

1     **Title**

2     Termination of pregnancy in Tasmania: Access and service provision from the perspective  
3     of general practitioners

4

5     **Keywords**

6     Family planning services. Health services: accessibility. Primary health care. Reproductive  
7     health services. Women's health services.

8

9     **Abridged title**

10    Termination of pregnancy provision in Tasmania

11

12

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13 **Abstract**

14 **Background:**

15 Termination of pregnancy (TOP) is considered an important component of sexual and  
16 reproductive health internationally, however there are known barriers in Australia and  
17 countries worldwide. This study investigates the issues for general practitioners (GPs)  
18 regarding aiding access to TOP and providing Early Medical Abortion (EMA) services for  
19 Tasmanian women.

20 **Aim:**

21 To identify the knowledge and attitudes of Tasmanian GPs regarding TOP services and to  
22 determine which known barriers to providing EMA are most significant for GPs in  
23 Tasmania, Australia.

24 **Materials:**

25 A survey was developed and piloted based on previous qualitative research which  
26 identified known barriers to accessing TOP. Surveys were posted to all identified GPs in  
27 Tasmania with a reply-paid envelope.

28 **Results:**

29 211 (27.4%) responses were returned. GPs identified difficulty in access to TOP services,  
30 particularly for rural women and those on low income. Almost half of GPs, excluding  
31 conscientious objectors, indicated they would be interested in providing EMA services  
32 however perceived barriers were significant. The most significant barriers related to  
33 accessing appropriate training and support. There was uncertainty around financial reward,  
34 support services, medical indemnity, and access to the medical abortifacient medications  
35 mifepristone and misoprostol.

36 **Conclusions:**

37 Accessing TOP remains an issue for Tasmanian women. Many Tasmanian GPs are  
38 interested in providing EMA services if barriers are addressed, however there is a lack of  
39 knowledge about the practicalities of implementing EMA. Providing practical support to  
40 GPs and increasing knowledge pertaining to EMA provision in general practice could  
41 improve access in primary care.

42

### 43 **Summary text**

44 Despite being recognised as an important aspect of reproductive health, access to  
45 termination of pregnancy remains challenging in many countries. This research examines  
46 the extent of known barriers to accessing termination of pregnancy from the perspective of  
47 general practitioners. The results of the study provide insights that can guide interventions  
48 to improve the support and provision of termination of pregnancy in primary care.

49

### 50 **Acknowledgements**

51 We would like to acknowledge the valuable contribution of Beth Grimmer, Eliza Walker,  
52 Ione Patten and Ella Orłowski to this work in the early stages. We also acknowledge the  
53 support by Family Planning Tasmania for open access publication of this paper.

### 54 **Financial support**

55 No financial support provided.

### 56 **Conflicts of interest**

57 [See title page.] No other conflicts are declared.

58

59 **Introduction**

60 The provision of access to safe termination of pregnancy (TOP) is considered  
61 internationally to be an important component of sexual and reproductive health care  
62 (World Health Organization 2012). While significant barriers exist globally to accessing  
63 TOP (Culwell and Hurwitz 2013), even relatively non-restrictive countries such as  
64 Australia experience structural, logistic, social and economic, religious and ideological  
65 barriers for women seeking TOP (de Moel-Mandel and Shelley 2017).

66

67 In Australia, an estimated 40% of couples have experienced an unintended pregnancy,  
68 with social disadvantage and rural residence being significantly associated (Rowe *et al.*  
69 2016). TOP can be performed as a surgical procedure or medically using the abortifacient  
70 pharmaceutical drug mifepristone along with misoprostol. Only two states in Australia  
71 collect and publish data on TOP (Grayson *et al.* 2005). The TOP rate in South Australia  
72 (SA) in 2017 was 13.2 per 1,000 women aged 15-44 years (Pregnancy Outcome Unit  
73 Prevention and Population Health Branch 2019) and in Western Australia (WA) in 2018  
74 the rate was 14.3 per 1,000 women (Galrao *et al.* 2019).

75

76 In Australia, legislative frameworks governing TOP vary from state to state (Appendix 1).  
77 Despite decriminalisation across the country, access to TOP services is known to be  
78 challenging for many women and clear barriers exist (Doran and Hornibrook 2014;  
79 Dawson *et al.* 2016; de Moel-Mandel and Shelley 2017; Shankar *et al.* 2017). Inequities in  
80 access to abortion services are more prevalent for women living in rural areas, women  
81 from minority groups in developed countries, adolescents and women in low income  
82 settings (Doran and Nancarrow 2015; Dawson *et al.* 2016).

83

84 GPs are often the first point of contact for women with unplanned pregnancy and  
85 providing medical abortions is well within the scope of General Practice (Mazza *et al.*  
86 2020). Early Medical Abortion (EMA) performed with mifepristone and misoprostol was  
87 approved for use by the Therapeutic Goods Association in Australia in 2012 (Grossman  
88 and Goldstone). GPs are able to become registered providers of EMA by undertaking  
89 online training. Despite known barriers (Dawson *et al.* 2017), data from WA does indicate  
90 increasing uptake of EMA provision in General Practice (Galrao *et al.* 2019). EMA with  
91 mifepristone and misoprostol accounted for 35% of TOP in SA in 2017 (Pregnancy  
92 Outcome Unit Prevention and Population Health Branch 2019) and 33% in WA in 2018  
93 (Galrao *et al.* 2019). General practitioners conducted 5.5% of TOPs in SA in 2017, albeit  
94 conducted in a hospital setting, (Pregnancy Outcome Unit Prevention and Population  
95 Health Branch 2019) and 10.6% in WA in 2018 (Galrao *et al.* 2019). In order to contribute  
96 to understanding the challenges faced by GPs in providing TOP support, including EMA,  
97 this research aimed to investigate the knowledge and attitudes of Tasmanian GPs  
98 regarding TOP services, and which known barriers to providing EMA are most significant.

99

## 100 **Materials and Methods**

101 We used a cross sectional survey design of all GPs in Tasmania, an island state of  
102 Australia with relatively dispersed population of 515,000. Information about the survey,  
103 and a link to complete it online, was sent by Primary Health Tasmania to GPs on their  
104 database. This resulted in a very small response rate and a decision to send hard copies of  
105 the survey was made. Practice addresses were identified through the Tasmanian Health  
106 Directory from Primary Health Tasmania (Primary Health Tasmania 2020). Records were  
107 cross matched with GP practice websites and if discrepancies existed the practices were  
108 called to determine their current practising GPs. No exclusion criteria were applied.

109 Surveys were sent between October and November 2018, with information on electronic  
110 completion also provided. No further reminders were sent. Participation was anonymous;  
111 however, GPs were asked to provide the rurality of their practice using the Rural, Remote  
112 and Metropolitan Areas Classification (RRMA) (Australian Government Department of  
113 Health 2008). RRMA was also applied to our invited population based on postcode so that  
114 we could determine whether our sample was representative. Surveys were returned in a  
115 provided reply-paid envelope. Consent was implied by survey completion and return.

116

117 The survey was developed from a review of published literature of qualitative studies  
118 investigating the barriers to provision and access of TOP services (Dawson *et al.* 2016;  
119 Dawson *et al.* 2017; de Moel-Mandel and Shelley 2017; Shankar *et al.* 2017). Two  
120 researchers extracted themes representing barriers for both access and provision of TOP  
121 services from these documents. In consultation with a third researcher final survey items  
122 were devised. Survey development involved transforming qualitative themes into a  
123 statement which required a response on a scale of 1-5, from strongly agree to strongly  
124 disagree (Appendix 2: Survey, identifies themes that were extracted). This methodology  
125 was guided by a mixed methods sequential exploratory strategy (Creswell and Creswell  
126 2017) whereby a second quantitative phase of research builds on an initial qualitative  
127 phase, building on what is known by, in this case, quantifying the degree to which known  
128 barriers actually exist. The survey was divided into two major lines of questioning, the  
129 first relating to GPs' experiences of providing counselling for and referring to a provider  
130 of TOP services for patients, and the second relating to GPs providing EMA services to  
131 patients. Participants who were conscientious objectors to providing TOP services were  
132 not required to complete the second section. The survey (Appendix 2) was piloted by five  
133 GPs, one of whom also showed it to colleagues. The GPs found that the survey on the

134 whole was understandable and the questions were discrete and unambiguous. Several  
135 minor improvements were made in response to feedback.

136

137 Data were analysed descriptively and presented as percentages. The strength of agreement  
138 in each question was compared to the overall agreement/disagreement for all questions  
139 with odds ratios calculated using ordered logistic regression, corrected for repeated  
140 measures. This allowed questions to be ranked according to strength of agreement. The  
141 impact of rurality (less than or greater than 10,000 population) and gender was determined  
142 using odds ratios comparing responses of the two groups. This study was approved by the  
143 Human Research Ethics Committee of Tasmania (H0017039), a state-wide service  
144 convened by the University of Tasmania.

145

## 146 **Results**

147 In October and November 2018, surveys were posted to 771 GPs across Tasmania and 211  
148 responses were received (27.4% response rate). The rurality breakdown of those who  
149 responded was similar to that of the invited Tasmanian GP population (Table 1). There  
150 was minimal missing data within the survey responses.

151

### 152 Access to TOP services

153 Ordered logistic regression allowed us to rank each question according to the degree of  
154 agreement (Table 2). The greatest level of agreement was in response to the statements  
155 that vulnerable patients should be provided with TOP in the public system (Q9), that  
156 greater leadership by decision makers is needed to improve TOP access (Q15), access is  
157 more difficult for women in rural areas (Q6) and there are challenges finding access to  
158 TOP for women on low income (Q4). There was support for providing TOP in the public

159 healthcare system (Q8). Doctors were confident in their counselling skills (Q2) and in  
160 knowing where to refer for nondirectional counselling as required (Q3). Participants were  
161 more likely to disagree with statements regarding lack of support for TOP for ethical  
162 reasons (Q11) or religious beliefs (Q12). They were also more likely to disagree with  
163 having concern about the legal implications of providing TOP (Q14).

164  
165 Female GPs showed some significant differences to male GPs (Table 2). Female GPs were  
166 more confident in their counselling skills for unplanned pregnancy (Q2) and knowledge of  
167 where to refer women for nondirectional counselling (Q3). Female GPs disagreed more  
168 strongly with the statement that there was limited demand for TOP advice and services  
169 (Q13), were more certain about service delivery in their area (Q1) and were more likely to  
170 believe that access is more difficult in rural areas (Q6) and that women had to travel to  
171 access TOP (Q18).

172

### 173 Provision of EMA services

174 Of the 211 respondents, 22 GPs (10.5%) stated they were conscientious objectors to  
175 providing TOP services, 182 stated they were not, two of whom failed to respond further  
176 despite this, and seven did not answer the question but provided subsequent responses  
177 which were included (Table 1). Just under half of GPs said that they would be interested in  
178 providing EMA services under the right circumstances (28.5% agree, 17.7% strongly  
179 agree), with a further 18.3% unsure (Table 3). There were more doctors prepared to  
180 provide EMA services in rural <10,000 population than larger centres (54.5% vs 43.4%).  
181 An important finding in the raw data (Table 3) is the relatively high number of  
182 respondents who were uncertain about potential barriers. Over one third of participants  
183 were unsure whether financial reward (49.2%), inadequate training opportunities (37.2%),

184 inadequate support services (39.0%), medical indemnity (54.3%), or access to medications  
185 (64.5%) posed a barrier for them.

186  
187 The questions regarding potential barriers to providing EMA were ranked according to the  
188 degree of agreement, with differences between male and female GPs represented in the  
189 second columns (Table 4). There was significant variation in responses with greatest  
190 barriers being inadequate training or knowledge (Q4), lack of opportunities for training  
191 (Q5), lack of after-hours care (Q8) and inadequate support (Q3). Issues that were seen as  
192 providing less of a barrier to providing EMA (greater disagreement with the statements)  
193 were indemnity (Q10), access to the medications (Q11), concern about being stigmatised  
194 (Q9) and colleagues' reactions (12).

195  
196 Female GPs were more likely than male GPs to be interested in providing EMA (Q1).  
197 Financial reward (Q2) and lack of training opportunities (Q5) were less likely to be  
198 viewed as barriers by female GPs compared with male GPs. Workload (Q7) and time (Q6)  
199 were also less likely to be seen as barriers compared with male GPs but did not reach  
200 statistical significance. E-health was seen more strongly by female GPs as a potential  
201 facilitator (Q15).

202  
203 We compared respondents from centres of less and greater than 10,000 population. The  
204 only trend noted was that after-hours care was less of a barrier to providing EMA for  
205 respondents from smaller population centres (OR 0.44; 95% CI 0.19 to 1.01; P=0.054,  
206 data not shown).

207

208 **Discussion**

209 Our research has highlighted challenges in accessing TOP services in Tasmania, but has  
210 also identified that there are a relatively large proportion of GPs who would be interested  
211 in providing EMA services under the right circumstances. The research has identified that  
212 the most significant barriers to providers providing EMA are inadequate knowledge and  
213 training opportunities, and inadequate opportunities for support and after-hours care.  
214 Further we demonstrated that there is uncertainty around important factors such as  
215 indemnity, financial reward, and access to medications.

216  
217 GPs felt strongly that vulnerable women should be provided with TOP in the public health  
218 system and that greater leadership from decision makers was required. Equitable access is  
219 known to remain an aspiration in many areas of Australia (Bateson *et al.* 2019), and lack  
220 of access in public clinics leads to financial challenges for many, particularly in rural and  
221 outer-urban settings (Bateson *et al.* 2019). At the time of this research there was  
222 considerable change in the landscape of provision of TOP in Tasmania. In December 2017  
223 the last dedicated provider of surgical terminations in Tasmania closed requiring many  
224 women to travel outside their region to access surgical termination with private providers,  
225 and with limited accessibility to low cost services (C Manen 2020, CEO Family Planning  
226 Tasmania, personal communication, 6 February). GPs in our study clearly identified a  
227 need for greater leadership by decision makers in ensuring equitable access to TOP in  
228 Tasmania and other outer urban and rural areas.

229  
230 Access to and information about TOP is more challenging for women living in rural and  
231 remote areas (Family Planning Alliance Australia 2018). While there were a greater  
232 proportion of GPs in rural areas willing to provide EMA, with the exception of afterhours  
233 care, the barriers were similar to those in urban locations. Other studies have found

234 specific challenges for women accessing EMA in rural areas including access to and  
235 availability of services locally, financial barriers, poor integration of care, privacy  
236 concerns and stigmatisation (Doran and Hornibrook 2014; Hulme-Chambers *et al.* 2018).  
237 We did not ask about access to ultrasound directly however this has been identified as a  
238 further potential barrier for rural GPs (Keogh *et al.* 2019). Providing training  
239 opportunities, support and ongoing mentoring for GPs is vital for increasing the number of  
240 EMA providers for Australian women, particularly for women who are vulnerable or  
241 living in rural areas (Mazza 2020). Our study provides evidence that with the correct  
242 support and training there is a potential workforce for providing EMA in rural Tasmania.  
243  
244 Delays in referral to a service provider is a common barrier reported by women trying to  
245 access TOP services (Dawson *et al.* 2016) which contributes to psychological distress  
246 (Doran and Hornibrook 2014). Our research supports previous studies which identify  
247 affordability as a major barrier to accessing TOP services (Doran and Hornibrook 2014;  
248 Dawson *et al.* 2016; Shankar *et al.* 2017) and supports more publicly funded TOP services  
249 being available to address this barrier (de Moel-Mandel and Shelley 2017).  
250  
251 One in ten GPs identified as conscientious objectors, and of those who did not almost half  
252 were willing to provide EMA; with the number greater among rural doctors. Training  
253 opportunities, after hours care, and availability of other support were seen as the most  
254 significant barriers by all GPs. In Tasmania, 91 doctors (including GPs and  
255 gynaecologists) are registered prescribers of the Mifepristone/Misoprostol for EMA  
256 however it is suggested that the numbers are lower than this as not all registered  
257 prescribers are actively prescribing. (Saxena 2020) Given the strength of opinion among  
258 our respondent GPs that adequate training was one of the greatest barriers, it is possible to

259 hypothesise that GPs do not feel that the relatively accessible online training required to  
260 become a registered prescriber is sufficient to gain confidence to prescribe. Confirming  
261 this would require further research. We found that structural barriers such as time,  
262 workload, legal, ethical and religious concerns about involvement with TOP management  
263 did not appear to be of significant importance in our cohort of GPs. This is encouraging as  
264 these barriers would be more difficult to address.

265  
266 Another important finding was the high level of uncertainty about many potential barriers.  
267 GPs appear unsure as to the implications for indemnity, access to the required medication,  
268 whether it would be financially rewarding, and whether training and tertiary support  
269 services would be available. This indicates that GPs who are prepared to provide EMAs  
270 are held back due to uncertainty about how the services would be implemented in their  
271 practice and that assistance in developing the necessary protocols might alleviate  
272 concerns. This research therefore strongly supports the concept recently put forward by the  
273 Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary  
274 Care (SHPERE) (Mazza 2020; SPHERE CRE 2020) which supports the development of a  
275 community of practice and peer support network, that could address the high degree of  
276 uncertainty around aspects of providing EMA services uncovered in this research.

277 Frameworks for providing EMA in primary care vary according to practice circumstances  
278 (Deb *et al.* 2020) , Mazza et al provides a framework for providing EMA services through  
279 general practice (Mazza *et al.* 2020) assist in designing a service.

280

281 Strengths of our study include a reasonable response rate from GPs in Tasmania and a  
282 representative geographic sample of the wider Tasmanian GP population. Ideally, we  
283 would have liked to send a reminder to complete the survey, however resource constraints

284 limited our ability to do that by mail. We also recognise that there may have been a self-  
285 selection bias with GPs more interested in TOP more likely to complete the survey. Rapid  
286 changes in the landscape of access to TOP in Tasmania at the time of this survey may have  
287 also influenced responses.

288

289 There is interest and a willingness to provide EMA services among Tasmanian GPs,  
290 including those working in rural and remote areas. However, poor knowledge about EMA  
291 is a major barrier to provision, and is a common research finding across countries  
292 (Subasinghe *et al.* 2021). The main barriers to providing the service are factors which can  
293 be relatively easily addressed such as providing training opportunities and practical  
294 support to implement EMAs into practice in primary care. By addressing these concerns  
295 there is potential to improve equitable access to services for Tasmanian women seeking  
296 TOP. Response to this survey indicates that GPs experiences on the ground is informative  
297 and that they should be part of the political conversation, at both a State and Federal level,  
298 in advocating for improved access to TOP services, including EMAs, for all women.

299

300

301

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302       **References**

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376

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378 Table 1: Rurality of practice and sex breakdown for survey respondents.

<b>Rural remote and metropolitan areas classification</b>		
RRMA Category	N (%) respondents	% invited population
M1 & M2 – Metropolitan (Capital cities, population centre >100,000, includes Hobart)	70 (34.3%)	34.1%
R1 - Rural (large rural centres, urban population centres between 25,000-99,999, includes Launceston)	43 (21.1%)	18.5%
R2 - Rural (small rural centre, urban centre population 10,000-24,999, includes Devonport, Burnie, Somerset, Blackman’s Bay, Kingston)	41 (20.1%)	16.1%
R3 - Rural (other rural area, urban centre population <10,000)	39 (19.1%)	28.2%
Rem1 - Remote (remote geographically, with population > 5,000)	1 (0.5%)	0%
Rem2 - Remote (remote geographically, with population < 5,000)	10 (4.9%)	4.2%
Total responses	204 (7 missing)	
<b>Gender</b>		
Female	119 (58.3)	
Male	85 (41.7)	
Total responses	204 (7 missing)	
<b>Conscientious Objectors</b>		
Yes	22 (10.8)	
	182 (89.2)	
Total responses	204 (7 missing)	

379

380 Table 2. Provision of services for counselling and referral for termination of pregnancy (TOP) in Tasmania

Question	OR <sup>†</sup>	95%CI	P-value	OR <sup>‡</sup> (Female v male)	95%CI	P- value
Mean response for each respondent	1.00			0.82	(0.70 to 0.96)	0.015
Q9 "Vulnerable patients should be provided with TOP in the public system"	10.53	(7.90 to 14.04)	<0.001	1.14	(0.67 to 1.93)	0.64
Q15 "Greater leadership by decision makers can improve TOP access"	7.21	(5.68 to 9.13)	<0.001	1.26	(0.79 to 2.01)	0.33
Q6 "It is more difficult for women in rural areas"	6.67	(5.18 to 8.57)	<0.001	1.73	(1.07 to 2.81)	0.026
Q2 "Confident in my counselling skills for unplanned pregnancy"	6.01	(4.71 to 7.66)	<0.001	2.75	(1.75 to 4.32)	<0.001
Q4 "Challenging to find access to TOP for low income women"	4.26	(3.28 to 5.52)	<0.001	0.95	(0.57 to 1.60)	0.86
Q7 "No opportunities to refer patients for TOP in the public system"	2.74	(2.04 to 3.69)	<0.001	0.41	(0.22 to 0.76)	0.004
Q3 "I know where to refer women for nondirectional counselling"	1.96	(1.47 to 2.61)	<0.001	2.09	(1.17 to 3.72)	0.012
Q5 "Challenging to find access to TOP for all women"	1.27	(0.98 to 1.64)	0.070	1.24	(0.72 to 2.14)	0.43
Q18 "Women in my area are required to travel to access TOP"	1.22	(0.94 to 1.57)	0.13	0.56	(0.34 to 0.94)	0.028
Q16 "Unacceptable delays in TOP when patients are referred"	0.98	(0.83 to 1.16)	0.82	0.75	(0.53 to 1.07)	0.12
Q10 "TOP service availability is adequate within the private system"	0.57	(0.44 to 0.74)	<0.001	1.42	(0.83 to 2.43)	0.20
Q1 "Unsure about TOP service availability in my area"	0.55	(0.42 to 0.72)	<0.001	0.56	(0.32 to 0.98)	0.042
Q13 "Limited demand for TOP advice and services in my practice"	0.54	(0.43 to 0.68)	<0.001	0.51	(0.31 to 0.83)	0.007
Q14 "Concerned about the legal implications of providing TOP services"	0.26	(0.20 to 0.33)	<0.001	0.89	(0.54 to 1.46)	0.64
Q17 "A shortage of female staff impacts on TOP advice"	0.26	(0.22 to 0.31)	<0.001	0.67	(0.45 to 0.99)	0.043
Q8 "TOP should not be a priority for the public care system"	0.15	(0.11 to 0.21)	<0.001	0.61	(0.34 to 1.10)	0.10
Q11 "I don't support TOP because of ethical reasons"	0.08	(0.06 to 0.11)	<0.001	0.59	(0.33 to 1.07)	0.081
Q12 "I don't support TOP because of my religious beliefs"	0.07	(0.05 to 0.10)	<0.001	0.72	(0.40 to 1.30)	0.28

381 † The strength of agreement in with the different questions was compared against the mean response for each respondent: odds ratio for each question was estimated using  
382 ordered logistic regression, corrected for repeated measures. Male and female respondents are not separated in this odds ratio column. "Agreement/Disagreement" scale  
383 is ordered in nature, and the ranking of the odds ratios is used to provide a rough ordering of the comparative strength of the different propositions posed by the  
384 questions. As there is no obvious way of standardising the "Agreement/Disagreement" measurements between different respondents, the mean  
385 "Agreement/Disagreement" response for each respondent was calculated, and this was used as the standardised baseline for judgement of the strength of agreement.

386 ‡ The relative strength of agreement amongst female respondents were compared with that of male respondents.

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Table 3: Responses for enablers and barriers for GPs providing medical termination of pregnancy (MTOPT) services, excluding conscious objectors.

Question <sup>‡</sup>	Strongly disagree N (%)	Disagree N (%)	Unsure N (%)	Agree N (%)	Strongly agree N (%)
Q1. I would be interested in providing MTOPT under the right circumstances (n=186)	21 (11.3)	45 (24.2)	34 (18.3)	53 (28.5)	33 (17.7)
Q2. There is not enough financial reward for me to provide MTOPT (n=183)	12 (6.6)	41 (22.4)	90 (49.2)	30 (16.4)	10 (5.5)
Q3. There are inadequate support services for me to offer MTOPT (n=182)	4 (2.2)	29 (15.9)	71 (39.0)	66 (36.3)	12 (6.6)
Q4. I do not have adequate training or knowledge to provide MTOPT (n=182)	10 (5.5)	32 (17.6)	11 (6.0)	98 (53.8)	31 (17.0)
Q5. There are a lack of opportunities for training and education on MTOPT (n=183)	9 (4.9)	34 (18.6)	68 (37.2)	61 (33.3)	11 (6.0)
Q6. I do not have the time in my practice to offer MTOPT (n=183)	13 (7.1)	75 (41.0)	29 (15.8)	54 (29.5)	12 (6.6)
Q7. My workload is too high to incorporate providing MTOPT into my practice (n=183)	12 (6.6)	78 (42.6)	24 (13.1)	59 (32.2)	10 (5.5)
Q8. The inability to provide after-hours care impacts on the ability for me to provide MTOPT services (n=183)	7 (3.8)	45 (24.6)	25 (13.7)	75 (41.0)	31 (16.9)
Q9. I am concerned about being stigmatised if I provide MTOPT services (n=183)	45 (24.6)	87 (47.5)	23 (12.6)	23 (12.6)	5 (2.7)
Q10. Medical indemnity is a barrier to me providing MTOPT services (n=184)	20 (10.9)	44 (23.9)	100 (54.3)	18 (9.8)	2 (1.1)
Q11. It is difficult to access misoprostol and mifepristone where I practice (n=183)	16 (8.7)	37 (20.2)	118 (64.5)	10 (5.5)	2 (1.1)
Q12. I am concerned about how my colleagues would react if I provided MTOPT services (n=185)	49 (26.5)	87 (47.0)	34 (18.4)	12 (6.5)	3 (1.6)
Q13. A lack of hospital support in case of complications prohibits me from providing MTOPT services (n=185)	17 (9.2)	50 (27.0)	61 (33.0)	39 (21.1)	18 (9.7)
Q14. If teleconferencing was available to assist in MTOPT I would use this service (n=181)	12 (6.6)	45 (24.9)	63 (34.8)	48 (26.5)	13 (7.2)

Q15. I am concerned about legal implications of providing MTOP (n=187)	62 (33.2)	73 (39.0)	30 (16.0)	19 (10.2)	3 (1.6)
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389 † MTOP is used in this table in place of Early Medical Abortion (EMA) because this was the terminology  
390 used in the survey. The terms can be used interchangeably

391 ‡ Denominator (n) varies slightly due to randomly missing data

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393 Table 4. Provision of medical termination of pregnancy (MTOP<sup>§</sup>) services in your practice: All GPs, and Female vs Male GPs

Mean response	OR <sup>†</sup>	95% CI	P-value	OR <sup>‡</sup> Female vs Male	95% CI	P-value
Mean level of agreement / disagreement	1.00			1.03	(0.80 to 1.34)	0.80
Q4 “I do not have adequate training or knowledge to provide MTOP”	3.65	(2.70 to 4.94)	<0.001	0.62	(0.36 to 1.07)	0.084
Q8 “The lack of after-hours care impacts on my ability to provide MTOP”	2.46	(1.77 to 3.41)	<0.001	1.95	(0.97 to 3.90)	0.060
Q3 “There are inadequate support services for me to offer MTOP”	1.76	(1.45 to 2.14)	<0.001	1.05	(0.71 to 1.56)	0.81
Q1 “I would be interested in providing MTOP under the right circumstances”	1.51	(1.01 to 2.24)	0.043	2.24	(1.00 to 5.02)	0.049
Q14 “Appropriate training would make me be interested in providing MTOP”	1.50	(1.07 to 2.10)	0.018	2.79	(1.44 to 5.42)	0.002
Q5 “There are a lack of opportunities for training and education on MTOP”	1.46	(1.17 to 1.82)	0.001	0.61	(0.39 to 0.94)	0.024
Q15 “E-health facilities would make me be interested in providing MTOP”	1.12	(0.85 to 1.48)	0.41	1.88	(1.06 to 3.34)	0.032
Q13 “A lack of hospital support for complications prohibits me providing MTOP”	0.96	(0.74 to 1.25)	0.76	1.33	(0.79 to 2.22)	0.28
Q2 “There is not enough financial reward for me to provide MTOP”	0.93	(0.76 to 1.13)	0.47	0.64	(0.42 to 0.99)	0.044
Q7 “My workload is too high to incorporate providing MTOP into my practice”	0.82	(0.60 to 1.10)	0.19	0.55	(0.29 to 1.01)	0.054
Q6 “I do not have the time in my practice to offer MTOP”	0.81	(0.60 to 1.10)	0.18	0.54	(0.28 to 1.03)	0.061
Q11 “It is difficult to access misoprostol and mifepristone where I practice”	0.69	(0.59 to 0.80)	<0.001	0.76	(0.54 to 1.07)	0.12
Q10 “Medical indemnity is a barrier to me providing MTOP services”	0.64	(0.55 to 0.75)	<0.001	0.85	(0.59 to 1.22)	0.38
Q9 “I am concerned about being stigmatised if I provide MTOP services”	0.23	(0.17 to 0.30)	<0.001	1.03	(0.61 to 1.74)	0.92
Q12 “I am concerned about my colleagues’ reactions if I provided MTOP”	0.20	(0.15 to 0.25)	<0.001	0.91	(0.56 to 1.49)	0.70

394 § MTOP is used in this table in place of Early Medical Abortion (EMA) because this was the terminology used in the survey. The terms can be used interchangeably

395 † The strength of agreement in with the different questions was compared against the mean response for each respondent: odds ratio for each question was  
 396 estimated using ordered logistic regression, corrected for repeated measures. Male and female respondents are not separated in this odds ratio column.  
 397 “Agreement/Disagreement” scale is ordered in nature, and the ranking of the odds ratios is used to provide a rough ordering of the comparative strength  
 398 of the different propositions posed by the questions. As there is no obvious way of standardising the “Agreement/Disagreement” measurements between

399 different respondents, the mean “Agreement/Disagreement” response for each respondent was calculated, and this was used as the standardised baseline  
400 for judgement of the strength of agreement.

401 ‡ The relative strength of agreement amongst female respondents were compared with that of male respondents.

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