clicking on the consent statement opened the instrument (see Appendix G for the PLSC of the Delphi study).

In the following three months, a total of 52 experts opened the link. Three did not read the PLSC and 12 decided, after reading the PLSC, not to continue. Nine experts expressed their wish to continue but never opened the questionnaire, and five only finished the demographic questions. The most common reason provided for not continuing with the Round One questionnaire related to not knowing enough of the subject. A first reminder was sent six weeks after the start of the study, and a final reminder was sent four weeks later. This resulted in a total panel size of 23.

6.3.2 Round Two

The data collected in Round One resulted in the development of 82 statements that were grouped into three broad themes. The analysis process that led to the development of these statements is discussed in Section 6.4.1. In Round Two, panellists were asked to rate the statements for agreement on a five-point scale. After each set of statements that focused on a particular aspect, panellists were also given the opportunity to elaborate on their ratings by providing additional and/or supportive remarks in a comment box. The use of
open-ended questions added breadth and further insight to the information gained from the rating scales (Clibbens, Walters & Baird 2012; Hasson, Keeney & McKenna 2000).

Rating scales often use a Likert-type scale, a technique developed in 1931 to measure attitudes, character and personality traits (Croasmun & Ostrom 2011; Likert 1932). They provide a range of response options for a certain statement or a group of statements, ranging from strongly agree to strongly disagree (Croasmun & Ostrom 2011). Likert scales are easy to implement and they primarily measure agreement and consensus (Keeney, Hasson & McKenna 2011). This approach was, therefore, the most appropriate to use in the current Delphi study. Much research has been conducted on the optimal number of response choices in a Likert-type scale, but the debate is still ongoing. Some researchers suggest that an optimal reliability is provided by a 7-point scale, while others claim that the number of used scale points does not affect the reliability and validity of an instrument (Croasmun & Ostrom 2011). Usually, however, there are five categories of responses, which range from strongly agree to strongly disagree with a neutral type of response in the middle (Jamieson 2004). The addition of a neutral response option, included in nearly all odd-numbered Likert scales, does not force the panellist to commit to a certain position and therefore reduces response bias (Croasmun & Ostrom 2011). This approach was adopted for the current study.

The generated statements for the Round Two questionnaire were subsequently tested by a panel of five ‘experts by experience’, all known contacts of the researcher. They were asked to provide their feedback via a questionnaire on Qualtrics. The pre-test questions asked about the instructions, the order of the questionnaire, the order and content of the statements, the language used, spelling or typographical errors, any emotions that the questions evoked and if the Qualtrics process worked without technical problems. Minor typographical corrections and edits were made based on the feedback.

Round Two commenced four months after the start of the Delphi study. All Round One panel members, including four additional Victorian ‘experts by
profession’ who were identified during the continuing search of the literature, were contacted via email. They were asked to participate in the Round Two questionnaire that was accessible via the provided link. Two reminders were sent over a period of six weeks. This follow-up strategy is consistent with Dillman, Smyth and Christian’s Total Design Method (2014) and is particularly important in the last two Delphi rounds, which are known for their high dropout rates (Keeney, Hasson & McKenna 2011; Sandrey & Bulger 2008). Efforts were made to keep the panel members motivated to participate. Strategies included a clear and repeated communication of the goal and benefits of the study, the inclusion of contact details for questions, clear information about the required time for each questionnaire, as well as the assurance of confidentiality and anonymity (Keeney, Hasson & McKenna 2011). The questionnaire closed approximately two months after opening. Of the 27 experts invited to participate in Round Two (23 panellists from Round One and four new potential panellists), 20 experts completed Round Two: Four former respondents did not participate and one of the four newly contacted experts joined.

### 6.3.3 Round Three

The analysis of the Round Two data, which is described in Section 6.4, showed that 57 of the 82 statements had reached the pre-determined consensus level of 75 percent. These statements were not included in Round Three. The remaining 25 statements that had not obtained consensus and two newly constructed statements, developed based on the data from the open-ended questions of Round Two (see section 6.4.2), were included in the Round Three questionnaire. Before release, the five known contacts of the researcher (‘experts by experience’) were again asked to pre-test the statements and the flow of the Round Three questionnaire. Again, only minor typographical corrections and edits were necessary.

All 23 panel members who had participated in Round One, as well as the additional panellist that was recruited in Round Two, were contacted by email one month after Round Two was completed. The email explained how consensus
on Round Two statements was defined, and that 57 out of the 82 Round Two statements (70%) had reached consensus. Panellists were asked to rate the 27 remaining statements for agreement on a 5-point Likert scale, and to include responses to open-ended questions with additional information about their statement ratings. Moreover, to improve consensus convergence, panellists were asked to first review the provided results of Round Two that were included in the email invitation for Round Three, to reflect on how their individual Round Two responses related to the rest of the panel, and if this encouraged them to reconsider and change their initial answer. A table showing Round Two agreement and disagreement percentages, the spread of the responses (interquartile range), the overall group median rating and individual Round Two ratings is included in Appendix H (Greatorex & Dexter 2000). A second table included in the invitation displayed all statements that were revised for the Third Round.

Two reminders were sent over a six-week period. The Delphi study closed eight weeks after opening and seven months after the start of the study. Nineteen experts participated in Round Three.

6.4 DATA MANAGEMENT AND ANALYSIS

This section describes the data management and analysis process of the three Delphi rounds. As the study used a mixed-method approach, qualitative and quantitative data analysis was undertaken. This process is described for each Delphi round separately in the following sections.

6.4.1 Round One

Demographic data of Round One were exported from Qualtrics (2015) to SPSS (IBM Corp. 2013). All dichotomous and multiple-answer questions were transformed from text into numeric variables. For example, the values for gender were labelled as female = 1 and male = 2, and the values for the age groups were classified from one to six, with 1 = 18-24-year-old and 6 = 65 years and older. All other qualitative questions were left as provided. Descriptive
statistics were used to analysis data regarding panellists’ characteristics, which included the classification of panellists into expert groups. While panel members were originally categorised as ‘experts by profession’ and ‘experts by experience’, this classification was redefined into the following three groups to better contextualise the study findings:

1. Physicians: GPs, gynaecologists/obstetricians or other
2. Nurses: PHCNs and nurses/midwives working in general practice, community health- or sexual/reproductive health primary care setting, academia or for a professional organisation
3. Others: academics, politicians and health promotion officers without a medical background.

No women with abortion experience or who were advocates of induced abortions agreed to participate in the study. The main characteristics of the panellists are displayed in Chapter Seven, Table 7.1.

The qualitative data obtained from the responses to the seven open-ended questions were first exported into Microsoft Word files, where they were sorted by question and then transferred into the computer software package NVIVO 11 (QSR International Pty Ltd. 2015), a data analysis software tool that helps to improve the rigor of a study (Leech & Onwuegbuzie 2011). The data generated from the question ‘what factors facilitate or hinder regional and rural PHC nurses when they are or want to be involved in the delivery of MA?’ were, for convenience of analysis, divided into facilitating factors and hindering factors. Thematic analysis (see section 4.5) was used to enable the reduction of this vast amount of data into overarching themes. Initial coding was performed across all seven questions and not within each question, which allowed for the identification of similarities in the overall data. This process was done deductively, meaning that the coding and the development of the themes was guided by pre-existing frameworks (Braun & Clarke 2006). While it has been argued that this particular analysis produces less rich data descriptions, literature engagement often provides more detailed data analysis, and allows coding for specific research questions (Braun & Clarke 2006). The evidence-
Based pre-existing frameworks that were used to guide the analysis process were: WHO’s (2015b) guideline ‘health worker roles in providing safe abortion care and post abortion contraception’; Costescu et al.’s (2016) clinical practice guideline for the provision of first-trimester MA in Canada; and the RCN (2017) guideline, covering England, Scotland and Wales, regarding the role of the nurse in termination of pregnancy services. From these guidelines, a range of predetermined codes were developed, which corresponded with all the different steps and processes involved in MA provision. Findings of the cross-sectional study relating to the perceived challenges of MA provision were also used as a guidance tool for the content analysis process, as they disclosed recurrent barrier themes in the data. All transcripts were anonymised and assigned with a unique identification code, which indicated profession (GP or PHCN) and participant number. Transcripts that provide further explanation or deepen the understanding of the presented data are used in Section 7.2 to strengthen the study’s findings. These responses are presented anonymously with a unique identification code in brackets, which indicates expert group and participant number. The deductive thematic analysis comprised six phases, which are displayed in Table 6.2, reproduced from Braun and Clarke (2006, p. 87).
Table 6.2 Phases of thematic analysis

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Familiarising with data</td>
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<tr>
<td>2</td>
<td>Generating initial codes</td>
</tr>
<tr>
<td>3</td>
<td>Searching for themes</td>
</tr>
<tr>
<td>4</td>
<td>Reviewing themes</td>
</tr>
<tr>
<td>5</td>
<td>Defining and naming themes</td>
</tr>
<tr>
<td>6</td>
<td>Producing the report</td>
</tr>
</tbody>
</table>

Source: (Braun & Clarke 2006, p. 87).

In the first stage of the analysis, the textual data were read multiple times to enable data familiarisation and immersion, and to develop an understanding of what overall information was provided. Next, all data were coded systematically using NVIVO 11 (QSR International Pty Ltd. 2015), which involved assigning fragments of text to specific codes. This process was intensified and broadened with the help of NVIVO’s auto-code and query functions, which identified recurring terms in sentences. The researcher, however, remained in charge of the overall analysis as to not overlook additional underlying relationships (Leech & Onwuegbuzie 2011). Additionally, some codes emerged inductively, which means that the coding and the development of the themes were guided by the content of the data and not driven by existing ideas (Braun & Clarke 2006).

Following this phase, all codes were searched for similarities and organised into categories. It was checked that the phrasing of the categories still matched the phrasing of the original expert responses. Responses that were too broad or vague, on the other hand, were left out to not introduce bias by attempting to interpret the meaning. The resulting categories were then
converted in a total of 118 statements. Nineteen of the statements concerned
the belief that a nurse-led model of MA provision in regional and rural Victoria
would improve access for women. All data showed that panellists already fully
agreed with this belief, using arguments that included decreased costs, less
stigma and privacy issues, reduced waiting times and easy communication.
Those 19 statements were therefore not included in Round Two. The 99
remaining statements were reviewed and grouped into three themes. The
themes were:

1. Views on a nurse-led model of care for MA provision in regional and rural
   Victoria.
2. Perceptions of current barriers to the implementation of a nurse-led model
   of care for MA provision in regional and rural Victoria.
3. Overcoming perceived current barriers to the implementation of a nurse-led
   model of care for MA provision in regional and rural Victoria.

In the last phase of the thematic analysis, all statements were once again
reviewed, defined and further searched for overarching topics that could be
grouped together, resulting in a final total of 82 statements (Braun & Clarke
2006). Seventeen statements were assigned to the first theme: ‘Views on a
nurse-led model of care for MA provision in regional and rural Victoria’; 25
statements were assigned to the second theme: ‘Perceptions of current barriers
to the implementation of a nurse-led model of care for MA provision in regional
and rural Victoria’; and 40 statements were assigned to the third theme:
‘Overcoming perceived current barriers to the implementation of a nurse-led
model of care for MA provision in regional and rural Victoria’.

All statements were pre-tested before the development of the Round
Two questionnaire by a panel of known contacts of the researcher and her
supervisors, to check for typographical errors, flow and understanding.
6.4.2 Round Two

All data obtained from the questionnaire were exported from Qualtrics into SPSS23 (IBM Corp. 2013). Response options were assigned with a value that ranged from one (strongly agree) to five (strongly disagree). Descriptive analysis was undertaken to describe the frequency and associated percentage of each statement as well as to determine the median and the inter-quartile range (IQR). The IQR, which is the difference between the 75th and 25th percentiles, showed the spread of scores in the distribution (von der Gracht 2012). The median was favoured as the measure of central tendency because Likert scale data should be considered ordinal, as it cannot be assumed that the difference between the different values have equal intervals (Keeney, Hasson & McKenna 2011; von der Gracht 2012). Consensus was reached for a statement if at least 75 percent of the experts agreed on the 5-point Likert scale in the top two (strongly agree/somewhat agree) or bottom two (somewhat disagree/strongly disagree) categories, and if the spread of the scores in the distribution (IQR) was equal or less than one, which is considered to be an appropriate consensus indicator (von der Gracht 2012). For statements that were negatively worded (such as: ‘completion of an abortion cannot be totally assessed by a PHC nurse’), consensus was reached if at least 75 percent of the experts disagreed with the statement and if the spread of the scores in the distribution (IQR) was equal or less than one. Fifty-seven out of the 82 generated statements (70%) reached the pre-defined consensus level and were, therefore, not included in Round Three.

The data collected from the open-ended questions were exported from Qualtrics into Excel (2013) for sorting, imported into NVIVO 11 (QSR International Pty Ltd. 2015) and analysed using deductive thematic analysis as per Round One (see section 6.4.1). This process enabled the merging of data with similar content into categories. The analysis of data regarding the phrasing of the statements resulted in a rewording of seven of the 25 statements that had not achieved consensus in Round Two, and the development of two new statements (see Table 6.3).
Table 6.3 Seven revised statements and two new statements for Round Three

<table>
<thead>
<tr>
<th>Original statements</th>
<th>Revised and new statements</th>
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<tbody>
<tr>
<td>The PHC nurse can manage post-abortion contraception, including the insertion of</td>
<td>The <strong>appropriately trained</strong> PHC nurse can manage post-abortion contraception, including</td>
</tr>
<tr>
<td>implants, PHC or the provision of injectable contraception</td>
<td>the insertion of implants, PHC or the provision of injectable contraception</td>
</tr>
<tr>
<td>All steps in the MA process that are handled by a PHC nurse should only be allowed</td>
<td>All steps in the MA process that are handled by an <strong>appropriately trained</strong> PHC nurse</td>
</tr>
<tr>
<td>under the supervision of a GP</td>
<td>should only be allowed under the supervision of a GP</td>
</tr>
<tr>
<td>Allow all registered nurses to be responsible for the whole MA process without a GP</td>
<td>Allow all <strong>appropriately trained</strong> registered nurses to be responsible for the whole MA</td>
</tr>
<tr>
<td>should only be required for the prescription of the abortion medication</td>
<td>process without a GP’s approval. The GP should only be required for the prescription of</td>
</tr>
<tr>
<td>GPs fear ramifications on both time and negative outcomes (complications) when</td>
<td>the abortion medication</td>
</tr>
<tr>
<td>providing MA services</td>
<td>GPs fear ramifications on negative outcomes (complications) when providing MA services</td>
</tr>
<tr>
<td>The government is nervous about discussing and/or promoting MA. They fear</td>
<td>The <strong>Victorian</strong> government is nervous about discussing and/or promoting MA. They fear</td>
</tr>
<tr>
<td>community backlash or anti-choice campaigns in parliament and their own party</td>
<td>community backlash or anti-choice campaigns in parliament and their own party</td>
</tr>
<tr>
<td>PHC nurses prefer locally organised MA group training sessions over online training</td>
<td>PHCNs require flexibility and choice regarding online training and locally organised MA</td>
</tr>
<tr>
<td>GP clinics should offer ultrasound and blood test services so women do not need to</td>
<td>group training sessions to maximise training opportunities</td>
</tr>
<tr>
<td>go somewhere else</td>
<td>GP clinics <strong>located in areas with limited local health services</strong> should offer ultrasound</td>
</tr>
<tr>
<td></td>
<td><strong>(after appropriate training)</strong> and blood tests so women do not need to go somewhere else</td>
</tr>
</tbody>
</table>

Through the analysis process, three sub-themes were identified from the data belonging to the second theme ‘perceptions of current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria’. These sub-themes were: logistical barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria; confidentiality, privacy, stigma and safety issues; and MA funding and public
perceptions. Overall, in the instrument of Round Three, the 27 remaining statements were subdivided into the themes as follows:

1. Views on a nurse-led model of care for MA abortion provision in regional and rural Victoria (five statements).

2. Perceptions of current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria
   a. Logistic barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria (three statements)
   b. Confidentiality, privacy, stigma and safety issues (10 statements)
   c. MA funding and public perceptions (three statements).

3. Overcoming perceived current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria (six statements).

6.4.3 Round Three

Similar to the analysis of Round Two, data were exported into a SPSS23 database (IBM Corp. 2013) and response options were assigned with values ranging from one (strongly agree) to five (strongly disagree). Descriptive analysis provided the frequency and associated percentage of each statement, as well as the median and the IQR. In this last round, 12 of the remaining 27 statements additionally reached the pre-set level of consensus of at least 75 percent agreement in the top two (strongly agree/somewhat agree) or bottom two (somewhat disagree/strongly disagree) Likert categories and had an IQR of one or less.

All findings of Round Two and Three, including the 15 statements that did not reach the set level of agreement, are discussed in Section 7.5, and presented into two newly defined themes. In the first newly defined theme, the previously used term ‘views’ on a nurse-led model was changed into ‘views on the construction’ of a nurse-led model, as findings converged towards the construction of a nurse-led MA provision model. The second newly defined theme comprised the perceived current barriers to the implementation of a MA nurse-led model of care, as well as the solutions to overcome those barriers. Just
as in the first round, anonymous transcripts of Round Two and Three are used to strengthen the study’s findings. They are assigned with a unique identification code in brackets, indicating expert group and participant number.

The Kruskal-Wallis H-test (KW test), a rank-based non-parametric test, was conducted on all statement data assembled over Round Two and Three, using SPSS23 (IBM Corp. 2013) (Argyrous 2011). This test was performed to identify potential differences between the responses provided by the three panellist groups, consisting of physicians, nurses, and others. Test results with a statistically significant difference, a p-value < 0.05, suggested a difference between at least one pair of the three panellist groups. To further analyse potential differences, a post-hoc test using Dunn’s test with Bonferroni correction was applied, which allowed for in-between group comparisons (Argyrous 2011).

The next chapter presents the findings of the Delphi study, and includes the different components involved in a nurse-led MA provision model.
CHAPTER 7
DELPHI STUDY FINDINGS

This chapter presents the findings of the Delphi study. The first section summarises the socio-demographic characteristics of the panellists. Next, the generation of the 82 statements in Round One is presented. The third and fourth section describe all statements from Round Two and Three that reached the predetermined level of consensus. In the final section, a nurse-led model of care for MA abortion provision in regional and rural Victoria is presented, based on all findings, including the barriers and solutions to the implementation of the model (see Figure 7.1). Verbatim quotes from Round Two and Three are included for illustrative purposes, and differences in data between the three panellists’ groups (physicians, nurses and others) are shown.

Figure 7.1 Overview of the findings of the three-round Delphi study
7.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE DELPHI PANELLISTS

A total of 24 panellists participated in the Delphi study, of which 17 responded to all three rounds. Two panellists were only involved in Round One and Two, one panellist responded to Round One and Three, and one panellist entered in Round Two and also participated in Round Three (see Figure 7.2). The response rates of Round Two and Three were 87 percent and 78 percent, respectively.

![Figure 7.2 Participant attrition over three Delphi rounds](image)

At Round One, 82.6 percent (n=19) of the panellists were females. Thirty percent (n=7) of the panellists were physicians, 43.5 percent (n=10) were nurses, either working as a PHCN, in academia or for a professional body, and 26.1 percent (n=6) were classified as ‘other’, which included academics, Victorian
politicians and health promotion officers without a medical background. Among all profession groups, 73.9 percent indicated a regional or rural location as their workplace setting. For GPs and PHCNs, a regional or rural location was required for participation in the study.

Most panellists (78.2%; n=18) were aged 45 years and over, and more than half (56%; n=10) were aged over 55 years. Forty three percent (43.4%; n=10) of the panellists had more than 10 years’ work experience. Most (87.0%; n=3) were qualified in Australia (see Table 7.1).

Table 7.1 Characteristics of the Round One panellists (n=23)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>17.4</td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>82.6</td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td>25-34</td>
<td>3</td>
<td>13.0</td>
</tr>
<tr>
<td>35-44</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td>45-54</td>
<td>8</td>
<td>34.8</td>
</tr>
<tr>
<td>55-64</td>
<td>9</td>
<td>39.1</td>
</tr>
<tr>
<td>≥65</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>7</td>
<td>30.4</td>
</tr>
<tr>
<td>Nurse</td>
<td>10</td>
<td>43.5</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>26.1</td>
</tr>
<tr>
<td>Years of experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤5</td>
<td>9</td>
<td>39.1</td>
</tr>
<tr>
<td>5-10</td>
<td>4</td>
<td>17.4</td>
</tr>
<tr>
<td>11-15</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td>16-20</td>
<td>3</td>
<td>13.0</td>
</tr>
<tr>
<td>≥21</td>
<td>6</td>
<td>26.1</td>
</tr>
<tr>
<td>Geographical work location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>6</td>
<td>26.1</td>
</tr>
<tr>
<td>Regional</td>
<td>12</td>
<td>52.2</td>
</tr>
<tr>
<td>Rural</td>
<td>5</td>
<td>21.7</td>
</tr>
<tr>
<td>Country of qualification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>20</td>
<td>87.0</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>13.0</td>
</tr>
</tbody>
</table>
7.2 ROUND ONE: THE DEVELOPMENT OF STATEMENTS

The analysis of the seven open-ended questions of Round One resulted in the formation of three themes and informed the development of 82 statements for Round Two. The statements were grouped under one of the three themes: 1) views on a nurse-led model of care for MA provision in regional and rural Victoria; 2) perceptions of current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria; and 3) overcoming perceived current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria. The following sections discuss the statements belonging to each of the three themes. Verbatim quotes from panellists are added to support the findings.

7.2.1 Views on a nurse-led model of care for MA provision in regional and rural Victoria

This theme describes the panellists’ opinions regarding current MA provision in regional and rural Victoria and the potential roles of PHCNs in the provision of MA.

Most first round panellists reported the current role of GPs in the provision of MA in their regional and/or rural areas to be very limited, as illustrated in the following quotes:

*Almost all GPs would not provide medical abortions in my region, and the ones who do - you would not know as they don’t openly promote that they provide it. So its luck of the draw with which GP you get and if they provide it* (Other2).

*Often women are forced to source where and who they can see to discuss the options for an unplanned pregnancy as few doctors provided MTOP’s [medical termination of pregnancy] and often they only provide this service to their own clients* (Nurse4).
In my area it is just difficult, if not impossible, to find a GP who will facilitate this service. Because it isn't readily available women are having to have later surgical terminations (Nurse1).

It was acknowledged that women with an unwanted pregnancy should be referred to an appropriately trained PHCN:

All women with this presentation [unplanned pregnancy] should be referred to a well-trained PHCN during the consultation for supplementary care and management. PHCNs are also very well connected and aware of the resources/clinics/supports available locally to refer the woman to (Nurse6).

If services do not offer MTOP their [PHCNs] role should be one of advocacy and referral, linking women up with all options pregnancy counselling or other practitioners who provide MTOP (Other6).

If they [PHCNS] could take this on, instead of waiting for a doctor - that would reduce the waiting time for women and make it easier - then this should be considered and delivered (Other2).

Generally, PHCNs were regarded as highly capable of delivering MA services, with roles including non-directive pregnancy support counselling, information provision, organising pregnancy dating ultrasounds and blood tests, and eligibility checks. These views are illustrated in the following quotes:

PHCNs have excellent skills generally in having challenging conversations about difficult topics, have more time to discuss the wellbeing of the patient and provide a more empathetic ear to listen to a woman’s concern. We also know patients are more likely to disclose sensitive issues to a nurse than a doctor (Nurse6).

Nurses could provide the initial appointment - organise dating scan, bloods etc., do a preliminary check for eligibility criteria’s, explain the process, cost etc. (Nurse4).

Allow Ultrasound and bloods to be ordered by nurses (Physician7).
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The non-directive pregnancy support counselling item number for women who are concerned about a pregnancy could be extended to nurses who have undergone training in non-directive pregnancy counselling (Nurse5).

Additionally, panellists recognised that the PHCNs’ role can include the management of post-abortion contraception and the provision of emotional support if required:

Practice nurses could provide morning after contraception, pregnancy testing and chlamydia checks. Routine procedures for nurses in other countries... ...Nurses also need to be able to explain to women what contraception options are available rather than just the pill (Nurse5).

Nurses can provide assistance with understanding how medication termination works, what is likely to happen and provide emotional support following the procedure (Nurse1).

Some panellists mentioned a lack of funding for nurse-led MA provision:

I think that there is no funding for the nurses to provide these services. At GPs clinics the nurses would need the GPs involvement to enable payment to be provided for this service (Nurse4).

Funding [required] - either direct funding for nurses to provide the service or for the primary health clinics to enable the employment of nurses (Other4).

Hinder: funding, no Medicare item number for nurse’s time (Physician7).

Overall, the panellists expressed different opinions for the independent provision of MA by PHCN:

I think that they [PHCNs] should be able to manage the client without need for GP intervention unless there is a complication (Other5).

Increase training for nurse-led models of care in collaboration with clinic medical staff. Increase multidisciplinary models of primary care provision (Other1).
Up skill primary health care nurses to assist in the provision of medication abortion (Other3).

They [PHCNs] could be trained to explain and support women and doctors through this process and to educate e.g. through media, schools (Physician4).

Based on the findings of the qualitative data of Round One, 17 statements were developed for Round Two to reach consensus regarding panellists’ views on a nurse-led model of care for MA provision in regional and rural Victoria (see Table 7.2).
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Table 7.2 Statements derived from panellists’ views on a nurse-led model of care for MA provision in regional and rural Victoria

<table>
<thead>
<tr>
<th>Statements: Views on a nurse-led model of care for MA provision in regional and rural Victoria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All women with an unwanted pregnancy should be referred to an appropriately trained PHCN</td>
</tr>
<tr>
<td>2. The PHCN role should include non-directive pregnancy counselling</td>
</tr>
<tr>
<td>3. The PHCN role should include contraception</td>
</tr>
<tr>
<td>4. A PHCN should be able to communicate the pros and cons of the medication abortion</td>
</tr>
<tr>
<td>5. A sufficiently trained PHCN is not able to independently rule out any contraindications to the use of abortion medication</td>
</tr>
<tr>
<td>6. It is within the scope of practice of a registered PHCN to independently refer a woman for an ultrasound (for pregnancy dating and ectopic pregnancy screening) and blood tests</td>
</tr>
<tr>
<td>7. PHCNs are able to interpret the results of an ultrasound and blood test in such a way that they can assess if MA provision is advisable</td>
</tr>
<tr>
<td>8. The administration of mifepristone can be independently handled by a PHCN</td>
</tr>
<tr>
<td>9. PHCNs can independently manage prophylactic pain medication</td>
</tr>
<tr>
<td>10. Non-life-threatening complications of MA, like haemorrhages or infections, should be managed by doctors only</td>
</tr>
<tr>
<td>11. Completion of an abortion cannot be totally assessed by a PHCN</td>
</tr>
<tr>
<td>12. The PHCN role can include the provision of emotional support following the procedure if required</td>
</tr>
<tr>
<td>13. The PHCN can manage post-abortion contraception, including the insertion of implants, IUDs or the provision of injectable contraception</td>
</tr>
<tr>
<td>14. All steps in the MA process that are handled by a PHCN should only be allowed under the supervision of a GP</td>
</tr>
<tr>
<td>15. MA in the primary health care sector can be provided by a PHCN in cooperation with a GP</td>
</tr>
<tr>
<td>16. Allow all registered nurses to be responsible for the whole MA process without a GP’s approval. The GP should only be required for the prescription of the abortion medication</td>
</tr>
<tr>
<td>17. General practice funding for nurse-led MA provision is currently included in the quarterly Practice Nurse Incentive Program payment, which includes a rural loading of up to 50% and is independent of Medicare item numbers. There is sufficient allowance in the Practice Nurse Incentive Program payment to cover nurse-led MA provision</td>
</tr>
</tbody>
</table>

7.2.2 Perceptions of current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria

The second theme, ‘perceptions of current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria’, describes the multitude of barriers, as perceived by the panellists that can hinder the development of a nurse-led MA provision model. One often
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mentioned barrier related to the stigma associated with abortions, and the fear of moral judgement and harassment when providing abortions in regional and rural communities. These concerns are illustrated in the following quotes:

*Fear of moral judgment by other health professionals who do not agree with termination of pregnancy - strong factor in smaller regions/towns* (Physician5).

*Concerns about privacy, especially in small communities; stigma associated with providing this service; negative publicity from members of conservative communities* (Other1).

*There is probably a greater stigma in rural areas to accessing medication abortions and there is more chance that the woman will know the health care provider* (Nurse4).

*The government may be nervous about discussing and/or promoting medication abortion. They will fear a community backlash or a campaign by anti-choice politicians in the parliament and possibly within their own parties* (Nurse5).

Additionally, panellists recognised the importance of the availability of GPs providing MA services, and of the GP’s support for PHCNs being involved with MA provision.

*Nothing happens without the GP being on board ... Therefore, the more GP’s are providing or even supportive of MTOP’s the better chance a nurse has to help with the process* (Nurse4).

*If the GP's themselves will not take on this role there is little likelihood they will support the nurse* (Nurse5).

*Concern by doctors that nurses unable to provide adequate service* (Physician7).

Further, it was emphasised that communities are not well informed about MA as an option for pregnancy terminations, as reflected in the following quotes:
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There is a distinct lack of information in the general community about medication termination (Nurse1).

More education on the need for women to have a choice - it should be a right not a privilege (Nurse4).

Panellists also acknowledged that change to current MA funding arrangements was required:

No Medicare item number for nurse’s time (Physician7).

MBS item numbers govern the scope of practice nurses more than anything else (Nurse5).

Other identified barriers to MA provision in regional and rural Victoria were the lack of MA training opportunities for PHCNs and the lack of locally accessible health care services. Some panellists raised concern about a lack of support from other health professionals and professional bodies, influenced by religious, ethical and personal principles. This concern was expressed by one participant as follows:

Conscientious objection to abortion by individual GPs, Board members or other allied health professionals working in rural and regional health care settings can greatly hinder provision of the service in the first place (Other3).

A total of 25 statements were developed for Round Two relating to the second theme: The perceptions of current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria (Table 7.3).
Table 7.3 Statements derived from panellists’ perceptions of current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria

<table>
<thead>
<tr>
<th>Statements: Perceptions of current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria</th>
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<tbody>
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<td>1</td>
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</tbody>
</table>
7.2.3 Overcoming perceived current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria

A range of ideas and solutions were provided by the panellists to help overcome perceived barriers for the implementation of a nurse-led MA model in regional and rural Victoria. Most solutions related to increased education and training options. The training of more GPs was recognised as an important first step:

*Education for GP's and clinic staff - you can get all the nurses on board but with [without] doctor's to support it they are powerless to assist* (Nurse4).

*Provide education and peer support to improve the numbers [of GPs] who consider abortion within the normal scope of general practice* (Other1).

*More [GPS] could be trained, supported, and protected (privacy wise, legally, from protesters and opponents, violence, etc). We could make medical termination a widely known and easily available option* (Physician4).

Training of PHCNs was also deemed very important, and financial support in the form of scholarships, funding and remuneration was highlighted:

*Incentives for rural and regional private and community health care providers to up skill primary health care nurses to assist in the provision of medication abortion. Affordable and accessible professional development and training offered on line and/or in regional centres rather than Melbourne* (Other3).

*Inclusion of an MTOP component in the nurses’ sexual and reproductive courses in Victoria* (Nurse9).

*I think that training and financial incentives could improve the provision of medication abortion* (Other4).

*Local Training for practice nurses so they feel confident to take on the work* (Nurse9).
Better education. Set guidelines. Easy access for patients both cost wise and logistically (Physician6).

If education is to be made available for them, there has to be financial support for the nurses to attend (e.g. scholarships) (Nurse6).

Education needs to be free, locally available and practices need to be remunerated for the time when nurses attend the education. We know from surveying our students that scholarship and distance education are the great enablers to education but we also know that many do not like distance education and want a more interactive format (Nurse5).

We know that a significant limitation for nurses expanding their scope is the cost of education - so if education is to be made available for them, there has to be financial support for the nurses to attend (e.g. scholarships) (Nurse6).

Another often provided solution to overcome perceived barriers for the implementation of a nurse-led MA model involved empowerment and support from health practitioners, the local community and government, as illustrated in the following quotes:

Empowerment - nurses are resourceful, connected, caring individuals who operate naturally within an interdisciplinary team. They are often unaware of their potential role and scope though and self-limit their professional development unnecessarily. Leadership, mentors and encouragement is needed. ‘Endorsement’ by their medical colleagues is vital too - this will empower nurses and avoid territory wars or people feeling threatened in their professional roles. (Nurse6).

Greater support from state health departments might be a possible solution (Nurse5).

Strong partnerships with doctors, non-hierarchical work places (Physician7).
Perhaps push from AMA or RACGP [The Royal Australian college of General Practitioners], govt [Government] to say this is a service that all women should be able to access (Physician6).

Adequate support from local community, government and GPs (Other6).

It was also suggested to improve mutual communication, MA funding models, stigma and legal regulations. Some of these suggestions are reflected in the following quotes:

Regular education/discussion sessions with health care providers - via PHN [Primary Health Network], local conferences, hospital grand rounds, articles in journals/medical magazines (Physician1).

Facilitate networking; Telephone access to specialist support (Physician5).

MBS item numbers govern the scope of practice nurses more than anything else- these can also be the facilitator. Create an item number for nurses to be involved and they will be (Nurse5).

Providing the services [by GPs and PHCNS] helps reduce stigma by making it part of a mainstream service (Physician7).

Need to promote that the service is offered in the settings (perhaps as "all option pregnancy counselling" or similar). More work on getting GPs and doctors on board and aware of medical abortion which will allow for more registration of nurses to provide medical abortion. More that is provided, more the stigma will go away and privacy/knowing the person will become less of an issue (Nurse2).

Support for nurses and GPs who wish to offer a service but are afraid of community backlash (Nurse5).

Allow nurse practitioner prescription of MS-2 Step (Physician7).

Make recommendations to parliament & working parties to change the laws allow a wider scope of practice (Nurse3).

Finally, it was acknowledged that evidence is required to demonstrate the effectiveness of nurse-led MA provision:
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**Nursing research to validate the role of nurses and demonstrate effectiveness** (Nurse6).

**Continue to challenge traditional nursing duty ‘norms’ and ensure stringent use of evidence, best practice and regulation as boundaries to practice scope are shifted** (Nurse7).

**Data collection systems so that the extent of the problem can be seen and improvements can be documented** (Other1).

A total of 40 developed statements were developed for Round Two to reach consensus on how to overcome perceived current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria (see Table 7.4).

### Table 7.4 Statements derived from panellists’ solutions on how to overcome current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria

<table>
<thead>
<tr>
<th>Statements: Overcoming perceived current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
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<tr>
<td>4</td>
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<tr>
<td>5</td>
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<td>6</td>
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<td>7</td>
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<tr>
<td>8</td>
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<tr>
<td>9</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>11</td>
</tr>
<tr>
<td>12</td>
</tr>
</tbody>
</table>
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**Statements: Overcoming perceived current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria**

13. Encourage nursing research to validate the role of PHCNs and demonstrate effectiveness of nurse-led MA provision

14. Continue to challenge traditional nursing duty ‘norms’ for MA, and ensure a stringent use of evidence and best practice, as scope of practice boundaries are shifted

15. Introduce data collection systems for monitoring and evaluation of nurse-led MA provision in regional and rural Victoria

16. Supportive information should be freely available to all MA providing nurses (e.g. resources on the MS Health website)

17. Create a Medicare Benefits Schedule (MBS) item number for PHCN consultations related to MA provision

18. Payment for nurse-led MA provision should be independent of any GP involvement

19. Guarantee access to quality specialist back-up when needed

20. Improve communication about MA between local hospitals, GPs and PHCNs

21. Develop best practice service models for MA which includes access to radiography and after care services

22. GP clinics should stock and supply abortion mediation so women do not need to go somewhere else

23. GP clinics should offer ultrasound and blood test services so women do not need to go somewhere else

24. When practice GPs refuse to provide MA, PHCNs should be able to initiate pre-testing before referral

25. GPs who provide MA should be made visible (e.g. advertise with “all-option pregnancy counselling offered at this general practice”)

26. Financially support women to facilitate MA access (e.g. for travel and childcare costs)

27. Change legislation to allow prescription of abortion medication by registered nurses in regional and rural Victoria

28. Make recommendations to parliament and working parties to change legislation to allow a wider scope of practice for PHCNs

29. Public awareness about the availability of MA can lead to increased public demand. This can act as a driver for improved service provision

30. Increase and improve the availability of medication abortion drugs in local pharmacies through MA education programs for pharmacists

31. Develop a dedicated team of MA-trained PHCNs to support the provision of MA services in smaller or more remote health care settings

32. Ensure that PHCNs who provide MA are covered by insurance

33. There should be support and endorsement of MA from local health professionals (including Boards of hospitals and community centres)

34. Emergency department staff should respond in a non-judgmental way in cases of abortion complications

35. There should be open endorsement of MA from peak bodies such as the Australian Medical Association, Royal Australian College of General Practitioners, nursing authorities and Government

36. There should be a statement of expectation from the Department of Health that medication abortion should be core business for primary health systems in regional and rural areas

37. There should be support and protection for PHCNs and GPs who wish to offer MA services but are afraid of community backlash, harassment or legal issues
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### Statements: Overcoming perceived current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria

<table>
<thead>
<tr>
<th>Statement</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>38 All GP practices should provide independent pregnancy counselling</td>
<td></td>
</tr>
<tr>
<td>39 Conscientious objection should be out in the open. The public needs to know if a doctor is a conscientious objector</td>
<td></td>
</tr>
<tr>
<td>40 Abortion should be seen as being part of comprehensive sexual and reproductive health care, consequently reducing abortion stigma</td>
<td></td>
</tr>
</tbody>
</table>

#### 7.3 ROUND TWO

The findings from Round Two are described in the following sections. The first section shows the consensus ratings on the statements relating to panellists’ views on a nurse-led model of care for MA provision in regional and rural Victoria. The second section regarding panellists’ perceptions of current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria, presents panellists’ levels of consensus across three sub-themes: logistical barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria; confidentiality, privacy, stigma and safety issues; and barriers concerning MA funding and public perceptions. Finally, consensus levels are described of panellists’ solutions on how to overcome current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria.

#### 7.3.1 Views on a nurse-led model of care for MA provision in regional and rural Victoria

Of the 17 statements regarding panellists’ views on a nurse-led model of care for MA provision in regional and rural Victoria, 11 (65%) statements obtained the pre-determined consensus level of at least 75 percent of (dis)agreement and an IQR equal or less than one. The statement that the PHCN role should include contraception achieved full consensus (100% agreement) (see Table 7.5). Nearly full consensus (95% agreement) was obtained for three statements: a PHCN should be able to communicate the pros and cons of the MA; PHCNs are able to interpret the results of an ultrasound and blood test in
such a way that they can assess if MA provision is advisable; and the administration of mifepristone can be independently handled by a PHCN.

Two of the six statements that did not obtain the 75 percent consensus level received low levels of agreement (Table 7.5). These statements were: non-life-threatening complications of MA, like haemorrhages or infections, should be managed by doctors only (45% disagreement, IQR = 2); and allow all registered nurses to be responsible for the whole MA process without a GP's approval, the GP should only be required for the prescription of the abortion medication (40% agreement, IQR = 2.75).

### Table 7.5 Consensus reached in Round Two for statements regarding panellists’ views on a nurse-led model of care for MA provision in regional and rural Victoria

<table>
<thead>
<tr>
<th>Statements</th>
<th>Median</th>
<th>IQR</th>
<th>Percent agree</th>
<th>Percent disagree</th>
<th>Consensus Round 2¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All women with an unwanted pregnancy should be referred to an appropriately trained PHCN</td>
<td>1</td>
<td>2</td>
<td>65</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2. The PHCN role should include non-directive pregnancy counselling</td>
<td>1</td>
<td>1</td>
<td>90</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>3. The PHCN role should include contraception</td>
<td>1</td>
<td>0</td>
<td>100</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>4. A PHCN should be able to communicate the pros and cons of the medication abortion</td>
<td>1</td>
<td>0</td>
<td>95</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>5. A sufficiently trained PHCN is not able to independently rule out any contraindications to the use of abortion medication</td>
<td>4</td>
<td>0</td>
<td>-</td>
<td>80</td>
<td>+</td>
</tr>
<tr>
<td>6. It is within the scope of practice of a registered PHCN to independently refer a woman for an ultrasound (for pregnancy dating and ectopic pregnancy screening) and blood tests</td>
<td>1</td>
<td>1</td>
<td>80</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>7. PHCNs are able to interpret the results of an ultrasound and blood test such a way that they can assess if MA provision is advisable</td>
<td>2</td>
<td>1</td>
<td>95</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>8. The administration of mifepristone can be independently handled by a PHCN</td>
<td>1</td>
<td>1</td>
<td>95</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>9. PHCNs can independently manage prophylactic pain medication</td>
<td>1</td>
<td>1</td>
<td>90</td>
<td>-</td>
<td>+</td>
</tr>
</tbody>
</table>
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| Statements                                                                 | Median IQR | Percent agree | Percent disagree | Consensus Round 2
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Non-life-threatening complications of MA, like haemorrhages or infections, should be managed by doctors only</td>
<td>3.5 2</td>
<td>-</td>
<td>45</td>
<td>-</td>
</tr>
<tr>
<td>11 Completion of an abortion cannot be totally assessed by a PHCN</td>
<td>4 1</td>
<td>-</td>
<td>85</td>
<td>+</td>
</tr>
<tr>
<td>12 The PHCN role can include the provision of emotional support following the procedure if required</td>
<td>1 0.75</td>
<td>90</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>13 The PHCN can manage post-abortion contraception, including the insertion of implants, PHC or the provision of injectable contraception</td>
<td>2 1.75</td>
<td>75</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>14 All steps in the MA process that are handled by a PHCN should only be allowed under the supervision of a GP</td>
<td>4 1</td>
<td>-</td>
<td>70</td>
<td>-</td>
</tr>
<tr>
<td>15 MA in the primary health care sector can be provided by a PHCN in cooperation with a GP</td>
<td>2 0.75</td>
<td>75</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>16 Allow all registered nurses to be responsible for the whole MA process without a GP’s approval. The GP should only be required for the prescription of the abortion medication</td>
<td>3 2.75</td>
<td>40</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>17 General practice funding for nurse-led MA provision is currently included in the quarterly practice nurse incentive program payment, which includes a rural loading of up to 50% and is independent of Medicare item numbers. There is sufficient allowance in the practice nurse incentive program payment to cover nurse-led MA provision</td>
<td>4 2</td>
<td>-</td>
<td>65</td>
<td>-</td>
</tr>
</tbody>
</table>

Notes: 1 Consensus for agreement was obtained (+) if valid percent agreement (or disagreement for negatively worded statements) was ≥ 75 percent and IQR ≤ 1. Consensus for agreement was not obtained (-) if valid percent agreement (or disagreement for negatively worded statements) was < 75 percent and IQR > 1.

7.3.2 Perceptions of current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria

This theme relates to panellists’ perceptions of current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria, and includes three sub-themes: 1) logistical barriers to the
implementation of a nurse-led model of care for MA provision in regional and rural Victoria; 2) confidentiality, privacy, stigma and safety issues; and 3) MA funding and public perceptions.

Of the 11 statements assigned to the first theme regarding logistical barriers, nine statements (82%) obtained the pre-determined level of consensus (see Table 7.6). No statement achieved full (100%) consensus; however, 95 percent consensus was achieved for three statements: there is insufficient availability of MA trained GP providers in regional and rural Victoria; traditionally, GPs prefer to be in charge over some services, which includes MA provision; and there is a lack of local allied professionals and accessible services for women (such as radiographers) in regional and rural Victoria. Two statements did not reach the pre-determined 75 percent consensus and IQR level: not all local pharmacies supply, or wish to supply, medication abortion drugs (75% agreement, IQR = 1.75); and there is a well-established positive collaboration between the Australian Medical Association and nursing authorities (40% disagreement, IQR = 1).

Of the 11 statements that were assigned to the second theme that focused on perceived confidentiality, privacy, stigma and safety issues in relation to MA provision, only two (18%) statements reached consensus (see Table 7.6). These statements were: women in regional and rural areas worry about confidentiality and privacy issues; and there is no support from local hospitals and community health services to GPs and PHCNs who provide MA services. Two statements, however, reached 75 percent consensus, but without the IQR ≤ 1 requirement. They were: the rural population does not complain about poor MA services in their area, because it is a private and contentious subject (75% agreement, IQR = 1.75); and GPs and PHCNs fear negative publicity from members of conservative communities and/or fear of personal vilification if they were to provide MA services (75% agreement, IQR = 1.75).

Of the three statements that were assigned to the third theme that focused on MA funding and public perceptions in relation to MA provision, only
one statement reached consensus (see Table 7.6). This statement was that GP involvement is required to enable payment for this service (80%).

Table 7.6 Consensus reached in Round Two for statements regarding panellists’ perceptions of current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria

<table>
<thead>
<tr>
<th>Statements</th>
<th>Median</th>
<th>IQR</th>
<th>Percent agree</th>
<th>Percent disagree</th>
<th>Consensus Round 2¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logistical barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>There is a lack of professional development and further training possibilities for PHCNs (including MA provision)</td>
<td>2</td>
<td>1</td>
<td>85</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>Not all local pharmacies supply, or wish to supply, medication abortion drugs</td>
<td>1</td>
<td>1.75</td>
<td>75</td>
<td>-</td>
</tr>
<tr>
<td>3</td>
<td>There is insufficient availability of MA trained GP providers in regional and rural Victoria</td>
<td>1</td>
<td>1</td>
<td>95</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>Without a GP’s approval for MA provision, nurse involvement is not supported</td>
<td>2</td>
<td>1</td>
<td>85</td>
<td>-</td>
</tr>
<tr>
<td>5</td>
<td>Traditionally, GPs prefer to be in charge over some services, which includes MA provision</td>
<td>2</td>
<td>1</td>
<td>95</td>
<td>-</td>
</tr>
<tr>
<td>6</td>
<td>There is a well-established positive collaboration between the Australian Medical Association and nursing authorities</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>40</td>
</tr>
<tr>
<td>7</td>
<td>There is a lack of local access to surgical back-up in regional and rural Victoria in the case of MA complications</td>
<td>2</td>
<td>0.75</td>
<td>80</td>
<td>-</td>
</tr>
<tr>
<td>8</td>
<td>There is a lack of local allied professionals and accessible services for women (such as radiographers) in regional and rural Victoria</td>
<td>2</td>
<td>0.75</td>
<td>95</td>
<td>-</td>
</tr>
<tr>
<td>9</td>
<td>There is a lack of after-hours care in small towns for women who go through MA</td>
<td>1</td>
<td>1</td>
<td>90</td>
<td>-</td>
</tr>
<tr>
<td>10</td>
<td>Many GPs are not aware that they can offer medication abortion</td>
<td>2</td>
<td>1</td>
<td>85</td>
<td>-</td>
</tr>
<tr>
<td>11</td>
<td>Most GPs are aware of the online MA training currently available</td>
<td>4</td>
<td>0</td>
<td>-</td>
<td>80</td>
</tr>
<tr>
<td>Confidentiality, privacy, stigma and safety issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Women in regional and rural areas worry about confidentiality and privacy issues</td>
<td>1</td>
<td>0.75</td>
<td>90</td>
<td></td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Statements</th>
<th>Median</th>
<th>IQR</th>
<th>Percent agree</th>
<th>Percent disagree</th>
<th>Consensus Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 The rural population does not complain about poor MA services in their area, because it is a private and contentious subject</td>
<td>2</td>
<td>1.75</td>
<td>75</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>14 GPs fear moral judgement by other health professionals if they were to provide MA services to their patients</td>
<td>2</td>
<td>2</td>
<td>70</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>15 There is pressure on GPs to conform to the conservative views of their colleagues regarding the provision of MA services</td>
<td>2</td>
<td>2</td>
<td>70</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>16 GPs are concerned about their safety and wellbeing if they were to provide MA services</td>
<td>2</td>
<td>1</td>
<td>65</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>17 GPs fear ramifications on both time and negative outcomes (complications) when providing MA services</td>
<td>2</td>
<td>2</td>
<td>70</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>18 There is a lack of specialist and other health professionals’ support available to GPs and PHCNs that provide MA services</td>
<td>2</td>
<td>1.75</td>
<td>70</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>19 There is no support from local hospitals and community health services to GPs and PHCNs who provide MA services</td>
<td>2</td>
<td>0.75</td>
<td>75</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>20 GPs and PHCNs fear negative publicity from members of conservative communities and/or fear of personal vilification if they were to provide MA services</td>
<td>1.5</td>
<td>1.75</td>
<td>75</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>21 GPs and PHCNs fear the presence of anti-choice protestors outside the facility if they were to provide MA services</td>
<td>2</td>
<td>2.75</td>
<td>60</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>22 The government is nervous about discussing and/or promoting MA. They fear community backlash or anti-choice campaigns in parliament and their own party</td>
<td>1.5</td>
<td>2</td>
<td>70</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**MA funding and public perceptions**

<table>
<thead>
<tr>
<th>Statements</th>
<th>Median</th>
<th>IQR</th>
<th>Percent agree</th>
<th>Percent disagree</th>
<th>Consensus Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>23 There is not enough funding to make nurse-led MA provision profitable</td>
<td>2</td>
<td>2</td>
<td>65</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>24 GP involvement is required to enable payment for this service</td>
<td>2</td>
<td>1</td>
<td>80</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>25 It appears that public expectations about equitable availability of abortion services are ahead of the actual implementation</td>
<td>2</td>
<td>1.5</td>
<td>65</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**Notes:** 1 Consensus for agreement was obtained (+) if valid percent agreement (or disagreement for negatively worded statements) was ≥ 75 percent and IQR ≤ 1. Consensus for agreement was not obtained (-) if valid percent agreement (or disagreement for negatively worded statements) was < 75 percent and IQR > 1.
7.3.3 Overcoming perceived current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria.

The final theme centred on panellists’ views on what needs to be done to overcome barriers to implementation of a nurse-led MA model. Thirty-four (85%) of the 40 statements obtained consensus, with 11 statements reaching 100 percent consensus. Six statements did not reach the pre-determined minimum requirements for consensus, although most agreement levels were close to 75 percent. All statements are presented in Table 7.7.

Table 7.7 Consensus reached in Round Two for statements regarding panellists’ solutions on how to overcome current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria

<table>
<thead>
<tr>
<th>Statements</th>
<th>Median</th>
<th>IQR</th>
<th>Percent agree</th>
<th>Percent disagree</th>
<th>Consensus Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 The state government should establish an action plan in partnership with primary health care networks to prioritise, promote and provide affordable, accessible MA professional development and training for GPs and PHCNs working in regional and rural Victoria</td>
<td>1</td>
<td>0</td>
<td>95</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>2 Incentives like scholarships should be offered to upskill PHCNs for MA provision</td>
<td>1</td>
<td>1</td>
<td>100</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>3 Incentives and support should be offered for rural and regional GPs to undertake MA training and service provision</td>
<td>1</td>
<td>0</td>
<td>100</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>4 Remuneration needs to be offered to practices when nurses attend professional development courses on MA</td>
<td>1</td>
<td>0.75</td>
<td>85</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>5 PHCNs prefer locally organised MA group training sessions over on-line training</td>
<td>2</td>
<td>1.75</td>
<td>70</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6 Professional development courses in sexual and reproductive health for nurses should include a MA provision component</td>
<td>1</td>
<td>0</td>
<td>95</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>7 A funded coordinator role needs to be established that offers guidance and help for PHCNs who want to do the MA training</td>
<td>1</td>
<td>1.75</td>
<td>75</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Statements</td>
<td>Median</td>
<td>IQR</td>
<td>Percent agree</td>
<td>Percent disagree</td>
<td>Consensus Round 2</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>--------</td>
<td>------</td>
<td>---------------</td>
<td>------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Professional development programs for GP accreditation should include MA provision</td>
<td>1</td>
<td>0.75</td>
<td>95</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Nurses need leaders and mentors to encourage and empower them in their professional development, which includes MA provision</td>
<td>1</td>
<td>1</td>
<td>95</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Establish a PHCN network for MA practice which includes mentoring, networking, and opportunities to share experiences and learn</td>
<td>1</td>
<td>0.75</td>
<td>100</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Create a MA provision model for PHCNs, which can provide guidance, support and help to develop their roles</td>
<td>1</td>
<td>0.75</td>
<td>100</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Direction is required from the Australian health practitioner regulation agency on the nurses' scope of practice in MA provision</td>
<td>1</td>
<td>1</td>
<td>90</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Encourage nursing research to validate the role of PHCNs and demonstrate effectiveness of nurse-led MA provision</td>
<td>1</td>
<td>0.75</td>
<td>90</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Continue to challenge traditional nursing duty 'norms' for MA, and ensure a stringent use of evidence and best practice, as scope of practice boundaries are shifted</td>
<td>1</td>
<td>0.75</td>
<td>90</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Introduce data collection systems for monitoring and evaluation of nurse-led MA provision in regional and rural Victoria</td>
<td>1</td>
<td>0.75</td>
<td>90</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Supportive information should be freely available to all MA providing nurses (e.g. Resources on the MS health website)</td>
<td>1</td>
<td>0</td>
<td>95</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Create a Medicare benefits schedule (MBS) item number for PHCN consultations related to MA provision</td>
<td>1</td>
<td>1</td>
<td>90</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Payment for nurse-led MA provision should be independent of any GP involvement</td>
<td>1.5</td>
<td>1.75</td>
<td>75</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Guarantee access to quality specialist back-up when needed</td>
<td>1</td>
<td>0</td>
<td>100</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Improve communication about MA between local hospitals, GPs and PHC nurses</td>
<td>1</td>
<td>0</td>
<td>100</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Develop best practice service models for MA which includes access to radiography and after care services</td>
<td>1</td>
<td>1</td>
<td>100</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>GP clinics should stock and supply abortion mediation so women do not need to go somewhere else</td>
<td>1</td>
<td>1</td>
<td>85</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Statements</td>
<td>Median</td>
<td>IQR</td>
<td>Percent agree</td>
<td>Percent disagree</td>
<td>Consensus Round 2</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
<td>------</td>
<td>---------------</td>
<td>------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>23 GP clinics should offer ultrasound and blood test services so women do not need to go somewhere else</td>
<td>2</td>
<td>1</td>
<td>70</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>24 When practice GPs refuse to provide MA, PHCNs should be able to initiate pre-testing before referral</td>
<td>1</td>
<td>1</td>
<td>85</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>25 GPs who provide MA should be made visible (e.g. advertise with &quot;all-option pregnancy counselling offered at this general practice&quot;)</td>
<td>1.5</td>
<td>1.75</td>
<td>75</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>26 Financially support women to facilitate MA access (e.g. for travel and childcare costs)</td>
<td>2</td>
<td>2</td>
<td>65</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>27 Change legislation to allow prescription of abortion medication by registered nurses in regional and rural Victoria</td>
<td>1</td>
<td>1</td>
<td>85</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>28 Make recommendations to parliament and working parties to change legislation to allow a wider scope of practice for PHCNs</td>
<td>1</td>
<td>1</td>
<td>89.5</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>29 Public awareness about the availability of MA can lead to increased public demand. This can act as a driver for improved service provision</td>
<td>1</td>
<td>1</td>
<td>95</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>30 Increase and improve the availability of medication abortion drugs in local pharmacies through MA education programs for pharmacists</td>
<td>1</td>
<td>0</td>
<td>95</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>31 Develop a dedicated team of MA-trained PHCNs to support the provision of MA services in smaller or more remote health care settings</td>
<td>1</td>
<td>0</td>
<td>95</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>32 Ensure that PHCNs who provide MA are covered by insurance</td>
<td>1</td>
<td>0</td>
<td>95</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>33 There should be support and endorsement of MA from local health professionals (including boards of hospitals and community centres)</td>
<td>1</td>
<td>0</td>
<td>100</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>34 Emergency department staff should respond in a non-judgmental way in cases of abortion complications</td>
<td>1</td>
<td>0</td>
<td>100</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>35 There should be open endorsement of MA from peak bodies such as the Australian Medical Association, royal Australian College of General Practitioners, nursing authorities and government</td>
<td>1</td>
<td>0</td>
<td>95</td>
<td>-</td>
<td>+</td>
</tr>
</tbody>
</table>
Chapter 7 | Delphi study findings

<table>
<thead>
<tr>
<th>Statements</th>
<th>Median</th>
<th>IQR</th>
<th>Percent agree</th>
<th>Percent disagree</th>
<th>Consensus Round 2</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>36. There should be a statement of expectation from the department of health that medication abortion should be core business for primary health systems in regional and rural areas</td>
<td>1</td>
<td>0.75</td>
<td>85</td>
<td>-</td>
<td>+</td>
<td>1 Consensus for agreement was obtained (+) if valid percent agreement (or disagreement for negatively worded statements) was ≥ 75 percent and IQR ≤ 1. Consensus for agreement was not obtained (-) if valid percent agreement (or disagreement for negatively worded statements) was &lt; 75 percent and IQR &gt; 1.</td>
</tr>
<tr>
<td>37. There should be support and protection for PHCNs and GPs who wish to offer MA services but are afraid of community backlash, harassment or legal issues</td>
<td>1</td>
<td>0</td>
<td>100</td>
<td>-</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>38. All GP practices should provide independent pregnancy counselling</td>
<td>1</td>
<td>1</td>
<td>90</td>
<td>-</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>39. Conscientious objection should be out in the open. The public needs to know if a doctor is a conscientious objector</td>
<td>1</td>
<td>0.75</td>
<td>90</td>
<td>-</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>40. Abortion should be seen as being part of comprehensive sexual and reproductive health care, consequently reducing abortion stigma</td>
<td>1</td>
<td>0</td>
<td>100</td>
<td>-</td>
<td>+</td>
<td></td>
</tr>
</tbody>
</table>

7.4 ROUND THREE

In Round Two, 57 of the 82 statements reached consensus. Based on the analysis of the data from the open-ended questions of Round Two, seven of the 25 statements that did not reach consensus were reworded, and an additional two statements were developed for inclusion in Round Three (see section 6.4.2). Round Three, therefore, included 27 statements, of which 12 reached consensus. The statements are presented in similar themes as Round Two, except for the first theme, where the term ‘views’ was changed into ‘views on the construction’ (see section 6.4.3). The three themes are discussed in the following sections and include: 1) views on the construction of a nurse-led model of care for MA provision in regional and rural Victoria; 2) perceptions of current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria; and 3) overcoming current barriers to the
implementation of a nurse-led model of care for MA provision in regional and rural Victoria.

### 7.4.1. Views on the construction of a nurse-led model of care for MA abortion provision in regional and rural Victoria

Two of the five remaining statements regarding the construction of a nurse-led model of care for MA abortion provision in regional and rural Victoria achieved consensus in Round Three: all women with an unwanted pregnancy should be referred to an appropriately trained PHCN (84% agreement, IQR=1); and the appropriately trained PHCN can manage post-abortion contraception, including the insertion of implants, intrauterine devices (IUDs) or the provision of injectable contraception (95% agreement, IQR=1) (see Table 7.8).

**Table 7.8 Consensus reached in Round Three for statements regarding panellists’ views on the construction of a nurse-led model of care for MA provision in regional and rural Victoria**

<table>
<thead>
<tr>
<th>Statements</th>
<th>Percent agree Round 2</th>
<th>IQR Round 2</th>
<th>Percent agree Round 3</th>
<th>IQR Round 3</th>
<th>Consensus Round 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All women with an unwanted pregnancy should be referred to an appropriately trained PHCN</td>
<td>65</td>
<td>2</td>
<td>84</td>
<td>1</td>
<td>+</td>
</tr>
<tr>
<td>2. Non-life-threatening complications of MA, like haemorrhages or infections, should be managed by doctors only</td>
<td>45^2</td>
<td>2</td>
<td>47^2</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>3^3. The appropriately trained PHCN can manage post-abortion contraception, including the insertion of implants, IUDs or the provision of injectable contraception</td>
<td>75</td>
<td>1.75</td>
<td>95</td>
<td>1</td>
<td>+</td>
</tr>
<tr>
<td>4^3. All steps in the MA process that are handled by an appropriately trained PHCN should only be allowed under the supervision of a GP</td>
<td>70^2</td>
<td>1</td>
<td>47^2</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>5^3. Allow all appropriately trained registered nurses to be responsible for the whole MA process without a GP’s approval. The GP should only be required for the prescription of the abortion medication</td>
<td>40</td>
<td>2.75</td>
<td>58</td>
<td>2</td>
<td>-</td>
</tr>
</tbody>
</table>

Notes: 1 Consensus for agreement reached (+) if valid percent agreement was ≥ 75% and IQR ≤ 1; 2 Percentage disagreement; 3 Newly worded statement in Round Three.
7.4.2 Perceptions of current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria

Of the 16 remaining statements regarding panellists’ perceptions of current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria, five reached the pre-determined consensus level in Round Three (see Table 7.9). Consensus statements are presented by sub-themes: 1) logistical barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria; 2) confidentiality, privacy, stigma and safety issues; and 3) MA funding and public perceptions.

One statement assigned to ‘logistical barriers’, reached consensus in Round Three: Eighty-four percent of panellists agreed (IQR=1) that not all local pharmacies supply, or wish to supply, MA drugs. The agreement levels of the other two statements remained the same. Three out of the 10 statements relating to ‘confidentiality, privacy, stigma and safety issues’ also reached consensus in Round Three. Ninety percent agreement (IQR=0) was achieved for the statement that declared that there is pressure on GPs to conform to the conservative views of their colleagues regarding the provision of MA services. The other two statements that reached consensus were: GPs fear moral judgement by other health professionals if they were to provide MA services to their patients (84% agreement, IQR=0); and GPs and PHCNs fear negative publicity from members of conservative communities and/or fear of personal vilification if they were to provide MA services (84% agreement, IQR=1). Finally, one of the three statements regarding ‘MA funding and public perception barriers’ reached consensus. The statement implied there is not enough funding to make nurse-led MA provision profitable (79% agreement, IQR=1).
### Table 7.9 Consensus reached in Round Three for statements regarding panellists’ perceptions of current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria

<table>
<thead>
<tr>
<th>Statements</th>
<th>Percent agree Round 2</th>
<th>IQR Round 2</th>
<th>Percent agree Round 3</th>
<th>IQR Round 3</th>
<th>Consensus Round 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logistical barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Not all local pharmacies supply, or wish to supply, medication abortion drugs</td>
<td>75</td>
<td>1.75</td>
<td>84</td>
<td>1</td>
<td>+</td>
</tr>
<tr>
<td>2. There is a well-established positive collaboration between the Australian Medical Association and nursing authorities</td>
<td>40²</td>
<td>1</td>
<td>47²</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>3. There is a lack of specialist and other health professionals’ support available to GPs and PHCNs that provide MA services</td>
<td>70</td>
<td>1.75</td>
<td>74</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Confidentiality, privacy, stigma and safety issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. The rural population does not complain about poor MA services in their area, because it is a private and contentious subject</td>
<td>75</td>
<td>1.75</td>
<td>74</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>5. GPs fear moral judgement by other health professionals if they were to provide MA services to their patients</td>
<td>70</td>
<td>2</td>
<td>84</td>
<td>0</td>
<td>+</td>
</tr>
<tr>
<td>6. There is pressure on GPs to conform to the conservative views of their colleagues regarding the provision of MA services</td>
<td>70</td>
<td>2</td>
<td>90</td>
<td>0</td>
<td>+</td>
</tr>
<tr>
<td>7. GPs are concerned about their safety and wellbeing if they were to provide MA services</td>
<td>65</td>
<td>1</td>
<td>74</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>8. GPs fear ramifications on negative outcomes (complications) when providing MA services</td>
<td>70</td>
<td>2</td>
<td>72</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>9. GPs concerns regarding MA service provision appear to be based mainly on workload and time</td>
<td>-</td>
<td>-</td>
<td>42</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>10. GPs and PHCNs fear negative publicity from members of conservative communities and/or fear of personal vilification if they were to provide MA services</td>
<td>75</td>
<td>1.75</td>
<td>84</td>
<td>1</td>
<td>+</td>
</tr>
<tr>
<td>11. GPs and PHCNs fear the presence of anti-choice protestors outside the facility if they were to provide MA services</td>
<td>60</td>
<td>2.75</td>
<td>68</td>
<td>2</td>
<td>-</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Statements</th>
<th>Percent agree Round 2</th>
<th>IQR</th>
<th>Percent agree Round 3</th>
<th>IQR</th>
<th>Consensus Round 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>12³ The Victorian government is nervous about discussing and/or promoting MA. They fear community backlash or anti-choice campaigns in parliament and their own party</td>
<td>70 2 58 2 -</td>
<td>-</td>
<td>47 3 -</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>14 ³ The Victorian Government is negligent about discussing and/or promoting MA</td>
<td>- -</td>
<td>-</td>
<td>- -</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>General practice funding for nurse-led MA provision is currently included in the quarterly practice nurse incentive program payment, which includes a rural loading of up to 50% and is independent of Medicare item numbers. There is sufficient allowance in the practice nurse incentive program payment to cover nurse-led MA provision</td>
<td>65² 2 63² 2 -</td>
<td>-</td>
<td>65 2 79 1 +</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>15 There is not enough funding to make nurse-led MA provision profitable</td>
<td>65 2 79 1 +</td>
<td>+</td>
<td>65 2 79 1 +</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>16 It appears that public expectations about equitable availability of abortion services are ahead of the actual implementation</td>
<td>65 1.5 68 2 -</td>
<td>-</td>
<td>65 1.5 68 2 -</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Notes: 1 Consensus for agreement reached (+) if valid percent agreement was ≥ 75% and IQR ≤ 1; 2 Percentage disagreement; 3 Newly worded statement in Round Three; 4 New statement in Round Three.

7.4.3 Overcoming perceived current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria

This theme focuses on the potential solutions to overcome perceived barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria. Of the six statements that had not yet reached consensus in Round Two, all but one statement obtained consensus (see Table 7.10). Full (100% agreement, IQR = 1) consensus was achieved for the statement that PHCNs require flexibility and choice for online training or locally organised MA training session, to maximise training opportunities. The statement that GPs
who provide MA should be made visible (e.g., advertise with ‘all-option pregnancy counselling offered at this general practice’) did not achieve consensus. It received an even lower agreement level in Round Three (68% agreement, IQR = 2) compared to Round Two (75% agreement, IQR = 1.75).  

Table 7.10 Consensus reached in Round Three for statements regarding panellists’ solutions on how to overcome current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria

<table>
<thead>
<tr>
<th>Statements</th>
<th>Percent agree Round 2</th>
<th>IQR Round 2</th>
<th>Percent agree Round 3</th>
<th>IQR Round 3</th>
<th>Consensus Round 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  PHCNs require flexibility and choice for online training or locally</td>
<td>-</td>
<td>-</td>
<td>100</td>
<td>1</td>
<td>+</td>
</tr>
<tr>
<td>organised MA training session, to maximise training</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>opportunities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2  A funded coordinator role needs to be established that offers guidance</td>
<td>75</td>
<td>1.75</td>
<td>79</td>
<td>1</td>
<td>+</td>
</tr>
<tr>
<td>and help for PHCNs who want to do the MA training</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3  Payment for nurse-led MA provision should be independent of any GP</td>
<td>75</td>
<td>1.75</td>
<td>90</td>
<td>1</td>
<td>+</td>
</tr>
<tr>
<td>involvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4  GP clinics located in areas with limited local health services should</td>
<td>70</td>
<td>1</td>
<td>95</td>
<td>1</td>
<td>+</td>
</tr>
<tr>
<td>offer ultrasound (after appropriate training) and blood</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>test services so women do not need to go somewhere else</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5  GPs who provide MA should be made visible (e.g. advertise with “all-</td>
<td>75</td>
<td>1.75</td>
<td>68</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>option pregnancy counselling offered at this general</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>practice”)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6  Financially support women to facilitate MA access (e.g. for travel</td>
<td>65</td>
<td>2</td>
<td>84</td>
<td>1</td>
<td>+</td>
</tr>
<tr>
<td>and childcare costs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: 1 Consensus for agreement reached (+) if valid percent agreement was ≥ 75% and IQR ≤ 1; 2 Newly worded statement in Round Three.

7.5 A NURSE-LED MODEL OF MA PROVISION AND THE BARRIERS AND SOLUTIONS TO IMPLEMENTATION

Based on the Delphi findings, a nurse-led model for MA provision in regional and rural Victoria was constructed, together with the identified barriers and solutions to the implementation of the model. The construction of the
model and the implementation barriers and solutions are presented in the following two sections. Verbatim quotes from Round Two and Three are added to illustrate the findings, and differences in views between panellists’ profession groups are shown.

### 7.5.1. Construction of a nurse-led model of care for MA abortion provision in regional and rural Victoria

Similar to existing frameworks (Costescu et al. 2016; RCN 2017; WHO 2015b), the following three phases of a nurse-led model of care for MA provision in regional and rural Victoria were identified:

1. Assessment of MA eligibility
2. Medication administration and management of side-effects
3. Evaluation of abortion completion and post-abortion care.

The statements from the three Delphi rounds that relate to the construction of a nurse-led MA model are structured around these three phases. The statements are presented in Table 7.11 and include the level of consensus reached and a comparison of the ratings between the three groups using the Kruskall-Wallis test. They are further explored per phase in the three sections following the table.

**Table 7.11** Construction of a nurse-led model of care for MA provision in regional and rural Victoria

<table>
<thead>
<tr>
<th>Consensus statements</th>
<th>IQR</th>
<th>Consensus (%)</th>
<th>Kw(^3) test</th>
<th>Kw p-value</th>
<th>Dunn test(^4)</th>
<th>Dunn p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment of MA eligibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. All women with an unwanted pregnancy should be referred to an appropriately trained PHCN</td>
<td>1</td>
<td>84</td>
<td>5.895</td>
<td>0.052</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The PHCN role should include non-directive pregnancy counselling</td>
<td>1</td>
<td>90</td>
<td>1.596</td>
<td>0.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. A PHCN should be able to communicate the pros and cons of the medication abortion</td>
<td>0</td>
<td>95</td>
<td>3.512</td>
<td>0.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consensus statements</td>
<td>IQR</td>
<td>Consensus(^1) (%)</td>
<td>KW(^3) test</td>
<td>KW p-value</td>
<td>Dunn test(^4)</td>
<td>Dunn p-value</td>
</tr>
<tr>
<td>---------------------</td>
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<td>---------------------</td>
<td>----------------</td>
<td>-------------</td>
<td>----------------</td>
<td>--------------</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>80(^2)</td>
<td>0.819</td>
<td>0.7</td>
<td>N-P</td>
<td>0.03</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>85</td>
<td>7.968</td>
<td>0.02</td>
<td>N-P</td>
<td>1.0</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>80</td>
<td>4.096</td>
<td>0.1</td>
<td>N-O</td>
<td>0.051</td>
</tr>
<tr>
<td>7</td>
<td>0.75</td>
<td>75</td>
<td>6.670</td>
<td>0.04</td>
<td>N-P</td>
<td>1.0</td>
</tr>
<tr>
<td>8(^5)</td>
<td>1</td>
<td>47(^2)</td>
<td>3.304</td>
<td>0.4</td>
<td>N-O</td>
<td>0.03</td>
</tr>
<tr>
<td>9(^5)</td>
<td>2</td>
<td>58</td>
<td>8.766</td>
<td>0.2</td>
<td>P-O</td>
<td>0.4</td>
</tr>
<tr>
<td>Medication administration and management of side-effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>95</td>
<td>3.639</td>
<td>0.2</td>
<td>N-O</td>
<td>0.03</td>
</tr>
<tr>
<td>11</td>
<td>1</td>
<td>95</td>
<td>4.172</td>
<td>0.1</td>
<td>P-O</td>
<td>0.4</td>
</tr>
<tr>
<td>12</td>
<td>0</td>
<td>100</td>
<td>1.166</td>
<td>0.6</td>
<td>P-O</td>
<td>0.6</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>90</td>
<td>0.976</td>
<td>0.6</td>
<td>P-O</td>
<td>0.6</td>
</tr>
<tr>
<td>Evaluation of abortion completion and post-abortion care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14(^5)</td>
<td>2</td>
<td>47(^2)</td>
<td>4.293</td>
<td>0.7</td>
<td>P-O</td>
<td>0.4</td>
</tr>
</tbody>
</table>

1. Consensus: The percentage of respondents indicating consensus on the statement.  
2. IQR: Interquartile range.  
3. KW Test: Kruskal-Wallis test.  
4. Dunn Test: Dunn test for multiple comparisons.  
5. Non-life-threatening complications of MA, like haemorrhages or infections, should be managed by doctors only.
Consensus statements | IQR  | Consensus (%) | KW test | KW p-value | Dunn test | Dunn p-value
---|---|---|---|---|---|---
15 Completion of an abortion cannot be totally assessed by a PHCN | 1 | 85 | 0.671 | 0.7 |  |  
16 The appropriately trained PHCN can manage post-abortion contraception, including the insertion of implants, IUDs or the provision of injectable contraception | 1 | 95 | 2.934 | 0.8 |  |  
17 The PHCN role can include the provision of emotional support following the procedure if required | 0.75 | 90 | 0.8378 | 0.02 | N-P | 1.0  
 |  |  |  |  | N-O | 0.01  
 |  |  |  |  | P-O | 0.1  

Notes: 1 Consensus for agreement reached if valid percent agreement was ≥ 75% and IQR ≤ 1; 2 Negatively worded, reverse coded with percentage disagreement; 3 Kruskal-Wallis H-test for the comparison of ratings between groups; 4 Post-hoc Dunn-Bonferroni test on each pair of groups, consisting of nurses (N), physicians (P) and others (O); 5 Non-consensus statements.

### 7.5.1.1 Assessment of MA eligibility

Nine statements were identified as tasks and components associated with the first phase of the nurse-led model of MA provision. In this phase, the pregnant woman contacts the PHC professional and the eligibility for MA is assessed. Panellists agreed (84%, IQR = 1) that all women with an unwanted pregnancy should be referred to an appropriately trained PHCN (Table 7.11, no. 1); however, it was noted that women should also have the option to visit a GP:

*I think women should have a choice of who manages their medical top [termination of pregnancy] esp. in country areas for confidentiality /privacy, some may prefer to see only a dr or only a nurse* (Physician4).

In addition, the importance of having one provider in charge of the whole MA process was highlighted:

*It is important for women to have a one stop shop which meets all their needs. It is often difficult to tell your story to several people* (Nurse1).

While most (90%, IQR = 1) panellists agreed a PHCN’s role should include non-directive pregnancy counselling (Table 7.11, no. 2), it was expressed by one
panellist that most women already know that they want an abortion and, therefore, do not need to be counselled on the choice to terminate:

...clearly communicate the pros and cons for ALL pregnancy options, as well as the steps involved in referral pathways. The latter is important for women living in rural and regional areas to have all information, including costs related to services, waiting times, distance & travel, service procedure & post health care & support (Other3).

When a woman decides to undergo a MA to terminate her pregnancy, panellists disagreed (80%, IQR = 0) that a sufficiently trained PHCN is not able to independently rule out any contra-indications to the use of MA (Table 7.11, no. 4). The tasks involved with the clinical assessment of contra-indications include taking a medical history, a physical examination, and assessing any comorbidities (RANZCOG 2016). There was overall consensus (80%, IQR = 1) that it is within the scope of practice of a registered PHCN to independently refer a woman for an ultrasound (for pregnancy dating and ectopic pregnancy screening) and blood tests (Table 7.11, no. 6).

Consensus (85%, IQR = 1) was also achieved for the statement that when practice GPs refuse to provide MA, PHCNs should be able to initiate pre-testing before referral (Table 7.11, no. 5). There was, however, a statistically significant difference in ratings between the panellists’ groups (KW test statistic = 7.968; p = 0.02), with physicians (24%) less likely to agree with the statement than nurses (41%; p = 0.03).

Opinions regarding the overall responsibilities of the PHCN in MA provision differed. While overall most panellists agreed (75%, IQR = 0.75) that MA provision in the PHC sector can be provided by a PHCN in cooperation with a GP (Table 7.11, no. 7), there was a statistically significant difference between the panellists’ groups (KW test statistic = 7.968; p = 0.02). Nurses (53%) were more likely to agree with the statement than panellists in the ‘other’ group (20%; p = 0.03). The scenario of MA provision by a PHCN in cooperation with a GP was welcomed by one PHCN:
...it would be fantastic if nurses had extended skills like ordering of tests etc. Then nurses could do all the work up and the GP would have all the information in consultation with the nurse and after seeing the client to order the medication (Nurse9).

One physician, however, questioned a prescription-only role of GPs:

As a GP, I would not feel comfortable with a prescription only role for abortion (Physician4).

Some panellists, on the other hand, favoured an alternative scenario, in which the PHCN becomes fully responsible for the MA process:

Appropriately trained PHCN led provision of MA, including authority to prescribe is the preferred model to significantly improve access to non-directive pregnancy choices counselling AND abortion services in rural areas (Other3).

Nurses can be trained to provide all steps of MTOP independently. ....If nurses were able to prescribe they could be trained to provide the treatment autonomously (Physician7).

It was additionally recommended that for PHCNs working in community health care settings, partnerships with service GPs should be set up:

There needs to be varying models that would allow nurse working in areas such as women’s health clinics or community health to independently prescribe and a collaborative model for use in a GP practice with a supportive GP (Nurse1).

While all steps of the first phase of the nurse-led model of MA provision are grounded within the PHCNs’ scope of practice (Australian Primary Health Care Nurses Association 2017), PHCNs in Victoria are currently not able to be independently responsible for the whole first phase MA process. They have to adhere to the MBS requirements (Department of Health 2017b) that request the personal attendance of the GP for specific services in order to qualify abortion requesting women for benefit refunds. Therefore, in addition to a first phase,
fully autonomous nurse-led MA model, another first phase ‘legally feasible’
nurse-led model was constructed that takes into account the required
involvement of a GP. A third nurse-led model, referred to as the ‘absence of a
(supportive) GP’ model, is included for PCHNs who work in settings that lack
immediate support of a GP. In this situation, PHCNs would be able to initiate pre-
testing before referral, albeit within the limits of above-described current MBS
boundaries. This model only consists of the first phase of the MA provision
process, as the following two phases are provided at another location by another
provider. A framework of the first phase of the three proposed nurse-led MA
models is shown in Figure 7.3. The steps specific for each model are depicted in a
different colour.
7.5.1.2 Medication administration and management of side-effects

Four statements were identified as tasks and components associated with the second contact of the pregnant woman with the PHCN, in which the MA is administered and expected side-effects are managed. Most (95%, IQR = 1) panellists agreed that PHCNs are able to interpret the results of ultrasounds and blood tests in such a way that they can assess if MA provision is advisable (Table
7.11, no. 10). Two panellists commented on their support for PHCNs’ ability to perform these tasks.

*With appropriate training, qualifications, and ongoing assessment of skills, updates etc, this should be safe* (Physician4).

*The issue is with the Medicare rebate for the ultrasound and pathology not the nurses’ ability to interpret* (Nurse1).

It was additionally acknowledged by most (95%, IQR = 1) panellists that the administration of mifepristone can be independently handled by a PHCN (Table 7.11, no. 11) and that PHCNs can autonomously manage prophylactic pain medication (90%, IQR = 1) (Table 7.11, no. 13). Further, panellists agreed (95%) that the PHCN’s role should include contraception (Table 7.11, no. 12).

As ‘fully autonomous’ nurse-led MA provision in the second phase of the nurse-led MA procedure is currently not possible in Victoria because PHCNs are not allowed to prescribe MA drugs (VLRC 2008), the ‘legally feasible’ model is included as a different in the framework (see Figure 7.4).
7.5.1.3 Evaluation of abortion completion and post-abortion care

Four statements were recognised as being part of the third phase of the nurse-led MA provision procedure, in which post-abortion care, if required, is provided and abortion completion is evaluated. No consensus (47%) was reached in relation to which health practitioner should manage non-life-threatening MA complications, such as haemorrhages or infections (Table 7.11, no. 14). Some panellists commented that, if appropriately trained, PHCNs should...
be able to manage non-life-threatening complications and that, if necessary, consultation or referral can be organised. It was suggested that:

*Appropriately trained nurses could have protocols for managing complications* (Physician 7).

Others questioned this strategy and advised that management of complications should always be done in collaboration with a physician. One panellist worried about access issues:

*...a woman experiencing a non-life threatening haemorrhage following MA may have greater access to a doctor after hours at a hospital than an appropriately trained PHCN* (Other 3).

It was additionally recognised that independent management of post-abortion complications by PHCNs could be problematic in more isolated rural areas.

Most (85%, IQR = 1) panellists disagreed with the statement that completion of an abortion cannot be totally assessed by a PHCN (Table 7.11, no. 15) and most (90%, IQR = 0.75) agreed that the PHCN’s role can include the provision of emotional support following the procedure if required (Table 7.11, no. 17). This last statement, however, showed a statistically significant difference in agreement ranking between the three panellists’ groups (KW test statistic = 8.378; p = 0.02). Nurses (44%) were more likely to agree with the statement than panellists in the ‘other’ group (22%; p = 0.01). The difference in rating was somewhat reflected in the following comment:

*...professional counselling should be offered where available, if not available then the PHC nurse could provide support* (Other 2).

Finally, consensus (90%, IQR = 1) was reached for the statement that appropriately trained PHCNs can manage post-abortion contraception, including the insertion of implants, IUDs or the provision of injectable contraception (Table 7.11, no. 16). However, despite reaching consensus, the views among panellists regarding PHCNs inserting implants and IUDs were diverse.
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Would be great if we could insert Implanon and give depo after training (Nurse7).

Nurses can council or refer but should not be trained for Implanon or IUD insertions (Physician1).

All steps belonging to the third phase of the nurse-led MA provision model (see Figure 7.5) can be independently handled by the PHCNs, and phase three is, therefore, identical for the fully autonomous and legally feasible nurse-led MA provision model.

Figure 7.5 Framework for the third phase of the fully autonomous and the legally feasible nurse-led MA provision model

7.5.2 Barriers and solutions to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria

Six overarching themes of barriers and solutions to the implementation of the three nurse-led models of care for MA provision in regional and rural Victoria emerged from the consensus statements. The first five themes focus on
different aspects of the MA process, while the final theme emphasises the importance of evidence validation and policy change:

1. Professional development and training opportunities
2. Support systems for health care professionals
3. Funding for a nurse-led model of MA provision
4. Accessibility support services
5. Confidentiality, privacy, stigma and safety issues
6. Evidence validation and policy change.

The statements that were perceived by the panellists, over the three Delphi rounds as current barriers to the implementation of the three nurse-led models of care for MA provision in regional and rural Victoria are presented in Table 7.12 and include the level of consensus reached and a comparison of the ratings between the three groups using the Kruskall-Wallis test.

<table>
<thead>
<tr>
<th>Consensus statements</th>
<th>IQR</th>
<th>Consensus (%)</th>
<th>KW test</th>
<th>KW test p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional development and training opportunities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Most GPs are aware of the online MA training currently available</td>
<td>0</td>
<td>80(^2)</td>
<td>4.375</td>
<td>0.1</td>
</tr>
<tr>
<td>2. There is insufficient availability of MA trained GP providers in regional and rural Victoria</td>
<td>1</td>
<td>95</td>
<td>2.359</td>
<td>0.3</td>
</tr>
<tr>
<td>3. There is a lack of professional development and further training possibilities for PHCNs (including MA provision)</td>
<td>1</td>
<td>85</td>
<td>3.385</td>
<td>0.2</td>
</tr>
<tr>
<td>4. Many GPs are not aware that they can offer MA</td>
<td>1</td>
<td>85</td>
<td>0.323</td>
<td>0.3</td>
</tr>
<tr>
<td>Support systems for health care professionals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Traditionally, GPs prefer to be in charge over some services, which includes MA provision</td>
<td>1</td>
<td>95</td>
<td>0.512</td>
<td>0.8</td>
</tr>
<tr>
<td>6. Not all local pharmacies supply, or wish to supply, MA drugs</td>
<td>1</td>
<td>84</td>
<td>2.188</td>
<td>0.3</td>
</tr>
<tr>
<td>7. Without a GP’s approval for MA provision, nurse involvement is not supported</td>
<td>1</td>
<td>85</td>
<td>0.163</td>
<td>1.0</td>
</tr>
<tr>
<td>8. There is no support from local hospitals and community health</td>
<td>0.75</td>
<td>75</td>
<td>0.151</td>
<td>0.9</td>
</tr>
</tbody>
</table>

Table 7.12 Barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria
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<table>
<thead>
<tr>
<th>Consensus statements</th>
<th>IQR</th>
<th>Consensus (%)</th>
<th>KW test</th>
<th>KW test p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>services to GPs and PHCNs who provide MA services</td>
<td>1</td>
<td>47(^2)</td>
<td>0.745</td>
<td>0.689</td>
</tr>
<tr>
<td>There is a well-established positive collaboration between the Australian Medical Association and nursing authorities</td>
<td>1</td>
<td>74</td>
<td>0.664</td>
<td>0.717</td>
</tr>
<tr>
<td>There is a lack of specialist and other health professionals’ support available to GPs and PHCNs that provide MA services</td>
<td>3</td>
<td>47</td>
<td>2.443</td>
<td>0.295</td>
</tr>
<tr>
<td>The Victorian Government is negligent about discussing and/or promoting MA</td>
<td>1</td>
<td>72</td>
<td>0.226</td>
<td>0.893</td>
</tr>
<tr>
<td>GPs fear ramifications on both time and negative outcomes (complications) when providing MA services</td>
<td>2</td>
<td>68</td>
<td>5.067</td>
<td>0.079</td>
</tr>
<tr>
<td>It appears that public expectations about equitable availability of abortion services are ahead of the actual implementation</td>
<td>1</td>
<td>80</td>
<td>1.397</td>
<td>0.5</td>
</tr>
<tr>
<td>Funding for a nurse-led model of MA provision</td>
<td>1</td>
<td>79</td>
<td>0.305</td>
<td>0.9</td>
</tr>
<tr>
<td>GP involvement is required to enable payment for this service</td>
<td>2</td>
<td>63(^2)</td>
<td>1.139</td>
<td>0.566</td>
</tr>
<tr>
<td>There is not enough funding to make nurse-led MA provision profitable</td>
<td>1</td>
<td>90</td>
<td>1.583</td>
<td>0.5</td>
</tr>
<tr>
<td>General practice funding for nurse-led MA provision is currently included in the quarterly practice nurse incentive program payment, which includes a rural loading of up to 50% and is independent of Medicare item numbers. There is sufficient allowance in the practice nurse incentive program payment to cover nurse-led MA provision</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accessibility support services</td>
<td>1</td>
<td>95</td>
<td>1.154</td>
<td>0.6</td>
</tr>
<tr>
<td>There is a lack of after-hours care in small towns for women who go through a MA</td>
<td>0.75</td>
<td>95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a lack of local allied professionals and accessible services for women (such as radiographers) in regional and rural Victoria</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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### Consensus statements

<table>
<thead>
<tr>
<th>Consensus statements</th>
<th>IQR</th>
<th>Consensus&lt;sup&gt;1&lt;/sup&gt; (%)</th>
<th>KW test&lt;sup&gt;2&lt;/sup&gt;</th>
<th>KW test p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 There is a lack of local access to surgical back-up in regional and rural Victoria in the case of MA complications</td>
<td>0.75</td>
<td>80</td>
<td>1.466</td>
<td>0.5</td>
</tr>
<tr>
<td>20 Confidentiality, privacy, stigma and safety issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Women in regional and rural areas worry about confidentiality and privacy issues</td>
<td>0.75</td>
<td>90</td>
<td>2.744</td>
<td>0.3</td>
</tr>
<tr>
<td>21 GPs and PHCNs fear negative publicity from members of conservative communities and/or fear of personal vilification if they were to provide MA services</td>
<td>1</td>
<td>84</td>
<td>3.112</td>
<td>0.2</td>
</tr>
<tr>
<td>22 There is pressure on GPs to conform to the conservative views of their colleagues regarding the provision of MA services</td>
<td>0</td>
<td>90</td>
<td>0.427</td>
<td>0.8</td>
</tr>
<tr>
<td>23 GPs fear moral judgement by other health professionals if they were to provide MA services to their patients</td>
<td>0</td>
<td>84</td>
<td>0.354</td>
<td>0.8</td>
</tr>
<tr>
<td>24&lt;sup&gt;4&lt;/sup&gt; The rural population does not complain about poor MA services in their area, because it is a private and contentious subject</td>
<td>3</td>
<td>74</td>
<td>0.971</td>
<td>0.615</td>
</tr>
<tr>
<td>25&lt;sup&gt;4&lt;/sup&gt; GPs are concerned about their safety and wellbeing if they were to provide MA services</td>
<td>2</td>
<td>74</td>
<td>1.557</td>
<td>0.455</td>
</tr>
<tr>
<td>26&lt;sup&gt;4&lt;/sup&gt; GPs and PHCNs fear the presence of anti-choice protestors outside the facility if they were to provide MA services</td>
<td>2</td>
<td>68</td>
<td>0.577</td>
<td>0.749</td>
</tr>
<tr>
<td>27&lt;sup&gt;4&lt;/sup&gt; The Victorian government is nervous about discussing and/or promoting MA. They fear community backlash or anti-choice campaigns in parliament and their own party</td>
<td>2</td>
<td>58</td>
<td>2.495</td>
<td>0.287</td>
</tr>
<tr>
<td>28&lt;sup&gt;4&lt;/sup&gt; GPs concerns regarding MA service provision appear to be based mainly on workload and time</td>
<td>2</td>
<td>42</td>
<td>3.711</td>
<td>0.156</td>
</tr>
</tbody>
</table>

Notes: 1 Consensus for agreement reached if valid percent agreement was ≥ 75% and IQR ≤ 1; 2 Negatively worded, reverse coded with percentage disagreement; 3 Kruskal-Wallis H-test for the comparison of ratings between groups; 4 Non-consensus statements.

Similarly, Table 7.13 presents all statements that were recognised to overcoming perceived barriers to the implementation of the three nurse-led models of care for MA provision in regional and rural Victoria. Included in the
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table are the consensus levels reached and a comparison of the ratings between the three groups using the Kruskall-Wallis test.

The six overarching themes of barriers and solutions to nurse-led MA model implementation are separately discussed in the following sections. The findings are supported by the qualitative data.

**Table 7.13 Overcoming perceived current barriers to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria**

<table>
<thead>
<tr>
<th>Consensus statements</th>
<th>IQR</th>
<th>Consen-sus (%)</th>
<th>KW test</th>
<th>KW test p-value</th>
<th>Dunn test</th>
<th>Dunn p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional development and training opportunities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Incentives and support should be offered for rural and regional GPs to undertake MA training and service provision</td>
<td>0</td>
<td>100</td>
<td>0.062</td>
<td>1.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Professional development courses in sexual and reproductive health for nurses should include a MA provision component</td>
<td>0</td>
<td>95</td>
<td>2.969</td>
<td>0.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The State Government should establish an action plan in partnership with PHC networks to prioritise, promote and provide affordable, accessible MA professional development and training for GPs and PHCNs working in regional and rural Victoria</td>
<td>0</td>
<td>95</td>
<td>0.15</td>
<td>1.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Supportive information should be freely available to all MA providing nurses (e.g. Resources on the MS health website)</td>
<td>0</td>
<td>95</td>
<td>5.299</td>
<td>0.07</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. PHCNs require flexibility and choice for online training or locally organised MA training session, to maximise training opportunities</td>
<td>1</td>
<td>100</td>
<td>0.629</td>
<td>0.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Incentives like scholarships should be offered to upskill PHCNs for MA provision</td>
<td>1</td>
<td>100</td>
<td>2.224</td>
<td>0.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Professional development programs for GP accreditation should include MA provision</td>
<td>0.75</td>
<td>95</td>
<td>0.610</td>
<td>0.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Remuneration needs to be offered to practices when nurses attend professional development courses on MA</td>
<td>0.75</td>
<td>85</td>
<td>0.190</td>
<td>0.9</td>
<td></td>
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Chapter 7 | Delphi study findings

<table>
<thead>
<tr>
<th>Consensus statements</th>
<th>IQR</th>
<th>Consensus¹ (%)</th>
<th>KW test²</th>
<th>KW test p-value</th>
<th>Dunn test³</th>
<th>Dunn p-value</th>
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<tbody>
<tr>
<td>Support systems for health care professionals</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>9  Direction is required from the Australian health practitioner regulation agency on</td>
<td>1</td>
<td>90</td>
<td>1.094</td>
<td>0.6</td>
<td></td>
<td></td>
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<tr>
<td>the nurses’ scope of practice in MA provision</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Improve communication about MA between local hospitals, GPs and PHCNs</td>
<td>0</td>
<td>100</td>
<td>2.333</td>
<td>0.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 There should be open endorsement of MA from peak bodies such as the Australian</td>
<td>0</td>
<td>95</td>
<td>1.016</td>
<td>0.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Association, royal Australian College of General Practitioners, nursing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>authorities and government</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 There should be support and endorsement of MA from local health professionals</td>
<td>0</td>
<td>100</td>
<td>0.968</td>
<td>0.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(including boards of hospitals and community centres)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>13 Establish a PHCN network for MA practice which includes mentoring, networking,</td>
<td>0.75</td>
<td>100</td>
<td>2.744</td>
<td>0.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and opportunities to share experiences and learn</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Create a MA provision model for PHCNs, which can provide guidance, support and</td>
<td>0.75</td>
<td>100</td>
<td>2.744</td>
<td>0.3</td>
<td></td>
<td></td>
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<tr>
<td>help to develop their roles</td>
<td></td>
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<tr>
<td>15 Develop a dedicated team of MA-trained PHCNs to support the provision of MA</td>
<td>0</td>
<td>95</td>
<td>1.166</td>
<td>0.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>services in smaller or more remote health care settings</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>16 Nurses need leaders and mentors to encourage and empower them in their</td>
<td>0.75</td>
<td>95</td>
<td>0.811</td>
<td>0.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>professional development, which includes MA provision</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Funding for a nurse-led model of MA provision</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Ensure that PHCNs who provide MA are covered by insurance</td>
<td>0</td>
<td>95</td>
<td>4.912</td>
<td>0.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Create a Medicare benefits schedule (MBS) item number for PHCN consultations</td>
<td>1</td>
<td>90</td>
<td>4.711</td>
<td>0.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>related to MA provision</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 A funded coordinator role needs to be established that offers guidance and help</td>
<td>1</td>
<td>79</td>
<td>1.473</td>
<td>0.5</td>
<td></td>
<td></td>
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<tr>
<td>for PHCNs who want to do the MA training</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
## Chapter 7 | Delphi study findings

<table>
<thead>
<tr>
<th>Consensus statements</th>
<th>IQR</th>
<th>Consensus (%)</th>
<th>KW test (p-value)</th>
<th>Dunn test (p-value)</th>
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<tbody>
<tr>
<td>20 Payment for nurse-led MA provision should be independent of any GP involvement</td>
<td></td>
<td>90</td>
<td>0.436</td>
<td>0.8</td>
</tr>
<tr>
<td>21 Financially support women to facilitate MA access (e.g. for travel and childcare costs)</td>
<td></td>
<td>84</td>
<td>0.845</td>
<td>0.7</td>
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<tr>
<td><strong>Accessibility support services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 Develop best practice service models for MA which includes access to radiography and after care services</td>
<td>1</td>
<td>100</td>
<td>2.333</td>
<td>0.3</td>
</tr>
<tr>
<td>23 Guarantee access to quality specialist back-up when needed</td>
<td></td>
<td>100</td>
<td>0.968</td>
<td>0.6</td>
</tr>
<tr>
<td>24 Increase and improve the availability of MA drugs in local pharmacies through MA education programs for pharmacists</td>
<td></td>
<td>95</td>
<td>5.078</td>
<td>0.8</td>
</tr>
<tr>
<td>25 GP clinics located in areas with limited local health services should offer ultrasound (after appropriate training) and blood test services so women do not need to go somewhere else</td>
<td>1</td>
<td>95</td>
<td>1.433</td>
<td>0.5</td>
</tr>
<tr>
<td>26 Public awareness about the availability of MA can lead to increased public demand. This can act as a driver for improved service provision</td>
<td></td>
<td>95</td>
<td>0.564</td>
<td>0.7</td>
</tr>
<tr>
<td>27 There should be a statement of expectation from the department of health that MA should be core business for primary health systems in regional and rural areas</td>
<td>0.75</td>
<td>85</td>
<td>0.519</td>
<td>0.8</td>
</tr>
<tr>
<td>28 GP clinics should stock and supply abortion medication so women do not need to go somewhere else</td>
<td></td>
<td>85</td>
<td>2.673</td>
<td>0.3</td>
</tr>
<tr>
<td><strong>Confidentiality, privacy, stigma and safety issues</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29 Emergency department staff should respond in a non-judgmental way in cases of abortion complications</td>
<td>0</td>
<td>100</td>
<td>0.00</td>
<td>1.0</td>
</tr>
<tr>
<td>30 Abortion should be seen as being part of comprehensive sexual and reproductive health care, consequently reducing abortion stigma</td>
<td>0</td>
<td>100</td>
<td>0.968</td>
<td>0.6</td>
</tr>
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</table>
### Consensus statements

<table>
<thead>
<tr>
<th>Consensus statements</th>
<th>IQR</th>
<th>Consensus (%)</th>
<th>KW test</th>
<th>KW test p-value</th>
<th>Dunn test</th>
<th>Dunn p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 There should be support and protection for PHCNs and GPs who wish to offer MA services but are afraid of community backlash, harassment or legal issues</td>
<td>0</td>
<td>100</td>
<td>4.898</td>
<td>0.09</td>
<td></td>
<td></td>
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<tr>
<td>32 Conscientious objection should be out in the open. The public needs to know if a doctor is a conscientious objector</td>
<td>0.75</td>
<td>90</td>
<td>3.605</td>
<td>0.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33 GPs who provide MA should be made visible (e.g. Advertise with &quot;all-option pregnancy counselling offered at this general practice&quot;)</td>
<td>2</td>
<td>68</td>
<td>8.217</td>
<td>0.02</td>
<td>N-P</td>
<td>0.082</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N-O</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>P-O</td>
<td>0.017</td>
</tr>
</tbody>
</table>

Evidence validation and policy change

<table>
<thead>
<tr>
<th>Consensus statements</th>
<th>IQR</th>
<th>Consensus (%)</th>
<th>KW test</th>
<th>KW test p-value</th>
<th>Dunn test</th>
<th>Dunn p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>34 Encourage nursing research to validate the role of PHCNs and demonstrate effectiveness of nurse-led MA provision</td>
<td>0.75</td>
<td>90</td>
<td>8.378</td>
<td>0.02</td>
<td>N-P</td>
<td>0.014</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N-O</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>P-O</td>
<td>0.119</td>
</tr>
<tr>
<td>35 Continue to challenge traditional nursing duty ‘norms’ for MA, and ensure a stringent use of evidence and best practice, as scope of practice boundaries are shifted</td>
<td>0.75</td>
<td>90</td>
<td>8.378</td>
<td>0.02</td>
<td>N-P</td>
<td>0.014</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N-O</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>P-O</td>
<td>0.119</td>
</tr>
<tr>
<td>36 Introduce data collection systems for monitoring and evaluation of nurse-led MA provision in regional and rural Victoria</td>
<td>0.75</td>
<td>90</td>
<td>7.157</td>
<td>0.03</td>
<td>N-P</td>
<td>0.024</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N-O</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>P-O</td>
<td>0.247</td>
</tr>
<tr>
<td>37 Make recommendations to parliament and working parties to change legislation to allow a wider scope of practice for PHCNs</td>
<td>1</td>
<td>90</td>
<td>7.887</td>
<td>0.02</td>
<td>N-P</td>
<td>0.017</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N-O</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>P-O</td>
<td>0.205</td>
</tr>
<tr>
<td>38 Change legislation to allow prescription of abortion medication by registered nurses in regional and rural Victoria</td>
<td>1</td>
<td>85</td>
<td>1.749</td>
<td>0.4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: 1 Consensus for agreement reached if valid percent agreement was ≥ 75% and IQR ≤ 1; 2 Kruskal-Wallis H-test for the comparison of ratings between groups; 3 Post-hoc Dunn-Bonferroni test on each pair of groups, consisting of nurses (N), physicians (P) and others (O); 4 Non-consensus statements.

**7.5.2.1 Professional development and training opportunities**

Four statements were identified as model implementation barriers relating to professional development and training opportunities. Panellists for instance agreed (85%, IQR = 1) that there is a lack of professional development
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and training possibilities for PHCNs, which includes MA provision (Table 7.12, no. 3). This view is reflected in the following quote:

*There is very limited training available for nurses re providing MTOP all the clinical training up to date is for GP's* (Nurse4).

Although it was recognised that MA education for PHCNs was offered, training seemed to be restricted to specific regional areas, which is illustrated as follows:

*There are possibilities for PHC professional development and training from a number of providers in the Goulburn Valley & North East Victoria* (Other3).

*The knowledge the nurses at our clinic have obtained has come from attending education days and sharing information on how other places provide MTOP services* (Nurse4).

Further, reasons were provided for the generally low attendance at these education days. One panellist stated:

*Attendance of PHCNs working in the primary health care sector is generally low. Anecdotal evidence through partnership programs & existing SH [sexual health] networks suggests that Practice Nurses working in GP clinics are already overworked* (Other3).

Most panellists additionally agreed (95%, IQR = 1) there is insufficient availability of MA trained GP providers in regional and rural Victoria (Table 7.12, no. 2). Moreover, panellists acknowledged (85%, IQR = 1) that GPs are often not aware that they can offer MA (Table 7.12, no. 4). It was, therefore, commented to expand MA education for GPs:

*Still need to push GP education* (Physican1).

Some respondents, however, thought that the low up-take of MA provision had other reasons, as reflected in the following quote:

*Busy workloads and time constraint may prevent more serious consideration* (Other3).
Besides from model implementation barriers related to professional development and training opportunities, eight statements were recognised as solutions to overcome perceived barriers (see Table 7.13). It was, for example, acknowledged (95%, IQR = 1) that sexual and reproductive health courses for nurses and professional development programs for GP accreditation should include a MA provision component (Table 7.13, no. 2 and 7). Although it was noted that such an implementation would not guarantee an increase in MA providers, additional screening of health practitioners could be a solution. This thought was reflected in the following quote:

_A moral objection to providing any primary care service could be screened out in the future, e.g. those doctors with a moral objection cannot practice in an area where their beliefs stop them from providing a service that is part of the suit of primary care_ (Physician7).

Further, it was agreed (95%, IQR = 0) that the State Government should establish an action plan in partnership with PHC networks to prioritise, promote and provide affordable, accessible MA professional development and training for GPs and PHCNs working in regional and rural Victoria (Table 7.13, no. 3). A funded coordinator could offer guidance and help for PHCNs who want to do the MA training (agreement level 79%, IQR = 1) (see Table 7.13, no. 19). To facilitate any financial burden, it was additionally agreed (85-100%, IQR = 0-1) that incentives (like scholarships for PHCNs), support and remuneration for practices with PHCNs attending MA courses needed to be offered (Table 7.13, no. 1, 6 and 8). One panellist emphasised the use of scholarships and incentives:

_Scholarships and incentives may be useful for PHCNs and GPs based in more isolated and/or disadvantaged communities, including health professionals working with newly arrived or aboriginal communities or those based in lone, smaller health services in towns and more isolated rural areas_ (Other3).

Another panellist suggested that MA training should not be provided to GPs without involving their practice PHCN(s):
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I feel that you actually need to have PHCN who is able to spend the time that GP’s do not have to perform this process within a Best Practice model. Training GP’s is great but they also need a trained nurse working with them (Nurse7).

7.5.2.2 Support systems for health care professionals

Nine statements focused on model implementation barriers relating to support systems for health care professionals. Panellists agreed (85%, IQR = 1) that without a GP’s approval for MA provision, nurse involvement is not supported (Table 7.12, no. 7). It was recognised that GPs without an interest in women’s health were not likely to become involved in MA provision:

Therefore, if doctors aren’t interested in providing MTOP services and the nurses in the practice have little influence on the services that are provided then...it is hard to imagine how the service will be implemented into those clinics (Nurse4).

GPs in private practice may not identify women’s sexual and reproductive health services as a priority for PHCN professional development and training (Other3).

Panellists also believed (95%, IQR = 1) that, traditionally, GPs prefer to maintain control over some services, including MA provision (Table 7.12, no. 5), and, therefore, do not want nurses to fully take on specific roles. One reason for maintaining control was, according to a panellist, an underlying concern about earnings:

GP services are also a livelihood for the doctors. Some may see this as affecting their income (Nurse2).

Another barrier relating to support systems concerned the supply of mifepristone. Panellists agreed (84%, IQR = 1) that not all local pharmacies supply, or wish to supply, MA drugs (Table 7.12, no. 6). Some argued that this lack of support from pharmacists was mainly caused by financial reasons:
...the fact that the medications are expensive and a potential financial liability (Physician7).

Others thought that the lack of pharmacists’ support could be related to the pharmacy’s infrastructure, or that had to do with a pharmacist’s moral judgement. These ideas are illustrated in the following quotes:

There was no private area in the pharmacy for patient consultation (Nurse1).

I have worked in a rural area where the pharmacist would not provide the morning after pill to anyone under 16 and preferred not to provide it at all (Nurse1).

A lack of support from local hospitals and community health services for GPs and PHCNs who provide MA services was also identified by the majority (75%, IQR = 0.75) of panellists (Table 7.12, no. 8). This was further defined by one participant as a:

...lack of encouragement but not actual support like theatre time for complications etc (Physician1).

No consensus (74%, IQR = 1) was reached for the statement that there was a lack of specialist and other health professionals’ support available to GPs and PHCNs that provide MA services (Table 7.12, no. 10), and views were diverse. For example, some participants believed there was a lack of support, while others thought there was an already positive shift in support. These differences in beliefs are highlighted in the following quotes:

There is a lack of support for MA across the board. This should be an easily accessible treatment for women. It should be as acceptable as going for a pill script (Nurse1).

The only specialist who would support this in our region is a 1 hour drive away for a patient (Physician6).

It has already started but needs more development and resources - a central nurse led model could facilitate this well (Physician4).
There is a great network of doctors who help other doctors out, but no organised assistance or supervision. It would be great to have a doctor’s hot line (or nurse if they were allowed to prescribe and manage) (Physician7).

Also, there was no agreement (47%, IQR = 1) reached regarding the presence of a well-established collaboration between the AMA and nursing authorities (Table 7.12, no. 9). Some panellists questioned the existence of such a collaboration, as the following quotes show:

Feel the AMA has a negative view of what nurses are capable of (Physician7).

The AMA will object to this and any other proposal that takes any power from the medical profession. The RACGP will object unless it can be seen to benefit GP’s (Nurse1).

Eight statements involved solutions to overcome some of the above-mentioned implementation barriers that relate to support systems for health care professionals. Most (95-100%, IQR = 0.75) panellists agreed that PHCNs need leaders, mentors and networks to support, encourage and empower them in providing MA services (Table 7.13, no. 13 and 16). It was acknowledged (95%, IQR = 0) that it is particularly important for smaller or more remote health care settings to have a dedicated team of MA-trained PHCNs that can support the provision of MA (Table 7.13, no. 15). One panellist recognised that independent management of the PHCN could be problematic in more isolated rural areas. The use of teleconference or the establishment of a local expert team for consultation purposes was suggested:

...supervision could be provided via teleconference should the local physician be unhappy to provide termination services or if there is no local physician (Nurse1).

Links to a ‘team’ or rural network of appropriately trained PHCNs and GPs, may be a practical strategy to assist the management of
prophylactic pain and non-life threatening complications for PHCNs working in more isolated rural areas (Nurse1).

The importance of local MA provision in those areas, however, was emphasised by one panellist:

*Best for local services to be the primary providers, not fly in fly out teams* (Physician1).

Overall, the development of a MA provision model for PHCNs was recognised (100%, IQR = 0.75) as being essential, as such a model can provide guidance, support and help to develop the PHCNs’ roles (Table 7.13, no. 14). This is illustrated in the following quote:

*We all need a strong structure on which to base our practice* (Nurse2).

Further, it was agreed (90%, IQR = 1) that direction is required from the Australian health practitioner regulation agency on the nurses’ scope of practice in MA provision (Table 7.13, no. 9). In addition, most panellists (95-100%, IQR = 0) thought that peak bodies, such as the AMA, the RACGP and nursing authorities, the government and local health professionals (including boards of hospitals and community centres) should show support and an open endorsement of MA provision (Table 7.13, no. 11 and 12). One panellist explained:

*These actions would lead to the demystifying of abortion in general and build community and professional knowledge and awareness. Ultimately these actions would go a long way in reducing stigma and to normalising access to comprehensive, safe abortion services as a legitimate and normal reproductive health service provided by health professionals in a range of mainstream health settings* (Other3).

Finally, in order to tackle the recognised lack of current support from local hospitals and community health services for GPs and PHCNs who provide MA services, all panellists agreed that communication between hospitals, GPs and PHCNs need to be improved (Table 7.13, no. 10).
7.5.2.3 Funding for a nurse-led model of MA provision

Three statements were recognised as model implementation barriers relating to the funding for a nurse-led model of MA provision, and five statements related to overcoming those funding barriers. Although there was no consensus (63% disagreement, IQR = 2) reached for the statement that there is sufficient allowance in the PNIP payment to cover nurse-led MA provision (Table 7.12, no. 16), several panellists expressed their concern regarding the current general practice funding for nurse-led MA provision:

- There will be greater remuneration in nurses providing services related to mental health or chronic disease plans (Physician7).
- Under the current funding model nurses working in general practice will not be allowed to provide MA (Nurse1).
- Unless there are financial incentives for the clinic it is hard to imagine how the service will be implemented (Nurse4).
- Funding will be a real barrier to be overcome (Physician1).
- Most panellists agreed (79%, IQR = 1) about a lack of funding to make nurse-led MA provision profitable (Table 7.12, no. 14). Several comments, however, were made related to the word ‘profitable’:
  - I would feel uncomfortable about seeing such a service as being profitable... surely only costs need to be covered (Nurse2).
  - Would nurses not be salaried? Should MA provision be funded by the public health system and therefore not require a profit motive? (Other1).
- Additionally, most panellists agreed (80%, IQR = 1) that GP involvement is required to enable payment for the MA service (Table 7.12, no. 14). Therefore, it was recognised (90%, IQR = 1) that payment for nurse-led MA provision outside GP practices should be independent of any GP involvement (Table 7.13, no. 20):
  - If nurses are to provide this service in community health and outreach services the funding must not be to the GP (Nurse1).
While most (90%, IQR = 1) panellists thought that an MBS item number should be created for PHCN consultations related to MA provision (Table 7.13, no. 18), it was at the same time emphasised that a woman’s confidentiality needed to be maintained:

*Creating an item number could be a confidentiality concern, perhaps incorporated into another suit of services* (Physician7).

The recommendation to financially support women to facilitate MA access (e.g., for travel and childcare costs) was supported by the majority (84%, IQR = 1) of panellists (Table 7.13, no. 21), although the implementation of this support was questioned, as illustrated by the following quotes:

*This is generous idea and would benefit many women, but I'm not sure about where the funding would come from or who would administer it* (Other1).

*Providing travel costs would have huge cost implications. Better to be aware of where help can be accessed and facilitate this* (Nurse2).

### 7.5.2.4 Accessibility support services

Three statements related to the accessibility of support services as a barrier to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria. Most panellists agreed (95%, IQR = 0.75) about the lack of local allied professionals and accessible services for women (such as radiographers) in regional and rural Victoria (Table 7.12, no. 18). This was explained by one panellist as being attributed to the ongoing stigma associated with abortion provision:

*This [stigma] contributes to fragmented or incomplete information about current abortion providers, local allied professionals and services in rural and regional Victoria* (Other3).

Other access problems that were recognised (80-90%, IQR = 0.75-1) were the lack of after-hours care in small towns for women who go through an MA,
and a lack of local access to surgical back-up in the case of MA complications (Table 7.12, no. 17 and 19). Most hospitals are located in regional centres, which are not always closely situated to some regional and rural areas. One panellist, however, did not see this lack of local services as a particular barrier for MA use:

*Yes there is a lack of services but there is a similar lack when a woman has a spontaneous abortion or a PPH [postpartum haemorrhage] or a placental abruption etc.* (Nurse1).

A total of seven statements were identified as solutions to barriers related to the accessibility of support services. Panellists agreed (85%, IQR = 0.75) that there should be a statement of expectation from the Department of Health that MA should be core business for primary health systems in regional and rural areas (Table 7.13, no. 27). The importance of this statement was stressed by two panellists, and is demonstrated in the following quote:

*Is the absolute key issue in this whole area - not just rural, all public hospitals incl. Catholic ones ... should be providing all legal options that women want and are in their best interests - just like all doctors should* (Physician1).

Further, panellists acknowledged (95%, IQR = 1) that public awareness about the availability of MA can lead to increased public demand, which can act as a driver for improved service provision (Table 7.13, no. 26). There was an overall agreement (95%, IQR = 1) that GP clinics located in areas with limited local health services should offer ultrasound (after appropriate training) and blood test services so women do not need to go somewhere else (Table 7.13, no. 25). Several panellists, however, conveyed their concern regarding ultrasound in general practice. This was expressed the following quote:

*It would be difficult for general practices to buy US [ultrasound] equipment and have degree of training necessary. Might be better placed in a super clinic* (Physician7).

Additionally, it was agreed (95%, IQR = 1), and deemed as ‘very important’ (Physician1) that GP clinics should stock and supply abortion
medication in the absence of a supporting pharmacist, so women do not need to go somewhere else (Table 7.13, no. 28). Some panellists, however, questioned the practicality of this solution, as reflected in the following quotes:

*There’s no current mechanism to do this within drug prescribing legislation in Victoria* (Physician7).

*Stocking of drugs would depend on storage requirements, expiry dates and cost. If supplied like vaccinations on the National Immunisation Schedule where there is no financial risk to the GP it would work* (Nurse1).

The importance of pharmacists’ support was recognised by most (95%, IQR = 0) panellists. They agreed that education programs for pharmacists could increase and improve the availability of MA drugs in local pharmacies (Table 7.13, no. 24).

Overall, there was full consensus (100%, IQR = 1) that in order to improve access to MA support services, best practice service models for MA need to be developed, which include access to radiographers and after-care services (Table 7.13, no. 22). Further, all (100%, IQR = 0) panellists identified that access to quality specialist back-up should be guaranteed when needed (Table 7.13, no. 23).

### 7.5.2.5 Confidentiality, privacy, stigma and safety issues

Nine statements were identified as model implementation barriers relating to confidentiality, privacy, stigma and safety issues. The study findings reflect that sexual and reproductive health is still a highly contentious issue in many rural and regional communities (Doran & Hornibrook 2014; Doran & Hornibrook 2016). Nearly all (90%, IQR = 0.75) panellists agreed that women in regional and rural areas worry about confidentiality and privacy issues (Table 7.12, no. 20). Some panellists elaborated on the lack of privacy in small communities:

*Anonymity is almost impossible, especially in health service settings and pharmacies* (Other3).
Often in smaller communities it is harder to access such services discreetly. Everyone knows everyone’s business (Nurse2).

It is very hard for women to speak out about abortion and there is often less anonymity in a rural community (Physician7).

In contrast, no agreement (74%, IQR = 3) was reached for the statement that the rural population does not complain about poor MA services in their area for privacy reasons and because it is a contentious subject (Table 7.12, no. 24). It was thought that this was caused by a lack of public knowledge regarding barriers to health and other services for people living in rural and regional communities:

There is a lack of community knowledge and understanding about abortion services and MA in general (Other3).

I think the [rural] public are not aware of the option for MA, and I think they expect to have to travel to Melbourne for abortion services. ...I don’t know if they actually think about the equitable availability of it (Other2).

Another issue that can affect physicians and PHCNs in providing MA care and pregnant women in seeking an abortion is the anticipation of abortion stigma from colleagues and family or friends when they learn about it. Most (84%, IQR = 1) panellists agreed that GPs and PHCNs fear negative publicity from members of conservative communities and/or fear of personal vilification if they were to provide MA services (Table 7.12, no. 21). Many added that health professionals worry the most about reactions from within the community:

For most GPs biggest concern is their patients and how they (the provider) would be perceived if they live in the community of their practice (Physician7).

I am aware of one female GP who provides the service but does not advertise it as she is afraid of people targeting her children verbally at school (Nurse1).
...worry more about being known negatively in the community as 'the abortion clinic' (Physician1).

It was also perceived (84%, IQR = 0) that GPs fear moral judgement by other health professionals if they were to provide MA services (Table 7.12, no. 23), although one panellist expressed a different view:

*Overall, abortion stigma and community backlash may be based more on perception than reality* (Other3).

Further, nearly all panellists (90%, IQR = 0) thought that there is pressure on GPs to conform to the conservative views of their colleagues regarding MA provision (Table 7.12, no. 22). This is illustrated in the following quote:

*I heard that [name of town] doctors in the not very distant past, who offered terminations, were then declined admitting rights at the only private hospital (of catholic background) - which was/is career limiting* (Physician4).

Safety and wellbeing of GPs seemed not to be perceived (74%, IQR = 2) as an issue in regard to MA provision (Table 7.12, no. 25). Also, panellists did not agree (68%, IQR = 2) that GPs and PHCNs fear the presence of anti-choice protestors outside the facility if they were to provide MA services (Table 7.12, no. 26). However, it was mentioned that harassment from anti-abortion protesters is still an ongoing problem for health workers and women attending fertility clinics:

*Anti-abortion groups and protesters in [name of town] still negatively impact access to surgical abortion for women living in NE Victoria and have an influence on the readiness of GPs to provide MA* (Other3).

Panellists, therefore, recognised that future MA providers in the primary health care sector should be protected, as the following quote illustrates:

*Safe access legislation in Victoria should reassure GPs and PHCNs interested in providing MA services* (Other3).
Opinions were divided, though, about the role of the Victorian government regarding the discussion and/or promotion of MA provision (Table 7.12, no. 11 and 27). They ranged from a positive to more sceptical views:

*I think the recent Vic governments both labour and liberal have been supportive* (Physician1).

*The government is not nervous it is negligent in its attitude to these services. They cannot even stop pregnancy counselling services from pretending they offer unbiased advice when they are right to life services in disguise* (Nurse1).

Nevertheless, the development of the Victorian Women’s Sexual and Reproductive Health Key Priorities 2017-2020 (Department of Health and Human Services 2017), which includes increasing the access to MA of women in the PHC sector as a key area, was mentioned by multiple panellists as evidence that the Victorian government is prepared to discuss abortion services, including MA. One panellist, though, questioned this development:

*...recent consultation with DHHS suggests that the focus may be on improving access to particular reproductive health services rather than abortion services* (Other3).

There were five statements that related to solutions for confidentiality, privacy, stigma and safety barriers to the implementation of a nurse-led model of care for MA provision. To reduce abortion stigma, it was perceived by all panellists (100%, IQR = 0) that abortion should be seen as being part of comprehensive sexual and reproductive health care (Table 7.13, no. 30). One panellist, however, questioned a compulsory inclusion of MA in sexual and reproductive health care:

*GPs are usually independent small businesses who will determine the range of services they provide and access to these services* (Physician5).

Further, it was agreed (100%, IQR = 0) that there should be support and protection for PHCNs and GPs who wish to offer MA services but are afraid of community backlash, harassment or legal issues (Table 7.13, no. 31).
Additionally, panellists recognised (100%, IQR = 0) that emergency department staff should respond in a non-judgmental way in cases of abortion complications (Table 7.13, no. 29). Although, one panellist expressed that potential judgements made by emergency department staff should not be a concern:

The woman need not declare that the abortion was induced. It could be spontaneous and therefore hospital service should be available if it is located close enough (Other1).

It was agreed (90%, IQR = 0.75) that conscientious objection should be out in the open. The public needs to know if a doctor is a conscientious objector (Table 7.13, no. 32):

If a dr’s objection isn’t known, and a patient books in to see that GP, the patient could then feel even more distress and may even avoid the discussion for fear of further judgement (Nurse6).

One panellist, however, did not agree, stating:

It is not possible, nor is it ethically appropriate, to mandate whether or not a GP has an obligation to make their views on abortion widely known (Physician5).

No agreement (68%, IQR = 2) was reached for the statement that GPs who provide MA should be made visible, for example with a notification that all-option pregnancy counselling is offered at the general practice (Table 7.13, no. 33). Nevertheless, there was a statistically significant difference in agreement ranking between the three panellists’ groups (KW test statistic = 8.217; p = 0.02). Panellists in the ‘other’ group were more likely to agree (39%) with the statement than physicians (8%; p = 0.02). This difference in opinions is illustrated in the following two quotes:

This could be something that happens in the future, but for now would be major disincentive for provision (Physician7).

Women need to be able to know what practice provides MA. ...health professionals let alone women do not know which ones do this (Other4).
7.5.2.6 The importance of evidence validation and policy change

An additional five statements were identified as solutions to overcoming current barriers to the implementation of a nurse-led model of MA provision in regional and rural Victoria. Those statements all related to the importance of evidence validation and policy change.

Overall agreement (90%, IQR = 0.75) was expressed for promotion of nursing research to validate the role of PHCNs and demonstrate effectiveness of nurse-led MA provision (Table 7.13, no. 34). There was, however, a statistically significant difference between the panellists’ group ratings (KW test statistic = 8.378; p = 0.02). Nurses (44%) were more likely to agree with the statement than physicians (22%; p = 0.01). A similar outcome (90%, IQR = 0.75) was found for the statement that expressed to continue to challenge traditional nursing duty ‘norms’ for MA, and ensure a stringent use of evidence and best practice, as scope of practice boundaries are shifted (Table 7.13, no. 35). This statement also showed a statistically significant difference between the panellists’ groups (KW test statistic = 8.378; p = 0.02), with nurses (44%) more likely to agree with the statement than physicians (22%; p = 0.01). A statistically significant difference (KW test statistic = 7.157; p = 0.03) in agreement rating was additionally found between nurses (44%) and physicians (28%; p = 0.02) for the statement that recognised that data collection systems for monitoring and evaluation of nurse-led MA provision should be introduced in regional and rural Victoria (Table 7.13, no. 36). This difference is expressed in the following two quotes:

*Having a quality aspect to data collection, such as that used by VCS [Victorian Cytology Service] for nurse led cervical screening, is vital to ensure a good service* (Nurse2).

*[Data collection systems should be introduced]...for all TOP [termination of pregnancy] services though* (Physician1).

There was, however, some concern that data collection systems on MA can support anti-choice propaganda:
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It’s problematic to collect data on provision of terminations as it can be used by anti-choice protesters to say that there are too many abortions occurring in Victoria or even a specific area. If this data was collected there would need to be strict confidentiality guidelines (Other4).

Consensus (90%, IQR = 1) was additionally obtained on the statement that advocated to make recommendations to parliament and working parties to change legislation to allow a wider scope of practice for PHCNs (Table 7.15, no. 37). Again, there was a statistically significant difference between the ratings of the panellists’ groups (KW test statistic = 7.887; p = 0.02). Nurses (47%) were more likely to agree with the statement than physicians (24%; p = 0.02). Further, most (85%, IQR = 1) panellist identified that legislation change is required to allow prescription of abortion medication by registered nurses in regional and rural Victoria (Table 7.13, no. 38). However, mandatory training as a requirement for prescription right were emphasised:

Access to prescription of abortion medication should be available to PHC & SH nurses [sexual health] with appropriate MA training and professional development (Other3).

Would need to be appropriately trained, not just as part of general registration (Physician7).

This chapter presented the findings of the three-round Delphi study, which led to the construction of three nurse-led models of care for MA provision in regional and rural Victoria and a discussion of the perceived barriers and potential solutions to the implementation of the models. The three models are:

1. A fully autonomous model: PHCNs are fully responsible for all steps involved in the MA process.
2. A legally feasible model: the involvement of GPs is required for specific tasks because of the boundaries of the Abortion Law Reform Act 2008 (Vic) and the MBS requirements (Department of Health 2017b).
3. An absence of a (supportive) GP model: PHCNs initiates pre-testing and referral to a MA provider in settings that lack immediate support of a GP.
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The next chapter draws together and discusses the findings from both the cross-sectional study and the Delphi study in relation to the current literature.
CHAPTER 8
DISCUSSION

A nurse-led model of MA provision in the PHC setting does not currently exist in Australia. Evidence, however, supports that an expansion of the role of appropriately trained PHCNs in the MA provision process can improve access to abortion, especially in areas that lack available providers (WHO 2015b). The fact that women will choose to self-manage abortions via alternative sources when abortion services are not available, should serve as an impetus for allowing nurses greater responsibility in providing MA (Aiken et al. 2018; Kapp et al. 2018).

This study, therefore, aimed to develop a nurse-led model of MA provision in the PHC setting of regional and rural Victoria, where, despite the legalisation of abortion in 2008, access in the rural and regional areas is still limited (de Moel-Mandel & Shelley 2017). The proposed nurse-led models of care for MA provision do not only address the current shortage of MA providers, but may also improve equity in access and an overall acceptability of abortion services (WHO 2015b).

Based on the findings from the Delphi study, three nurse-led models of MA provision were developed, which are displayed and discussed in the following sections. In the first and ideal ‘fully autonomous’ model, PHCNs are independently responsible for all steps involved in the three phases of the MA process. The second nurse-led model of MA provision is the ‘absence of a (MA supportive) GP’ model that can provide guidance to PCHNs that work in settings that lack immediate support of a GP. In this model, PHCNs can assess MA eligibility and initiate pre-testing before the woman is adequately and timely referred to a local MA provider. The third nurse-led model of MA provision is the model that is ‘legally feasible’ in Victoria, taking into account the current boundaries of the Victorian Abortion Law Reform Act 2008, TGA (2012) prescription regulations, and the MBS requirements (Department of Health...
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2017b), which request the involvement of practice GPs in some of the steps of the MA provision process.

The fully autonomous and legally feasible nurse-led model acknowledge and include three consecutive phases of MA care, which take place over several days. The ‘absence of a (MA supportive) GP’ model, however, only involves the first phase of the MA provision process, as the next two phases are delivered by an off-site MA provider. The three phases of MA care are:

1. Assessment of MA eligibility
2. Medication administration and management of side-effects
3. Evaluation of abortion completion and post-abortion care.

Figure 8.1 shows a framework of the phases of the nurse-led MA models.

The high interest for MA provision among the PHCN participants of the cross-sectional study shows that the implementation of a three-phase nurse-led MA model of care in regional and rural Victoria could be feasible, especially since PHCNs in Victoria are allowed to be involved in the prevention and management of unintended pregnancies, which includes MA provision (ANMF 2011; 2014; VLRC 2008). Further, task-sharing roles are already implemented in numerous other PHC areas in Australia, such as type 2 diabetes, hypertension and ischaemic heart disease management, and cervical cancer screening (Eley et al. 2013; Howe 2016).

Drawing on the findings from both studies and within the context of the existing research literature, this chapter discusses the three research questions of the study:

1. What are the current and potential future roles of GPs and PHCNs in regional and rural Victoria in the delivery of medication abortion services?
2. What would a nurse-led model of care for MA provision in regional and rural Victoria look like?
3. What are the anticipated barriers and solutions to the implementation of a nurse-led model of care for MA provision in regional and rural Victoria?
Chapter 8 | Discussion

First, the ideal fully autonomous nurse-led MA provision model is discussed, including current limitations to implementation, followed by the absence of a (MA supportive) GP model. Next, the currently legally feasible model is presented and anticipated barriers and solutions to implementation are addressed. Finally, the study strengths and limitations are identified.
Figure 8.1 Phases of the nurse-led models of care for MA provision
8.1 A FULLY AUTONOMOUS NURSE-LED MODEL OF CARE FOR MA PROVISION

The ideal and most effective model for nurse-led MA provision would be a fully autonomous model, with PHCNs being solely and independently responsible for all steps in the three-phase MA process (see Figure 8.2). All tasks and components of the first phase of this model match the ‘assessment of MA eligibility’ criteria, as described by RCN (2017) and WHO (2015b) guidelines. The PHCN is the first person of contact for women who want to discuss their unplanned pregnancy options, although the option of seeing a GP as the point of first contact would still be available. PHCNs will be appropriately trained to be able to provide non-directive pregnancy counselling, and, when the choice has been made for pregnancy termination, to discuss abortion options, including the pros and cons of an MA procedure. Next, the PHCN independently assesses a woman’s eligibility for an MA, with the tasks involved grounded within their scope of practice (Australian Primary Health Care Nurses Association 2017). Any contra-indications for MA are ruled out by obtaining a medical history, assessing comorbidities and performing a physical examination. When found eligible, the PHCN refers the woman for a blood test and a pelvic ultrasound.

All steps of the second phase of the nurse-led MA provision procedure also match existing guidelines for nurse-led MA provision (Costescu et al. 2016; RCN2017; WHO 2015b) and the PHCNs’ scope of practice (Australian Primary Health Care Nurses Association 2017). When the MA-requesting woman revisits the PHC setting, the qualified and appropriately trained PHCN reviews the pathology and ultrasound results to confirm the woman’s eligibility for the MA procedure. Next, the PHCN prescribes the MA scripts and provides comprehensive information for medication use, the expected procedure, potential side-effects, and the follow-up arrangements. According to RANZCOG (2016) guidelines, the woman also receives prophylactic pain medication and extensive instructions on how to access advice or what to do when complications such as haemorrhages or infections occur. Finally, the PHCN discusses potential post-abortion contraception options.
The third phase of the nurse-led MA provision procedure involves the period after the woman has taken the abortion medication. In this phase, the PHCN manages all non-life-threatening complications, and in the case of more severe complications, organises a referral to a local physician. In addition, the PHCN assesses abortion completion, which includes clinical evaluation and an indication serum hCG determination and/or sonography, and a contraception plan is initiated (RANZCOG 2016). Additionally, if necessary, the PHCN can provide emotional support following the procedure.

All Delphi expert groups agreed that a PHCN can independently manage all steps involved in the MA procedure, except for the management of non-life-threatening MA complications, such as haemorrhages or infections. For nurses, the belief that they are unable to manage non-life-threatening complications could be based on the findings of Halcomb et al. (2014), who described low confidence levels among general practice nurses for some more complicated key activities. For GPs, this belief could be related to a general lack of trust in the skills and capability of practice nurses in regards to abortion provision (Newton et al. 2016a). Moreover, GPs seem to underestimate the scope of practice of practice nurses (The Australian Primary Health Care Nurses Association 2015). All those beliefs, however, are not consistent with the recommendations of WHO (2015b) that recognise post-abortion infection and bleeding to be within the scope of practice of trained PHCNs and midwives. PHCNs should be able to manage questions related to common medication side-effects and any non-life-threatening complications, with the guidance of (newly drafted) protocols, such as the ‘algorithm for phone triage of bleeding with medication abortion’, published by the Reproductive Health Access Project (2014).

The total number of visits to the clinic required for all the steps in the nurse-led model of MA provision can differ. In the Gateway Health model, for instance, at the end of phase two, mifepristone is taken at the pharmacy and misoprostol at home (Tomnay et al. 2018). Another option, endorsed by the RANZCOG (2016), is that mifepristone is taken at the clinic and misoprostol at home. This, however, implies that the woman must return to the clinic after her
visit to the pharmacy, which can be problematic if the pharmacy is not close by. Alternatively, the abortion medication can be picked up at the pharmacy, and both mifepristone and misoprostol are to be taken at home, such as done when using telemedicine services provided by the Tabbot Foundation and Marie Stopes (Hyland, Raymond & Chong 2018).

The follow-up, or third phase of the model, can either be provided at the clinic or via a telephone consultation if women do not wish or are not in the position to return to the clinic. The Gateway Health model offers both these options (Tomnay et al. 2018). It was demonstrated that abortion completion can be safely and effectively assessed at home, using ultrasound and/or serial pregnancy tests combined with a clinical history over the phone (Costescu et al. 2016; Oppegaard et al. 2014).
Figure 8.2 A fully autonomous nurse-led model of care for MA provision

Note: Step 1 and step 11 only need to be provided if required.
While the ‘fully autonomous’ nurse-led model of MA provision has the potential to considerably improve access to abortion services in regional and rural areas, the findings of the cross-sectional study show that PHCNs and GPs have significant different opinions regarding the potential of MA provided by nurse practitioners and registered nurses. GPs were less supportive of this group of health practitioners becoming involved with MA provision. Although this finding can have implications for the implementation of a nurse-led MA model, the Delphi panellists, including GPs, generally agreed that a nurse-led MA model is acceptable and feasible in the PHC setting of regional and rural Victoria. Further, in light of the increasing roles of PHCNs in general practice and because of the time-consuming nature of MA provision, it is to be expected that a nurse-led provision model is more likely to be successful compared to a solo GP model (Tomnay et al. 2018). The Delphi panellists, however, did not reach consensus for the statement to allow all appropriately trained registered nurses to be responsible for the whole MA process without a GP’s approval, with the GP only required for the prescription of the abortion medication. This outcome seems to imply that panellists do not agree with PHCNs taking on independent responsibilities regarding MA provision. However, the fact that panellists agreed that legislation change is required to allow PHCNs’ abortion medication prescription right suggests that panellists actually disagree with the last part of the statement (regarding GPs only being required for the prescription of the abortion medication), therefore indicating to support autonomous provision of MA by PHCNs.

Notwithstanding the overall support for a fully autonomous nurse-led MA model, this model is currently not implementable in Victoria due to three main factors. First, there is no separate remuneration system in place for PHCNs delivering MA-related consultations, and thus, to make the service viable, GP consultations need to be included during the MA process. Second, ultrasound and blood test referrals required for the assessment of MA eligibility, need to be provided by GPs to enable women to receive Medicare rebates. The PNIP, introduced in 2012 (see section 2.7.2), does not appear to incentivise PHCNs to
expands their scope of practice as it does not allow PHCNs to access MBS items that relate to associated activities, such as pathology referrals (Joyce & Piterman 2011; McKenna et al. 2015). The third reason why the fully autonomous model is currently not implementable in Victoria is that abortion medication prescriptions in Australia can only be supplied by physicians (TGA 2012).

Therefore, to be able to implement a three-phase, fully autonomous nurse-led MA provision model, the Delphi participants recommended the introduction of task-specific funding and remuneration, for example, in the form of a Medicare item number for MA provision. Further, the Delphi panellist supported a legislation change to allow prescription of abortion medication by registered nurses in regional and rural Victoria.

8.2 ABSENCE OF A (MA SUPPORTIVE) GP NURSE-LED MODEL OF CARE FOR MA PROVISION IN REGIONAL AND RURAL VICTORIA

In the situation that there are no MA providing or supporting GPs at a clinic, PHCNs can use an alternative model of MA provision. This ‘absence of a (MA supportive) GP’ model (see Figure 8.3) only consists of the first phase of the MA provision process. The specific step of this one-phase model is that before adequate referral, the PHCN autonomously arranges the ultrasound and blood test required for the assessment of the woman’s eligibility for MA. This procedure allows an off-site MA provider, such as a local GP, a private abortion clinic, or a telemedicine service, to immediately continue the MA procedure in phase two. The model, therefore, not only speeds up the MA process in the absence of a (MA supportive) GP but also bypasses any obstructions to referrals, which consequently will not only improve access to MA abortion, but also improve abortion options that are restricted by pregnancy duration (Dawson et al. 2017). While overall consensus was achieved for the statement that lead to the construction of this model, physicians were less likely to agree with the statement than nurses, which could be explained by the previously mentioned belief that doctors want to remain in control over provided services (see section
7.5.2.2). Still, just as in the fully autonomous model, the pathology test referrals for the assessment of MA eligibility require the involvement of GPs to enable women to receive Medicare rebates. This condition, therefore, currently restricts implementation of the ‘absence of a (MA supportive) GP’ nurse-led model in regional and rural Victoria.

Figure 8.3 Absence of a (MA supportive) GP nurse-led model of MA provision
Note: Step 1 only needs to be provided if required

8.3 A LEGALLY FEASIBLE NURSE-LED MODEL OF CARE FOR MA PROVISION IN REGIONAL AND RURAL VICTORIA

Although the fully autonomous model is the preferred model to significantly improve abortion access in the regional and rural areas of Victoria, restrictions in the current health care system signify that this model is currently not a viable option. Given this, the next best approach is a model that can work within the current system. The implementation of a ‘legally feasible’ nurse-led model, however, can still be advantageous, as similar models are successfully
used in most developed countries, such as Sweden, the UK and France. In these so-called full-service models (see section 2.5.1), the physician’s involvement is merely required for prescriptions and consultations (Berer 2009; Kishen & Stedman 2010). All the tasks performed by PHCNs in the legally feasible nurse-led MA model (see Figure 8.4) received a high level of support from the Delphi panel.

Most steps in the legally feasible model are similar to the steps in the fully autonomous model with PHCNs performing (nearly) all of the consecutive tasks in the three-phase process. However, to enable remuneration for the MA consultations, GP supervision or GP consultations are required at certain stages. Pathology referrals (in phase one) and MA scripts (in phase two) need to be provided by GPs to allow women to receive Medicare rebates, and to comply with current legal requirements of the Abortion Law Reform Act 2008 (Vic) and the TGA (2012).
Figure 8.4 A legally feasible nurse-led model of care for MA provision

Note: Step 1 and step 13 only need to be provided if required.
To bypass abortion prescription by GPs, a range of solutions are described in the literature. In one study, for example, trained PHCNs delivered free, safe and effective MA to 554 women visiting referral and family planning centres located in isolated rural communities of Kyrgyzstan (Johnson Jr et al. 2018). Prior to the study, the PHCNs received mifepristone–misoprostol composite packs, pain relief medicines, pregnancy tests and a full range of contraceptives. The nurse-led MA process included pre-abortion counselling, assessment of gestational age (through ultrasounds referrals) and MA eligibility, as well as medication provision and post-abortion contraception discussions. The intervention was effective and reported an extremely successful follow-up (100%), which was ascribed to the fact that the PHCNs were known, respected and trusted members of the local communities (Johnson Jr et al. 2018). A similar system was used in Iowa, US, where the on-site stocking of mifepristone allowed for MA provision with telemedicine in remote clinics without a physician (Wiebe & Grossman 2014). While the Kyrgyzstan model can offer a good solution to avoid the involvement of GPs in the second phase of the model, the storage of low turnover medication can be challenging, due to the costs involved and the strict legislative requirements in Victoria. Requirements, for example, dictate that medication need to be stored in cool and dry lockable facilities and that PHCNs can only administer medication following written or oral instructions of a physician (DHHS 2015b).

A second solution to bypass GP involvement for prescription is by sourcing the abortion medication via the Tabbot Foundation (2017), the telemedicine service that is available since 2015 in five Australian jurisdictions, including Victoria. Although at present the foundation arranges the required ultrasound and blood tests, and organises telephone consultations with experienced medical practitioners, these tasks can potentially, in consultation, also be performed by local PHCNs, which enables an in-person interaction and a continuity of care (Grossman & Grindlay 2017). In this case, the foundation’s remaining process will be to send the abortion medication to the eligible confirmed women, who will receive the package within 24–72 hours, depending
on their location. Such a shared care model with the private sector is encouraged by the Victoria Government’s plan (2017) to improve the sexual and reproductive health of Victorian women. A model like this, however, is complex, and requires extensive discussions with both parties involved. Further, prescription still depends on physicians associated with the Tabbot Foundation, and would potentially increase the costs involved with the total MA process.

A final solution to bypass GP prescription is to introduce a model that allows registered nurses to prescribe abortion medication as a designated prescriber. A similar model has been introduced in 2011 in New Zealand for diabetes nurses, which allowed them to prescribe most diabetes related medicines (NMBA 2017). However, to be able to develop such a model the NMBA needs to develop registration standards that determines educational and practice requirements for the permission of prescription under supervision (NMBA 2017).

8.4 BARRIERS AND SOLUTIONS TO THE IMPLEMENTATION OF A LEGALLY FEASIBLE MODEL IN VICTORIA

Despite the reported support for the steps involved in the legally feasible nurse-led MA process, there are a range of factors that can influence effective implementation of a legally feasible nurse-led MA model in regional and rural Victoria. In the following sections, barriers and potential solutions to model implementation are assessed and addressed along each of the six independent yet interconnected access dimensions of Saurman’s framework: acceptability, awareness, availability, affordability, accessibility and adequacy (see Chapter One, section 1.3) (Gulliford et al. 2002; Saurman 2016). The accessibility and adequacy dimensions, however, are combined and discussed as one due to the overlap in influences found in this study.

8.4.1 The acceptability of nurse-led MA provision

An acceptable service, according to Saurman (2016, p. 37), ‘responds to the attitude of the provider and the consumer regarding characteristics of the
service and social or cultural concerns’. The acceptability of a legally feasible nurse-led MA model in regional and rural Victoria, therefore, not only relies on the attitude and consequential support of all involved key stakeholders on the supply-side of the service, but also on the opinions of regional and rural communities regarding nurse-led MA provision.

Regarding the supply-side, the Delphi panellists recognise that for the successful implementation of a nurse-led MA model unconditional support and approval is first and foremost required from practice GPs, as their involvement remains currently essential. The cross-sectional study findings, however, suggest that GPs consider obstetricians/gynaecologists and GPs as potential MA providers but less so nurse practitioners and registered nurses, and that in general, GPs still prefer to maintain control over services such as MA provision. It is plausible that medical professionals might limit nurse practitioner’s scope of practice because of their perceived traditional and hierarchical view on the relationship between nurses and doctors and because they worry about responsibility and trust (Barton 2006; Jakimowicz, Williams & Stankiewicz 2017; Newton et al. 2016a; Phillips et al. 2009). Australian research (Newton et al. 2016a), on the other hand, has demonstrated that GPs and other health professionals do support advanced nursing roles, including MA provision. The overall study findings, and particularly the fact that only seven (17.9%) GPs of the cross-sectional study indicated to be very familiar with the MA procedure, thus implicate a need for improved awareness and valuation of PHCNs’ scope of practice, as well as for further education on MA, as discussed below. The ‘absence of a (MA supportive) GP’ nurse-led model can bypass the need for a supportive GP and deliver speedy and competent referrals. However, unfortunately, pathology tests ordered by PHCNs to assess MA eligibility are currently not rebated by Medicare to women.

Panellists additionally agreed that for a successful expansion of the PHCN role in MA provision, support and approval is required from other health care professionals who are directly or indirectly involved with all steps of the nurse-led MA provision process. They include practice reception staff members,
involved with the appointments for the different phases of the nurse-led MA model, local ultrasonographers required for the pregnancy-dating ultrasounds, local accredited pharmacists for the dispensing of the abortion medication, and emergency department staff of local hospitals for the treatment of potential MA complications. These professionals should deliver their service in a dignified way, respecting the woman’s privacy and her needs (WHO 2012).

The findings also show that support and approval is required from the key stakeholders who are directly or indirectly involved with the MA procedure, such as local hospitals, to assist women in the case of complications and community health settings involved with nurse-led MA provision outside general practice. The importance of collaborative support and partnerships is identified in the national and international literature, while a lack of this support was found to be one of the main reasons for MA trained physicians in the US for not taking up abortion provision (Dawson et al. 2016; Freedman et al. 2010; Newton et al. 2016a; Sorhaindo & Morris 2016).

Similarly, support and endorsement of the implementation of a nurse-led MA model is required from educational and professional peak bodies, such as the AMA, the RACGP and nursing authorities. The Delphi panellists, however, recognised a different outlook of AMA on the involvement of PHCNs in the MA process. Their point of view was demonstrated in AMA’s General Practice Nurse Position Statement (2015), which, among other things, indicated that a general practice nurse’s role should not include the making of diagnoses, specialist referrals, independent ordering of pathology, or the prescription of medication. The declaration caused a strong reaction from APNA’s policy adviser Simon Howe (2015), who expressed his strong disagreement with AMA’s view around PHCNs’ scope of practice.

Finally, support is required from the Department of Health, who, according to the study findings, should declare MA provision, being part of sexual and reproductive health services, to be a core business for primary health systems in regional and rural areas. This would improve the acceptability of MA, including MA provided by PHCNs.
The acceptability of a legally feasible nurse-led MA model in regional and rural Victoria also heavily relies on the attitude and opinions of regional and rural communities. The current study found that issues of confidentiality and privacy in relation to nurse-led MA provision were perceived to be a well-recognised concern for women in regional and rural areas. An advantage of MA provision in the PHC setting over provision in private clinics is, that privacy and confidentiality can be more easily maintained as women visiting a general practice for a MA cannot be distinguished from other patients seeking medical care (Tomnay et al. 2018). This benefit can positively influence women’s acceptance of MA service provision in PHC settings. The value of nurse-led MA provision at community level has been demonstrated in a study by Johnson Jr et al. (2018) who reported that women’s trust in locally known and respected PHCNs resulted in a 100 percent follow-up rate after MA provision.

Similar to previous research (Dawson et al. 2017; Freedman et al. 2010; Martin et al. 2014), this study suggests that GPs and PHCNs anticipate negative publicity and reactions from conservative members of the community if they were to provide abortion services. Further, they fear being morally judged by other health professionals and are therefore easily pressured to conform to their colleagues’ conservative views regarding MA provision. Taken together, these findings suggest that community-level abortion stigma, as well as practice restrictions imposed by ideologically opposed colleagues, do influence health workers in their decision to provide abortion care, especially in rural and regional communities where sexual and reproductive health, including abortion, is still a highly contentious topic (Doran & Hornibrook 2016).

One solution to improve the acceptability of a nurse-led MA model is to reduce abortion stigma. The panellists unanimously agreed that abortion should be seen as a standard component of comprehensive sexual and reproductive health care in order to build community and professional knowledge and awareness. This viewpoint highlights the importance of education on abortion as a primary target for change, emphasising facts relating to the safety, the commonality and frequency of the procedure in Australia and in the rest of the
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world (Levandowski et al. 2012). While it is not likely that negative beliefs and standpoints around abortion will ever disappear, increased knowledge and experience have shown to decrease negative attitudes towards abortion (Lipp 2011). Similar anti-stigma approaches for other health issues, such as mental illness and HIV/AIDS, have shown positive results (Corrigan et al. 2012).

The cross-sectional and Delphi study findings both indicate that GPs and PHCNs are not concerned about safety, wellbeing or harassment factors if they were to provide MA services. These findings are congruent with the observation of Sifris (2013), who stated that overall harassment experience in Australia has been moderate. Although pro-life activity outside abortion clinics is still an ongoing problem in most parts of Australia, which requires, according to the panellists, support and protection for MA providers, this is less of an issue in Victoria, where a safe access zone legislation was introduced in 2015 (*Public Health and Wellbeing Amendment (Safe Access) Bill 2015 (Vic)*). Further, it is to be expected that providers will experience less harassment in the PHC setting where they are less likely to be identified. Indeed, Tomnay et al. (2018) do not mention any form of experienced harassment in their study regarding the nurse-led MA service provided in the Gateway Health clinic.

**8.4.2 The awareness of effective nurse-led MA provision and legal regulations**

Saurman (2016) outlined that a service retains awareness through effective communication and information provision among users and providers involved. To be able to successfully implement a nurse-led MA provision model, awareness among health professionals and the public of this safe, legal and effective alternative to surgical abortions is required. Retaining awareness is especially important in rural and remote communities, as they are often affected by a high mobility of the population and low stability rates of health practitioners (Saurman 2016). Low levels of awareness and familiarity with the MA procedure were identified among the participants of the cross-sectional study, despite their overall positive attitude to abortion and extensive practice experience with
women with unplanned pregnancies. This finding is in line with previous studies. Ganatra, Guest and Berer’s (2015), for instance, reported a worldwide lack of accurate knowledge of MA regimes and process management, even in locations where MA is legalised and among current MA providers. Similarly, only a few GP and PHCN participants of the cross-sectional study indicated that they were currently directly, or via their practice, involved in MA provision. The lack of MA knowledge and provision among this sample of predominantly pro-abortion GPs and PHCNs suggests a need for improved education on abortion practices, especially since it can be anticipated that participating GPs and PHCNs will be more knowledgeable with MA because of their interest in the topic, than their colleagues in the rest of regional and rural Victoria.

The identified uncertainty among the cross-sectional study participants regarding the legal restrictions involved with the provision of MA in Victoria needs to be addressed to improve MA awareness. This finding, however, is not very surprising, considering that the law that regulates abortion practice in Australia, and which originated from the English ‘Offences against the Person Act 1861’, has been amended over the years in a different way in every state and territory, resulting in a complex mix of inconsistent and unclear abortion laws (de Costa et al. 2015; de Moel-Mandel & Shelley 2017). Victoria is currently one of only three jurisdictions, together with the Australian Capital Territory and Tasmania, where abortion has been decriminalised (de Moel-Mandel & Shelley 2017). These legal inconsistencies and the threat of significant ramifications for being involved in a practice that is still considered a criminal act in the rest of Australia, may influence those considering providing MA services. Improving awareness and knowledge of MA provision via the medical curricula of medical and nurse students can potentially facilitate future MA uptake, specifically among PHCNs, which will increase nurse-led MA provision (Akin et al. 2012; Dawson et al. 2017; Myran et al. 2015).

A growing body of knowledge on nurse-led MA provision will improve overall awareness of the model and improve implementation. The Delphi panellists agreed upon the importance of evidence validation and the use of a
data collection system to monitor and evaluate nurse-led MA provision. Further, they acknowledged that nursing research needs to be encouraged to validate the role of PHCNs and to evaluate the effectiveness of nurse-led MA provision. Nurses, however, were more likely to recognise the importance of further research than physicians, which hypothetically could be related to the fact that these research projects will mainly focus on nurses. This finding thus implies that evidence-based practice research needs to be initiated by nurses. Studies about the evolving roles of PHCNs in Australian general practice have already been conducted for a range of other nurse-led roles, as discussed in Section 8.1, and findings demonstrate that increased roles of PHCNs show possible benefits for PHCNs, GPs and patients (Abbott et al. 2013; Lorch et al. 2015; Phillips et al. 2009). The evaluation report of the Victorian Cervical Cytology Registry for nurse-led cervical screening can serve as a good example for evidence validation, showing numbers of cervical screening tests performed by nurses, as well as the health setting and location of where the Pap smear was collected (Ang & McAllen 2016). By monitoring MA providing PHCNs, an ongoing quality and professional accountability can be guaranteed.

Overall, the Delphi findings suggest that public awareness about MA provision can lead to increased public demand, which can act as a driver for improved service provision, specifically in the form of a nurse-led MA provision. Further, raising awareness of MA service provision and related regulations among health care professionals may remove MA uptake barriers, increase the number of MA providers, and improve the potential of a nurse-led MA provision service. The importance of awareness and knowledge of MA among health professionals is also recognised in the Victorian Government’s strategy (2017) to improve the sexual and reproductive health of all Victorian women. To increase access, the strategy specifically encourages innovative PHC models of MA provision in the regional and rural areas of Victoria.
8.4.3 The availability of nurse-led MA provision services and providers

An available service is defined as having ‘adequate services and resources to meet the volume and needs of the consumers and communities served’ (Saurman 2016, p. 37). The availability of nurse-led MA provision in regional and rural Victoria thus mainly depends on the success of implementation of the model, which relates to the willingness of GPs and PHCNs to take up the service. In the cross-sectional study, nearly half (46.7%) of the GPs and three-quarters of the PHCNs (76.9%) expressed their interest in MA training. The high interest of PHCNs in receiving MA training reflects the increasing development of nurses’ roles in general practice, stimulated by the growing burden of chronic disease management and preventative health services (Ehrlich, Kendall & John 2013; Halcomb et al. 2008b; Halcomb et al. 2014; McKenna et al. 2015). Participants not interested in providing MA indicated a range of reasons for their decision, which were classified as reasons for never wanting to provide or assist with MA. In addition, most participants who were interested in MA training also anticipated a range of barriers to MA uptake, which may directly hinder the implementation of a nurse-led model of MA provision in regional and rural Victoria. These barriers were classified as reasons for not considering to provide or assist with MA, even though willing.

To increase the availability of nurse-led MA provision models, interventions that improve MA uptake by clinicians need to target those barriers that are typical for the clinician’s particular stage of readiness to consider the service (Seelig et al. 2006). Seelig et al. (2006) relate this recommendation to Prochaska’s transtheoretical model of change, which emerged from the analysis of principal theories of psychotherapy and behaviour change (Prochaska, Redding & Evers 2008). The model hypothesises that in order to achieve a successful behavioural change in people, the change needs to be considered as a process that unfolds through a series of stages, each requiring a specific intervention program (Prochaska, Redding & Evers 2008) (see Figure 8.5). This section only discusses the first two stages of Prochaska’s transtheoretical model,
as the remainder stages relate to the implementation and maintenance of the nurse-led MA model, which are outside the scope of the current study.

In the earliest stage of Prochaska’s transtheoretical model, called the pre-contemplation stage, individuals do not have the intention to change their behaviour, most often because they are under-informed and/or unmotivated (Prochaska, Redding & Evers 2008). It was postulated that the participants in the cross-sectional study who indicated never wanting to be involved with MA were situated in this pre-contemplation stage of change. Most of the study participants provided reasons for never wanting to provide or assist with MA indeed involved overall concerns, such as the need for surgical back-up in case of complications, the existence of too many legal restrictions or the lack of support from colleagues, and were not related to religious, moral or ethical beliefs. These findings are in accordance with the findings reported in the qualitative Australian study by Dawson et al. (2017). Seelig et al. (2006), therefore, suggest to stimulate the interest of those pre-contemplating providing MA in such a way that they will move to the next, contemplating stage. They advise focusing interventions on the benefits and feasibility of MA provision via conference presentations and media articles, rather than highlighting specific concerns.

Action-oriented interventions, however, can influence those clinicians that have progressed to the contemplation stage, the next stage of Prochaska’s transtheoretical model (Prochaska, Redding & Evers 2008). This stage relates to the cross-sectional study participants who provided reasons for not considering taking up MA provision, even though they were willing. Although those clinicians are actively contemplating becoming an MA provider, their final decision is still hindered by a range of concerns about training, stigma, and the professional and administrative practicalities that are associated with abortion care. These findings are in line with research from the US (Hwang et al. 2005; Whaley & Betstadt 2016) and Australia (Dawson et al. 2017), and have been shown to be the main reason for the shortage of abortion providers in settings where abortion is legal. The MA uptake barrier most frequently indicated by the PHCNs was the lack of MA training opportunities, and this finding was also discovered in
the Delphi study. Some PHCNs related this lack of training to Marie Stopes’ online MA training module, which is currently only available to prescribing physicians (MS Health 2017). There are a range of training programs and guidelines available for medical practitioners, including GPs (RACGP 2005; 2016, 2017; 2017). However, only the Centre of Excellence in Rural Sexual Health (CERSH), in collaboration with the University of Melbourne (Stephens 2018), periodically provides training and support sessions in MA provision that are suitable for GPs as well as PHCNs. Training, though, is critical as it has been shown that health providers who receive educational as well as clinical experience with abortion care are more likely to accept abortion provision within their scope of practice (Jackson 2011). Further, training builds confidence and prepares health professionals for new roles (WHO 2015b). The Delphi study findings suggest that all sexual and reproductive health courses for PHCNs (and GPs) should include an MA provision component and that these programs need to be promoted and provided via the Victorian Government in partnership with primary health care networks. This strategy can potentially improve PHCN uptake of MA provision and facilitate nurse-led MA provision model implementation in regional and rural Victoria. Additionally, PHCNs seem to worry more than GPs about the need for surgical back-up in the case of complications and the absence of local ultrasound facilities. This finding suggests that PHCNs are potentially less informed about the availability of local support services, which implies that this group of health practitioners particularly needs to be provided with information to ameliorate their apprehensions.
8.4.4 Affordability of the nurse-led MA model

Affordable services relate to the costs involved for the service provider as well as for the user (Saurman 2016). The study findings indicate that full integration of PHCNs in the MA process is hindered by a shortage of funding to make a nurse-led model successful, as there is no remuneration system in place for PHCNs delivering MA related consultations. Further, GPs in Australia receive most of their income on a fee-for-service basis through third party insurers such as Medicare (RACGP 2015). There is no specific Medicare item number for MA provision and, therefore, many MA providing GPs charge an out-of-pocket fee on top of the Medicare rebate to make the service viable (Children by Choice 2017). A mixture of two to three long and short consultations, sometimes combined with MBS item 4001 (GP-provided pregnancy support counselling) results in patients’ costs that range from $350 to $580 AUD upfront and after (partial) Medicare rebate from $200-300 AUD (Children by Choice 2018a). These amounts exclude the necessary pathology and ultrasound tests, which can sometimes be
bulk-billed, and the cost of the abortion medication, which varies from $12 to $50 AUD depending on Health Care Card availability.

To facilitate MA access, the study findings additionally indicate that financial support for abortion requesting women is required. This support relates not only to the in general high cost of MA provision, but also to the additional expenditures often required for travel, accommodation and childcare (Nickson, Smith & Shelley 2006). The cost of an MA provided in the PHC sector, while still high, is more affordable than when early MA is provided in the private sector, such as at Marie Stopes clinics where women pay approximately $440 AUD (after Medicare) for an early MA (Marie Stopes International Australia 2018). In contrast, when the MA service is delivered through the public system, such as at Gateway Health clinics, all appointments are bulk-billed and women only pay for the medication (Gateway Health 2018a; Tomnay et al. 2018). In these settings, the sexual health nurse employed by the clinic is funded by the Government (Tomnay et al. 2018).

8.4.5 The accessibility and adequacy of support services

The final factors that need to be addressed to make the nurse-led MA model successful relate to the accessibility and adequacy dimensions of Saurman’s framework (Saurman 2016). Locally accessible and adequate, well-organised MA services are essential for the improvement of abortion access in regional and rural areas. Of particular importance for the establishment of these services is the presence of local allied health professionals and diagnostic facilities, which are essential for the assessment of MA eligibility, the first phase of the nurse-led MA model. The study findings, however, suggest a lack of these support systems in rural and remote Victoria. These findings confirm previously reported socio-economic and geographic inequities in access to health services.

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5 Bulk billing is a payment option under the Medicare health insurance system of Australia, in which a medical service provider can bill Medicare directly for a range of health services listed in the MBS, and the patient does not pay any fees.

6 A Health Care Card is a concession card which enables eligible persons to get cheaper prescription medicines under the PBS.
which can cause lower health outcomes for Australian residents in rural and remote communities compared to people living in metropolitan areas (Humphreys 2009; Thomas, Wakeman & Humphreys 2015). A lack of local ultrasound access, for instance, was one of the main reasons indicated by cross-sectional study participants for not wanting to be involved with MA provision. An ultrasound examination before the termination of a pregnancy is currently mandated by the RANZCOG (2016) for pregnancy dating, to ascertain the appropriate dose and regimen of the abortion medications, and to exclude ectopic pregnancies or uterine abnormalities. Ultrasounds, however, are expensive and their requirement limit the locations where abortions can be offered (RCOG 2011). Further, it has been recognised that most women know with certainty the date of their last menstrual period and/or the date of conception (RCOG 2011). The mandatory use of ultrasound dating is, therefore, often questioned in the literature, and ultrasound outcomes have been compared with those of solely clinical assessments, such as the woman’s last menstrual date and/or a pelvic examination. A study by Schonberg et al. (2014), and a systematic review by Kulier and Kapp (2011), for instance, found that for MA before 63 days’ gestation, the use of clinical methods was as safe, efficient and accurate as using ultrasounds. Currently, guidelines from the UK (RCOG 2011), Canada (Costescu et al. 2016), the American College of Obstetricians and Gynecologists (Creinin & Grossman 2014) and WHO (2012) all state that routine pre-abortion ultrasounds are unnecessary. In France, for example, ultrasounds are presently only employed in 30 percent of induced abortion procedures (Costescu et al. 2016).

While the study findings recommend that, to address the lack of local ultrasound access, GP clinics should offer this service after appropriate training, the evidence highlights the fact that an ultrasound is arguably not required for pregnancy dating. The current lack of ultrasounds in regional and remote settings should, therefore, in theory, not limit MA provision, unless there is a discrepancy between the date of the last menstrual period and the size of the
uterus or in the case of symptoms that suggest an ectopic pregnancy (RCOG 2011).

Another factor that was recognised in this study as being important to the implementation of a nurse-led MA model is the access to local and supportive pharmacists. To improve the collaboration of pharmacists with general practices in MA provision services, it was advised to increase the knowledge of pharmacists with the help of education programs. Additionally, the study findings recommend that in the absence of cooperating pharmacists, GP clinics should stock and supply abortion medication (see also section 8.4). While under the National Health Act 1953 (s. 92), a GP can obtain permission to supply PBS subsidised pharmaceuticals in areas without convenient access to an official pharmacy, this solution is unfortunately not currently possible in areas where pharmacists are present but non-supportive (Department of Human Services 2017a). A collaboration with local pharmacists can also lead, as suggested by Children by Choice (2017), to arrangements, that enable women to take the medication, in private and under observation, at the pharmacy. This practice, implemented by Gateway Health, makes the process of drug prescription and the subsequent intake of the medication easier and less time-consuming for women (Tomnay et al. 2018).

Locally accessible support services are also required during the third phase of the nurse-led MA model, specifically in regards to the management of non-life threatening complications in regional and rural areas. The cross-sectional study participants expressed their concern regarding the lack of a 24-hour contact advice service in case of complications. It should be noted, however, that this concern is unfounded, as women obtaining abortion medication are provided with the MS-2 Step Consumer Medicines Information instruction insert (MS Health 2014), a requirement of the TGA (2014). This insert contains the number of the MS Health Nurse After-Care Telephone Service, which can be contacted for questions on a 24-hour basis. The effectiveness and safety of such a contact number has been demonstrated by the evaluation study (Belton 2017) of a similar 24-hour telephone service, delivered by the Tabbot
Foundation (2018), an organisation that provides telemedicine MA services to women residing in most parts of Australia.

The study findings additionally revealed concerns regarding insufficient access to after-hours care and surgical back-up in the case of complications for women who go through an MA in small towns. These concerns, however, can be refuted by a study from Ireland (Aiken et al. 2017) that evaluated self-management with self-administration of abortion medication, obtained through the online telemedicine service of Women on Web (2017). It was concluded that concerned women were able to successfully self-screen potentially serious complications, and to seek, after advice over the telephone, medical assistance at the nearest hospital. Surgical intervention after the MA procedure was required in 4.5% of the cases, which is equivalent to the percentage found in clinical settings, but lower than comparable complications reported during childbirth in the UK, or complications associated with spontaneous terminations outside the medical system, in which case women need to cope with the shock of the unexpected bleeding, cramping and expulsion as well (Aiken et al. 2017; Kapp et al. 2017; Ngo et al. 2011). A study from Norway (Lokeland et al. 2014) reported a similar percentage of women (4.9%) in need of a surgical intervention after taking mifepristone in a clinic and then self-administering misoprostol at home. This study (2014) additionally reported that nearly all complications occurred more than 24 hours after misoprostol administration, but that travel distance did not influence treatment outcome. This conclusion contradicts the requirements of the RANZCOG (2016) and the Tabbot Foundation (2018), who indicate that MA should not be performed in isolated settings with driving times of more than two hours from emergency care. Overall, restrictions on travel distance to emergency clinics seem to be of minor importance in preventing adverse events, as they are comparable to the distance women need to travel for a delivery, which is in fact a less safe procedure than an MA. Lokeland et al. (2014) concluded that MA should be offered to all women irrespective of where they live. Overall, concerns regarding the management of MA complications in the third phase of the model are unfounded, as systems are in place to support
women who experience MA complications regardless of who provides the MA or where the women live.

While the study findings suggest that the developed legally feasible model could be implemented in rural and regional Victoria, with the potential barriers addressed, the findings must be interpreted within the context of the strengths and limitations of the study.

8.5 STUDY STRENGTHS AND LIMITATIONS

This section discusses the study’s strengths and limitations, and how they can affect the interpretation of the findings. A key strength of the cross-sectional study is the multiple sampling methods used to obtain large enough sample sizes for the two target populations. The characteristics of the GP sample are comparable with data from the regional and rural GP workforce of Victoria in terms of gender, mean age and employment status (full-time) (RWAV 2016). The over-representation of Australian-trained GPs is most likely related to the study’s contentious topic, which mainly attracted health care providers with a strong positive stance on abortion (80% of participants approved of abortions in all circumstances), reflecting the overall acceptance of abortion among the wider Australian-born population (RWAV 2016). The religious backgrounds of the 50 percent of overseas-trained doctors in the current regional and rural GP workforce of Victoria, could possibly explain their reluctance to participate in this study. As Jelen (2009, pp. 223-4) noted:

*Given the relationship of the abortion issue to ultimate concerns of human life, and to questions of sexual morality, it is not surprising that much opposition to legal abortion has had a religious basis.*

The PHCN sample was also broadly similar to the known characteristics of the Australian practice nurse in regards to gender and age (Australian Medicare Local Alliance 2012). Overall, the participants seem to be a reasonable representation of GPs and PHCNs working in regional and rural Victoria, and the...
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study's findings may, therefore, be transferable to the general population of GPs and PHCNs in this setting.

A key strength of the Delphi study was the selection of the panellists. The literature about the criteria for selection of a Delphi panel, however, is undecided, which is unfortunate as this selection relates directly to the quality of the study's outcome (Hsu & Sandford 2007). Who can be assessed to be an expert, as knowledge does not equal expertise, and experience does not equal knowledge or being an expert (Keeney, Hasson & McKenna 2011)? Without the existence of proper guidelines, it has been suggested that Delphi panellists should represent the whole range of stakeholders who not only need to have knowledge and experience with the specific topic, but also the ability, willingness and time to participate, and all of this combined with valuable communication skills (Adler & Ziglio 1996; Boulkedid et al. 2011; Hasson, Keeney & McKenna 2000; Hsu & Sandford 2007). With these suggestions in mind, considerable effort was undertaken for the selection of the Delphi experts in this study, however, it cannot be assumed that the final panellists were a good representation of all key professionals involved in women’s sexual and reproductive health issues and were well-positioned to advocate for women’s rights.

Another strength was the Delphi’s sample size, which fit well within the commonly acceptable range (Day & Bobeva 2005; Hsu & Sandford 2007). Moreover, the study’s 17 percent overall attrition rate over the three rounds is relatively low compared to similar e-Delphi studies, which showed rates between 23 and 28 percent (Gephart et al. 2013; Haines & Critchley 2009; Hewitt & Cappiello 2015; Thomas, Wakeman & Humphreys 2014). This low attrition rate, as well as the extensive and perceptive comments provided by the panellists, indicate an ongoing commitment of the panellists to the study’s topic. Although the anonymous nature of the study allowed panellists to express their views about the topic without any restrictions, peer pressure or influence from expert dominance, anonymity can also potentially lead to nondisclosure or limit exploratory thinking (Hsu & Sandford 2007; Keeney, Hasson & McKenna 2011). Further, as most panel members of an expert group often know each other, the
arising ‘quasi-anonymity’ could make panellists feel pressured to conform, resulting in either adapting or abandoning the process, both influencing the outcomes (Hsu & Sandford 2007; Keeney, Hasson & McKenna 2011). There seemed, however, to be no evidence of both phenomena in this study.

The response rates to the cross-sectional questionnaires, however, were low. Of the 309 regional and rural GPs invited to participate in the study, 34 GPs were recruited from the selected sample (11%). An additional five GPs were recruited via snowball sampling. These results are not unexpected, first of all, because GP recruitment for online questionnaires has shown to be challenging, and GP response rates are generally much lower than those of the general population (Bonevski et al. 2011; McKinn et al. 2015; Pit et al. 2007). A multitude of Australian studies reported GP response rates that ranged from <0.1% to 8.7% (Aitken, Power & Dwyer 2008; Crouch, Robinson & Pitts 2011; Parkinson et al. 2014), and even the yearly Australian benchmark study of GP activity generally obtains response rates under 30 percent (Bonevski et al. 2012; Britt et al. 2015; Britt et al. 2014). Second, response rates could have been influenced by the contentious subject of the questionnaire. The relationship between sensitive topics and non-response has previously been raised as an issue in other research, and seems to be linked to the respondent’s concerns that confidentiality will not be maintained (Booth-Kewley, Larson & Miyoshi 2007; De Schrijver 2012; Kays, Gathercoal & Buhrow 2012). Sensitive topic questionnaires, therefore, tend to have higher non-response rates than questionnaires that relate to less-sensitive topics (Tourangeau & Yan 2007). Overall, however, it can be determined that, despite the contentious subject, the GP return rate of the questionnaire in this study was slightly higher than rates achieved in similar studies. Response rate determination was, however, not possible for the PHCNs, due to the absence of a national database and sampling frame, although the sample size of 30 participants was low compared to sample sizes in two similar studies, which ranged from 104 (Australia-wide) to 160 (New South Wales) (Joyce & Piterman 2011; Merrick et al. 2012). While the cross-sectional study
samples seemed to be representative of the target population, the opinions of the participants may differ from the opinions of non-respondents.

With the absence of an existing instrument, the GP and PHCN questionnaires were partly modelled on ones used in previous studies, with the remaining items developed for the purpose of this study. To improve the reliability and validity of these non-validated instruments, a pre-test and pilot test were conducted prior to data collection (Rattray 2007). Pre-tests and pilot tests were also conducted on the Delphi questionnaires. These procedures helped to identify content ambiguities and technical problems, improved content validity, and allowed for an optimisation of the quality and achievability of the Delphi process (Shariff 2015).

A study strength was using online data collection methods. Online data collection has shown to result in more legible responses, an ease of use of data entry and processing, a fast delivery and response time, and a reduction in overall costs (Snyder-Halpern, Thompson & Schaffer 2000). Further, online questionnaires can be accessed at participants’ most convenient place and time (Donohoe, Stellefson & Tennant 2012). Other advantages are that response rates for sensitive topic questionnaires tend to be higher if conducted online rather than by other methods, that participants demonstrate less inhibition in answering questions, and that the questions tend to cause less social desirability bias (Kays, Gathercoal & Buhrow 2012; Tourangeau & Yan 2007). While online data collection has many advantages, its use can potentially limit study participation for panellists residing in rural areas. Despite the rapid developments and popularisation of the internet, internet access outside metropolitan areas in Australia can still be very poor and unreliable (AMA 2017). It is, however, unlikely that these limitations have impacted this study as it can be expected that health services in regional and rural Victoria generally have good and reliable internet.

Even though the researcher was solely responsible for undertaking the qualitative analysis of the seven open-ended questions of Round One, the ongoing discussions about the analysis of the identified themes with researcher’s
supervisors enhanced the reliability of the coding process (Alhojailan 2012). Discussions around the external and internal validity of Delphi studies and the influence of bias are, however, ongoing (Hasson & Keeney 2011; Keeney, Hasson & McKenna 2011). Similarly, the reliability of the Delphi method remains questionable, as there is no proof that similar results can be obtained if the same information was given to a different panel (Hasson, Keeney & McKenna 2000). However, all steps were taken to ensure the results were as reliable and valid as possible given the Delphi limitations.

Overall, the use of a large heterogeneous group of knowledgeable and interested panellists, during multiple Delphi rounds with good response rates, as well as the comparison of findings with a second methodological technique (the cross-sectional study) and related published evidence, increased the study’s methodological rigour and supported the overall findings of the study for the development of a nurse-led model of MA provision in the PHC setting of regional and rural Victoria (Efstathiou, Ameen & Coll 2008; Hasson & Keeney 2011; Hasson, Keeney & McKenna 2000). Whether response bias had an influence on the study outcomes is unclear: although the respondents’ general positive attitude towards abortion may systematically differ from non-respondents, the absence of information about the overall Victorian GPs’ and PHCNs’ stance towards abortion does not allow for comparison between the two groups. Finally, as this study was conducted in regional and rural Victoria, legal and geographical differences between jurisdictions do not make the findings generalisable to the rest of Australia.

The next, concluding chapter of this thesis will address the implications of this study for practice, policy and future research.
A nurse-led model of MA provision is a viable option to expanding abortion access in rural and regional Victoria. Although a number of barriers to implementation were identified, including stigma, lack of MA training, and a lack of support systems, it is possibly to overcome these barriers within the constraints of the health service system. While currently used approaches of MA provision, such as the Gateway model (Hulme-Chambers et al. 2018) and the use of telemedicine for MA provision (Belton 2017), have many benefits, this study proposes more comprehensive nurse-led MA provision models that allow the delivery of MA at a more personal level and close to where women live. Access to safe abortion is considered a fundamental reproductive right for women, and the developed nurse-led MA models have the potential to increase access to equitable, affordable, safe and confidential abortion services for women residing in underserved communities (CRR 2004; 2013; United Nations 1994).

The extensive and rich data provided by the participants of this study, informed by the prevailing literature, resulted in the development of three nurse-led models of care for MA provision: a fully autonomous nurse-led model; a legally feasible nurse-led model; and an absence of a (MA supportive) GP nurse-led model, which allows PHCNs to initiate pre-testing before referral. The fully autonomous and the legally feasible nurse-led model consist of three phases: 1) assessment of MA eligibility; 2) medication administration and management of side-effects; and 3) post-abortion care. The absence of a (MA supportive) GP nurse-led model only consists of the first phase of the MA provision process, as the next two phases are delivered by an off-site MA provider.

The extent of the PHCN involvement in the delivery of the MA services in the PHC setting of Victoria is currently limited by legal restrictions that do not allow PHCNs to prescribe abortion medication, by MBS restrictions, which require GP involvement for pathology referrals to enable Medicare rebates, and
by the lack of PHCN remuneration for MA-related consultations (Abortion Law Reform Act 2008 (Vic); Department of Health 2017b). These limitations imply that the preferred fully autonomous nurse-led model and the absence of a (MA supportive) GP nurse-led model are not yet achievable in Victoria. Nonetheless, implementation of a legally feasible model also has the potential to increase abortion access in regional and rural Victoria.

This study reports a high level of interest among GPs and PHCNs in receiving MA training, however, it suggests that a lack of training opportunities and local support services are deterrents to MA provision uptake, as well as stigma and the uncertainty about the legality of abortion, although harassment is not. Due to the increasing roles of PHCNs in general practice and because MA provision is a time-consuming process, nurse-led MA provision is more likely to be successful than solo GP provision (Tomnay et al. 2018). While a legally feasible nurse-led MA model is acceptable in the PHC setting of regional and rural Victoria, the study findings show a range of barriers that can hinder model implementation.

In this final chapter, implications for practice and policy are outlined to overcome recognised model implementation barriers, and recommendations are made to address them. The implications for practice relate to the lack of: support for nurse-led MA provision; MA awareness and knowledge; MA training options; and MA-related health services. The implications for policy relate to the federal MBS and policy restrictions. In addition, recommendations for future research are listed.

### 9.1 IMPLICATIONS AND RECOMMENDATIONS FOR PRACTICE AND POLICY

Although all the different components of the legally feasible nurse-led MA model fall within the scope of practice of most PHCNs, the following implications and recommendations for practice need to be considered. All
practice and policy implications and recommendations relate to the six access dimensions of Saurman’s (2016) framework.

For the implementation of a nurse-led model of MA provision, unconditional support and endorsement is required from practice GPs, other local health professionals, community health services, local public hospitals, professional organisations and government (Saurman’s acceptability dimension). The findings of this study, however, indicate a perceived lack of support and endorsement for nurse-led MA provision, in particular from GPs who often seem to hold a traditional view on the PHCNs’ scope of practice. The overall acknowledged unfamiliarity with the potential roles of PHCNs in general practice demonstrates the importance of awareness and valuation of PHCNs’ scope of practice. Similarly, the recognised unawareness and unfamiliarity with the MA procedure has implications for intervention strategies. It is, therefore, recommended that further education for GPs (and PHCNs) is required to address underlying unfounded concerns about the legality of abortion, procedure complications, potential lawsuits and/or the lack of a specialised infrastructure. Additionally, workshops, symposia, conferences and journal/media articles should provide more general information that focuses on the benefits, safety and legality of MA provision in the PHC sector, particularly when provided by PHCNs (DHHS 2017). Information provision is particularly required for key stakeholders such as the AMA, as their attitude and more opposing point of view to PHCNs’ scope of practice can have a major influence on policy and the implementation of nurse-led MA provision (AMA 2015; WHO 2015b).

The ongoing stigma that surrounds abortion provision, and the resulting negative publicity and judgements of colleagues and community members, especially in regional and rural areas, can also affect the implementation of a nurse-led MA model (Saurman’s awareness dimension). While negative beliefs and standpoints around abortion may never totally disappear, the findings of this study demonstrate the importance of educational interventions with an emphasis on facts relating to safety, the commonality and frequency of induced abortions in Australia (Lipp 2011). These interventions, together with the
establishment of relationships with local businesses and community members, will signal that abortion is an essential part of sexual and reproductive health care and should, therefore, not be treated differently to other health care provisions. This study, therefore, recommends building community and professional abortion knowledge and awareness to shift social and cultural attitudes and norms, and to put mechanisms in place to guarantee ongoing support and protection for MA providers against community backlash, harassment or legal issues.

Successful implementation of a legally feasible nurse-led model of MA provision in regional and rural Victoria is hindered by the reported lack of MA training options for PHCNs (Saurman’s availability dimension). This calls for a strategy that includes regulatory structures for competency-based training and accreditation, combined with ongoing guidance, support and mentoring of PHCNs (WHO 2015b). It is, therefore, recommended that MA training should be expanded beyond MS Health and integrated within the programs provided and/or coordinated by professional GP and nurse organisations, including sexual and reproductive health courses. Further, it is recommended to make locally organised accredited MA training for GPs and PHCNs affordable and accessible, with incentives and practice remunerations for training attendance provided. A funded coordinator needs to be appointed to offer guidance and help for PHCNs who want to do the MA training, and a PHCN network should offer MA mentoring to learn and share experiences. All these recommendations are in accordance with the key priorities of the recently released plan of the Victorian Government that aims to improve the sexual and reproductive health of Victorian women (DHHS 2017). While leaders and mentors are required for the professional development of PHCNs, including MA provision, direction on the nurse’s scope of practice for MA provision ought to be provided by the Australian Health Practitioner Regulation Agency.

The study findings also identified that poor accessibility to supportive health services, such as ultrasound facilities, pharmacists and emergency departments, can serve as a barrier for the implementation of nurse-led MA
provision in rural and regional Victoria (Saurman’s accessibility and adequacy dimensions). By declaring MA provision to be a core service for primary health systems in underserved areas, abortion access may potentially improve. At the same time, PHCNs should strengthen or newly create local partnerships with supportive health services to ensure the overall success of nurse-led MA provision. In the absence of local support services, however, the following should be considered. First, concerns regarding the lack of closely available health practitioners for surgical interventions can be addressed by clearly instructing women on when to seek medical help, using a 24-hour contact advice service, such as the one provided by Marie Stopes, as a back-up service. It was suggested that PHCNs should be able to recognise, after proper instructions and with the use of protocols, when consultation or referral is needed in the case of complications. Likewise, restrictions on driving times to hospitals need to be less explicit, as similar driving times are required for deliveries or spontaneous abortions (Lokeland et al. 2014). Second, general practices in areas without an easily accessible pharmacist, could consider supplying and dispensing the abortion medication themselves (Department of Human Services 2017a). Otherwise, in the situation where a pharmacist is present but unsupportive, shared care models with private MA providers, such as the Tabbot Foundation, could be explored to improve medication access (DHHS 2017). Third, when local ultrasound facilities are absent, GP clinics could offer (after appropriate training) in-house ultrasounds. The literature, on the other hand, suggests that the use of a pre-abortion ultrasound is often medically unnecessary (Kapp et al. 2017; RANZCOG 2016). By making the current mandatory pre-abortion ultrasound optional and only necessary when gestational duration is uncertain or when an ectopic pregnancy is suspected, the nurse-led MA procedure will be simplified and MA access will improve (Kapp et al. 2017). It is, therefore, recommended that regulatory structures and/or mechanisms need to be adjusted to improve access to MA-related supportive health services.

Besides the implications and recommendations for practice that need to be considered for the implementation of a legally feasible nurse-led model of
MA care in the regional and rural areas of Victoria, the following implications and recommendations for policy arise when a fully autonomous model is to be implemented.

The establishment of a fully autonomous nurse-led MA provision model is currently restricted by the PHCNs’ lack of access to MBS item numbers for the independent reimbursement of their activities related to MA provision, and by the lack of a financial remuneration for MA consultations provided by PHCNs (Saurman’s affordability dimension). This implicates that alternative funding models are required that facilitate PHCNs to be independently responsible for MA provision. It is thus recommended to introduce task-specific funding for PHCNs to enable Medicare rebates, and to change PHCN remuneration, for example, in the form of a Medicare item number for nurse-led MA provision, or to adapt the Gateway Health model that employs a sexual health nurse funded by the Government (Tomnay et al. 2018).

Currently, in Australia, only physicians can prescribe MA drugs. Consequently, the implementation of a fully autonomous nurse-led MA provision model implies that this regulation needs to be addressed (Saurman’s availability dimension). Alternative solutions, such as the onsite storage of MA and solitary handling of the medication by the PHCN or the development of shared care models with telemedicine providers, will give PHCNs a more autonomous role in the MA provision process, even though GPs remain the actual prescribers. Additionally, PHCNs can be granted a designated prescriber status, which allows them to prescribe independently, albeit under the supervision of a GP (NMBA 2017). Nonetheless, to implement a fully autonomous nurse-led MA provision model, prescription policy change is recommended to include abortion medication in the list of scheduled medicines that are approved by the NMBA. However, NMBA approved scheduled medicines can only be prescribed by nurse practitioners, midwives, and rural and isolated practice endorsed registered nurses, and not many of them actually work in general practice (NMBA, 2017). Therefore, besides policy change, it is
also recommended to extend prescribing rights to suitably qualified registered nurses.

9.2 RECOMMENDATIONS FOR FUTURE RESEARCH

This study raises several opportunities for future research. First, full implementation of the legally feasible model in the PHC sector of regional and rural Victoria requires a trial of the model, which should include an assessment of the feasibility, effectiveness, safety and acceptability of the proposed model from the perspectives of GPs, PHCNs and patients. Further research needs to establish if implementation of the nurse-led model will indeed improve access to safe abortion services in the regional and rural areas of Victoria. Next, when the role of the PHCN in MA provision increases over time, continuing monitoring and evaluation is warranted to ensure that provided care remains effective and safe. Second, it is recommended to extend the geographical base of this study to other jurisdictions in Australia where abortion access for women is limited. Future research may focus on the implementation of jurisdiction-specific formats of the nurse-led model in these areas.

Although abortion in Victoria is legal, women from regional and rural areas still encounter access barriers. The provision of MA in the PHC setting is a globally recognised solution to the shortage of surgical abortion providers, but this study, supported by the existing evidence base, showed that only a few GPs and PHCNs from regional and rural Victoria are currently involved in this procedure. The developed legally feasible nurse-led MA provision model may have the potential to improve abortion access in underserved regions of Victoria, while reform is required to allow the implementation of the more effective fully autonomous model. The study additionally recommends a range of support elements that would enable PHCNs to develop their newly defined autonomous roles and to take on these new responsibilities.

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APPENDICES
APPENDIX A: PLAIN LANGUAGE STATEMENT AND CONSENT
FORM CROSS-SECTIONAL STUDY

To: The participant

Plain Language Statement Date: January 2016

Full Project Title:
Towards a collaborative model of care for medication abortion provision in regional and rural Victoria

Ethical approval:
Obtained from Deakin University Human Research Ethics Committee (nr 2015-313)

Principal Researchers:
Dr Melissa Graham and Associate Professor Julia Shelley (School of Health and Social Development, Deakin University, Burwood)

Student Researcher:
Caroline de Moel, PhD candidate (School of Health and Social Development, Deakin University, Burwood)

Dear participant,

You are invited to take part in a research project that is being conducted by Deakin University. You have been randomly selected from the Medical Directory of Australia database as a general practitioner working in rural / regional Victoria (GPs only). This Plain Language Statement contains detailed information about the project and it will explain all the procedures involved so that you can make a fully informed decision whether you would like to participate or not.

Please read this statement carefully and feel free to contact us if you have any questions related to this project or the information in this document.

Purpose
The aim of this study is to develop a nurse-led collaborative model of care for the provision of medication abortion in regional/rural Victoria.

Background
In Australia about half of all pregnancies are unplanned and about one in four pregnancies will end in a termination. While abortion was legalised in Victoria in 2008, there is still a range of barriers that can undermine safe and easy access to abortion services, particularly for women who live in regional/rural areas. These barriers, mostly related to the shortage of regional providers, necessitate an alternative and viable solution. Nurses, who are an integral part of the primary health care setting, could potentially play an enhanced and
valuable role in the provision of abortion, and medication abortion in particular. This approach has been extensively used and tested in a range of overseas countries. For the development of a nurse-led collaborative model of care for the provision of medication abortion in regional/rural Victoria, two separate but interconnected studies will be conducted. The first one is this questionnaire, targeted at general practitioners and primary health nurses in regional/rural Victoria. Both groups will be surveyed separately about their views and attitudes on, and experiences with (medication) abortion provision. This inventory will provide an insight into the current provision of medication abortion in regional/rural Victoria. Additionally, it will guide the context of the second study that will use the Delphi technique* to query the opinions and knowledge of experts in the field in order to reach consensus for the development of the model.

Procedure
This online questionnaire consists of multiple-choice questions and should take approximately 10 minutes to complete. 

If you would like to go into the draw to win a weekend away to the value of about $500, please fill in the form at the end of the questionnaire (GPs only).

Possible risks and benefits of participation
Risks: This study contains questions that can relate to your personal beliefs, experiences and practices. If any question makes you feel uncomfortable, please either skip this question or discontinue your participation in the questionnaire.

Benefits: This study will look at an alternative solution for the shortage of abortion provision in Victoria’s regional areas. It will explore the possibilities and challenges of medication abortion provision via a nurse-led model of care. The development of such a model can be used to define and enhance the role of the practice nurse, alleviate the workload of the general practitioner, change the position of abortion provision in our present-day health care system, and ultimately improve access to safe abortions in regional areas.

Privacy and Confidentiality
Please be assured that no data will be published that would allow individual participants to be identified. This questionnaire is completely anonymous. The contact details you provide if you wish to go into the prize draw (for GPs only) or be part of the Delphi panel will be separated from your data upon receipt and deleted immediately after the prize draw. Data will be stored on password-protected University servers. In accordance with Deakin University management policies, all data will be destroyed after a minimum of five years after last publication: paper documentation will be shredded and all electronic files will be deleted from computer hard drives and backups.

Results of the project
The results will be published in the Doctoral thesis of the student researcher and in academic journals and presented at professional conferences. If you wish to receive a copy of the summary findings please contact Caroline via email cdemoel@deakin.edu.au.
Appendices

Voluntary participation
Your participation in this project is entirely voluntary and you can refuse to participate or stop answering the questions at any time you choose to do so. As the questionnaire is anonymous it will not be possible to withdraw your data once you have submitted.

*The Delphi technique is a structured group communication process between a panel of experts about a practical problem. In successive rounds of questionnaires, the experts will answer a range of questions that will all be reviewed and reported back. This process will encourage the participants to reconsider their initial answers in the following rounds until consensus is reached.

Consent
By completing this survey you have consented to our use of the information you provide, in the manner we have described above.
This study has not received funding from any source.

Questions
If you have any concerns or questions about this project, please contact one of the researchers:
Caroline de Moel, PhD candidate  0479 173 590  cdemoel@deakin.edu.au
Dr. Melissa Graham, supervisor  +61 3 92517271  melissa.graham@deakin.edu.au

Complaints
A human ethics panel at Deakin University has approved the ethical aspects of this research project. If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact:
The Manager, Ethics and Biosafety, Deakin University, 221 Burwood Highway, Burwood Victoria 3125, Telephone: 9251 7129, research-ethics@deakin.edu.au
Please quote project number 2015-313

◯ I have read the Plain Language Statement and Consent form, understand my rights as a participant, and wish to complete the following survey
◯ I have read the Plain Language Statement and Consent form and no longer wish to participate in this study
APPENDIX B: NURSE QUESTIONNAIRE

Start of Block: Section A: Background information

Q1 What is your current occupation?

- General practice nurse (1)
- Community health service nurse (2)
- Other, please specify (3)

Q2 What is the highest nursing degree you have completed?

- Enrolled nurse (1)
- Registered nurse (2)
- Rural and isolated practice endorsed registered nurse (3)
- Nurse practitioner (4)
- Other, please specify (5)

Q3 What is the postcode of your work address?

Q4 Do you work:

- Full-time (1)
- Part-time (hours/week) (2)
Q5 What is your gender?

- Male (1)
- Female (2)
- Other (3)

Q6 What is your age (in years)?

End of Block: Section A: Background information

Start of Block: Section B: Your clinical experience

Q7 How many years have you been working in clinical practice?

Q8 What percentage of your current clinical work is spent providing care for women aged 13-45 years?

- 0% (1)
- 0-33% (2)
- 33-66% (3)
- 66-100% (4)

Q9 Do you see women with unintended pregnancies as part of your practice?

- No (1)
- Yes (2)
Appendices

Display This Question:
If Do you see women with unintended pregnancies as part of your practice? = Yes

Q10 Do you include abortion counselling in your consultation? (Providing information to assist with a decision)

- Yes (1)
- No (2)

Q11 Have you ever referred women for abortions?

- No (1)
- Yes (2)

Display This Question:
If Have you ever referred women for abortions? = Yes

Q12 I refer most women for abortions:

- To a local abortion provider (1)
- To Melbourne (2)
- I do both (3)
- Other: (4) ______________________________________________________

End of Block: Section B: Your clinical experience
Section C: Medication abortion

Q13 For the next several questions the term MEDICATION ABORTION will be used to describe an early abortion (before 63 days of gestation), performed with the use of pharmaceutical agents such as mifepristone and misoprostol. Have you ever heard of medication abortion?

- No (1)
- Yes (2)

Q14 How familiar are you with medication abortion?

- Not very familiar (1)
- Somewhat familiar (2)
- Very familiar (3)

Q15 Does your practice provide medication abortions?

- No (1)
- Yes (2)

Q16 Since when does your practice provide medication abortion?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Q17 What is your best estimate about the numbers of early medication abortions (i.e. before 63 days of gestation) that were performed in your practice in 2015?

________________________________________________________________
________________________________________________________________
________________________________________________________________

Q18 What is your best estimate about the distance abortion-requesting women live from your clinic? (please provide percentages for each answer)

Within 25 kilometres of your clinic: _______ (1)
25-50 kilometres from your clinic: _______ (2)
50-100 kilometres from your clinic: _______ (3)
50-100 kilometres from your clinic: _______ (4)
Total: _______

Q19 In the past 12 months, how many times have you:

<table>
<thead>
<tr>
<th></th>
<th>Never (1)</th>
<th>Less than 5 times (2)</th>
<th>Equal to or greater than 5 times (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisted a doctor in providing medication abortion? (1)</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>Provided and managed a medication abortion? (2)</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>Treated and/or referred women for medication abortion related complications? (3)</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
</tbody>
</table>
Q20 During the time that your practice has prescribed medication abortion have you, other staff members or your practice encountered any acts of harassment or challenges? (check all that apply)

<table>
<thead>
<tr>
<th></th>
<th>Not at all (7)</th>
<th>Occasionally (8)</th>
<th>Frequently (9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Picketing (1)</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Vandalism (2)</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Threats to family members (3)</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>No support from other health professionals in region (4)</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Other, please specify: (5)</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

Q21 Do you hide the fact that you work in a clinic that provides medication abortion from any of the following people? (check all that apply)

<table>
<thead>
<tr>
<th></th>
<th>Yes (1)</th>
<th>No (2)</th>
<th>Not applicable (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>My spouse or partner (1)</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>At least one of my children (2)</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>At least one parent (3)</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>At least one close friend (4)</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>At least one neighbour (5)</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>
Q22 Do you know if any of the following problems are encountered by the medication abortion provider(s) at your practice (mark all that apply)?

- [ ] Unclear legal restrictions (2)
- [ ] The facility where I work does not permit it (3)
- [ ] No physicians available for back-up (4)
- [ ] Unwillingness of local pharmacist to supply mifepristone (12)
- [ ] Lack of 24-hour contact advice (13)
- [ ] No access to ultrasound (5)
- [ ] No access to surgical back-up in case of complications (6)
- [ ] No support from colleagues (7)
- [ ] No support from community (8)
- [ ] No support from friends and family (9)
- [ ] Fear of anti-abortion harassment (10)
- [ ] Other, please specify (11)

End of Block: Section C: Medication abortion

Start of Block: Section D: Personal beliefs and attitudes

Q23 Please indicate which of the following statements you mostly agree with: I think surgical and medication abortions should be

- [ ] Legal under any circumstances (1)
- [ ] Illegal in all circumstances (2)
- [ ] Legal only under certain circumstances (3)
Appendices

Q24 What circumstances do you think justifies an abortion (mark all that apply):

☐ A gestational age of 12 weeks or less (1)

☐ A gestational age of 20 weeks or less (2)

☐ A pregnancy that is the result of rape or incest (3)

☐ A pregnancy that is life threatening (4)

☐ The detection of a fetal abnormality (5)

☐ A problem with the gender of the foetus (6)

☐ The woman already has too many children (7)

☐ The woman is too young (under 17 years old) (8)

☐ Other, please specify (9)

Q25 I would support my colleagues in providing abortions

☐ Yes (1)

☐ No (2)
Q26 I believe that medication abortions fall within the scope of practice of the following health practitioners (please indicate the degree to which you agree with the following statements):

<table>
<thead>
<tr>
<th>Health Practitioner</th>
<th>Strongly disagree (6)</th>
<th>Disagree (7)</th>
<th>Neither agree nor disagree (8)</th>
<th>Agree (9)</th>
<th>Strongly agree (10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrician / Gynaecologist (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practitioner (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Practitioner (3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural and isolated practice endorsed Registered Nurse (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered Nurse (5)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enrolled Nurse (6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwife (7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

End of Block: Section D: Personal beliefs and attitudes

Start of Block: Section E: Interest in medication abortion provision

Q27 I would like to be trained to provide medication abortions to manage unintended pregnancies

- Already providing (1)
- Yes (2)
- No (3)

*Skip To: End of Block If I would like to be trained to provide medication abortions to manage unintended pregnancies = Already providing*
Q28 What are the possible reasons for NOT providing or assisting with medication abortions EVEN THOUGH you are willing (mark all that apply):

- No training opportunities (1)
- Unsure of legal restrictions (2)
- The facility where I work does not permit it (3)
- No physicians available for back-up (4)
- Unwillingness of local pharmacist to supply mifepristone (12)
- Lack of 24-hour contact advice (13)
- No access to ultrasound (5)
- No access to surgical back-up in case of complications (6)
- I would not feel comfortable being personally involved (22)
- My colleagues would not be supportive (7)
- My community would not be supportive (fear of stigmatisation) (8)
- My friends and family would not be supportive (9)
- Fear of anti-abortion harassment (10)
- Other, please specify (11)
Appendices

Q29 What are your reasons for NEVER wanting to provide or assist with medication abortions (mark all that apply):

- I am morally / ethically opposed (1)
- There is no need for more abortion providers (2)
- Anti-abortion harassment (3)
- Too many legal restrictions (4)
- I worry about the need for surgical back-up (5)
- My colleagues would not be supportive (6)
- My community would not be supportive (7)
- My friends and family would not be supportive (8)
- Other, please specify (9)

End of Block: Section E: Interest in medication abortion provision

Start of Block: Block 6

Q30 This was the last question of the questionnaire. After this point editing is no longer possible. The following part of the questionnaire will ask for your interest in the Delphi study. You will now be redirected

End of Block: Block 6

Start of Block: Section F: Interest in Delphi study

The data provided in this part of the questionnaire will not be shared and will not be connected with the responses you provided in the above questions.

All contact details will be deleted immediately after Delphi panel completion. For any questions, please contact: cdemoel@deakin.edu.au
Q1 Would you be interested in participating in the next phase of the study? This Delphi study* will aim to gain consensus on the development of a nurse-led collaborative model of care for medication abortion provision in regional Victoria.

*It will involve your online participation in three successive rounds of questionnaires. After each round all the aggregated anonymous responses of the panel will be shared with the group and will allow participants to reconsider their previous answers in the following rounds until consensus is reached.

- No (1)
- Yes (2)

Display This Question:
If Would you be interested in participating in the next phase of the study? This Delphi study* will... = Yes

Q34 Please provide your name and email address below:

- First name (1) ________________________________
- Surname (2) ________________________________
- Email address (3) ________________________________
- Telephone number (optional) (4) ________________________________

End of Block: Section F: Interest in Delphi study
APPENDIX C: GP QUESTIONNAIRE

Start of Block: Section A: Background information

Q1 What is your gender?

- Male (1)
- Female (2)
- Other (3)

Q2 What is your age (in years)?


Q3 How many years have you been working as a general practitioner?


Q4 Do you work:

- Full-time (1)
- Part-time (hours/week) (2)

Q5 Are you:

- Vocationally registered (1)
- Non-vocationally registered (2)
- A registrar (3)
In which country did you receive your original qualification?

- Australia (1)
- Other, namely (3)

How do you describe your practice

- Solo practice (1)
- Group practice with 2-4 general practitioners (2)
- Group practice with more than 4 general practitioners (3)
- Other, namely (4)

What is the postcode of your main work address?

If you work at multiple sites, please provide corresponding postcodes.

Are other primary health care providers part of your team?

- No (1)
- Yes (2)

Display This Question:
If Are other primary health care providers part of your team? = Yes
The other members of your primary care team include (check all that apply):

- Practice nurse(s) (1)
- Allied health care provider(s) (2)
- Indigenous health worker(s) (3)
- Pharmacist(s) (4)
- Other, namely (5)

End of Block: Section A: Demographics

Start of Block: Section B: Your clinical experience

What percentage of your current clinical work is spent providing care for women aged 13-45 years?

- 0% (1)
- 0-33% (2)
- 33-66% (3)
- 66-100% (4)

Do you see women with unintended pregnancies as part of your practice?

- No (1)
- Yes (2)

Display This Question:
If Do you see women with unintended pregnancies as part of your practice? = Yes
Appendices

Q13 Do you include abortion counselling in your consultation? (Providing information to help with a decision)

- Yes (1)
- No (2)

Q14 Have you ever referred women for abortions?

- No (1)
- Yes (2)

Display This Question:
If Have you ever referred women for abortions? = Yes

Q15 I refer most women for abortions:

- To a local abortion provider (1)
- To Melbourne (2)
- I do both (3)
- Other: (4) ________________________________________________

End of Block: Section B: Your clinical experience

Start of Block: Section C: Medication abortion

Q16 For the next several questions the term MEDICATION ABORTION will be used to describe an early abortion (before 63 days of gestation), performed with the use of pharmaceutical agents such as mifepristone and misoprostol. Have you ever heard of medication abortion?

- No (1)
- Yes (2)

Skip To: End of Block If For the next several questions the term MEDICATION ABORTION will be used to describe an early abo... = No
Appendices

Q17 How familiar are you with medication abortion?
   - Not very familiar (1)
   - Somewhat familiar (2)
   - Very familiar (3)

Q18 Do you provide medication abortions?
   - Yes (1)
   - No (2)

Skip To: Q21 If Do you provide medication abortions? = No

Q19 Since when do you provide medication abortion?

________________________________________________________________
________________________________________________________________

Q20 What is your best estimate about the numbers of early medication abortions (i.e. before 63 days of gestation) that were performed by you

________________________________________________________________
________________________________________________________________

Q21 Does your practice provide medication abortions?
   - No (1)
   - Yes (2)
   - Don’t know (3)

Skip To: Q28 If Does your practice provide medication abortions? != Yes

Q22 Since when does your practice provide medication abortion?

________________________________________________________________
Q23 What is your best estimate about the total numbers of early medication abortions (i.e. before 63 days of gestation) that were performed in 2015 in your practice?

________________________________________________________________

Q24 What is your best estimate about the distance abortion-requesting women live from your clinic? (please provide percentages for each answer)

Not applicable: _______ (5)
Within 25 kilometres of your clinic: _______ (1)
25-50 kilometres from your clinic: _______ (2)
50-100 kilometres from your clinic: _______ (3)
> 100 kilometres from your clinic: _______ (4)
Total: _______

Q25 During the time that your practice has prescribed medication abortion have you, other staff members or your practice encountered any acts of harassment or challenges? (check all that apply)

<table>
<thead>
<tr>
<th></th>
<th>Not at all (7)</th>
<th>Occasionally (8)</th>
<th>Frequently (9)</th>
<th>not applicable (10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Picketing (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vandalism (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Threats to family members (3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No support from other health professionals in region (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, please specify: (5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Q26** Do you hide the fact that you work in a clinic that provides medication abortion from any of the following people? (check all that apply)

<table>
<thead>
<tr>
<th></th>
<th>Yes (1)</th>
<th>No (2)</th>
<th>Not applicable (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>My spouse or partner (1)</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>At least one of my children (2)</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>At least one parent (3)</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>At least one close friend (4)</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>At least one neighbour (5)</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
Q27 Have you encountered any of the following problems in the process of medication abortion provision?

- Not applicable (30)
- Unsure of legal restrictions (2)
- The facility where I work does not permit it (3)
- Financially unviable (12)
- No physicians available for back-up (4)
- Unwillingness of local pharmacist to supply mifepristone (21)
- Lack of 24-hour contact advice (22)
- No access to ultrasound (5)
- No access to surgical back-up in case of complications (6)
- My colleagues are not supportive (7)
- My community is not supportive (8)
- My friends and family are not supportive (9)
- Fear of anti-abortion harassment (10)
- Other, please specify (11)

Q28 Please indicate which of the following statements you mostly agree with: I think surgical and medication abortions should be

- Legal under any circumstances (1)
- Illegal in all circumstances (2)
- Legal only under certain circumstances (3)
Display This Question:

If Please indicate which of the following statements you mostly agree with:  
I think surgical and m... = Legal only under <u>certain</u> circumstances

Q29 What circumstances do you think justifies an abortion (mark all that apply):

☐ A gestational age of 12 weeks or less (1)
☐ A gestational age of 20 weeks or less (2)
☐ A pregnancy that is the result of rape or incest (3)
☐ A pregnancy that is life threatening (4)
☐ The detection of a fetal abnormality (5)
☐ A problem with the gender of the foetus (6)
☐ The woman already has too many children (7)
☐ The woman is too young (under 17 years old) (8)
☐ Other, please specify (9)

Q30 I would support my colleagues in providing abortions

☐ Yes (1)
☐ No (2)
Q31 I believe that medication abortions fall within the scope of practice of the following health practitioners (please indicate the degree to which you agree with the following statements):

<table>
<thead>
<tr>
<th>Health Practitioner</th>
<th>Strongly disagree (16)</th>
<th>Disagree (17)</th>
<th>Neither agree nor disagree (18)</th>
<th>Agree (19)</th>
<th>Strongly agree (20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrician / Gynaecologist (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practitioner (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Practitioner (3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>Rural and isolated practice endorsed Registered Nurse (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered Nurse (5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enrolled Nurse (6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwife (7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

End of Block: Section D: Personal beliefs and attitudes

Start of Block: Section E: Interest in medication abortion provision

Q32 I would like to be trained to provide medication abortions to manage unintended pregnancies

- Already providing (1)
- Yes (2)
- No (3)

*Skip To: End of Block If I would like to be trained to provide medication abortions to manage unintended pregnancies = Already providing*
Q33 **What are the possible reasons for NOT providing or assisting with medication abortions EVEN THOUGH you are willing (mark all that apply):**

- No training opportunities  (1)
- Unsure of legal restrictions  (2)
- The facility where I work does not permit it  (3)
- Financially unviable  (12)
- No physicians available for back-up  (4)
- Unwillingness of local pharmacist to supply mifepristone  (21)
- Lack of 24-hour contact advice  (22)
- No access to ultrasound  (5)
- No access to surgical back-up in case of complications  (6)
- I would not feel comfortable being personally involved  (30)
- My colleagues would not be supportive  (7)
- My community would not be supportive (fear of stigmatisation)  (8)
- My friends and family would not be supportive  (9)
- Fear of anti-abortion harassment  (10)
- Other, please specify  (11)

-----------------------------------------------------------------------------------------------------------------------------------
Q34 What are your reasons for NEVER wanting to provide medication abortions (mark all that apply):

- I am morally / ethically opposed (1)
- There is no need for more abortion providers (2)
- Anti-abortion harassment (3)
- Too many legal restrictions (4)
- Financially unviable (10)
- I worry about the need for surgical back-up (5)
- My colleagues would not be supportive (6)
- My community would not be supportive (7)
- My friends and family would not be supportive (8)
- Other, please specify (9)

End of Block: Section E: Interest in medication abortion provision

Start of Block: Section F: End Questionnaire

This was the last question of the questionnaire. After this point editing is no longer possible. The following part will allow you to enter your contact details for the prize draw and will record your interest in the Delphi study.

End of Block: Section F: End Questionnaire

Start of Block: Second part: Interest in Delphi study and prize draw

The data provided in this part of the questionnaire will not be shared and will not be connected with the responses you provided in the above questions.

All contact details will be deleted immediately after the prize draw and after Delphi panel completion. For any questions, please contact: cdemoel@deakin.edu.au
Appendices

Q1 Would you like to go into the prize draw for a weekend away for two?

- Yes (1)
- No (2)

Display This Question:
If Would you like to go into the prize draw for a weekend away for two? = Yes

Q2 Please enter your contact details

- First name (3)_______________________________________________
- Surname (7) _______________________________________________
- Email address (5) ___________________________________________
- Contact phone number (optional) (6) __________________________

Q3 Would you be interested in participating in the next phase of the study? This Delphi study* will aim to gain consensus on the development of a nurse-led collaborative model of care for medication abortion provision in regional Victoria.

*It will involve your online participation in three successive rounds of questionnaires. After each round all the aggregated anonymous responses of the panel will be shared with the group and will allow participants to reconsider their previous answers in the following rounds until consensus is reached.

- No (1)
- Yes (2)

Display This Question:
If Would you be interested in participating in the next phase of the study? This Delphi study* will... = Yes
Appendices

Q36 Please provide your name and email address below:

- First name (1) _____________________________________________
- Surname (2) _______________________________________________
- Email address (3) ___________________________________________
- Contact phone number (optional) (4) __________________________

End of Block: Second part: Interest in Delphi study and prize draw
APPENDIX D: INVITATION LETTER DELPHI STUDY EXPERTS
BY PROFESSION

Dear participant,

It is a well-known fact that women who live in the non-metropolitan regions of Victoria face many barriers when they want to terminate an unwanted pregnancy. Although abortion with medication can potentially facilitate access, the uptake of this service by general practitioners still slow.

Deakin University is conducting a study that will investigate how practice nurses can play an important role in the delivery of medication abortions. This model is already successfully used for many years in overseas countries and will increase the availability of early abortion services in regional / rural communities.

The study will use the Delphi technique, an online anonymous group communication process between experts in the field over three rounds of questionnaires, in order to reach consensus between panellists for the development of this model in Victoria.

You are invited as a professional expert to participate in this study. Although your involvement will require some time and commitment, it offers a unique opportunity to influence current abortion practice in Victoria. Your participation will be gratefully appreciated and will improve the quality of the study findings.

Please forward this invitation to colleagues who may be interested in this study. The survey and additional information is accessible online via:
https://deakinhealth.qualtrics.com/SE/?SID=SV_0NfKmiObWHLhNCJ or
http://cdemoel.wixsite.com/delphi

Thank you in advance for your participation. For any question or concerns feel free to contact me at cdemoel@deakin.edu.au. Ethics approval for the study is obtained from Deakin University Human Research Ethics Committee (nr 2015-314).

Sincerely,

Caroline de Moel, MD, MPH, PhD candidate
School of Health and Social Development, Faculty of Health
Deakin University
Melbourne Burwood Campus www.deakin.edu.au
APPENDIX E: INVITATION FLYER DELPHI STUDY EXPERTS BY EXPERIENCE

Are you a woman aged 18-44 years from regional or rural Victoria and an advocate for Sexual Health and Reproductive Rights? Would you be interested to participate in a study that aims to improve the access to safe abortion services in regional and rural Victoria?

It is a well-known fact that women who live in the non-metropolitan regions of Victoria face many barriers when they want to terminate an unwanted pregnancy. Although abortion with medication* can potentially facilitate access, the uptake of this service by general practitioners is slow.

DEAKIN UNIVERSITY is conducting a study that will investigate how practice nurses can play an important role in the delivery of medication abortions. This model has already been successfully used for many years in overseas countries and will increase the availability of early abortion services in regional/rural communities.

The study will use the Delphi technique, an online anonymous group communication process over three rounds of questionnaires, in order to reach consensus between participants for the development of this model in Victoria.

Although your involvement will require some time and commitment, it offers a unique opportunity to influence current abortion practice in Victoria. Your participation will be gratefully appreciated as your interest, experience and / or advocacy for abortion will improve the quality of the study findings.

Please forward this invitation to friends or colleagues who may be interested in this study.

For more information and the first survey visit: http://cdemoel.wixsite.com/delphi

*Medication abortion: an early abortion (maximal 63 days after conception) performed with the use of pharmaceutical drugs.
APPENDIX F: ROUND ONE DELPHI QUESTIONNAIRE

ROUND ONE QUESTIONNAIRE

This questionnaire consists of two parts

• Part A is a short demographic questionnaire.

• Part B consists of seven open-ended questions.

PART A: DEMOGRAPHIC QUESTIONNAIRE

Please provide your contact information

What is your full name?

What is your work title?

What is your Email address?

What is your telephone number?

What is your gender?

☐ Male

☐ Female
What is your age?
18-24 years old
25-34 years old
35-44 years old
45-54 years old
55-64 years old
65 years or older

What is your country of origin?
Australia
New Zealand
The United Kingdom
Other, please specify:

Which of the following best describes your current occupation? Tick as many answers as possible:
General practitioner from regional Victoria
Practice nurse from regional Victoria
Nurse Academic
Nurse involved in policy development
Nurse from professional body
Sexual Health Nurse Practitioner
Obstetrician/Gynecologist
Politician
Other, please specify:

Please describe the main activity you undertake in your current job(s):


Please indicate the number of years of experience you have in this role:
Not applicable
Less than 5 years
5-7 years
8-10 years
11-15 years
16-20 years
More than 21 years

Which of the following best describes the primary geographical location you most frequently work in (if applicable):
Not applicable
Urban
Suburban
Regional
Rural
Other, please specify: 

Please explain your interest in the study:

PART B: SEVEN OPEN-ENDED QUESTIONS

For the next questions the term MEDICATION ABORTION will be used to describe an early abortion (before 63 days of gestation), performed with the use of pharmaceutical agents such as mifepristone and misoprostol.
Appendices

Please answer the following questions IN AS MUCH DETAIL AS POSSIBLE

**Q1:** What do you think is the current role of general practitioners and primary health care nurses in the provision of early medication abortion in regional/rural Victoria?

**Q2:** How do you think the role of **general practitioners** in the provision of medication abortion could be improved?

**Q3:** How do you think the role of **primary health care nurses** in the provision of medication abortion could be improved?

**Q4:** What factors facilitate or hinder regional and rural primary health care nurses when they are or want to be involved in the delivery of medication abortion services in regional/rural Victoria?

**Q5:** What do you believe are solutions or recommendations to improve primary health nurse participation in the provision of medication abortion in regional/rural Victoria?
Appendices

Q6: What obstacles can potentially prevent these improvements?

Q7: How do you think the obstacles of question 6 can be addressed?

Please use this box to add any additional comments.

Thank you for your interest in the study and for completing round one.

The findings of the round one questionnaires will be assembled, categorised and organised into key statements. You will receive a new questionnaire in due time that consists of these statements, and you will be asked to rate each of them on a scale for agreement or disagreement. This next questionnaire will probably only take 15 minutes to complete.
APPENDIX G: PLAIN LANGUAGE STATEMENT AND CONSENT FORM DELPHI STUDY

To: Participants

PLAIN LANGUAGE STATEMENT

Date: August 2016

FULL PROJECT TITLE
Towards a collaborative model of care for medication abortion provision in regional and rural Victoria

ETHICAL APPROVAL:
Obtained from Deakin University Human Research Ethics Committee (2015-314)

PRINCIPAL RESEARCHERS
Dr Melissa Graham and Professor Ann Taket (School of Health and Social Development, Deakin University, Burwood)

STUDENT RESEARCHER
Caroline de Moel, MD, MPH, PhD candidate (School of Health and Social Development, Deakin University, Burwood)

Dear participant,

You have been identified as an expert by profession or as an advocate for women's sexual and reproductive health and rights, and are invited to take part in a research project that is being conducted by Deakin University. This Plain Language Statement contains detailed information about the research project. It will explain all the procedures involved in this project so that you can make a fully informed decision whether you are going to participate.

Please read this statement carefully and feel free to contact us for questions related to this project or the information in this document.

PURPOSE

The aim of this study is to develop a nurse-led collaborative model of care for the provision of medication abortion in regional and rural Victoria.

BACKGROUND

In Australia about half of all pregnancies are unplanned and about one in four pregnancies will end in a termination. While abortion was legalised in Victoria in
Appendices

2008, there are still a range of barriers that can undermine safe and easy access to abortion services, particularly for women who live in regional/rural areas. Those barriers, most related to the shortage of local providers, necessitate an alternative and conceivable solution.

Nurses, who are an integral part of the primary health care setting, could potentially play an enhanced and valuable role in the provision of abortion, and medication abortion in particular. This approach has been extensively used and tested in a range of overseas countries.

For the development of a nurse-led collaborative model of care for the provision of medication abortion in regional/rural Victoria, this study will use the Delphi technique to query the opinions and knowledge of experts in the field.

PROCEDURE

The Delphi technique consists of a group communication process that aims to achieve expert consensus about a specific topic with the use of successive rounds of questionnaires. The major benefit of this method is that it allows a diverse group of specialists from a widespread geographical area to anonymously express their views without any restrictions, peer pressure or influence from expert dominance.

The key elements of the Delphi are as follows:

1. The **first round** starts with some general demographic questions. Then you will be asked to give your opinion on three questions regarding medication abortion provision in regional/rural Victoria
2. The researcher will generate a list of key statements from all the panel responses
3. In the **second round** you will rate these statements on levels of agreement and include supporting arguments for your ratings to augment the scales.
4. All results will be analysed and feedback will be provided, not only on the levels of agreement of all panel members for each statement but also on how your response compares to the rest of the group
5. The **third round** questionnaire will contain the same statements as round two, but it will allow you, based on the feedback, to reconsider and revise your earlier responses
6. The responses of the panel members therefore converge across the rounds of questionnaires. Consensus will be reached when 75% of the participants agree with the statement.

Each round will take about 30-45 minutes to complete.

POSSIBLE RISKS AND BENEFITS OF PARTICIPATION

Risks: This study contains questions/statements that can relate to your personal beliefs, experiences or practices. If any of the questions/statements makes you feel uncomfortable, please either skip this question or discontinue your participation in the study.

Benefits: This study will look at an alternative solution for the shortage of abortion
provision in Victoria’s regional areas. It will explore the possibilities and challenges of medication abortion provision via a nurse-led model of care. The development of such a model can be used to define and enhance the role of the practice nurse, alleviate the work-load of the general practitioner, change the position of abortion provision in our present-day health care system, advocate for policy change and ultimately improve the access to safe abortions for women living in regional/rural Victoria.

**PRIVACY AND CONFIDENTIALITY**

Please be assured that no data will be published that would allow individual participants to be identified. All the personal data you provide will be kept completely anonymous to other participants, so responses cannot be attributed back to you. However, it should be noted that panel members of expert groups often know each other, which can result in feeling pressured to conform to the group's view.

The names, addresses and identifying details of the participants, disclosed in the demographic questionnaire of round one, will remain confidential to the research team and will be separated from responses upon receipt. You can be assured that all data will be handled and processed confidentially according to the rules of National Statement on Ethical Conduct in Human Research. Following Deakin University management policies, all data will be stored on password-protected University servers and destroyed after a minimum of five years after last publication.

**RESULTS OF THE PROJECT**

Results of this study will be published in the Doctoral thesis of the student researcher and in academic journals. Overall findings will be presented at professional conferences. If you wish to receive a copy of the summary findings, please contact Caroline via email: cdemoel@deakin.edu.au.

**VOLUNTARY PARTICIPATION**

Your participation in this project is entirely voluntary and you can refuse to participate or stop answering the questions at any time.

**CONSENT**

By completing and submitting each round of questionnaires you have consented to our use of the provided information in the manner we have described above.

This study has not received funding from any source.

**QUESTIONS**

If you have any concerns or questions about this project, please contact one of the researchers:

Caroline de Moel, PhD candidate, M: 0479 173 59, E: cdemoel@deakin.edu.au
Dr. Melissa Graham, supervisor, T: +61 3 92517271, E: melissa.graham@deakin.edu.au
Prof. Ann Taket, supervisor, T: +61 3 92443798, E: ann.taket@deakin.edu.au
COMPLAINTS

A human ethics panel at Deakin University has approved the ethical aspects of this research project. If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact: The Manager, Ethics and Biosafety, Deakin University, 221 Burwood Highway, Burwood Victoria 3125, T: +61 3 92517129, E: research-ethics@deakin.edu.au. Please quote project number (2015-314)

Please forward this invitation to colleagues who may be interested in this study.
## APPENDIX H: FEEDBACK FROM ROUND TWO PROVIDED TO PANELLISTS IN ROUND THREE

<table>
<thead>
<tr>
<th>Statements</th>
<th>Valid percent agree</th>
<th>Valid percent disagree</th>
<th>IQR&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Group Median&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Personal rating&lt;sup&gt;2&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  All women with an unwanted pregnancy should be referred to an appropriately trained PHC nurse</td>
<td>65</td>
<td>2</td>
<td>1</td>
<td>3.5</td>
<td>2</td>
</tr>
<tr>
<td>2  Non-life-threatening complications of MA, like haemorrhages or infections, should be managed by doctors only</td>
<td>45</td>
<td>45</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>3  The PHC nurse can manage post-abortion contraception, including the insertion of implants, PHC or the provision of injectable contraception</td>
<td>75</td>
<td></td>
<td>1.75</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4  All steps in the MA process that are handled by a PHC nurse should only be allowed under the supervision of a GP</td>
<td>30</td>
<td>70</td>
<td>1</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5  Allow all registered nurses to be responsible for the whole MA process without a GP's approval. The GP should only be required for the prescription of the abortion medication</td>
<td>40</td>
<td>45</td>
<td>2.75</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>6  General practice funding for nurse-led MA provision is currently included in the quarterly practice nurse incentive program payment, which includes a rural loading of up to 50% and is independent of Medicare item numbers. There is sufficient allowance in the practice nurse incentive program payment to cover nurse-led MA provision</td>
<td>15</td>
<td>65</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>7  Not all local pharmacies supply, or wish to supply, medication abortion drugs</td>
<td>75</td>
<td></td>
<td>1.75</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>8  There is a well-established positive collaboration between the Australian Medical Association and nursing authorities</td>
<td>15</td>
<td>40</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>9  The rural population does not complain about poor MA services in their area, because it is a private and contentious subject</td>
<td>75</td>
<td></td>
<td>1.75</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>10 GPs fear moral judgement by other health professionals if they were to provide MA services to their patients</td>
<td>70</td>
<td></td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>11 There is pressure on GPs to conform to the conservative views of their</td>
<td>70</td>
<td></td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Statements</td>
<td>Valid percent agree</td>
<td>Valid percent disagree</td>
<td>IQR¹</td>
<td>Group Median²</td>
<td>Personal rating³</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------</td>
<td>------------------------</td>
<td>------</td>
<td>---------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>colleagues regarding the provision of MA services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 GPs are concerned about their safety and wellbeing if they were to provide MA services</td>
<td>65</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 GPs fear ramifications on both time and negative outcomes (complications) when providing MA services</td>
<td>70</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 There is a lack of specialist and other health professionals’ support available to GPs and PHC nurses that provide MA services</td>
<td>70</td>
<td>1.75</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 GPs and PHC nurses fear negative publicity from members of conservative communities and/or fear of personal vilification if they were to provide MA services</td>
<td>75</td>
<td>1.75</td>
<td>1.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 GPs and PHC nurses fear the presence of anti-choice protestors outside the facility if they were to provide MA services</td>
<td>60</td>
<td>2.75</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 The government is nervous about discussing and/or promoting MA. They fear community backlash or anti-choice campaigns in parliament and their own party</td>
<td>70</td>
<td>2</td>
<td>1.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 There is not enough funding to make nurse-led MA provision profitable</td>
<td>65</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 It appears that public expectations about equitable availability of abortion services are ahead of the actual implementation</td>
<td>65</td>
<td>1.5</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 PHC nurses prefer locally organised MA group training session over on-line training</td>
<td>70</td>
<td>1.75</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 A funded coordinator role needs to be established that offers guidance and help for PHC nurses who want to do the MA training</td>
<td>75</td>
<td>1.75</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 Payment for nurse-led MA provision should be independent of any GP involvement</td>
<td>75</td>
<td>1.75</td>
<td>1.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 GP clinics should offer ultrasound and blood test services so women do not need to go somewhere else</td>
<td>70</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 GPs who provide MA should be made visible (e.g. advertise with &quot;all-option</td>
<td>75</td>
<td>1.75</td>
<td>1.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Appendices

<table>
<thead>
<tr>
<th>Statements</th>
<th>Valid percent agree</th>
<th>Valid percent disagree</th>
<th>IQR(^1)</th>
<th>Group Median(^2)</th>
<th>Personal rating(^3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>pregnancy counselling offered at this general practice”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financially support women to facilitate MA access (e.g. for travel and childcare costs)</td>
<td>65</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: 1 Inter-quartile range: spread of scores in the distribution; 2 Middle value of all the responses; 3 Participant’s personal rating of each statement in Round Two