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Supplementary Material

How can we encourage the provision of early medical abortion in primary care? Results of a best–worst scaling survey

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Supplementary material

How can we encourage the provision of early medical abortion in primary care? Results of a best-worst scaling survey

1 Literature search

Medline, Embase, PubMed and EconLit were searched to identify Australian and international literature using the following search terms: abortion, medical abortion, medical termination of pregnancy, MTOP, barriers, facilitators, qualitative, providers, health care professionals, primary care.

We excluded papers which reported on barriers and facilitators from the perspectives of low-income countries which are not relevant to the Australian health care system. We also excluded papers which discussed barriers and facilitators from an international perspective which focussed on country-specific legal and social/religious issues which affect the legal provision of abortion. As abortion has been decriminalised in all states of Australia, these papers were not relevant to this research.

1.1 Barriers

Doran and Nancarrow 2015[1] identified 'moral opposition' and other negative attitudes of health care professionals, as well as the harassment of providers as important barriers. Other barriers included lack of training opportunities, resource issues such as insufficient support at the hospital level and professional isolation due to too few providers. Baird 2015[2] found that logistical issues such as access to MA medication and ultrasound, psychological services and support services for follow-up and to manage complications were important barriers as were not wanting to be inundated with patients and the challenges of integrating the provision of MA into their current practice. In addition to the issues identified by Baird 2015[2] and Dawson *et al* 2016[3], 2017[4] also noted issues such as the belief that MA is beyond a general practitioner's (GP's) scope of practice, that the provision abortion requires specialist services and not wanting to be stigmatised as an abortion provider. Other barriers echoed those reported above, including the fear of being clinically 'isolated' i.e. not having a support network of colleagues and/or practices to enable them to debrief and discuss problems and solutions.

1.2 Facilitators

It is notable that facilitators were less commonly identified separately from barriers; in some papers they were reported almost incidentally as the opposite of the barriers. Where they were investigated separately, some facilitators were the reverse of barriers. For example, the availability of a community of practice and transparent referral pathways to hospital both identified by Dawson *et al* 2017[3] and Doran and Nancarrow 2015[1] are examples of this. However, the other facilitators identified – a desire to increase access to abortion for under-served women and/or communities, previous experience in the provision of abortion, request/s from women or other health care professionals to provide abortion and knowledge of the research evidence regarding abortion are not the reverse of barriers (Baird 2015[2]; Doran and Nancarrow 2015[1]; Dawson *et al* 2017[3].

[1] Doran, F, Nancarrow, S (2015) Barriers and facilitators of access to first-trimester abortion services for women in the developed world: a systematic review. *J Fam Plann Reprod Health Care* 41, 170-80.

[2] Baird, B (2015) Medical abortion in Australia: a short history. *Reprod Health Matters* 23, 169-76.

[3]

[43] Dawson, AJ, Nicolls, R, Bateson, D, Doab, A, Estoesta, J, Brassil, A, Sullivan, EA (2017) Medical termination of pregnancy in general practice in Australia: a descriptive-interpretive qualitative study. *Reprod Health* 14, 39.

2 Details of the designed experiment

We used triples rather than larger choice sets based on feedback to a version with choice sets of sizes 3 and 4 and 5. All respondents to that version preferred the smaller choice sets.

Based on recommendations in Orme 2005[5] we choose to have each item presented to each respondent 3 times. Based on the results in Furlan and Turner 2014[6] we decided that 15 versions was appropriate.

For the design on 6 items each pair of items was missing from exactly one version (and so across the 15 versions the design was pairwise balanced). For the design on 15 items each pair of items appeared together either 6 or 7 times across the 15 versions, which is as close to equal pair balance as is possible for 15 items presented in triples with each item appearing in 3 triples, and with 15 versions.

3 Comparison of Ekas sample with the National Health Workforce Dataset (NHWDS)

The sample of GPs (N = 150) and RNs (N = 150) recruited using Ekas Marketing Research Services Australia (ekas.com.au) was compared to the Australian GP and RN workforce in the NHWDS (hws.health.gov.au) for differences in key demographics. No significant differences were found. The relevant data are shown below.

3.1 Gender

Table 1. Comparison of gender - GPs

	GPs - Australia 2021				Ekas Sample	
	N	%	N (FTE)	% (FTE)	N	%
Female	18,491	48.3%	12,703.2	41.0%	62	41.3%
Male	19,783	51.7%	18,268.6	59.0%	88	58.7%

Table 2. Comparison of gender - RNs

	RNs - Australia 2021		Ekas Sample	
	N	%	N	%
Female	292,833	88.3%	129	86.0%
Male	38,746	11.7%	20	13.3%
Other	-	-	1	0.7%

[5] Orme, B (2005) Accuracy of HB estimation in MaxDiff experiments. *Sawtooth Research Paper Series* 1-7.

[6] Furlan, R, Turner, G (2014) Maximum difference scaling: Exploring the impact of design elements on results. *International Journal of Market Research* **56**, 367-385.

3.2 Age

Table 3. Comparison of age - GPs

	GPs - Australia 2021				Ekas Sample	
	N	%	FTE - N	FTE - %	N	%
0 - 39	9,914	25.9%	5,863.5	18.9%	37	24.7%
40 - 54	14,032	36.7%	12,709.0	41.0%	113	75.3%
55 - 64	8,367	21.9%	7,854.3	25.4%		
65+	5,964	15.6%	4,545.0	14.7%		
Under 40	9,914	25.9%	5,863.5	18.9%	37	24.7%
40+	28,363	74.1%	25,108.3	81.1%	113	75.3%

Table 3. Comparison of age - RNs

	RNs - Australia 2021		Ekas Sample	
	N	%	N	%
Under 30	60,041	18.1%	9	6.0%
30-39	94,226	28.4%	55	36.7%
40-49	69,669	21.0%	41	27.3%
50-59	65,827	19.9%	27	18.0%
60+	41,829	12.6%	18	12.0%
Under 40	154,267	46.5%	64	42.7%
40+	177,325	53.5%	86	57.3%

3.3 Urban/ rural practice location

Table 5. Practice location - GPs

GPs – Australia 2021			Ekas Sample		
	N (FTE)	% (FTE)		N	%
MM1 - Metropolitan	22,956.5	74.1%	**Inner metro**	67	78.7%
			Outer metro	51	
MM2 - Regional Centres	2,672.1	8.6%	**Regional centre**	17	11.3%
MM3 - Large rural towns	2,148.8	6.9%	**Rural town**	13	8.7%
MM4 - Medium rural towns	1,334.2	4.3%			
MM5 - Small rural towns	1,497.7	4.8%			
MM6 - Remote communities	222.3	0.7%	**Remote Setting**	2	1.3%
MM7 - Very remote communities	140.1	0.5%			

Table 6. Practice location - RNs

RNs Australia - 2019			Ekas Sample		
	N (FTE)	% (FTE)		N	%
MM1 - Metropolitan	182,475.6	74.3%	**Inner metro**	78	74.0%
			Outer metro	33	
MM2 - Regional Centres	23,987.2	9.8%	**Regional centre**	32	21.3%
MM3 - Large rural towns	18,560.0	7.6%	**Rural town**	7	4.7%
MM4 - Medium rural towns	7,667.0	3.1%			
MM5 - Small rural towns	7,424.9	3.0%			
MM6 - Remote communities	3,039.0	1.2%	**Remote Setting**	-	-
MM7 - Very remote communities	2,342.4	1.0%			

4 Details of Models

The MNL model is the most commonly used model to model the choices made in a choice experiment. It assumes that preferences are homogeneous across respondents. Estimates from this model align closely with the count analysis described in the paper.

If we want to allow parameters to differ for different individuals then the mixed logit model (MIXL) is the most common extension of the MNL model. In the MIXL model it is assumed that the vectors of parameters come from some underlying distribution and it is the parameters of this distribution that are estimated. As is commonly done, in this paper we have assumed that the underlying distribution is normal and we have estimated models with two different forms for the covariance matrix. In one form the covariance matrix is assumed to be diagonal and in the other no restrictions are placed on the entries in the estimated covariance matrix. We have also allowed the mean vector to take one of two forms - it can be the same for all health professionals or there can be different means for GPs and for registered nurses (RNs).

We have used the Bayesian Information Criterion (BIC) to distinguish between the models and have chosen the model with the lowest BIC to calculate the relative attribute importance values presented in the paper.

4.1 Details of the best model for facilitators

The model with the lowest BIC was the correlated MIXL model in which the means were different for the two professions. The results of the model, estimated using the gmnl package in R, are given in Table 1. The base facilitator was F2 (availability of a community of practice to support provision) and the base profession was RNs. Since we have allowed the covariance matrix to have non-zero correlations, there are estimates for all of the entries in that matrix. There are 5 estimated variances, indicated by F1:F1, F3:F3 etc and the remaining entries are covariances, one of which, F5:F6, is not significantly different from 0.

Table 7. Coefficients and standard errors of Facilitators

	Difference from Base for GPs Mean (SE)	Base (RNs) Mean (SE)	Covariance Matrix Elements (SE)
F1 - Desire to increase access to abortion for under-served women/communities	-0.87 (0.36)*	-0.16 (0.26)	
F3 - Transparent referral pathways to local hospitals	0.42 (0.31)	-0.59 (0.22)**	
F4 - Previous experience providing EMA	1.52 (0.39)***	-2.25 (0.29)***	
F5 - Request from women or other HCP to provide EMA	-0.57 (0.38)	-1.16 (0.27)***	
F6 - Knowledge of the research evidence regarding EMA	-0.21 (0.38)	-1.47 (0.27)***	
F1:F1			2.69 (0.22)***
F1:F3			0.49 (0.21)*
F1:F4			1.06 (0.24)***
F1:F5			1.91 (0.24)***
F1:F6			1.11 (0.26)***
F3:F3			2.13 (0.17)***
F3:F4			1.18 (0.21)***
F3:F5			0.80 (0.18)***
F3:F6			0.80 (0.20)***
F4:F4			2.41 (0.20)***
F4:F5			0.67 (0.15)***
F4:F6			1.21 (0.20)***
F5:F5			1.72 (0.16)***
F5:F6			0.28 (0.19)
F6:F6			2.17 (0.17)***

*Base level: F2 - Availability of a community of practice to support provision; Base profession: RNs; P values: < 0.001***, < 0.01**, < 0.05*; SE: standard error; GP: general practitioner; RN: registered nurse; EMA: early medication abortion; HCP: health care provider.*

4.2 Details of the best model for barriers

The model with the lowest BIC was the uncorrelated MIXL model in which the means were different for the two professions. The results of the model, estimated using the gmnl package in R, are given in Table 2. The base barrier was B9 (logistical constraints (need for pathology/ ultrasound)) and the base profession is RNs. Since we have assumed that covariance matrix is diagonal as well as the means we have an estimate of the standard deviation for each of the attributes. All of these are significantly different from 0, indicating significant heterogeneity.

Table 8. Coefficients and standard errors of Barriers

	Difference from Base for GPs Mean (SE)	Base (RNs) Mean (SE)	Std. Dev (SE)
B1 - Legal requirements that EMA can only be provided by a medical practitioner	0.21 (0.19)	1.01 (0.13)***	0.90 (0.11)***
B2 - Stigma of being known as an EMA provider	-1.87 (0.22)***	2.12 (0.16)***	1.27 (0.12)***
B3 - Lack of support from senior clinicians in the community/local hospitals to manage complications	-0.40 (0.27)	0.31 (0.20)	2.06 (0.17)***
B4 - Difficulty in advertising EMA	-0.96 (0.23)***	0.79 (0.16)***	1.50 (0.12)***
B5 - Remuneration not worth it	-0.53 (0.17)**	1.43 (0.13)***	0.69 (0.10)***
B6 - Limited knowledge of EMA	0.97 (0.24)***	-0.22 (0.18)	1.54 (0.12)***
B7 - Lack of clinical guidelines	-0.15 (0.16)	1.56 (0.12)***	0.49 (0.11)***
B8 - Resources (time, effort, $) required to be trained/credentialed	0.40 (0.18)*	0.18 (0.13)	0.92 (0.12)***
B10 - Lack of demand from women	0.16 (0.17)	0.96 (0.12)***	0.66 (0.10)***
B11 - Amount of information provision/ counselling required	-0.37 (0.20)	2.01 (0.14)***	1.02 (0.12)***
B12 - Some women who are not my patients may not return for follow-up	-0.05 (0.20)	1.78 (0.14)***	1.07 (0.11)***
B13 - No relationship with needed support services (pharmacists, ED, psych support)	-0.19 (0.18)	1.20 (0.13)***	0.88 (0.10)***
B14 - Not wanting the be inundated with patients from other practices	0.02 (0.18)	0.68 (0.13)***	0.90 (0.11)***
B15 - Lack of support from practice colleagues to provide continuity of care	-0.11 (0.17)	1.28 (0.12)***	0.80 (0.10)***

*Base level: B9 - Logistical constraints (need for pathology / ultrasound); Base profession: RNs; P values: < 0.001***, < 0.01**, < 0.05*; GP: general practitioner; RN: registered nurse; SE: standard error; EMA: early medical abortion; ED: emergency department.*

5 Feedback from respondents

The feedback from the respondents was generally positive and the survey well received. Only 15% of respondents found the survey to be difficult or extremely difficult (Table 3). An additional follow-up question asked respondents if there were any other factors not included in the survey that they thought were important to consider. Most respondents (~60%) did not feel that there were any other important barriers or facilitators to include. Those who did suggest other factors commented that legal issues, cost to client/ financial issues, Medicare rebates, cost of training, EMA provided by pharmacists, ethical reasons, religious concerns, and health literacy of consumers could also be important to consider.

Table 9. Survey Feedback

	All participants (N = 300)
Please rate how easy or difficult it was to complete the choice questions?	
Extremely easy	43 (14.3)
Easy	131 (43.7)
Neither easy nor difficult	82 (27.3)
Difficult	41 (13.7)
Extremely difficult	3 (1.0)

6 Example of a version of the full survey

Survey: EMA Barriers and Facilitators Best Worst Scaling
Survey provider: Survey Engine GmbH
Date of collection: September 2021
Conducted by: Centre for Health Economics Research and Evaluation (CHERE), University of Technology Sydney

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Thank you for taking the time to complete this survey. We appreciate your input into our research.

What is the research study about?
The purpose of this research is to gain an understanding of the factors that either hinder or help GPs and nurses working in primary care to provide early medical abortion (EMA). Your responses indicating which factors would be most helpful or most likely to hinder your provision of early abortion services will be used to help inform decision-makers in Australia.

Who is conducting this research?
Professor Marion Haas, Professor Deborah Street, and Dr Jody Church from the Centre for Health Economics Research and Evaluation (CHERE) at the University of Technology Sydney. The research is funded by an NHMRC research grant (SPHERE: Sexual and Reproductive Health for Women: Achieving better outcomes through primary care), which aims to improve the quality, safety, and capacity of sexual and reproductive health care services to achieve better outcomes for women.

Do I have to take part in this research study?
Participation in this study is voluntary. It is completely up to you whether or not you take part. If you decide to participate, please continue with the survey by clicking on NEXT. If you begin, you can change your mind at any time and stop the survey.

Are there any risks?
We don't expect this questionnaire to cause any harm or discomfort.

What will happen to the information collected?
The survey is anonymous, and your identity can never be linked to your answers. Submission of this online questionnaire is an indication of your consent to the research team collecting and using your answers to the questions for the research project. At the end of this research, we will store the survey data for future use in research projects that are an extension of this one, developing methods for the evaluation of health care treatments and choice surveys. The data will remain the responsibility of the researchers named above and will always be treated confidentially. We plan to publish the results of this research in academic journals and reports for medical organisations and health departments.

What if I have concerns or a complaint?
If you have concerns about the research that you think we can help you with, please feel free to contact Marion Haas at marion.haas@uts.edu.au or Jody Church at jody.church@uts.edu.au.

If you would like to talk to someone who is not connected with the research, you may contact the Research Ethics Officer on 02 9514 9772 or Research.ethics@uts.edu.au and quote this number ETH18-2507.

Are you opposed to abortion for moral, religious or ethical reasons?

Select only one answer

- ○ Yes
- ○ No

Research Aim

Early medical abortion (EMA) is currently legal in Australia. EMA involves the use of two medications (*mifepristone* and *misoprostol*) in pregnancies up to 63 days gestation. Misoprostol is given 36-48 hours after the mifepristone.

Although it is intended that primary care play an important role in the provision of EMA, currently only a small number of GPs are registered to do so.

The aim of this research is to investigate the factors that either hinder or help GPs and nurses working in primary care to provide EMA.

The survey we have designed will take you approximately 15 minutes to complete.

Do you agree to be part of this research and for the results of this survey to be published in a form that does not identify you?

Select only one answer

- ○ Yes
- ○ No

Your task in this survey

Please imagine that you are approached by your Primary Health Network (PHN) who would like to find out under what circumstances you or your practice would be prepared to provide EMA for women in your community.

You decide that you are willing to consider this idea and the first step is to complete this survey.

Section 1: you will be asked to complete some hypothetical choice tasks

Part A: rank different factors that might help facilitate access to EMA
Part B: rank different factors that might act as barriers to EMA

Section 2: you will be asked some questions about yourself and your work

Section 3: you will be asked some follow-up questions and there is an opportunity for you to provide feedback about the survey or this topic in general

Section 1

PART A
Please read the list of factors that if implemented might make it more likely that you would consider providing EMA to the women in your community.

Indicate which factor would be **most helpful** to you providing EMA and which factor would be **least helpful** to you providing EMA.

Please note: there are no right or wrong answers here, we are interested in your opinion.

Question 1 of 6

Which of these factors would be **most helpful** to you providing EMA to the women in your community?

Which of these factors would be **least helpful** to you providing EMA to the women in your community?

	Request from women or other HCP to provide EMA	Desire to increase access to abortion for under-served women/ communities	Availability of a community of practice to support provision ⓘ
Most helpful?	○	○	○
Least helpful?	○	○	○

Question 2 of 6

Which of these factors would be **most helpful** to you providing EMA to the women in your community?

Which of these factors would be **least helpful** to you providing EMA to the women in your community?

	Transparent referral pathways to local hospitals ⓘ	Previous experience providing EMA	Desire to increase access to abortion for under-served women/ communities
Most helpful?	○	○	○
Least helpful?	○	○	○

Question 3 of 6

Which of these factors would be **most helpful** to you providing EMA to the women in your community?

Which of these factors would be **least helpful** to you providing EMA to the women in your community?

	Request from women or other HCP to provide EMA	Knowledge of the research evidence regarding EMA	Previous experience providing EMA
Most helpful?	○	○	○
Least helpful?	○	○	○

Question 4 of 6

Which of these factors would be **most helpful** to you providing EMA to the women in your community?

Which of these factors would be **least helpful** to you providing EMA to the women in your community?

	Transparent referral pathways to local hospitals ⓘ	Request from women or other HCP to provide EMA	Knowledge of the research evidence regarding EMA
Most helpful?	○	○	○
Least helpful?	○	○	○

Question 5 of 6

Which of these factors would be **most helpful** to you providing EMA to the women in your community?

Which of these factors would be **least helpful** to you providing EMA to the women in your community?

	Transparent referral pathways to local hospitals ⓘ	Knowledge of the research evidence regarding EMA	Availability of a community of practice to support provision ⓘ
Most helpful?	○	○	○
Least helpful?	○	○	○

Question 6 of 6

Which of these factors would be **most helpful** to you providing EMA to the women in your community?

Which of these factors would be **least helpful** to you providing EMA to the women in your community?

	Previous experience providing EMA	Desire to increase access to abortion for under-served women/ communities	Availability of a community of practice to support provision ⓘ
Most helpful?	○	○	○
Least helpful?	○	○	○

Please tell us what factors were very important to you when completing the choice tasks about things that would help you to provide EMA?

Select all that apply

- ☐ Desire to increase access to abortion for under-served women/communities
- ☐ Availability of a community of practice to support provision
- ☐ Transparent referral pathways to local hospitals
- ☐ Previous experience providing EMA
- ☐ Request from women or other HCP to provide EMA
- ☐ Knowledge of the research evidence regarding EMA

- ☐ I do not consider any of these to be very important

PART B

Please read the list of factors that may be hindering you from being able to provide EMA to the women in your community.

Indicate which factor would be **most likely to hinder** you providing EMA and which factor would be **least likely to hinder** you providing EMA.

Please note: there are no right or wrong answers here, we are interested in your opinion.

Question 1 of 15

Which of these factors would be **most likely to hinder** you providing EMA to the women in your community?

Which of these factors would be **least likely to hinder** you providing EMA to the women in your community?

	Difficulty in advertising EMA	Lack of clinical guidelines	Legal requirement that EMA can only be provided by a medical practitioner
Most likely to hinder?	○	○	○
Least likely to hinder?	○	○	○

Question 2 of 15

Which of these factors would be **most likely to hinder** you providing EMA to the women in your community?

Which of these factors would be **least likely to hinder** you providing EMA to the women in your community?

	No relationship with needed support services (pharmacists, ED, psych support)	Resources (time, effort, $) required to be trained/ credentialed	Legal requirement that EMA can only be provided by a medical practitioner
Most likely to hinder?	○	○	○
Least likely to hinder?	○	○	○

Question 3 of 15

Which of these factors would be **most likely to hinder** you providing EMA to the women in your community?

Which of these factors would be **least likely to hinder** you providing EMA to the women in your community?

	No relationship with needed support services (pharmacists, ED, psych support)	Limited knowledge of EMA	Lack of support from practice colleagues to provide continuity of care
Most likely to hinder?	○	○	○
Least likely to hinder?	○	○	○

Question 4 of 15

Which of these factors would be **most likely to hinder** you providing EMA to the women in your community?

Which of these factors would be **least likely to hinder** you providing EMA to the women in your community?

	Lack of clinical guidelines	Stigma of being known as an EMA provider	Some women who are not my patients may not return for follow-up
Most likely to hinder?	○	○	○
Least likely to hinder?	○	○	○

Question 5 of 15

Which of these factors would be **most likely to hinder** you providing EMA to the women in your community?

Which of these factors would be **least likely to hinder** you providing EMA to the women in your community?

	No relationship with needed support services (pharmacists, ED, psych support)	Lack of support from senior clinicians in the community/ local hospitals to manage complications	Stigma of being known as an EMA provider
Most likely to hinder?	○	○	○
Least likely to hinder?	○	○	○

Question 6 of 15

Which of these factors would be **most likely to hinder** you providing EMA to the women in your community?

Which of these factors would be **least likely to hinder** you providing EMA to the women in your community?

	Lack of demand from women	Amount of information provision/ counselling required	Stigma of being known as an EMA provider
Most likely to hinder?	○	○	○
Least likely to hinder?	○	○	○

Question 7 of 15

Which of these factors would be **most likely to hinder** you providing EMA to the women in your community?

Which of these factors would be **least likely to hinder** you providing EMA to the women in your community?

	Logistical constraints (need for pathology / ultrasound)	Legal requirement that EMA can only be provided by a medical practitioner	Some women who are not my patients may not return for follow-up
Most likely to hinder?	○	○	○
Least likely to hinder?	○	○	○

Question 8 of 15

Which of these factors would be **most likely to hinder** you providing EMA to the women in your community?

Which of these factors would be **least likely to hinder** you providing EMA to the women in your community?

	Difficulty in advertising EMA	Not wanting to be inundated with patients from others' practices	Amount of information provision/ counselling required
Most likely to hinder?	○	○	○
Least likely to hinder?	○	○	○

Question 9 of 15

Which of these factors would be **most likely to hinder** you providing EMA to the women in your community?

Which of these factors would be **least likely to hinder** you providing EMA to the women in your community?

	Difficulty in advertising EMA	Remuneration not worth it	Lack of support from senior clinicians in the community/ local hospitals to manage complications
Most likely to hinder?	○	○	○
Least likely to hinder?	○	○	○

Question 10 of 15

Which of these factors would be **most likely to hinder** you providing EMA to the women in your community?

Which of these factors would be **least likely to hinder** you providing EMA to the women in your community?

	Amount of information provision/ counselling required	Resources (time, effort, $) required to be trained/ credentialed	Limited knowledge of EMA
Most likely to hinder?	○	○	○
Least likely to hinder?	○	○	○

Question 11 of 15

Which of these factors would be **most likely to hinder** you providing EMA to the women in your community?

Which of these factors would be **least likely to hinder** you providing EMA to the women in your community?

	Lack of demand from women	Lack of support from senior clinicians in the community/ local hospitals to manage complications	Lack of support from practice colleagues to provide continuity of care
Most likely to hinder?	○	○	○
Least likely to hinder?	○	○	○

Question 12 of 15

Which of these factors would be **most likely to hinder** you providing EMA to the women in your community?

Which of these factors would be **least likely to hinder** you providing EMA to the women in your community?

	Not wanting to be inundated with patients from others' practices	Logistical constraints (need for pathology / ultrasound)	Lack of support from practice colleagues to provide continuity of care
Most likely to hinder?	○	○	○
Least likely to hinder?	○	○	○

Question 13 of 15

Which of these factors would be **most likely to hinder** you providing EMA to the women in your community?

Which of these factors would be **least likely to hinder** you providing EMA to the women in your community?

	Remuneration not worth it	Logistical constraints (need for pathology / ultrasound)	Limited knowledge of EMA
Most likely to hinder?	○	○	○
Least likely to hinder?	○	○	○

Question 14 of 15

Which of these factors would be **most likely to hinder** you providing EMA to the women in your community?

Which of these factors would be **least likely to hinder** you providing EMA to the women in your community?

	Lack of clinical guidelines	Not wanting to be inundated with patients from others' practices	Resources (time, effort, $) required to be trained/ credentialed
Most likely to hinder?	○	○	○
Least likely to hinder?	○	○	○

Question 15 of 15

Which of these factors would be **most likely to hinder** you providing EMA to the women in your community?

Which of these factors would be **least likely to hinder** you providing EMA to the women in your community?

	Remuneration not worth it	Lack of demand from women	Some women who are not my patients may not return for follow-up
Most likely to hinder?	○	○	○
Least likely to hinder?	○	○	○

Please tell us what factors were very important to you when completing the choice tasks about things that hinder you from providing EMA.

Select all that apply

☐ Legal requirements that EMA can only be provided by a medical practitioner	☐ Stigma of being known as an EMA provider	☐ Lack of support from senior clinicians in the community/local hospitals to manage complications
☐ Difficulty in advertising EMA	☐ Remuneration not worth it	☐ Limited knowledge of EMA
☐ Lack of clinical guidelines	☐ Resources (time, effort, $) required to be trained/credentialed	☐ Logistical constraints (need for pathology / ultrasound)
☐ Lack of demand from women	☐ Amount of information provision/ counselling required	☐ Some women who are not my patients may not return for follow-up
☐ No relationship with needed support services (pharmacists, ED, psych support)	☐ Not wanting the be inundated with patients from others	☐ Lack of support from practice colleagues to provide continuity of care

☐ I do not consider any of these to be very important

Please indicate your level of agreement with the following statements:

Select one response from each row

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
It is acceptable for medical specialists (eg gynaecologists) to provide EMA	○	○	○	○	○
It is acceptable for clinics providing sexual and reproductive health care (eg Marie Stopes, Family Planning) to provide EMA	○	○	○	○	○
It is acceptable for GPs with training and registration to provide EMA	○	○	○	○	○
It is acceptable for Nurse Practitioners with training and registration to provide EMA	○	○	○	○	○

Section 2

The following questions will ask about you and your background.

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1. What is your current age in years?

Select only one answer

-- select one --

2. What is your gender?

Select only one answer

- ○ Male
- ○ Female
- ○ Other

3. What state or territory do you practise in?

Select only one answer

-- select one --

4. Where do you practise?

Select only one answer

- ○ Inner metro
- ○ Outer metro
- ○ Regional centre
- ○ Rural town
- ○ Remote setting

5. What is your profession?

Select only one answer

- ○ General practitioner
- ○ Nurse

GP specific questions

6. What are your affiliations?

Select all that apply

- [ ] Registrar
- [ ] FRACGP
- [ ] FACRRM
- [ ] DRANZCOG
- [ ] FPAA National Certificate in Reproductive and Sexual Health
- [ ] Other

7. Do you have a special clinical interest?

Select all that apply

- [ ] Sexual and reproductive health
- [ ] Women's health
- [ ] O & G
- [ ] Other

8. How long have you been practising?

Select only one answer

-- select one --

9. Do you work full time or part-time?

Select only one answer

- ( ) Full-time
- ( ) Part-time

10. How many hours per week do you work?

Enter text below

hours

11. How many GPs are working in your practice, including you?

Enter text below

GPs

12. Does your practice bulk-bill patients?

Select only one answer

- Yes, all patients
- Yes, some patients
- No patients are bulk-billed

13. What is your primary place of work?

Select only one answer

- General practice
- Family Planning Organisation
- Refugee Health
- Marie Stopes Australia
- Women's Health Service
- Other

14. Have you previously provided EMA?

Select only one answer

- Yes
- No

14b. Have you referred women to another practitioner for EMA?

Select only one answer

- Yes
- No

15. Are you currently involved in the provision of EMA?

Select only one answer

- Yes
- No

16. Which of the following best describes your EMA practice?

Select only one answer

- ○ I am a certified EMA provider
- ○ I am not a certified EMA provider but I am involved in assessment and follow-up care

Nurse specific-questions

6. Are you working as?

Select only one answer

- ○ Registered nurse
- ○ Registered nurse (advanced practice)
- ○ Nurse practitioner
- ○ Other

7. Do you have a special clinical interest?

Select all that apply

- ☐ Sexual and reproductive health
- ☐ Women's health
- ☐ O & G
- ☐ Other

8. How long have you been practising?

Select only one answer

-- select one --

9. Do you work full time or part-time?

Select only one answer

- ○ Full-time
- ○ Part-time

10. How many hours per week do you work?

Enter text below

hours

11. Have you previously been involved in EMA care (eg EMA assessments and follow-up)?

Select only one answer

- ○ Yes
- ○ No

12. Are you currently involved in the provision of EMA?

Select only one answer

- ○ Yes
- ○ No

13. Which of the following best describes what you do?

Select all that apply

- ☐ EMA counselling and assessment
- ☐ Provision of EMA (not prescribing)
- ☐ Follow-up and post-EMA

Section 3

This is the final section of the survey.
We appreciate any comments or feedback you provide.

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1. Please rate how easy or difficult it was to complete the choice questions.

Select only one answer

Extremely easy	Easy	Neither easy nor difficult	Difficult	Extremely difficult
○	○	○	○	○

2. Are there any other factors not included in the survey that you think are important to consider?

Please list any features you think we missed.

3. Do you have any other comments about this survey?

Enter text below

Thank You!

The survey is now complete.

We appreciate your help with our research.

Please press 'submit answers and finish' below to end the survey.