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A nurse-led model of care to improve access to contraception and abortion in rural general practice: Co-design with consumers and providers

Jessica E. Moulton[1,2] | Noushin Arefadib[1,2] | Jessica R. Botfield[1,2,3] | Karen Freilich[1,2] | Jane Tomnay[4] | Deborah Bateson[5] | Kirsten I. Black[6] | Wendy V. Norman[7,8] | Danielle Mazza[1,2]

[1]SPHERE, NHMRC Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care, Melbourne, Victoria, Australia

[2]Department of General Practice, School of Public Health and Preventive Medicine, Monash University, Melbourne, Victoria, Australia

[3]Family Planning NSW, Sydney, New South Wales, Australia

[4]Centre for Excellence in Rural Sexual Health, University of Melbourne, Melbourne, Victoria, Australia

[5]Daffodil Centre, Faculty of Medicine and Health, The University of Sydney, Sydney, New South Wales, Australia

[6]Faculty of Medicine and Health, University of Sydney, Sydney, New South Wales, Australia

[7]Department of Family Practice, University of British Columbia, Vancouver, British Columbia, Canada

[8]Faculty of Public Health and Policy, Public Health, Environments & Society, London School of Hygiene and Tropical Medicine, London, UK

Correspondence
Jessica E. Moulton, SPHERE Centre of Research Excellence, 553 St Kilda Rd, Melbourne, VIC, 3044, Australia.
Email: jessica.moulton@monash.edu

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Abstract

Aim: To describe key features of a co-designed nurse-led model of care intended to improve access to early medication abortion and long-acting reversible contraception in rural Australian general practice.

Design: Co-design methodology informed by the Experience-Based Co-Design Framework.

Methods: Consumers, nurses, physicians and key women's health stakeholders participated in a co-design workshop focused on the patient journey in seeking contraception or abortion care. Data generated at the workshop were analysed using Braun and Clarkes' six-step process for thematic analysis.

Results: Fifty-two participants took part in the co-design workshop. Key recommendations regarding setting up the model included: raising awareness of the early medication abortion and contraceptive implant services, providing flexible booking options, ensuring appointment availability, providing training for reception staff and fostering good relationships with relevant local services. Recommendations for implementing the model were also identified, including the provision of accessible information, patient-approved communication processes that ensure privacy and safety, establishing roles and responsibilities, supporting consumer autonomy and having clear pathways for referrals and complications.

Conclusion: Our approach to experience-based co-design ensured that consumer experiences, values and priorities, together with practitioner insights, were central to the development of a nurse-led model of care.

Implications for the Profession and/or Patient Care: The co-designed nurse-led model of care for contraception and medication abortion is one strategy to increase access to these essential reproductive health services, particularly in rural areas, while providing an opportunity for nurses to work to their full scope of practice.

Impact: Nurse-led care has gained global recognition as an effective strategy to promote equitable access to sexual and reproductive healthcare. Still, nurse-led contraception and abortion have yet to be implemented andevaluated in Australian general practice. This study will inform the model of care to be implemented and evaluated as part of the ORIENT trial to be completed in 2025.

Reporting Method: Reported in line with the Standards for Reporting Qualitative Research (SRQR) checklist.

Patient or Public Contribution: Two consumer representatives contributed to the development of the co-design methodology as members of the ORIENT Intervention Advisory Group Governance Committee.

KEYWORDS
action research, family planning, health services research, intervention development, models of care, multiprofessional care, practice nursing, reproductive health, rural nursing, service user perspectives

1 | INTRODUCTION

Universal access to sexual and reproductive healthcare (SRH) services, including early medication abortion (EMA) and long-acting reversible contraception (LARC; intrauterine devices and subdermal implant), is central to achieving equitable health and well-being outcomes (World Health Organization, 2022). According to Taft et al. (2018), approximately 26% of Australian women had unintended pregnancies in the decade up to 2015, with one-third of these pregnancies resulting in abortions (Taft et al., 2018). For people living in rural Australia, accessing abortion and LARC services can often be challenging (Senate Standing Committees on Community Affairs, 2023) due in part to the limited number of health practitioners working in rural and remote communities (Doran & Hornibrook, 2016; Noonan et al., 2023). Delivery of EMA in a general practice setting has the potential to increase access and lower costs, however, access is not equal (Mazza et al., 2020). In 2019, approximately 50% of women in remote Australia lived in areas where the EMA medication had not been prescribed by a GP (Kopp Kallner et al., 2015). As a result of these 'abortion deserts' (Cartwright et al., 2018), abortion seekers in rural and remote areas face the challenge of travelling considerable distances to services, often incurring high out-of-pocket costs, creating financial and logistical obstacles and leading to delayed access to essential healthcare (Kruss & Gridley, 2014). Similar challenges exist to accessing contraception in rural and remote Australia, particularly LARC, including limited availability of LARC devices, lack of awareness and misinformation about LARC options among providers (Garrett et al., 2015; Mazza et al., 2012, 2017; Senate Standing Committees on Community Affairs, 2023).

Moreover, while the Australian government health insurance scheme (Medicare) offers a patient rebate for primary care-provided procedural abortions, the average 'out of pocket' cost for a procedural abortion can range between AU $400 and AU $500 (Baird, 2015). While this is prohibitive for many people, for those residing in rural areas, the expense is compounded by the costs associated with travelling long distances and the potential need for accommodation (Baird, 2015). This issue is further exacerbated because, in Australia, the provision of LARC and abortion care is largely restricted to physicians (Family Planning NSW, 2020; Marie Stopes Australia, 2020), preventing nurses from delivering these services through simple redistribution of tasks between physicians and nurses, and expansion of their scope of clinical practice (Botfield et al., 2020, 2021; Moulton et al., 2021).

An established body of evidence demonstrates that nurse-led models of care can effectively address such barriers to access (Moulton et al., 2021; World Health Organization, 2015) and are safe, feasible, cost-effective and acceptable to patients (Barton et al., 2013; Hammersley et al., 2022; Kopp Kallner et al., 2015; Mainey et al., 2020). As such, nurse-led abortion and contraception care is endorsed by the World Health Organization (World Health Organization, 2015, 2022), and practiced in various countries. This includes the provision of LARC by registered nurses in Australia (Botfield et al., 2020) and Canada (Carson et al., 2022) and nurse-midwives in Sweden (Berer, 2009), and abortion services provided by auxiliary nurse-midwives in Nepal (Andersen et al., 2016), registered nurses in Canada (Carson et al., 2022), nurse-midwives in Sweden and South Africa (Berer, 2009) and advanced practice nurses (including nurse practitioners and nurse-midwives) in the United States (Berer, 2009).

In Australia, there are three primary categories of nurses, with different levels of training requirements. They are as follows: nurse practitioners, who hold a master's degree in nurse practitioner studies; enrolled nurses, who have undertaken a diploma or advanced diploma level programme; and registered nurses, who hold a bachelor of nursing (Freund et al., 2015). Registered nurses make up the majority (82%) of the primary health care workforce in Australia (Australian Institute of Health and Welfare, 2020), and they, as well as nurse practitioners (2.7% of the workforce (Australian Institute of Health and Welfare, 2020)), can provide LARC insertion. Similarly, as of 1 August 2023, any appropriately qualified health practitioner, including nurse practitioners, can prescribe EMA medication (Therapeutic Goods Administration, 2023).

However, despite their ability to deliver these important services, nurse provision of LARC and EMA services is not widely practised in Australia (Senate Standing Committees on Community Affairs, 2023). Moreover, while nurse-led models for EMA and LARC have been evaluated in Australian public sector community health settings (Tomnay et al., 2018), they have not been tested or evaluated in general practice. Bridging this evidence gap through the co-design of a nurse-led model that places consumer experiences, values and priorities at the centre has the potential to address pervasive barriers to equitable access to essential reproductive health services for those living in rural Australia.

2 | BACKGROUND

The co-design process presented in this paper is part of the ORIENT trial (improving rural and regional access to long-acting reversible contraception and medical abortion through nurse-led models of care, task sharing and telehealth) trial (Mazza et al., 2023). The ORIENT trial aims to assess the effectiveness of a co-designed nurse-led model of care in general practice in increasing the uptake of LARC and improving access to EMA in rural and regional areas. The findings from this co-design study will be used to develop the nurse-led model of care which will be used in the ORIENT Trial. Prior to implementation of the model in rural and regional general practice, we will assess the perceived feasibility and acceptability of the model through interviews with primary care providers. Employing a co-design process ensured that the lived experiences and knowledge of both consumers and providers formed the foundation of the model, resulting in a model that is more likely to address key barriers to access, well-received by consumers and providers and is feasible for implementation in Australian rural and regional general practice (Dawda & Knight, 2018; Doyle et al., 2013).

3 | THE STUDY

3.1 | Aim

This paper aims to:

- Elucidate the perspectives of consumers, health professionals and key women's health stakeholders on what constitutes an ideal nurse-led EMA and LARC model of care.
- Describe key features of a co-designed, nurse-led model of care for EMA and LARC in general practice in rural and regional Australia.

4 | METHODS

This study is reported in line with the Standards for Reporting Qualitative Research (SRQR) checklist (O'Brien et al., 2014).

4.1 | Design

We applied an experience-based co-design approach, informed by the Australian Healthcare and Hospitals Association and Consumers Health Forum of Australia's 'Experience-Based Co-design' (EBCD) framework and toolkit (Dawda & Knight, 2018). Experience-based co-design calls for active involvement by both consumers and healthcare professionals, in collaboration with researchers, to create service delivery models that are acceptable, sustainable, evidence based and feasible (Dawda & Knight, 2018). This approach helps identify aspects of care provision that require improvement and offers a framework within which improvement activities can be carried out. Given its particular relevance to quality improvement, EBCD is widely used by researchers and practitioners across a range of healthcare settings, including mental health, palliative care, emergency medicine and neonatal care (Donetto et al., 2014).

Developed in 2017, the EBCD Toolkit uses existing resources from the United Kingdom and New Zealand, contextualized for the Australian healthcare setting, with the goal of embedding patient-centred care within healthcare systems (Dawda & Knight, 2018). This approach has five key stages: (1) set up the study for success by ensuring this initial process is carried out with involvement from key stakeholders; (2) gather the experiences of care providers and recipients; (3) understand the experience of care providers and recipients and identify areas for service delivery improvement; (4) improve the experience by working collaboratively to identify how user and provider experiences can be improved; and (5) ensure that the improved experience can be sustained or enhanced through ongoing evaluation.

Stages 1 and 2 of this approach were conducted in preparation for the ORIENT trial and are described in two separate protocol papers (Mazza et al., 2023; Moulton et al., 2022). This study describes stages 3 and 4 during which we gained a comprehensive understanding of consumer and provider experiences, validated previously collected data and translated these into a draft nurse-led model of care. The perceived feasibility and acceptability of this draft model will be assessed as part of a separate study, which will be used to refine the model as needed, prior to its use in the ORIENT trial. The final stage of the EBCD approach, which involves evaluating the impact of the final co-designed model, will occur through the conduct of the ORIENT trial due to be completed in 2025.

4.2 | Theoretical framework

This research can be situated within a 'pragmatic constructivist' paradigm (Nørreklit et al., 2006), combining aspects of both Pragmatism and Constructivism theories. This paradigm centres on the role of interpretation and context in knowledge development which is inherent in constructivism, while also considering the practical and solution-focused approach of pragmatism (Nørreklit et al., 2006).

The principles of Participatory Action Research (PAR), an emerging paradigm, methodology and theory of learning

(Wood, 2020; Zuber-Skerritt, 2018), guided this study to ensure that the voices and lived experiences of consumers and providers were prioritized. Participatory Action Research is situated within a participatory paradigm (Wood, 2020), a broader philosophical orientation that emphasizes the importance of democratic participation, inclusivity and collaboration in various aspects of society, including research and decision-making processes. Overall, PAR is designed to enable action (Baum et al., 2006; Petras & Porpora, 1993). Moreover, it recognizes and addresses the unequal power dynamic that exists between researchers and research participants, calling for power to be deliberately shared between the two. This was particularly important in our study given that many existing models of care are developed based on evidence generated from studies that perceived consumers as passive 'subjects' (Baum et al., 2006; Pyett, 2002). Applying the principles of PAR allowed us to generate new evidence for a new model of care based on the belief that research participants must be actively involved in the research planning and implementation process. Consequently, we were able to develop a model of care that is more applicable to end users and offers a greater likelihood of achieving favourable outcomes.

4.3 | Study setting and recruitment

Purposive sampling was used to achieve diversity among consumer and stakeholder groups (e.g. healthcare practitioners, academics, policymakers, peak bodies and advocates) with expertise in rural health or nursing and midwifery policy and practice, or expertise and/or lived experience accessing or facilitating access to SRH in rural or regional Australia. Existing stakeholder networks and contacts through the SPHERE Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care (NHMRC SPHERE Centre of Research Excellence, 2024), who are overseeing the ORIENT trial, as well as publicly available contact details were used to identify potential participants. One hundred and fourteen stakeholders and consumers were invited to participate via email. Of these, 61 expressed interest and were emailed an explanatory statement detailing the study's aim, data management and confidentiality measures, as well as a consent form. Fifty-seven participants returned their electronic consent forms, of whom five were later unable to participate.

4.4 | Data collection

4.4.1 | Stakeholder workshop activities and materials preparation

To maximize the effectiveness and appropriateness of all workshop activities, we engaged in ongoing consultations with the ORIENT trial's Advisory Group and Executive Committees (convened prior to the trial's commencement), comprised of internationally recognized experts in SRH, as well as policymakers, consumer representatives and frontline clinical service providers. Additional consultations were held with external stakeholders, including rural and regional practice nurses and general practitioners (GPs). As a result, tools and templates relevant to stages 3 and 4 of the EBCD framework (Dawda & Knight, 2018) were adapted and used to guide the workshop.

Prototyping

Prototypes are frequently incorporated into the co-design process to help assess and ensure that the improvement (or model) will function as intended, and act as an early draft of a health service improvement activity in EBCD (Barton et al., 2013). For the co-design workshop, we tailored the EBCD Toolkit's 'prototyping' activity to provide participants with five examples of EMA and LARC service delivery models (or 'prototypes') currently employed in primary care. This offered participants tangible examples for contemplation and modification while they worked towards shaping the optimal patient journey for nurse-led EMA and LARC provision in the general practice setting.

This approach was chosen to facilitate participant reflection on what has or has not worked effectively in these contexts, aiding in the identification of essential improvements to ensure the co-designed model's appropriateness for rural and regional general practice.

To develop draft model of care prototypes, we first conducted a rapid review of international evidence on key components of effective nurse-led service delivery for EMA or LARC care (de Moel-Mandel et al., 2019; Group BMJP, 2021; Mazza et al., 2020; Moulton et al., 2021; Rome et al., 2022; World Health Organization, 2015, 2022). This led to the identification of five key factors, which were subsequently incorporated into a table template (see Table 1). We then identified existing EMA and LARC models of care in Australian primary care settings through consultation with the ORIENT trial governance committees. Due to limited published data pertaining to the existing EMA and LARC models, we contacted service providers to obtain detailed insights into how each model informed EMA and LARC service delivery. The table template was then used to systematically organize these data and create a unique prototype for each of the five draft models of care (Appendix A), offering a step-by-step summary of their service delivery approach. The five prototypes were sent to the respective providers to confirm their accuracy and to accommodate any potential amendments, resulting in minor changes to wording and structure.

Patient journey mapping

To facilitate meaningful understanding of the patient journey to accessing EMA and LARC, we used patient journey mapping, which provides a way of visualizing the service experiences of consumers in the likely sequence of the 'touchpoints' they go through (Barton et al., 2013). Service touchpoints can include any interactions consumers have with providers, as well as websites, signage and even the physical structure of facilities.

Before the workshop, the EBCD Framework's patient journey mapping template was used to develop two patient journey

TABLE 1 Example draft model of care prototype (public sector nurse-led EMA) with a description of each component.

Patient journey stage	Description	Example from a public sector nurse-led EMA model of care (supplied by service provider)
Appointment triage	How would the consumer enter and be booked into the service?	Women booked into service via different methods: 1. Self-referral—ring up and speak to the nurse 2. General reception 3. Referrals from GPs 4. Local hospital that triages referrals for procedural abortions and discusses EMA with woman
Assessment of consumers	How is the consumer assessed for eligibility for EMA, including pregnancy options counselling, information provision and domestic violence and/or reproductive coercion screening within the service?	• Everything is managed by nurse. Nurses facilitate pregnancy options counselling and assessment and provide support for consumers regarding access • Telephone consults can be done by a sexual and reproductive health (SRH) nurse before booking a GP appointment (for consumers who are unable to come into the clinic and remote/rural)
Test ordering and interpreting of results	Who orders relevant investigations for comprehensive abortion care, including any STI screening required, and who interprets the results within the service?	• Nurse organizes gestational dating ultrasound and investigations and provides referrals if appropriate • If there are ultrasound access issues, the nurse refers consumers to other services
Prescription/administration of EMA	How does the prescription and administration of EMA process occur within the service?	• Next appointment is with the doctor to go through informed consent and provide a script for EMA medication
Aftercare, follow-up and complications	How does the follow-up process occur following an EMA within the service, and what happens if the consumer has any complications?	• Then, third appointment is follow-up with the nurse where contraceptive options are discussed and given, e.g. Implanon and any psychosocial support provided • Consumers are referred to the local hospital for any complications following EMA • Women are booked for IUD insertions by GP if that choice is made
Systems and support	What are the systems and supports in place around the practice that allow the service to run effectively?	• The service has developed good relationships with local pharmacists and radiologist services • Currently, due to lack of ultrasound access, the service has an URGENT process with the local hospital medical imaging department • The service also has connections with social work and other support services if required
Business and funding model	What business model does the practice use and how is the model funded?	• GPs are salaried • Nurses are funded by a variety of funding sources • One nurse is funded under the Primary Care Clinics Practice Incentives Program (PIP) • Other Nurses are under diverse programmes which are all funded by the State Government • The Nurse Practitioner utilizes MBS rebate for timed consult funding
Consumer flow between nurse and doctor	How do nurses and doctors work together within the practice to provide the service, and who leads the care?	• Nurse leads majority of consultations except for an appointment with the doctor to provide a script for EMA medication. • Days when GPs are not in the clinic, and nurses run clinic without GPs in the building – contacted via telephone if required. • Nurses make all the appointments and change appointments if gestation is different from expected and communicate with the woman.

templates (one for EMA and one for LARC) (Appendix B). These were designed to reflect the key stages of the consumer journey and help describe the application of our nurse-led model in practice. During the workshop, participants utilized these templates to describe the consumer experience at each 'touchpoint' and make recommendations for how the ideal model would improve consumer experiences.

To develop the templates, we conducted a rapid review to gain a better understanding of the key stages involved in EMA or LARC service delivery (de Moel-Mandel et al., 2019; The Faculty

of Sexual and Reproductive Healthcare, 2021; Mazza et al., 2020; Rome et al., 2022; World Health Organization, 2015, 2022). Six key touchpoints were identified: (1) appointment triage and booking; (2) assessment; (3) investigations; (4) administering EMA and contraceptive implant insertion; (5) follow-up; and (6) responding to complications (including referral pathway). The template was presented to the ORIENT trial governance committees, who suggested the inclusion of telehealth as an additional touchpoint. Finally, in consultation with clinicians from the governance committees, two case studies (one for EMA and one for LARC), were developed to be used in conjunction with the patient journey template.

4.4.2 | Stakeholder workshop

An online workshop was held in June 2021, using Zoom videoconferencing (Braun & Clarke, 2006). The workshop, which lasted five hours, was facilitated by the last author. With consent from participants, the workshop was recorded using the Zoom video and audio-recording function.

The workshop commenced with a presentation of each of the five prototypes described above. This facilitated the opportunity for participants to assess the efficacy of the existing prototypes and identify areas for improvement to develop a new model of care specific to general practice in rural and regional Australia. Participants were then divided into five 'solutions groups' (using the Zoom breakout room function), where the case studies, prototypes and consumer journey template were used to facilitate a discussion about the consumer experience at each 'touchpoint' to EMA and LARC care. Each 'solutions group' was facilitated by a subject matter expert who, where appropriate, used a facilitator template to pose questions unique to each touchpoint of the consumer journey. The facilitator template for the 'Assessment' touchpoint is provided as an example (see Table 2). Each group was assigned a scribe, who recorded a summary of key discussion points and shared it with participants, and who were asked to notify the scribe if any key points were omitted. Once each group had workshopped their ideal model, a collective group discussion was facilitated to reach a consensus on the recommended actions and ideal model of care.

4.5 | Data analysis

Recordings from the workshop were transcribed verbatim. Transcripts, notes taken by each scribe and Zoom chat transcripts were deidentified and imported into NVivo (Lumivero, 2020). Inductive and deductive thematic analysis was guided by Braun and Clarkes' six-step process (Braun & Clarke, 2006). This entailed: (1) the first author reviewed the transcripts for accuracy and concurrently made notes to generate meaning; (2) the first author conducted open coding, tagging the data with both semantic and latent codes (explicitly stated ideas vs. implicit meaning [Braun et al., 2016]); (3) codes were first organized into initial themes deductively according to each touchpoint within the patient journey for EMA or LARC; inductive (data-driven) coding was then carried out for data that were not directly related to the key touchpoints in the patient journey, but were relevant to the successful design and implementation of the model (Braun & Clarke, 2012, 2021); (4) the first author then reviewed initial themes and engaged in additional interpretation and naming and defining of themes; and (5) themes were then reviewed by a second author who cross-checked the dataset by reviewing all transcripts to ensure that the overall analytic story was congruent with the generated themes. Throughout this process, the first author routinely sought feedback from the research team.

TABLE 2 Facilitator template for the 'Assessment' touchpoint.

Stage: Assessment
Q. Based on a nurse-led model for the general practice setting, how would the consumer be assessed? PROMPTS used by facilitators 1. How would the consumer be provided non-directive pregnancy counselling including informing the consumer of both EMA and procedural termination of pregnancy options and screening for DV and RC? 2. If the consumer wanted to access EMA, how would medical eligibility be determined (e.g. checklist, guidelines, etc.) 3. Would the assessment be 1 or 2 steps? 4. How would this consumer be billed for the assessment? 5. How could the consumer experience be optimized? Directed at consumers

4.6 | Ethical considerations

This study was approved by the Monash University Human Research Ethics Committee (reference 27509).

4.7 | Rigour and reflexivity

We adhered to Lincoln and Guba's strategies for strengthening rigour and trustworthiness in qualitative research (Lincoln, 1985), including criteria for credibility, transferability, dependability and confirmability. To strengthen the study's credibility, strategies such as prolonged engagement with the research context and data (Johnson et al., 2020), triangulation of sources (Johnson et al., 2020) and peer debriefing (Lincoln, 1985) were employed. To support transferability, the research process has been detailed here and in our published protocol (Moulton et al., 2022). Dependability and confirmability were ensured through systematic and transparent record keeping and maintaining a detailed audit trail for each step of the process. The first author is a young white Australian doctoral student and social science researcher. Her background is in public health, with a focus on health equity, SRH and gender-based violence. To help identify potential subjectivities which could impact analysis and interpretation of data, the first author maintained a reflexivity journal where thoughts and decisions relevant to the study, including analysis, were

documented. The research team comprises clinicians (nurse and physician) and public health academics in Australia and Canada. The team holds diverse expertise and experience in both facilitating and accessing SRH care including in rural and regional areas. This study was conducted as part of the first author's doctoral programme.

5 | FINDINGS

5.1 | Characteristics of participants

A total of 52 participants attended the workshop (see Table 3).

5.2 | Themes

We generated five themes from the workshop data, incorporating the six touchpoints of the consumer journey: (1) Appointment triage and booking: addressing stigma and structural barriers to care; (2) Assessment and investigations: facilitating informed decision-making, clear protocols and roles and responsibilities; (3) Administering EMA and LARC insertion: supporting consumer autonomy; (4) Follow-up: consumer-driven care; and (5) Responding to complications and referral pathway: the need for clear pathways. Participants' priorities and views relating to each theme are presented here. We present representative de-identified quotes from participants, alongside their participant identification number and primary professional role.

5.2.1 | Theme 1—Appointment triage and booking: Addressing stigma and structural barriers to care

This theme relates to the first touchpoint of the patient journey: recommendations relating to the first contact a consumer makes with the practice when seeking EMA or LARC care. It also discusses factors relevant to setting up a nurse-led service, including how to address the perceived stigma of seeking abortion care, such as judgemental language used by reception staff, and structural issues, such as complicated appointment booking systems.

Participants described how the stigma surrounding abortion care often made it challenging for consumers to inform reception staff that they wanted an appointment for EMA. As a result, unaware of the time-sensitive nature of their care needs, a priority appointment was not always booked, leading to delayed care. Stigma was also identified as manifesting in the form of perceived judgement from practice staff, including reception staff and clinicians, as well as fear of judgement from the community, delaying or preventing consumers from contacting the clinic for abortion care. Similarly, participants cited instances where the stigma surrounding abortion care had on occasion led to consumers being denied services by pathology, radiology, pharmacy and emergency care. This stigma also led to reduced access to necessary medication and devices including the contraceptive implant and EMA medication.

> We've got a good half dozen services down this region, that will not provide it because they don't want to be known as the abortion doctor....
>
> P52, Sexual Health Nurse

Addressing the stigma associated with abortion and contraception, while tackling existing structural barriers to access, was viewed as critical to ensuring timely access to the service, particularly given the time-sensitive nature of the provision of EMA care (i.e. up to 9 weeks gestation in Australia). Central to this was the normalization of abortion and LARC care in rural and regional communities. Four ways that GP clinics could address these issues were suggested: (i) raising awareness of EMA and LARC services; (ii) providing flexible booking options; (iii) ensuring appointment availability; (iv) training for reception staff; (v) fostering good relationships with relevant local services; and (vi) having adequate stock of the contraceptive implant and EMA medication in-clinic (see Table 4).

TABLE 3 Participants by stakeholder group.

	Total $n = 52$
Stakeholder group	
Consumer	5
Nurse • Practice Nurse $n = 3$ • Nurse Practitioner $n = 5$ • Community/Sexual health nurse $n = 7$	15
General Practitioner	6
Academic	4
Policymaker	7
Representative from sexual and reproductive health (SRH) organization (i.e. peak bodies and advocates)	12
Representative from workforce organization (i.e. nursing and other health professional peak bodies)	3

TABLE 4 Summary of key findings related to theme 1—Appointment triage and booking.

Key findings	Process	Example/Other considerations
(1) *Appointment triage and booking: addressing stigma and structural barriers to care*		
Raising awareness of the service	Update website including: • Staff profiles • Service list to include EMA and LARC • Instructions on how to book	• Update staff profiles and note if they provide EMA and LARC • Under 'services provided' add EMA and LARC • Provide information on pregnancy and contraceptive options • Instructions on how to book such as asking for a longer appointment, or keywords to use such as 'urgent gynae appointment'
	Display posters in the practice waiting room, bathroom and/or clinic rooms	• Depending on practice and community, poster could advertise abortion/contraception services or be more generic such as 'sexual health nurse services'
	Raising awareness among other providers	• Advise other providers that patients can be referred for EMA/LARC
Providing flexible booking options (setting up the booking service)	Pre-recorded phone line	• Pre-recorded messages when the patient calls the practice such as: 'press 1 for women's health nurse, press 2 for reception'
	Pre-recorded phone message	• While on hold advising that the practice offers EMA/LARC appointments, and terminology the patient could use such as to request an appointment with the 'sexual health nurse'
	Update online booking service	• Update options on the booking service to allow patients to book in for 'sexual health consultations'
Ensuring appointment availability	Determine and set aside regular appointment availability for EMA and LARC	• Option 1: Set clinic day(s) for EMA/LARC • Option 2: Reserve/block times for EMA/LARC
Training for receptionist(s) staff	Training for sensitive enquiry including the keywords and process for booking abortion or contraception appointments	• Could also provide a flow chart or algorithm to aid appointment scheduling
Fostering good relationships with relevant local services	Connect with allied health and support services to build relationships and promote timely, accessible care	• Identify local allied health providers, including pharmacy; pathology; radiology; gynaecologists and emergency care • Identify local support/referral services, e.g. mental health services, Aboriginal and Torres Strait Islander health services
Having adequate stock in clinic	Having stock of the contraceptive implant and EMA medication in clinic	

(i) Raising awareness of the service

Promoting available abortion and LARC services, including instructions on how to access them, was identified as one strategy that clinics could employ to normalize these services and reduce their stigma.

> … abortion care is a part of routine reproductive (care) and women's health and if we as the providers are ashamed or feel too stigmatised … then things aren't going to change
>
> P26, SRH organisation representative, Physician

Suggested ways of promoting these services included: updating the practice website to highlight information on pregnancy options (i.e. medication and procedural abortion) and staff offering these services; displaying posters in the clinic to promote these services; and offering instructions on how to book a LARC or abortion appointment through the website or via telephone (e.g. making sure to ask for a 'double appointment' when calling for these services).

> I don't like to talk to the receptionists…because… small town, everybody knows each other, and [there's not that] information on the website, [about] needing to book a longer appointment. That information is so valuable… and it creates a sense of support…
>
> P4, Consumer

Participants highlighted the significance of increasing awareness among providers at other clinics who could refer consumers to their service where required.

(ii) Providing flexible booking options

Participants also noted the importance of creating an easy appointment 'booking system' for these services. Suggestions included

implementing a pre-recorded message to be played while consumers were on hold, informing them about how to inquire about or book an appointment for these services. Additionally, they suggested updating the website to include key words that consumers could use to communicate their need for an 'urgent gynae appointment' to reception staff. Clinics could also offer the option of online booking for EMA and LARC services.

> People might not have the nursing staff to be able to do this, but we have a voice message that says if you're calling for medical termination of pregnancy press 1… and that will send you straight through to a voicemail or hopefully a nurse, but most of the time [you can leave] a voicemail that is only checked by the nursing staff.
>
> P48, Sexual Health Nurse

(iii) Training for reception staff

Many participants noted the importance of training first point-of-contact staff to ensure sensitive enquiry and that appointments are organized appropriately with no judgement, stigma or delay.

> Within our GP clinic… a really important step was to educate our [reception staff] which is our first point of call for patients… to appropriately make appointments for these women… They [reception staff] undertook training on how to sensitively ask questions of women ringing up in regards to unintended pregnancies and then making the appropriate appointment.
>
> P47, Nurse practitioner

Participants felt that reception staff need to be knowledgeable of the care pathways, terminology, privacy considerations and gestational requirements for EMA and the need to prioritize EMA appointments to ensure they are happening in a timely manner. Further suggestions for receptionist upskilling include diversity training (including cultural and LGBTQIA+ sensitivity training) and knowledge of appropriate translation services. Many participants highlighted that providing tools such as scripts, protocols and flowcharts for booking EMA and LARC appointments could aid reception staff in sensitive enquiry. This may include asking the patient if they would like a longer appointment, a double appointment or an appointment with the nurse (whom they may refer to as the '*sexual health nurse*' depending on how the service has been advertised to consumers).

(iv) Ensuring appointment availability

Participants identified the importance of setting aside time for EMA appointments to ensure greater accessibility. Participants suggested that clinics could have appointments blocked out specifically for urgent EMA appointments. This could be a set at weekly time and day, or more sporadic depending on demand.

> Logistically… you almost need to have appointments put aside in general practice already, like for the occasion that someone's going to call up for an [EMA], otherwise you're not going to fit them in.
>
> P41, Sexual Health Nurse

(v) Fostering good relationships with relevant local services

Participants suggested that clinics should establish strong relationships with local services, including pharmacy, pathology, radiology, gynaecologists and emergency care, to ensure that consumers had timely access to LARC or abortion care. This was considered to be especially important in areas where local services were particularly limited. Challenges faced by consumers who relied on other local services for LARC and abortion care included high demand and long waitlists for services such as ultrasounds, pharmacies not stocking EMA medication or the contraceptive implant (because of poor awareness or moral objection) and feeling judged by these services (e.g. radiologists assuming the consumer has a wanted pregnancy and discussing it as such), to more explicit judgement (e.g. radiologists purposely showing images of the foetus or pointing out a heartbeat despite the consumers requests not to).

Participants said that developing good relationships with external services would potentially address some of these issues and facilitate greater awareness of these issues and how to address them.

> It's important to make sure you have that relationship with a local hospital… emergency type entry point that some people might try to access if they've… suddenly got an emergency of some sort. And… the building of relationships with someone that will be non-judgemental and accept the person quickly is key.
>
> P22, Policymaker

It was emphasized that clinics should prioritize relationship building with a local pharmacy or pharmacies willing to maintain an adequate supply of EMA medication and contraceptive implant.

(vi) Having adequate stock of the contraceptive implant and MS-2Step in-clinic

Having adequate stock of the EMA medication and contraceptive implant in-clinic would help address limited availability in some regional and rural pharmacies. It would also streamline access, as consumers could receive the medication during their appointment, eliminating the need to visit a pharmacist who may not have the product available.

> ...if it's possible to house devices inhouse from a consumer perspective if you're not particularly health literate... it can be confusing... The more simplified the process is for women, the easier it is for them, the more empowered they are.
>
> P5, Consumer

> Especially working with young people, and in rural towns where the step of them going to the chemist, where they might bump into other people as well. All those things are barriers.
>
> P39, Practice Nurse

5.2.2 | Theme 2—Assessment and investigations: Facilitating informed decision-making, clear protocols and roles and responsibilities

Theme 2 relates to the assessment process for consumer eligibility for EMA or LARC, exploring the ideal methods for conducting such appointments. It also incorporates the investigations' touchpoint, which pertains to how the consumer would be provided with investigations, and who would be responsible for providing referrals and interpreting results. Participants identified four ways in which the nurse-led model could facilitate an optimal assessment appointment and delivery and interpretation of investigations: (i) provision of accessible contraception and abortion patient information; (ii) ensuring privacy and safety through patient-approved clinic-to-patient communication processes; (iii) clear clinic protocols incorporating flexible delivery approaches; and (iv) establishing roles and responsibilities (see Table 5).

(i) Provision of accessible EMA and LARC patient information

Participants highlighted the necessity of facilitating informed decision-making by ensuring access to educational resources and information on EMA and LARC, including available options, costs, processes and potential side effects, as well as a list of relevant health and other support services.

Participants agreed that written resources should be evidence based and in simple language that excludes clinical/medical jargon.

Participants also underscored the importance of translating such resources into other languages to ensure equitable access to consistent information regardless of cultural background.

> I think some really good, easy English resources for patients and some available in translated languages as well would be good to support that practice because different practitioners would provide a different level of information or service.
>
> P1, Consumer

To ensure informed decision-making, practitioners should also discuss available options with consumers during their initial assessment appointment.

> ... Step 1 needs to be a detailed discussion... just actually talking about their options... you get a lot of people still who are calling for MTOP [medical termination of pregnancy] who think you take a pill and the pregnancy dissolves and then you have a period... going through what's... involved in both procedures as an initial step, often saves you a lot of time down the track if people decide that actually, MTOP isn't for them.
>
> P48, Sexual Health Nurse

(ii) Ensuring privacy and safety through patient-approved clinic-to-patient communication processes

Many participants said that ensuring consumer safety and privacy was central to ensuring service accessibility. Given the prevalence of family violence and reproductive coercion, clinics should have clear protocols that maintain the safety and privacy of consumers. Suggested protocols included: flexible options for sharing information with consumers (e.g. via email, text, website or hard copy), asking consumers' preferences for how they would like to be contacted for appointment confirmation, gaining consent before sending out information and asking the appropriateness of leaving a voice message or sending a text before doing so.

Additional privacy measures include ensuring that all consumer files are password protected, ensuring the consumer's correct contact number is obtained (particularly for younger consumers who may have their parents' number on file) and allowing 'no-contact options' for communication, such as sending referrals and investigations directly to providers.

> ... Sending emails and texts can be a problem for (many) women... Women are ringing who are... very worried about their partner's finding out, but they need this highly confidential service and quickly. And they don't want any email traffic to be intercepted by their partner.
>
> P22, Policymaker

(iii) Clear clinic protocols incorporating flexible delivery approaches

Participants felt it was important for the nurse-led model to have clear protocols and incorporate flexible approaches to service delivery for greater consistency and accessibility. Overall, there was consensus among participants regarding the need to offer appointments in a way that was responsive to the unique needs and circumstances of each consumer. Participants said that under the nurse-led model,

TABLE 5 Summary of key findings related to theme 2—Assessment and investigations.

Key findings	Process	Example/Other considerations
(2) *Assessment and investigations: facilitating informed decision-making, clear protocols and roles and responsibilities*		
Provision of accessible contraception and abortion patient information	Options counselling provided during the assessment appointment	• Detailed discussion of contraceptive and/or pregnancy options including medication abortion and procedural abortion
	Information packs provided prior to the initial appointment with both simple English and translated versions available	Information including: • Contraceptive and/or abortion options • Possible risks and complications • Relevant allied health and other available support services
	Delivery of the information pack dependent on patient preference	• Option 1: Link to relevant patient information booklet via text and/or email • Option 2: Relevant booklet sent via email (PDF attached) • Option 3: Patient to collect hard copy in person
	Referral (if required)	• If patient chooses an IUD, refer to an IUD inserter either within the practice or an external provider • If patient chooses procedural abortion or is not eligible for EMA, refer to an appropriate provider
Ensuring privacy and safety through patient-approved processes	Key considerations: • Consumer preference for method of communication • Confirming preferred contact details • Consent gained from consumer prior to communication. • Ensure privacy measures are in place	Privacy measures include: • Having 'no-contact' options such as sending referrals directly to providers • Passwords on patient files • Reception staff asking patients for the best contact number, particularly younger patients who may have their parents' number on file
Clear clinic protocols incorporating flexible delivery approaches	• Book 30-min appointment with practice nurse and overlapping ~15 min appointment with GP (for billing, support, questions, prescription, etc.) • Conduct EMA/LARC assessment as per procedure	EMA specific: • Ensure patients are within gestational limits by the time they complete tests/investigations • Ensure patient is consenting and not under duress or coerced into abortion (i.e. reproductive coercion) If proceeding with implant: • Provide script for contraceptive implant device
Establishing roles and responsibilities	• Practice nurse or GP to order investigations in the assessment appointment as per current practice (note: EMA may be time sensitive) • Practice nurse to utilize admin time for review and interpretation of results within their scope of practice • Any concerns or results outside their scope to be discussed with GP	Advise patients of local providers (e.g. pharmacy, pathology, radiology)

all assessment appointments should be facilitated by a practice nurse, with GPs providing support where required.

> … All that counselling and initial discussion would happen with the nurse. And then if… they need a script… a pathology form signed… or an ultrasound request… that doctor walks in the door and knows… we're getting to the point of asking for script [for MS2-Step]… So that could be dealt with there and then
>
> P39, Practice Nurse

Participants recommended the patient journey could also be supported by reducing the number of required appointments, where appropriate, and offering flexible appointment options, including telehealth.

> … A lengthy phone consult for the assessment, which might be more suitable for women in rural areas or (those who) cannot come to a centre or a GP practice at that time
>
> P42, Nurse Practitioner

Participants noted that many clinics require three appointments from assessment to the provision of EMA, which they felt could be excessive and a barrier to care. Participants shared that ideally, only one or two in-person appointments should be required, with telehealth available for any additional care requirements, such as follow-up.

> … If we could get away with 2 (in-person appointments) that would be preferable from a consumer point of view
>
> P36, Workforce organisation representative, Nurse

Participants also highlighted the need for flexibility including the option for investigations to be provided as an e-script (via text message or email) or sent directly to pathology/radiology providers for a no-contact option, particularly for anyone who may be experiencing family violence or reproductive coercion.

Finally, participants emphasized the need for protocols that would ensure that: 1) anyone who did not meet the required gestational limit for accessing EMA was offered a referral for a procedural abortion, and 2) all medication abortions were informed and voluntary, and not sought under duress. Screening for family violence was seen as central to this process.

> … We have some challenges with women who aren't actually consenting for their own abortions, you know those things are complex…
>
> P34, SRH Organisation Representative, Physician

(iv) Establishing roles and responsibilities

Participants expressed some confusion regarding who (e.g. practice nurses or GPs) would assume responsibility for interpreting investigations:

> … I mean currently it's the GP or the medical practitioner but it doesn't need to be
>
> P11, General Practitioner

> Facilitator: '… So ideally nurses would be able to do that and the interpretation is done by nurses or by doctors?'
>
> P11, General Practitioner: '… Ultimately the nurses; … they are interpreting stuff all the time in every other area of medicine. This is just another area that we need to release'.

While most felt that practice nurses would be best placed to interpret results and make care decisions, some said that the GP may also like to review any results before prescribing the EMA medication. The level of trust between practice nurses and GPs was central to facilitating a positive consumer experience at this touchpoint.

5.2.3 | Theme 3—Administering EMA and LARC insertion: Supporting consumer autonomy

This theme relates to the ideal patient journey for prescription and/or administration of the EMA medication and contraceptive implant insertion. Participants emphasized that to ensure this model addressed barriers to EMA and LARC access, it is important that consumer choice and autonomy are prioritized, especially concerning their preferences for scheduling EMA administration. Participants felt that increasing providers' confidence in providing EMA was more likely to encourage patient autonomy, as this may reduce providers' fear of negative outcomes if the patient chooses to take the medication at home. It was suggested that mentoring and peer support could increase GPs confidence. Participants also discussed the clinical process and workflow for the provision of (i) EMA medication and (ii) contraceptive implants (see Table 6).

(i) Prescription/administration of abortion medication

Participants agreed that the nurse would discuss results from the investigations with consumers and provide information about the EMA process and aftercare, including what to do in case of emergency. The nurse would also determine the consumers' preferences for follow-up and answer any questions. The GP would discuss the consent process, receive signed informed consent from the consumer and provide a script for EMA medication (either to the consumer or sent electronically to the pharmacy).

TABLE 6 Summary of key findings related to theme 3—Administering EMA and LARC insertion.

Key findings	Process	Example/Other considerations
(3) *Administering EMA and LARC insertion: supporting consumer autonomy*		
Appointment structure	Book 30-min appointment with practice nurse and overlapping ~15 m appointment with GP (for billing, support, questions, STI treatment if required, etc.)	
Prescription/administration of EMA	• Practice nurse: Discuss any investigation results, EMA process and aftercare, follow-up requirements and contraception needs^ • GP: Obtain consent and provide script for MS2 step and confirm follow-up arrangements • Book follow-up appointment with practice nurse pending consumer preference	*^Depending on contraception: GP provide script; book for implant insertion with practice nurse / refer for IUD*
Insertion of Implant	• Discuss investigation results and insertion process, obtain consent for insertion and undertake insertion • GP to treat or follow-up relevant investigations if necessary • Book follow-up appointment with practice nurse (if required)	

Some participants had diverging views regarding the location of EMA medication administration, with some stating that providers would prefer to see abortion seekers take the medication – either at the clinic or pharmacy, to ensure it had been taken before the gestation limit of 9 weeks and help with monitoring. However, others, particularly consumers, felt that it was important for consumers to make this decision so that they could time this around personal commitments and other factors such as childcare and availability of support persons.

> [Requiring patients to take the medication at the pharmacy] doesn't really allow women to schedule it according to when they've got childcare, and if (they) have the support person at home. I think that's really rather coercive actually…
>
> P32, SRH Organisation Representative

Some participants felt that the scheduling of medication administration was largely influenced by GPs' understanding of the EMA process, where GPs who had a greater understanding of EMA were more comfortable with consumers having greater control.

(ii) LARC provision (implant insertion or IUD referral)

Participants recommended that in the nurse-led model, the consumer can choose to receive the contraceptive implant at their initial appointment, where appropriate. Participants agreed that the GP would provide the script and obtain consent for insertion, while the nurse would discuss the process, including potential complications, with the consumer before implant insertion.

For those booked with a GP, it was suggested that the GP would obtain consent and provide a script before referring to the clinic nurse for same-day insertion or rebooking the consumer for a nurse insertion appointment. Those requesting an IUD would be referred to an IUD inserter, either within the clinic or an external provider. Participants also emphasized the need for established referral pathways for anyone wanting an IUD insertion under sedation.

5.2.4 | Theme 4—Follow-up: Consumer-driven care

This theme describes participant perceptions on how follow-up care should be provided after EMA or contraceptive implant provision. Participants largely agreed provision of follow-up care should be shaped by the unique needs of each consumer (see Table 7).

For EMA, participants noted the importance of nurses' engaging in discussions with consumers regarding their preferred method of follow-up during the assessment or prescription touchpoints. Participants emphasized the utility of telehealth for increasing access for rural and remote consumers and preventing 'unnecessary travel time'. It was suggested that the practice could utilize auto-fills or other protocols to prompt nurses to document consumer preferences and follow-up accordingly. To ensure that the requirement for follow-up was not a barrier to access, particularly for rural and remote people, participants suggested that consumers could also have their follow-up with a provider closer to home.

> … We don't need to be babying women… women are very good at telling us if they're not well or if they've got complications and some people do want or need more support. But generally, the vast majority of people having a medical abortion can do their own follow-up at home… if there's a complication, they'll contact you… But otherwise, they can manage that themselves
>
> P26, SRH organisation representative, Physician

The use of low-sensitivity urine pregnancy tests to confirm EMA completion was also suggested as an option to reduce access

TABLE 7 Summary of key findings related to theme 4—Follow-up.

Key findings	Process	Example/Other considerations
(4) *Follow-up: consumer-driven care*		
Follow-up (F2F or TH)	• Practice nurse to follow-up with patient as per agreed arrangements	• Text message or phone call the day after the treatment is complete and reminder to complete follow-up blood test (BHCG) or low-sensitivity urine pregnancy test 10 days after treatment. Patient to contact clinic to confirm test result • Text or phone call reminder to complete follow-up blood test (BHCG) or low-sensitivity urine pregnancy test 10 days after treatment, followed by an in-clinic/telehealth appointment. • Patient can also follow-up with a provider closer to home if located a significant distance from the clinic, with which the clinic can collaborate

barriers for consumers as it negated the need to go to a pathology provider and can be completed at home.

Most participants believed that scheduling a follow-up appointment after a contraceptive implant insertion should be optional, contingent upon the patient's request, rather than mandatory.

5.2.5 | Theme 5—Responding to complications and referral pathway: The need for clear pathways

The final theme explores how complications should ideally be managed and considerations for ensuring adequate pathways to emergency care (see Table 8).

Participants highlighted the need for the model to include protocols and clear referral pathways to emergency care in the event of post-abortion/implant insertion complications. Participants had diverging views regarding whether complications (e.g. suspected retained products of conception) should be addressed by the nurse or GP. One consumer noted that to ensure continuity of care, it would be ideal for the nurse to be the first point of call, with the GP available to assist.

> I think for the sake of continuity of care, if it was to be led by the nurse that they've had the whole way through because they'll trust that person, they have a relationship with them already
>
> P5, Consumer

It was agreed that emergency appointments should always be available to ensure complications can be managed promptly. Consumers should also be given the option to discuss any concerns with the nurse via telehealth, without the need to physically attend the clinic, unless required. Participants also emphasized the importance of informing consumers to present to their local emergency department if they have serious concerns.

6 | DISCUSSION

Timely access to essential SRH is a significant challenge for people residing in rural and regional Australia (Senate Standing Committees on Community Affairs, 2023). Nurse-led models could increase equitable EMA and LARC service provision by addressing key barriers in these areas such as the lack of local providers and workforce shortages (Senate Standing Committees on Community Affairs, 2023). This study utilized a co-design methodology to develop a nurse-led model of care that addresses inequitable access to EMA and LARC through general practice delivery. The model is designed to facilitate collaboration between GPs and registered nurses, with the flexibility to be tailored based on the specific composition of each practice, such as the inclusion of nurse practitioners and enrolled nurses. Employing experience-based co-design allowed us to understand the challenges faced by consumers and providers at each touchpoint of the patient journey, providing the foundation for a care model that was reflective of the needs and priorities of its end users. This study highlights key components of a co-designed model of care. The resulting draft model involves practice nurses conducting assessments, insertion of implants and follow-up of EMA and LARC, in collaboration with GPs.

This study provides further evidence supporting the inclusion of EMA and contraceptive implant insertions within the purview of nursing practice (World Health Organization, 2022). Participants largely believed that appropriate nurses could lead all stages of the EMA and contraception processes, with support from a GP, where required. To that end, there is a growing global emphasis on team-based care models and the expanding roles of nurses in abortion and contraception healthcare delivery (Botfield et al., 2021; Mainey et al., 2020). Consistent with evidence on team-based care, trust between the nurse and GP, and effective collaboration and communication were considered critical to the feasibility of the nurse-led model. Existing evidence suggests improving inter-professional collaboration between nurses and GPs through communication, professional development and non-hierarchical supportive work practices is essential to improving quality care (McInnes et al., 2017).

Our participants highlighted the pervasive influence of stigma surrounding abortion and contraceptive care in rural and regional Australia. Although abortion stigma is universal, it is particularly problematic in rural towns due to geographic isolation, reduced choice due to fewer providers and privacy concerns due to smaller communities (Noonan et al., 2023; Doran & Hornibrook, 2016). Stigma manifests across interconnected spheres, including individual, community, institutional, legal and policy levels (Kumar et al., 2009). Provider-based stigma, including judgement from unsupportive providers, can adversely impact quality of care

TABLE 8 Summary of key findings related to 5—Responding to complications and referral pathway.

Key findings	Process	Example/Other considerations
(5) *Responding to complications and referral pathway: The need for clear pathways*		
Complications (if experienced)	• Patient is to be booked for urgent appointment with the GP • If reception staff is unsure, patient is to be transferred to practice nurse to triage • If emergency care is required, refer to hospital or appropriate service	For EMA, one can write a letter 'in advance' with information about EMA and gestation dates, blood test results, etc. that the consumer could take to emergency care if required

and abortion seekers' emotional and psychological well-being (Sorhaindo & Lavelanet, 2022). Perceived stigma can manifest as providers questioning the abortion seeker's decision or using discouraging language. Additionally, providers may engage in gatekeeping or obstructing access, either through actively discouraging individuals from accessing services or denying care (Sorhaindo & Lavelanet, 2022). Our findings reflect this evidence and highlight how perceived stigma permeates the patient's journey at concurrent points and adversely affects an individual's ability to access EMA and LARC services. Addressing and mitigating stigma is imperative to ensure that individuals feel supported through patient-centred care and empowered in their reproductive choices (Makleff et al., 2023; Sorhaindo & Lavelanet, 2022).

International evidence indicates that normalizing abortion is one key strategy to address stigma and facilitate access to high-quality, consumer-centred abortion care (Baird & Millar, 2019; Maxwell et al., 2021; Purcell et al., 2020). Healthcare professionals can play a pivotal role in normalizing abortion services by standardizing abortion as routine healthcare and reframing negative rhetoric around abortion, emphasizing its moral 'good' to abortion seekers, colleagues and the community (Maxwell et al., 2021).

Integrating abortion into routine healthcare provided by nurses can potentially contribute to normalizing abortion, helping to diminish the perception of abortion as an isolated or stigmatized procedure. In a randomized controlled trial in Kenya, Sudhinaraset et al. (Sudhinaraset et al., 2022) found that a nurse-led mobile abortion intervention resulted in reduced abortion-related stigma compared to standard care. Consistent with existing evidence (Cashman et al., 2021; Maxwell et al., 2021), our participants emphasized that normalizing abortion in the community was crucial to enhancing access to these services in rural and regional areas. They underscored the significance of reducing stigma and minimizing care delays. Therefore, a pivotal component of the nurse-led model of care involves identifying and collaborating with relevant local service providers to raise awareness of the services through their respective websites and networks.

Our findings also highlight the importance of person-centred contraceptive and abortion care to facilitate greater access to these services. According to the Nursing and Midwifery Board of Australia, person-centred care is a central standard of practice underpinning healthcare delivery by nurses (Nursing and Midwifery Board Australia, 2020). Nurses and midwives are recognized for their capacity to empower patients and direct interventions towards addressing broader social determinants of health by understanding the specific needs of local populations (Institute of Health Equity, 2024). Given their training and the extensive socio-cultural diversity within the global nursing and midwifery workforce, the participation of nurses and midwives in task-sharing models could also contribute to providing culturally concordant healthcare, thereby reducing health inequities in primary care (Gilliss et al., 2010; West et al., 2010). There is evidence that team-based care models can also better support patient-centred care (Mundt & Swedlund, 2016). Participants identified flexibility and tailoring of the model, along with supporting consumers in making informed decisions based on their individual preferences and needs, as key elements for facilitating person-centred care within the model. This is supported by an established body of literature that advocates for informed decision-making in reproductive healthcare, emphasizing the importance of shared decision-making and informed consent (Afulani et al., 2023).

The significance of patient autonomy in determining the timing of EMA medication administration was recognized as central to patient-centred care. While some participants noted that less-experienced GPs may be more inclined to observe patients during the medication administration, mandating requirements for patients to take the EMA medication at the clinic or pharmacy is no longer considered best practice (Schummers et al., 2022; World Health Organization, 2022). Peak bodies, such as the World Health Organization, view the freedom of choice as to where and when to take abortion medication as a key facilitator of an enhanced patient experience and autonomy (World Health Organization, 2022). The World Health Organization also stipulates that the location (e.g. on-site vs. off-site) for EMA administration should not be mandated and recognizes self-management of abortion as a legitimate pathway for abortion care, highlighting its significance in patient-centred care (World Health Organization, 2022). Additionally, evidence suggests that serious adverse events or complications are not more likely to occur when EMA medication is unrestricted (Schummers et al., 2022).

Participants proposed that nurses could facilitate person-centred care by practising contraception or abortion options counselling that prioritizes consumers' needs, preferences and lived experiences when selecting an abortion method or commencing or discontinuing a contraceptive method (American College of Obstetricians and Gynecologists, 2023). This is pertinent in light of a growing body of evidence that highlights the rising number of consumers reporting feeling excluded from the decision-making process or pressured towards certain methods (Brandi et al., 2018; Caddy et al., 2022; Gomez & Wapman, 2017; Higgins et al., 2016; Mann et al., 2019). Gomez and Wapman (2017) suggest that addressing this issue is significant given that for some consumers, this can lead to mistrust of providers and reluctance around future contraceptive use, directly contributing to health inequities.

This comprehensive and adaptable model of care has the potential to address existing disparities in access to sexual and reproductive services, as well as inequitable health and well-being outcomes in rural and regional areas. Further studies are necessary to assess the long-term impact of these strategies and investigate the scalability of the proposed model in different healthcare settings. Once implemented as part of the ORIENT trial, the model of care will be evaluated for its effectiveness, cost-effectiveness and acceptability to consumers and providers. This critical evidence can then be used for potential scale-up of the model into other settings.

6.1 | Limitations

While the workshop involved a large and diverse group of stakeholders with a range of roles and experiences, there was

limited representation from Aboriginal Community Controlled Health Services who deliver universal healthcare services to many First Nations Australians. This underscores the need for future research to evaluate the model's cultural concordance and make tailored adjustments where necessary. As a result, we cannot be certain of the model's applicability to specific sub-populations, including First Nations people, migrant and refugee groups and the LGBTQIA+ community. Finally, data pertaining to our participants' broader demographic characteristics, such as gender, ethnicity and years of professional experience, were not collected, potentially limiting the generalisability of our findings.

7 | CONCLUSIONS

Persistent barriers to sexual and reproductive healthcare in rural and regional Australia could be addressed by supporting nurses to work to their full scope of practice and to deliver these essential services in areas of need. Building upon internationally recognized strategies and leveraging the expertise of key stakeholders, we developed a nurse-led model of care that responds to the unique challenges and needs of consumers and practitioners in rural and regional areas. Our findings provide guidance on how to establish and deliver a nurse-led model of care, and the key factors that must be considered at each touchpoint of the patient journey.

AUTHOR CONTRIBUTIONS

JEM, NA, JRB, KF, JT, DB, KIB, WVN and DM: Made substantial contributions to conception and design, acquisition of data or analysis and interpretation of data. JEM, NA, JRB, KF, JT, DB, KIB, WVN and DM: Involved in drafting the manuscript or revising it critically for important intellectual content. JEM, NA, JRB, KF, JT, DB, KIB, WVN and DM: Gave final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content. JEM, NA, JRB, KF, JT, DB, KIB, WVN and DM: Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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CONFLICT OF INTEREST STATEMENT

DM has received research and conference attendance funding and speaker fees and has been an advisory board member for Bayer, Organon and MSD. DB has provided education for doctors sponsored by Bayer and Organon and has been an advisory board member for Bayer, Organon and MSD. DB has never received personal remuneration for these services. During this study, WVN was a member of the Board of Directors of the Society of Family Planning. She receives family planning research grants from Canadian and UK governments and not-for-profit associations, none of which are related to this study.

PEER REVIEW

The peer review history for this article is available at https://www.webofscience.com/api/gateway/wos/peer-review/10.1111/jan.16299.

DATA AVAILABILITY STATEMENT

Data available on request due to privacy/ethical restrictions.

ETHICS STATEMENT

All data utilized have been lawfully acquired in accordance with The Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from Their Utilization to the Convention on Biological Diversity. This study was approved by the Monash University Human Research Ethics Committee (reference 27509).

TRIAL AND PROTOCOL REGISTRATION

- This study will inform the intervention for the ORIENT Trial, which is registered with the Australian New Zealand Clinical Trials Registry (ACTRN12622000086763)
- Protocols for this study and the ORIENT Trial can be found at: https://bmjopen.bmj.com/content/13/3/e065137 and https://onlinelibrary.wiley.com/doi/10.1111/ajr.12937.

ORCID

Jessica E. Moulton https://orcid.org/0000-0001-7172-9470
Noushin Arefadib https://orcid.org/0000-0001-8478-6730
Jessica R. Botfield https://orcid.org/0000-0001-6157-9739
Deborah Bateson https://orcid.org/0000-0003-1035-7110
Kirsten I. Black https://orcid.org/0000-0003-0030-2431
Wendy V. Norman https://orcid.org/0000-0003-4340-7882
Danielle Mazza https://orcid.org/0000-0001-6158-7376

TWITTER

Jessica E. Moulton jessicamoulton_
Jessica R. Botfield Jess_Botfield
Karen Freilich KarenFreilich
Deborah Bateson DrDebBateson
Kirsten I. Black KirstenIslaB
Wendy V. Norman wvnorman
Danielle Mazza SPHERE_CRE Danielle_Mazza

REFERENCES

Afulani, P. A., Nakphong, M. K., & Sudhinaraset, M. (2023). Person-centred sexual and reproductive health: A call for standardized measurement. *Health Expectations*, *26*(4), 1384–1390.

Allen, M., Allen, J., Hogarth, S., & Marmot, M. (2013). *Working for health equity: The role of health professionals*. [Internet]. University College London Institute of Health Equity. https://www.instituteofhealthequity.org/resources-reports/working-for-health-equity-the-role-of-health-professionals

American College of Obstetricians and Gynecologists. (2022). *Patient-centered contraceptive counseling*. [Internet]. Committee on Health Care for Underserved Women, Contraceptive Equity Expert Work Group and Committee on Ethics. https://www.acog.org/clinical/clinical-guidance/committee-statement/articles/2022/02/patient-centered-contraceptive-counseling

Andersen, K. L., Basnett, I., Shrestha, D. R., Shrestha, M. K., Shah, M., & Aryal, S. (2016). *Expansion of safe abortion services in Nepal through auxiliary nurse-midwife provision of medical abortion, 2011–2013* (2nd ed., pp. 177–184). John Wiley & Sons, Ltd. https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=edsbl&AN=vdc.100081704977.0x000001&site=eds-live&scope=site&custid=s2775460

Australian Institute of Health and Welfare. (2020). *A profile of primary health care nurses, Data*. [Internet]. https://www.aihw.gov.au/reports/primary-health-care/a-profile-of-primary-care-nurses/data

Baird, B. (2015). Medical abortion in Australia: A short history. *Reproductive Health Matters*, *23*(46), 169–176.

Baird, B., & Millar, E. (2019). More than stigma: Interrogating counter narratives of abortion. *Sexualities*, *22*(7–8), 1110–1126.

Barton, G. R., Fairall, L., Bachmann, M. O., Uebel, K., Timmerman, V., Lombard, C., & Zwarenstein, M. (2013). Cost-effectiveness of nurse-led versus doctor-led antiretroviral treatment in South Africa: Pragmatic cluster randomised trial. *Tropical Medicine & International Health*, *18*(6), 769–777.

Baum, F., MacDougall, C., & Smith, D. (2006). Participatory action research. *Journal of Epidemiology and Community Health*, *60*(10), 854–857.

Berer, M. (2009). Provision of abortion by mid-level providers: International policy, practice and perspectives/Pratique de l'avortement par des prestateurs de soins de niveau intermediaire: politiques, pratiques et perspectives dans plusieurs pays/Realizacion de abortos por personal de nivel medio: Politicas, practicas y perspectivas internacionales. *Bulletin of the World Health Organization*, *1*, 58–63.

Botfield, J. R., Lacey, S., Fleming, K., McGeechan, K., & Bateson, D. (2020). Increasing the accessibility of long-acting reversible contraceptives through nurse-led insertions: A cost-benefit analysis. *Collegian*, *27*(1), 109–114.

Botfield, J. R., Wright, S. M., Fenwick, S. E., & Cheng, Y. (2021). Training nurses in contraceptive implant procedures: Implications for practice in Australia. *Collegian*, *28*(1), 114–120.

Brandi, K., Woodhams, E., White, K. O., & Mehta, P. K. (2018). An exploration of perceived contraceptive coercion at the time of abortion. *Contraception*, *97*(4), 329–334.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Braun, V., & Clarke, V. (2012). Thematic analysis. In *APA handbook of research methods in psychology, Vol 2: Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 57–71). American Psychological Association (APA handbooks in psychology®).

Braun, V., & Clarke, V. (2021). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, *21*, 37–47.

Braun, V., Clarke, V., & Weate, P. (2016). Using thematic analysis in sport and exercise research. https://uwe-repository.worktribe.com/output/3123247/using-thematic-analysis-in-sport-and-exercise-research

Caddy, C., Williams, H., Hocking, J., & Coombe, J. (2022,). "I never went to see that doctor again": A qualitative study examining Australian women's experiences requesting removal of LARC within 12 months of insertion. *Contraception*, *110*, 81–85.

Carson, A., Paynter, M., Norman, W. V., Munro, S., Roussel, J., Dunn, S., Bryant-Lukosius, D., Begun, S., & Martin-Misener, R. (2022). Optimizing the nursing role in abortion care: Considerations for health equity. *Nursing leadership (Toronto, Ontario)*, *35*(1), 54–68.

Cartwright, A. F., Karunaratne, M., Barr-Walker, J., Johns, N. E., & Upadhyay, U. D. (2018). Identifying National Availability of Abortion Care and Distance From Major US Cities: Systematic Online Search. *Journal of Medical Internet Research*, *20*(5), e186. https://doi.org/10.2196/jmir.9717

Cashman, C., Downing, S. G., & Russell, D. (2021). Women's experiences of accessing a medical termination of pregnancy through a Queensland regional sexual health service: A qualitative study. *Sexual Health*, *8*(3), 232–238.

Dawda, P., & Knight, A. (2018). *Experience-based Co-design: A toolkit for Australia*. Consumers Heath Forum of Australia.

de Moel-Mandel, C., Graham, M., & Taket, A. (2019). Expert consensus on a nurse-led model of medication abortion provision in regional and rural Victoria, Australia: A Delphi study. *Contraception*, *100*(5), 380–385.

Donetto, S., Tsianakas, V., & Robert, G. (2014). *Using experience-based Co-design (EBCD) to improve the quality of healthcare: Mapping where we are now and establishing future directions*. King's College London.

Doran, F. M., & Hornibrook, J. (2016). Barriers around access to abortion experienced by rural women in New South Wales, Australia. *Rural and Remote Health*, *16*(1), 3538.

Doyle, C., Lennox, L., & Bell, D. (2013). A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open*, *3*(1), e001570.

Family Planning NSW. (2020). Nurses well placed to undertake contraceptive implant procedures [Internet]. https://www.fpnsw.org.au/media-news/media-releases/nurses-well-placed-undertake-contraceptive-implant-procedures

Freund, T., Everett, C., Griffiths, P., Hudon, C., Naccarella, L., & Laurant, M. (2015). Skill mix, roles and remuneration in the primary care workforce: Who are the healthcare professionals in the primary care teams across the world? *International Journal of Nursing Studies*, *52*(3), 727–743.

Garrett, C. C., Keogh, L. A., Kavanagh, A., Tomnay, J., & Hocking, J. S. (2015). Understanding the low uptake of long-acting reversible contraception by young women in Australia: A qualitative study. *BMC Women's Health*, *15*(1), 72.

Gilliss, C. L., Powell, D. L., & Carter, B. (2010). Recruiting and retaining a diverse workforce in nursing: From evidence to best practices to policy. *Policy, Politics & Nursing Practice*, *11*(4), 294–301.

Gomez, A. M., & Wapman, M. (2017). Under (implicit) pressure: Young Black and Latina women's perceptions of contraceptive care. *Contraception*, *96*(4), 221–226.

Hammersley, V., Kelman, M., Morrice, L., Kendall, M., Mukerjhee, M., Harley, S., Schwarze, J., & Sheikh, A. (2022). Mixed-methods evaluation of a nurse-led allergy clinic model in primary care: Feasibility trial. *Clinical and Translational Allergy*, *12*(8), e12180.

Higgins, J. A., Kramer, R. D., & Ryder, K. M. (2016). Provider bias in long-acting reversible contraception (LARC) promotion and removal: Perceptions of young adult women. *American Journal of Public Health*, *106*(11), 1932–1937.

Johnson, J. L., Adkins, D., & Chauvin, S. (2020). A review of the quality indicators of rigor in qualitative research. *American Journal of Pharmaceutical Education*, *84*(1), 7120.

Kopp Kallner, H., Gomperts, R., Salomonsson, E., Johansson, M., Marions, L., & Gemzell-Danielsson, K. (2015). The efficacy, safety and acceptability of medical termination of pregnancy provided by standard care by doctors or by nurse-midwives: A randomised

controlled equivalence trial. *BJOG: An International Journal of Obstetrics & Gynaecology*, *122*(4), 510–517.
Kruss, J., & Gridley, H. (2014). 'Country women are resilient but. …': Family planning access in rural Victoria. *The Australian journal of rural health*, *22*(6), 300–305.
Kumar, A., Hessini, L., & Mitchell, E. M. H. (2009). Conceptualising abortion stigma. *Culture, Health & Sexuality*, *11*(6), 625–639.
Lincoln, Y. S. (1985). *Naturalistic inquiry*. Sage Publications.
Lumivero. NVivo 13 (2020, R1). https://www.lumivero.com
Mainey, L., O'Mullan, C., Reid-Searl, K., Taylor, A., & Baird, K. (2020). The role of nurses and midwives in the provision of abortion care: A scoping review. *Journal of Clinical Nursing*, *29*(9–10), 1513–1526.
Makleff, S., Belfrage, M., Wickramasinghe, S., Fisher, J., Bateson, D., & Black, K. I. (2023). Typologies of interactions between abortion seekers and healthcare workers in Australia: A qualitative study exploring the impact of stigma on quality of care. *BMC Pregnancy and Childbirth*, *23*(1), 646.
Mann, E. S., White, A. L., Rogers, P. L., & Gomez, A. M. (2019). Patients' experiences with South Carolina's immediate postpartum long-acting reversible contraception Medicaid policy. *Contraception*, *100*(2), 165–171.
Maxwell, K. J., Hoggart, L., Bloomer, F., Rowlands, S., & Purcell, C. (2021). Normalising abortion: What role can health professionals play? *BMJ Sexual & Reproductive Health*, *47*(1), 32–36.
Mazza, D., Bateson, D., Frearson, M., Goldstone, P., Kovacs, G., & Baber, R. (2017). Current barriers and potential strategies to increase the use of long-acting reversible contraception (LARC) to reduce the rate of unintended pregnancies in Australia: An expert roundtable discussion. *The Australian & New Zealand Journal of Obstetrics & Gynaecology*, *57*(2), 206–212.
Mazza, D., Burton, G., Wilson, S., Boulton, E., Fairweather, J., & Black, K. I. (2020). Medical abortion. *Australian Journal of General Practice*, *49*(6), 324–330.
Mazza, D., Harrison, C., Taft, A., Brijnath, B., Britt, H., Hobbs, M., Stewart, K., & Hussainy, S. (2012). Current contraceptive management in Australian general practice: An analysis of BEACH data. *The Medical Journal of Australia*, *197*(2), 110–114.
Mazza, D., Shankar, M., Botfield, J. R., Moulton, J. E., Chakraborty, S. P., Black, K., Tomnay, J., Bateson, D., Church, J., Laba, T. L., Kasza, J., & Norman, W. V. (2023). Improving rural and regional access to long-acting reversible contraception and medical abortion through nurse-led models of care, task-sharing and telehealth (ORIENT): A protocol for a stepped-wedge pragmatic cluster-randomised controlled trial in Australian general practice. *BMJ Open*, *13*(3), e065137.
McInnes, S., Peters, K., Bonney, A., & Halcomb, E. (2017). Understanding collaboration in general practice: A qualitative study. *Family Practice*, *34*(5), 621–626.
Moulton, J. E., Mazza, D., Tomnay, J., Bateson, D., Norman, W. V., Black, K. I., & Subasinghe, A. K. (2022). Co-design of a nurse-led model of care to increase access to medical abortion and contraception in rural and regional general practice: A protocol. *The Australian Journal of Rural Health*, *30*(6), 876–883.
Moulton, J. E., Subasinghe, A. K., & Mazza, D. (2021). Practice nurse provision of early medical abortion in general practice: Opportunities and limitations. *Australian Journal of Primary Health*, *27*(6), 427–430.
MSI Australia. (2020). *Nurse-led medical termination of pregnancy in Australia: Legislative scan* [Internet]. https://www.mariestopes.org.au/wp-content/uploads/Nurse-led-MToP-in-Australia-legislative-scan.pdf
Mundt, M. P., & Swedlund, M. P. (2016). A human factors systems approach to understanding team-based primary care: A qualitative analysis. *Family Practice*, *33*, 721–726.
Nørreklit, L., Norreklit, H., & Israelsen, P. (2006). The validity of management control topoi: Towards constructivist pragmatism. *Management Accounting Research*, *17*, 42–71.
NHMRC SPHERE Centre of Research Excellence. (2024). SPHERE Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care. [Internet] https://www.spherecre.org/
Noonan, A., Black, K. I., Luscombe, G. M., & Tomnay, J. (2023). 'Almost like it was really underground': A qualitative study of women's experiences locating services for unintended pregnancy in a rural Australian health system. *Sexual and Reproductive Health Matters*, *31*(1), 2213899.
Nursing and Midwifery Board Australia. (2020). https://www.nursingmidwiferyboard.gov.au/
O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for reporting qualitative research: A synthesis of recommendations. *Academic Medicine*, *89*(9), 1245–1251.
Petras, E. M., & Porpora, D. V. (1993). Participatory research: Three models and an analysis. *The American Sociologist*, *24*(1), 107–126.
Purcell, C., Maxwell, K., Bloomer, F., Rowlands, S., & Hoggart, L. (2020). Toward normalising abortion: Findings from a qualitative secondary analysis study. *Culture, Health & Sexuality*, *22*(12), 1349–1364.
Pyett, P. (2002). Working together to reduce health inequalities reflections on a collaborative participatory approach to health research. *Australian and New Zealand Journal of Public Health*, *26*(4), 332–336.
Rome, E. S., Lunde, B., Kaznoch, D., & Mahoney, N. (2022). Long-acting reversible contraceptives (LARC) toolkit: Starting, building, and maintaining optimal care delivery of LARCs for adolescents and young adults [Internet]. *Cleveland Clinic* https://my.clevelandclinic.org/-/scassets/files/org/pediatrics/long-acting-reversible-contraceptives-toolkit?utm_campaign=larctoolkit-ccch-url&utm_medium=offline&utm_source=redirect&utm_content=larctoolkit-ccch-url
Schummers, L., Darling, E. K., Dunn, S., McGrail, K., Gayowsky, A., Law, M. R., Laba, T. L., Kaczorowski, J., & Norman, W. V. (2022). Abortion safety and use with normally prescribed mifepristone in Canada. *The New England Journal of Medicine*, *386*(1), 57–67.
Senate Standing Committees on Community Affairs. (2023). *Ending the postcode lottery: Addressing barriers to sexual, maternity and reproductive healthcare in Australia*. [Internet]. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ReproductiveHealthcare/Report
Sorhaindo, A. M., & Lavelanet, A. F. (2022). Why does abortion stigma matter? A scoping review and hybrid analysis of qualitative evidence illustrating the role of stigma in the quality of abortion care. *Social Science & Medicine*, *311*, 115271.
Sudhinaraset, M., Landrian, A., Cotter, S. Y., Golub, G., Opot, J., Seefeld, C. A., Phillips, B., & Ikiugu, E. (2022). Improving stigma and psychosocial outcomes among post-abortion Kenyan women attending private clinics: A randomized controlled trial of a person-centered mobile phone-based intervention. *PLoS ONE*, *17*(6), e0270637.
Taft, A. J., Shankar, M., Black, K. I., Mazza, D., Hussainy, S., & Lucke, J. C. (2018). Unintended and unwanted pregnancy in Australia: A cross-sectional, national random telephone survey of prevalence and outcomes. *The Medical Journal of Australia*, *209*(9), 407–408.
The Faculty of Sexual and Reproductive Healthcare (FSRH). (2021). FSRH Guideline (February 2021) progestogen-only implant. *BMJ Sexual & Reproductive Health*, *47*(Suppl. 1), 1–62.
Therapeutic Goods Administration (TGA). (2023). Amendments to restrictions for prescribing of MS-2 Step (Mifepristone and Misoprostol)| [Internet]. https://www.tga.gov.au/news/media-releases/amendments-restrictions-prescribing-ms-2-step-mifepristone-and-misoprostol
Tomnay, J. E., Coelli, L., Davidson, A., Hulme-Chambers, A., Orr, C., & Hocking, J. S. (2018). Providing accessible medical abortion services in a Victorian rural community: A description and audit of service delivery and contraception follow up. *Sexual & Reproductive Healthcare: Official Journal of the Swedish Association of Midwives*, *16*, 175–180.

West, R., Usher, K., & Foster, K. (2010). Increased numbers of Australian indigenous nurses would make a significant contribution to 'closing the gap' in indigenous health: What is getting in the way? *Contemporary Nurse: A Journal for the Australian Nursing Profession*, *36*(1/2), 121–130.

Wood, L. (2020). *Participatory action learning and action research: Theory, practice and process*. Routledge & CRC Press. [Internet]. https://www.routledge.com/Participatory-Action-Learning-and-Action-Research-Theory-Practice-and/Wood/p/book/9781138339064

World Health Organization. (2015). *Health worker roles in providing safe abortion care and post-abortion contraception*. WHO.

World Health Organization. (2022). *Abortion care guideline [Internet]*. World Health Organization Guidelines. Report No.: Licence: CC BY-NC-SA 3.0 IGO. https://www.who.int/publications/i/item/9789240039483

Zuber-Skerritt, O. (2018,). An educational framework for participatory action learning and action research (PALAR). *Educational Action Research*, *26*(4), 513–532.

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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