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Expert consensus on a nurse-led model of medication abortion provision in regional and rural Victoria, Australia: a Delphi study

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ABSTRACT

Objective: To develop a nurse-led model of medication abortion provision for the primary health care setting of regional and rural Victoria, where, despite decriminalization, access to abortion services is restricted.

Study design: This study used a three-round Delphi process to explore consensus about a nurse-led medication abortion model. We recruited a panel consisting of physicians, nurses and other experts involved with or interested in medication abortion provision. The research team thematically analyzed the responses to the seven open-ended questions of the first questionnaire. In subsequent rounds, panelists rated the 83 generated statements for agreement, using feedback and statistical summaries.

Results: A total of 24 panelists participated; 17 completed all three rounds. Through the iterative process, the panel reached consensus (at least 75% agreement level) on 69 statements, relating to model construction and the barriers to model implementation and their solutions. Due to current health care system restrictions we not only developed a 'fully autonomous' nurse-led model, but also a 'legally feasible' model. For nurses working in primary health settings that lack GP support we additionally constructed an 'absence of a (medication abortion supportive) general practitioner' model.

Conclusion: Nurse-led medication abortion provision is a recognized strategy to improve access to equitable, affordable and safe abortion services for women residing in underserved areas. The constructed models and recommendations for practice and policy can serve as a guide to expand the role of primary health care nurses in the provision of medication abortion in Victoria and beyond.

Implications: The findings of this study indicate that a nurse-led model of medication abortion provision is feasible in service poor areas of Victoria and that model implementation has the potential to improve abortion access. The models are adaptable for use in other settings.

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1. Introduction

In 2012, medication abortion became more accessible in Australia when Marie Stopes received approval from the Therapeutic Goods Administration to become the sponsor and sole distributor of mifepristone [1]. Currently, medication abortion is permitted for abortions up to 9 weeks into a pregnancy, however, prescription is only allowed by physicians who have completed Marie Stopes' online training program [1]. Furthermore, medication abortion needs to be offered in settings where suitable emergency care is available, and pre-abortion ultrasounds and post-abortion anti-D provision to Rh-negative women¹ are mandatory requirements [2].

Victoria is Australia's second-smallest state with a size (237,600 km²) comparable to that of the United Kingdom [3]. The state has a population of 6.5 million people, of which approximately 77% live in Melbourne, an urban agglomeration of 9992.5 km² [4]. While abortion provision in Victoria is legal up to 24 weeks' gestation, most abortion services are located in and around Melbourne, which particularly affects abortion access for women living in regional and rural areas [5,6]. These areas are defined as having somewhat to very restricted access to the nearest town for goods and services [7]. This existing inequity may be improved by shifting medication abortion into the primary health care setting, yet, the involvement of regional and rural general practitioners (GPs) remains low [8].

A globally recognized strategy to address the shortage of abortion providers and to improve equity in access to abortion services is to involve primary health care nurses (PHCNs) in the medication abortion process [9,10]. Due to the time-consuming multi-phase

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process, which includes pre-abortion screening, interpretation of pathology tests, medication administration and follow-up, nurse-led medication abortion provision is more likely to be successful than solo GP provision [11]. Furthermore, appropriately trained PHCNs have been shown to provide early medication abortion and associated tasks as effectively, safely and satisfactorily as physicians [9,10]. Implementing a nurse-led medication abortion model in Victoria is feasible, as qualified registered nurses are entitled by law to administer the physician-prescribed medication to women, and their scope of practice includes all the essential clinical competencies required [5,12,13].

Currently, two medication abortion provision approaches are used in Australia to improve abortion access in underserved regions: a medical practice in North-East Victoria offering nurse-led provision with GP support [11]; and telemedicine, available since 2015 through Marie Stopes and, until recently, the Tabbot Foundation [14]. Additionally, women increasingly seek to self-manage their abortions with medications obtained from online sources, although no information about this practice is yet available from Australia [15].

Nurse-led provision could complement these existing methods and deliver safe abortion services at a personal level and closer to women's homes. This study, therefore, aimed to develop such a model for the primary healthcare setting of regional/rural Victoria.

2. Methods

We used the Delphi technique, which allows a geographically spread-out panel of experts to confidentially express their opinion on less researched topics without restrictions or peer-pressure [16]. This method seeks to build group consensus, using sequential questionnaires or 'rounds' [16]. In the first round, panelists offer their qualitative opinions on the issue and in subsequent rounds they rate the generated data for agreement. Feedback from each round gives panelists the opportunity to reconsider initial opinions [17]. We set the consensus level at 75% agreement (including inter-quartile range ≤ 1) because this level is most commonly used in Delphi studies [17]. We considered panelists to be an expert if they belonged to one of the following groups and were involved with or interested in medication abortion provision:

- Physicians: GPs from regional/rural Victoria or gynecologists/obstetricians
- Nurses: nurses/midwives working in general practice, community- or sexual/reproductive health, academia or for a professional organization
- Others: academics, politicians and health promotion officers without a medical background.

In order to attain adequate representation from the three groups, we used non-probability sampling, including snowballing techniques. The principal researcher (C.deM.) identified 82 potential panelists through literature and Internet searches and sent out invitations to participate in the study. Additionally, C.deM. contacted professional nursing organizations, women's health agencies, and Primary Health Networks to publish the study invitation on their social media platforms.

The first-round questionnaire, delivered using Qualtrics [18] software, consisted of seven open-ended questions. Questions asked about the current and potential future roles of GPs and PHCNs in the provision of medication abortion in regional/rural Victoria, and about the factors that can influence the involvement of PHCNs in the delivery of this service. Socio-demographic items allowed for clustering of the responses in the different expert groups and for matching panelists' data across rounds. In the two subsequent quantitative rounds panelists rated the generated statements from Round 1 for agreement, elaborated on their ratings in comment boxes, and reconsidered and changed initial

responses [16,19]. We sent out two reminders for each of the three rounds. To minimize researcher bias and comprehension errors, a convenience sample of experts with a similar professional or interest background as the panel pre-tested each round. They ensured that the wording and structure of the questionnaires were clear and concise, and they verified ease of usability. Deakin University Human Research Ethics Committee approved this study (number 2015–314).

The principal researcher, in continuous consultation with the other two authors, analyzed the data after each round. Data analysis from the open-ended questions included thematic analysis and deductive reasoning using NVIVO11 [20,21]. Pre-existing frameworks [9,22] guided this process. The quantitative data analysis with SPSS22 [23] comprised descriptive statistics for the demographic variables and the calculation of agreement percentages including measure of dispersion (inter-quartile range).

3. Results

A total of 24 panelists participated in the Delphi study, of which 17 responded to all three rounds (Fig. 1). Response rates of Rounds 2 and 3 were 87% and 78%, respectively.

Round 1 panelists included 10 nurses (44%), seven physicians (30%), and six professionals (26%) from the 'other' group. Nearly three-quarters ($n=17$; 74%) had a regional or rural location as their workplace setting. The characteristics of the Delphi panelists are listed in Table 1.

The analysis of the seven open-ended questions resulted in the formation of 83 statements, of which 69 achieved consensus in the following two rounds (Table 2). The statements related to the construction of the nurse-led model and to the barriers and solutions to model implementation.

3.1. Construction of a nurse-led medication abortion model

Generally, panelists reported the current role of GPs in the provision of medication abortion in their regional/rural areas to be very limited, and they regarded PHCNs as highly capable of delivering a range of medication abortion services. All panelists recognized that a nurse-led medication abortion model is essential to support, guide and develop PHCNs' roles, although different opinions were expressed about the independent provision by PHCNs. Many panelists (75%), for instance, agreed that medication abortion provision can be provided by a PHCN in cooperation with a

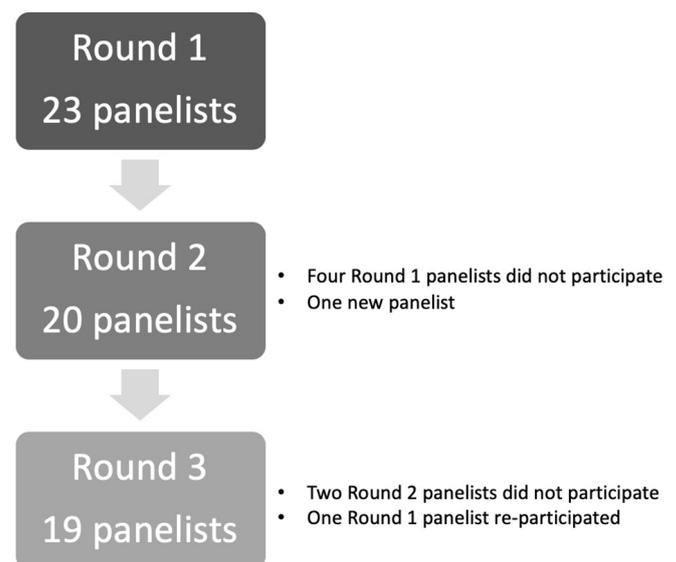


Fig. 1. Panelist attrition over three Delphi rounds.

Table 1
Characteristics of the Delphi panelists (N=23)

	Round 1 (N=23) n (%)	Round 2* (N=20) n (%)	Round 3* (N=19) n (%)
Occupation			
Physician	7 (30)	6 (30)	5 (26)
Nurse	10 (44)	8 (40)	9 (47)
Other	6 (26)	6 (30)	5 (26)
Gender			
Male	4 (17)	3 (15)	2 (11)
Female	19 (83)	17 (85)	17 (90)
Age (years)			
<35	4 (17)		
35–44	1 (4)		
45–54	8 (35)		
≥55	10 (44)		
Years of experience			
≤5	9 (39)		
5–10	4 (17)		
11–15	1 (4)		
≥15	9 (39)		
Geographical work location			
Urban	6 (26)		
Regional	12 (52)		
Rural	5 (22)		
Country of qualification			
Australia	20 (87)		
Other	3 (13)		

Note: * Round 2 and Round 3 did not collect demographic data.

GP, and only less than half of the panelists (47%) agreed that GP supervision is required for all steps in the medication abortion process. Additionally, most panelists (85%) agreed to legislative change to allow PHCNs' abortion medication prescription right. Correspondingly, the panelists did not reach consensus (58%) for the statement that appropriately trained registered nurses are allowed to be solely responsible for the whole medication abortion process, but with the GP still required for the prescription of the abortion medication.

Analysis of the data identified, similar to existing models [9,22], three phases in the nurse-led medication abortion process. In the first phase, women with an unwanted pregnancy contact the PHCN, although the option to visit the GP should also be offered. When medication abortion is preferred, the PHCN assesses eligibility. Most panelists (80%) agreed with the statements that sufficiently trained PHCNs are able to rule out any medication abortion contraindications, and that it is within the scope of practice of registered PHCNs to independently refer women for an ultrasound and blood tests. Further, most (85%) agreed that PHCNs should initiate pre-testing before referral when practice GPs refuse to provide medication abortion. Nearly all panelists (95%) agreed that, in the second phase of the model, appropriately trained PHNs are able to interpret the pathology results in such a way that they can assess if medication abortion provision is advisable. Furthermore, PHCNs are, according to the panelists, able to independently administer mifepristone (95%), and manage prophylactic pain medication (90%) and future contraception (95%). The third phase of the model involves abortion completion evaluation and post-abortion care. Panelists did not reach consensus (47%) about doctors needing to be solely responsible for the management of non-life-threatening medication abortion complications. Most (85%), however, agreed that appropriately trained PHCNs are able to assess abortion completion.

Based on these findings, three nurse-led models of medication abortion provision were developed (Fig. 2). In the ideal 'fully autonomous' model, PHCNs are independently responsible for all steps involved in the three phases of the process. However, since mifepristone can only be prescribed by medical practitioners, and the healthcare system requires GP involvement for pathology referral refunds [24,25], a second, 'legally feasible' model was con-

structed that takes into account these boundaries. In the third, 'absence of a (medication abortion supportive) GP' model, PHCNs that work in settings without immediate GP support, can assess medication abortion eligibility and initiate pre-testing before adequately referring women to a local medication abortion provider.

3.2. Barriers to model implementation and potential solutions

Six overarching barriers and solutions to nurse-led medication abortion model implementation emerged from the consensus statements. Firstly, most panelists (85%) agreed there was a lack of medication abortion training possibilities for PHCNs. Nearly all (95%) acknowledged that sexual and reproductive health courses for PHCNs should include a medication abortion provision component and needed to be provided by the Victorian Government in partnership with primary health care networks. Furthermore, incentives (100%) and remuneration (85%) need to be offered for practices to facilitate PHCN's course attendance. Secondly, most panelists (85%) agreed that support of the model is required from practice GPs and all involved stakeholders on the supply-side of the service, ranging from reception staff members, local hospitals, pharmacists to, ultimately, professional peak bodies and the Department of Health. All panelists (100%) recognized the importance of good communication about medication abortion provision between GPs, PHCNs and hospitals and most (95%) agreed that PHCNs need leaders, mentors and networks, especially in more remote settings. The third implementation barrier related to the current funding model, which requires GP involvement to enable payment for nurse-led medication abortion provision. Nearly all panelists (90%) agreed that specific funding should be created for PHCN consultations related to medication abortion provision. Next, the majority of panelists acknowledged a local lack of (supportive) health professionals for pathology and pharmaceutical services (95%), after-hour care (90%), and for back-up in the case of complications (80%). Most panelists (85%) agreed that the Department of Health should issue a Statement of Expectation about medication abortion being a core business for primary health systems in regional and rural areas and they all (100%) acknowledged that access to radiographers and after-care services should be guaranteed when needed. The fifth barrier to model implementation was associated with the recognized influence of abortion stigma [8]. Nearly all panelists (90%) agreed that abortion seeking women from regional/rural communities worry about confidentiality and privacy issues. Furthermore, GPs and PHCNs fear moral judgment by other health professionals (84%) and negative publicity or personal vilification from members of conservative communities if they were to provide medication abortion services (84%). All panelists recognized that abortion should be seen as being part of comprehensive sexual and reproductive health care and that there should be support and protection for medication abortion providing health professionals. Finally, in order to implement the model, most panelists (90%) agreed that the traditional doctor-nurse distribution of labor, in which the PHCN's role mainly involves assistance and procedural activities, needs to be challenged. Further, that recommendations to parliament and working parties need to be made to change legislation to allow a wider scope of practice for PHCNs.

4. Discussion

The Delphi panelists generally agreed that a 'legally feasible' nurse-led model of medication abortion provision is acceptable in the primary health setting of regional/rural Victoria. Successful implementation of the model, however, requires a change in the current funding model and adjustments of regulatory structures. Furthermore, to provide the PHCN a more autonomous role, medication abortion prescription policy change is recommended, or alternative solutions, such as onsite medication abortion storage or designated prescriber roles can be intro-

Table 2
Final consensus levels of the generated statements.

Statements	Consensus* (%)	IQR**
Construction of a nurse-led MA model		
1 All women with an unwanted pregnancy should be referred to an appropriately trained PHCN	84	1
2 The PHCN role should include non-directive pregnancy counseling	90	1
3 A PHCN should be able to communicate the pros and cons of the medication abortion	95	0
4 A sufficiently trained PHCN is not able to independently rule out any contraindications to the use of abortion medication	80****	0
5 When practice GPs refuse to provide MA, PHCNs should be able to initiate pretesting before referral	85	1
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	80	1
7 MA in the primary health care sector can be provided by a PHCN in cooperation with a GP	75	0.75
8*** All steps in the MA process that are handled by an appropriately trained PHCN should only be allowed under the supervision of a GP	47****	1
9*** 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 MA	58	2
10 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	95	1
11 The administration of mifepristone can be independently handled by a PHCN	95	1
12 The PHCN role should include contraception	100	0
13 PHCNs can independently manage prophylactic pain medication	90	1
14*** Non-life-threatening complications of MA, like hemorrhages or infections, should be managed by doctors only	47****	2
15 Completion of an abortion cannot be totally assessed by a PHCN	85****	1
16 The appropriately trained PHCN can manage post-abortion contraception, including the insertion of implants, IUDs or the provision of injectable contraception	95	1
17 The PHCN role can include the provision of emotional support following the procedure if required	90	0.75
Barriers to model implementation		
18 Most GPs are aware of the online MA training currently available	80****	0
19 There is insufficient availability of MA trained GP providers in regional and rural Victoria	95	1
20 There is a lack of professional development and further training possibilities for PHCNs (including MA provision)	85	1
21 Many GPs are not aware that they can offer MA	85	1
22 Traditionally, GPs prefer to be in charge over some services, which includes MA provision	95	1
23 Not all local pharmacies supply, or wish to supply, MA drugs	84	1
24 Without a GP's approval for MA provision, nurse involvement is not supported	85	1
25 There is no support from local hospitals and community health services to GPs and PHCNs who provide MA services	75	0.75
26*** There is a well-established positive collaboration between the Australian Medical Association and nursing authorities	47****	1
27*** There is a lack of specialist and other health professionals' support available to GPs and PHCNs that provide MA services	74	1
28*** The Victorian Government is negligent about discussing and/or promoting MA	47	3
29*** GPs fear ramifications on both time and negative outcomes (complications) when providing MA services	72	1
30*** It appears that public expectations about equitable availability of abortion services are ahead of the actual implementation	68	2
31 GP involvement is required to enable payment for this service	80	1
32 There is not enough funding to make nurse-led MA provision profitable	79	1
33*** 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	63****	2
34 There is a lack of after-hours care in small towns for women who go through a MA	90	1
35 There is a lack of local allied professionals and accessible services for women (such as radiographers) in regional and rural Victoria	95	0.75
36 There is a lack of local access to surgical back-up in regional and rural Victoria in the case of MA complications	80	0.75
37 Women in regional and rural areas worry about confidentiality and privacy issues	90	0.75
38 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	1
39 There is pressure on GPs to conform to the conservative views of their colleagues regarding the provision of MA services	90	0
40 GPs fear moral judgment by other health professionals if they were to provide MA services to their patients	84	0
41*** The rural population does not complain about poor MA services in their area, because it is a private and contentious subject	74	3
42*** GPs are concerned about their safety and wellbeing if they were to provide MA services	74	2
43*** GPs and PHCNs fear the presence of anti-choice protestors outside the facility if they were to provide MA services	68	2
44*** 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	58	2
45*** GPs concerns regarding MA service provision appear to be based mainly on workload and time	42	2
Possible solutions to model implementation		
46 Incentives and support should be offered for rural and regional GPs to undertake MA training and service provision	100	0
47 Professional development courses in sexual and reproductive health for nurses should include a MA provision component	95	0
48 The State Government should establish an action plan in partnership with PHC networks to prioritize, promote and provide affordable, accessible MA professional development and training for GPs and PHCNs working in regional and rural Victoria	95	0
49 Supportive information should be freely available to all MA providing nurses (e.g. Resources on the MS health website)	95	0
50 PHCNs require flexibility and choice for online training or locally organized MA training session, to maximize training opportunities	100	1
51 Incentives like scholarships should be offered to upskill PHCNs for MA provision	100	1
52 Professional development programs for GP accreditation should include MA provision	95	0.75
53 Remuneration needs to be offered to practices when nurses attend professional development courses on MA	85	0.75
54 Direction is required from the Australian health practitioner regulation agency on the nurses' scope of practice in MA provision	90	1
55 Improve communication about MA between local hospitals, GPs and PHCNs	100	0
56 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	95	0
57 There should be support and endorsement of MA from local health professionals (including boards of hospitals and community centres)	100	0
58 Establish a PHCN network for MA practice which includes mentoring, networking, and opportunities to share experiences and learn	100	0.75
59 Create a MA provision model for PHCNs, which can provide guidance, support and help to develop their roles	100	0.75
60 Develop a dedicated team of MA-trained PHCNs to support the provision of MA services in smaller or more remote health care settings	95	0
61 Nurses need leaders and mentors to encourage and empower them in their professional development, which includes MA provision	95	0.75
62 Ensure that PHCNs who provide MA are covered by insurance	95	0
63 Create a Medicare Benefits Schedule ¹ (MBS) item number for PHCN consultations related to ma provision	90	1

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Table 2 (continued)

Statements	Consensus* (%)	IQR**
64 A funded coordinator role needs to be established that offers guidance and help for PHCNs who want to do the MA training	79	1
65 Payment for nurse-led MA provision should be independent of any GP involvement	90	1
66 Financially support women to facilitate MA access (e.g. for travel and childcare costs)	84	1
67 Develop best practice service models for MA which includes access to radiography and after care services	100	1
68 Guarantee access to quality specialist back-up when needed	100	0
69 Increase and improve the availability of MA drugs in local pharmacies through MA education programs for pharmacists	95	0
70 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	95	1
71 Public awareness about the availability of MA can lead to increased public demand. This can act as a driver for improved service provision	95	1
72 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	85	0.75
73 GP clinics should stock and supply abortion medication so women do not need to go somewhere else	85	1
74 Emergency department staff should respond in a non-judgmental way in cases of abortion complications	100	0
75 Abortion should be seen as being part of comprehensive sexual and reproductive health care, consequently reducing abortion stigma	100	0
76 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	100	0
77 Conscientious objection should be out in the open. The public needs to know if a doctor is a conscientious objector	90	0.75
78*** GPs who provide MA should be made visible (e.g. Advertise with "all-option pregnancy counseling offered at this general practice")	68	2
79 Encourage nursing research to validate the role of PHCNs and demonstrate effectiveness of nurse-led MA provision	90	0.75
80 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	90	0.75
81 Introduce data collection systems for monitoring and evaluation of nurse-led MA provision in regional and rural Victoria	90	0.75
82 Make recommendations to parliament and working parties to change legislation to allow a wider scope of practice for PHCNs	90	1
83 Change legislation to allow prescription of abortion medication by registered nurses in regional and rural Victoria	85	1

Notes: *Consensus for agreement is reached if valid percent agreement was $\geq 75\%$ and IQR ≤ 1 ; **The inter-quartile range shows the spread of the scores in the distribution; ***Non-consensus statements; ****Negatively worded statements are reverse coded with percentage disagreement.

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. Their benefits schedule lists all services subsidized by the Australian Government.

duced [26]. In areas without an easily accessible pharmacist, shared care models with telemedicine providers could be further explored [27,28].

Additionally, implementation requires interdisciplinary and organizational support for nurse-led medication abortion provision, which seems to be associated with awareness of the medication abortion procedure, local regulations, and the potential roles of

PHCNs in general practice [29]. Interventions should therefore signal that abortion is an essential part of sexual and reproductive health care and should not be treated differently to other health care provisions. Consequently, professional education needs to address underlying unfounded concerns about the legality of abortion, procedure complications, and/or the lack of a specialized infrastructure. More general information provision should focus on the benefits,

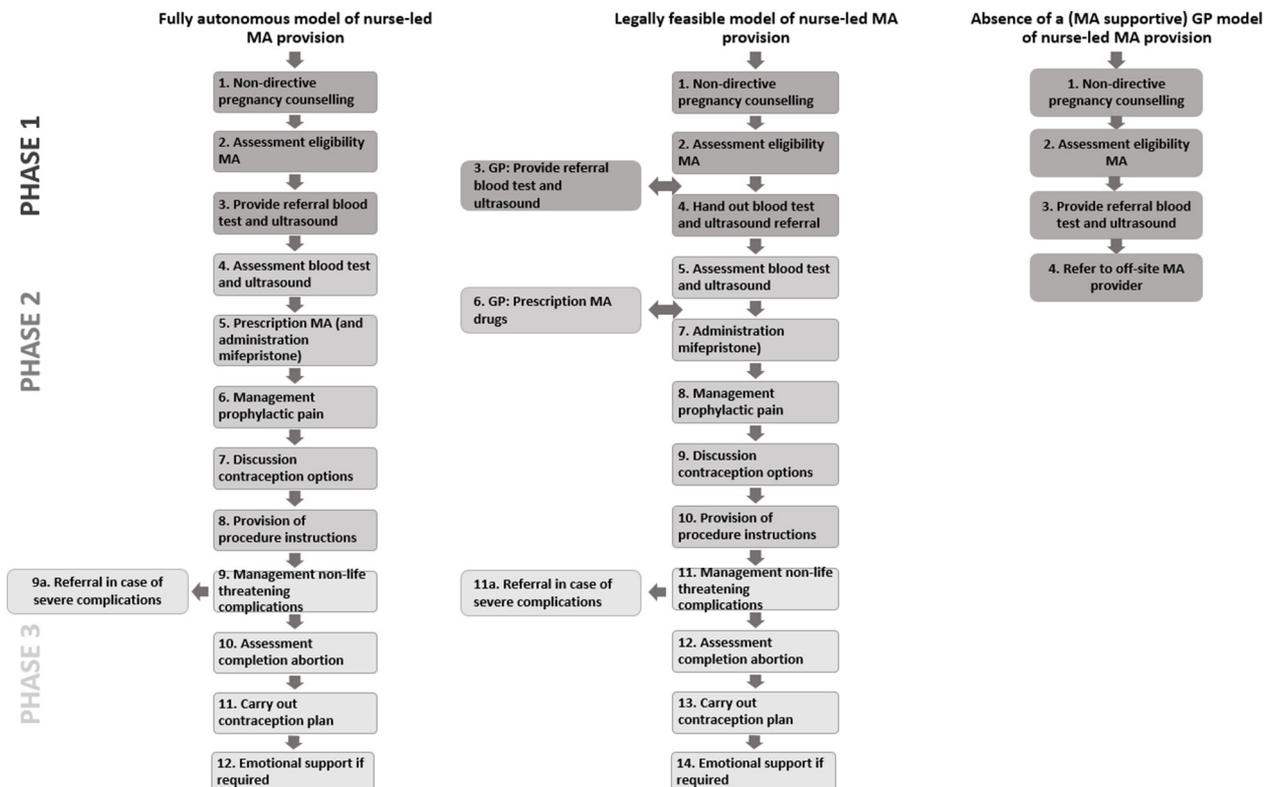


Fig. 2. Three models of nurse-led MA provision. Note: Non-directive pregnancy counseling and a contraception plan only need to be provided if required.

safety, commonality and frequency of induced abortions in Australia to shift social and cultural attitudes and norms [30,31].

While local supportive health professionals are important for the improvement of abortion access in regional and rural areas, they are not crucial. Concerns regarding the lack of closely available physicians for surgical interventions in the case of complications are disputable, as women can be instructed on when to seek medical help, using trained PHCNs and Marie Stopes' 24-h accessible telephone advice service for support. Likewise, the recommendation that medication abortion provision can only be offered in settings with suitable emergency care need to be less explicit, as no driving time restrictions are in place for deliveries or spontaneous abortions [32]. Finally, the use of a pre-abortion ultrasound is often medically unnecessary, and making this mandatory procedure optional will simplify and de-medicalize medication abortion provision and facilitate abortion access [33–35].

The reported lack of medication abortion training opportunities for PHCNs calls for a strategy that includes regulatory structures for competency-based medication abortion training and accreditation for PHCNs, combined with ongoing guidance, support and mentoring [9]. Training should be expanded beyond Marie Stopes and integrated within the programs provided and/or coordinated by professional GP and nurse organizations. Further, locally organized accredited training for GPs and PHCNs should be made affordable and accessible.

The main limitation of this study is the use of a self-selected sample, and it can therefore not be assumed that the panelists were a good representation of all key professionals interested in medication abortion provision. Similarly, there is no guarantee that comparable results will be obtained from a different panel. However, considerable effort was undertaken for the selection of the Delphi experts, resulting in a sample size that fits well within the commonly acceptable range, and a relatively low attrition rate (17%), which, together with the extensive comments provided, indicate an ongoing commitment of the panelists to the study's topic.

This Delphi study developed three models for nurse-led medication abortion provision in regional and rural Victoria, including recommendations to overcome implementation barriers. The study raises several opportunities for future research, including a trial of the models to assess feasibility, effectiveness, safety and acceptability. Additionally, research may focus on the implementation of the nurse-led model in jurisdictions beyond Victoria where abortion access for women is limited. Due to the current requirements for pre-abortion ultrasounds, anti-D administration to Rh-negative women, and clinical follow-up, our nurse-led model still remains a largely medicalized procedure [2]. Thus, to further expand access to abortion care in Australia's service-poor areas, regulatory policy updates are required and further research could explore simplification of service delivery, using support mechanisms such as technological innovations for self-management of abortion care and self-assessment of abortion completion.

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