

**REPRODUCTIVE JUSTICE:**

**IMPROVING ACCESS TO ABORTION SERVICES IN**

**AOTEAROA NEW ZEALAND**

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## Abstract

With the recently introduced Abortion Legislation Bill 2019, 2020 could be the year that Aotearoa decriminalises abortion. The Bill, if passed, would remove abortion from the Crimes Act 1961 and treat it, instead, as a health issue. Current legislation has been heavily critiqued for undermining patients' human rights to healthcare and bodily autonomy, causing lengthy delays in treatment, and contributing to stress. Access to abortion is unequal for different members of society, particularly for those who face socioeconomic disadvantages, are marginalised, rural, Māori, religious, migrant, or a combination thereof. Factors that obstruct access may be legal, geographical, socioeconomic, cultural and societal. Additionally, stigma, the lack of availability of willing abortion practitioners, and conscientious objection represent significant barriers. Improving access to abortion would assist in the achievement of reproductive justice and Aotearoa's national and international agreements, such as Te Tiriti o Waitangi and the United Nation's Sustainable Development Goals.

This study explores how access to abortion can be improved, particularly for the most disadvantaged, whether or not the law changes. It aims to contribute to improved and more equitable access to abortion services. Undertaken from a social constructivist and transformative epistemology, semi-structured interviews were conducted with 13 abortion providers, academics and advocates, as they are the knowledge-holders of abortion access. The research is guided by the framework of reproductive justice, which recognises every aspect which may hinder or empower a person's right to control their fertility. The study found that decriminalisation and telemedicine have the greatest potential to improve access to abortion in Aotearoa, particularly for the most disadvantaged. Other ways to improve access, regardless of law change, include improved cultural competency, efforts to reduce stigma, changes to conscientious objection, and integrated services. Decriminalisation would assist in improving access to abortion and making advancements towards reproductive justice and human rights. However, questions remain over the future of funding, training and access.

**Keywords:** *abortion, access, Aotearoa, law change, reproductive justice.*

**Trigger warning:** *This thesis mentions violence, rape, and coercion.*

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## List of abbreviations

ALRANZ	Abortion Law Reform Association of New Zealand
APGANZ	Abortion Providers Group Aotearoa New Zealand
ASC	Abortion Supervisory Committee
CO	Conscientious objection
CSAA	The Contraception, Sterilisation, and Abortion Act (1977)
DHB	District Health Board
EMA	Early medical abortion
GAD	Gender and development
GI	Guttmacher Institute
GP(s)	General practitioner(s)
ICPD	International Conference on Population and Development (United Nations)
IPV	Intimate partner violence
LARC(s)	Long-acting reversible contraceptive(s)
MA	Medical abortion
MDG(s)	Millennium Development Goal(s)
O&G	Obstetrics and Gynaecology
RJ	Reproductive justice
SRHR	Sexual and reproductive health and rights
UN	United Nations
UN CEDAW	United Nations Convention/Committee on the Elimination of all Forms of Discrimination Against Women
(UN) SDG(s)	United Nations Sustainable Development Goal(s)
WHO	World Health Organisation

## Chapter 1: Introduction to research

### 1.1 Introduction

Where life begins and what constitutes as a life is a philosophical matter that holds no objective answer (Beattie, 2010). Those who believe life begins at conception typically assign greater protection to the unborn, while those who believe life begins at birth typically assign greater protection to the pregnant-person. As such, the “abortion debate” remains a contemporary one that shows no sign of lying stagnant. In reality, this binary debate is insufficient at capturing the diverse reproductive experiences of pregnant-people (Beattie, 2010; Smith, 2005; Hannah, Cook, & Manea, 2019), a key understanding recognised by advocates of reproductive justice (RJ), which combines intersectional feminism with reproductive health, human rights and activism. In accordance with the philosophical debates, it is difficult, at both international and national scales, to reach consensus and many barriers to abortion remain. Abortion access is an important development issue as it intersects with health and wellbeing, empowerment, feminism, equity, human rights, poverty alleviation, RJ, and sexual and reproductive health and rights (SRHR).

Abortion in Aotearoa is criminalised under the Crimes Act 1961 and by the Contraception, Sterilisation, and Abortion Act 1997 (CSAA), which allows abortions under exceptional circumstances in pregnancies that,

present a serious danger to the life of a woman, serious danger to the physical or mental health of a woman, pregnancies resulting from incest or sexual relations with guardian, pregnancies in women of mental subnormality, and pregnancies presenting fetal abnormality. (Silva, McNeill, & Ashton, 2010, p. 2)

The law has remained mostly unchanged since then, despite various calls for reform (Abortion Supervisory Committee, 2016, 2017, 2018; United Nations Convention on the Elimination of all Forms of Discrimination Against Women, 2012; Sparrow, 2010, 2013; Te Whāriki Takapou, Abortion Law Reform Association of New Zealand, & Family Planning New Zealand, 2017; Edmond & Burke, 2017; McCulloch & Weatherall, 2017). The Abortion Supervisory

Committee (ASC), which oversees abortion law and practice, has requested that Parliament reform abortion law since 1988 (ASC, 2003). There is a risk of prosecution under the CSAA, although this does not happen in practice. One can face up to 14 years in prison for “unlawfully” administering an abortion, seven years for supplying the means to procure an abortion, and a \$200 fine for receiving an unlawful abortion (Leslie, 2010, p. 4). Additionally, rape or age are absent as a legal reason for abortion. In 2012, the United Nations urged Aotearoa to reform and ensure access to abortion,

The Committee notes with concern, however, the convoluted abortion laws which require women to get certificates from two certified consultants before an abortion can be performed, thus making women dependent on the benevolent interpretation of a rule which nullifies their autonomy. The Committee is also concerned that abortion remains criminalized in the State party, which leads women to seek illegal abortions, which are often unsafe. (UN CEDAW, 2012, p. 8)

In 2019, the government considered three possible models of abortion law reform that would treat abortion as a health matter (Law Commission, 2018). The government settled on Model C<sup>1</sup> which would allow abortions up to 20 weeks’ gestation, at which point a statutory test would be required. In early 2020, Parliament will decide if Aotearoa’s law will be decriminalised, treated as a health matter, modernised, and brought “into line with many other developed countries” (Melville, 2019, p. 2). The process of obtaining an abortion would become much simpler. The number of abortions taking place is not expected to increase, based on global experiences (Singh, Remez, Sedgh, Kwok, & Onda, 2017; Peiró, Colomer, Alvarez-Dardet, & Ashton, 2001). While some of the barriers to accessing abortion may disappear with legal reform, some barriers could remain, depending on how the implementation of reform is carried out by government and health officials.

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<sup>1</sup> Model C as described in the Law Commission (2018, p. 12) report allowed abortions up to 22 weeks without any test. However, in August 2019, a more conservative version of Model C was announced, amending the statutory test to 20 weeks, likely due to political pressure. In February 2020, it was again amended to require not one, but at least two medical practitioners’ approval at 20 weeks (Abortion Legislation Committee, 2020).

## The abortion process

Silva et al. (2010) outline the current process of seeking an abortion in Aotearoa under current (pre-reform) legislation. An individual seeking an abortion must visit a general practitioner (GP) or a Family Planning doctor for a referral for an abortion. A written referral is a legal prerequisite (one cannot simply refer oneself). A patient must legally be offered counselling (which may be compulsory, depending on the clinic). The patient must then undergo blood tests, vaginal swabs and ultrasound scans. An individual or their doctor must then book an appointment at the abortion clinic (which is most likely to be in a major centre). At the appointment, two certifying consultants meet with the patient and decide if they believe the legal criteria for abortion is met. If so, an abortion can proceed. If a consensus is not reached, the patient must see a third certifying consultant. If they do not receive two approvals, the procedure cannot proceed. Denied individuals face the options of travelling to Australia, seeking an illegal termination, or continuing their unwanted pregnancy. 99% of abortions are authorised, indicating that certifying consultants appear to be predominantly supportive of people's decisions (*Right to Life New Zealand Inc. v. The Abortion Supervisory Committee*, 2012).

Abortion is free for New Zealand citizens and residents, while non-residents can expect to pay between \$700 and \$2,400 (Law Commission, 2018, p. 45). Usually there is a cost for ultrasounds (Family Planning, 2014a). Sometimes, financial assistance can be arranged if the patient needs assistance with transport or accommodation costs, particularly if the patient's District Health Board (DHB) does not have an abortion clinic (Family Planning, 2014a). Such is the case in the South Canterbury DHB which offers no abortion services (Abortionservices.org.nz, 2017).

## Problems under the current legislation

Despite criminalisation, abortion is common. About 30% of Aotearoa women will experience abortion during their lifetime (Standards Committee, 2018, p. 1). However, individuals must bear a complicated process to access this essential health service, a process which, according to Edmond and Burke (2017, p. 200)

and the Justice Committee (2018, p. 2), is “unnecessarily” complicated.<sup>2</sup> Delays are common, increasing the risk of complications and psychological distress. Currently, in Aotearoa, the abortion process lasts 25 days on average, representing a significant delay by international standards (Silva, McNeill, & Ashton, 2010, 2011a, 2011b<sup>3</sup>).

97.3% of all abortions performed in Aotearoa are on the grounds of preserving the mental or physical health of the mother (ASC, 2018, p. 21). However, those grounds do not accurately reflect the reasons or circumstances which lead patients to seek abortion (Edmond & Burke, 2017).<sup>4</sup> Burgess (2017) found the most common reasons are not being ready for parenthood, relationship reasons or being alone. Instead, the legal status of abortion necessitates that abortion-seekers must be prepared to exaggerate the poor state of their mental health to receive this form of healthcare (Leslie, 2010; Bellamak, 2018; H. Cooke, 2017; F. Cooke, 2017). Abortion’s criminalisation contributes to abortion stigma and reinforces the notion that abortion is an “exceptional choice” (Leask, 2015). Additionally, the right of health practitioners to conscientiously object to being involved with anything gynecologically-related is another major access hurdle in Aotearoa. Denying healthcare to certain people can fuel stigmatisation and harassment of the abortion-seeker (Amnesty International, n.d.). Stigma can be a barrier for patients seeking services (McCulloch & Weatherall, 2017). The requirement of some clinics for patients to undergo counselling may also hinder timely access.

The law is argued to be paternalistic in the sense that (particularly) women are not trusted to make their own decisions and must present as being in need of protection from the harm of continuing the pregnancy (Leask, 2014; Erdman, 2012). Te Whāriki Takapou et al. (2017) emphasise that the law privileges the voices of two to three certifying consultants over the voice of the abortion-seeker

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<sup>2</sup> See Figure 7, Appendix, for a flowchart illustrating just how complicated the process is (ALRANZ, n.d.).

<sup>3</sup> To be concise here, I have chosen to present the authors' names for the studies in this order. In the original studies, authors are listed as follows: Silva, Ashton and McNeill in the 2011b study, and Silva, McNeill and Ashton (2010) and (2011a) in the other two studies.

<sup>4</sup> The authors do not expand on the reasons why patients seek abortions. Currently, the true reasons are difficult to determine as patients must fit a narrow ‘exceptionalist’ criteria to access abortion.

whose will, life-path and health is in question. Earley and Martin (2018) write that no other medical procedure requires patients to “jump through hoops” such as “seeing two separate doctors” (para. 20). Additionally, Te Whāriki Takapou et al. (2017) argue that the requirement for certifying consultants to approve an abortion not only perpetuates paternalism but provides no health benefits to patients. Fees paid to certifying consultants totalled \$4,068,482.08 in the year ended 30 June 2018 (ASC, 2018, p. 29).

Aotearoa’s 1977 abortion law is argued to be outdated socially, medically and technologically (ASC, 2016; Edmond & Burke, 2017). Under current legislation, an abortion may only be performed<sup>5</sup> on a licensed premise. This includes medical abortions (MA) (taking two pills), invented after the enactment of the law, which could otherwise be performed safely at home (Baird, 2017). Individuals on lower incomes suffer disproportionately under this process as multiple visits to service locations are required and there may be associated costs of travel and accommodation (Te Whāriki Takapou et al., 2017; Edmond & Burke, 2017). If abortion becomes decriminalised, abortion medication could be available via telemedicine - that is, medical abortion prescribed over the phone or videoconferencing with qualified practitioners, couriered to the patient to be safely undertaken, hence benefiting rural individuals in particular.

### Unequal access

Although illegal, abortion has been largely accessible by most seeking the service in Aotearoa (McCulloch & Weatherall, 2017; *Right to Life New Zealand Inc. v. The Abortion Supervisory Committee*, 2012). However, difficulties in accessing abortion services are political, sexist and classist (Beattie, 2010; Orr, 2017) and access is unequal. Rural-dwellers, young people, people with little resources and support, and Māori often suffer the greatest barriers to reaching services (Te Whāriki Takapou et al., 2017; Law Commission, 2018, p. 121; Justice Committee, 2018). Furthermore, service availability varies geographically and across clinics. One’s geographical location is a major influencer over the process of seeking an abortion (Silva & McNeill, 2008). Individuals who live rurally are at a particular

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<sup>5</sup> The High Court decided in 2003 that a medical abortion is ‘performed’ when the patient takes their drug(s) (Standards Committee, 2018, p. 7). Therefore, this is a court-decided practice and not one that is medically-driven.

disadvantage due to service availability, distances to clinics and associated costs such as childcare, time off work, petrol and accommodation (Sparrow, 2013; Te Whāriki Takapou et al., 2017; Justice Committee, 2018). Inequality in abortion access is an issue of human rights and discrimination as it hinders some people from accessing healthcare.

## 1.2 Abortion as a development concern in Aotearoa

Sexual and reproductive health have long been important tenets of development, although arguments encompass a range of concerns, from overpopulation to human rights and gender equality. Within these discussions, abortion is not always directly addressed, or is reduced to life-saving circumstances. For approximately 50 years, sexual and reproductive health and rights (SRHR) have been addressed within development literature, including gender and development (GAD) theories, United Nations development agreements, and literature which focuses mainly on unsafe abortion in developing countries.

Irrespective of one's philosophical stance towards abortion, it seems highly unjust that those with privilege can access it safely while others cannot. Development seeks to enhance human rights and wellbeing and to reduce inequalities and poverty (Desai & Potter, 2014). From this perspective, current legislation undermines people's dignity, human rights and autonomy by denying them the right to access a health service and to have control over their bodies, reproductive choices and life paths (UN CEDAW, 2012; UN, 1976; Edmond & Burke, 2017; McCulloch & Weatherall, 2017; Te Whāriki Takapou et al., 2017; Amnesty International, n.d.; Family Planning, 2017b). Legal access to abortion would ensure that people have legal autonomy over their bodies, upholding their human right to autonomy and healthcare (UN, 1976; Orr, 2017; UN CEDAW, 2012; Edmond & Burke, 2017; Amnesty International, n.d.; Human Rights Watch, 2018; Fried, 2000).

Legal access to abortion would also uphold commitments that Aotearoa has made under Te Tiriti o Waitangi (Law Commission, 2018) and the United Nations Sustainable Development Goals (UN SDGs). Under Te Tiriti o Waitangi, Māori have the right to rangatiratanga.<sup>6</sup> This right is currently denied by removing Māori

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<sup>6</sup> Self-determination.

people's autonomy over their bodies and reproductive health. The SDGs aim to eliminate discrimination: Goal 5 of the SDGs aims to eliminate discrimination against women and girls (UN SDGs, 2015a), while Goal 10 aims to eliminate discriminatory laws (UN SDGs, 2015b). The current law is discriminatory because it only affects pregnant people, who are mostly women and girls, and denies them the right to make decisions over their bodies (Amnesty International, n.d.; Te Whāriki Takapou et al., 2017; Family Planning, 2017b). Under international human rights law, people have the right to be free from discrimination (Amnesty International, n.d.).

### 1.3 Research aims

This research aimed to examine how access to abortion can be improved in Aotearoa using a reproductive justice lens — whether or not the law changes in 2020. It aimed to understand how access to abortion differs for different people in Aotearoa, by examining the barriers that present challenges for abortion-seekers, and to understand how access could be in the future. Abortion practitioners, advocates and academics were interviewed. This group was chosen because of their deep understanding of the challenges and complexities of the abortion-seeking landscape. The research will contribute to the scarce Aotearoa New Zealand literature on abortion and make suggestions for improvements to access and services.

### 1.4 Research methodology

This qualitative study was undertaken from a permeable epistemology (Mertens, 2020), bridging social constructivist and transformative epistemological understandings, and using a reproductive justice (Ross, 2017) conceptual framework. This lens has been employed to explore the implications of differences in access. RJ accounts for the intersecting factors that complicate one's achievement of reproductive autonomy, such as reproductive health, human rights, intersectional feminism and activism. Under RJ, people (particularly women and girls) are empowered to have “the economic, social and political power and resources to make healthy decisions about [their] bodies, sexuality and reproduction” (Asian Communities for Reproductive Justice, 2005, p. 1). Through this framework, abortion access was approached from a broad variety of angles. Qualitative and transformational methodologies were examined



and employed. Of these, semi-structured interviews were conducted with 13 abortion providers, academics and advocates, with the aim to contribute to system change and social equity.

It must also be noted that the political and legal situation changed vastly throughout the duration of this research. The legislative changes discussed in this thesis are based on what was available at the time of writing. The information provided is up to date as of February 2020. The Abortion Legislation Bill 2019 (“the Bill”) is yet to have its second and third reading. Further changes to the proposed legislation are possible. The Bill is described as having “strong support” and will “likely pass its third reading” (Coughlan, 2020, para. 19). Support has been solidified by an open letter signed in February 2020 by 34 organisations (Family Planning, 2020; Appendix A2). The timeline below shows the relevant documents that have affected or changed the proposed legislation over the course of this research, which began in January 2019. Of particular note are the ways in which Model C has transformed, and may continue to transform, despite medical and feminist advocate communities calling for Model A (Molyneux, 2019).

#### *Timeline of proposed abortion legislative changes*

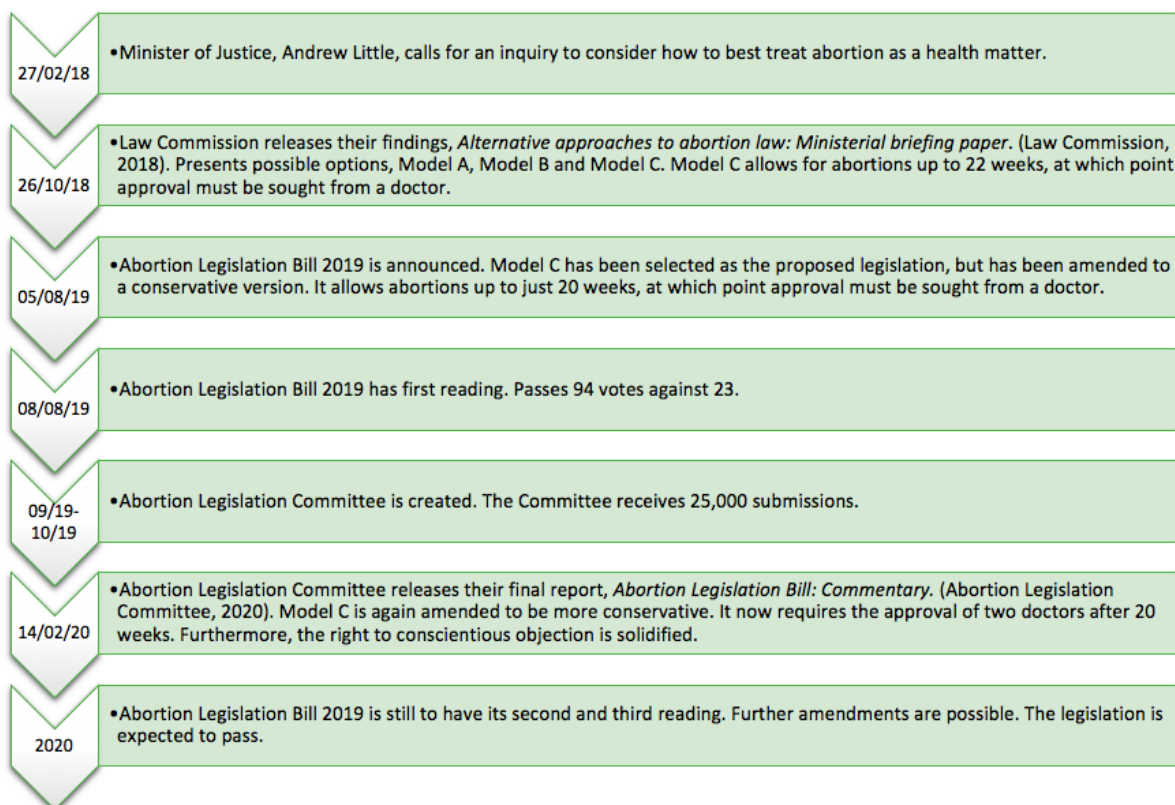


Figure 1. Timeline of proposed abortion legislative changes [source: author]

Finally, an ongoing challenge is that medical and development literature often addresses women and girls in their discussions of abortion. Where possible, gender-neutral, inclusive terms have been used in this text, such as ‘patient,’ ‘individual,’ or ‘abortion-seeker.’ Development studies is a field sensitive to the intricacies of diversity, one that tries to be ethical in all of its work and to minimise harm. In line with those understandings, it is important to acknowledge that people across the gender spectrum experience abortions, not just women and girls (Amnesty International, n.d., Edmond & Burke, 2017). These people are often excluded from pregnancy and abortion discussions.

## 1.5 Research questions

The primary aim of this research was to examine how access to abortion can be improved in Aotearoa, whether or not the law changes, under a reproductive justice lens. My research questions were:

1. What does ‘access’ to abortion mean in the current New Zealand context?
  - a. Who do participants believe are the least privileged in terms of ability to access services?
2. What might ‘access’ look like under the proposed legislation?
  - a. How will the legislation influence abortion providers’ practices?
3. How do participants believe that access can be improved, whether or not the law changes?
  - a. What is needed to assist those facing intersecting inequalities to access abortion services?
4. How does *reproductive justice* materialise in the abortion context?

## 1.6 Chapter summary

To summarise, abortion in Aotearoa is a criminalised health service that results in inequitable access and hardship. Access is affected by legal, geographical, social, cultural and socioeconomic barriers. Access to reproductive health services is a key challenge for the wellbeing, autonomy and human rights. Although decriminalisation is expected to improve access, reduce stigma, and improve the fulfilment of human rights, national and international agreements, and RJ, it is predicted that access issues would still remain, particularly for rural

people (Moir, 2018). Therefore, this thesis seeks to understand access to abortion services through an RJ lens that takes seriously Aotearoa's commitments to national and international treaties and agreements.

## Chapter 2: Abortion in development

### 2.1 Chapter introduction

Abortion has been addressed in development debates through varied pathways. Although matters of gender, sexual and reproductive health and rights (SRHR), human rights and empowerment are addressed within development studies research and United Nations agreements, there is a dearth of development research concerning safe and legal abortion in ‘developed’<sup>7</sup> nations. A key argument of this thesis is that ‘development’, human rights and gender equality, are also important in ‘developed’ countries. Inequalities also exist in them and access isn’t always just and equitable.

This first half of this chapter (2.2) situates and explores abortion in the context of development. To establish why safe, legal and accessible abortion is so central to the development agenda, first, the barriers to abortion access and their disproportionate effect on poor, young and marginalised abortion-seekers are examined. Following, I present the global abortion statistics focusing on occurrence and the consequences of unsafe abortion, on which much of the development literature is based. Then, I expand on the theories of gender and development (GAD), and the quandary of the exclusion of abortion from UN agreements and its discussion in the development literature in ‘developed’ nations. The direct discussion of abortion is often excluded from these documents and debates or is restricted to life-saving circumstances due to the desire to reach international consensus. It is the critique of myself and others that abortion should be included for the sake of people’s intrinsic humanity and empowerment, not only concerns over population and women’s economic potential (Kabeer & Subrahmanian, 1999).

Next, I investigate development-specific literature regarding health, human rights and empowerment, which are strong contributors to global arguments for decriminalisation. Finally, the focus turns to reproductive justice, which bridges the literary gaps between these debates, upholding that justice is impossible without access to abortion, even within ‘developed’ countries where abortion is

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<sup>7</sup> For simplicity, I refer to countries as either ‘developed’ or ‘developing’, according to UN categorisation. It is worth noting, however, that these labels, and the hierarchical relations they seem to suggest, have been heavily critiqued in post-development literature.

already safe. While international development agreements and goals are restricted in order to reach consensus, RJ can be a radical theory for demanding system transformation.

## 2.2 Development: safe and legal abortion in ‘developed’ countries?

When abortion is addressed in development-specific literature, it is predominantly in regard to abortion in ‘developing’ countries; sexual and reproductive health and rights (SRHR) in developing countries; the consequences of unsafe abortion; SRHR for environmental and population concerns; and sex-selective abortions (Sen, 2003). When abortion is addressed outside of development literature, it is usually situated within the disciplines of medicine and psychology.

However, safe and legal abortion in *developed* countries such as Aotearoa, where access can also be inequitable, is evidently also a development issue, due to the numerous inequalities and the denial of rights that abortion-seekers face. Cornwall, Standing, and Lynch (2008) provide ample rationale to apply these concepts to developed countries, too. They argue that unwanted pregnancies and abortions are linked to wider development challenges like poverty and access to healthcare. For some, abortion can be the difference between life and death, health and ill-health, entering deeper poverty or being able to care properly for the children they already have. Importantly, they emphasise, “it is these interlinked issues – legal reform, the provision of accessible and affordable services and strengthening women’s capacities to exercise agency over their own bodies – that make safe abortion a development issue” (Cornwall et al., 2008, p. 3).

### 2.2.1 Barriers to, and inequalities in, abortion access

Barriers to abortion access exist globally and can be legal, social, cultural, religious, geographical, political, education-related or bureaucracy-related (Singh et al., 2017; “Barriers to an early abortion remain in developed countries”, 2015). These barriers reinforce environments that are classist, racist and sexist, as they disproportionately affect those who are already marginalised - mostly poor women and girls, who are often indigenous or migrants (Beattie, 2009; Orr, 2017). Migrants may face additional language and cultural barriers to RJ (Nakae, n.d.). These are central concerns of development studies. For example, in Latin

America, it is the poor, rural, indigenous, and uneducated women or girls who suffer the most under restrictions (Oberman, 2013; Viterna, 2012; Witte-Lebhar, 2015). In the USA, the most affected are the “young, rural, undocumented, and low-income women [...] disproportionately, women of color” (Fried & Yanow, n.d., p. 13). Regardless of abortion’s legal status, predominantly, those holding privilege in society can often access safe abortions.

Some of the barriers to abortion access are imposed by law, while others are imposed by stigma or cultural beliefs, or the geographic availability of services. For example, abortion has traditionally been condemned by the Catholic church. As such, countries with predominantly Catholic populations often have restrictive laws (Center for Reproductive Rights, n.d.). One’s social context, particularly facing social stigma, can also affect how one seeks information and obtains an abortion. Singh et al. (2017) found that stigma can cause some to choose riskier clandestine abortions, even when legal options are available. Geographical distance to services, meanwhile, can affect one’s ability to access abortion, as can “onerous certification regulations for private-sector providers, inadequate access to public-sector facilities [...and] a poor understanding of the law among both women and providers” (Singh et al., 2017, p. 16).

Even where abortion is legal, conscientious objection (CO) from practitioners or entire institutions continues to obstruct access. For example, Chile’s major Catholic hospital has refused to provide life-saving abortions despite legalisation - a decision upheld in court (Montero & Villaroel, 2018; Vivanco, 2018). Alternatively, practitioners may choose not to engage with abortion services due to cultural beliefs (Singh et al., 2017, p. 20). Singh et al. (2017, p. 23) suggest that access to medical abortion can help to overcome matters of CO.

Despite increasing global acceptance of abortion being a ‘medical procedure,’ and many reforming their laws in recent decades to allow safer access to abortions, mostly due to a recognition of the consequences of legal denial (Cornwall et al., 2008), plenty of countries,<sup>8</sup> including Aotearoa, still have restrictive abortion access (Center for Reproductive Rights, n.d.). However,

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<sup>8</sup> An interactive map of the world outlining global abortion laws can be found at <http://www.worldabortionlaws.com/map/> (Center for Reproductive Rights, n.d.).

abortion occurrence is largely unaffected by legal restrictions (GI & WHO, 2012; Cornwall et al., 2008; Erdman, 2012) therefore such restrictions leave people vulnerable to unsafe abortion (Cornwall et al., 2008; Amnesty International, n.d.). Regardless of legality or safety, women, girls and gender minorities have undergone risky abortions for thousands of years (Orr, 2017) and will continue to in the future. As Cornwall et al. (2008) write:

They will seek them because of their social, economic, health or other personal circumstances. They will seek them because they have experienced rape and sexual assault. If safe services are not available, they will turn to unsafe ones [...] This leaves poorer women more vulnerable to impairment, illness through infection and death than middle-class women who are able to pay for safer options. For the poorest women, and for young women with no money and no access to information about what services might be available, the only option is self-abortion, despite the steep risks it involves. (Cornwall et al., 2008, p. 2)

To provide an extreme example of barriers and resulting inequalities, in El Salvador (a predominantly Catholic nation), abortion is illegal in every circumstance, even when the patient's life is at risk (Oberman, 2013). Abortion-seekers can be, and are, imprisoned for obtaining abortions, even miscarriages,<sup>9</sup> condemned with sentences of up to 45 years (Buncombe, 2016). The majority of those who are imprisoned are poor, young, single mothers, under-educated, indigenous, or a combination thereof (Viterna, 2012). Why? These are the women most likely to enter the public health system, where regardless of circumstance (whether attempting abortion or suffering a genuine obstetric emergency), some wake handcuffed to their hospital beds and are transferred directly to prison (Oberman, 2013; Viterna, 2012). They lack the necessary resources to seek justice. Middle- and upper-class people are better resourced to afford safer black-market options, engage in international 'abortion-tourism,' or bribe officials for their right to privacy in order to evade prosecution (Sousa, Lozano, & Gakidou,

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<sup>9</sup> Although difficult to believe, in 2018, 25 women were in prison for "miscarriages, stillbirths and other pregnancy-related complications" (Center for Reproductive Rights, 2018, para. 1). Some have been released since, thanks to activists, but many remain behind bars.

2010; Ortiz-Ortega, 2005; Oberman, 2013; Viterna, 2012; Witte-Lebhar, 2015; Watts, 2015).

Addressing the barriers to abortion that exist across *developed* countries, the unauthored article “Barriers to an early abortion remain in developed countries” found,

From the providers' perspective, the main barriers included moral opposition to abortion, lack of training, too few physicians, harassment of staff by opponents of abortion and insufficient resources. From the women's perspective, the barriers were lack of local services (particularly for women in rural areas, on low incomes or from minority groups), clinicians' negative attitudes to abortion, and cost. (“Barriers to an early abortion remain in developed countries,” 2015)

The health and mortality consequences of unsafe abortion are explored below.

### 2.2.2 Global abortion statistics

According to the Guttmacher Institute (GI) and the World Health Organisation (WHO), around one in five pregnancies worldwide end in abortion (GI & WHO, 2012), equating to approximately 56 million abortions annually (WHO, 2018). Around 25 million of those are considered ‘unsafe’<sup>10</sup> (WHO, 2018), 97% of which occur in developing countries (Ganatra et al., 2017). Around five million women are hospitalised for abortion-related complications, and around 47,000 women die from unsafe abortions annually (GI & WHO, 2012). Between 8% and 11% of maternal deaths globally are attributed to abortions (Singh et al., 2017, p. 33). Deaths from unsafe abortion, sadly, are preventable (Amnesty International, n.d.). The percentage of women seeking abortions is similar for women living in developed and developing countries (GI & WHO, 2012).

When abortions are performed by trained professionals in sanitary conditions, they are one of the safest medical procedures available and are safer than

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<sup>10</sup> The World Health Organization defines unsafe abortion as “a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both” (GI & WHO, 2012, p. 1).



childbirth (Justice Committee, 2018; Amnesty International, n.d.). In the United States, it was found that legally induced abortions are 14 times safer than childbirth (Raymond & Grimes, 2012).

### 2.2.3 Gender and development

Gender and development (GAD) research considers how gender affects development outcomes, as development policies and practices are not gender-neutral, affecting men and women differently (Rogers, Castree, & Kitchin, 2013). Desai and Potter (2014) explain why women are central to the development agenda,

Increasingly, the political participation of women has become crucial to access the male-dominated world of policymaking. Empowerment involves challenging existing power relations and gaining greater control over sources of power especially challenging patriarchy and inequality. It is a process by which women redefine and extend what is possible for them on an individual basis to bring about transformation. Women's interest can only be served when both the formal and informal spaces are brought together and negotiated by the women's movement. (Desai & Potter, 2014, p. 385)

In this quote, the authors bring together key issues of gender, development, policymaking, empowerment, inequality and transformation, all of which are central to this thesis. However, they speak of women as a homogenous group. Mohanty (1988) has critiqued Western feminist discourse that has either treated women as a homogenous group or differentiated slightly by examining the experiences of "Western" and "Third World" women. In reality, women's experiences within and across nations are heterogeneous.

With the passing decades, paradigms and global development interventions, understanding of gender and development has shifted from raising the economic input of women and girls to understanding diverse relationships of power that interplay, particularly between gender, class, race, ability, sexuality and other identities (Rogers et al., 2013; Mohanty, 1988). These concerns parallel those of reproductive justice (Asian Communities for Reproductive Justice, 2005; Ross,

2017) and intersectional feminism (Crenshaw, 1989), both of which emphasise the different experiences that can result from interplay of different aspects of one's identity.

The contemporary acknowledgements of intersecting identities are a welcome transformation from the early GAD approaches concerning women's reproductive health, which were birthed from global population concerns. Notably, the 1970s, 1980s and 1990s saw United Nations conferences on population and development, which embedded SRHR further into the development agenda. Emphasising this point, Harcourt (2017) has indicated that SRHR were mainstreamed into the development sphere via concern over "gender, population and women's health programs," only later expanding to "gender equality, human rights and public health" (Harcourt, 2017, p. 193).

Early approaches to GAD agendas have been criticised. Kabeer and Subrahmanian (1999) critique how some development agendas historically added women into their policies as afterthoughts, or focused on women in terms of their reproduction, rather than focusing on their intrinsic humanity or feminist empowerment. Rowlands (1997) defines empowerment as, "more than participation [in development ...] it must also include [...] people to perceive themselves as able and entitled to make decisions" (p. 14). This definition of empowerment can be applied to the choice to abort. Leach (2015) has critiqued paradigms that have focused on population. In particular, critiquing the UN, Leach writes,

Population paradigms frequently attribute poverty to overpopulation; see the causes of environmental degradation and natural resource scarcity in population growth or mismanagement by poor people; and link reducing women's fertility to mitigating climate change or preventing environmental destruction. (UNDP, 2011, as cited in Leach, 2015, p. 77)

Kishwar (2014), draws attention to a lacuna in many development reports, that is, the lack of attention to gender equality in 'developed' countries. Not only are these reports Eurocentric, a central critique of Mohanty (1988), but they also fail to critically examine practices and politics in the developed world. She writes,

there is hardly any mention of the problems faced by women in developed countries. The assumption is that they have solved all their problems and have provided benchmarks and a road map for countries of the South [...] In this Eurocentric worldview, problems of women in developed countries are erased out of existence. (Kishwar, 2014, p. 403)

In the conversations I've had throughout the development of this research I have realised that this assumption has been the case with abortion law in Aotearoa. People are often shocked to learn that abortion remains criminalised. They often refer to Kate Sheppard,<sup>11</sup> highlighting a common assumption that Aotearoa has progressive women's rights and therefore should already have progressive abortion laws.

The above provides an overview of GAD theories, introducing population to the development agenda and critiquing what were often-Eurocentric approaches, with little attention to intersecting identities. Below, key United Nations agreements are examined with regard to SRHR.

#### 2.2.4 United Nations international development agreements

There is a long-standing history of prioritising sexual and reproductive health in international development agreements, most notably driven by the United Nations. The controversial nature of abortion, however, coupled with the drive to reach international consensus, has meant that abortion is often excluded from United Nations agreements or heavily restricted - even within the conferences and agreements below regarding population and women's empowerment. However, this thesis takes the position that abortion is an essential part of SRHR, and any absence of legal access or choice contributes to maternal health and mortality statistics (Chapter 2.2.2), and, that gender equality cannot be achieved without safe and legal access to abortion. Aotearoa is a signatory to the following agreements and therefore has an obligation to strive to fulfil the varying commitments.

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<sup>11</sup> Kate Sheppard is a famous suffragist attributed with gaining women the right to vote in Aotearoa in 1893.

Over three decades, three major United Nations conferences have been held on population: the World Population Conference at Bucharest in 1974, the International Conference on Population in Mexico City, 1984 and the International Conference on Population and Development (ICPD) in Cairo, 1994. They asserted the human right to SRHR, situated in the context of empowerment, economic sustainability, and concern over population control. These conferences and agreements have continued to contribute to subsequent agreements such as the ICPD Programme of Action, 1995 Beijing Platform for Action, the Millennium Development Goals, and the Sustainable Development goals.

The ICPD Programme of Action, adopted by 179 countries at the ICPD in Cairo, 1994 (United Nations, 1994), has been one of the most significant international agreements on SRHR in recent decades. It radicalised the importance of SRHR in the development agenda, which had previously focused on fertility control and the “population problem” (Reichenbach, & Roseman, 2009, p. 4). Sadly, even though progress was made, the ICPD Programme of Action had lost momentum during the 2000s. The agreement affirmed that “human rights, including reproductive rights, were [are] fundamental to development and population concerns” and that “empowering women and girls is both the right thing to do and one of the most reliable pathways to improved well-being for all and sustainable development” (United Nations, 2014, p. xi). Demonstrating the complexity of reaching consensus, it was an agreement that took two years of discussion to reach between “feminists, public health professionals, development economists, demographers, environmentalists, faith communities, donors, and governments” (Reichenbach, & Roseman, 2009, p. 4). Principle 4 of the ICPD Programme of Action affirms that,

Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women’s ability to control their own fertility, are cornerstones of population and development-related programmes. The human rights of women and the girl child are an inalienable, integral and indivisible part of universal human rights. The full and equal participation of women in civil, cultural, economic, political and social life, at the national, regional and international levels, and the eradication of all forms of discrimination on grounds of sex,

are priority objectives of the international community. (United Nations, 2014, p. 15)

A 20-year review of the ICPD Programme of Action resulted in an updated Framework of Action (United Nations, 2014). The new Framework extended the programme indefinitely, provided continued direction going forward, and brought new concern over environmental sustainability as an aspect of sexual and reproductive health (United Nations, 2014). Regarding abortion, the Framework of Actions asserts that,

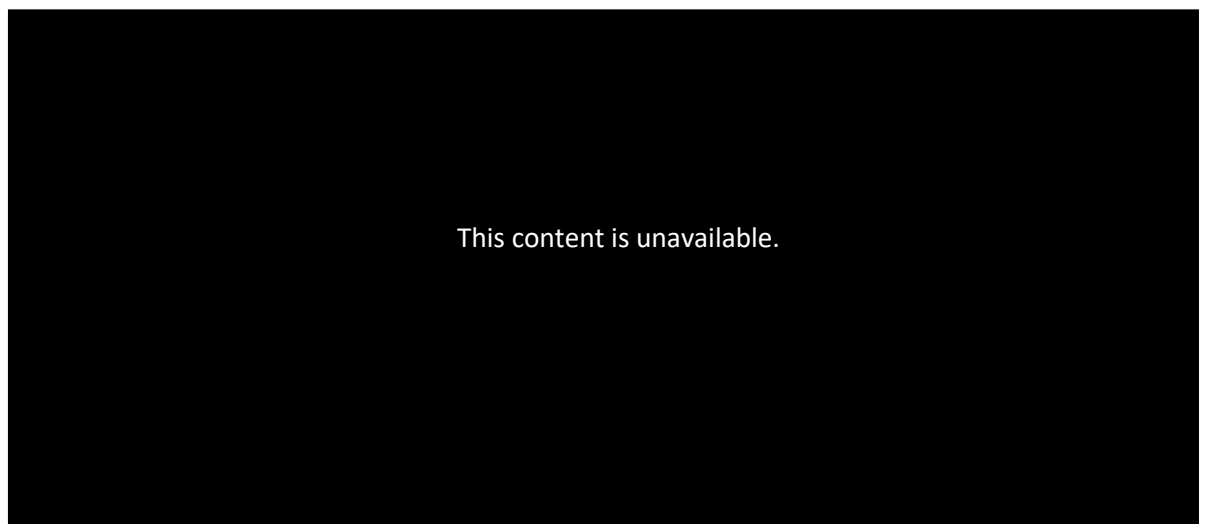
unnecessary restrictions on abortion should be removed [...] Governments should provide access to safe abortion services, both to safeguard the lives of women and girls and as a matter of respecting, protecting and fulfilling human rights, including the right to health. (United Nations, 2014, p. 81)

Additionally, the United Nations Beijing Conference of 1995 emphasised women's issues as fundamental to human rights and social justice (Rogers et al., 2013). The conference resulted in the 1995 Beijing Declaration and Platform for Action (UN, 1995) which focused on encouraging international action in support of the human rights and health of women and girls. Specifically, "Women need to be healthy in order to realize their full potential. This includes proper nutrition, sexual and reproductive rights, and mental health, as well as freedom from violence" (UN Women, n.d., para. 10).

A central pillar of both the Cairo and Beijing proceedings was the right of women to determine the number and spacing of children. Cornwall et al. (2008) argue that a denial of this right is a breach of women's human rights. Both proceedings speak of abortion often, however mostly in terms of protection from unsafe abortion and forced abortion, or condemnation of abortion as a method of family planning. This may be due to the varying moral and religious stances of United Nations members on abortion and compromises being a necessary part of reaching any agreements. However, I argue that women struggle to determine the number and spacing of children without access to appropriate contraception and safe abortion services.

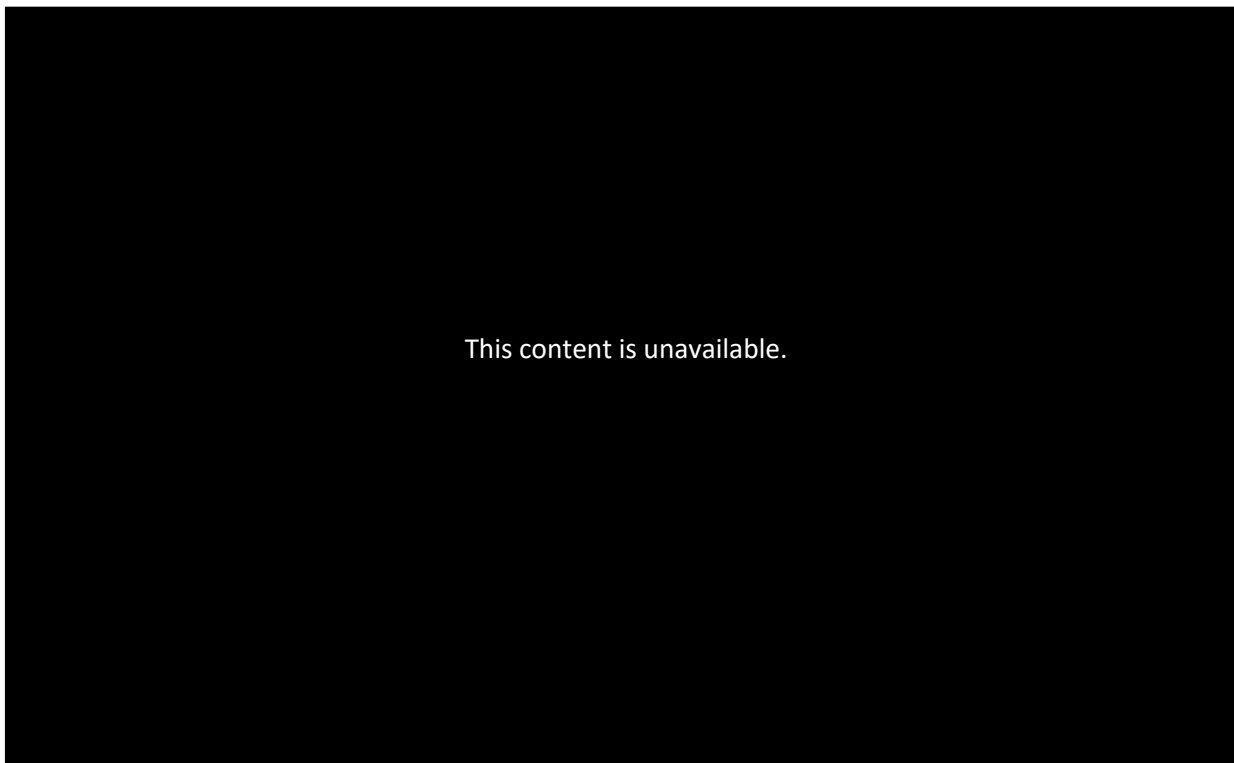
Following the progressive advancements in SRHR in the development agenda in the late 20<sup>th</sup> century, The Millennium Development Goals (MDGs) were signed by 189 nations in 2000 (MDG Achievement Fund, n.d.). Their lack of attention to SRHR left advocates scrambling to re-integrate the ICPD agenda into this important development framework (Crane, 2005). Nevertheless, MDG 5 required a 75% reduction in the maternal mortality ratio from abortion-related causes by 2015 (Cornwall et al., 2008, p. 3), a goal more relevant for developing countries. MDG 3 aimed to “promote gender equality and empower all women” (Figure 2, below), which is relevant for all countries alike. By Rowlands’ (1997, p. 4) definition, empowerment and equality, MGD 3, are impossible to achieve if women are not “able and entitled to make decisions” such as accessing safe and legal abortion.

#### *Millennium Development Goals*



*Figure 2. Millennium Development Goals. Retrieved from Millennium Development Goals, by Gavi, Retrieved 2020, Jan. 27, from <https://www.gavi.org/our-alliance/global-health-development/millennium-development-goals>.*

Following the MDGs, the Sustainable Development Goals (SDGs) were adopted in 2015 by 193 countries. These contemporary goals are shown in the figure below:



*Figure 3. Sustainable Development Goals. Retrieved from Sustainable Development Goals, by United Nations, Retrieved 2019, May 24, from <https://www.un.org/sustainabledevelopment/blog/2015/12/sustainable-development-goals-kick-off-with-start-of-new-year/>.*

Particularly relevant to abortion access is *Goal 5: Achieve gender equality and empower all women and girls* (UN SDGs, 2015a). It has two particularly relevant targets:

- 5.6 Ensure universal access to sexual and reproductive health and reproductive rights.
- 5.C Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels.

Aotearoa as a signatory, therefore, has an obligation to ensure access to sexual and reproductive health rights (SRHR) services such as abortion. Currently, inequalities of abortion access exist for New Zealanders, therefore violating Goals 5.6 and 5.C. They also violate SDG 3, which regards good health and wellbeing (UN SDGs, 2015a). As abortion is a part of SRHR, access to abortion healthcare

must be ensured. Moreover, *Goal 10: Reduce inequality within and among countries*, states in target 10.3, “ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard” (UN SDGs, 2015b). Aotearoa’s current abortion legislation violates these goals. Additionally, the United Nations Development Programme stated, “Women’s ability to make reproductive choices carries ramifications for the environment and for women’s empowerment, and women’s political empowerment has consequences for proenvironment policy and practice” (UNDP, 2011, p. 61). Therefore, sustainable development is not possible without the wide-scale ability of women to make reproductive choices.

#### 2.2.5 Abortion access: the links between human rights, healthcare, bodily autonomy and decriminalisation

Development literature calls for legal access to safe abortions, mostly in developing countries, predominantly under restricted criteria. The strongest drivers of liberalising abortion laws globally are framing abortion as a matter of health, human rights and bodily autonomy. The arguments are almost always intermeshed. Abortion is a matter of healthcare (see SDG 3, UN SDGs, 2015a), therefore a human right that a person should be able to choose to receive if they seek it. The Guttmacher Institute has reported that “public objections to legalization can coexist with and eventually be overridden by concerns over women’s health” (Singh et al., 2017, p. 30). McCulloch and Weatherall (2017) believe taking the stance of a liberal feminist to abortion access is the best legal approach because it promotes SRHR, promotes one’s basic human right to act autonomously, and treats abortion as a healthcare issue rather than a moral or legal one.

Returning to Cornwall et al. (2008), they assert, “access to safe abortion is a matter of human rights, democracy and public health, and the denial of such access is a major cause of death and impairment, with significant costs to development” (p. 1). Their quote highlights the intersections of abortion, RJ, access and development. Ensuring safe and legal access assists in upholding people’s autonomy, human rights, empowerment, the struggle for gender equality, as well as women’s potential to contribute to economic development.



## Abortion as healthcare

The assertion that abortion is a matter of healthcare is shared by many internationally and has been a central pillar for reform in Aotearoa (Ross, 2017; Amnesty International, 2018; Human Rights Watch, 2018; ASC, 2016; Te Whāriki Takapou et al., 2017; Moir, 2018). Good health and wellbeing is central to SDG 3 (UN SDGs, 2015a), and abortion is a part of sexual and reproductive health. Abortion as healthcare gained prominence internationally through Millennium Development Goal 5: *Reduce maternal mortality [...] & achieve universal access to reproductive health*. Worldwide, abortion is the second leading cause of maternal mortality (Cornwall et al., 2008). The argument then becomes: individuals have the right to live; therefore, they have the right to access life-saving healthcare such as abortion.

## Abortion as a human right

“Rights-based” paradigms are central to current development thinking (Cornwall et al., 2008). Abortion as a human right encompasses a range of factors, including an individual’s right to health, life, reproductive healthcare, integrity, autonomy and decision-making, freedom of religion and conscience, equal protection under the law and freedom from cruel and degrading treatment (Walsh, Mollmann, & Heimbürger, 2009; Cornwall et al., 2008, p. 5; UN, 1976). In the context of abortion, law reform to enable safe and equitable access is a necessary outcome of a human rights approach (Erdman, 2012). In addition, Cornwall et al. (2008) build a link between abortion, human rights and democracy, as a lack of access to abortion restricts people’s ability to exercise agency and act as democratic citizens, and to contribute to their families and nation.

Many multilateral organisations consider abortion to be a human rights matter. For example, many United Nations organisations consider abortion a human right, at least under certain circumstances, and urge certain restrictions to be lifted. This includes the UN CEDAW, the Committee on the Rights of the Child, The UN Human Rights Committee, the Committee on Economic Social and Cultural Rights, and the Committee against Torture (Human Rights Watch, 2018). Amnesty International and Human Rights Watch have advocated strongly for the decriminalisation of abortion (Amnesty International, 2018; Human Rights Watch, 2018).

## Abortion as autonomy and empowerment

The third central argument for abortion reform internationally is that the right to choose is a matter of reproductive/bodily autonomy and empowerment (UN, 1976; McReynolds-Pérez, 2017; Budde & Heichel, 2017; Cornwall et al., 2008). Cornwall et al. (2008) define empowerment as an individual's "capacity to exercise their own judgement or exert their own will" (p. 3). The concept of empowerment, particularly for women and girls, is highly relevant for contemporary development thinking, solidified by Sen's (2001) discussions of freedoms and agency, and *SDG Goal 5: Achieve gender equality and empower all women and girls* (UN SDGs, 2015a). When barriers to abortion are in place, whether social, legal, cultural or otherwise, women and gender minorities are less able to exert their own will and their right to choose abortion as a valid response to pregnancy. Erdman (2012) discusses access to abortion services and information as a way of trusting women and empowering them to make decisions over and protect their bodies, health and lives (p. 85). New Zealand researchers also argue for empowerment, autonomy and trusting women as important drivers of the impending law change (Edmond & Burke, 2017; Leask, 2014; McCulloch & Weatherall, 2017). For example, Edmond and Burke (2017) condemn the Crimes Act 1961's silence on individuals making the decision to abort because they do not wish to have a child, stating "this undermines a person's ability to plan and exercise control over one's life" (p. 201).

### 2.2.6 Reproductive justice

GAD theories mainstreamed women into the development agenda, and the United Nations agreements solidified commitments to SRHR, and development literature has ample literature calling for access to safe abortion in developing countries. However, safe and legal abortion is still limited in these debates and neglects the barriers and inequities of access in developed countries. RJ, which combines empowerment, SRHR, autonomy, economics, and gender, could be considered as bridging the gap between development and abortion, and all matters that affect somebody's reproductive choices. The goal of RJ is improving the lives of women and families. RJ is also a praxis that combines reproductive health, human rights, intersectional feminism and activism. RJ can be defined as,

the complete physical, mental, spiritual, political, economic, and social well-being of women and girls, and will be achieved when women and girls have the economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives. (Asian Communities for Reproductive Justice, 2005, p. 1)

The concept “reproductive justice” was coined in 1994 by twelve Black women who protested a pro-choice conference in Chicago to have full recognition of their reproductive and sexual human rights (Ross, 2017). Similarly to Beattie (2010), Smith (2005) and Hannah et al. (2019), they recognised that the binary pro-life/pro-choice debate, also Eurocentricity, are insufficient in capturing the diverse intersectional inequalities that women faced.<sup>12</sup> RJ hence recognises the important intersections of race, gender, class, ableism, nationality and sexuality, and that reproductive oppression affects all areas of a woman’s life (Bond, n.d., p. 15).

Ross (2017) states, “the ability of any woman to determine her own reproductive destiny is linked directly to the conditions in her community—and these conditions are not just a matter of individual choice and access” (p. 4). RJ recognises that one’s access to abortion services is not only dependent on one’s personal choice to have an abortion. The circumstances of one’s community, their experience of social justice, and the laws governing reproductive health also have an impact.

RJ advocates for complete reproductive education, freedom of choice, access to abortion and contraception, freedom from coercion, and ensuring that people who do choose to have children have the resources to raise them (Fried & Yanow, n.d., p. 12). In doing so, it focuses on the intersection of complex issues which both parents and would-be parents share, like the need for resources, information, healthy children and strong family justice (Paltrow, n.d.). It also encapsulates reproductive health, reproductive rights and social justice movements, critiquing the isolation of abortion from other movements such as disability rights or the environment, and these movements’ Eurocentricity (Ross,

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<sup>12</sup> Smith’s (2005) article takes this insight further, considering the pro-life/pro-choice paradigm as masking structures of white supremacy.

2017). It widens the focus from legal access to abortion to broader reproductive oppression, which can be defined as “the control and exploitation of women, girls, and individuals through our bodies, sexuality, labor, and reproduction” (Ross, 2017, p. 4).

RJ aims to critique the social frameworks that privilege some groups over others. It calls upon necessary government intervention for safe, affordable and accessible reproductive services to uphold women’s rights. Structural inequalities are challenged by RJ, the goal being system transformation so that women can be empowered to embrace their rights. Under RJ, women must have the power and resources to make decisions over their “bodies, lives, families, and communities” (Poggi, n.d., p. 12).

Sharing some parallel concerns with RJ, Sen (2001) discusses development in terms of one’s capability to exercise personal freedoms and agency, advancements in development being measured by the removal of “unfreedoms.” In doing so, he notes that “the freedom of agency that we individually have is inescapably qualified and constrained by the social, political and economic opportunities that are available to us” (Sen, 2001, p. xii). These considerations of agency compliment RJ, as Sen’s “unfreedoms” could be likened to community, circumstance, and “reproductive oppression” that RJ seeks to address (Bond, n.d.; Ross, 2017; Fried & Yanow, n.d.).

### 2.3 Chapter summary

This chapter has shown how abortion has been situated in the development literature: that women are central to development concerns via GAD theories; the UN commitments that seek to protect SRHR and promote health and gender equality; the morbid consequences and injustices of abortion access barriers; and finally, RJ, which assists in engraining safe and legal abortion access, even in developed countries, as central to development. RJ can radically demand that people anywhere have the necessary resources and are empowered to make any choices they choose for themselves, their families and communities, including the choice to abort, without needing to fit ‘exceptionalist’ criteria.

## Chapter 3: Decriminalisation, potential futures and improving access

### 3.1 Chapter introduction

As this thesis focuses on improving access in Aotearoa via decriminalisation, Chapter 3 is dedicating to highlighting the future possibilities of the abortion environment post-decriminalisation, by providing case studies of Australia and Canada, which are similar in terms of their previous laws and in aspects of their settler-colonial culture. These cases provide an overview of the successes and challenges of decriminalisation. The chapter explores the possibilities of abortion entering primary care, as well as being available via telemedicine, both of which could occur in the future in Aotearoa.<sup>13</sup>

### 3.2 Improving access with decriminalisation: the examples of Australia and Canada

Easing restrictions on abortion does not lead to an increase in the occurrence of abortion, rather, access to abortions is eventually made simpler for those who seek it (Singh et al., 2017; Peiró et al., 2001). This has been the case in Canada and in certain states of Australia<sup>14</sup> (Baird, 2017). This section examines these examples, as case studies of abortion liberalisation, as they are affluent, Western democracies, similar to Aotearoa in some regards and also sharing similar past abortion laws. Decriminalisation is a precondition of improved access (Baird, 2017) but does not solve issues of access alone, as will be explored. The Guttmacher Institute states,

Although legality is the first step toward safer abortion, legal reform is not enough in itself. It must be accompanied by political will and full implementation of the law so that all women— despite inability to pay or reluctance to face social stigma—can seek out a legal, safe abortion. (Singh et al., 2017, p. 5)

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<sup>13</sup> Depending on practitioners' up-take.

<sup>14</sup> In four of their six states: Australian Capital Territory, Victoria, Tasmania, and the Northern Territory.

## Australia

Baird (2017) studied the effect of decriminalisation on access to abortion for patients across four Australian states, finding that decriminalisation alone does not improve access to abortion in the short-term. For example, in Australia, a neoliberal approach to abortion healthcare emerged in Australia post-decriminalisation. Baird explains,

decriminalization does not necessarily deliver any improvement in women's access to abortion, at least in the short term [...] Most abortions are provided through the private sector at financial cost to women. If all women are to enjoy their human rights to full reproductive health care, the public health system must take responsibility for the adequate provision of abortion services; ongoing and vigilant activism is central if this is to be achieved [...] it is only when public health departments take responsibility that equitable access will be delivered. (Baird, 2017, p. 197-198)

According to Baird (2017), in Australia, liberal market attitudes filter to the public health system, including abortion healthcare. As a result, inequalities continue to exist between who can access abortion, due to disparities of economic means, education, and geography. It is possible that a free-market approach to abortion care in Aotearoa could also come about with law change, in which the consumer pays, as the current legislative proposal does not state whether or not abortion will remain free for New Zealand residents.

In Tasmania, post-decriminalisation in 2013, private clinics closed, citing new bureaucratic or financial constraints. Additionally, public hospitals and GPs remained hesitant to provide abortions. There is also no evidence of GPs taking up the provision of medical abortions. Access to abortion in Tasmania has decreased significantly. Prior to decriminalisation in Tasmania, abortion access was dependent on "fly-in-fly-out" doctors who operated fortnightly (Baird, 2017, p. 203). An ambiguous law and issues of conscientious objection also hindered people's access, similarly to in Aotearoa. As a result, those who could afford it would fly to Melbourne for private care.

To combat access inequality and the neoliberal approach post-decriminalisation, affordable abortion became available in Australia via the Tabbot Foundation (Tabbot Foundation, n.d.), a telemedicine<sup>15</sup> service. Medical abortion can be safely taken at home, benefiting rural-dwellers in particular (Baird, 2017), as patients can be sent pills and have access to 24/7 medical support via telephone numbers or videoconferencing. However, access inequalities still exist, even with the affordable offerings of the Tabbot Foundation. For example, citizens in the Australian Capital Territory are still required to undertake the abortion on approved premises, therefore, they cannot legally take their abortion medicine at home. In Tasmania, clinics cited the popularity of the Tabbot Foundation as a part of their justification for closing. Regardless of the availability of tele-abortion, rural-dwellers are still disadvantaged if needing to travel for ultrasounds and/or blood tests.

Another positive affect of decriminalisation was the relief for both abortion seekers and providers by changing the interactions between them (Baird, 2017). Similarly to Aotearoa's 'exceptionalist' laws, patients in the Australian state of Victoria previously had to prove that they fit social and economic criteria for abortion prior to decriminalisation in 2008. Abortion-seekers no longer had to exaggerate their circumstances and providers no longer had to fear prosecution. Interestingly, Baird found that decriminalisation caused no perceived decrease in stigma for either party. These are considerations that must be taken in Aotearoa, too.

## Canada

Although abortion has been decriminalised in Canada since 1988, policies and practices of practitioners in the healthcare system, as well as the geographical dispersal of clinics, continue to inhibit access, particularly for people who are affected by "financial, geographical, cultural, or age factors" (Kaposy, 2010, p. 18). Similarly to Aotearoa, prior to 1988, patients could only receive abortions under the approval of (three) physicians to preserve the life or health of the mother.

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<sup>15</sup> Telemedicine will be expanded on in Chapter 3.4

Kaposy (2010) has researched the ways to continue to improve access to abortion in Canada. His suggestions are summarised in the table below, largely mirroring what advocates, academics and providers in Aotearoa argue for:

Table 1

*What should be done to improve access to abortion?*

- Abortion should be publicly funded
- More hospitals and clinics should offer abortion services
- Policies should be employed that encourage doctors to learn and practice abortion techniques
- Conscientious objection should be void if it means that the patient will miss out on receiving an abortion
- Conscientious objectors should have notices in the clinic of their objections, informing patients of their objection prior to making appointments
- The Ministry of health should provide a list of locally available, willing providers
- Abortion-seekers should be able to self-refer to abortion clinics
- Abortion access information should be readily accessible to the public
- Objecting doctors creating barriers via delays or the refusal of information should be sanctioned
- Policy makers should commit to improving abortion access

*Note.* Adapted from *Improving abortion access in Canada*, by Kaposy, 2010, Retrieved 2020, Jan. 27, from <https://doi.org/10.1007/s10728-008-0101-0>.

As can be seen from these cases in Australia and Canada, abortion access remains a significant challenge for many people, despite decriminalisation. Some of the main reasons for this are CO, geographical barriers, and how systems and practitioners react to changes in laws. Next, the chapter examines how abortion can be effectively administered in primary-care settings, if the will from practitioners is there to do so.



### 3.3 Improving access with primary-care

Abortion in primary-care (also referred to here as community care), refers to abortion being available in “the community, usually from a general practitioner (GP), practice nurse, nurse practitioner, pharmacist or other health professional working within a general practice” (Ministry of Health, 2020, para. 1). The proposed legislation would allow a greater scope of health practitioners to be involved in the provision of abortion, as well as support SDG 3, regarding health and wellbeing (UN SDGs, 2015a). The World Health Organization supports medical abortion in primary-care as it does not require specialist skills, knowledge or equipment (WHO, 2012). An article by Yanow (2013) explains,

The skills needed to provide abortions—including the ability to assess gestational age, provide counseling, provide medications, perform manual or electric vacuum aspiration, and conduct postabortion follow-up—are in the scope of practice of primary clinicians [...] These skills are comparable to those required to perform a first-trimester abortion. (Yanow, 2013, p. 15)

Snook and Silva (2013) have shown that abortion in primary-care can be an effective and safe way to deliver abortion care. In 2009, Aotearoa’s first community-based abortion service was initiated.<sup>16</sup> They described the clinic as a “low resource setting” in an area with “high-deprivation” (Snook & Silva, 2013, p. 153). 44% of the population in that DHB area were Māori and two thirds lived in areas with deciles 1-3 (in Aotearoa, deciles measure the socioeconomic status of a zone on a scale of 1-10). Previously, in that particular DHB, many patients had to travel inter-region for access to services, as there were issues with local hospital staff and conscientious objection. The clinic they studied started providing abortion services to fill the gap in health services. The study found a high up-take of medical abortions, at 82%. They happened, on average, two days after the first appointment at the clinic since being referred, again, much faster than the average 25 day wait (Silva et al., 2010). Unique to other abortion clinics, patients had access to private waiting rooms with comfortable reclining chairs. The performing doctor gave their phone number for the patient to call with concerns at any hour. Patients could access counselling as and when they

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<sup>16</sup> In a clinic unidentified by the paper.

requested, including post-abortion. Holistic care was shown towards the abortion-seekers who were mostly high-needs, socioeconomically marginalised women. The clinic proved that culturally and physically safe abortion services can be provided efficiently in the community.

Considering RJ, the clinic assisted in reducing inequalities and hardships while improving health outcomes for patients, taking into consideration their comfort and holistic wellbeing. Their patients lived in the most deprived area in the country by DHB zoning (Snook & Silva, 2013). The initiation of abortion services at the local sexual health clinic helped to bridge the gap between poverty, geography and access. The model has not been replicated elsewhere in Aotearoa.

### 3.4 Improving access with telemedicine

Medical abortion (MA) via telemedicine is an effective and safe way to overcome issues of abortion access (particularly geographically), privacy and autonomy, and has been used globally even in regions with highly restrictive laws (Singh et al., 2017; Ehrenreich & Marston, 2019; Wiebe, 2014; Women on Web, n.d.; Hyland, Raymond, & Chong, 2018). Telemedicine includes videoconferencing, phone calls and email support to people seeking and undergoing an abortion. Via telemedicine, doctors consult with, and/or counsel, patients over the phone and may prescribe MA pills (mifepristone and misoprostol) direct-to-patient. Patients are followed up on, including several weeks later when they are sent urine pregnancy tests to evaluate the successfulness of the abortion. Ehrenreich and Marston (2019) found the “provision of MA via telemedicine versus face-to-face provision have comparable clinical outcomes, and low prevalence of adverse events” (p. 2). Weibe (2014) provided evidence that practitioners can provide effective pre- and post-abortion consultation over videoconferencing, overcoming issues of access for rural-dwellers.

This service has been extended globally by the organisation Women on Web, which couriers abortion pills to patients around the globe where abortion is restricted. They must pass a tele-consultation with licensed doctors to ensure the abortion will be safe (Women on Web, n.d.). The consultation assesses the appropriateness of the treatment, including gestational age, risks to health and

access to emergency medical care. This organisation charges on a donation basis, overcoming economic as well as geographical and legal barriers.

Telemedicine services for abortion can be particularly relevant in terms of reproductive justice, due to the reduction in inequalities. Ehrenreich and Marston (2019), in the USA, found that telemedicine was effective in overcoming the “burdens of travel, childcare expenses, and social judgement; disadvantages which disproportionately affect low-income women” (p. 9) - all of which are relevant factors for abortion-seekers in Aotearoa. Telemedicine is one way to overcome issues of access, particularly for rural or low-income people. Additionally, it assists physicians, who would otherwise have to travel to rural clinics to provide abortion care.

A retrospective study of the previously mentioned Tabbot Foundation (Chapter 3.2), found that 97% of patients were highly satisfied with their tele-abortion process (Hyland et al., 2018, p. 338). Patients in this study were sent abortion pills within an average of 15 days from registration, much quicker than the current 25-day process in Aotearoa. 60% of the patients in their study lived in rural communities, demonstrating the demand for rural access, privacy and autonomy.

Telemedicine was once used in Aotearoa, too. 0800-ABORTION was established and trialled during 2015-2016 to minimise delays that patients seeking abortion are subjected to, therefore reducing health risks (ALRANZ, 2016; Johnston, 2015; Silva et al., 2010). It succeeded in reducing waiting times by half for abortion-seekers by eliminating the need for a patient to find a referring doctor. Patients could call to receive a referral and have their tests and appointments arranged (Johnston, 2015). However, the economic model, which was self-funded by practitioners, proved to be economically unsustainable.

### 3.5 Improving access via cultural competency

Cultural competency in healthcare settings is essential for reducing disparities in treatment (van Ryn & Fu, 2003), honouring RJ, and assisting in patient’s ability to safely access services (Papps & Ramsden, 1996; De Souza, 2015). In the USA, it was found that “the behaviors of health care providers, the lack of familiarity with, and discrimination toward, individuals of different backgrounds are significant contributors to health disparities” (Abrishami, 2018, p. 443). Patient-

centred care is one way to combat disparities, consider one's intersecting identities, and assist in upholding RJ. Factors associated with health disparities are:

Table 2

*Factors associated with health disparities*

- Race/ethnicity
- Age
- Cultural and linguistic barriers
- Disability
- Education
- Genetic and biological factors
- Geographic location
- Income
- Sexual identity
- Sexual orientation

*Note.* Adapted from *The Need for Cultural Competency in Health Care*, by Abrishami, D., 2018, Retrieved from <http://content.ebscohost.com/>

### 3.6 Chapter summary

This chapter explored the effects of decriminalisation on access, stigma and wellbeing, highlighting that access may be decreased in the short-term but is a precondition to improved care in the long-term (Baird, 2017). Primary care and telemedicine have proven to be an effective way to provide abortion services (Baird, 2017; Snook & Silva, 2013) and have potential for a post-decriminalisation environment in Aotearoa, too. Now, the research moves to examine the current and potential future environment in Aotearoa in greater depth.

## Chapter 4: The Aotearoa abortion context: history, legislation, access and proposed changes

### 4.1 Chapter introduction

Aotearoa literature on abortion is scarce and there is barely any research on Māori and abortion (Law Commission, 2018, p. 63). Much of the work that does exist originates from organisational and advocacy bodies such as Family Planning, ALRANZ, the UN and the ASC. This thesis, therefore, draws on and contributes to this scant literature and makes connections between gender, development and abortion reform in Aotearoa. This chapter explores the past, present and the future laws and the historical circumstances behind these laws. It then describes how practice differs from the law and explains the pro-reform critiques of the present and future laws. Finally, the chapter concludes with a discussion of the geographical dispersal of abortion clinics and the resulting impacts on access.

### 4.2 Aotearoa abortion statistics

Around 30% of women in Aotearoa will experience an abortion in their lifetime, despite its criminal status (Standards Committee, 2018, p. 1). The number of abortions has been steadily decreasing in the past years from a height of 18,511 abortions in 2003, to 12,823 in 2016 (MacPherson, 2017). Aligning with international trends, the decline in abortion numbers can be significantly attributed to improved contraceptive access and long-acting reversible contraceptives (LARCs) (Family Planning, 2017a). In 2016, 88% of patients were provided with contraception at the time of the abortion to prevent future unintended pregnancies (ASC, 2016, p. 8). Currently, 97.3% of abortions in Aotearoa are performed on the grounds of serious danger to the mental health of the woman (ASC, 2018, p. 21), a disproportionate criterion made obvious in the table below:

Table 3

*Induced abortion by grounds for abortion*

This content is unavailable.

*Note.* Reprinted from *Report of the Abortion Supervisory Committee 2018*, by Abortion Supervisory Committee, 2018, Retrieved Mar. 27, from <https://www.justice.govt.nz/assets/Documents/Publications/ASC-Annual-Report-2018.pdf>.

In 2015 and 2016 alone, 516 abortion requests were deemed “unjustified” according to information obtained from the Abortion Supervisory Committee under the Official Information Act (Te Whāriki Takapou et al., 2017). This means that the abortion-seekers were denied abortion by at least one of the three possible certifying consultants whose role it is to evaluate whether or not they meet the legal criteria for abortion. There have been approximately 2500 “not justified” certificates issued in the last decade (Penfold & Bingham, 2019). Reasons for non-justification are not kept and sometimes patients themselves are not informed of the reasons for their rejection (H. Cooke, 2017).

#### 4.3 Proposed changes to abortion legislation 2020

In February 2018, Justice Minister Andrew Little requested an inquiry into the current abortion law. The resulting inquiry provided an extensive review of abortion in New Zealand and proposed three alternative laws. These options are displayed in the table below:

Table 4

*Alternative legal models for when abortion would be lawful*

This content is unavailable.

*Note.* Reprinted from *Alternative approaches to abortion law: Ministerial briefing paper* (p. 12), by Law Commission, 2018(b), Retrieved April 2019, from <https://lawcom.govt.nz/sites/default/files/projectAvailableFormats/Law%20Commission%20-%20ALR%20Ministerial%20Briefing%20Paper%20-%20FINAL.pdf>

In August 2019, it was announced that the government had chosen a conservative version of Model C after “months of stalling and back-and-forth negotiations between coalition partners” (“Abortion law reform: Government

announces Bill for 20-week medical test”, 2019). The new, conservative version tightened the requirement of a statutory test from a gestational period of 22 weeks to 20 weeks. The Bill passed its first reading with 94 in support and 23 opposed (Melville, 2019). It was again amended in February 2020 (Abortion Legislation Committee, 2020).

If the Bill passes in 2020, abortion will be decriminalised and treated as a health service (Melville, 2019). The law would be modernised and brought “into line with many other developed countries” (Melville, 2019, p. 2), a move desired by many in Aotearoa (Moir, 2018; Te Whāriki Takapou et al., 2017; McCulloch & Weatherall, 2017). The need for certifying consultants would be eliminated and a broader range of health professionals could provide abortions including nurses, nurse practitioners, midwives and GPs. The patient would not need approval before 20 weeks. The abortion-seeker could safely undergo medical abortion in their own home, a major hurdle for current access inequities. This could vastly improve access to abortion for rural-dwellers. The proposed changes are summarised in the table below:

Table 5

*Proposed changes to abortion law*

- Removing abortion from the Crimes Act 1961 (and hence the Ministry of Justice)
- Bringing abortion under the Ministry of Health
- Making abortion regulated by health bodies, like all other health procedures
- Removing the requirement for certifying consultants
- Removing the Abortion Supervisory Committee
- Allowing patients to self-refer
- Broadening the scope of who can provide an abortion - GPs, nurses, nurse practitioners, midwives
- Making medical abortions able to be undertaken safely at home
- Allowing practices to apply for “safe-zones” where protesters would not be allowed

*Note.* Adapted from *Alternative Approaches to Abortion Law: Ministerial Briefing Paper*, by Law Commission, 2018, Retrieved from <https://lawcom.govt.nz/sites/default/files/>.



It is important to note that the disestablishment of certifying consultants will have several financial implications. Certifying consultants are paid fees, in addition to their salary, which come from the Ministry of Justice. The removal of abortion from the Crimes Act 1961 will mean the termination of this incentive if it does not get addressed in the proposed legislation. In turn, this may make practitioners disenfranchised, or, make providing abortions less attractive - particularly for those who travel to provide care. Conversely, the approximately \$4 million annually (ASC, 2018, p. 29) will become freed up and could be invested into abortion services.

#### 4.4 History of abortion in Aotearoa

This section explores the history of abortion law in Aotearoa, and the colonial, racist and sexist contributions to current abortion legislation. This history highlights where such restrictions to access originate from, as well as to provide a solid foundation for law reform and advance towards RJ.

Aotearoa's abortion laws have historically followed British law. Aotearoa inherited restrictive laws in 1861 from England, which condemned abortion (McCulloch & Weatherall, 2017), but did not change its law when Britain reformed in 1967 (Sparrow, 2013). For much of the 20<sup>th</sup> century, Aotearoa had one of the highest rates of maternal mortality globally due to illegal abortion (Sparrow, 2014). The law of this time made it illegal to assist in or receive an abortion until the current law was implemented in 1978 (Sparrow, 2013). There have been no deaths from abortion-related causes since the introduction of the Contraception, Sterilisation and Abortion Act 1977 (CSAA) (Kathleen,<sup>17</sup> personal communication, 2019).

In the 19<sup>th</sup> century, motherhood was seen as natural and desirable for women. Any deviation from this sentiment in the form of seeking an abortion was considered irrational and selfish (Leslie, 2010, p. 3; Leask, 2013, p. 104). Under colonial gender constructions, it was considered that (white) motherhood was a sacred duty (Brookes, 1981, as cited in Leask, 2013; McCulloch & Weatherall, 2017). In the early 20<sup>th</sup> century there was fear over the superior fertility rates of Māori women (Smyth, 2000, as cited in McCulloch & Weatherall, 2017), and fear

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<sup>17</sup> A participant.

of “race suicide” (van der Krogt, 1998, p. 298). In 1922, the *New Zealand Medical Journal* warned that birth control would cause “countries suitable for the white races [to be] over-run by coloured races” (cited in Brookes 1981, p. 27, as cited in Leslie, 2010). In 1937, the Dominion newspaper published a polemic that read, “the selfish refusal to bear or rear children is a crime against the nation” (Leask, 2013, p. 104). White women were condemned for denying motherhood in an infamous report by 1937 Committee of Inquiry into the Various Aspects of the Problem of Abortion in New Zealand, commonly referred to as the McMillan Report (McMillan, Fraser, Chapman, Corkhill, & Paget, 1937). Part of this condemnation was driven by a government facing an ageing population and a declining tax base (Brookes, 1981, p. 128, as cited in Leask, 2013) and fear over Aotearoa being unable to defend itself in future wars (van der Krogt, 1998, p. 326). These examples highlight the eugenic thinking (Leslie, 2010; Leask, 2013), pro-natalist and nationalist grounds (Brookes, 1981, as cited in Leask, 2013), and sexist and racist beliefs prevalent at the time.

In the early 20<sup>th</sup> century, WWI made way for the emergence of the characterisation of the ‘desperate’ woman, desperate due to the economic and social upheaval of the time (Leslie, 2010). Women of this time were judged by their desire to parent their existing children more effectively (p. 18). This, in turn, altered the discursive landscape. Concepts such as ‘psychological harm’ became much more common. While ‘selfish’ or ‘irrational’ women were still unable to access abortion, it became more acceptable to allow ‘desperate’ women and women facing ‘psychological harm’ to access it. The idea of providing abortion to ‘sexually appropriate’ or ‘deserving’ women became more considered in society in the 20<sup>th</sup> century (Leslie, 2010). Using similar language, the McMillan Report (McMillan et al., 1937) made distinctions between ‘worthy’ and ‘unworthy’ causes for abortion, providing the example of a ‘deserving’ woman: “she approaches the menopausal stresses with anxiety and apprehension, having done her duty to family and race, often having lived an exemplary self-sacrificing life” (McMillan et al., 1937, p. 18).

Building on the ‘psychological harm’ exception of WWI, the ‘mental health exception’ grew in acceptance in 1938. Dr Bourne, in England, approved an abortion for a suicidal 14-year-old girl who had been gang-raped in order to

prevent her becoming a “mental wreck” (Davies 1938, as cited in Leslie, 2010; Leask, 2013). He is credited with establishing the mental health ground for abortion, that is, preserving the ‘life’ of the mother (Leslie, 2010). The girl embodied the idea of a “deserving” woman - desperate, innocent and sexually chaste (Leask, 2013).

In the 1970s, the feminist debate over abortion was fierce. Aotearoa’s first abortion clinic opened in 1974, prompting protests (McCulloch & Weatherall, 2017). The Royal Commission of Inquiry into Contraception, Sterilisation and Abortion was established in response to the outcry, eventually producing The New Zealand Royal Commission’s report (1977). The report provided very little medical or human rights information but contained a consistently conservative tone of moral judgement over the decline of church attendance and the traditional Christian/Western nuclear family. The Contraception, Sterilisation and Abortion Act 1977 resulted from this report and has not been amended substantially since despite substantial critique. The Act has, however, been interpreted far more liberally than the Commission intended by practitioners embracing the ‘mental health exception’ as a way to uphold choice (McCulloch & Weatherall, 2017).

The same feminist arguments from the 1970s remain prevalent, four decades later: that women are rational and capable of making their own decisions regarding the continuation of their pregnancies, that the abortion decision should be between a patient and their doctor, and that patients should not have to present themselves as psychologically disturbed to be able to obtain an abortion (Leslie, 2010). In Aotearoa’s current mental health paradigm, abortion-seekers are painted as needing psychological support, legal guidance and pity, rather than competent humans capable of making their own decisions (Leask, 2013). Leask argues that “in challenging women’s status as moral actors, the mental health paradigm insidiously challenges women’s very ability to choose abortion” (p. 104). A deserving/undeserving dichotomy remains, allowing “deserving” abortions to take place while still pathologising them (Baird, 2001, as cited in Leask, 2013). The laws governing abortion are detailed in the next section.

#### 4.5 Current abortion legislation

To provide context to the discussions and issues of the legislation governing abortion laws, they are detailed below:

##### ***Contraception, Sterilisation and Abortion Act 1977 (the CSAA)***

The abortion section of the CSAA is overseen by the Abortion Supervisory Committee (ASC). The ASC is responsible for licensing hospitals and clinics, ensuring adequate standards at facilities, appointing certifying consultants and reporting to Parliament (Edmond & Burke, 2017). Medical practitioners and nurses have the right to refuse “to perform or assist in the performance of an abortion” (CSAA s46,1) under the grounds of CO.

##### ***The Crimes Act 1961***

Under the Crimes Act 1961, abortion is a crime that could result in up to 14 years imprisonment for anyone “who causes the death of any child that has not become a human being” (s182,1). Abortion may be considered under certain grounds, however. Those are:

187A:

- (a) that the continuance of the pregnancy would result in serious danger (not being danger normally attendant upon childbirth) to the life, or to the physical or mental health, of the woman or girl; or
- (aa) that there is a substantial risk that the child, if born, would be so physically or mentally abnormal as to be seriously handicapped; or
- (b) that the pregnancy is the result of sexual intercourse between—
  - (i) a parent and child; or
  - (ii) a brother and sister, whether of the whole blood or of the half blood; or
  - (iii) a grandparent and grandchild; or
- (c) that the pregnancy is the result of sexual intercourse that constitutes an offence against section 131(1); or
- (d) that the woman or girl is severely subnormal within the meaning of section 138(2).

### ***Health Practitioners Competence Assurance Act 2003***

Under this act, a health practitioner can object “on the ground of conscience” to provide a reproductive health service, “(including, without limitation, advice) with respect to contraception, sterilisation, or other reproductive health services” (s174,1). This includes the ability to refuse to perform abortions, provide contraception, cervical examinations or C-sections. “When this section applies, the health practitioner must inform the person who requests the service that he or she can obtain the service from another health practitioner or from a family planning clinic” (s174,2). Anecdotally, this does not always happen.

### ***Care of Children Act 2004***

Under current law, Section 38 of the Care of Children Act 2004 allows children “of whatever age” to consent to an abortion without parental knowledge or consent (Morrison, 2015). In 2017, 99 abortions happened to patients under the age of 16, and 67 legal guardians were informed (ASC, 2018, p. 14).

## **4.6 Critiques of Aotearoa’s abortion laws**

Critiques regarding the current legislation are plentiful. Various advocates for law reform label the current law negatively, for example as “antiquated” (Bellamak, 2018), “outdated and clumsy” (ASC, 2016, p. 3) and “offensive” (Kirk, 2017). The United Nations Committee on the Elimination of Discrimination against Women (UN CEDAW) has expressed concern over Aotearoa’s abortion access, arguing that the current “convoluted abortion laws” nullify individuals’ autonomy, giving that to health practitioners, and leaves them dependent on the “benevolent interpretation” of laws (UN CEDAW, 2012, p. 8, 2018, p. 11). Edmond and Burke (2017) label the current law “restrictive and punitive” (p. 203), and unreflective of the reasons that people seek abortions in reality. Leslie (2010) refers to the law and practice as a “psychiatric masquerade” between patients and health professionals in which patients are forced to lie about their mental health and professionals pretend to believe them in order to provide them healthcare (Leslie, 2010; Bellamak, 2018). Edmond and Burke (2017) consider it “demeaning to be labelled as having a serious mental health problem to be able to access a service” (Edmond & Burke, 2017, p. 204; F. Cooke, 2017).

From a legal perspective, the law is open to different subjective interpretations and individual patients and doctors are vulnerable to prosecution (Edmond & Burke, 2017; McCulloch & Weatherall, 2017). Since 2004, apart from an 18-month period, the Abortion Supervisory Committee has been involved in litigation continuously due to the uncertainty in the current law (Te Whāriki Takapou et al., 2017). This includes a trial that lasted six years (*Right to Life New Zealand Inc v. The Abortion Supervisory Committee*, 2012).

### Te Tiriti and inequalities

Importantly, current abortion law fails to honour treaty obligations. The government is required to “safeguard Māori Health concepts and mātauranga Māori in healthcare provision and medical practice” (Law Commission, 2018, p. 62). The gap between national and Māori incomes doubled between 2006 and 2013, leaving Māori particularly vulnerable to the costs associated with access to health services (Te Whāriki Takapou et al., 2017). A recent report, highlighting the Eurocentric model of healthcare, stated,

the higher pregnancy, sexually transmitted infection and abortion statistics for Māori indicate timely access to culturally responsive contraceptive and reproductive health care at low or no cost is lacking [...] The current abortion framework undermines the autonomy of women, including tino rangatiratanga over reproductive health as guaranteed by the Treaty of Waitangi; and creates an inequitable system with significant barriers to access for women, which disproportionately impact Māori. (Te Whāriki Takapou et al., 2017, as cited in Law Commission, 2018, p. 64)

### Outdated laws

The CSAA requires abortions to be performed in a licensed institution, a medically outdated requirement that significantly hinders abortion access. Medical abortions had not been invented in 1977 when the Act was implemented. Currently the law imposes unnecessary time and financial burdens on individuals who could otherwise take one to two pills over two days in the comfort of their own home (Sparrow, 2013; Edmond & Burke, 2017; Justice Committee, 2018). Instead, they are legally required to take a mifepristone pill at the clinic and return 24-36 hours later to take a misoprostol pill (Sparrow, 2013). This

disproportionately affects low-income and/or rural people, often Māori, who have to award more time and travel costs to the abortion process (Te Whāriki Takapou et al., 2017).

### **Conscientious objection (CO)**

CO hinders access to reproductive healthcare, including abortion. Ballantyne, Gavaghan, and Snelling (2019) consider the current framework unbalanced towards the right of the doctor to CO rather than to the right of the patient to access timely services. According to them,

Current CO provisions regarding termination referral in New Zealand impose an unreasonable burden on women. It is highly plausible that refusal to provide indirect referral can cause significant patient harms: potential inability to find another provider, delay in access to care, increased financial cost (time off work, cost of additional consultation, travel), stigma, embarrassment or loss of trust in the ‘non-judgmental’ role of providers, which may have significant implications for some patient groups that already have a tenuous relationship with the health system and the medical profession. (Ballantyne et al., 2019, p. 68)

In response to the Law Commission’s report, the New Zealand Medical Association (NZMA) expressed support for the existing CO framework but did not state why (Law Commission, 2018, p. 159). In contrast, organisations responding in favour of a diminishing the future role of CO were: The New Zealand College of Midwives, the Australian and New Zealand College of Psychiatrists and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (Ballantyne et al., 2019). Despite this support, CO was upheld in the February 2020 report (Abortion Legislation Committee, 2020).

### **The mental health exception**

The ‘mental health exception’ (Leslie, 2010), that is, the argument that “the continuance of the pregnancy would result in serious danger [...] to the life, or to the physical or mental health, of the woman or girl” (s87a), has become the basis on which 97.3% of all abortions in Aotearoa are performed (ASC, 2018, p. 21). This presents feminist issues in several ways. Critically, the law removes an

individual's human right to make decisions over their own body (Edmond & Burke, 2017; Leask 2013, 2014, 2015; Morrison, 2015; McCulloch & Weatherall, 2017; Te Whāriki Takapou et al., 2017). Secondly, I would suggest that this implies that individuals who have a mental health condition are incapable of becoming 'good mothers'. This is despite the fact that one in six individuals in Aotearoa will suffer a mental health condition in their lifetime (Mental Health Foundation, 2014). This is not only a 'masquerade' of both the abortion-seeker and the health professionals (Leslie, 2010) but is also offensive to the many New Zealanders who suffer their own mental health struggles yet successfully raise children.

### Exclusion of age and violation

Age and rape are not grounds for abortions in Aotearoa, although they may be taken into consideration (Crimes Act 1961, s187A(2)b). Edmond and Burke (2017), Bellamak (2018) and advocacy group ALRANZ (2014) highlight this as an inexcusable omission and as a violation of human rights. Ironically, it was historically assumed that abortion-seekers would lie about rape in order to access abortions, therefore increasing its occurrence (McMullin et al., 1977, as cited in Leask, 2013). Since then, many have been required to exaggerate the state of their poor mental health, instead (Leslie, 2010; Bellamak, 2018).

### Language

It has also been argued that language in the current legislation is problematic. The language in the CSAA is "outdated and clumsy" (ASC, 2016, p. 3) and "offensive" (Kirk, 2017). Like the Crimes Act 1961, the CSAA refers to women who are unable to consent as "mentally subnormal" (S34). The ASC iterates, "the term 'mentally subnormal' is not only outdated but is considered a derogatory term and the use of it in modern legislation is inappropriate" (ASC, 2016, p. 4). The ASC express the ongoing difficulties that arise for many in the profession due to the unclear wording. The ASC considers it essential that the CSAA be updated to reflect modern technology, society and practice. They have re-emphasised this position on many occasions (ASC 2016, 2017, 2018). Noteworthy is the use of the 'he' pronoun used when referring to doctors in the CSAA, language that has been critiqued as exclusionary by many (Edmond & Burke, 2017; Justice Committee, 2017; ASC, 2016; Kirk, 2017). Certainly, the ASC emphatically states it is "not acceptable in today's society where women



work as medical professionals, doctors and specialists in the field. Women should also be represented in the wording of legislation” (ASC, 2016, p. 4). The CSAA also refers to “a woman’s own doctor.” This language no longer reflects the relationships between patients and varying general practitioners (GPs), nor the greater availability of services (ASC, 2016, p. 4), nor modern acceptance that it is not only women who seek abortions but a whole range of people along the gender spectrum (Amnesty International, n.d.; Edmond and Burke, 2017).

#### 4.7 Delays to accessing services

Silva et al. (2010) investigated the timeliness of abortion services in Aotearoa, that is, from the point of entry into the health system to the date of termination. They found that the average waiting time was 25 days. Delays in accessing services increase the physical and psychological risk to the patient, both of which rise rapidly with foetal development. Psychological risks include emotional repercussions, psychological distress and anxiety. The risk of abortion complications and mortality increases exponentially with gestational age, a significant increase in risk in the eighth or ninth week (Bartlett, Zane, & Berg, 2004; Zhou, Nielsen, Møller, & Olsen, 2002; Ferris, McMain-Klein, Colodny, Fellows, & Lamont, 1996; Buehler, Schulz, Grimes, & Hogue, 1985; as cited in Silva et al., 2010). Individuals who have an abortion (safely and legally) in the second trimester are significantly more likely to die from complications than those who have the procedure at or before eight weeks (Bartlett et al., 2004; Zhou et al., 2002, as cited in Silva et al., 2010).

Abortion in Aotearoa occurs significantly later in the first trimester than other developed countries. Over 50% of the subjects studied by Silva et al. received a termination after ten weeks or more, by which point the gestational window for an early medical abortion (EMA) has been missed. Once a woman has chosen to have an abortion, it is widely agreed by clinicians that it is better to complete the process sooner for better clinical and psychological outcomes. In 2016 in New Zealand, only 57% of abortions were performed before the tenth week of gestation, compared to 81% in the U.K. (Te Whāriki Takapou et al., 2017). Only 15.4% of abortions in 2016 were medical abortions, indicating a very low uptake, especially in comparison to European nations (Law Commission, 2018, p. 48). For example, in England and Wales, 62.5% of abortions in 2017 were surgical,

and over half of abortions in Sweden, Finland and France are surgical (Law Commission, 2018, p. 48). Aotearoa's low up-take is partially because of the law requiring individuals to undergo an abortion on licensed premises (McCulloch & Weatherall, 2017; Edmond & Burke, 2017).

25 days represents a significant delay in accessing services and needs to be improved. Delays can be patient-related, such as recognition of pregnancy and the ensuing decision-making process; structural, such as bringing together funds for appointments; and health-system related, such as complicated referral processes. Although it may be tempting for GPs to assume that patients need longer to think about their decision (or simply paternalistic), the decision-making process happens largely outside of health services (Silva et al., 2011a). Silva, McNeill and Ashton (2010, p. 24) found that 63.3% of abortion-seekers had already made their decision upon suspicion or immediate confirmation of pregnancy.

#### 4.8 Barriers to abortion access in Aotearoa

The World Health Organization (WHO) considers Aotearoa's abortion laws to be "highly restrictive" and recommends that "regulatory, policy and programmatic barriers that hinder access to and timely provision of safe abortion care should be removed" (Johnson, Mishra, Lavelanet, Khosla, & Ganatra, 2017, p. 543). Bellamak, president of ALRANZ, views the largest barriers to abortion as "lack of accessibility, poor integration of medical abortions, and delay in accessing care" (Bellamak, 2018). No other health procedure for consenting patients requires authorisation/decision-making from two other consultants or mandatory assessments (Edmond & Burke, 2017; Family Planning, 2017b). An abortion-seeker's decision lying in the hands of other people is not only stressful (Edmond and Burke, 2017) and delays services (Silva et al., 2010), but undermines a woman's human right to bodily autonomy (UN, 1976; Amnesty International, n.d.; Edmond & Burke, 2017; UN CEDAW, 2012, p. 8; Cornwall et al., 2008; Walsh et al., 2009).

Edmond and Burke (2017) explain some of the barriers to access in Aotearoa. An individual seeking an abortion can expect an average of four appointments before entering an abortion clinic. Costs associated with these appointments

could be doctors' fees, the cost of multiple trips, finding childcare and taking time off work. Abortion is free for New Zealand residents at public clinics but private clinics charge. The authors provide the example of rural abortion-seekers in Taupo or Rotorua having to travel to the Waikato or Tauranga for services. In a study by Silva et al. (2010, p. 24), almost 80% of abortion-seekers found it difficult to keep their pregnancy private which may be partially due to these challenges. The travel time patients undertook in that study ranged from 1 minute to 10 hours.

Edmond and Burke (2017) also identified that intimate partner violence (IPV) is a compounder of stress during the abortion process. 55% of women in Aotearoa will have experienced at least one form of IPV at least once in their lifetime (Fanslow & Robinson, 2011). Edmond and Burke (2017) state,

Abusive and controlling partners could heighten a woman's fear about seeking an abortion, making it difficult to access abortion and contraception services. Requiring up to seven visits, including the visits referenced above and those with the abortion provider, undermines women's ability to pursue an abortion without their partner's knowledge. In light of this, the current legislation does not facilitate abortion access for women experiencing domestic violence. (Edmond & Burke, 2017, p. 203)

#### 4.9 Public opinion on abortion

Opinion on abortion is divisive due to its philosophical nature about the status of a foetus. There is very little research on people's experience in the abortion system in Aotearoa (McCulloch & Weatherall, 2017). Abortion experiences are heterogeneous; every individual can experience theirs differently (Baird, 2001, as cited in Leask, 2014). Interestingly, research suggests that Māori and Asian identifying people are less supportive of abortion relative to Pākehā (Vowles, Coffé, & Curtin, 2017; Huang, Osborne, & Sibley, 2019).

In June 2019, a study was released on the attitudes of abortion of 19,973 New Zealanders (Huang et al., 2019). The data came from the 2016/17 New Zealand Attitudes and Values Study. Up until then, most information about abortion attitudes in Aotearoa came from media polls. The authors use the data to recommend that Aotearoa implement the law change suggested by the UN

CEDAW as it would be well-received by the public and could alleviate some of the stigma around abortion-seeking.

In a recent poll conducted by Newshub and Reid Research, people were asked if they believed abortion should be decriminalised. 69.9% answered 'yes,' 23.6% answered 'no' and 6.5% said they 'didn't know' (O'Brien, 2019). Of those who answered 'yes,' 36.7% of people preferred Model A, 43.2% preferred Model B, 12.0% preferred Model C and 8.1% didn't know (O'Brien, 2019). Yet, Model C was chosen.<sup>18</sup>

#### 4.10 Abortion providers

Access to abortion services varies by geographic location. As at October 2018, when the Law Commission's report was released, there were 22 abortion clinics in Aotearoa. They are listed in the table below, showing the wide variation of services offered:

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<sup>18</sup> A political decision explained in 6.3.1.

Table 6

*Abortion services available by DHB area*

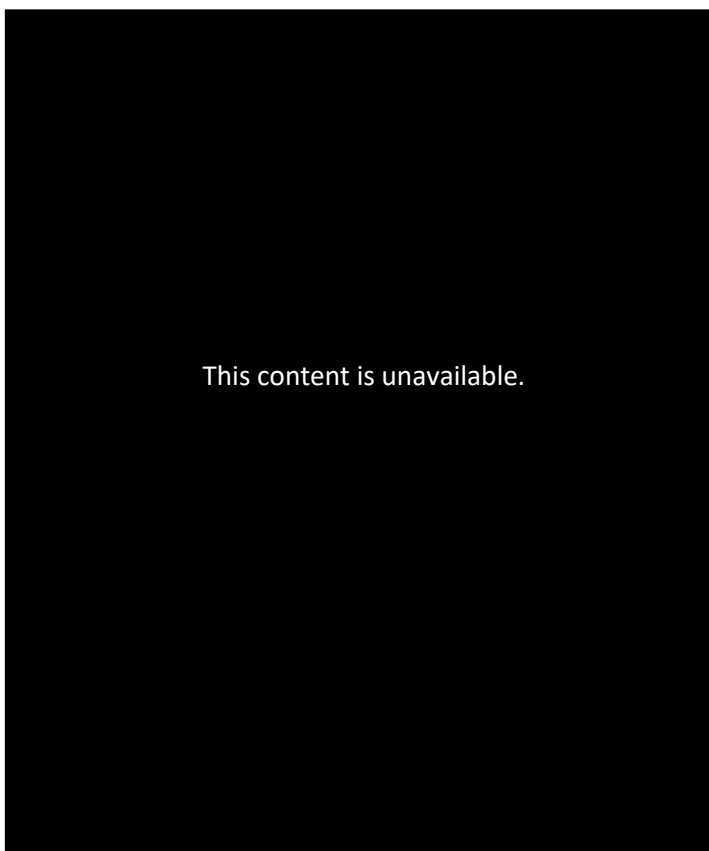
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*Note.* Reprinted from *Alternative approaches to abortion law: Ministerial briefing paper* (p. 38), by Law Commission, 2018(a), Retrieved April 2019, from <https://lawcom.govt.nz/sites/default/files/projectAvailableFormats/Law%20Commission%20-%20ALR%20Ministerial%20Briefing%20Paper%20-%20FINAL.pdf>.

The geographical dispersion of the clinics is shown on the map below. Note that the West Coast and Whanganui have no abortion clinics. Patients from these areas must be referred to services in other DHBs. Some financial assistance may be offered, depending on the referring DHB and the financial circumstances of the individual. For example, for patients referred from the Timaru Hospital & Community Services, the South Canterbury DHB provides some accommodation assistance and Work and Income New Zealand may be able to assist with travel costs (AbortionServices.org.nz, 2017). The Abortion Supervisory Committee has an ongoing concern about abortion access in Auckland (ASC, 2017; Justice Committee, 2018). While the greater Auckland area contains 6 of the country's 22 abortion clinics, the ASC expresses concerns over transport issues, geographic dispersal of the city, access to pre-decision counselling and its large population. In particular, they call for services to be added to Manukau (ASC 2017, p. 5).

#### *Geographic dispersal of abortion clinics*



*Figure 4. Geographic dispersal of abortion clinics [source: author].*

#### 4.11 Chapter summary

This chapter examined the context of abortion access in Aotearoa, highlighting the inequalities and injustices that exist due to the current laws, including their substantial critiques, and their colonial, conservative, eugenic history. Delays to accessing services are common, as are barriers to access, which disproportionately affect socioeconomically-disadvantaged and/or rural abortion-seekers. Reform is supported by the public and proposed changes would make advancements towards access equity and RJ. The chapter also explored the statistics regarding abortion in Aotearoa, as well as the service availability around the country. The next chapter explores the methods behind this research.



## Chapter 5: Research methodology

### 5.1 Chapter introduction

This chapter describes how research theory and tools were implemented to investigate the research aims and questions. Assumptions are naturally made by the researcher over what is “knowledge” and “how we know it” (Sumner & Tribe, 2008, p. 59). The research design should also take the philosophy of the researcher into consideration (Murray & Overton, 2014). These assumptions have a flow-on effect over research design and the type of “knowledge” that is sought and produced. Reflecting upon and identifying these assumptions helps to understand our worldviews and biases, and to situate the research in the field of academia. The field of development studies, in particular, rejects the idea that research should be purely objective and empirical-analytical (Murray & Overton, 2014; Sumner & Tribe, 2008).

The following diagram provides a brief overview of my research design:

#### *Research design*

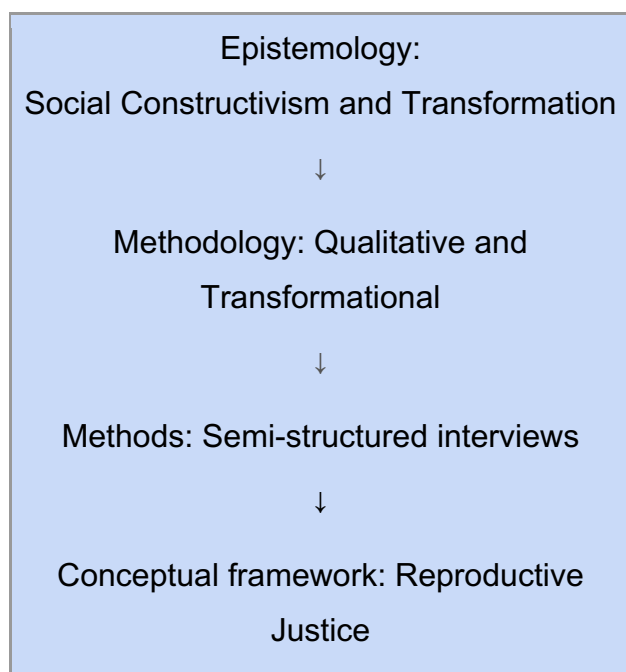


Figure 5. Research design

I approached the research with an awareness of abortion access worldwide manifesting vast inequities and injustices. Although development research

usually focuses on developing countries, intersecting inequalities in society exist everywhere, including Aotearoa.

Development studies is concerned with social justice and improving the quality of life for people, especially those who are marginalised (Scheyvens & McLennan, 2014), or “poor” (Sumner & Tribe, 2004). Development studies and constructivist theory both seek social transformation. The marginalised group in this research are pregnant people seeking abortions, particularly those facing socioeconomic, geographic and structural barriers to accessing services. Reproductive justice, a transformative framework, is used as a lens throughout this research precisely because of its focus on intersectionality. This framework was described more fully in Chapter 2. I used RJ as a lens to investigate the inequalities around abortion access and in a SRHR setting.

## 5.2 Epistemology: social constructivism and transformation

### 5.2.1 Permeability of paradigmatic positions

My research is influenced by both constructivist and transformative paradigms. Mertens (2020) discusses the permeability of paradigmatic positions. Researchers in the sphere of qualitative methods are becoming more aware of the need to situate their work in social justice and for previously oppressed voices to enter the academic debates and influence research. The author emphasises that social constructivists borrow ethical dimensions from feminists to address issues of social justice. This blurred stance moves towards a resemblance of transformative paradigms. Where my research converges with transformative methods is the desire for social justice and change for traditionally oppressed or marginalised people. Where my research deviates is the exclusion of the marginalised people, themselves. The reasons for this choice will be discussed in Chapter 5.2.3.

### 5.2.2 Social constructivism

A social constructivist stance takes the position that there is no single, objective truth to be found. Rather, multiple constructed knowledges exist which are situated within different contexts (Mertens, 2020). These multiple truths may change throughout the research process as they are constructed and reconstructed. The constructivist researcher is influenced by hermeneutics, that

is, interpreting meaning in specific environments. The goal of the research is to understand what realities exist for multiple participants. Understanding meanings contributes to understanding behaviours or environments (Eichelberger, 1989, as cited in Mertens, 2020). Social constructivism asserts that “Everything we know has been determined by the intersection of politics, values, ideologies, religious beliefs, language, and so on” (Costantino, 2012, para. 15). A social constructivist epistemology is particularly relevant for the abortion debate. As multiple, constructed ‘truths’ exist, the researcher endeavours to seek multiple meanings with the participants. The researcher cannot claim an objective knowledge or result. Interpretation of the data is situated in particular contexts for particular participants and cannot be generalised across whole populations. Academic validity and support of the findings can be supported by including examples and direct quotations from the research (Mertens, 2020), which has been done extensively throughout Chapter 6. The constructivist research process is interactive between the researcher and participants. The researcher is not independent of the research, they are an active participant, investigating and constructing meanings with participants. This suggests an interpersonal form of data collection such as interviewing and considerations of positionality. Indeed, semi-structured interviews were the method of choice for this research.

This research, both in the literature review and analysis, investigates the multiple realities that exist both for health professionals and marginalised peoples. It demonstrates how these realities have been, and are currently, shaped and influenced by historical, political, legal, geographical and religious backgrounds. Acknowledging that multiple constructed realities exist, questions to my participants were deliberately broad so that they could provide wide-ranging responses, speaking to their own knowledges. For example, some acknowledged the racism and eugenic thinking that has been historically embedded in our abortion laws (in Chapters 4.4 and 6.2.1). Others questioned the political nature and academia that sometimes overshadowed the lived realities of people seeking abortions (Chapter 6.2.5).

### 5.2.3 Transformative paradigm

A transformative epistemological stance broadly suits this research because it focuses on human rights and social justice, providing “a philosophical framework that explicitly addresses issues of power and justice” (Mertens, 2020, p. 25). The transformative paradigm has emerged partially in response to inadequate representation of such issues in positivism, postpositivism and constructivism (Mertens, 2020). Essentially, other paradigms do not sufficiently address the concerns of diverse groups such as Marxists, feminists, disabled people and ethnic minorities. Transformative methodologies are about bringing about social and political change by confronting social oppression, therefore, could be employed to combat reproductive oppression. A wider understanding of the reasons for the continuation of their oppression by the oppressor is encouraged. In this research, the oppressors were considered the wider legal, geographical, political, historical and socioeconomic factors that lead to in-access.

One key component, however, is lacking from the research for it to truly fit a transformative epistemology (Mertens, 2020). Transformative methodologies privilege the views and lived experiences of marginalised groups and minorities who have traditionally been oppressed, necessitating the positioning of the researcher alongside the marginalised group. It ought to indicate a joint effort to reach social transformation. Lived experiences are of central importance. In my research, the marginalised group(s) are those who seek abortions, particularly, those who face the highest barriers. Their lived experiences were only alluded to from secondary data sources (mostly interviews). The reasons for such a decision to exclude the marginalised groups themselves are discussed under Chapter 5.6.

Mertens (2020) states that in a transformative epistemology, “an explicit connection is made between the process and outcomes of research and furtherance of a social justice agenda” (Mertens, 2020, p. 31). Finley (2012, para. 1), asserts that, “the ends of transformational research are [...] futuristic, formed in existentialist hope that the world we currently live in could be improved by breaking down power structures that result in oppression.” My research ambitions were to support systematic change by providing a collection of solutions to those who could best influence the future environment. In turn, these could influence policy and practice to improve abortion access, particularly to enable those with

the least privilege to have more equitable access to abortion services when they require them.

Similarly to constructivism, transformative methods also borrow from feminist research (Mertens, 2020). Feminist research focuses on gender inequalities and social injustice which, in the context of abortion inequity research, is highly relevant. Feminist research considers discrimination and inequality as embedded in structures and institutions. In my research, for example, I argue that the legislation surrounding abortion is a major contributor to the current state of inequitable and unjust access. Feminism also views knowledge as power that should be shared. I indeed co-brainstormed the research topic based on the gaps that organisations had identified, and I will provide findings back to them.

Mertens (2020) encourages the exploration of respect, beneficence and justice in transformative research. Respect encompasses cultural norms, which in this research, have been spoken about in regard to thoughts, feelings and stigma over abortion. Beneficence encourages the promotion of human rights. This research certainly takes the position that the pregnant person's RJ is denied under current legislation and seeks to uncover ways to address this. Additionally, it acknowledges the UN's call for reform and their position that current laws violate the human rights of women (UN CEDAW, 2012).

### 5.3 Methodology

Research methods depend on the epistemology of the study and the questions one seeks to answer (Murray & Overton, 2014). Privileging the interactive nature of constructivist and transformative research, qualitative methods were utilised to investigate and understand the environment, experiences and knowledges that participants had. The questions I sought to answer required predominantly qualitative research, which seeks to produce knowledge, explore phenomena, understand the "why" and the "how," and tends to focus on specific communities (Stewart-Withers, Banks, McGregor, & Meo-Sewabu, 2014).

Interviewing, observation and reviewing documents produced by the studied groups is encouraged in the constructivist methodology (Eichelberger, 1989, as cited in Mertens, 2020). I did no observation as that would have both gone above

the scope of this research and had patient privacy implications. I did read documents and include literature produced by New Zealand academics, practitioners, advocacy groups and people who had experienced abortion in Aotearoa. Mertens (2020) also writes that the participants' backgrounds should be included. I deliberately excluded identifying information from the final report and thesis due to privacy concerns.

The transformative approach requires efforts being made to obtain multiple perspectives and therefore better interpretations and understandings (Mertens, 2020). Where perspectives diverge, opportunities exist to reconsider positions. In my analysis, I provide examples of where the positions of participants diverge. I certainly found my personal positions challenged and evolving through my interactions with participants.

Mertens (2020) discusses the formation of research questions materialising as the research progresses. Due to internal university processes, research questions were formulated prior to gaining ethical approval and undertaking research. However, the questions themselves adapted as new understandings and political situations arose during the research process. As Mertens (2020) emphasises, the research process is rarely linear. This was certainly true of this research. For example, an original research question asked about the future environment under each of the three potential models, which were still undecided upon beginning this thesis in March 2019. In July 2019, it was announced that the government had chosen a conservative option of Model C and my questions and focus adapted to the new political environment.

Another example of the non-linear nature of research was a change in the country and focus. Often development research involves foreigners in another culture or in another language. Especially in a foreign context, the researcher enters the field with a position of power (Scheyvens & McLennan, 2014). Originally, I aimed to conduct abortion access research in Mexico City. Ultimately, I chose to "stay home" (Robbins, 2006, as cited in Scheyvens & McLennan, 2014). This was partially for practical concerns such as funding, safety, and my capability to transcribe and translate interviews conducted in Spanish, my second language. More so, it was a decision made based on a greater perceived chance to effect

change. I felt that the concepts of development studies could equally be applied to the inequities of abortion access in Aotearoa. By doing research at home, the research process was comparatively more native, less complex, and interviews were produced and analysed to a higher quality than I believe would have otherwise been produced. Conducting research in Aotearoa also minimised the potential for perceived power imbalances. Quite the contrary, I felt that my participants were the holders of knowledge and privileged me by sharing it.

#### 5.4 Positionality

Transformational methodology necessitates the interaction between the researcher and participants, therefore, the researcher is not independent of the research process. Finley (2012), when discussing transformative methodologies and interviewing, mentions that the researcher is “aware that his or her own contributions to the interview might affect the content of the conversation” (para. 4). Positionality acknowledges that the researcher and their position to the research and research subjects “may influence aspects of the study, such as the types of information collected, or the way in which it is interpreted” (Sultana, 2007, p. 376). Murray and Overton (2014) consider it “impossible” that one’s individuality will not influence the research in some way. Positionality’s origin lies in feminist thinking (Murray & Overton, 2014), which influences the constructivist and transformative paradigms.

My positionality is: a mid-twenties, cis-gender, able-bodied, Pākehā, female, pro-reform, intersectional feminist researcher who is capable of becoming pregnant and seeking an abortion. My positionality certainly will have influenced the research design, process, relationships, results and analysis. Naturally, it’s inherently more personal when your own reproductive choices are being legally examined and debated in a changing political and social environment. I must also acknowledge that I have no formal medical or legal background. It’s possible that solutions or ideas I may present may not fit the reality of abortion care in the present or future.

My personal interest in abortion, and views of, were sparked and influenced by my experiences living in Chile, and later, my master’s research on abortion in Chile, Mexico, El Salvador, Nicaragua and Aotearoa. Chile is highly Catholic and

abortion, in any cases, was illegal at the time, even when the woman might die.<sup>19</sup> In the media, I witnessed countless stories of children becoming pregnant through sexual violation and incest with no choice but to continue their risky pregnancies because “all life is precious.” I ask, if this is the case, how can 21% of doctors still refuse to help a pregnant woman whose life is at risk (Livingstone, 2019)? Illegal abortion and its devastating consequences seemed highly unjust to me, and the class disparities in (particularly) girl’s and women’s access to abortion raised questions of social justice.

The quality of my relationship with participants and other interpersonal factors, along with the semi-structured method of interviewing, could have produced different conversations and therefore different results (Finley, 2012). Participants may have framed their answers to me in a number of different ways and these answers formed the basis of my analysis. With some participants, I already had established relationships through a shared interest in reproductive justice. Those interviews were conducted in more organic ways, complete with sarcasm and humour. Perhaps those participants had framed or altered their answers towards me, having known my opinions prior. Alternatively, perhaps having known me, they were able to provide more genuine answers without the same level of social constraint that comes with being interviewed by strangers. Heuser (2012) discusses the crossovers of private-professional relationships in development work. He theorises that deeper knowledges and friendships can be shared when the professional transcends into interpersonal relationships. Finley (2012, p. 887) also discusses that under transformative methodologies, since research is interactive and collaborative, “all parties to the interview are encouraged to relate their thoughts, feelings, and beliefs about the topics of conversations. Personal narratives and stories about life’s experiences are encouraged during conversational exchanges.”

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<sup>19</sup> Abortion was legalised in Chile under certain exceptional circumstances in 2017. Many hospitals are private and/or Catholic and impose conscientious objection across their entire institutions. Public hospitals are also not required to have a willing abortion-provider on hand. In reality, barriers to access remain even in cases where it is now “legal.” Clandestine abortions are still common (Livingstone, 2019).



## 5.5 Methods

A social constructivist-transformative epistemology necessitates an interactive approach to inspire change. The development field typically aspires to mutually beneficial partnerships and is wary about the exploitation of participants by extracting data while returning little back (Brockington & Sullivan, 2003). Transparency and reciprocity are essential values in a transformative paradigm. This was demonstrated by the clear documents provided to participants (along with requested transcripts, audio files and summaries) and the ability to make changes to the analysis. As such, I aimed for constructive partnerships rather than extractive research. To counter the one-way flow of information, I consulted casually with several organisations prior to choosing a topic, to understand what might be beneficial for them, and what matched my research interests. It was important to me to produce research that would be insightful in some ways for those responding to the future of abortion access. The answer that was repeatedly provided was that there was such a dearth of research and that anything would be helpful. In returning a final report and thesis to participants/organisations who are in positions to influence policy and system transition if the legislation passes, I hope to influence change.

One of the methodological challenges of this thesis was conducting research in an environment of change: where proposals about legal reform were constantly in the media, and decisions being made as to which of the three options for legal reform would be put forward. My writing, and my interview questions, had to be adjusted constantly to match the political situation of the day, week or month - even as little as two weeks before hand-in. As such, interviews with participants often touched on the media of the week. Constant revision of content and research focus was necessitated. This influenced my decision to choose to conduct semi-structured interviews. In this way, interview questions could be exploratory of the possible future scenarios yet responsive to environmental changes, as well as allow space to follow the participants' lines of answering and to uncover new understandings. Enforcing a rigid set of questions was inappropriate as there was no objective answer I sought, nor did I have enough knowledge to know what to ask at times. In fact, even those working in that space are uncertain about what the future environment could look like. I was also inspired by Leask (2015) who conducted semi-structured interviews with women

in Dunedin over the topic of abortion. Her use of methods allowed her to follow the participant's dominant ideas and aspects that interested them. I found this a respectful way of making an interview engaging for the other party.

Enquiring through qualitative methods allowed me to explore complex topics and to gain an understanding of organisations' policies and realities that were not evident in the literature. It was not easily accessible information to those outside of the health profession. For example, after four interviews I understood that the reasons there were differing gestational limits set across practices was due to the availability, skill and will of trained practitioners. I had assumed they were policies set aligned with the moral standards of practices. It was seven interviews before I learned that the pool of abortion providers is small, necessitating some to travel to other regions regularly to provide services. I had assumed that providers were all local. If I had used a strict set of questions, these deeper understandings would not have arisen because I would not have known to ask for it. This method allowed me to gain insights which were more holistic in bringing together the complex realities of abortion care in Aotearoa and the uncertainty of the future environment. The interviews also allowed me to challenge my own assumptions.

A critique of qualitative research is that quality depends on the researcher (Stewart-Withers et al., 2014). This was my first time conducting primary research and I assume that my level of ability, along with my positionality, influenced the research outcomes in subtle ways.

Furthermore, RJ is a transformative framework that I have engaged with substantially throughout this research. At first, I struggled with the sentiment of using a framework developed by Black women who felt that abortion paradigms did not meet their diverse needs or sufficiently acknowledge the intersecting inequalities they faced. People with positionality like mine did not encapsulate their needs. Was it ethical for me to claim their framework and adapt it to a New Zealand context? Was it appropriation? I recognise there is some irony in choosing to use this framework. I have not faced radical, or racial, reproductive discrimination like the women who coined this term. However, I do agree with them that RJ manifests unequally for different groups in society. For example, this is seen in the disproportionately high rates of abortion for Māori and Pasifika

and/or rural patients facing higher costs to access services. In an article, Ross, one of the 12 Black women, wrote “Offered to the intellectual commons of inquiry” (Ross, 2017, p. 286). I interpreted this as an academic invitation to advance RJ. After consultation with academics in my school, I decided to use its holistic approach as a basis to investigate abortion access in the context of Aotearoa. RJ provided fertile ground to explore the intersections of diverse and complicated enablers to safe and legal abortion in Aotearoa. I used RJ as a lens to investigate inequities. For example, I asked participants during interviews to identify the members they saw as the most disadvantaged, and how they believed more equity could be achieved for these members of society. I used the definition, “the complete physical, mental, spiritual, political, economic, and social well-being of women and girls” (Asian Communities for Reproductive Justice, 2005, p. 1) to investigate all areas in which abortion inequities could be seen - the health system, the legal and political systems, societal ideas and stigmas surrounding abortion, feminist ideas of bodily autonomy and predominantly Māori ideas of holistic wellbeing.

## 5.6 Participant selection and recruitment

When developing a topic, I questioned whether or not to interview people who themselves had had an abortion. Ultimately, I decided to interview practitioners, advocates and academics across Aotearoa. It is difficult to categorise my participants in just one of the three categories as many participants overlapped. Just two of my participants had never directly been involved in abortion practice. I did not ask whether participants themselves had undergone abortions, however, some of them spoke openly about their own experiences. I decided on these participants for four reasons:

- Firstly, they would best be able to answer my research questions about overarching structural barriers. They would be able to make suggestions for the improvement of access broadly and could share their experiences of certain groups of people coming through services over time.
- Secondly, minimising harm is a central component of ethical development research. As I would be asking professional people for whom abortion is an everyday procedure, it would minimise the risk of psychological harm to participants, especially compared to interviewing people who may have

experienced conception and/or abortion-related trauma. Ultimately, I decided that I did not possess sufficient resources to safely support a participant potentially being triggered by my questions. There also may have also been higher risk of privacy issues in asking people to talk about their abortion experiences.<sup>20</sup>

- Thirdly, the practitioners/advocates/academics will be part of forming the abortion landscape moving forward.
- Fourthly, participant recruitment was an ongoing struggle for months and it became clear that I needed to broaden the geographic scope from what I had originally planned to Aotearoa-wide.

Email invitations providing a one-page research proposal and requesting interviews were sent to organisations/people involved professionally in the provision of abortion (see Appendix for these documents). I began inviting participants in June. With each interested party, various organisational ethics processes and research committees were navigated. Some participant concerns led me to adjust the scope of my research in order to ensure that participants and/or their organisations were non-identifiable. By early September, I had conducted three interviews. Some had rejected my request for participation, stating their positions were well-represented publicly. Others expressed their desire to remain apolitical while the Bill was in Parliament awaiting its first reading (it was read on 08/08/19). One organisation's internal ethics process lasted approximately four months. Participants were difficult to access due to politics, bureaucracy, and perhaps their own will or fear of misrepresentation. I personally underestimated the complexity of dealing with many organisations' internal approval processes.

After participant recruitment became challenging, I turned to snowball sampling via my participants. Using a snowball sampling method allowed me to access people who I would not have otherwise come across. Participants emailed their colleagues, giving those people the choice to get in contact with me or not. This was successful partially because of the invite coming from their trusted colleagues and partially due to timing. At that stage it was September, several

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<sup>20</sup> On reflection, perhaps such a strong privacy concern could partially be me unintentionally perpetuating the assumption that abortion is taboo and should not be talked about.

months after July's media attention over a pro-choice march (Molyneux, 2019), the announcement of Model C, and the Bill's first reading.

Post-completion, this thesis will be made available, along with a two-page summary report, to participants and their organisations. This aligns with my desire for a constructive partnership in the research process and my desire to improve more equitable health outcomes for marginalised people in society. Each is aware that the thesis will be publicly available on the Victoria University website, as stated on their information sheets.

### 5.7 Data collection and analysis

Once participation was confirmed via the consent forms, interview times and locations were accordingly agreed upon. Interviews took between 30-60 minutes, in person, over videoconference, and over the phone.

Many participants indicated that they'd prefer to be named. In consultation with my supervisor, ultimately, it was decided that all participants would be assigned pseudonyms due to the small pool of abortion practitioners/advocates/academics in Aotearoa. The few unnamed participants and their respective regions would have risked being identifiable to readers. Therefore, all names were pseudonyms in order to protect every participant's privacy.

Interviews were recorded and transcribed with verbal permission. Data management processes included transferring all recordings and documents onto a single, secure computer in my thesis office and immediately deleting them from my devices (laptop and cell-phone). They were only uploaded elsewhere for the purposes of sharing with the participant. All printed forms were kept in a locked filing cabinet under my desk, in a key-card accessible postgraduate office.

In order to write my analysis, I transcribed all interviews. One interview I could not transcribe because of recording difficulties. In that case, I took notes during and "brain-dumped" all that I remembered from the interview and sent that to the participant to check it was an accurate representation. Some valuable insight may have been lost in this instance. In some interviews, participants requested that certain parts not be transcribed or used. Their requests were respected.

I re-read all transcriptions and conducted a thematic analysis. In a separate document, I listed the key themes, compiling relevant quotes from the interviews under each. I identified key patterns, contrasts and suggestions, keeping RJ forefront.

Some participants did amend their answers upon seeing their transcripts post-interview. Others opted not to receive a transcript, summary, report or final thesis at all. Participants were provided with a draft analysis chapter before 10/02/2020 to make any changes before my full thesis was submitted. This ensured that the research relationship was collaborative, respectful and accurately represented before publication.

## 5.8 Ethical considerations

Development studies is a multidisciplinary academic field that investigates inequalities ranging from covert power to economic or social injustices. Hence, important moral considerations of my research were power relations, harm reduction, improving outcomes for people, and positionality. Abortion is a sensitive topic and care needed to be taken to ensure a respectful and productive research partnership. Some working in this field have personal experience with abortion, discrimination, stigma and health complications, or know of loved ones who have. Self-awareness and 'reading the room' were necessary to understand and respect the tone that the participant was taking on the matter.

Ethical approval was granted by the Victoria University Human Ethics Committee.<sup>21</sup> Various organisations gave approval via their research committees or internal research approval processes. Abortion is a controversial and sensitive issue and there is the potential for backlash from members of the community. In order to minimise this risk, pseudonyms were used.

## 5.9 Health and safety

The safety of my participants was prioritised by rigorous data handling and by giving them choice over the place of interview. Due to comfort, time-constraints or geography, most selected videoconferencing. Pseudonyms were used to

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<sup>21</sup> Reference 0000027512. See Appendix A1.8

protect their identities. Emotionally, as practitioners working daily in this field with their own access to support, I believe they were also not harmed by my research. In fact, most of them were enthusiastic to chat and thanked me for doing this research.

My school's health and safety procedures and requirements were followed. I made a safety plan with my supervisor, particularly for those interviews in person.

Emotionally, however, I often read stories of gross injustices including violation and abuse. In some of my interviews, I heard unsettling information. I saw a counsellor throughout my research in order to discuss the feelings that arose for me. I took time out for self-care. Ultimately, I took a significant amount of time off during my research. I was able to afford this time because I had been preparing for this thesis via every assignment in Master's Part 1 and pre-reading over the summer.

It is also possible that individuals in the wider community may target myself in person or online, or my research if they come across it. After speaking with participants engrained in this area, this is very unlikely to happen. Even advocates in the media, with decades of experience, have faced very little personally-directed backlash by members of the public or oppositional groups.

## 5.10 Limitations

Bias can infiltrate research via the researcher, the researched, or the research process itself (Sumner & Tribe, 2004, 2008). Personal values, imperfect recall, political motives and accessibility of data are all some of the reasons that bias can occur. White (2002) describes two kinds of researchers. A "data-analyst" collects, analyses and finds conclusions from data. A "data-miner" collects data that matches their pre-existing position to appear to support it. Evidently, writing a thesis on *improving access* to abortion, using a transformative methodology and interviewing advocates/practitioners/academics in that space clearly indicates my personal stance. The choice of participant indicates that data was collected that mostly resonated with the political pro-choice side. Almost all of my participants were explicitly supportive of reform. Therefore, I won't deny bias towards the political abortion debate itself. However, *within* that side of the

debate, I acted as a “data-analyst” by using thematic analysis and considering all data/suggestions. I transcribed all of my interviews so that my own recall bias and interpretations of the interviews could be minimised, challenged and re-examined. I did my analysis by themes and included anything relevant to do with those topics, whether I personally agreed with the suggestions or not. I actively included parts of the research that I felt personally challenged by in the analysis. Ultimately, a constructivist-transformational epistemology is about honouring the expertise and diverse knowledges of the participants.

To combat bias during my interviews, I provided participants with a clear information sheet, consent form and question guide prior, meaning they could prepare prior if desired. Participants were offered full recordings and transcripts. These methods are as Sumner and Tribe (2004) suggest should happen in qualitative development research to ensure it is rigorous, valid and minimise bias. Noteworthy, it is possible that participants may have responded differently knowing they were being recorded (Sumner & Tribe, 2008, p. 119).

Bias can also occur in any secondary source (Sumner & Tribe, 2008, p. 119), therefore it could be present in my literature review. In development studies, in-house research to support specific policy agendas is common (Sumner & Tribe, 2008, p. 121). This is something to be aware of as some sources may be biased. Furthermore, due to the nature of my research aims and questions, sources often came from advocacy organisations, news outlets or academics who supported improved access to abortion. Non-academic sources have been used, due to a dearth in local research, which are not academically peer reviewed. It must also be kept in mind that abortion has been criminalised in Aotearoa since 1977. It is possible that stigma, illegality and fear of prosecution or personal retribution could have led to inaccurate or incomplete information in those secondary sources, or indeed, in my own primary research.

Other factors that may introduce bias are snowball sampling and the exclusion of some data. It is likely that being referred to someone’s colleague to speak about abortion means they have similar opinions and share similar values. Some information has been left out of my analysis in order to protect participants’



identities and the organisations/regions they represent. Unfortunately, this has meant that some rich data and examples have been omitted.

### 5.11 Chapter summary

To summarise, the epistemology of this research is predominantly social constructivist, in that knowledge is constructed and socially mediated. However, Mertens (2020) argues for the permeability of paradigms, which has been considered in this research. The research also utilises many elements of a transformative epistemology/methodology because it is focused on bringing about change to a system of oppression. I have a personal connection to the topic (see positionality), I am motivated by understanding how power has manifested through social, political, legal, cultural and historical means, and I endeavour to support changing the status quo. RJ is employed, which has a transformative aim, to investigate the systems of oppression for different groups of people. The reason it is not a fully transformative paradigm is that I do not employ the community-integrated participatory methods that are usually associated with the transformative paradigm. I have not interviewed abortion-seekers/-receivers who are by default directly oppressed by legal structures. Instead, I interviewed people who can affect change in the current and possible environment. This is partially to protect abortion-experiences from risk of trauma, partially due to supporting those who have the power to make change, and partially due to the limitations of this thesis.

## Chapter 6: Analysis and discussion

### 6.1 Chapter introduction

The central inquiry of this research is, “how can access to abortion be improved, in Aotearoa, with or without a law change, bearing in mind the concerns raised by reproductive justice?” In total, I spoke with thirteen abortion practitioners, advocates and academics across Aotearoa. Their pseudonyms are: Kathleen, Linda, Diana, Maria, Morgan, Rachel, Jessica, Emily, Jennifer, Ettie, Christina, Cynthia and Louise. This chapter draws out themes that recurred during the interviews, their implications for RJ, and their relationship to key ideas identified in the literature. My research questions were as follows:

1. What does ‘access’ to abortion mean in the current New Zealand context?
  - a. Who do participants believe are the least privileged in terms of ability to access services?
2. What might ‘access’ look like under the proposed legislation?
  - a. How will the legislation influence abortion providers’ practices?
3. How do participants believe that access can be improved, whether or not the law changes?
  - a. What is needed to assist those facing intersecting inequalities to access abortion services?
4. How does reproductive justice materialise in the abortion context?

In order to address these questions, this chapter is structured as shown in Figure 6 (next page). The chapter is organised into two main sections. Section One answers *Question 1. What does ‘access’ to abortion mean in the current New Zealand context?* Section Two answers *Question 2: What might ‘access’ look like under the proposed legislation?* Consider the two sections a potential before-and-after law change comparison. Every sub-heading in Section Two is a question, reflecting the fact that there remain many unknowns about the future environment.

Woven throughout these two sections are the considerations addressed by *Question 3* and *Question 4*, highlighting where *access* and *reproductive justice* are hindered and can be improved, also, how different people experience both.

They are integrated throughout both sections because both could be improved whether or not the law changes. In line with a transformative methodology (Mertens, 2020), ample participant quotes are provided, to both privilege their voices and validate the findings.

### *Structure of discussion chapter, accounting for the research questions*

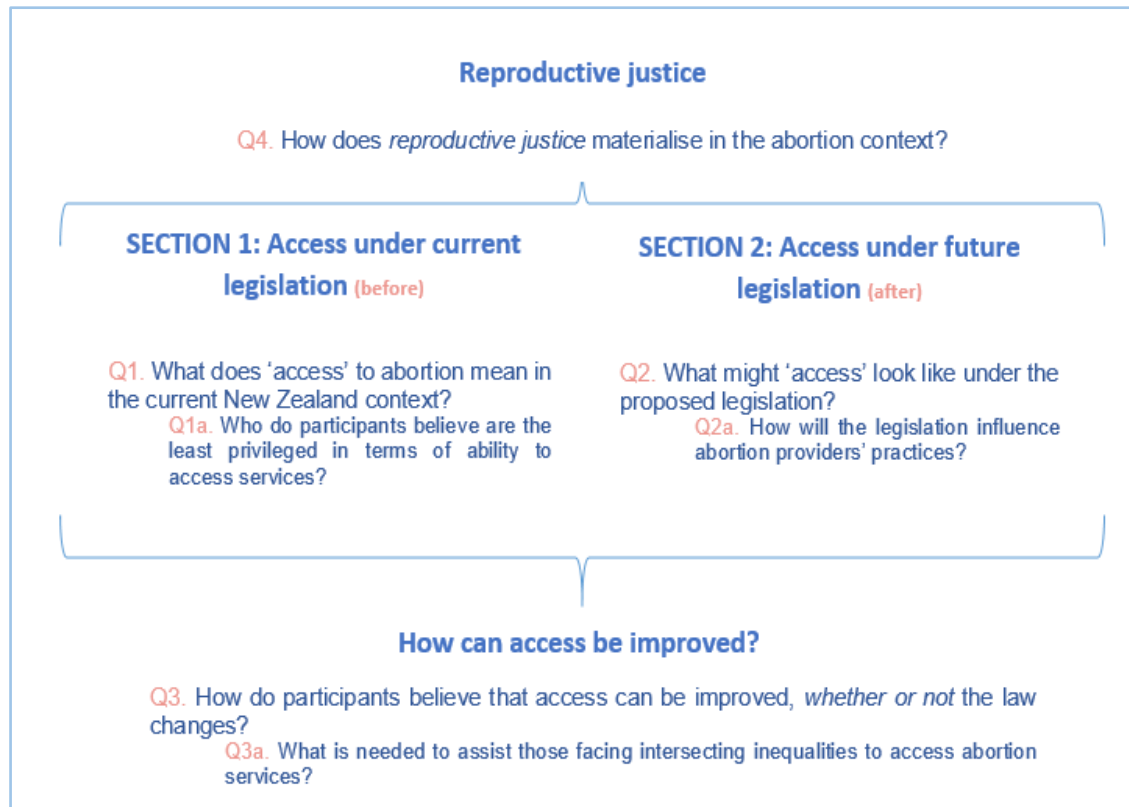
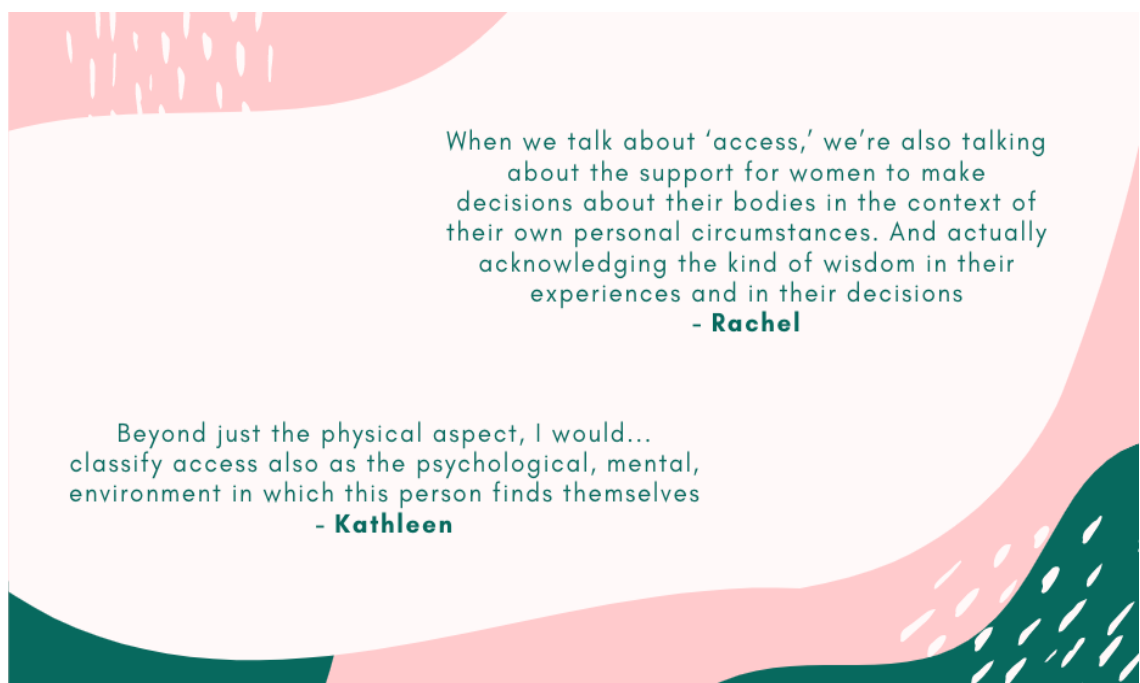


Figure 6. Structure of discussion chapter, accounting for the research questions

In general, participants considered abortion as healthcare and supported decriminalisation. This is unsurprising, given the participants' backgrounds. All participants agreed that socioeconomically- and/or geographically-disadvantaged people faced the highest barriers to accessing services, reflecting findings in both the national literature (Te Whāriki Takapou et al., 2017; Law Commission, 2018, p. 121; Justice Committee, 2018) and international literature (Beattie, 2009; Orr, 2017; Oberman, 2013; Viterina, 2012; Witte-Lebhar, 2015; Fried & Yanow, n.d.). Participants mentioned Māori, migrants, religious people and Pasifika as facing additional access hardship due to social, cultural or practical barriers.

Most participants believed that abortion would be more accessible as a result of decriminalisation, but its occurrence would not increase, in-line with the global research by the Guttmacher Institute (Singh et al., 2017) and Peiró et al. (2001). Almost all saw reform as a “step in the right direction,” in those words or similar. However, like Baird (2017) found in Australia, future access depends on how the health system responds to any legal reform. Would clinics reduce their services, or even close? Would abortion remain free or would a consumer-pays model emerge? Who would provide the necessary training and funding? Would telemedicine become an everyday part of abortion services? Would decriminalisation reduce stigma and other barriers? What would the roles of cultural competency, counselling and holistic care be? How would RJ manifest in the future? Certainly, many practitioners believed that telemedicine has the biggest potential to improve access to abortion, but they simultaneously question the quality of care that primary-care practitioners would be able to provide, especially if only treating abortion occasionally. The complexities of access are drawn out in this chapter.

## 6.2 Section One: What does ‘access’ to abortion mean in the current New Zealand context?



Quotes on defining ‘access’

Embarking on this research, I considered ‘access’ to mean overcoming the geographical, legal, economic, societal and structural barriers to reach services.

In Aotearoa, these barriers exist, and they largely align with those discussed in the literature. Intersecting barriers result in inequities, delays and struggles, particularly for Māori, rural, socio-economically disadvantaged, Pasifika, migrants or religious people (Te Whāriki Takapou et al., 2017; Law Commission, 2018, p. 121; Justice Committee, 2018). As my understanding of RJ grew, I came to understand access in broader terms, as anything that could hinder someone from feeling safe and welcomed by abortion services. Under RJ, it is not only the access barriers listed above, but “the complete physical, mental, spiritual, political, economic, and social well-being” of people (Asian Communities for Reproductive Justice, 2005, p. 1). Participants also helped to broaden, complicate and shape my understanding of ‘access,’ as the beginning quotes demonstrate. That is why themes are included in this discussion that may not initially appear access-related, such as counselling or cultural competency. However, my findings suggest that such matters should also be part of a discussion on access to abortion.

‘Access’ in this study, therefore, transformed to be broadly conceptualised to include all factors that may hinder somebody from safely accessing services (physically, culturally, spiritually and emotionally) or experiencing any aspect of RJ. This broader concept of access, informed by RJ, helped me to see the interconnectedness of inequalities. Under an RJ lens, one cannot talk of abortion without talking of education and contraception, for example. One cannot talk about contraception without economic ability. Nor can one discuss counselling without considering bodily autonomy. Therefore, I now understand ‘access’ to include broader matters of holistic wellbeing, including contraception and spirituality.

New understandings about access also resulted from interviews, about areas that were unknown to me from simply reading the literature. The paucity of abortion literature is a significant factor here. For example, for high-risk pregnancies in which the foetus or the pregnant person might experience difficulty, patients must travel to a main city for consultation with maternal foetal medicine specialists. If they decide to undergo an abortion, they must return to their local DHB area for care, causing further hardship.

Importantly, each licensed premise has a differing gestational limit not due to organisational policies, as I originally assumed (discussed in Chapter 5.5), but due to differing willingness and ability of staff to perform abortions and to what gestation. Abortion services, particularly surgical, are only available on certain days at clinics partially due to practitioner availability. Some practitioners travel often to provide services across different regions. Medical abortion can be done any weekday but delays to accessing services mean that some miss the gestational window, usually around 10-weeks. Additionally, in keeping the best interest of patients and their personal circumstances in mind, off-protocol ways of undertaking medical abortion are being prescribed to reduce time and cost burdens for patients.<sup>22</sup> This results in a situation where practitioners must balance the circumstances of the patient with medical best practice. Jessica said, “We don’t have equity in access to healthcare in any regard, but when it comes to a healthcare procedure that it needs to be done in a particular place, one of 27<sup>23</sup> licensed institutions, then that’s further increasing inequity” (Jessica, 2019).

I also learned about the complexities that alcohol, drug use and child protection services had on abortion-seeking. Alcohol and drug use contribute to access issues in terms of people missing their appointments, Christina explained. Sometimes they arrive intoxicated, providing practitioners with the conundrum of obtaining informed consent. Sometimes, people seek abortions because they feel it less traumatic than having their children removed from their care.

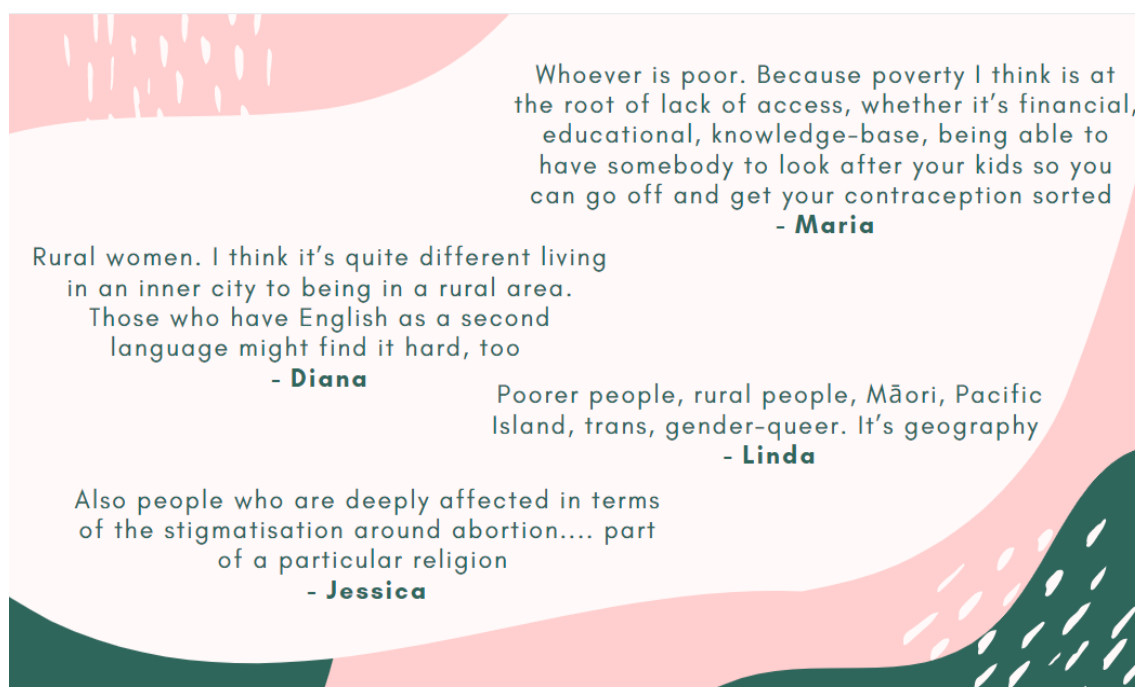
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<sup>22</sup> This will be expanded upon in Chapter 6.2.4.

<sup>23</sup> The Law Commission (2018) report only identifies 22 licensed institutions.

## 6.2.1 Who are the most disadvantaged groups in terms of abortion access?

### The “tyranny of distance” and the “post-code lottery”



Quotes regarding the most disadvantaged people in Aotearoa in terms of abortion access

Participants' identification of the most disadvantaged groups remains largely consistent with the literature. Participants identified the most disadvantaged groups of people as the poor, the marginalised, the rural, Māori, Pasifika, trans, gender-queer, religious and migrants, mirroring the disadvantaged groups identified by Te Whāriki Takapou et al. (2017), the Law Commission, (2018, p. 121) and the Justice Committee (2018). Conversely, those who are advantaged when it comes to accessing abortion are “people who live in an urban-centre, who can navigate health systems, aren't a member of an oppressed or minority group, people who have good support” (Jessica, 2019). Evidently from the ample international research, RJ manifests very differently for these different groups of people.

### The “post-code lottery”

Overwhelmingly, those who face barriers to abortion access are geographically-and/or socioeconomically-disadvantaged. The most disadvantaged people are situated at their intersection. As Jennifer said, “geography is the biggest problem. Because if you don't have money, geography makes it worse” (Jennifer, 2019). Jessica provided the concerning example of a woman who claimed it was “easier

for her to continue her pregnancy than it was to come to [omitted] to have an abortion” (Jessica, 2019), indicating the severity of geographical issues and disempowerment that people may feel. Three participants used the same expression, “post-code lottery,” to describe access to abortion (and healthcare, generally). The “tyranny of distance” was one participant’s phrase that struck me for its powerful condemnation of geography and associated intersecting inequalities. Rachel discussed rural barriers to access, such as underfunding and poverty, being partially offset by a dedicated community and/or practitioners who voluntarily drive people to services.

### **Māori and non-Pākehā**

Often, those who are situated at the intersection of being geographically- and/or socioeconomically-disadvantaged are non-Pākehā. Māori and Pasifika people in Aotearoa tend to be of lower socioeconomic status (Urale, O’Brien, & Fouché, 2019, p. 82). Socioeconomic status and fertility rates are inversely related, which may partially explain the higher fertility rates of Māori and Pasifika people. Contributing to the higher fertility rates are other factors such as education levels, religiosity, access to health services and timely reproductive health and contraception advice. Unintended pregnancies are more likely to occur in populations with lower education levels (Girma & Patton, 2015, as cited in Urale et al., 2019). Māori face additional intersecting inequalities of colonisation, oppression and a history of eugenics<sup>24</sup> (Smyth, 2000, as cited in McCulloch & Weatherall, 2017; Leslie, 2010). For Rachel, more questions have to be asked about why Māori are disproportionately represented in abortion statistics. She said,

For Māori, it takes on a different kind of inflection because of the history of eugenics that has been interwoven, whether it’s child protection, or sexual and reproductive health services, and infant care services. This idea of ‘Who is a desired reproductive subject?’ Or, ‘Whose reproduction is valued?’ When I look at the statistics we have to think carefully, ‘Why would people celebrate Māori women having a lot of abortions? What is

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<sup>24</sup> See Chapter 4.4



that about?' You know, are these women being supported - in terms of having babies or not - what's going on there? (Rachel, 2019)

Rachel's quote reminds of the racist fears of "race suicide" (van der Krogt, 1998, p. 298) and support of Māori abortion in favour of "countries suitable for the white races" that persisted in early 20<sup>th</sup> Century Aotearoa (Brookes 1981, p. 27, as cited in Leslie, 2010).

### **Socioeconomic disadvantage and deprivation**

In 2009, a New Zealand study showed that the cost of raising a single child to the age of 18 was between \$137,000 and \$295,000 NZD (Claus, Kilford, Leggett, & Wang, 2010, as cited in Urale et al., 2019). This cost is expected to be far greater a decade on and does not account for continuing support after the age of 18. Disallowing people to terminate unwanted pregnancies forces them to risk their health, experience the difficult process of adoption or commit to serious care, self-sacrifice and financial expenditure. Maria explained, "if you've got \$5 for your pill and \$5 for your two different medical abortion pills, that's \$15. You've got to find \$15 out of your weekly benefit" (Maria, 2019). For most, \$5 won't be a problem. But for those for whom it is, inability to access termination could have serious financial consequences for them, thus violating the achievement of RJ.

Rachel shared examples of Māori patients presenting at later gestational stages due to access barriers. Some turned up irate by the time they reached the service. She spoke broadly about issues associated with clients in health services being considered "problematic" or "trouble" because they were not able to physically make it to appointments they wanted to attend (Rachel, 2019). Rachel said "they can't actually get there, they can't afford the petrol. So, they get classified as a 'trouble' person. Someone who is non-compliant. As if they don't want to go when they actually do want to go but they can't" (Rachel, 2019).

Christina, Morgan, and Emily spoke of the challenges of providing abortions in high deprivation zones. The stories they told were emotional and highlighted diverse social issues. For example,

They know that their baby will be affected by the drugs. There's a high risk of having the child taken off them at birth. It's not infrequent to do an abortion on someone in those areas who have already had children not in their care [...] Sometimes it's actually not legal - it's not Oranga Tamariki, it's not a government-imposed thing, it's family members. They don't turn up to the appointments and when they do turn up, they're late or they're stoned. Trying to get informed consent and all that stuff... (Christina, 2019)

Or Emily, who shared,

We have women coming, who are being harassed by Oranga Tamariki, who find it more palatable to have a 16-week abortion than to deliver their baby and have it taken off them. I find that so distressing. (Emily, 2019)

To clarify, in the participant revision of this chapter, Linda emphasised, "this is more about what they feel than what subjectively someone might say Oranga Tamariki are doing" (Linda, 2020).

### Information poverty

People who face information-poverty are also disadvantaged in accessing abortion. Navigation of health systems was brought up by Jessica and Emily. Both participants recognised that some people struggle due to lack of education, language ability, familiarity with systems, or low reading levels. To provide some examples, Ettie was a midwife for many years and she spoke of Pasifika people who, because of their faith, had grown up without quality sexual health education. She had met "young women who didn't know where their baby was going to come out. Who were in *labour*" (Ettie, 2019). In another example, her colleague had cared for someone with mental health conditions who was not aware that it was "possible to help her not be pregnant" any longer (Ettie, 2019).

### Associated access costs

Even though abortion is free for New Zealand residents, costs associated with accessing services can be a major barrier. Furthermore, surgical lists are only done on certain days of the week, partially due to traveling practitioners. People on precarious incomes often find it challenging to take time off work for treatment.

Christina gave an example of a woman who she suspected was homeless. She had missed her appointment and was still several hours away when called. When asked why she didn't come, she responded, "I just didn't have any money for petrol today" (Christina, 2019). One practitioner estimated the cost of a 'free' abortion being approximately \$700 for those living rurally in their particular DHB area. In contrast, the cost is around \$80 for those living close to the centre. Their estimations took into account the costs of up to fourteen hours driving return, an overnight stay, petrol, childcare and time off of work. An example was provided by Maria of abortion-seekers often not meeting the criteria for transport/accommodation subsidies despite some having to travel 3.5-hours and stay for one or two nights. SDG 5 seeks gender equality between genders (UN SDGs, 2015a), yet, how can equality be achieved between genders if we cannot first decrease the vast inequalities that exist between women?

### **An urban example: Auckland**

Urban geographic and socioeconomic barriers such as travel time and distance can still be a stressful challenge for some abortion-seekers. For example, in Auckland, it could still take one over an hour to reach the clinic from some parts of the city. This echoes the Abortion Supervisory Committee's concerns about access difficulties in Auckland (ASC, 2017; Justice Committee 2018).

### **A rural example: the Chatham Islands**

In an extreme case of geographical barriers and paucity of information, it was challenging to find any information concerning what occurs for patients who request abortions in the Chatham Islands, a 2.5-hour flight away from the nearest licensed premise. I asked participants where patients from the Chatham Islands have to go. Kathleen, Linda and Diana did not know, although their guesses were that patients would have to travel to Christchurch. In two years of research for this thesis, I only ever found one mention of the Chatham Islands. Even then, the website had inaccurate information.<sup>25</sup> Eventually, the Canterbury DHB confirmed participants' assumptions that Chatham Island residents must travel to

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<sup>25</sup> Abortionservices.org.nz listed the Chatham Islands under the Hawkes Bay DHB, but the Chatham Islands are actually under the Canterbury DHB. I attempted to contact Abortionservices.org.nz via form submission but the website itself was unable to complete my request.

Christchurch for abortion.<sup>26</sup> More questions remain. The cost of travel and accommodation may be partially offset by the National Travel Assistance policy for some people (Ministry of Health, 2005). This document was last revised a decade ago. Theoretically, patients fly to Christchurch to take two pills on a licensed premise or to receive a surgical abortion. Are there enough certifying consultants on the Chatham Islands that can approve abortion? Do they collaborate with mainland certifying consultants? Are they conscientious objectors? In the future, will telemedicine services assist abortion-seekers there to abort safely at home?

### Intimate partner violence (IPV)

IPV is another factor that affects one's RJ, abortion access, and good health and wellbeing under SDG 3 (UN SDGs, 2015a). Ettie and Christina spoke of their own concerns for the physical safety of some abortion-seekers and their lives, or the future child's. Ettie wants to see "reproductive justice [...] in some countries women cannot have the babies they want to have [...] this is not just about abortion rights. This is about a woman who wants to have a baby and her partner punches her in the gut so she won't." Expanding on these themes, Ettie gave another stark example of the complexities of RJ,

women's ability to control their fertility [...] to control their own sexual pleasure, to control having the children they want, not having the children they don't want, or aborting the child they do want to protect that future child from this incredibly dangerous person. So, I think for women, again, women on the margins, we need to have processes in place so that women who are living in a violent relationship can access abortion without getting beaten and killed. I think that there's a lot of access issues to address. (Ettie, 2019)

Both of her quotes exemplify the complexity of RJ, the abortion decision, abuse and coercion, bodily autonomy, rights and protection. It demonstrates how the politics of 'pro-life/pro-choice' debate are truly insufficient in addressing RJ.

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<sup>26</sup> I had also sent an email to a health clinic in the Chatham Islands and received no response.

## Empathy for patients

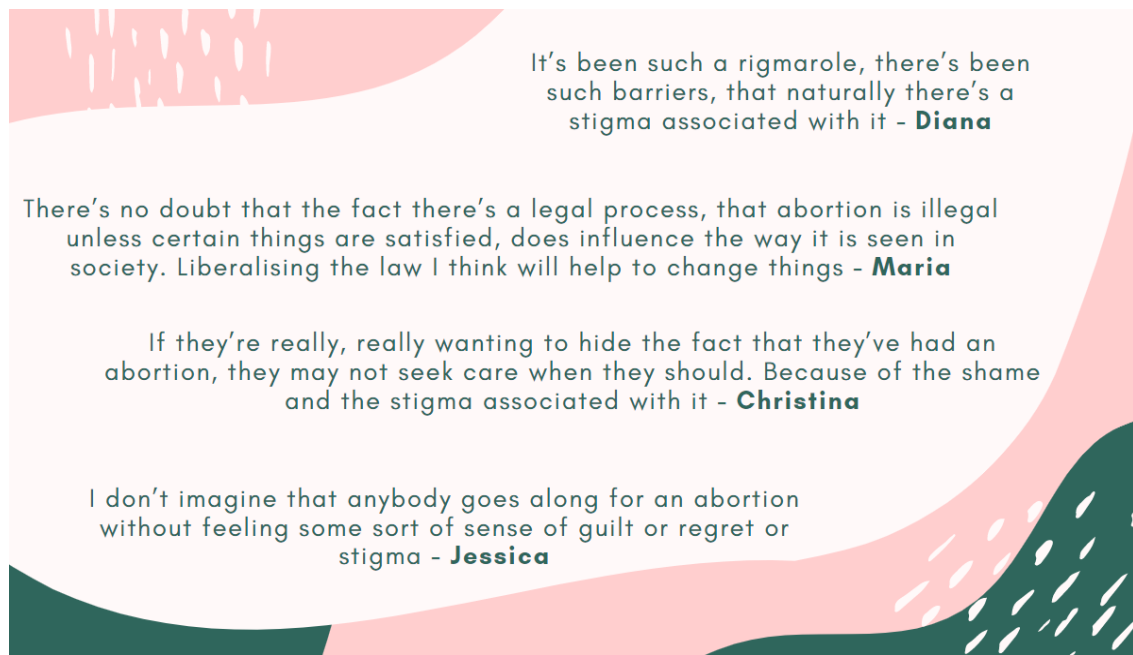
Empathy can help patients, at vulnerable times, to access the appropriate services regarding their pregnancy decision. Louise emphasised that when patients haven't turned up, it's usually for a reason. She handled it by gently offering support, exemplified in the below quote which really encapsulates the woman-centred, holistic care that the providers I talked to strive to provide,

I'd just flick them a text - 'oh, you've missed your appointment today, is there anything I can do?' Because I'm not rushing that appointment. They might need something else instead. Finding a midwife, maybe? I can help them with that. Or more counselling. Or rearranging - you know, child was sick. So, it's just being mindful [...] We have a little safety plan just in case but normally it's the woman's decision if they don't turn up by day two. (Louise, 2019)

When addressing the question of people missing their appointments, participants emphasised the need for responding to patients with patience, tolerance and empathy, as well as the need for self-reflection and being alert to your own privilege. Morgan said,

The natural tendency is to react with annoyance. Want everything to run on time and not waste resources. Easy to have that opinion when you come from a nice house with a nice bed, with a tank of gas and breakfast on the table. Good to remind yourself that you are there to serve. (Morgan, 2019)

### 6.2.2 Stigma's effect on access



Quotes on stigma

Stigma was raised repeatedly as a barrier to accessing services, in line with McCulloch and Weatherall (2017), the Guttmacher Institute (Singh et al., 2017) and Amnesty International (n.d.). Stigma remains persistent despite around 30% of women in Aotearoa experiencing abortion during their reproductive years (Standards Committee, 2018, p. 1). In the USA study by Ehrenreich and Marston (2019), an example was presented of a woman travelling alone to a clinic 450km away because she was scared of social judgements in her hometown.

The quotes above from Diana and Maria encapsulate some opinions that the criminal status of abortion is partially responsible for maintaining abortion stigma. As Jessica points out in her quote, abortion is a confronting decision for many, and stigma can make it harder. For Maria, supporting patients through an incredibly intimate and vulnerable time without the stigma and shame is of utmost importance and supports their RJ.

### Adverse health outcomes

Not only can stigma affect a patient's feelings but can also adversely affect their actions and health outcomes via how they access services. Participants discussed the dangerous consequences that stigma can have on patient health, as Christina alluded to above. Jennifer gave a frightening example,

They [the ambulance service] need to know how to manage people who are in the shower, collapsed. Because that's where they go, because they're hiding their miscarriage,<sup>27</sup> they go to the bathroom. They get crampy pains, they get in the shower because they want the heat because that's going to help, and then they collapse with cervical shock in the shower. That's what ambulances find. And that is about hiding the abortion. Because where you should be is in your bed! With your hottie!<sup>28</sup> With someone being supportive of you! (Jennifer, 2019)

### Historical circumstances

Participants made clear that the historical circumstances discussed in Chapter 4.4 have contributed to the stigma on abortion today. For example, Linda explained, because so many passed away due to childbirth in the past, the focus shifted from saving the woman to caring for the new-born. "They knew that women died, they couldn't stop it. But they'd aim for the healthy baby. And that persisted into the 20<sup>th</sup> century - the idea that the baby was more important" (Linda, 2019). The idea that the baby is more important than the woman has persisted. This, in turn, contributes to the stigma around women seeking abortion. Unless they are at psychological risk (Leslie, 2010) or in need of protection (Te Whāriki Takapou et al., 2017) they are still stigmatised by society as being 'selfish.' Therefore, stigma continues to contribute to the 'exceptionalist' thinking that is reinforced by our laws (Leask, 2015), the present mental health paradigm, and access issues.

Additionally, Linda pointed out both the paternalism and the gendered nature of decision-making, "if men had to make a decision like that, it would not be a question [ [...]] Women are viewed with this sort of frailty and need of support that they don't actually need" (Linda, 2019). This quote aligns with the critiques from Leask (2013, 2014), McCulloch and Weatherall (2017) and (Te Whāriki Takapou et al., 2017) over Aotearoa's current legislation treating women paternalistically, as fragile and in need of protection.

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<sup>27</sup> Again, Jennifer means 'induced miscarriage' via the abortion medication.

<sup>28</sup> Hot water bottle.

### **Eurocentricity, choice and destigmatisation**

Participants critiqued stigma and Western approaches to combating it. While Kathleen suggested being active in telling stories like “yeah, I had an abortion and I don’t regret it” as a way to combat societal stigma and improve access, Ettie discussed how some efforts to destigmatise may actually be counterproductive and actually reinforce stigma and barriers. She gave the example of the “shout your abortion” campaign (Shout Your Abortion, n.d.). This type of campaign, she believed, is very Western-focused and could be offensive to many people. For example, she explained, the “Western women’s liberation thing is women have control over their own bodies and bodily autonomy. But in actual fact, in Māori culture, she doesn’t. Certainly, in Indian culture, she doesn’t” (Christina, 2019). For example, a Māori cultural belief is that the foetus has wairua and is a part of whakapapa. “Shouting” about “killing whakapapa” could be considered quite offensive, hence reinforcing the stigma. Le Grice and Braun (2017), interestingly, indicate how pervasive the “woman’s choice” movement has become throughout recent Māori abortion discourse - in their study, “woman’s choice” was spoken about in the context of protecting new life from challenging circumstances, demonstrating the nuanced positions that can be held. Ettie held a compromise between the two positions, “I think it’s quite possible to hold a ‘both/and’ position rather than an ‘either/or’ position. I don’t think binaries are helpful in destigmatising” (Ettie, 2019). She believed there are gentler ways to destigmatise abortion, such as talking openly about it in an un-quietened voice, normalising it.

### **Spontaneous versus induced abortion**

Participants pointed out the moral judgements and stigma that comes with deliberate, early abortion versus miscarriage,<sup>29</sup> even though they are very similar in nature and their required care. Linda expressed, “If it happened by nature, ‘oh well, it’s just nature.’ But if it happened by medicine, ‘it’s terrible’” (Linda, 2019). This highlights the taboo around abortion the moral judgements that come with questions like “how did the pregnancy get there?” “How did the pregnancy end?” (Linda, 2019).

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<sup>29</sup> Also referred to as spontaneous abortion.

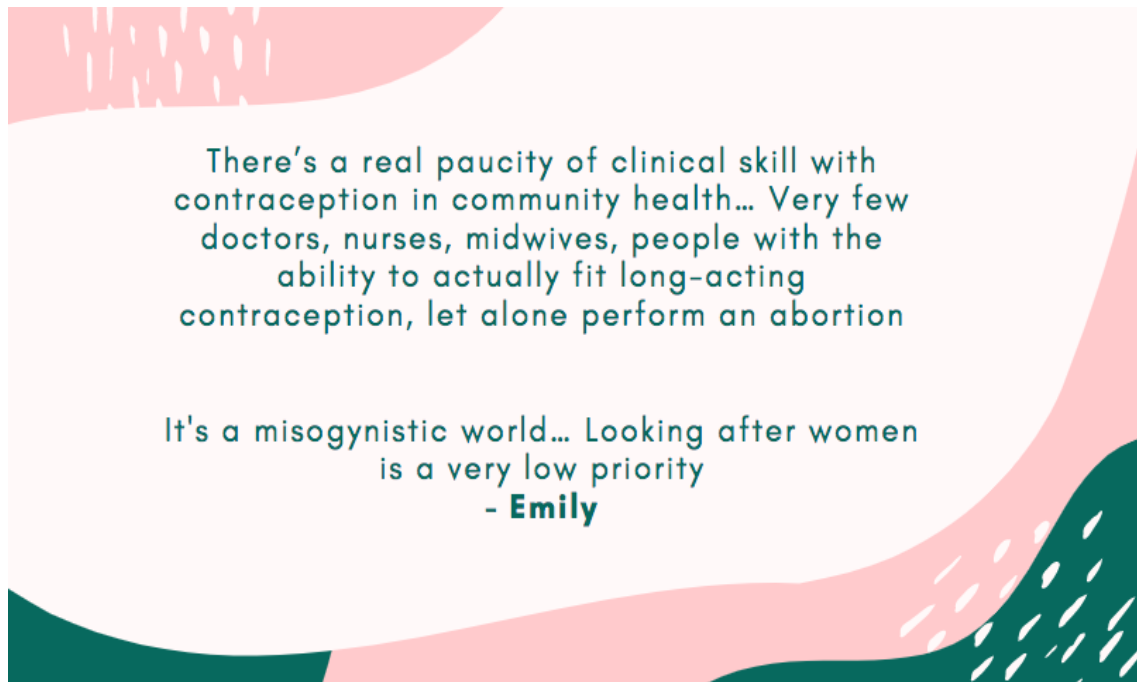


### Stigma, practitioners, and moral reasoning

Stigma is not only prominent in society facing abortion-seekers, but abortion practitioners, too. Linda, Rachel and Louise expressed examples of stigma they personally face. Some medical colleagues would not speak to them. Some participants didn't tell people that they did abortions, even their own children. Ettie gave an example of her sexual health colleagues feeling the need to hush their voices in public when speaking of sexual health matters. She pointed out that if they're uncomfortable talking about sexual health, they're "not going to be comfortable talking about abortion care, either" (Ettie, 2019). There is a perceived silence on abortion from providers due to the effects of stigma, which Maria believed contributed to a "whole vacuum that the anti-abortion rhetoric has been able to grow in. That abortion is 'exceptional.' That only in really extreme circumstances would you ever consider it, that it's a bad thing" (Maria, 2019).

Some practitioners felt demonised by the very patient's they gave abortions to. People can be very anti-abortion but still receive services. It can be morally easier for some, culturally or religiously, to reason that the practitioner is the 'evil' person for performing the procedure, not *them* (Joffe, 2013). Christina explained that it's an attitude of "you did it to me, I didn't do it to myself" and wondered "if that's why they chose surgical over medical" (Christina, 2019), as for a medical abortion, the patient themselves takes the pills. She even gave the example of a patient who was only five weeks pregnant who insisted on accessing a surgical procedure. Christina suspected this was because of the patient's religious beliefs and that it was easier for her to reason that the practitioner was the 'evil' person, rather than herself.

### 6.2.3 Disinterest in sexual and reproductive health



Quotes regarding disinterest in sexual and reproductive health

Common threads throughout the practitioners' interviews were frustration at a general disinterest in women's sexual and reproductive health, the siloed approach to abortion care, and the Health Practitioners Competence Assurance Act 2003, which allows a very high level of conscientious objection. This disinterest is influenced by societal stigma regarding sexual health, which influences the availability of training and services, particularly for abortion. These factors, in combination, contribute to abortion access inequalities and hinder the achievement of RJ. The links that emerged can be best summarised by the following quote:

Historically and through to the present, abortion care is predominantly a siloed activity, on the periphery of other sexual and reproductive health services. This marginalised position underscores abortion as a stigmatised activity that has never been fully enfranchised as a legitimate aspect of women's health. (Hoggart, 2017, as cited in Hannah et al., 2019, p. 4)

#### Health Practitioners Competence Assurance Act 2003 (HPCCA)

Sexual health disinterest and taboo is legally reflected in the HPCCA, which allows practitioners to refuse anything related to reproductive healthcare: to

prescribe contraception, refer for or supply abortion,<sup>30</sup> or even conduct C-sections or cervical smears (as discussed in Chapter 3.5) - all of which disproportionately affect women. Conscientious objection (CO) amongst the medical community is a “hideous” problem across sexual and reproductive health in general, especially abortion, said Jessica, who personally found the act incredibly “judgemental” and “anti-women” (Jessica, 2019). Linda and Emily both used strong language calling out the lack of good healthcare for pregnant women as “misogyny” (Linda, Emily, 2019). The paucity of skill in the opening quote is a result of stigma, disinterest and CO, Emily explained.

The opinions of participants reflected the condemnation of current CO under the HPCCA by Ballantyne et al. (2019), who argue that there are “critical differences in power, freedom and vulnerability between the patient and the doctor,” (p. 67). These researchers highlight that medical ethics assigns significant weight to patient choices, yet the requirement of certifying consultants and the generous allowance of CO assigned to health practitioners can render patient choices obsolete. CO seeks to ‘psychologically protect’ the doctor rather than the abortion-seeker whose life path and health are in question, favouring their right to CO over the patient’s right to timely abortion (Johnson et al., 2017).

CO and bodily autonomy appear to be standing in contrast to one another, one favouring the doctor and one favouring the patient. CO reinforces a paternal approach in which the abortion-seeker’s right to access medical care and their own bodily autonomy is violated (Ballantyne et al., 2019; Te Whāriki Takapou et al., 2017). This leaves people’s control over their bodies, choices and future uncertain (McCulloch & Weatherall, 2017). Therefore, CO violates patient’s rights to RJ, including how and when they become pregnant, their right to access healthcare, and the right to decide what happens to their own bodies (Asian Communities for Reproductive Justice, 2005). This, in turn, inhibits their ability to act in an empowered way (Cornwall et al., 2008; Erdman, 2012), hence obstructing the achievement of gender equality under the UN SDGs (2015a).

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<sup>30</sup> They must legally inform the patient that they can seek abortion elsewhere (Ballantyne et al., 2019, p. 65). Anecdotally, this doesn’t always happen.

### Hindering holistic care

The treating of reproductive care, particularly abortion care, as a siloed practice does not leave space for the holistic care of patients and their wellbeing, in the opinions of many participants I spoke with. Emily, Jennifer and Ettie explained that the current system is focused around a diagnosis - an unwanted pregnancy and solving it - but a model of holistic care should also include consultancy for contraception and violence, for example. They did acknowledge that practitioners endeavour to provide excellent patient-centred care within the structural limitations they face. Many participants expressed a desire for centralised funding and non-siloed, integrated services, similar to maternity services, to be better able to provide holistic care. Patient-centred abortion care would empower patients and allow them to be trusted about their decisions and future (Erdman, 2012; Leask, 2014).

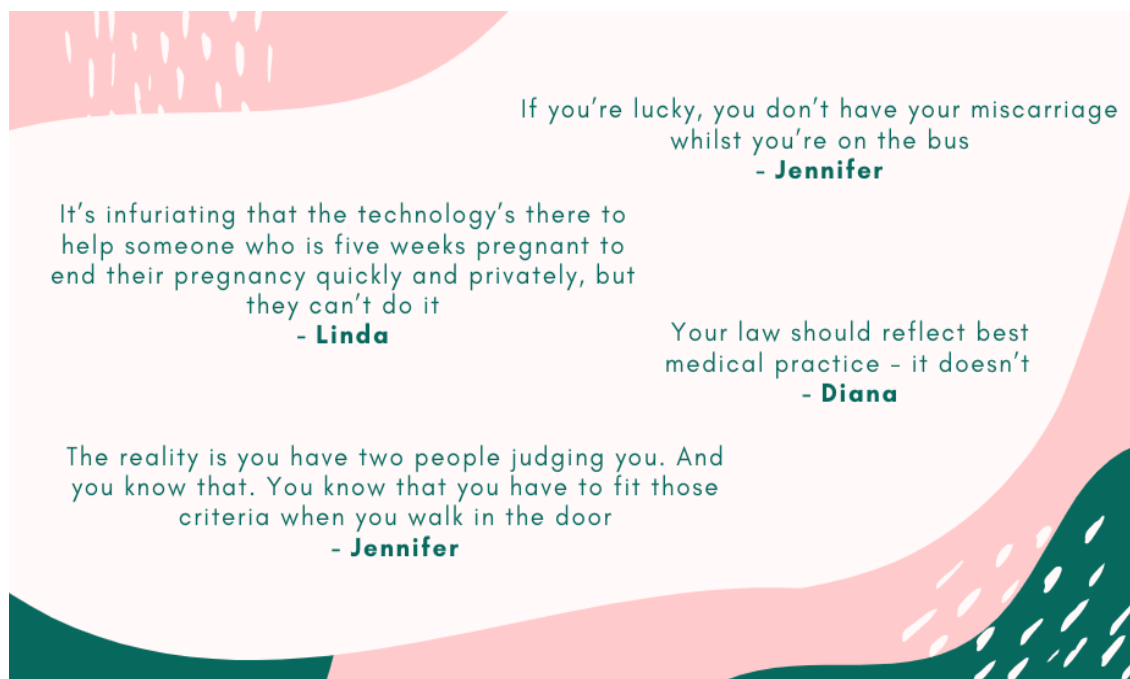
### Hindering formal training

Disinterest in women's health also affects, and is affected by, tertiary training. Aotearoa has no formal, practical, abortion training, and very limited (non-compulsory) theoretical training. People either train informally on-site or are hired already trained from overseas. This situation makes it difficult for Aotearoa to achieve SDG 3, good health and wellbeing (UN SDGs, 2015a). Training poses questions for the future: who will provide training? Who will determine who is 'appropriately' trained to provide abortions? What will the demand for training be, considering current disinterest, stigmatisation and the possible removal of financial incentive?<sup>31</sup> What will the effect on access be?

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<sup>31</sup> See Chapter 4.3. Certifying consultants are paid fees in addition to their salary. A loss of income could cause disenfranchisement via a loss of incentive to provide abortions.

## 6.2.4 System failures resulting from restrictive laws



Quotes on the failings of the current legislation

Participants were almost unanimously negative about the current laws and their detrimental effects on systems, practices, and patients' wellbeing, resources and access. One of the only pieces of praise was that at the very least, abortion is legally accessible for most who seek it in Aotearoa. Current restrictions contribute to a range of system failures for patients and practitioners, that in turn affect access. Under the United Nations International Covenant on Civil and Political Rights, people have the right to self-determination, and freedom from degrading treatment and discrimination (UN, 1976). Sadly, this is not happening in the context of Aotearoa's abortion laws.

### Practice issues

Critiques mostly centred around restrictive laws, funding-models, licenced premises, the siloed approach to care and stories of indignity. Rachel described the health system as "disconnected from the realities of the people for whom it's supposed to serve" (Rachel, 2019). Since 2009, the ASC has provided a voluntary set of guidelines called Standards of Care (Standards Committee, 2018) to abortion providers, although they are not enforceable by law. DHBs aren't necessarily following its guidelines, Morgan said. Linda expressed frustration about nurses doing most of the work but needing a doctor's signature

under the law. Practitioners overwhelmingly would like to have legal and financial support to provide better, more effective and holistic, patient-centred care.

### Delays

Half of all delays happen before a patient reaches a clinic (Silva et al., 2010). Even within major cities, considered 'easier' to access abortion in, Louise spoke of doctors deliberately delaying referrals. She described, "the pregnancy could be 5 weeks [...] by the time they come to us, they can be at 12" (Louise, 2019), representing a significant increase in physical and emotional risk to the patient, as well as causing some to miss the gestational window for an early medical abortion. It was not explicitly discussed why they delay patients, but my assumptions are: consciousness, paternalistic ideas about patients needing more time to think the decision over, delaying them to miss the gestational window, or hoping they will change their mind. Jessica spoke about delays for receiving scans in the public system resulting in the patients who could afford to receiving theirs privately, creating inequity regarding who is resourced to receive timely care.

### Travel and "off-protocol" medical abortion

Medical Abortion (MA) by pills has been a long-standing issue in law. Linda finds it, "infuriating that the technology's there to help someone who is five weeks pregnant to end their pregnancy quickly and privately, but they can't do it" (Linda, 2019). If it weren't for current legislation, patients would be able to take their medication timely and safely at home, as has been successful in Australia (Baird, 2017; Hyland et al., 2018). Further inequalities materialise for those required to travel for service, facing additional structural problems compared to those living in an urban centre. There is limited financial support available for patients required to travel, stay away from home, leaving their support networks, families and children, coming alone to stay in an unfamiliar city for one or two nights to undergo abortion. Particularly if the pregnancy is a later gestation or there is additional bleeding, patients might be required to stay two nights due to concerns over complications. It's very challenging for many patients, as Louise explains, "she's in-between a rock and a hard place because she's not ready to go home to four children [...] they've come down without family knowing. That's the hard thing" (Louise, 2019). The new legislation would allow the health profession to

create clinical guidelines and regulate their sector alongside the Ministry of Health, rather than the Ministry of Justice or the High Court. Any concerns about patients miscarrying in transit could be mitigated.

As noted in Chapter 6.2.1, in urban centres like Auckland, access can be an issue for those who are socioeconomically disadvantaged. Jennifer spoke of the geographic dispersal of the city if one buses to the clinic, assumedly by those who cannot afford to drive or wish to keep their abortions hidden. The legal requirement of abortion needing to be performed on a licenced premise lead some to the unfortunate fear of miscarrying on public transport,

You travel to Epsom Day Unit, take your first set of tablets, travel home, then travel back and you take your second set of tablets. If you're lucky, you don't have your miscarriage whilst you're on the bus. And we think 'it's Auckland,' but actually, on a bus, it could take a long time. It's also a big cost. (Jennifer, 2019)

In response to challenges like the above and the inequalities caused by the current law, some clinics have adopted a method of prescribing medical abortion that was described by some participants as “off-protocol” (Jennifer, 2019), or “extremely problematic” (Kathleen, 2019). Although, this is subjective and debatable by practitioners, as the method could be considered ‘best practice’ depending on the patient’s resources and circumstances. In considering the patient and their needs, the patient may take both pills simultaneously to reduce the number of appointments they need, therefore reducing associated costs such as time, childcare, petrol or accommodation. In this way, the patient only need return if more intervention is required. Jennifer explained her personal stance,

There are some people who are choosing to use a regime that is less effective, more likely to have a continuing pregnancy, because they can give it all on one day which means people only have to travel once and also because they're taking it all at one time they're less likely to miscarry on the way home because it'll take that bit longer for it to happen. So we're actually choosing something that is suboptimal, that is not best practice, because we can't just give it to the women to take home and take at the

time which is convenient for her, which is probably the weekend or some day when she's not working. (Jennifer, 2019)

A study by Creinin et al. (2007) examined the effects of taking the pills simultaneously versus at different time intervals. Across 1,128 subjects, they found "women can use regimens with vaginal misoprostol<sup>32</sup> without any time delay between medications with efficacy that is similar to those with a delay" (p. 893). The study suggested that the outcome is similar if both pills are taken simultaneously, but patients experience more adverse side-effects compared to taking the medication 6-8 hours apart.

Participants emphasised that patients should have choices in the matter of administration, which is difficult under the current law. The proposed legislation, supported by practitioners, would mean that patients could take their pills home with them, a solution that balances their circumstances with the most 'effective' administration of pills. RJ would be supported by this option, by providing patients improved, easier access and enable them to make the best choice for their circumstances.

### **'Exceptionalist' laws and the little space for honest conversations**

Participants also critiqued how the law forces patients and practitioners to navigate 'exceptionalist' laws (Leask, 2015), leaving little space to discuss feelings honestly without the risk of being denied an abortion. Jennifer explained the difficulty,

We try and provide care as much as possible across the country, but the reality is you have two people judging you. And you know that. You know that you have to fit those criteria when you walk in the door [...] Having a therapeutic relationship with someone is very, very difficult when you've just been their judge (Jennifer, 2019).

Hannah et al. (2019), who are nurses and midwives, write about the moral ambiguity of abortion decisions and services. Current legislation, they discuss,

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<sup>32</sup> Misoprostol is the second abortion pill. The first is mifepristone.



takes a “tick-box” approach to conversations (Hannah et al., 2019, p. 5). This space assumes abortion is amoral and forces patients into categories of mental health, crime and women’s rights. It leaves inadequate room to address the moral ambiguity and considerations that many people face in the abortion decision in reality.

### **Moral ambiguity**

Hannah et al. (2019) also critique the women’s rights approach, arguing that instead for many, an in-between space exists outside of the pro-life/pro-choice binary, mirroring the reflections of Beattie (2010) and Smith (2005). As they state, “for many women, a foetus is ‘not nothing’” (Hannah et al., 2019, p. 5). This sentiment was echoed by some participants in my study. Abortion is a decision that no one takes lightly, not patient, nor practitioner. Half of the abortion practitioners mentioned the emotional difficulty they sometimes face when doing abortions.

Especially salient in conversations about holistic care was the space that Māori women generally occupy. Theirs could perhaps be considered an in-between space. Culturally, foetuses are considered whakapapa, a taonga that has wairua before birth (Le Grice & Braun, 2017). For Māori especially, moral and philosophical deliberations may be much harder and binary arguments inadequate in acknowledging their in-between position. If a foetus is considered to have wairua, the Western, ‘my body my choice’ type arguments could actually be offensive and marginalising.

### **Hostile environments**

Some participants expressed concern over some environments being hostile. One participant felt it was inappropriate that support people weren’t allowed into the room during the procedure at most clinics. I learnt of at least one clinic that required patients to show ID before entering. Even though practitioners try to provide the best care, “the practitioners are trying to utilise concepts like manaakitanga, embracing people, but people turn up and the oppressiveness of the context, combined with the stigma of abortion, has just got them pissed off” (Rachel, 2019). Consequently, these environments affect patients’ experiences and feelings of safety and welcome.

### 6.2.5 Cultural competency



Quotes concerning cultural competency in abortion care

As discussed in Chapter 3.5, cultural competency is essential in reducing health disparities between patients (van Ryn & Fu, 2003; Abrishami, 2018), key components addressed by development and RJ. In an Aotearoa context, cultural competency is essential for upholding cultural safety for Māori and other cultural communities, Te Tiriti o Waitangi, the customs and beliefs of all cultures, and the safety of all genders and sexualities (Papps & Ramsden, 1996; De Souza, 2015). However, literature on abortion and Māori is scarce. Laurance (2019) found that inadequate health policy leads to issues of cultural incompetency, which can in turn increase prejudice and discrimination and harm patients' cultural safety (Lee, 2016). McCulloch and Weatherall (2017) discuss improvements to cultural competency being able to materialise via law change by allowing practitioners a broader ability to uphold cultural practices. The ASC Standards of Care document expresses,

Service providers can express manaakitanga in diverse ways. Manaakitanga can be inferred through a warm and welcoming smile or physical procedures such as a caring touch. It may also be inferred through conversation that creates a space to allow people to open up,

share, and feel safe in doing so, or through humour that makes people feel included and put at ease. (Standards Committee, 2018, p. 1)

### Sufficiency and holistic care

Opinions were mixed on the sufficiency of cultural competency amongst providers. Almost all participants emphasised the desire to be able to provide better patient-centred, holistic care, so that patients feel empowered and safe to access services. Most participants expressed that *individuals* took great care to respect cultural competency but *systems* as a whole are not sufficient and could be improved. Focusing on patient-centred care and validating their patients' needs was participants' priority regardless of culture, gender or sexual orientation. However, our health systems are designed in a Eurocentric manner. Ettie explained,

A key problem that I see in nursing and in healthcare generally is that there's been the rigorous adoption of concepts such as cultural safety, te whare tapa whā, Mason Durie's concept of holistic healthcare from a Māori worldview. Nurses are assessed on cultural competency, etc. So, there's a whole lot of rhetoric that, from my view, makes people believe they are working in a bi-cultural, culturally safe way. Whereas for the most part, our healthcare organisations are strongly biomedically-driven and are strongly monocultural. And so, to access our services is alienating and terrifying for a lot of people. Their needs don't get met. (Ettie, 2019)

### Māori culturally-informed practices

A homogenised Māori worldview on abortion does not exist, Maria emphasised, mirroring the research of Le Grice and Braun (2017). However, understanding the ideas of conception in te ao Māori is an especially important aspect of cultural competency (Papps & Ramsden, 1996; De Souza, 2015). Emily spoke of some Māori offense and disinterest from Māori in performing/receiving abortions, reflecting the dominant discourse surrounding Māori and abortion (Le Grice and Braun, 2017). She said, "The idea of killing whakapapa [...] While Māori women do do it, it's not something they're happy with" (Emily, 2019). Rachel offered additional insights into the significance of conception and whakapapa in te ao Māori,

[...] a new conception that has not coming into being. In birth, we talk about shifting in between different worlds - te kore, te po, te ao marama. So, the conception hasn't reached te ao marama - and that might not just be in the physical form, but in terms of the woman and their whānau's hopes, aspirations and dreams for the developing embryo – what could have been a baby. I don't think there has been spiritual support for Māori in abortion services that acknowledge the fundamental importance of the spiritual wellbeing of the woman, of the whānau, and of the loss of conception. (Rachel, 2019)

Some of the practices that some clinics are using to support cultural competency, many surrounding Māori customs, are the following:

Table 7

*Examples of culturally-informed practices in use by abortion providers in Aotearoa*

- Waiata
- Whānau care services
- Kaumātua regularly blessing the practice
- Water in the room
- Allowing support people with the patient during the procedure
- Providing transgender services.
- Offering Japanese jizo statues<sup>33</sup>
- Ceramic burial pots<sup>34</sup>

Note. Information summarised from interviews.

Rachel expressed that improving access for Māori, with or without law change, could focus on better sexual and reproductive health education and information.

<sup>33</sup> Japanese statues representing children who have died before their parents. Sometimes used in ceremonies.

<sup>34</sup> One practice had commissioned the local potter to produce burial pots for the products of conception (the removed foetus). Burying the tissue is considered a way of returning the whenua (placenta) to the whenua (land).

She also suggested young people having hypothetical conversations with their parents to gauge their level of support if they were to face an unplanned pregnancy. Participants generally expressed the need for both Māori and Pasifika people who have had abortions to be specifically asked what they would want in abortion services. In regard to Māori practitioners, Morgan and Rachel supported encouraging more use of te reo and more Māori practitioners as “they are a valuable resource to their own people” (Morgan, 2019). Rachel also suggested bringing in a specialised women’s health kaumātua. Rachel hopes for more Māori practitioners who are proficient in te ao Māori, social justice, equity and queer understandings. This would help to improve access and the achievement of RJ for a range of people, particularly those of whom were identified as the most disadvantaged people for abortion access (Chapter 6.2.1).

### **Disconnected realities: Māori, and gender identities**

It appears there is a disconnect between patients’ lived experiences and cultural competency in academia and politics (Joffe, 2013). For example, Christina said, “most of the Māori women I treat are just ordinary, ordinary people that actually aren’t that attuned to those sorts of cultural issues” (Christina, 2019). In another example, one apparent disconnect was the gender-inclusive language of ‘pregnant people.’ Maria said, “I am personally starting to use that language [...] to be a little bit more inclusive” (Maria, 2019). However, others expressed that most women do not identify with that term and it can complicate their experience of abortion (which, conversely, could be said for people excluded by the word ‘women,’ too). One participant expressed how that did little to validate the lived experiences of the women in front of her. Morgan mentioned they had a trans service available but were yet to treat a trans person in their entire career. They said that people identifying as lesbians came in at times, but they personally treated everyone with the same dignity and respect. Patient-centred care was again emphasised, “Hopefully, you wouldn’t feel that it would matter [their ethnicity, gender or orientation]. Address that person’s care directly” (Morgan, 2019).

### **Pasifika, migrants and the religious**

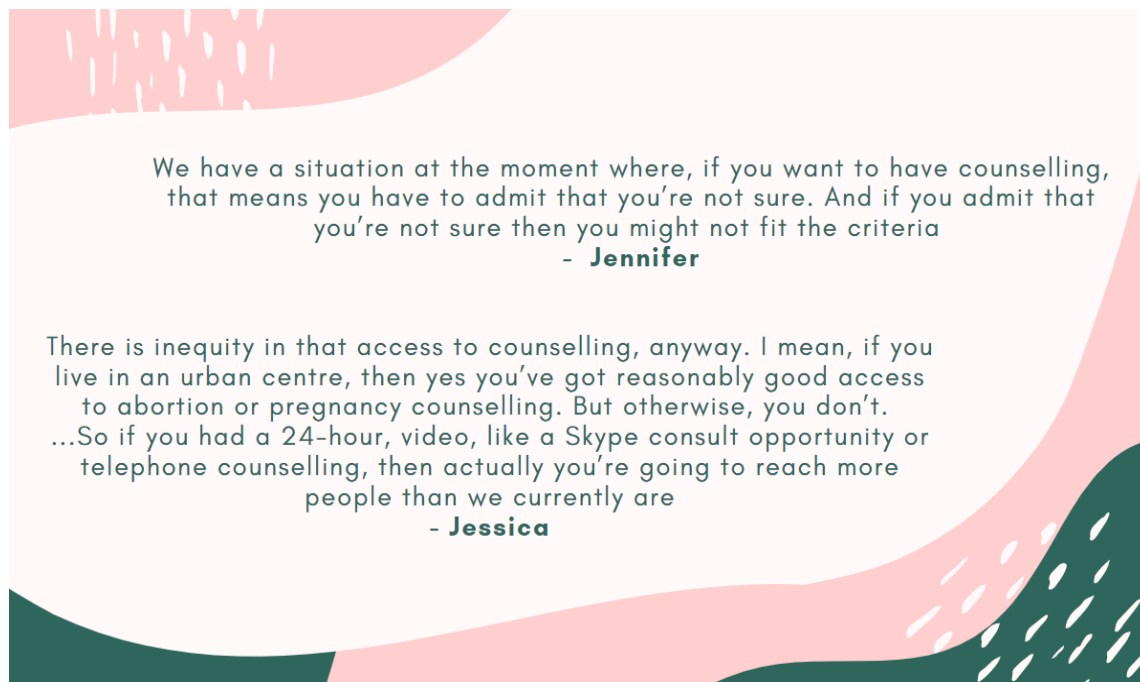
Practitioners spoke of cultural competency and Pasifika people, mostly addressing that Pasifika communities often had deeply held religious beliefs that

conflicted with their decisions to abort. Louise expressed the challenge for practitioners of balancing cultural and religious beliefs with physical safety. For some people, she said, “They don’t like hospitals, they don’t think it’s God’s way, you know, if something’s going to happen [...] We’ve got to honour what they want [...] But also need to make it safe so the woman survives” (Louise, 2019).

Christina spoke of non-residents, particularly new immigrants, being unable to access publicly funded abortions and the cultural challenges that followed, mirroring Nakae’s (n.d.) expression that migrants can face additional challenges to RJ. For example, sometimes ‘interpreters’ came along with them who were actually family members. The ASC (2016) has raised concerns about family acting as interpreters due to possible coercion or misrepresenting the translations. The ASC advises that “only reputable services with suitably trained interpreters be used” (ASC, 2016, p. 8). Having translators is another way that abortion services can be improved to uphold patient’s holistic safety and access, free of misinterpretations.

To summarise Chapter 6.2.5, cultural competency is essential for respecting patients’ cultural safety so that they can feel safe, welcomed and informed throughout their interactions accessing services.

## 6.2.6 Counselling



Quotes on current and future counselling access and associated concerns

Abortion-related counselling is offered at all clinics, free of charge, pre- and post-abortion, and can help people with their pregnancy decision. Emily and Jessica suggested telephone counselling as an option to overcome geographical barriers in the future, whether or not the law changes. Counselling support for abortion decisions can be very beneficial to abortion-seekers as they contemplate all of their options, thoughts and feelings. Theoretically, counselling provides a safe space to consider termination or continuation of pregnancy while simultaneously investigating matters such as contraception, coercion and abuse. However, Aotearoa's 'exceptionalist' laws (Leask, 2015) make it difficult for patients to be honest and open about their reasons for seeking an abortion. On this note, Emily opined that most counselling was inadequate for dealing with the "heart of the matter" for many people (Emily, 2019). Louise was told anecdotally by a counsellor at another service that many people were coming back for post-abortion counselling.

### Compulsory or not? Safety, coercion, and empowerment

Compulsory counselling is a source of debate, calling into questions matters of bodily autonomy, choice, RJ and empowerment. Participant opinions were mixed. Cynthia and Louise felt very strongly about compulsory counselling for patients.

For example, Louise said it's "non-judgemental, safe [...]" And they've seen six people before we've done the termination. And we're still always questioning, 'are you sure this is what you want?'" (Louise, 2019), ensuring that the patient is making their best choice. Several participants felt that because a patient is legally required to see many people, as well as some clinics requiring that a patient undergoes counselling, the current system offers some form of protection against coercion. Louise spoke in favour of compulsory counselling,

They [counsellors] know how to open somebody up and they know when somebody needs a bit more time. If they're not sure they'll bring them back for another appointment. And sometimes then those women don't go through because they've been given the pregnancy option. It's not just an abortion option. It's that whole picture. They look at family violence, they look at child protection. (Louise, 2019)

However, for the same reasons some supported compulsory counselling, others opposed being forced to undergo counselling in order to access abortion. Rachel felt that counselling was often pushed unnecessarily due to an inherent assumption that abortion is traumatic, "in which case some women are like 'What? I don't feel anything about having an abortion, I know what I want, and I don't need counselling'" (Rachel, 2019). Kathleen pointed out, "according to the New Zealand Association of Counsellors [...] counselling really only works if it is voluntary" (Kathleen, 2019). Jennifer disputed that the law provides protections, expressing,

In the present situation, you have to tell a story that will jump through hoops [...] to two people. It is very hard to be honest [...] Particularly when you have to tell the same story twice or at least a story that is going to fit twice. It's much easier to actually be honest and to share your concerns [...] if you want to have counselling, that means you have to admit that you're not sure. And if you admit that you're not sure then you might not fit the criteria [...] You feel like if you admit you're being coerced you then lose your option. (Jennifer, 2019)

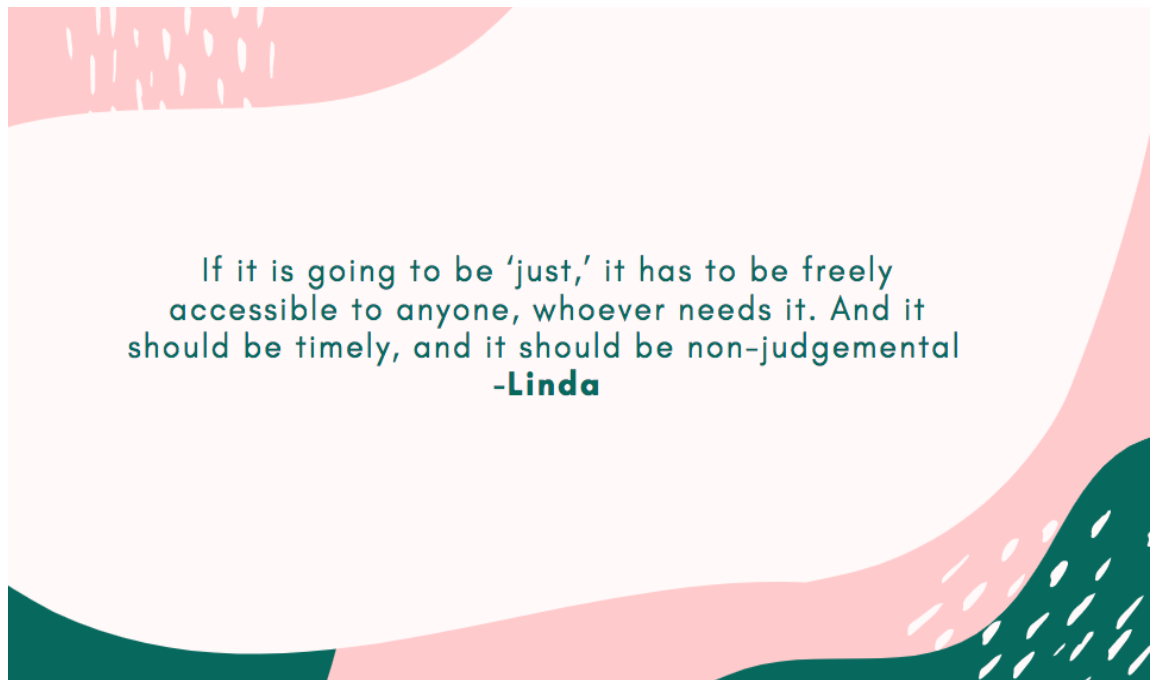


From different perspectives, both approaches strive to provide the best for patients and uphold their RJ, choices and safety.

#### 6.2.7 Summary of the current context

Section One has examined the current context of abortion access, addressing the substantial issues of access that exist because of: laws, geography, socioeconomic disadvantage, IPV, deprivation, stigma, disinterest in SRHR, system failures, CO and cultural competency. Recalling the definition of RJ, patients' "physical, mental, spiritual, political, economic, and social well-being" are severely impacted in the current environment (Asian Communities for Reproductive Justice, 2005, p. 1). The "power and resources to make healthy decisions about [...] reproduction" vary greatly between different groups in society due to their personal circumstances. These can be systematic, for example, socioeconomic status (Urale et al., 2019) or the ongoing effects of colonisation (Smyth, 2000, as cited in McCulloch & Weatherall, 2017; Leslie, 2010). Following, Section Two examines what the abortion context could look like in the future, particularly, what might access look like and how to improve it.

### 6.3 Section Two: What might 'access' look like under the law change?



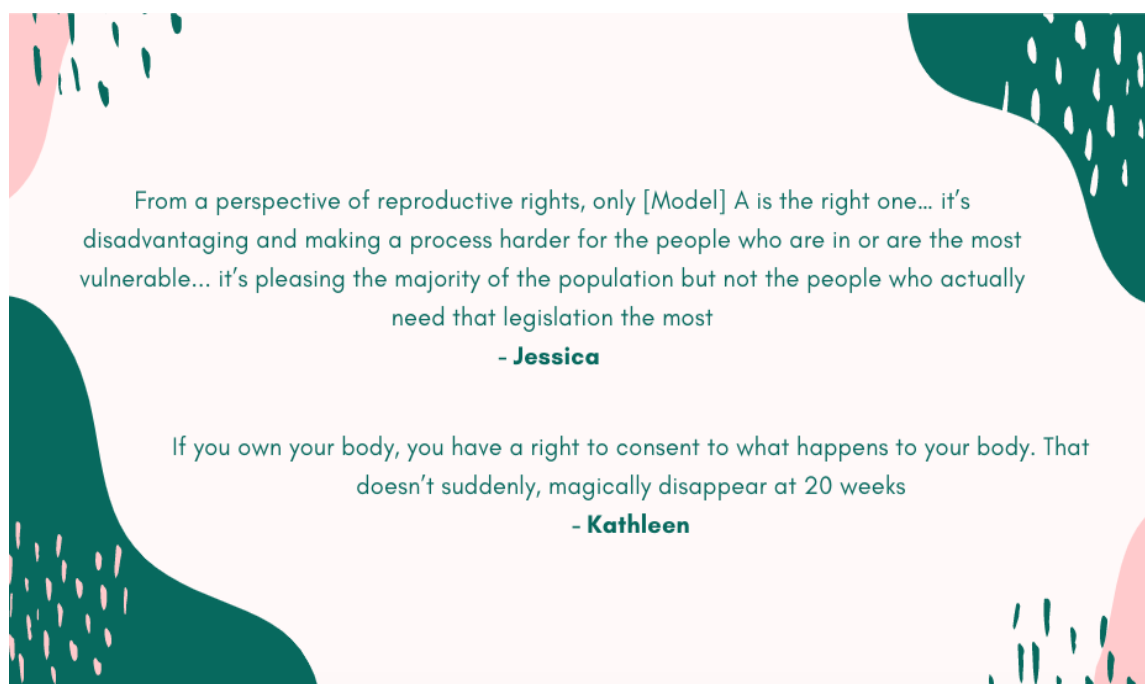
Quote regarding Linda's hope for RJ

Now that the present environment has been examined, considering what access looks like for different people in society, the following section turns to what the future environment might look like, whether the law changes in 2020 or not.

Participants were largely supportive of reform. Almost all agreed that access to services would be improved without the need for two certifying consultants. As discussed previously, it is well documented that once an abortion decision is made, timely access to services is best for patients as physical and psychological risk increases with gestational age (Silva et al., 2010). Aotearoa's current legislation results in an abortion environment which is averse to patients' health and wellbeing. Women are still not trusted to make their own decisions and are pathologised by a paternalistic law (Leask, 2013; McCulloch & Weatherall, 2017; Erdman, 2012). The proposed legislation would be a partial solution to some issues of access, timeliness, equity, bodily autonomy and human rights. Access to abortion could be improved via reform (in time), telemedicine and MA. People would vastly be able to make better choices for themselves and their whānau, assisting in the achievement of RJ.

However, participants expressed concerns about the future of abortion care and many uncertainties remain at the present time. Even if the law changes, some barriers to access would still remain such as stigma, rural access and persistent socioeconomic inequalities. Although a vast improvement to current legislation, Model C imposes arbitrary gestational limits that will affect people in emotionally vulnerable situations. The availability of surgical abortions could be threatened before access improves, like in Australia (Baird, 2017). It is unknown how systems will respond, how long this will take, and where funding will come from. To begin with, 6.3.1 examines the government's decision of Model C.

### 6.3.1 Conservative Model C, a “political decision?”



Quotes regarding the collective disappointment of a Model C announcement

Most participants felt disappointed, yet unsurprised, at the choice of Model C by the government, which would require approval after 20-weeks gestation. Health professionals and pro-choice campaigners had championed Model A (Molyneux, 2019), as Model A was acknowledged by the sector as the only model that ensured bodily autonomy for abortion-seekers. Sustainable Development Goal 5.C - *Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels*, could only be realised if Model A were adopted, for these reasons. Linda, who has three decades of experience as a sexual health nurse, described Model

A as the “only sensible thing,” and Model C as “a step in the right direction [...] It’s just helping get them across the line” (Linda, 2019). Maria had this to say:

I was at the hui where every single professional group was represented at the Law Commission. Everybody voted for Model A. Every single group [...]. there were nurses, midwives, social workers, counsellors, RANZCOG,<sup>35</sup> APGANZ, GPs, Ministry of Health, various DHBs, Family Planning and sexual health providers [...] There were about 40 people there representing every single stakeholder on the provider side that you could think of. (Maria, 2019)

Much like the media, participants suspected the choice to go with (a conservative version of) Model C was a political decision, influenced by New Zealand First<sup>36</sup> (Coughlan, 2019; Satherley & Prendergast, 2019). Participants celebrated the fact that for most abortion-seekers, the proposed legislation addresses their needs. For the 0.6%<sup>37</sup> of people who have abortions after 20 weeks (Picken, 2018), a statutory test must be met. A statutory test again places the decision to abort in the hands of a practitioner, continuing the denial of people’s human rights (UN, 1976). As in the opening quotes, Kathleen expressed, “if you own your body, you have a right to consent to what happens to your body. That doesn’t suddenly, magically disappear at 20 weeks” (Kathleen, 2019). ALRANZ, in response to the decision, released a media statement that read, “pregnant people make life-altering decisions every day [...] without the approval of some random authority figure. Deciding to receive abortion care is no different” (ALRANZ, 2019, para. 5). Diana pointed out that practitioners would always be involved at 20 weeks, anyway, rendering the test a political decision.

### The tragedy of late-term abortions

Jessica expressed a feeling of injustice about Model C as it would impact people who are arguably the most vulnerable - those having late-term abortions.

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<sup>35</sup> The Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

<sup>36</sup> The current government is a coalition of Labour, the Greens and New Zealand First (NZF). Model C was announced and almost immediately, Winston Peters of NZF, requested a referendum on the matter, “at odds with a recent interview given by his senior MP Tracey Martin” the day before. Mr Little (Labour, the Minister of Justice) “appeared angry” and said, “It’s never been raised with me in the months of discussion we’ve had” (McCulloch, 2019, para. 11-16).

<sup>37</sup> As of 2016.

Participants emphasised often that abortion is not a decision taken lightly. It has an emotional toll on both patients and practitioners, *particularly* those that are late-term. Late-term abortions are tragic situations for families, mostly due to foetal abnormality or a foetus that is incompatible with life. Linda explains, “It’s a loving decision and it’s a family decision. They could go on to give birth to the dead baby. That’s where people need choices about what happens, to be compassionate” (Linda, 2019). Those decisions were made in team settings with the whānau and their wishes.

### Statutory test

At the time of the interviews, one doctor’s approval was needed after 20 weeks. However, the proposed legislation was again amended in February 2020 to require multiple doctors to consult on the appropriateness of the procedure (Abortion Legislation Committee, 2020). I asked some participants how they felt about the lack of clear criteria for the statutory test. What counts as “appropriate” circumstances for a patient’s mental or physical health or wellbeing (Melville, 2019)? Could a health practitioner be taken to court over a subjective interpretation? Participants pointed to a historic liberal interpretation of abortion laws in Aotearoa (McCulloch & Weatherall, 2017), both in terms of abortion provision and CO. Linda had this to say,

I think that’s enabling in a way because it’s then up to the person who is pregnant and the other [people] to figure out whether it’s appropriate. I mean, I think some doctors will feel that they are at risk if there isn’t a clear definition, that someone could sue them or take them to court, or go to the HDC<sup>38</sup> or something. (Jennifer, 2019)

Maria also believed it would be liberally interpreted in favour of the abortion-seeker. Although, Kathleen argued that legally, we might find “appropriate circumstances” being defined in the High Court, similarly to how the requirement to have an MA on a licensed premise was defined there, rather than by the medical community (Standards Committee, 2018, p. 7).

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<sup>38</sup> Health and Disability Commissioner.

### 6.3.2 What will happen if the law changes?

[Ideally] Women who are **most on the margins** would be able to know how to get an abortion, know who could provide it, know where to go, know they will be seen immediately, they wouldn't be given another appointment to come back, so they could drop in. For that process to be as swift as possible, as long as that swiftness suited the woman. And for it not to cost her. So she's not having to come back and pay for parking, for instance... Ideally, it's a **one-stop-shop**, so everything is done so you're not sent away for anything. Why I'm saying for the most marginalised women, is I think **if it can be accessed for the most marginalised women then it's going to suit for everyone else**. So it should be possible to get your scan done and get your pregnancy test done, get your bloods done, get everything done, and get your abortion done, without having to go anywhere new and different, find anything new and different. Because at every one of those transitions, a woman is likely to fall through the cracks.

**Every white middle-class woman will get her abortion. And with the change of law we can be assured that that will happen. But we can't be assured that all will have access under the new legislation.**

- Ettie

Quote concerning a participant's concern for equal access in the future

If the proposed legislation becomes law, abortion will be decriminalised, treated as a health service, modernised and brought "into line with many other developed countries" (Melville, 2019, p. 2). The need for certifying consultants will be eliminated and a broader range of health professionals could provide abortions including nurses, nurse practitioners, midwives and GPs. Participants believed the changes should be nurse-led. The patient could self-refer and would not need approval before 20 weeks. Patients could bypass GPs or Family Planning clinics entirely up to 20 weeks, if desired. Access to services would be improved by reducing the number of appointments needed, allowing self-referral to clinics, and being able to undergo medical abortion (MA) earlier, at home. Telemedicine could be an effective way to reach rural patients. All of these measures would support advancements in RJ.

McCulloch and Weatherall (2017) believe that decriminalisation would also help to reduce stigma. Rachel agreed with this, saying "It creates a more humane space for people who are seen for genuine health reasons to be seen in the appropriate context, rather than being implicitly or explicitly criminalised, within the space of the justice system" (Rachel, 2019).

Because the referral process currently accounts for half of the delays in accessing abortions (Silva et al., 2010), the ability to self-refer suggests that people will be able to access services at earlier gestational stages, easing the risk of complications and/or psychological distress. Less patients would miss the gestational window for a MA, providing them more options. Participants were generally enthused about self-referral. Linking self-referral with bodily autonomy and RJ, Diana described, “self-referral means that you are in charge of your own body and it’s confidential” (Diana, 2019).

What might primary-care practice look like? Abortion would be available at primary-care locations, such as a GP practice (so long as the GP was a trained, non-conscientious objector). Linda explained, “you might go to your GP and say ‘I want to go on the pill,’ or you might go to your GP and say ‘I’m 5 weeks pregnant and I don’t want to be pregnant anymore’” (Linda, 2019). Medical abortions (MAs) would likely become more popular, and Morgan believes that most practitioners would be comfortable providing MAs up to 12 weeks, perhaps to 15, as the care for an early medical abortion (EMA) is very similar to that of miscarriage management. Participants largely supported MA being done in the community (primary-care) so long as practitioners were appropriately trained/accredited, were empathetic and patient-centred, and there were strategies in place for patient follow-up. As stated in Chapter 3.3, the World Health Organization also supports MA in primary-care as it does not require specialist skills, knowledge or equipment (WHO, 2012, p. 67). Most participants supported primary-care for its accessibility, while some were of the opinion that patients receive better care when abortion is an integrated service because they are known to the health practitioners. However, there is uncertainty about the future availability of the abortion pills.

Emily partially agreed with the proposed changes. She agreed that first-trimester abortion should be available “within a community-based, comprehensive sexual and reproductive health service” (Emily, 2019). However, she had a strong concern over the medicalisation of abortion overshadowing the “emotional, social and spiritual aspects of fertility [...] with profound consequences for women” (Emily, 2019), highlighting the importance of RJ and holistic care.

The Bills Digest (Melville, 2019, p. 3) suggests that once amended, under the Contraception, Sterilisation, and Abortion Act 1977, the term “woman” will mean “a person of any age who is capable of becoming pregnant.” This addresses some of the critiques over gendered language provided in Chapter 4.6 (Edmond & Burke, 2017; Justice Committee, 2017; ASC, 2016; Kirk, 2017), but does not make mention of the term “doctor” being referred to with he/him pronouns.

### 6.3.3 How might systems transition to a new law?



Quote concerning the quality of care under new legislation

Legally, if the Abortion Legislation Bill 2019 passes, it will come “into force on the day after the date of Royal assent” (Melville, 2019, p. 2). Practically, however, services won’t adjust overnight. Ettie expressed, “Everyone will heave a sigh of relief and then we will have to start to find processes of how these services are going to be integrated into the community” (Ettie, 2019). Her quote echoes the relief that practitioners felt in Victoria, Australia, post-reform of their ‘exceptionalist’ laws (Baird, 2017). Participants believed the changes could take many years and access could worsen before it improves (expanded in Chapter 6.3.5). Systematic changes, training, funding and telemedicine services will collectively take years to materialise. The Guttmacher Institute has stated,

legal reform is not enough in itself. It must be accompanied by political will and full implementation of the law so that all women— despite inability to



pay or reluctance to face social stigma—can seek out a legal, safe abortion. (Singh et al., 2017, p. 5)

Presently, there is much uncertainty. Practitioners aren't even aware at this stage if they would need to sign anything after 20 weeks, let alone larger system overhauls. As an example of slow responses, Linda highlighted that MA has been available since the 1980s, yet it only became popular in Aotearoa around 2006.

### Community care

There are uncertainties around whether or not GPs/community practitioners would choose to engage with abortion care, leaving questions of access in smaller communities uncertain. Christina believed they would, slowly. Several participants were concerned about the quality of care that could be offered in primary-care settings, particularly, that inexperienced practitioners wouldn't be ready to provide the same level of care and empathy. In the study by Snook and Silva (2013), there were initial concerns that community-based services wouldn't be safe or effective. However, this type of care was successful at providing services in high-need communities, with low resources, under a restrictive law. The question must then be asked, why aren't more of these community clinics available? Participants suggested it was due to a myriad of factors that affect the 'disinterest' in women's health, discussed in Chapter 6.2.3. Rachel had been at a conference overseas where these concerns were prevalent,

The doctors were making a case for the importance of monitoring the health of the woman after taking the pills, while the community volunteers were pushing back and asking why there couldn't be solutions that supported better access to early stage abortion in the community. (Rachel, 2019)

Christina raised the point that in healthcare, a compromise exists between a concentration of expertise and easier geographic access. Jessica emphasised that care "needs to be safe care, both in terms of the procedure and how they treat the person [...] the last thing we want is for a GP to say [...] 'here are your pills and off you go'" (Jessica, 2019). Linda believes, "the more people that

become skilled at supporting people to get an abortion early in their pregnancy, the better it is” (Linda, 2019).

### **The future of willing practitioners**

The stigmatised and siloed nature of abortion care has contributed to the current small pool of practitioners and a lack of formalised training. Participants were unsure whether there would be increased interest in abortion training, and whether that would be organic or via compulsory modules. Some participants emphasised the unpleasant aspects of their roles which they believed acted as a deterrent to people choosing to practice abortion care. As such, large gaps in abortion care could still exist if the legislation passes and could remain that way for an undetermined length of time. Although opinions varied on future interest, Morgan believed that the current generation of doctors were much more comfortable with abortion as part of general medical care than previous generations, providing hope for the greater availability of willing abortion providers in the future. It appeared that future training on providing abortions could become available through medical colleges. Ettie discussed,

There would have to be a major upskilling process [...] who wants to deliver this care, how will we deliver it [...]? It will be much easier with the law change to access a medical abortion. Because there may be many more practitioners who can get up to speed with that much more quickly than providing surgical abortion. So, we need practitioners in rural and remote areas who can provide surgical abortions. (Ettie, 2019)

### **Future funding**

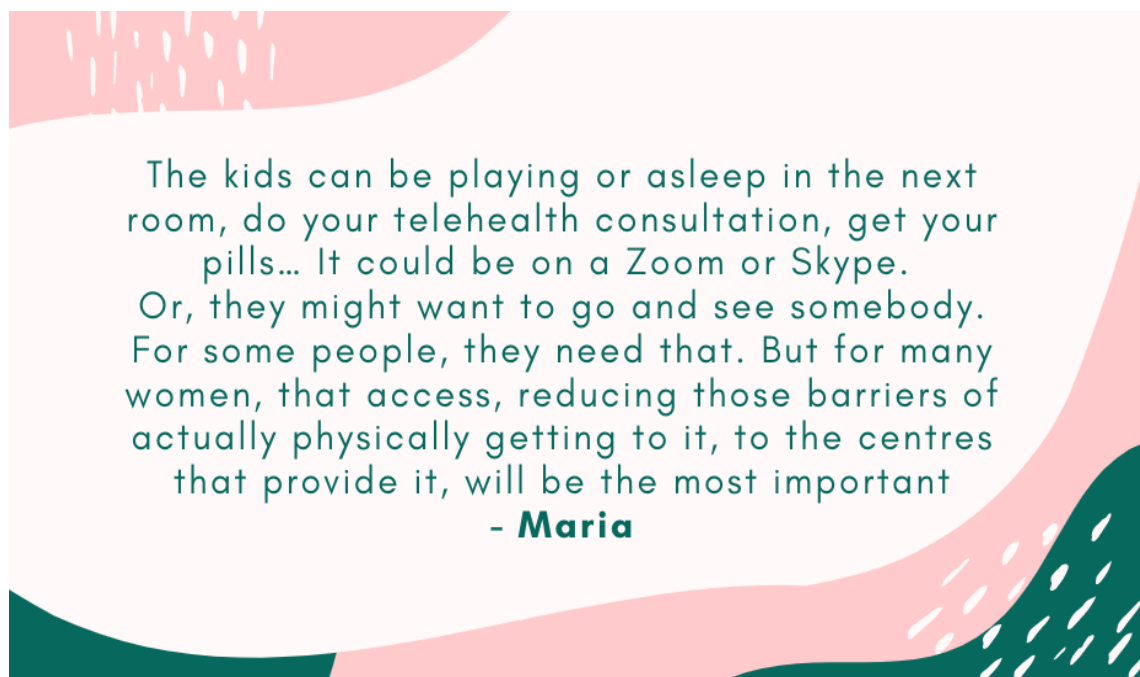
Funding is a major area of concern and uncertainty. Currently, abortion care is funded by each DHB. If legislation passes, will funding continue to be channelled through DHBs (considered a cause of the ‘post-code lottery’ by participants) or will it be nationalised? Participants suggested that the best funding approach would be similar to maternity care, a nationally funded service. Will the procedure remain publicly funded or become a neoliberal model, as occurred in Australia (Baird, 2017)? Jennifer explained that the Bill asserted the need for counselling to be funded but states nothing about abortion remaining free for patients. What

part will the Ministry of Health play? Will providers' loss of income via certifying consultant fees be attended to - a significant portion of their income?

### Future training

As for training, Christina would like to see every future abortion provider complete a Te Tiriti o Waitangi course. Maria would like to see bias and attitudinal training. Jessica and Jennifer would like to see obligatory abortion training under obstetrics and gynaecology (O&G). All of these suggestions support advancements towards access and RJ. Jennifer pointed out, "you would never become a truck driver and then say, 'I won't drive red trucks.' Why would you do O&G if you don't agree with abortion when abortion is clearly a part of O&G?" (Jennifer, 2019). Ettie believed future training should come from a combination of academic and practitioner educators to provide "truly holistic, women-centred healthcare" (Ettie, 2019). Perhaps the question ought to be, 'how to improve *interest* in complete gynaecological healthcare?'

#### 6.3.4 Is tele-abortion the answer to access inequities?



Quote regarding the potential of abortion-seekers to make better choices for themselves

Overwhelmingly, telemedicine was suggested by participants as the option with the most potential to overcome the geographical, financial and time barriers to abortion services, hence providing more equitable access. In fact, telehealth services are already popular in Aotearoa. Registered nurses speak with

approximately 290,000 per year covering an array of helplines such as 1737 or the Alcohol Drug Helpline, via The National Telehealth Service (Ministry of Health, 2019). Telemedicine abortion services are common globally, offered by organisations such as the Tabbot Foundation (Tabbot Foundation, n.d.) and Women on Web (Women on Web, n.d.). Tele-abortion could be re-instated, similar to 0800-Abortion. Tele-counselling is also a possibility. Maria believes a future centralised, national telehealth service wouldn't be expensive and should be funded by the Ministry of Health. She argued, "they're saving \$4 million in Ministry of Justice fees – that money needs to go somewhere" (Maria, 2019). Additionally, participants suggested that telemedicine consultations could be valuable in reutilising the skills of abortion practitioners, providing options for the redundant certifying consultants who might otherwise become disenfranchised and choose to stop providing.

Maria makes an important distinction in the opening quote above. Some people prefer to see health professionals or counsellors face-to-face. That option wouldn't be removed if the law changes. But for those who face varying barriers, or for those who wish to retain anonymity, telemedicine could be a safe and viable option. Providing people timely options assists in upholding RJ. Regardless of whether the law changes, telemedicine is an option, but political willpower and funding could be barriers.

How might telemedicine work in Aotearoa? Similarly to in Australia, an abortion-seeker could phone or videoconference a centralised service to have an initial screening with a nurse and/or arrange counselling. The nurse would decide whether an early medical abortion is appropriate given the gestational age of the foetus and factors such as access to emergency care. If so, a script and guidelines might be emailed to a local pharmacy for the abortion-seeker to collect their pills. Or, they might receive pills couriered by post. The patient would take the pills, following instructions. They could likely bypass their GP, if desired. They would be monitored by nurses online/by phone and could call at any hour with any concerns. Patients would be informed about what measures to take in case of complications. Several weeks later they would take a low sensitivity urine pregnancy test and/or blood tests to check if the abortion was successfully completed.

## Telemedicine concerns

Not everyone I interviewed was enthusiastic about telemedicine. Some were ambivalent or against it. Emily expressed distaste at the idea, remarking how face-to-face contact is sometimes taken for granted, as is education, and demonstrates how RJ can materialise differently for different people: “The idea of an 0800 number for this sort of work makes me feel unwell. I mean, it might be alright for an articulate person who can understand things, but you know, not everybody has the reading age of 16” (Emily, 2019). This is a valid concern and patients in this scenario would require effective screening and monitoring or face-to-face consultation. It could be the case under telemedicine that an abortion-seeker needn’t see anyone at all. Ettie has concerns over this,

One of the reasons I’ve been ambivalent about women being able to abort in pills over the counter, is it can be incredibly helpful to meet a safe health practitioner and have somebody you can talk to in privacy and in confidence about ‘how come you’re pregnant and do you want this to happen? Can I be of help to you? Is there information I’ve got that could be helpful for you and your life? And by the way, while we’re here, are you safe in your relationship or not? Is there any other information you need? Have you had a sexual health screen lately?’ You know, that wonderful opportunistic work that practitioners can do. (Ettie, 2019)

## Telemedicine, in summary

As the option with the greatest potential to reduce access inequalities according to these findings, the benefits and concerns of telemedicine are summarised in the table below:

Table 8

### *Advantages and concerns of tele-abortion services*

Advantages of tele-abortion	Concerns & questions of tele-abortion
<ul style="list-style-type: none"><li>• Overcome geographical, financial and time barriers by making EMA and counselling accessible locally</li><li>• 24/7 medical advice</li><li>• Confidentiality - if desired, the patient's regular GP doesn't have to find out. Especially relevant for some in small communities</li><li>• Reutilises practitioners' skills</li><li>• Patients would have better options regarding taking pills apart or together</li><li>• Ensures access to specialised, empathetic practitioners</li><li>• Reduces discrimination of access</li><li>• Upholds achievement of reproductive justice</li></ul>	<ul style="list-style-type: none"><li>• Only available up to a certain gestation</li><li>• Depends on the availability of nearby emergency care</li><li>• Physically appearing at a practice gives the option to provide greater holistic care such as checking for STIs, coercion or IPV</li><li>• Who will fund this?</li><li>• How will follow-up and monitoring be done?</li><li>• Interest and uptake (tele-abortion is legally possible now, yet it isn't available)</li><li>• Access to MA threatens demand for surgical abortion (next chapter)</li></ul>

*Note.* Information summarised from interviews.

### 6.3.5 Could the proposed legislation actually worsen abortion access?



Quotes regarding the concern of practitioners over possible abortion access decreases in the short-term

A major concern of participants is that reform could cause prolonged in-access to abortion prior to its improving. Christina expressed, "Access to surgical abortion could be threatened by the increase in medical abortion" (Christina, 2019). Why is this the case? Firstly, participants predict that demand will adjust in the favour of medical abortions, decreasing the demand for surgical. Reduced demand for surgical abortion, in turn, could mean that surgical services might become too expensive to keep open, particularly in smaller centres. "It's thousands of dollars an hour to have a theatre dedicated to surgery," explained Christina. Patients requiring or electing surgical abortion might have to travel to larger centres, or may miss the gestational window for MA. This trend in demand is also predicted by the Government (Ministry of Justice, 2019) and is consistent with the Australian example (Baird, 2017). Indeed, private surgical clinics in Tasmania, Australia, closed once the Tabbot Foundation started offering tele-abortion services (Baird, 2017).

Cynthia and Louise pointed out that some abortion-seekers opt for surgical abortions because they can get long-acting reversible contraceptives (LARCs) inserted simultaneously. Inadvertently, the popularity of the Mirena, which

became funded in November 2019 (Feek, 2019), could partially offset an expected increase in MA post law change.

Secondly, the proposed legislation in its current form does not specify that abortion would remain free for New Zealand residents. If a free-market approach prevailed, such as prevailed in Australia (Baird, 2017), services could become expensive and exacerbate existing inequities.

Thirdly, the government must address the potential funding shortfall of certifying consultant fees. Certifying consultants are usually the ones who perform the abortions. Christina explained, “Each certificate I sign, I get \$150. So, if I do 10 abortions in a day, I’m actually getting \$1500 from the Ministry of Justice [...] more than half of my income is actually coming from the Ministry of Justice” (Christina, 2019). With the removal of abortion from the Crimes Act (which comes under the Ministry of Justice) and a redundant need for certifying consultants, current certifying consultants could lose a significant portion of their income. It’s uncertain if the funding shortfalls would be met and if practitioners would continue to provide/travel if they were not compensated. This could affect the availability of services in the short-term.

### Concerns over MA

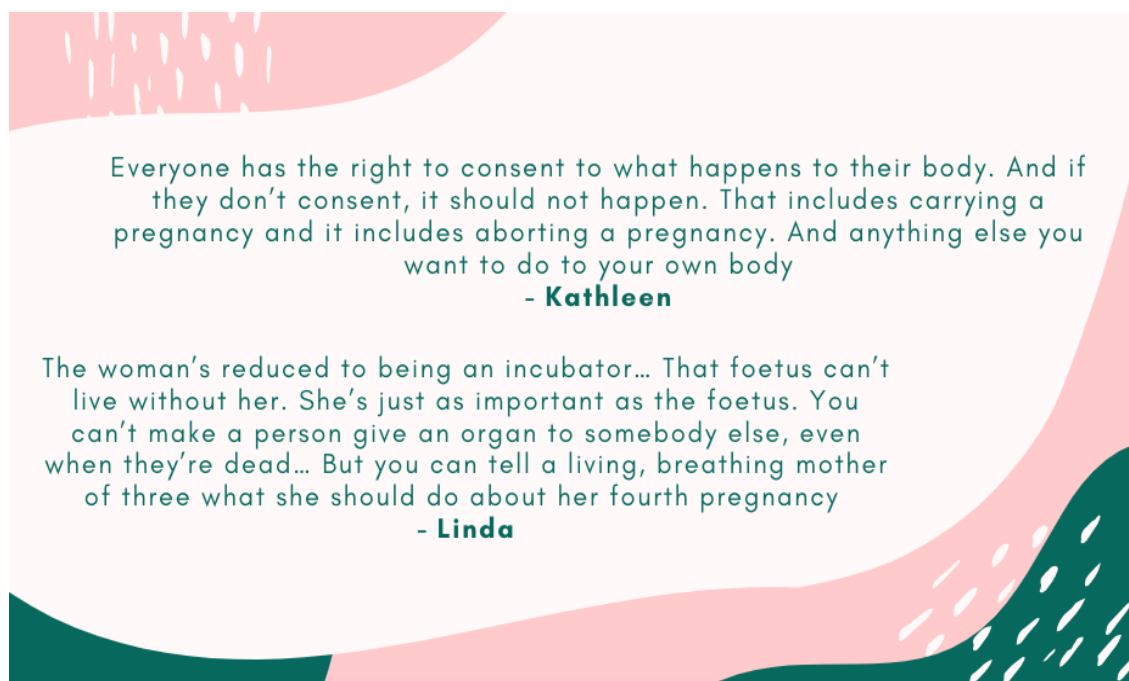
Some participants indicated that the pills, despite their potential to make access more equitable, are not the be-all-and-end-all of abortion access. An increase in MA could mean an increase in acute admissions, Christina explained. “Medical abortion has a re-admission rate of about 5% because of retained pregnancy tissue or too much bleeding. Surgical has a readmission rate of 1% or 2%” (Christina, 2019). Admissions leave patients vulnerable to staff who may not be empathetic to abortion. They also have privacy implications for patients trying to abort discreetly, as acute admission staff could see “all the abortion notes, social work notes, reasons for wanting an abortion. Any other admission that woman has for any other reason” (Christina, 2019). Emily warned that “the pills are not a walk in the park [...] They’re very, very aggressive” (Emily, 2019). Jessica discussed how some patients find the emotional burden of a medical abortion greater than that of a surgical abortion. Patients might opt for surgical for those reasons.



## Transforming access

Access, therefore, would transform but, while it may reduce inequalities in some cases, there may still be access issues to address for quite some years. Despite the uncertainties, Jennifer believes that the legislation change is still well needed. She expressed, “Even though this Bill could actually make things worse before it makes things better, actually, we really need a change” (Jennifer, 2019). This echoes Baird’s quote from Chapter 2.3.1, “while decriminalization may be a precondition for the improvement of access to abortion services, it is only when public health departments take responsibility that equitable access will be delivered” (Baird, 2017, p. 198).

### 6.3.6 What about conscientious objection and bodily autonomy?



Quotes concerning bodily autonomy, CO, and consent

As discussed previously (Chapters 4.5 and 6.2.3), conscientious objection (CO) in Aotearoa is an ongoing threat to abortion access. Participants largely shared these sentiments and expressed frustration at current CO regulations, scathing over the ability to object to anything that is gynecologically-related, like providing contraception. This is a very sexist situation as women are disproportionately affected by CO - for example, can you imagine men ever being refused condoms? Ballantyne et al. (2019), in response to the Law Commission’s 2018 report, demand “at a minimum, providers with a CO should be required to ensure an

indirect referral to another provider who is willing to refer the woman to abortion services” (Ballantyne et al., 2019, p. 64). They supported the ‘modest’ approach to CO put forward in the Law Commission Report (2018).

Notably, the Abortion Legislation Committee’s report (2020) has upheld the right to CO except in the case of medical emergency. To the disapproval of women’s rights organisations, sexual violation, including rape, has not been classed as a medical emergency. Bellamak, of ALRANZ, described the move as “callous” (Dreaver, 2020, para. 15).

Some participants would like to see the proposed legislation go further to protect access because there is an issue in practice where people are hired as non-conscientious objectors and then refuse to perform abortions. Linda emphasised, “There should be clear work standards which say if you are hired as a non-conscientious objector you will be in breach of contract if you then invoke conscientious [objection]” (Linda, 2020), hence obstructing access. Practitioners would like to see CO explicitly stated if the person/practice is a conscientious objector. Maria did believe that CO should still be an option, however. Otherwise, the risk would be that practitioners are forced to do something they don’t want to, which in turn risked harming patients with their “judgemental” attitudes (Maria, 2019). Under the new legislation, patients could self-refer to a clinic, reducing their risk of being met with CO.

### Objection to “CO”

A third of participants expressed their distaste of the phrase ‘conscientious objection’ and suggested alternative terms such as ‘those who refuse to treat/provide care.’ CO has its origins in war and people who refused to fight were punished. In the abortion context, it is not the doctor but the patient who is punished. Maria expressed, “When you use it in a medical setting, the person with the power is making no sacrifices whatsoever. He’s not putting anything on the line for this but is disadvantaging and harming somebody else’s rights” (Maria, 2019), violating RJ. Ettie suspected that most people who conscientiously object,

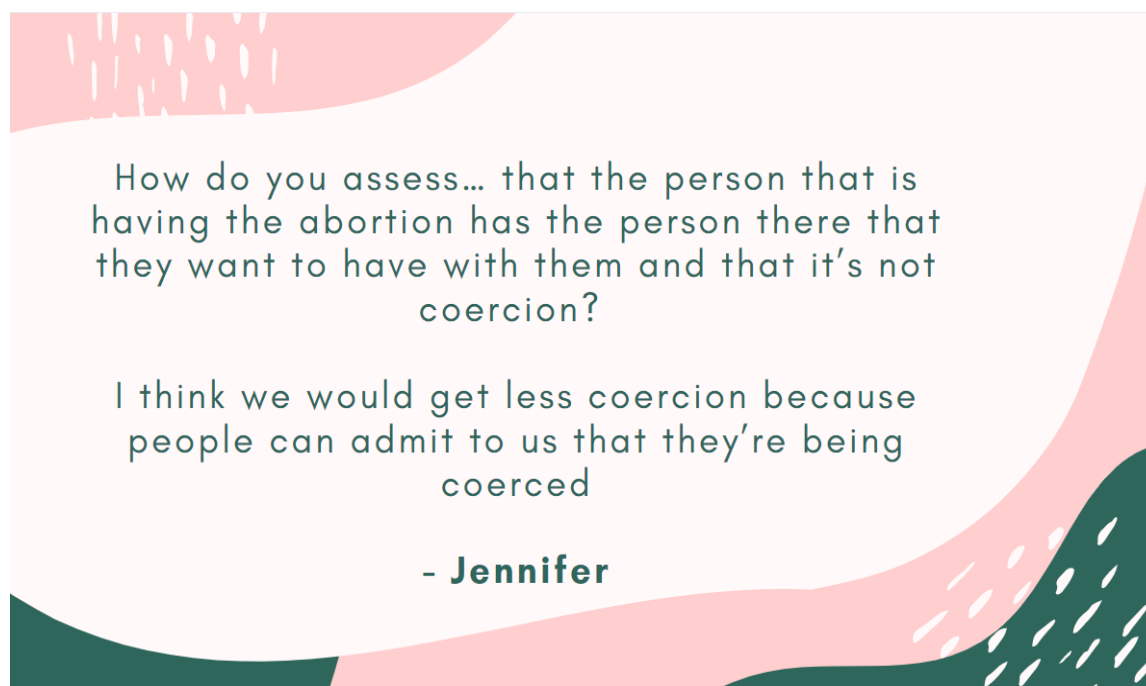
have absolutely no idea about what life is like [...] how contraception fails  
[...] intimate partner violence [...] what happens in countries where abortion

is illegal [...] really, conscientious objector, if your 11-year-old child was raped, would you still be a conscientious objector? (Ettie, 2019)

Ettie's confronting quote brings together intersecting factors that RJ and the SDGs seek to address. She describes coercion, violation, access to contraception, access to abortion, people's bodily autonomy and choices and ability to control how many children they want, along with violence and legal restrictions. All are relevant to SDG 5, which seeks to ensure access to sexual and reproductive health and promote the empowerment of women and girls (UN SDGs, 2015a).

All participants agreed that abortion or pregnancy continuation should be the choice of the pregnant person (with respect to their circumstances, partner and whānau) and be supported by health professionals, no matter the choice.

#### 6.3.7 Would coercion be easier?



Quotes concerning coercion

Coercion violates somebody's achievement of RJ by disempowering them and denying them the right to control their fertility. The announcement of Model C raised questions of coercion across politicians, the media and participants as some people believe that the current law provides safeguards (House of Representatives, 2019; "Abortion law reform: Government announces Bill for 20-

week medical test”, 2019). Patients could theoretically get an abortion without physically seeing a practitioner. Whether or not coercion would increase under the new legislation received mixed feedback in my research, but the majority believed it would not.

### Unpacking the concept of “removing safety nets”

Most services insist on seeing patients on their own, at least briefly, when considering their abortion decision. The purpose is to check for IPV, safety, and coercion. If tele-abortion eventuates, practitioners will have to consider how to make these assessments over the phone. Practitioners have to be conscious of coercion and safety but can find this difficult territory to navigate. Christina explained that some people do not wish to be seen alone, which could be because they truly value a joint decision with their partner, or it could be because that patient is being coerced by that other person. Additionally, seeing patients alone upholds the Eurocentric “my body my choice” approach. Christina explained that asking to see the patient on their own can be really offensive to some, who saw it as a “really white, western way of doing things” (Christina, 2019).

As was touched on in Section One, the current legislation makes it difficult for patients to be honest due to the fear of not fitting the criteria for abortion. Jennifer expressed, “I think we would get less coercion because people can admit to us that they’re being coerced” (Jennifer, 2019).

Ettie believed that certifying consultants do not provide a ‘safety net’ against coercion, therefore, arguments against decriminalisation to maintain ‘safety nets’ were redundant. She explained, “many practitioners would be working with women who they don’t totally know will be alive to see them the next time. Women who are in very dangerous, coercive relationships. I certainly don’t think certifying consultants [...] are providing a ‘safety net’” (Ettie, 2019). She explained that nobody can entirely mitigate abuse and control, including health professionals. Violence is complex. Perhaps, with abortion in primary-care and services hopefully moving towards more holistic care, this situation could be improved under the new legislation.

### 6.3.8 Would decriminalisation reduce stigma, hence access?

A lot of the things that a woman has to do to get an abortion she keeps **secret**... from her family, friends... their partners. Because there is that **shame**... **guilt** associated... Women tell me they feel **selfish** having an abortion because they're not giving the child a **chance at a life**. Some women feel guilty for **not coping**. Women are **embarrassed** because there is stigma associated with the 'fact' you must be **slack** to have allowed yourself to get pregnant when there are contraceptive methods out there. So there's the embarrassment and shame associated with the fact that they **mucked up**. And then there's the guilt associated with the fact they're being selfish. The two groups that I find are the most stressed out about decision and upset about their decision are either the **religious** – really strict religious people, mostly **Catholic**, but a lot of the **evangelical Christian**. They've been brought up in a very Catholic or very evangelical Christian upbringing where they are **taught every Sunday how evil and bad abortion is and then they want to have an abortion**. So they feel really bad and they're really upset about their decision. And then there's also the **Māori** culture where the pregnancy is **not just owned by the woman, it's actually owned by the extended family**. It's part of the whanau. The baby isn't just yours, the unborn baby inside your tummy actually belongs to your partner, and your mothers, and the partner's whanau, and grandparents, mokopuna. They feel, sometimes, really, really guilty

- Christina

Quote regarding the effects of stigma on abortion experience and access

Participants' opinions were mixed regarding whether or not decriminalising abortion would assist in reducing stigma. And, in turn, if a reduction in stigma might lead to better access. Baird (2017) found that upon decriminalisation in Australia, perceived stigma did not decrease for either the patient or the practitioner, but the relationship between the two parties could become more natural and honest. The Guttmacher Institute has reported,

Although legal restrictions on abortion strongly reinforce stigma, removing such restrictions does not automatically eliminate it. Even in countries where abortion is broadly legal, women's feelings of isolation and anxiety over having a stigmatized procedure can result in their fear of being judged harshly by health professionals, and of being treated as an outcast by their family and community. (Singh et al., 2017, p. 30)

The beginning quote above highlights some of the complex emotions and thoughts that an abortion-seeker might go through as well as how one's personal identity(ies) can affect their feelings about the situation. Christina highlights the personal, societal, religious and cultural considerations that are influenced by stigma. It is worth emphasising that contraception can fail with perfect usage

(Family Planning, 2014b). But, even so, stigma can lead patients to feel “they mucked up,” as Christina expressed. Kathleen would like to see a cultural shift against judging each other’s choices, hence reducing stigma. She believes that stigma is “The biggest thing that we all can have something to do with” (Kathleen, 2019). Jessica and Ettie both believe that stigma is far too complex and slow shifting to say that decriminalising abortion would reduce it. Jessica believes “reducing stigma needs to come as a global approach and not just through legislation [...] from education” (Jessica, 2019). Maria believed that reducing stigma would assist access,

Inevitably it [decriminalisation] will be a part of reducing stigma, and increasing access, and that will help. And just the fact we’re talking about it on the news, on the radio, people are talking about it, I think all those things will help. (Maria, 2019)

Next, the chapter presents what could still be improved even if the Crimes Act 1961 remains.

#### 6.3.9 What if the law does not change?



Quote regarding future access if the law does not change

Participants were asked what improvements to services could be made if the law does not change, hence improving patients’ access, experiences, wellbeing and

advancements towards RJ. Ultimately, better access to contraception and education, the timeliness of services, and tackling stigma were mentioned as the next best ways forward under this scenario. The Law Commission (2018) report indicated that at the very least, “outdated and confusing” terms in the law should be amended (Law Commission, 2018, p. 175). McCulloch and Weatherall (2017) believe “a lot can still be done within the current legal framework to improve services, such as greater access to early medication abortion and speedier referral” (p. 98). Jennifer evidently agreed in the opening quote of this section. Participants attributed the current state to the disinterest discussed in Chapter 6.2.3.

From the interviews, making improvements would depend on several factors. Firstly, it would depend on the broader will of practitioners and students to train and deliver services, including telemedicine. This is complicated by the stigmatised and emotionally challenging nature of the work. Secondly, the opening of abortion clinics in places such as the West Coast, where there are none, could improve access for rural people who often face increased intersecting inequalities. This would depend on the will of local DHBs and practitioners. Or, overcoming this barrier, the government could integrate abortion care into national funding models.

Participants mentioned that telemedicine could again be a possibility under restrictions, depending on will and funding. Diana pointed out that this type of service could legally be provided now but is not, such as 0800-Abortion was in the past. The service ultimately shut down due to high demand and low resources, which included self-funding.

Other suggestions were made regarding ways to improve access under a restrictive environment. Jennifer believed that all methods of abortion could be provided in all hospitals with limited license, and up to 12 weeks for GP practices. The reason they saw this not happening was that “It’s really, really down to the fact that we’ve got this stigma that’s stopping us doing things. And we’ve got the ability to stop doing things because we [...] can just say we conscientiously object” (Jennifer, 2019). Conscientious objection would remain a barrier if the law does

not change but a reduction in stigma over time could reduce the occurrence of CO.

The suggestions that emerged are summarised in the table below:

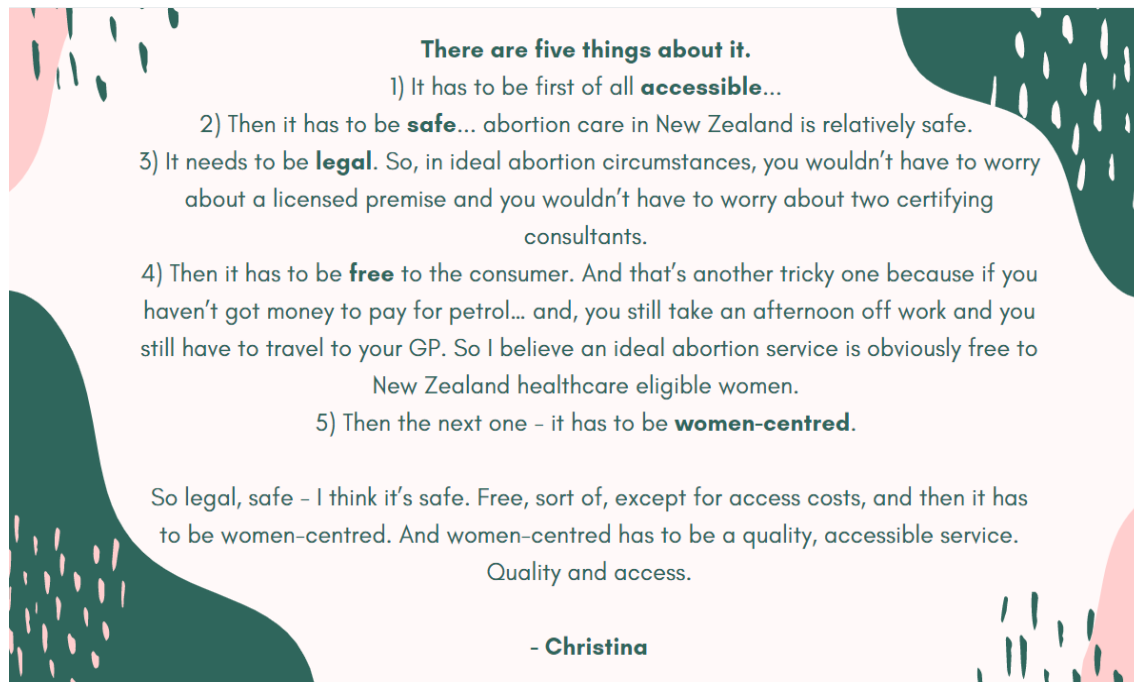
Table 9

*Ways to improve access and/or RJ if the legislation does not pass*

<b>Ways to improve access and/or services if the legislation does not pass</b>
<ul style="list-style-type: none"><li>• Telemedicine for abortion and/or counselling</li><li>• Centralised funding model (rather than funding channelled through DHBs)</li><li>• Integrated health services (not siloed abortion-care)</li><li>• Training modules in tertiary education</li><li>• Training for professionals e.g. alongside conferences, bias and attitudinal training, Te Tiriti o Waitangi, etc.</li><li>• Providing abortions to all gestations at all major hospitals</li><li>• Better assisting those who need financial, transport and accommodation support (and not reimbursements as some cannot afford the upfront costs)</li><li>• Improving cultural competency</li><li>• Improved sexual and reproductive health education of young people</li><li>• Free contraception</li><li>• Efforts to reduce societal stigma</li><li>• Clarifying confusing terms in the legislation</li></ul>



## 6.4 Chapter summary



Quote from Christina regarding the five things she desires under the law change (numbers added by author).

This chapter presented the findings of the research, covering the four research questions, regarding disadvantaged groups in society, matters of RJ, and how access could be improved to abortion, whether or not the law changes.

Current access to abortion is affected by a range of structural barriers, including: criminal status, societal stigma, a disinterest in sexual and reproductive healthcare, and a lack of training and funding. Barriers to the individual abortion-seeker living within those structures were found to be consistent with literature. Those barriers are economic, geographical and cultural. Those who are most disadvantaged sit at the intersection of poverty and geography, a sentiment quoted strongly by participants in the phrases “post-code lottery” (Morgan, Christina, Jennifer, 2019) and “tyranny of distance” (Maria, 2019). The people populating this position are often already-marginalised groups such as Maori, Pasifika or immigrants. Evidently, abortion access is complex, and a RJ lens has helped to understand the intersecting inequalities that people of different identities and circumstances face.

The findings in this chapter suggest that the most effective ways to improve abortion access and make advancements towards RJ in Aotearoa are via

decriminalisation and access to telemedicine services. The benefits to pregnant people would be numerous. Patients would no longer access services under the Crimes Act 1961, hence allowing both patients and practitioners to be more honest about their thoughts, concerns, and feelings without having to match an 'exceptionalist' criteria (Leask, 2015) or risk being denied. Decriminalisation would provide a wider range of practitioners an improved scope to provide patient-centred, holistic healthcare, without fear of prosecution. This would in turn positively affect the wellbeing of patients, who would be empowered to exert their will and exercise their own judgement (Cornwall et al., 2008), and have the trust in their decisions upheld (Erdman, 2012). However, access to surgical abortion might be threatened by a predicted increased demand for medical abortion and telemedicine services. Abortion clinics might close, or practitioner's offerings may be reduced, particularly in rural areas, unless shortfalls in funding are addressed.

Ultimately, many questions remain about the future of abortion access in Aotearoa and will depend upon how the system reacts to a potential law change. Changes would take many years to materialise and barriers to access would still remain in place, such as geography and CO. If the law remains in its current state, improvements to reproductive justice and access could be made via improvements to services and the funding of a tele-abortion service. It is up to the will of those within the health system to make changes equitable, with political support.

## Chapter 7: Conclusions

The purpose of this research was to investigate, “how can access to abortion be improved, in Aotearoa, with or without a law change, bearing in mind the concerns raised by reproductive justice?” It examined: the barriers to accessing abortion; critiques of the current laws; the proposed legislation; which groups of people are the most disadvantaged; how access to services can be improved; what the future environment might look like in Aotearoa; and future challenges and opportunities. Undertaken from a permeable social constructivist and transformative epistemological stance, the research was influenced by reproductive justice (RJ) which recognises every aspect which may hinder or empower a person’s right to control their fertility. The framework reaches further than the binary pro-life/pro-choice debate, recognising in depth the intersecting identities and reproductive oppression that affects all areas of a person’s life. There has been little academic research on abortion access in Aotearoa, and a dearth of development research on safe and legal abortions in ‘developed’ countries. This study contributes to a significant gap in the literature, and, in addition to analysing the full extent of access inequalities in Aotearoa, it provides a collation of ideas intended to be of assistance to those active in the abortion health and access space, in order to influence the future environment for more equitable access.

Semi-structured interviews were undertaken with 13 abortion providers, academics and advocates, with the aim of influencing change and social justice. Participants were selected due to their diverse knowledges about overarching structural barriers and their ability to shape the abortion landscape moving forward. Participants were able to make suggestions for the improvement of access broadly and could share their examples and experiences of people coming through services over time without risk to patient confidentiality. Additionally, the topic of abortion brings about associated topics such as the circumstances of conception, which can sometimes be traumatic. By interviewing people for whom abortion is an everyday topic, and who are well-resourced to seek support if needed, it minimised any potential risk of harm by the research to trigger people themselves who might have had an upsetting experience of abortion or related topics. Minimising harm is an essential component of ethical development research.

This research found that access to abortion across in Aotearoa is unequal, particularly for people who are socioeconomically-disadvantaged, rural, marginalised, young, Māori, Pasifika, migrant, gender-queer, religious, or a combination thereof, in accordance with the literature (Te Whāriki Takapou et al., 2017; Law Commission, 2018; Justice Committee, 2018). Many examples of abortion-seekers facing inequalities were given, many of whom had to travel long distances with little support, sometimes staying several nights in cities there were unfamiliar with, expending significant time and resources. The intersection of geography and socioeconomic status was emphasised repeatedly, as was the phrase “post-code lottery.” Often, those populating this position were Māori, who are disproportionately reflected in abortion statistics, simultaneously to facing the highest access barriers. In the examples provided by participants, they faced the culmination of socioeconomic deprivation, cultural belief systems, hostile environments, poverty, and a harsh history of colonisation and racism.

Decreasing barriers for all, especially those who are most marginalised and face the most inequitable barriers to abortion, is one step towards RJ and Aotearoa’s commitment to Te Tiriti o Waitangi (Law Commission, 2018), the SDGs (2015) the UN CEDAW (2012), and the ICPD Programme of Action (UN, 1994). Abortion access is a complex issue and is important to human development everywhere because of its intersections with RJ and development goals such as improvements to gender equality, healthcare, empowerment, sexual and reproductive health and rights (SRHR), and human rights (Ross, 2017). However, abortion’s discussion in development literature and UN agreements is often restricted to life-saving circumstances, due to its controversial nature. RJ bridges the gaps between this literature and abortion’s place in development.

Despite abortion’s common occurrence in Aotearoa, it is a criminalised health issue only available under ‘exceptionalist’ laws (Leask, 2015) and has been heavily critiqued. The convoluted process to access an abortion currently causes “unnecessary” hardship (Edmond & Burke, 2017, p. 200; Justice Committee, 2018, p. 2), lengthy delays, increasing physical and psychological risk (Silva et al., 2010), and requires gross exaggerations about the patient's mental health (ASC, 2018; Leslie, 2010; Bellamak, 2018). 97.3% of abortions are performed on

the grounds of preserving the mental health of the patient, a situation that is unreflective of the reasons patients seek abortions (Edmond & Burke, 2017; Burgess, 2017), described by Leslie (2010) as a “psychiatric masquerade.” Research indicates that current legal requirements violate abortion-seekers’ human right to bodily autonomy and healthcare, are paternalistic, and pathologise women by making them appear psychologically vulnerable (Te Whāriki Takapou et al., 2017; Leask, 2013, 2014; McCulloch & Weatherall, 2017). Outdated laws and practices impede significantly on individuals’ time and resources (Edmond & Burke, 2017). Furthermore, the history of abortion condemnation in Aotearoa stems from historic conservative, religious, colonial views and racism towards Māori (Leslie, 2010; Brookes, 1981, as cited in Leask, 2013; Smyth, 2000, as cited in McCulloch & Weatherall, 2017; van der Krogt, 1998). All of these aspects, and their disproportionate effect on the already-marginalised, violate the advancement of reproductive justice.

Substantial advancements towards RJ can be made in Aotearoa to better meet the goals of the framework. RJ is defined as, “the complete physical, mental, spiritual, political, economic, and social well-being of women and girls [...necessitating] the economic, social and political power and resources to make healthy decisions about [...] reproduction” (Asian Communities for Reproductive Justice, 2005, p. 1). Evidently from this and other research, currently people are not having these rights met in the abortion-seeking landscape in Aotearoa.

In early 2020, Aotearoa may pass the Abortion Legislation Bill 2019, which would decriminalise abortion, treat it as a health matter, modernise the process, and bring it “into line with many other developed countries” (Melville, 2019, p. 2). If the Bill passes, abortion would be able to enter primary-care, which according to literature and participants, could pave the way for more equitable abortion access and holistic care (WHO, 2012; Snook & Silva, 2013). It would allow abortion to enter primary-care, making it more available at a wider range of places, at earlier gestations, with a less convoluted process. It would allow people to undergo medical abortions safely and comfortably at home, and would allow for patients to be sent the pills and access health professionals via telemedicine (Baird, 2017; Singh et al., 2017; Ehrenreich & Marston, 2019; Wiebe, 2014; Women on Web, n.d.; Hyland, et al., 2018). This research found that decriminalisation and

telemedicine provide the greatest opportunities to improve equitable access to abortion in Aotearoa, particularly for those identified as the most disadvantaged, hence promoting RJ.

For the most part, the Bill will make improvements towards easing the burdens on patients, including the costs of multiple appointments, as well as supporting bodily autonomy, access to timely services, and creating a space to have honest conversations without the fear of being denied, or prosecuted (Baird, 2017). However, the Bill was also critiqued by participants, for the political decision to go with Model C (when the medical community demanded Model A), and for its arbitrary 20-week limit, only affecting people faced with tragic circumstances like their baby suffering immensely if born (Picken, 2018). Participants emphasised that in all abortion care, compassion is needed. Furthermore, participants desired substantial changes to conscientious objection, but this did not materialise in the February 2020 report (Abortion Legislation Committee, 2020).

Additionally, it was predicted by participants that access could worsen for the interim while the structural systems adjust to new legislation and governing bodies, although participants agreed that change is a “step in the right direction” and desperately needed. An increase in medical abortion is predicted to cause a decrease in surgical abortion, meaning some services may close due to the high costs of theatre. As was found in Australia, decriminalisation alone will not improve access, but it is a precondition (Baird, 2017). Rather, improving access to abortion will depend on how the government and the health system (and perhaps even societal stigma materialises once it is decriminalised) responds as a whole.

Whether the law changes or not, socioeconomic and geographic barriers would still exist, as would practical barriers such as the gestational limits offered in clinics and matters of CO. There are substantial questions remaining over the future of funding, training, GPs up-taking abortions, stigma, and whether or not abortion will remain free for New Zealand residents. There are also substantial concerns over the ability of primary-care professionals to provide empathetic services when they may only see a patient requesting abortion occasionally.

Prescribing medical abortion pills is simple but creating a judgement-free and compassionate environment is predicted to be a challenge.

Regardless of whether the law changes, abortion will continue to exist (GI & WHO, 2012; Cornwall et al., 2008; Erdman, 2012; Orr, 2017) and improvements can be made to the process to ease the burden of patients who seek it. Whether or not the Bill passes, access to abortion and services can still be improved, via: the funding of a tele-abortion service, improved cultural competency, encouraging the training of abortion providers, efforts to reduce societal stigma, a centralised funding model, integrated health services, amended wording in the legislation, improved education and the improved availability of contraception.

Ultimately, participants were supportive of law change despite the challenges it might present, as change, in their collective opinion, is desperately needed. It is the hope of participants that the future abortion-landscape will allow for compassionate, patient-centred and holistic care that caters to their emotional, cultural and spiritual needs in all interactions. Only then will justice, equality, rights, RJ and Aotearoa's commitments be advanced.

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## Appendix

### A1 The New Zealand abortion process in 2018

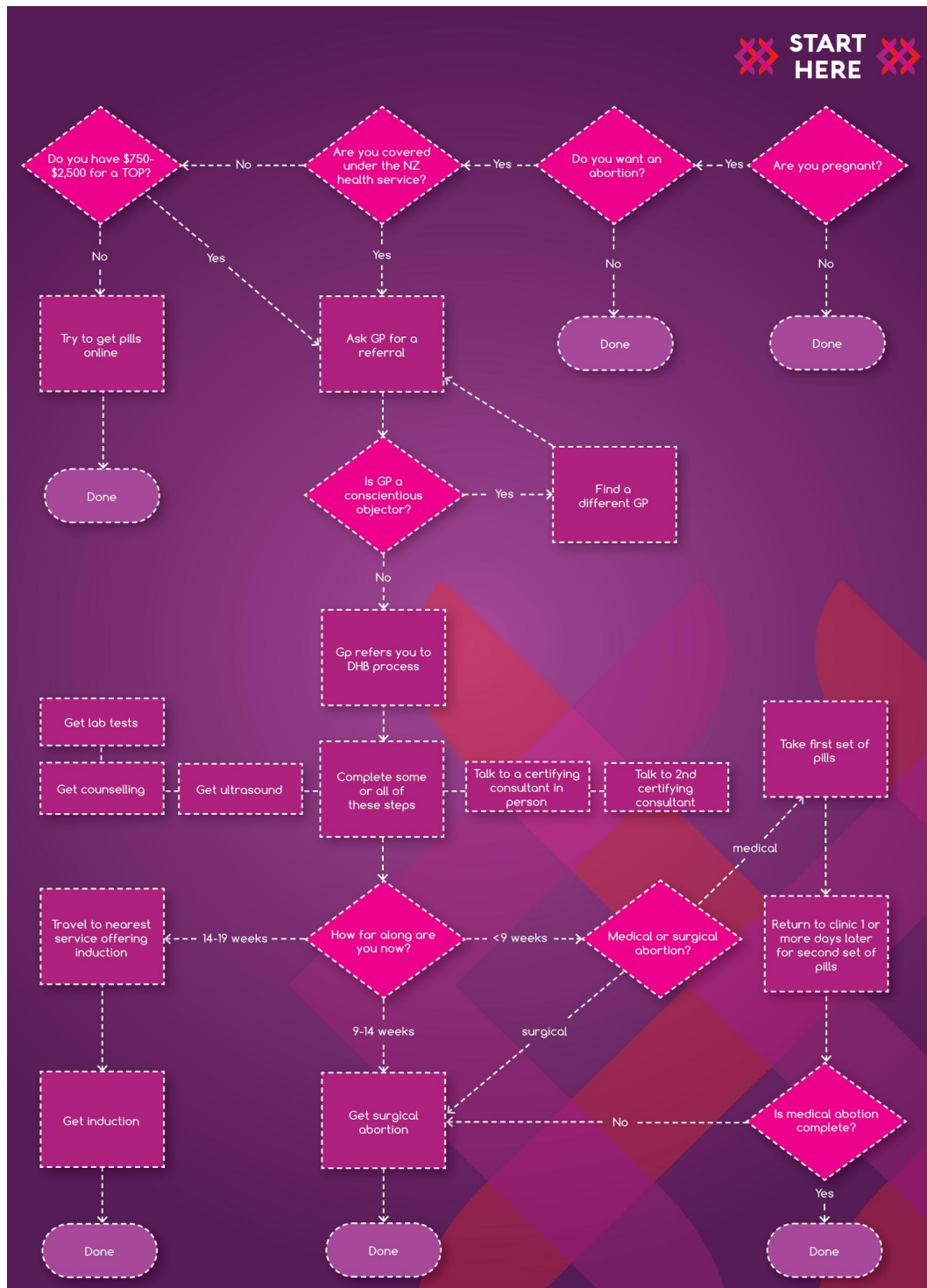


Figure 7. The New Zealand process in 2018. Retrieved from *The Abortion Process – How does NZ compare?*, by ALRANZ, n.d., Reprinted with permission. Retrieved 2019, 7 May, from <http://alranz.org/the-abortion-process/>

A2 Organisations that signed an open letter to Parliament in support of reform in February 2020

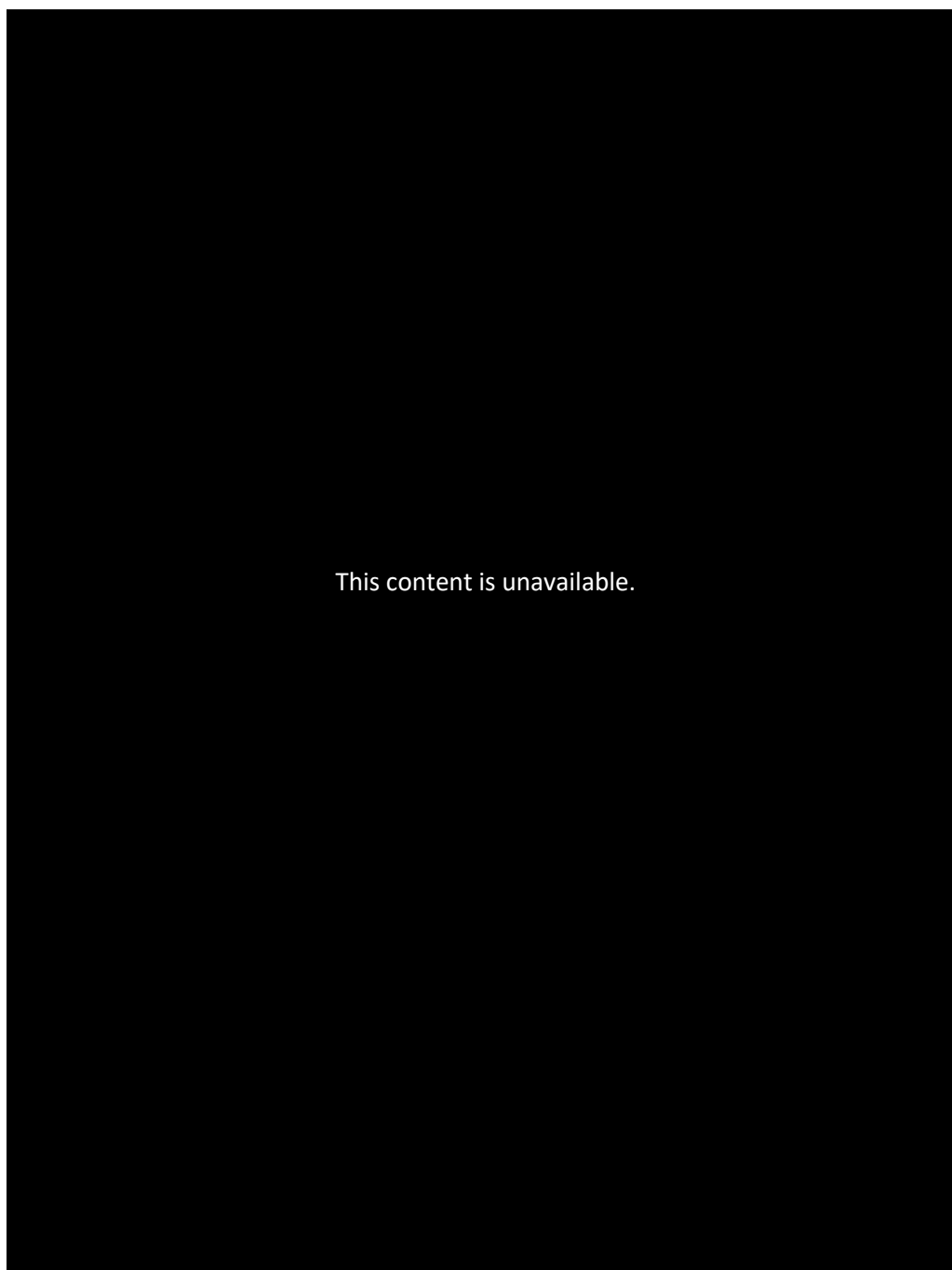


Figure 8. Open letter in support of abortion law reform and a more compassionate healthcare system, Retrieved From *Family Planning New Zealand*, by Family Planning New Zealand, 2020, Retrieved 2020, 19 February, from [https://www.familyplanning.org.nz/media/304296/open-letter-abortion-legislation-bill-final.pdf?fbclid=IwAR0IMGiHxn7rmxsRKvSt6v4j8cfV0Uv\\_qgMdQxZJxLE\\_fi32gAHmjDUoa8I](https://www.familyplanning.org.nz/media/304296/open-letter-abortion-legislation-bill-final.pdf?fbclid=IwAR0IMGiHxn7rmxsRKvSt6v4j8cfV0Uv_qgMdQxZJxLE_fi32gAHmjDUoa8I)

## A3 Information sheet (participants)



### *Reproductive Justice: Improving abortion access in Aotearoa New Zealand*

#### INFORMATION SHEET FOR PARTICIPANTS

You are invited to take part in this research. Please read this information before deciding whether or not to take part. If you decide to participate, thank you. If you decide not to participate, thank you for considering this request.

#### Who am I?

My name is Penny Downing, I am a Masters student in Development Studies at Victoria University of Wellington. This research project is work towards my thesis.

#### What is the aim of the project?

This project aims to contribute to the understanding of the barriers to and enablers of abortion access in Aotearoa New Zealand. Your participation will support this research by sharing your knowledge, experiences and opinions, as someone working in this area.

This research has been approved by the Victoria University of Wellington Human Ethics Committee [reference 0000027512].

#### How can you help?

You have been invited to participate because you work with services that support women to access abortion. The topic of abortion in New Zealand is under-researched and your knowledge will contribute to academic understanding about how abortion access can be improved. A summary report of the findings and a copy of the completed thesis will be provided to you and your organisation. If you agree to take part I will interview at a location of your choosing. This could be your workplace or Skype, for example – wherever you feel most comfortable talking about your experiences working in the field.

I will ask you questions about what challenges you see currently for people accessing an abortion, what access challenges you could see under the proposed law change (Option C) (Law Commission, 2018), and ways in which abortion access could be improved. I will also ask you questions about how access might vary for different groups of people around New Zealand, and for some examples, if you have any, of a story of a person you encountered who faced a barrier to reaching abortion services.

I estimate that the interview will take 30-45 minutes. I will audio record the interview, with your permission, in order to transcribe parts. You can choose to not answer any question or stop the interview at any time, without giving a reason. You can withdraw from the study by contacting

me at any time before 01/11/2019. If you withdraw, the information you provided will be destroyed or returned to you.

**What will happen to the information you give?**

You will not be named in the final report (unless you request to be) but your organisation will be named (provided you have the authority to agree to this on behalf of the organisation). The organisation can also choose not to be named. Only my supervisor and I will read the notes or transcript of the interview. The interview transcripts, summaries and any recordings will be kept securely and destroyed on 03/04/2025.

**What will the project produce?**

The information from this research will be used to produce a report of the findings of the research and Master of Development Studies thesis. A copy of each will be provided to participating interviewees and organisations.

**If you accept this invitation, what are your rights as a research participant?**

You do not have to accept this invitation if you don't want to. If you do decide to participate, you have the right to:

- choose not to answer any question;
- ask for the recorder to be turned off at any time during the interview;
- withdraw from the study before 01/11/2019
- ask any questions about the study at any time;
- receive a copy of your interview recording;
- receive a copy of your interview;
- read over and comment on a written summary of your interview;
- be able to read any reports of this research by emailing the researcher to request a copy.

## A4 Consent to interview (participants)



### *Reproductive Justice: Improving abortion access in Aotearoa New Zealand*

#### CONSENT TO INTERVIEW (Participants)

This consent form will be held for 5 years.

Researcher: Penny Downing, School of Geography, Environment and Earth Sciences, Victoria University of Wellington.

- I have read the Information Sheet and the project has been explained to me. My questions have been answered to my satisfaction. I understand that I can ask further questions at any time.
- I agree to take part in an audio recorded interview.

I understand that:

- I may withdraw from this study at any point before 01/11/2019 and any information that I have provided will be returned to me or destroyed.
- The information I have provided will be destroyed on 03/04/2025.
- Any information I provide will be kept confidential to the researcher and the supervisor.
- I understand that the findings may be used for a Masters thesis, a 2-page summary report and/or presented to conferences.
- I understand that the notes/recordings will be kept confidential to the researcher and the supervisor.

Options:

- Would you like to be personally named or anonymous (please select)?    Named ☐    Anonymous ☐
- Would you like your organisation to be named or anonymous (please select)?    Named ☐    Anonymous ☐
- I would like a copy of the recording of my interview:    Yes ☐    No ☐
- I would like a copy of the transcript of my interview:    Yes ☐    No ☐
- I would like a summary of my interview:    Yes ☐    No ☐

- I would like to receive a copy of the final report (2 page summary of findings) and have added my email address below. Yes ☐ No ☐
- I would like to receive a copy of the final thesis and have added my email address below. Yes ☐ No ☐

Signature of participant: \_\_\_\_\_

Name of participant: \_\_\_\_\_

Date: \_\_\_\_\_

Contact details: \_\_\_\_\_



## ***Reproductive Justice: Improving abortion access in Aotearoa New Zealand***

### **INFORMATION SHEET FOR ORGANISATIONS**

Thank you for your interest in this project. Please read this information before deciding whether or not your organisation will take part. If you decide to participate, thank you. If you decide not to take part, thank you for considering my request.

#### **Who am I?**

My name is Penny Downing, I am a Masters student in Development Studies at Victoria University of Wellington. This research project is work towards my thesis.

#### **What is the aim of the project?**

This project aims to contribute to the understanding of the barriers to and enablers of abortion access in Aotearoa New Zealand. Your participation will support this research by sharing your knowledge, experiences and opinions, as someone working in this area.

This research has been approved by the Victoria University of Wellington Human Ethics Committee [reference 0000027512].

#### **How can you help?**

If you agree to take part, I will interview one/some of your employees. I will ask them questions about what challenges they see currently for people accessing an abortion, what access challenges they could see under the proposed law change (Option C) (Law Commission, 2018), and ways in which abortion access could be improved. The interviews will take 30-45 minutes. Employees can state when they would like the interviews to occur. The interviews will take place privately either in a workplace or over video call. Each individual participant will be asked to provide consent before their involvement in the research. I will audio record the interview with the permission of the participants and write it up later.

- The interviewees will have the choice of being identified by name or by pseudonym.
- Your organisation can decline to be named, if desired.

#### **What will happen to the information the participants give?**

Participants in this research will decide whether they chose to be named or not in the resulting summary report and thesis. Organisations can also choose whether to be named or not.



Myself, the researcher, will be aware of the identity of your organisation and the identity of participants. All participant wishes for privacy will be upheld.

Only myself and my supervisor, and participants if requested, will have access to the *notes or transcript of the interview*. The *interview transcripts, summaries and any recordings* will be kept securely and destroyed on 03/04/2025.

Be aware that the identities and contributions of participants will be kept confidential from your organisation if requested.

**What will the project produce?**

The information from this research will be used to produce a report of the findings of the research and Masters of Development Studies thesis. A copy of each will be provided to participating interviewees and organisations.

**If you accept this invitation, what are the rights of your organisation?**

You do not have to accept this invitation if you don't want to. If you do decide that your organisation will participate, you have the right to:

- ask any questions about the study at any time;
- withdraw your organisation's participation from the study before 01/11/2019, however, individual participants retain the right to decide if their data will be withdrawn;
- be able to read a report of this research.

## A6 Consent to participate (organisations)



### *Reproductive Justice: Improving abortion access in Aotearoa New Zealand*

#### CONSENT TO PARTICIPATE (ORGANISATION)

This consent form will be held for a minimum of 5 years.

Researcher: Penny Downing, School of Geography, Environment and Earth Sciences, Victoria University of Wellington.

- I have read the Information Sheet and the project has been explained to me. My questions have been answered to my satisfaction. I understand that I can ask further questions at any time.
- I agree that my organisation will take part.

I understand that:

- I may withdraw this organisation from this study at any point before 01/11/2019 and the information provided up to this date by members of the organisation will be used in the project.
- Any information the participants provide will be included in a final report but the transcripts/notes/recordings will be kept confidential to the researcher and the supervisor.
- The identities of the participants will not remain confidential to the researcher(s).
- I understand that the findings may be used for a Masters thesis, a 2-page summary report and/or presented to conferences.

Options:

- I wish for the organisation to be named Yes ☐ No ☐
- I would like to receive a copy of the final report and have added my email address below. Yes ☐ No ☐
- I would like to receive a copy of the final report (2 page summary of findings) and have added my email address below. Yes ☐ No ☐
- I would like to receive a copy of the final thesis and have added my email address below. Yes ☐ No ☐



### *Reproductive Justice: Improving abortion access in Aotearoa New Zealand*

#### QUESTION GUIDE for Participants (Semi-structured interviews)

*The following questions are intended to serve as a discussion guideline only. Semi-structured interviews allow for readiness to change and the flexibility to follow new paths of inquiry offered by the participant (Lamnek, 1989, as cited in Sarantakos, 1998, p. 256).*

#### Current environment

1. What does abortion “access” mean to you?
2. What can you tell me about people overcoming barriers to reach abortion services?
3. How do people access abortion in your region?
4. What groups of people do you believe to be the most advantaged/disadvantaged when it comes to seeking abortion services?
5. Abortion access can be different for different groups of people, what can you tell me about that?

#### Future environment

1. Thinking of each of the proposed law change, what do you think access to abortion will look like?
  - a. For the specific groups of people we’ve discussed?
  - b. How do you think access could be improved for those groups specifically?
2. What are the biggest ways overall that you can see abortion access improved?
3. If/when the law changes, what do you think will happen to the availability of abortion clinics?
4. If/when the law changes, what do you think will happen to the availability of services available at abortion clinics?
5. How do you believe the sector will respond (i.e., more training, more available services, more clinics, etc.)?
6. How might funding and training work in the future?
7. Have you got anything else you would like to discuss or find important to discuss that hasn’t been touched on here today?



*Reproductive Justice: Improving abortion access in Aotearoa New Zealand*

QUESTION GUIDE (Semi-structured interviews)

*The following questions are intended to serve as a discussion guideline only. Semi-structured interviews allow for readiness to change and the flexibility to follow new paths of inquiry offered by the participant (Lamnek, 1989, as cited in Sarantakos, 1998, p. 256).*

Questions

Introductions

1. Introductions:
  - a. What is your role and organisation?
  - b. Tell me about your professional background?

Current environment

1. What does abortion "access" mean to you?
  - a. Anything else to add?
2. How do people access abortion in Wellington?
  - a. What happens when someone is referred from another District Health Board?  
How do they access services here in the Capital?
  - b. Are people who are traveling from another DHB more likely to undergo a surgical abortion, in your opinion? (Surgical abortion takes about ten minutes. A medical abortion takes between 24-48 hours to complete and both pills over that time period must be taken at the abortion clinic).
3. What can you tell me about the political, social, socioeconomic, cultural, financial, legal barriers that exist?
  - a. What barriers to you see in Wellington in particular?
4. What can you tell me about people overcoming barriers to reach abortion services?
  - a. Do you have any personal accounts of meeting people who had overcome hurdles to access the service? These could be to do with distance travelled, the childcare that was needed, being referred to other DHBs, etc.?
5. What groups of people do you believe to be the most disadvantaged when it comes to seeking abortion services?

- a. Why?
- 6. Have you heard of *Reproductive Justice* before? (Explain if not).
- 7. What's your personal take on abortion? (Some view it as a human right, a health issue, others view it as murder even)
  - a. Specifically, do you view abortion as a human right?
  - b. Do you view abortion as a health issue?
  - c. Do you believe a person has the right to choose whether or not they get an abortion?
- 8. Abortion access can be different for different groups of people, what can you tell me about that?
  - a. There isn't much research at all on gender minorities seeking abortion, although there is international research suggesting ways to improve their pregnancy care. Is the topic of gender minorities and abortion ever raised in your circles? What can you tell me about that?
- 9. Do you support abortion being moved out of the Crimes Act?
  - i. Until what gestational period?

#### Future environment

- 1. Which of the 3 alternative models (A, B or C), if any, would you like to see pass?
  - a. Can you please explain why you chose that option?
- 2. Thinking of each of the three alternative Models, what do you think access to abortion will look like under each?
  - a. For Wellington?
  - b. For the North Island?
  - c. For New Zealand?
- 3. What are the biggest ways you can see abortion access improved?
- 4. Thinking of the groups of people we've discussed who face barriers to access, how do you think access could be improved for those groups specifically?
- 5. If/when the law changes, what do you think will happen to the availability of abortion clinics?
  - a. How do you imagine these will be funded?
- 6. If/when the law changes, what do you think will happen to the availability of services available at abortion clinics?
  - a. How do you imagine these will be funded?
- 7. Have you got anything else you would like to discuss or find important to discuss that hasn't been touched on here today?
- 8. What general (or specific) suggestions do you have on improving abortion access?

## A9 Ethics approval



### MEMORANDUM

TO	Penny Downing
FROM	Convenor, Human Ethics Committee
DATE	11 June 2019
PAGES	1
SUBJECT	<b>Ethics Approval</b> <b>Number:</b> 0000027512 <b>Title:</b> Reproductive justice: Improving access to abortion services in Aotearoa New Zealand

Thank you for your application for ethical approval, which has now been considered by the Human Ethics Committee.

Your application has been approved from the above date and this approval is valid for three years. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with the research.

Kind regards,

Convenor, Victoria University of Wellington Human Ethics Committee