Supplemental materials for:

Munro S, Guilbert E, Wagner M, et al. Perspectives among Canadian physicians on factors influencing implementation of mifepristone medical abortion: a national qualitative study. *Ann Fam Med.* 2020;18(5):413-421.

Appendix 1: Interview Guides

Interview Guide A

Physician initial interview (3 months after training to prescribe mifepristone)

To begin, please tell me about your practice setting and your role in it.

1. Can you please tell me about your experience with mifepristone so far?
    a. *How many mifepristone terminations have you provided to date?*
    b. *How does that compare to the number of terminations you typically provide using other methods?*
2. What is your past experience with abortion care? (*Probe for type of abortion services available*)
3. What do you feel are the advantages of mifepristone as a new treatment?
    a. *Do you see there being any downsides to having mifepristone available in Canada?*
4. How do other providers in your community feel about mifepristone and abortion care?
    a. *What are your relationships like with other key people in your community? (Such as other providers, pharmacists, managers)*
    b. *Do/Did you have a formal plan for implementing mifepristone in your community? What does it look like?*
    c. *Can you describe the patient care pathway for mifepristone medical abortion in your practice? (Such as appointments, prescribing, dispensing, and where and how each step takes place)*

I would like to talk a little more about any obstacles you have faced in providing mifepristone.

5. What things make it challenging to provide? Has _____ been a factor? (How?)
    - *Cost (such as provincial coverage, financial disincentives, uncertainty about coverage)*
    - *Billing codes (such as lack of billing codes; lack of compensation)*
    - *Clinical workflow (such as counselling; following up; changing from a surgical to a medical abortion clinic; time pressure)*
    - *Documentation (such as Health Canada forms, consent forms)*
    - *Drug availability and dispensing (such as ordering it)*
    - *Government support (such as political factors)*
    - *Regulations (such as physician dispensing)*
    - *Community presence of anti-choice attitudes (such as among protestors or colleagues)*
    - *Having access to surgery, ultrasound, or labs*
    - *Human resources (such as counsellors; staff burn out)*
    - *Availability of information (such as confusion about regulations; where to get training; where to get updates)*
    - *Training (such as the requirement to get training)*

6. What changes would make it easier for you to provide mifepristone?

Let's talk about your experience with the training program:

7. What made you decide to take the mifepristone training program?
8. What was your experience of the training process?
    a. *How easy or difficult was it to get the training?*
    b. *Was this a typical training experience for you? How was it different from how you typically do professional development?*
    c. *How could the training be improved?*

I would also like to know about any support or feedback you are receiving. We spoke earlier about your relationships with your colleagues in your community.

9. Are there any key individuals that have rallied to support mifepristone, either in your community or elsewhere in Canada? Can you describe what they did?
    a. *Is there any person or organization you would describe as unsupportive? (What did they do?)*
10. Have you exchanged information with anyone about mifepristone, either inside or outside of your setting?
    a. *What did that look like? (For instance, have you spoken to the media or contacted your college registrar?)*
    b. *Have you learned about any changes to mifepristone regulations or coverage? What have you learned? Where did you get the information?*
11. Are you a member of the Canadian Abortion Providers Support platform, also known as the "CAPS" website?
    a. If YES: *Tell me your thoughts about it. / What do you like or dislike about the website? / How can it be improved?*
    b. If NO, explain what the website is before following up: *Would joining this website be useful for you? (Why / why not?) / To help us make it useful for you, what information would you want from the website?*
12. What do you like about other communities of practice that you belong to, such as email list serves?
13. How will you know that you are achieving good outcomes with mifepristone in your community?

I have come to the end of my questions.

14. Is there anything else you think I should know?
15. Do you have any questions for me?

Interview Guide B

Healthcare professionals, such as family physicians, who were eligible to become mifepristone prescribers but did not pursue this practice

1. Please tell me about your practice setting and your role in the past 12 months.
    a. *What are the areas of focus for your clinical practice?*
2. Can you please tell me what you know about medical abortion and the new abortion pill called mifepristone?
3. What do you feel are the advantages of the new abortion pill?
    a. *Do you see there being any downsides to having the abortion pill available in Canada?*
4. Have you ever provided abortion care before? Can you please describe the care you provided?
    a. *How do you feel about abortion?*
5. Are you aware of the Society of Obstetricians and Gynaecologists of Canada mifepristone training program for physicians and pharmacists?
    a. If YES: *Tell me your thoughts about it.*
    b. If NO, explain what the training is before following up: *Would taking this training be useful for you? (Why / why not?)*
6. Can you describe the abortion care available in your practice setting or community?
7. How do other providers in your community feel about the abortion pill?
    a. *What are your relationships like with other key people in your community who would be involved in providing the abortion pill? (Such as other physicians, pharmacists, managers)*
    b. *What are your relationships like with abortion providers?*
    c. *What relationships or networks do you feel are necessary for you to provide the abortion pill?*
    d. *Do you have a formal plan for implementing the abortion pill in your community? Do you know of anyone else's plans? What does they look like?*
8. Are there any key individuals that have been leaders in implementing the abortion pill, either in your community or elsewhere in Canada? Can you describe what they did?
    a. *Is there any person or organization you would describe as unsupportive? (What did they do?)*
9. Have you exchanged information with anyone about the abortion pill, either inside or outside of your setting?
    a. *What did that look like? (For instance, have you spoken to the media or contacted your college registrar?)*
    b. *Have you learned about any changes to abortion pill regulations or coverage? What have you learned? Where did you get the information?*

I would like to talk a little more about any factors that may be an obstacle for you to providing the abortion pill.

10. Has _____ been a factor? *(How?)*
    - *Cost (such as provincial coverage, financial disincentives, uncertainty about coverage)*
    - *Billing codes (such as lack of billing codes; lack of compensation)*
    - *Clinical workflow (such as counselling; following up; changing from a surgical to a medical abortion clinic; time pressure)*
    - *Documentation (such as Health Canada forms, consent forms)*
    - *Drug availability and dispensing (such as ordering it)*

- *Government support (such as political factors)*
- *Regulations (such as physician dispensing)*
- *Community presence of anti-choice attitudes (such as among protestors or colleagues)*
- *Having access to surgery, ultrasound, or labs*
- *Human resources (such as counsellors; staff burn out)*
- *Availability of information (such as confusion about regulations; where to get training; where to get updates)*
- *Training (such as the requirement to get training)*

11. Would you ever consider providing medical abortion with mifepristone?
    a. If YES*: What changes would make it easier for you to provide?*
        i. *Probe for changes to their personal opinions; professional support; training; policies and regulations; practical aspects of practice*
    a. If NO*: Why?*

12. What support or feedback would be necessary for you to practice mifepristone medical abortion?
13. Are you aware of the Canadian Abortion Providers Support platform, also known as the "CAPS" website?
    a. If YES: *Tell me your thoughts about it.*
    b. If NO, explain what the website is before following up: *Would joining this website be useful for you? (Why / why not?) / To help us make it useful for you, what information would you want from the website?*
14. How will you know that the abortion pill is well received and used in your province?

I have come to the end of my questions.

15. Is there anything else you think I should know?
16. Do you have any questions for me?
17. Is there anyone else you recommend we talk to?

Interview Guide C

Physician repeat interview (12 months after initial interview)

1. Please tell me about your experience since our interview on [Month/Date].
   a. Have you begun to <u>prescribe</u> mifepristone? Why / Why not?
   b. Have others in your community begun to prescribe mifepristone?

If they provide mifepristone:

2. Can you describe the patient care pathway for mifepristone medical abortion in your practice? (*Such as appointments, prescribing, dispensing, and where and how each step takes place*)

I would like to talk a little more about any obstacles you have faced in providing mifepristone.

3. In our last interview, you said that these things have been a factor for you in providing mifepristone: [*list factors*] I'm going to go through each of these one at a time.
4. Is _____ still a factor for you? (*How? What has changed? Why?*)
   a. [Probe about new factors that emerged from data collection and analysis after the participant's interview]
5. Are there any other changes that would make it easier for you to provide mifepristone?

I would also like to know about any support or feedback you are receiving.

6. Since our last interview, have you exchanged information with anyone about mifepristone, either inside or outside of your community?
7. Have you learned about any changes to mifepristone regulations or coverage? What have you learned? Where did you get the information?
8. Are you a member of the Canadian Abortion Providers Support platform, also known as the "CAPS" website?
   a. If YES: *Tell me your thoughts about it. / What do you like or dislike about the website? / How can it be improved?*
   b. If NO: *Why did you choose not to join the CAPS website?*

I have come to the end of my questions.

9. Is there anything else you think I should know?
10. Do you have any questions for me?

Interview Guide D

Stakeholders

1. Please tell me about your role and your organization.
2. How long have you been in this role?
3. From your perspective, please tell me the story of how mifepristone came to be in Canada.
4. When did you first get involved with bringing mifepristone to Canada? What has your role been?
5. Tell me about your understanding of the rules and regulations set by Health Canada.
6. Tell me about your understanding of the rules and regulations set by your regulatory body.
7. Tell me your process for implementing mifepristone in your organization/setting.
8. How have those processes changed since approval?
9. What would you have done differently?
10. What have the challenges been? *Probe for the following and for factors that emerge from data collection/analysis with physicians:*
    - *Cost / Financial disincentives / Coverage*
    - *Pharmacy stock*
    - *Access to surgery, ultrasound, labs*
    - *Government support*
    - *Regulations (product monograph, Risk Management Plan, training)*
    - *Human resources (i.e. turnover, burnout)*
11. What has reduced those challenges?
12. What needs to change to make it easier to implement mifepristone in your setting?
13. Who are the different groups involved in implementing mifepristone? What have they done?
14. Tell me about how you have engaged with other groups? *Probe for the following:*
    - *Key individual, experts*
    - *Degree of support (or unsupportive)*
    - *Degree of communication*
    - *Quality of information exchange*
    - *Feedback with the media*
15. Can you tell me about your organization's values and how they relate to mifepristone?
16. What are the advantages of mifepristone as a new treatment?
17. Can you describe any potential downsides to implementing mifepristone?
18. How will you know that you are achieving good outcomes with implementing mifepristone?
    a. What kind of outcomes are you tracking or looking for or look for? \
    b. How do you measure successful implementation of Mife?
19. Is there anyone else you recommend I speak with?
20. Is there anything else you think I should know?
21. Do you have any questions for me?

Appendix 2: Themes and Representative Quotations

Table 1: Federal restrictions made mifepristone "more complicated than it needs to be"
Physicians' ability to implement mifepristone in routine care was influenced by federal restrictions

Theme	Description	F	B	Quotation
Mandated training and certification	Prescribers and dispensers were required to complete a training program		X	"It [the training] is going to limit women's access to medications. It might be a person, for example -- I've seen this – where they're intent to do this module, but they just haven't gotten around to it. Then suddenly you have a patient there who wants a medical, and they just don't have the time to do it, to go through the module and get the prescribing right. That's a barrier versus if you could prescribe the medication and then get some mentorship by someone who has experience with using the medication, which is kind of how we use all of our medications." *006_Phys – family physician from the Territories, previous medical and surgical abortion experience*
	Prescribers and dispensers were required to certify their identity with the manufacturer		X	"Until recently, we had to get registered with the company as [abortion] prescribers, and I really was uncomfortable with that. We did it, but I really hated the notion that a private corporation has my name, address, and information. If they get hacked, that information could be potentially accessed, if there was a data breach." *035_Phys – primary care professional from the Territories, previous medical and surgical abortion experience*
Limits on prescribing and dispensing	Physician-only dispensing		X	"We're not set up to dispense medications from our office. We wouldn't have been able to dispense it just through the clinic that I work in. I think, that's better, that it's not dispensed by physicians. I don't know of any other medication that is dispensed by physicians." *036_Phys – rural Saskatchewan family physician, previous medical and surgical abortion experience*
	Prescribers were required to provide 24 hour on-call follow up for patients		X	"The sort of requirement to be available on call is no fun because that is not traditionally how I practice. I've basically gotten a second phone just to use for on call, which is a nuisance. I don't want to give my private cell number, but I don't have a call service. Traditionally I don't have to do after hours … it bugs me that we're expected to be on call for free, forever" *029_Phys – rural British Columbia family physician, no previous abortion experience*
Restrictions for patient access	Mandated patient consent form		X	"I know we had groups to talk to us that said, 'This is ridiculous. Women shouldn't be walking around with their informed consent and giving that to the pharmacy to the prescription filled.' We said, 'What are you talking about?' There was information out there that it was a requirement from Health Canada, which was not the case. When we heard that that was an option to have women carry their informed consent and show that at

			the pharmacy, we didn't think that was a good idea. We actually rejected that. We said, 'We don't think for various privacy concerns that that's appropriate.'" *007_Stakeholder – government decision maker*
	Requirement to watch the patient ingest the drug	X	"I've never seen any other drug – and we've prescribed lots of toxic, horrible things – that had to be given by the doctor directly and watch the patient take the dose." *008_Phys – rural Saskatchewan family physician, no previous abortion experience* "It was interpreted to mean that the patient would have to be in the presence of a doctor, in front of the doctor to take the drug, which was kind of unheard of for any drug to be handled that way. It was perceived as being very paternalistic; 'Women can't be trusted.'" *022_Stakeholder – national advocate*
	Gestational age limit was lower than recommended by guidelines	X	"I mean, the Health Canada original guideline really conflicted with the SOGC guideline in what the evidence stated. … There is strong evidence that Mife is good up to nine, 10 weeks. I think that that is something that I would be willing to do and other providers at our facility would too." *015_Phys – urban Saskatchewan family physician, previous medical and surgical abortion experience*
	Ultrasound to confirm gestational age required before prescription	X	"Right now, an ultrasound is required. Maybe that can soften too. If this woman has regular periods at exactly every 28 or 30 days or whatever their period is, they had a normal, regular period, and now they are pregnant and now are starting to get sore breasts. If you are in a remote community where ultrasound is not accessible, maybe you can actually trust women." *020_Phys – urban Ontario family physician, previous surgical abortion experience*
Perceptions of the policy process	Regulatory approval of mifepristone in Canada was "slow"	X	"I was thrilled that it was going to be approved. I felt like it was a long time coming." *030_Phys – urban Ontario family physician, previous surgical abortion experience* "It just seemed like Health Canada was a little bit slow. Kind of like mifepristone was regulated in a way that almost no other drug that I use as a family physician is regulated, right?" *015_Phys – urban Saskatchewan family physician, previous medical and surgical abortion experience*
	Federal politics and policies influenced the approval process	X	"The original application was initiated during the Conservative government, so they [the distributor] were probably strategically positioning that application in a way that would have been a bit more palatable for acceptance, or they were hoping would not have the resistance, but now that we have a supportive federal government in place and don't expect that kind of resistance and certainly have been working hard with Health Canada, etc., you know. There's some back work to do now to kind of remove some of the initial

	strategies and approaches." *008_Stakeholder – government decision maker*

F: Facilitator; B: Barrier

Table 2: Navigating the "huge bureaucratic process" of organizational implementation
Physicians' ability to implement mifepristone in routine care was influenced by health system and structural factors

Theme	Description	F	B	Quotation
Billing and costs	Physician compensation for medical abortion	X	X	"I don't even have a billing code for telemedicine. I don't have a billing code for medical abortions. I don't have a billing code for ultrasounds out-of-hospital. I don't have a billing code for any of the counselling that we do … Suggesting that introducing Mife is just all of a sudden going to increase regional access to abortion, I think, is egotistical of people." *005_Phys – urban New Brunswick family physician, previous medical and surgical abortion experience*
	Patient affordability and provincial coverage	X	X	"I think the biggest thing is cost. That's the hugest thing. To offer women, 'Here you can have a medication abortion or a surgical procedure' and say, 'The surgical procedure is free, but you have to pay $325' — or whatever it is — 'for your medication abortion,' I think that's not giving a, it's not a real choice. I think that's a problem." *001_Phys – rural British Columbia family physician, previous medical and surgical abortion experience*
Bureaucracy	Local administrative and procedural obstacles		X	"We're part of a hospital. There's a huge bureaucratic process that I have had very little to do with implementing. I'm just going to just wait and apply with it when it becomes [available] … Once we do, it'll just be part of routine care." *003_Phys – urban Ontario family physician, previous medical and surgical abortion experience* "I would love to be able to [prescribe]. That's not in my realm of decision making ... I've asked at our meeting what could potentially be happening. I asked that kind of directly to the [Department Head], and they kind of said they really haven't heard anything yet and more information should be maybe forthcoming, so that's the last I've heard from them. I plan to bring it up again in our next meeting" *025_Phys – rural Nova Scotia family physician, no previous abortion experience*
	Moving ahead in some provinces, while lagging behind in others	X		"The College of Physicians and Surgeons and College of Pharmacists in Ontario and BC have basically come out with statements telling their members that you can, basically, ignore the Health Canada requirements. You don't have to do an ultrasound unless you think it is necessary … pharmacists can now dispense directly to patients. We have gotten rid of that requirement or that expectation, at least, in those two provinces." *022_Stakeholder – national advocate* "Well, firstly, I think the big mistake was wanting to bring in the Mife abortion pill to Quebec, as it was done in the rest of Canada. Secondly, Quebec is not only different in terms of the number of abortion services, but also in terms of its laws. So, Health Canada does not have

			all the powers, even in Quebec. The Collège des médecins is the other party that one must work with to develop this type of thing." *Stakeholder E4 – facility leader*
Rural care	Population and resource needs of rural communities	X	"Yesterday, I did a surgical termination on a woman who had to travel literally 12 hours from the northern part of the province for a surgical procedure. I kept thinking, you know, if there had been a provider in her community or a nurse practitioner who could have done a medical. She had to leave four children in a community that's 12 hours away, right?" *002_Phys – rural British Columbia OB-GYN, previous medical and surgical abortion experience*
Implementation process	Access to ultrasound, laboratory, and surgical resources	X	"There is the assumption that you have speedy laboratory and access to ultrasound. That just isn't always the case because when we do have an ultrasound tech, it's usually a long list. Doing a dating ultrasound is pretty low priority for most of the things that are out there." *026_Phys – rural family physician from the Territories, previous medical and surgical abortion experience* "My experience with medical abortions done with methotrexate and misoprostol is it's something you want to make sure is covered but not because you ever need it, but because you might need it. So access to urgent D&C, for instance, if need be, would be important, but the truth is with any place where they're going to have miscarriages, which is everywhere, would also have to have access to those services, so it's no more of an issue for this than it is for a miscarriage." *016_Stakeholder – College/regulatory body decision maker*
	Finding ways to stock and dispense the drug	X	"Initially, it seemed to be that I would have to order them, pay, and charge the patient, and they may or may not get it reimbursed from the insurance. I think if I had to go through that process, that would be difficult in sorting out, 'How am I going to be stocking this in my office? How am I going to charge patients?' From my understanding, that has been eased, and I can actually just prescribe it." *004_Phys – urban Ontario family physician, no previous abortion experience*
	Getting experience with the tasks of a new practice	X	"I've prescribed it, I think, only once … I had the perfect patient come into my office who I knew would be a candidate, so we scrambled to get the investigations done. I spent a summer weekend doing the online training and then prescribed it. The pharmacy was really open to doing it. They were like, 'Yeah, we were meaning to ask you if we should do this.' I was like, 'I've been meaning to ask you guys if we should do this,' so we did, and it was textbook. She was the perfect candidate. It went perfectly. No problems. No hitches, and it was great." *034_Phys – rural Nova Scotia family physician, no previous abortion experience*

	Task shifting from a surgical to medical abortion practice	X	X	"We were so surgically focused, when we got around to dedicating a whole day to doing medical abortions because the demand was that high, we didn't really lay off staff because we have so many casual people. We had to reorganize our day so that instead of having five nurses on, we only needed one. That was a bit of a change for the clinic. Moving forward, if we have to do more of that, then that will be a significant change for this site because we have been organized as a surgical facility, and we will end up being more like a doctor's office." *003_Stakeholder – abortion facility administrator*
	Patient counselling	X		"We're not trained counsellors, and we are often pressed for time. Again, in our dream world, we would have a counsellor on site as well, so the woman could see us and also a counsellor." *031_Phys – family physician from the Territories, previous medical and surgical abortion experience*
	Patient follow-up		X	"We have many patients that come from different cities, up to an hour, an hour and a half away. We would love to do some of the follow-up just over the phone, so they physically don't have to come in, but we do not have a way of getting the blood work in other facilities. The only way we can do it is have them physically come to the hospital to have that done. That was another obstacle." *028_Phys – urban Ontario family physician, previous medical and surgical abortion experience*

F: Facilitator; B: Barrier

Table. 3: Challenges with diffusion and dissemination of policy information
Physicians' ability to implement mifepristone in routine care was influenced by communication and interaction with colleagues, advocacy groups, and news media

Theme	Description	F	B	Quotation
Collegiality	Collaboration with peers, consultants, and pharmacists to make implementation work	X		"We do a lot of just 'off the side of our desk' medicine in a rural setting, so when you do something for the first or second time or you don't do it very often, it's good to have other medical colleagues you can run something by or say, 'What do you think of this? Is this crazy? Do you have any other ideas?' That is huge for me when I'm trying something new or doing something new just to have others around me that maybe don't have a lot more experience than me but that are supportive and a good sounding board." *040_Phys – rural British Columbia family physician, previous medical abortion experience*
	Having a mentor	X		"We just had an e-mail come round through the Division of Family Practice from the obstetrician in [city] who does the unplanned pregnancy clinic saying she sees these women coming to her from here, and she knows it's difficult, and can she support us in getting started [with mifepristone], and do we want a session? I replied, 'Yes, I absolutely would love that.' That would actually be the thing that would nudge me over the edge I think would just be to have that personal contact." *039_Phys – rural British Columbia family physician, no previous abortion experience*
Communication	Making sense of changing and inconsistent information on regulations		X	"I think it's good for people to wait a little bit and not kind of jump in because it gets confusing … I kind of want to wait until some other changes happen so I can say, 'This is how it is. You don't need pharmacists to do this. Physicians aren't required to do this,' or whatever because to *undo* information will be a lot harder." *008_Stakeholder – government decision maker*
	Availability of a community of practice for quality information	X		"I think it [the Canadian Abortion Providers Support (CAPS) platform] is a fantastic resource because it has a lot of information on how to provide services, on where to find pharmacists. I like the fact that it is a sort of members only website, at least some parts of it. I think there's been a lot of design going into making that a safe and non-hackable space … It's sort of a nice centralized way of getting information and distributing information to the people who are among the providers." *021_Phys – urban British Columbia OB-GYN, previous medical and surgical abortion experience*
	Awareness of mifepristone as a new option		X	"I don't think patients know about it, but it's even more important for doctors. I don't think doctors know about it, ones who aren't watching for it. For me, it was on my radar because it was interesting to me. It was an equity issue for me, but I am not, like,

			your average person. I have a particular interest in it, right?" *008_Phys – rural Saskatchewan family physician, no previous abortion experience* "I did speak to the owner of the pharmacy that we deal with all the time about it being on the market. She didn't even know what it was. When I was saying, 'Mifegymiso is now available.' She said, 'What is that?' I said, 'It is the abortion pill.' She was like, 'I had never heard of it.'" *020_Stakeholder – Atlantic province abortion facility administrator*
Being an advocate	The role of advocacy in improving access to family planning services	X	"I think what people don't understand is if a woman wants to terminate a pregnancy, she will. That means that she will even do it illegally or dangerously, and she will terminate that pregnancy. What we are going to see if there are any cutbacks on abortion services, we are going to see injured and sick and even dead women. That's why I feel that I am more resolved to provide those services." *033_Phys – urban Ontario OB-GYN, no previous abortion experience*
Anti-choice attitudes	Avoiding scrutiny as an "abortion doctor"	X	"Some of them that are abortion providers basically have to sneak their way into the clinic so people picketing outside don't see them or they don't let their extended family know that they are abortion providers. You certainly know that people that are living their life doing this don't feel like they can do it openly, which is unfortunate if you look at the support that there actually is amongst Canadians, that we still have to be doing it kind of in the dark." *004_Phys – urban Ontario family physician, no previous abortion experience*
	Experiencing conscientious objection	X	"The reason we don't do abortions at our hospital is essentially because of the insurmountable anti-choice elements among the staff. We would have cleaning people who wouldn't clean the OR. We would have nurses who wouldn't participate in the case. We would have a number of anaesthetists who wouldn't provide any kind of anaesthesia backup for the OBs who were doing abortions before at our hospital … We can't even start talking about Mife until we start talking about just accepting abortion as a whole." *005_Phys – urban New Brunswick family physician, previous medical and surgical abortion experience*

F: Facilitator; B: Barrier

Table 4: Adoption by individuals: 'A process rather than an event'
Physicians' ability, motivation, and skills to implement mifepristone in routine care

Theme	Description	F	B	Quotation
Perceived benefits of mifepristone	Mifepristone abortion is effective, reliable, and safe	X		"It's way more predictable than methotrexate and misoprostol. It's been much easier to use in my very limited experience, but even just talking to other people who have been using it, it's been much easier to use. I think there's going to be much more uptake from physicians who weren't normally providing abortions before but who will be open to do it because of the relative ease of using the mifepristone" *006_Phys – family physician from the Territories, previous medical and surgical abortion experience*
	Patients experience more comfort, options, and access with mifepristone	X		"I think there's huge benefits for the patient's convenience. I think in terms of being able to manage this in a primary care environment, including their home at their convenience, not when a surgeon is available or not. I think the patient has a lot control over the situation, so I see it as a huge benefit." *019_Stakeholder – Advocate*
Motivation	Experiencing motivation to start providing	X		"I had intentions of doing it [the training] … but then I had a referral with a patient requesting it, so that prompted me to get the certification done so that I would be able to do my best to provide that for her." *032_Phys – rural Saskatchewan OB-GYN, previous surgical abortion experience*
	Experiencing "inertia" (waiting to start providing)		X	"Knowing that there's all these fast-changing regulations, especially knowing that the pharmacy-training piece was going to fall away eventually is part of why I waited … I'm more hopeful now that I will be able to convince the pharmacists in the community to stock it." *021_Phys – urban British Columbia OB-GYN, previous medical and surgical abortion experience*
	Assuming there is good access and the service is not needed		X	"The availability is there. It's kind of mainly my own inertia … I feel like it's such a low barrier, but to be honest with you, it's an even lower barrier that I have my patients be seen by [an abortion clinic] across the street." *042_Phys – urban British Columbia family physician, previous medical abortion experience*
Experience	Gaining comfort and competence through hands-on experience	X		"We were very nervous to do medicals on people who were out in rural without much support, but we've moved increasingly to … being a lot less nervous about that. With Mife, our results are going to better, quicker, and more assured. That's going to be even less a constraint. [What caused that shift that made you less nervous?] I think experience." *018_Phys – urban Saskatchewan family physician, previous medical and surgical abortion experience*
Reinforcement	Observing patient satisfaction and drug effectiveness	X		"I see the same patients all the time. That patient, I've seen her three times since. She hugs me every time. She's so happy. That's a thing. You see, I would see them again and again and again because it's a small, defined community, so I will know. If somebody doesn't have a

	good outcome, I will know about that, too. In that way, it's very easy." *034_Phys – rural Nova Scotia family physician, no previous abortion experience*

F: Facilitator; B: Barrier