

Abortion services in Aotearoa New Zealand: The voices of wāhine on improving access.

Report to Manatū Hauora

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This report would not have been possible without the generous contribution of survey and interview participants. Ngā mihi nui ki a koutou. We are grateful for your time and allowing us to share your stories. We hope our collective efforts bring to light the voices of wāhine.

Me aro koe ki te hā o Hine-ahu-one.

Pay heed to the dignity of women.

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Executive summary

The vision of Manatū Hauora (the Ministry of Health) is for abortion services in Aotearoa New Zealand to be accessible, equitable, person-centred, and high-quality. This research was conducted to provide direct consumer feedback on how wāhine access and experience abortion services following the abortion law reforms of 2020.

We aimed to identify aspects of equitable, timely, safe, and accessible abortion services in Aotearoa New Zealand; that is what works now and what can be improved. The experiences of wāhine were collected in 126 anonymous surveys and seven confidential interviews, augmented by 13 confidential interviews with healthcare providers.

The findings suggest that many steps have been taken towards achieving the Manatū Hauora vision for abortion services in Aotearoa New Zealand but there is still work to be done.

Elements of equitable, safe, and accessible abortion services in Aotearoa New Zealand include:

- Culturally safe staff at all steps of the abortion care pathway.
- Knowledge and freedom to self-refer to an abortion service.
- Providing wāhine with a choice between telehealth and in-person abortion services.
- Clear and accurate information for wāhine at all steps.
- Offering counselling before and after abortion for information and emotional support.
- Removing time and financial barriers for wāhine.
- Offering choices for post-abortion contraception and facilitating its provision.
- Whānau inclusiveness.
- Ensuring no contact with protesters.

These elements, including those introduced by recent reforms, must be protected or enhanced where needed to fully realise the Manatū Hauora vision. To this end, recommendations are made for policy and oversight of practice, for health services, and for national professional organisations and councils. Abortion care does not begin or end with the abortion procedure itself and despite decriminalisation, this healthcare continues to take place in a societal context of considerable stigma and judgement. Our recommendations extend beyond health services and include wider support for wāhine such as supportive working environments.

Recommendations

Recommendations for policy, strategy, data, and regulation

(Manatū Hauora)

1. Retain the safeguards enshrined in the new legislation, and protect any elements of equitable, safe, and accessible abortion services that are currently in place.
2. Work with stakeholders to ensure that there is clear information about clinical pathways adapted to the local circumstances available online for primary care. There is an urgent need for these pathways. Ensure that this information is kept current.
3. Ensure a whole sector approach to future abortion annual reports by including detailed analyses of the impact of DECIDE services. Conduct additional research to ensure an in-depth understanding of the impact of telehealth EMA services: wāhine experiences, equity, after-care, complications and contraception provision.
4. Work with other areas of government on legislation or policy for supportive working environments when employees have an acute medical or surgical procedure, similar to leave rights related to family violence, bereavement, and maternity care, recognising that there will be varying needs for leave.
5. Establish and maintain strict and transparent governance of abortion care data, in line with the values expressed by wāhine here.

Recommendations for commissioning, workforce and service planning

(Te Whatu Ora)

1. Protect a local choice for wāhine between in-person and telehealth abortion services.
2. Work with stakeholders to ensure that there is clear information about clinical pathways adapted to the local circumstances available online for primary care. There is an urgent need for these pathways. Ensure that this information is kept current.
3. Develop and promote practical and clear health navigation tools and information for wāhine wanting to self-refer.

4. Provide all abortion services with portable ultrasound scanners and train staff in their use for point of care scanning.
5. Support all abortion services to optimise manaakitanga, which can take many forms (petrol vouchers, free parking vouchers, taxi chits, kai, and creating a welcoming clinical space inclusive of all cultures).
6. Work with stakeholders to develop further information for wāhine about abortion types, what to expect, how to prepare for EMA at home, pain management, and recovery. Rangatahi in particular desire more information. Ensure that this information is culturally inclusive, and that online information is kept current.
7. Explore ways to ensure wāhine who access telehealth EMA also have access to long-acting reversible contraception.

Recommendations for health services

(abortion services general practice, and sexual and reproductive health services)

1. Recognise the importance of the first contact with a health service and reinforce with all staff (including reception, switchboard, and after-hours staff) that kindness, warmth, and respect are fundamental expectations in all healthcare interactions.
2. Ensure all staff undertake and regularly refresh cultural safety training at all levels of the health service.
3. Engage local Māori cultural advisors to lead and develop processes and practical actions to consistently support wāhine Māori in a culturally safe way (particularly around whenua-ki-te-whenua – the returning of the products of conception to the whenua).
4. Enhance systems and processes for follow-up care and after-hours care, including information for wāhine and staff.

5. Recognise the value that wāhine place on clear information at all stages about abortion types, what to expect, how to prepare for EMA at home, pain management and recovery. Rangatahi in particular may need information provided in a range of ways and times.
6. General practice and sexual and reproductive health services (such as Sexual Wellbeing Aotearoa) are a first point of contact for many wāhine. Timeliness for wāhine would be supported by directly providing the contact information of the local abortion service.
7. Ensure wāhine have multiple opportunities to have conversations about contraception and are offered a choice of contraception. Ensure that these conversations are handled respectfully.
8. Ensure that counselling is offered at multiple points in the pathway, especially to rangatahi.
9. Strengthen processes for asking wāhine for consent for their abortion data to be used.

Recommendations for national professional organisations and councils

1. Continue to provide education, training, and professional standards relating to cultural safety.
2. Provide information and education for members about the 2020 law changes and current abortion care pathways, and how to reduce barriers to timeliness for wāhine.
3. Work with stakeholders to ensure that there is clear clinical pathway information adapted to the local circumstances available online, including pathways for medical, surgical and later abortion services.

Context

In March 2020, just 24 hours before the Level 4 COVID-19 lockdown in Aotearoa New Zealand, the Abortion Legislation Act 2020 was passed in Parliament. The law governing abortion was taken from the Crimes Act and brought into health legislation. A summary of the key changes is given in **Figure 1**. The intent of the law change was to bring it in line with the tenets of reproductive justice to enable access to timely, equitable, and publicly funded abortion services. The aim was to place wāhine, women and pregnant people¹ at the centre of the law and decrease inequities (Snelling 2022).

Figure 1: A summary of law reforms introduced in the Abortion Legislation Act 2020

The key changes of the law reforms were:

- decriminalising abortion when performed by health practitioners, allowing a wider range of registered health practitioners to perform abortions, subject to their scope of practice (ie, medical, midwifery or nursing)
- allowing self-referral to an abortion service
- removing the statutory criteria to access an abortion. A health practitioner may perform an abortion before 20 weeks gestation. After 20 weeks gestation, a health practitioner may only perform an abortion if they reasonably believe the abortion is clinically appropriate in the circumstances
- removing the requirement for premises providing abortion services to be licensed. Abortions can now occur in a range of settings, including primary care
- requiring counselling to be available to anyone considering abortion, without making counselling mandatory
- requiring health practitioners who conscientiously object to abortion provision to tell the person of their objection and how to access details of their closest abortion provider.

Reproduced from: Ministry of Health. 2021. Abortion Services Aotearoa New Zealand: Annual report. Wellington: Ministry of Health (Ministry of Health 2021).

Data compiled by Manatū Hauora indicate that although wāhine are now accessing abortion services at an earlier gestation than before the law change, wāhine Māori and Pacific are accessing abortion at later gestations on average than non-Māori, non-Pacific wāhine. This means inequities in abortion care exist, but the reasons for these inequities are not known. These knowledge gaps have implications for service delivery. Wāhine experiences of abortion care since the law reform, and their

¹ We use the kupu (word) wāhine inclusively to refer to women and people with a uterus, from all cultures.

views on what would make abortion services more accessible and culturally safe, have not been canvassed.

The voices of wāhine must be heard to inform the direction Manatū Hauora takes in developing, supporting, and funding abortion services, thereby fulfilling the objectives of the law change. Wāhine and whānau have important insights to help identify elements of accessible and best-practice abortion services, benefitting health and well-being for all.

This research will provide direct consumer feedback on how wāhine are accessing and experiencing abortion services in Aotearoa New Zealand. The findings are intended to directly inform the design and delivery of accessible, acceptable, and wāhine-centred abortion services in Aotearoa New Zealand, with the goal of achieving equitable outcomes.

Aim and Approach

Aim

The research aimed to identify aspects of equitable, timely, safe, and accessible abortion services in Aotearoa New Zealand (what works now and what can be improved).

Approach

Manatū Hauora contracted Te Tātai Hauora o Hine – National Centre for Women’s Health Research Aotearoa (NCWHRA), Victoria University of Wellington, to conduct surveys and interviews with abortion service users, with a particular focus on wāhine Māori, Pacific women, their whānau/aiga, and rangatahi (youth; under 25 years of age). Interviews with abortion providers and clinic staff were also conducted. This was important because wāhine who experience significant challenges accessing care may also be unlikely to participate in an interview for the same reasons, but abortion service workers will be able to relate non-identifying accounts of the difficulties some wāhine face. In this context, healthcare provider interviews were used to augment the voices of wāhine.

Istar Ltd funded the initial development of the survey, prior to Manatū Hauora funding. Manatū Hauora was consulted about the topics to be included in the survey and interviews, but all final decisions about the design and methods were made by the Te Tātai Hauora o Hine project team. Interpretation of findings and preparation of this report were conducted independently of any funder.

Te Tātai Hauora o Hine led the project, and partnered with The University of Otago, The University of Auckland, and Malatest International. This multidisciplinary team included clinicians and researchers with expertise in abortion, women's health, Māori health, Pacific health, public health, sexual and reproductive health, gynaecology, nursing, general practice, and evaluation.

In 2022, Manatū Hauora funded a 24-hour national telehealth service (DECIDE) to provide abortion information by website and free phone number. DECIDE was expanded in November 2022 to provide early medical abortion (EMA) in the first ten weeks of pregnancy by telehealth. In this research only three survey participants had all appointments with an abortion service by telehealth and the experiences of wāhine having telehealth EMA are not represented at all in the interviews. Including detailed analyses of the impact of DECIDE services in future annual abortion reports is very important for a whole-of-sector approach to understanding abortion care (including aftercare, contraception provision, complications, and equity indicators such as timeliness). It is also crucial to conduct additional future research gathering direct feedback from wāhine using telehealth EMA services.

A quantitative survey collects broad information from many people. Qualitative interviews collect in-depth information from a smaller number of people. Some information can easily be collected in a survey and other information is more appropriately collected by interviews (e.g. about culturally safe abortion care). These two methods were used to comprehensively understand how wāhine experience abortion care to inform the design and delivery of accessible, acceptable, and wāhine-centred abortion services in Aotearoa New Zealand.

This project explored the following topics:

- background information (e.g. age, ethnicity, rurality)
- cultural safety
- information (e.g. how helpful it was, how easy or hard to get information)
- the kinds of support wāhine experienced and what would have helped more (from healthcare providers, whānau and other support people)
- physical access: travel, time, costs, making and attending appointments (in-person and telehealth)
- abortion options, tests, and costs
- counselling
- follow-up care (including contraception)
- telecommunication access, safety, and privacy

Ethics

Human research ethics approval was obtained from the Southern Health and Disability Ethics Committee (ethics reference: 2022 FULL 13067) and locality authorisation was gained from the six regions involved.

Anonymous survey

The project was advertised at abortion services in six regions of Aotearoa: Northland, Auckland, Lakes, Capital and Coast, Canterbury, Southern. Nearly three-quarters of abortions in Aotearoa New Zealand are provided in these areas. All people attending for abortion care between January 2023 and November 2023, and aged 14 years or more were eligible to take part. Filling in the anonymous survey was taken as implied consent. Most people chose to complete the survey online, but paper versions of the survey were available. The details for resources and agencies for further help or support were also provided. The data of wāhine Māori, Pacific women, and rangatahi were prioritised in the analysis and interpretation of survey data. Prioritised ethnicity was used, consistent with other Manatū Hauora reports and datasets. Prioritised ethnicity means that each wāhine was allocated to a single ethnic group. Ethnicity was allocated in the following order: Māori; Pacific peoples; and non-Māori, non-Pacific.

Wāhine could choose to take part in the survey, an interview, or both. Wāhine could indicate their interest in learning more about being interviewed via a link at the end of the survey that took them to a confidential site, or by scanning a QR code independent of the survey.

Confidential interviews

Interviews with wāhine Māori and Pacific women (aged ≥14 years) who had accessed abortion services since the law reform were undertaken by experienced Māori and Pacific researchers from Te Tātai Hauora o Hine and Malatest International, underpinned by Kaupapa Māori and Pacific research methodologies (Helu-Thaman 1992, Tamasese 1997, Smith 1999, Maua-Hodges 2000).

Whānau/aiga were recruited by asking wāhine who participated in an interview whether they had a family member or support person who was part of their experience that we could approach for an interview. Healthcare providers were recruited via purposive sampling. Those who decided to participate in an interview were asked to sign a consent form or give verbal consent at the time of the interview.

Interview data were analysed using reflexive thematic analysis, which is a dialogue between data, theory, and interpretation (Braun and Clarke 2019). We see this as compatible with Kaupapa Māori and Pacific research as it acknowledges the subjective, contextual, and interpretive work of qualitative analysis. Interview transcripts were coded inductively, with the codes then organised and re-organised until final themes are created. This analysis brings to the forefront the experiences of participants from a strengths-based position that sees being Māori and Pacific as normal.

Findings

Summary of participants

Survey

A total of 190 survey responses were received, and 126 were complete enough to be included in this report (66.3%). Demographic characteristics of survey participants are given in Table 1. Nearly one-third of participants were Māori (n=39, 31.5%) and 18 (14.5%) were Pacific (prioritised ethnicity). Nearly half of participants were rangatahi (<25 years old, n=51, 40.5%). Approximately three-quarters of participants (n=94, 77.7%) had their abortion under ten weeks' gestation, and no one had their abortion after 18 weeks' gestation. Most wāhine lived in urban regions (n=101, 83.5%) while 20 (16.5%) lived rurally.

We note intersectionality among the survey participants. Six wāhine were both Māori and Pacific ethnicities and are included as Māori due to prioritised ethnicity. The 51 rangatahi included 19 Māori (37.3%) and 10 Pacific women (19.6%), and the 20 rural wāhine included seven Māori (35.0%) and five rangatahi (25.0%). Almost all (122/124, 98.4%) participants identified as female. Three participants had a disability consistent with the Washington Group Short Set on Functioning (Washington Group on Disability Statistics 2024).

Interviews

A total of 20 interviews were conducted: six wāhine, one whānau member, and 13 healthcare providers. Interviewed wāhine were aged between 19 and 34 with most participants aged under 25. Four participants identified as Māori, two as Māori and Pacific, one as Pacific², and one as New Zealand European³. Healthcare providers represented a range of professions, with extensive experience in different secondary care settings across different regions.

Integration of survey and interview findings

The findings from the survey and interviews have been presented and interpreted together, leading to conclusions and recommendations that are based on both data types.

² Pacific groups included Samoan and Cook Island Māori.

³ We realised during the interview this participant was non-Māori and non-Pacific. We decided to respect her story by including it in the analysis and her kōrero aligned with those of Māori and Pacific wāhine.

Table 1: Demographic characteristics of survey participants

	Number of responses (%)
Survey completion	Total responses: 190
100%	92 (48.4)
75-99%	34 (17.9)
<75%	64 (33.7)
Total ethnicity	Total responses: 124
Māori	39 (31.5)
Pacific Peoples (Samoan, Cook Islands Māori, Tongan, Niuean, Fijian)	24 (19.4)
Asian (Chinese, Fijian Indian, Filipino, Indian, Laotian)	14 (11.3)
NZ European and Other European	86 (69.4)
Prioritised ethnicity	Total responses: 124
Māori	39 (31.5)
Pacific Peoples	18 (14.5)
Other: (NZ European, Asian, Other European)	67 (54.0)
Age (range: 16-47 years)	Total responses: 126
<20	12 (9.5)
20-24	39 (31.0)
25-29	30 (23.8)
30-34	20 (15.9)
≥35	25 (19.8)
Gestation (range: 5-18 weeks)	Total responses: 121
<10 weeks	94 (77.7)
Rurality⁴	Total responses: 121
Urban 1	92 (76.0)
Urban 2	9 (7.4)
Rural 1	12 (10.0)
Rural 2	5 (4.1)
Rural 3	3 (2.5)

⁴ Defined using the Geographic Classification for Health: Urban 1 is the most urban, Rural 3 is the most rural. (<https://journal.nzma.org.nz/journal-articles/defining-rural-in-aotearoa-new-zealand-a-novel-geographic-classification-for-health-purposes>)

Cultural safety

We begin the findings section of this report with cultural safety, as equity, accessibility, and high-quality care cannot be achieved without it. This topic was largely explored by the interviews. The findings of this research suggest that wāhine generally experienced culturally safe care, but there was also room for significant improvement. Culture includes Indigenous status, age or generation, gender, sexual orientation, socioeconomic status, ethnicity, religious or spiritual belief and disability (Medical Council of New Zealand 2019). Culturally safe care focuses on the delivery of quality care through changes in thinking about power relationships and patients' rights (Papps and Ramsden 1996). In understanding power imbalances and racism, both within health services and among the individuals who work in them, cultural safety shifts responsibility onto those institutions and health workers to address performance of services in meeting the health realities of Māori, including ensuring access to care (Ellison-Loschmann and Pearce 2006). Wāhine interviewed in this study were asked about how staff related to them, whether resources resonated with them, and any other aspects in and around health service delivery and care that could have made them feel more comfortable and safe.

Warmth from reception and switchboard staff was commented on whether it was given or absent. This first contact with an abortion service was vital as it set the scene for the rest of the engagement.

I think right from the receptionist to my last goodbye with the nurse, everything was so warm. I felt like they really cared for me...They were so warm, welcoming. I felt safe 100% of the time.
Wahine 5

The implications of a 'cold' reception went beyond discomfort and could feel like a racist judgement.

I guess it's important to have those frontline staff; the reception, a bit more welcoming. I mean, if I wasn't sort of as privileged as I probably am; I could have easily felt they were being racist. Wahine 3

Healthcare providers also highlighted the importance of manaakitanga (process of showing respect, generosity and care) and efforts to ensure a safe and welcoming environment from first engagement.

Manaakitanga is very important to me. Our receptionist is gorgeous, you know that person is the face on what is welcoming to the department...and working together [with a Kaupapa Māori advisor] in partnership so that women actually have the best experience they can have.
Healthcare provider 10

Interviewed wāhine valued whanaungatanga (relationship building) from abortion service staff. Staff introduced themselves and shared something of their lives. They asked questions about patients and

took time to listen. Kindness, authenticity, and serenity were valued by wāhine. Participants appreciated staff emphasis on taking time and not rushing.

Every time I got a new nurse, they'd introduced themselves to me...I think it makes more, not connected but better than someone just coming in, "Give me your arm," you know? Like, "My name is John. Give me your arm." Wahine 5

Healthcare providers also noted the importance of whanaungatanga. Taking time to know and relate to wāhine and whānau was essential to building trusting and safe relationships. However, it was noted that given current funding structures, having the time to build meaningful relationships is often difficult.

Everything that the Ministry puts out is in little funding packages, and when you go to general practice...they make you an appointment...might just take 15 minutes. In our clinic all general appointments are half an hour because you'll probably find there's something else that you should do while you're there...The meet and greet takes a wee while, but in doing that, you're receiving somebody, and they value that and then they come back. Healthcare provider 1

Wāhine talked about instant connection and rapport with people who share cultural elements with them, whether this was ethnicity or gender. Shared similarities, combined with whakawhanaungatanga instilled a relationship where wāhine could relate to the clinician as a person.

The presence of female staff that's quite prevalent now, and before I just didn't really consider the importance of that, but then going through this you say, 'oh, yes, these women get it, because they are just like me'. Wahine 3

All healthcare providers discussed ways in which culturally safe care within a clinical space were, or could be, supported by staff engagement/communication. They identified culturally/ethnically matched staff and the ability to communicate in te reo or other languages. However, limited workforce capacity and diversity in some regions minimised opportunities to provide this level of service.

While availability of staff 'just like me' were noted by wāhine and staff as a strength for engagement and communication, there were other important elements of care voiced by wāhine, notably staff listening and responding appropriately. Wāhine emphasised situations where staff communicated with them thoughtfully and clearly. Sometimes staff offered to hold the participant's hand. These ways of communicating and connecting helped reassure wāhine.

When I couldn't understand what they were saying they explained it in a better way. Wahine 6

Wāhine appreciated staff not making assumptions about their personal situations.

Yeah, it was really good that they didn't kind of ask any questions so much, and they didn't ask anything about my partner either, but yeah, so I think that would be good for people that aren't in such a stable relationship because that would be quite stressful I think – getting asked about partners. Wahine 4

Wāhine valued manaakitanga shown by abortion service staff in providing a comfortable space, seating, a cup of tea, and kai. In one example the clinic offered a taxi home. These actions helped wāhine and whānau/aiga to feel valued and looked after.

They give a bit of a kai afterwards. Not that I could really eat, but those are just nice whakaaro. They just actually showed concern for you, or that's what it feels like. And that's important that you feel like people aren't just looking at you, like, 'oh, here comes another abortion case who can't keep their child, and made this bad decision', it doesn't feel like that anymore. Wahine 3

The physical clinic environment was discussed by wāhine in relation to experiences of culturally safe care. Some wāhine noted the physical clinic spaces they entered felt cold and uninviting, and this impacted their feelings of cultural safety.

When we first arrived, I guess it's a very uninviting sort of entry and waiting area, like you're a bit of a criminal. Or it's sort of like - I had to go WINZ for my mother yesterday, and it felt like I was in a WINZ office. It's real rawe kōre feeling; like, just real sad. Wahine 3

Some healthcare providers also noted the importance of creating a calm and welcoming physical space and shared some tangible examples of achieving this.

We started with plants, some paintings, [we've] got a [important Māori artefact]. Healthcare provider 10

Discussions about the products of conception were handled sensitively but sometimes lacked practical support. Sensitivity around these discussions was appreciated by wāhine and whānau.

[Daughter] commented on the theatre nurse, on how awesome she was. And then she came in and just had a kōrero with her and asked obviously those certain questions like, "What do you want done with the fetus?" It was just, I didn't have that, so that was pretty awesome. Being able to have that doctor come in and actually check up on you and just find out what would you like to do? Whānau 1

Wāhine described a need for more guidance on collecting the products of conception. A lack of clarity and practical support at this stage can cause distress.

I didn't know how big the box had to be. Maybe they should have boxes at the hospital for us, like because I had to go to Countdown and beg them to give me a little box from the florist that they don't normally sell. So, and then like storage; I can't just bring the thing back and put it in my freezer, so just having that space available for you to store it while you make plans for it. I don't know if that's asking too much, but that's what would make me feel better. Wahine 3

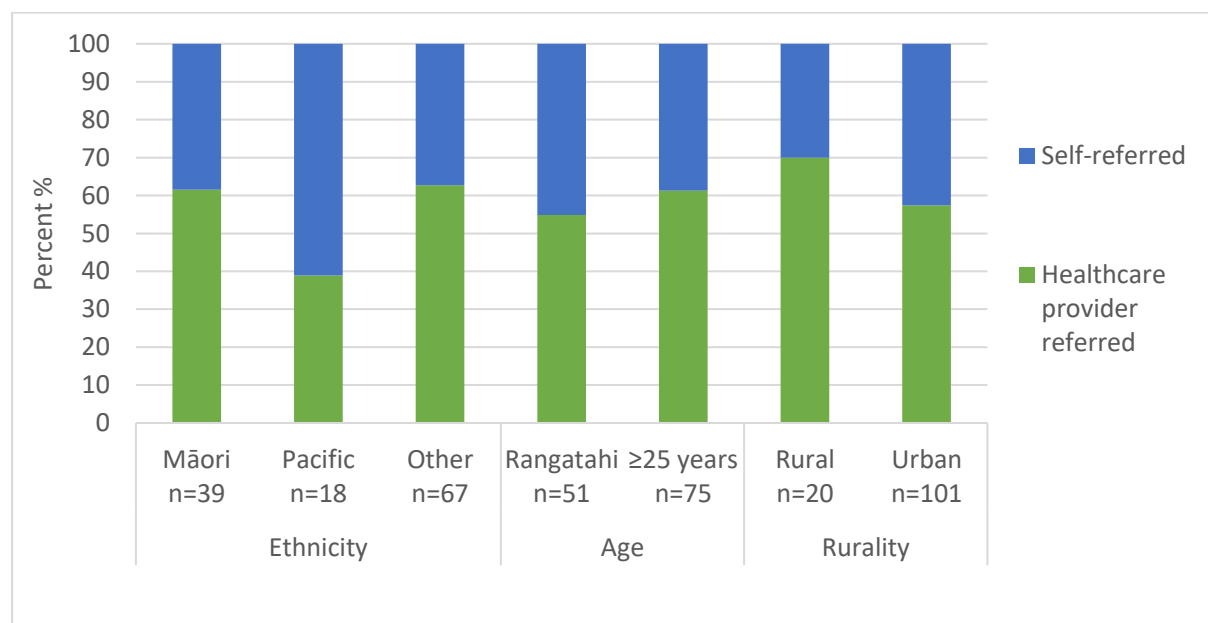
Some healthcare providers shared examples of conversations and practical considerations around storage and burial of the products of conception. However, from wāhine experiences noted above, it appears that this is not consistently practiced across all regions.

For our tissue, we got kete bags... we can gift women their tissue back in a kete to take home for burial. We've got burial instructions there and for the post operative side. Healthcare Provider 10

First contact with the health system after deciding to have an abortion

Wāhine who were aware of self-referral to an abortion service favoured this option. One of the major reforms of 2020 was the ability to access an abortion service without a referral from another healthcare provider first. This option was taken up by a substantial number of surveyed wāhine: 38.5% Māori (15/39), 61.1% Pacific (11/18), 45.1% rangatahi (23/51), 30.0% rural wāhine (6/20) (**Figure 2**), but the first contact with the abortion care pathway for 58.7% of wāhine (74/126) was a referral from another healthcare provider. For most wāhine this was a general practitioner. Sexual Wellbeing Aotearoa (formerly Family Planning) also remained a first contact for many wāhine (usually a phone call). Timeliness for wāhine could be supported by first contacts directly providing the contact information of the local abortion service. The importance of making contact with an abortion service was also emphasised by survey participants who felt having an abortion could be made easier by an online booking system (31.3%, 36/115) or a 24-hour helpline about abortion and abortion services (15.7%, 18/115).

Figure 2: Self-referral to an abortion service or referral by another healthcare provider.



Surveyed wāhine who saw a healthcare provider before the abortion service reported a range of ways that this stage of the pathway could be made more accessible, indicating that challenges and obstacles are often encountered:

- Clearer information about abortion: 12.5% Māori (3/24)
- Healthcare providers not making assumptions about pregnancy intentions: 5.4% overall (4/73)
- More welcoming clinics, culturally safe care, privacy and confidentiality: 8.3% Māori (2/24) for each

Some interview participants were not aware of the option of self-referral to an abortion service, but noted their first point of contact gave clear information and referred them directly to the abortion clinic.

He (GP) just like, explained where I would have to go. Like the blood test and stuff. Yep. And then just to call, he gave a number to call. And then he said that I just needed to make an appointment. And that was it. Wahine 6

However, for one wahine it took almost three weeks from first search for information on the internet, to several phone calls, a GP appointment, an ultrasound appointment and a further GP appointment. Finally, she contacted the abortion clinic directly to secure an appointment. This wahine shared her anxiety and anger at her long and unnecessary pathway to access abortion care. Not only were there multiple points where healthcare providers failed to give her the correct information but on reflection, it would seem at least one tried to block her from accessing the service. This led to a confusing and lengthy engagement with many services. We have not given the quotes from this wahine a label in this context to add another layer of anonymity.

So, between when I found out, I didn't even know that I could self-refer. That's the part that pissed me off the most. I didn't know I could just self-refer to the clinic and then they would have walked me through everything. This was beyond stupid. This was actually stupid.

Not only was incorrect information provided but despite her request for an abortion, the first GP also offered to prescribe pregnancy medication.

It was almost like he doubted my decision. I was like, 'Nah, nah, I'm [age] years old. I've made my decision. Don't do that. Don't do that.' I didn't say this. I just said, "No, thank you." But, that was the reaction in my head. That pissed me off. I was like, 'How dare you? How dare you?'

In another example, a primary healthcare provider advised a subsequent and unnecessary appointment with another primary healthcare provider, rather than offering details of the closest abortion provider (as required by law).

Timeliness

Timeliness emerged as a recurring priority for wāhine throughout both the survey and interviews in this study, and the ability to self-refer facilitated this. Among surveyed wāhine who saw another healthcare provider before the abortion service, the three most suggested improvements to access at this stage of the care pathway related to timeliness or physical access:

- 1) a shorter time between booking and the appointment with the first healthcare provider: 27.4% overall (20/73), 37.5% Māori (9/24), 32.1% rangatahi (9/28).
- 2) easier to get to the appointment with the first healthcare provider: 16.4% overall (12/73), 33.3% Māori (8/24), 14.3% rangatahi (4/28), 14.3% rural wāhine (2/14).
- 3) a telephone appointment: 13.7% overall (10/73), 16.7% Māori (4/24), 28.6% Pacific (2/7), 17.9% rangatahi (5/28).

Most surveyed wāhine who self-referred had their first appointment with the abortion service a few days or the week after they first requested an abortion (80.8%, 46/52), and only 11.5% (6/52) reported it taking more than a week. Wāhine who did not self-refer reported a longer time to the first appointment with the abortion service, with 24.3% (18/74) reporting it taking more than a week.

First contact with the abortion service

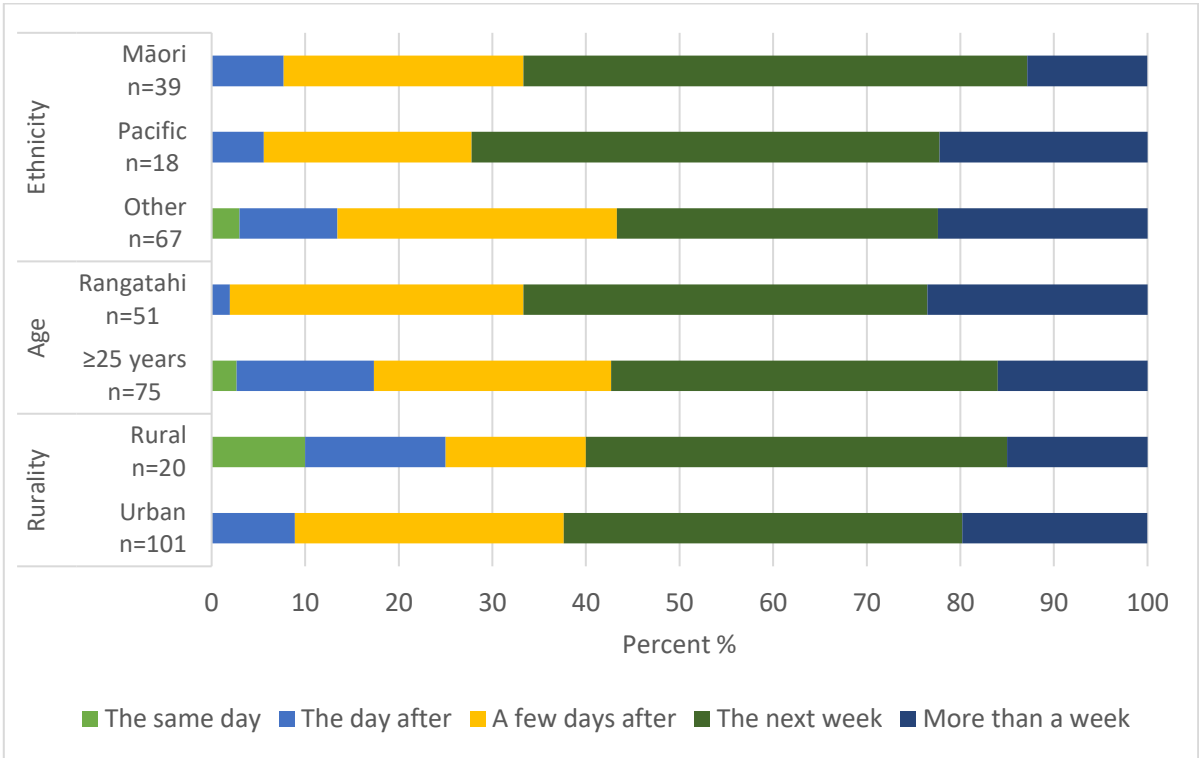
Most surveyed wāhine (72.2%, 91/126) found it easy or very easy to make the first appointment with the abortion service (find the phone number or website, book by phone or online). Interviewed wāhine who self-referred described some very direct, seamless and positive experiences when booking with an abortion service.

I just told them that "I'm ringing in to book an abortion," and they were like, "Okay sweet, we'll just transfer you to the right people that can help you with the department...and when they transferred me the people on the other end were lovely. They didn't go like, "Oh, you want to book an abortion, or why do you want an abortion?" They were like, "Okay sweet. We can book you in on this time at this day if that's okay for you. We can put that down." Wahine 1

The lady was really good; she put me straight through to a nurse who explained I could have the surgical [or] the medical abortion... I was quite surprised about how easy that part was to be honest. Wahine 4

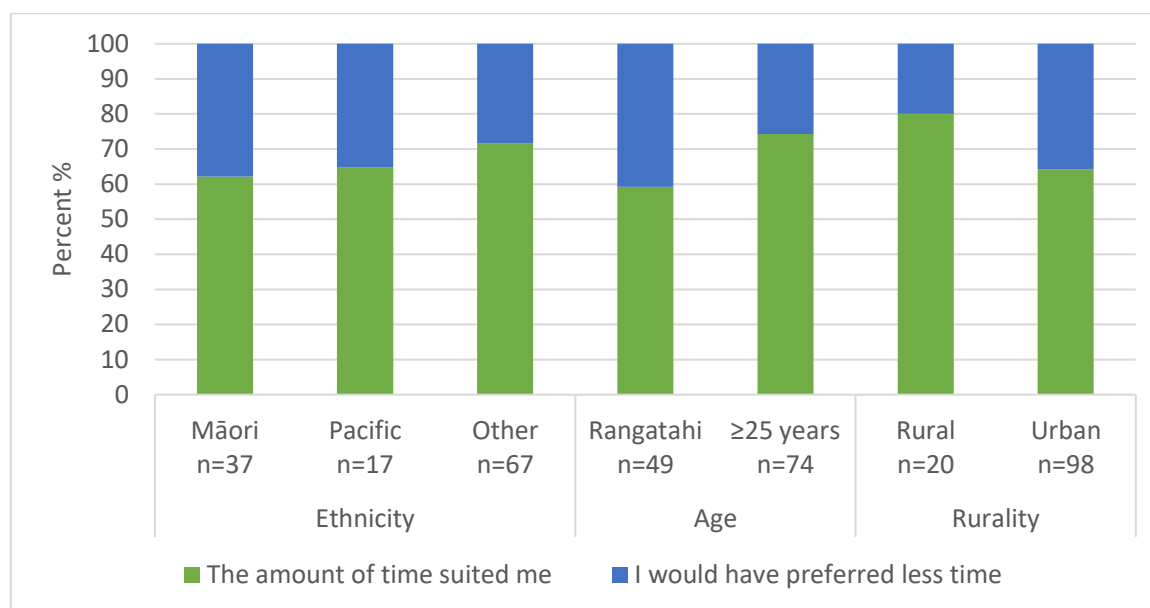
Most surveyed wāhine had their first appointment with the abortion service a week or less after they first requested an abortion (81.0%, 102/126). However, nearly one-quarter of Pacific women (22.2%, 4/18) and rangatahi (23.5%, 12/51) reported waiting more than a week for this time sensitive care (Figure 3).

Figure 3: Time between first requesting an abortion and an appointment with an abortion service.



Timeliness was highlighted at this stage as well. The majority of all surveyed groups felt that the amount of time between the first appointment with the abortion service and the abortion was appropriate (68.3% overall, 84/123) (Figure 4). Additionally, a considerable number would have preferred less time between the two (31.7% overall, 39/123), particularly Māori and rangatahi (Figure 4). Importantly, not a single wahine would have preferred more time.

Figure 4: Preferences for the time between first appointment with the abortion service and the abortion.



Most surveyed wāhine felt it was easy or very easy to find the abortion service (79.2%, 99/125). Barriers to physically locating the abortion service described in the interviews included not having clear directions about where to go and a lack of signage. These barriers led to feelings of discomfort and embarrassment.

I remember going up to the front counter and seeing 'maternity unit', I was like 'I'm in the right place.' I got to the counter, and I was like, "Oh my name's [redacted] I'm here for my appointment." She goes, "Oh. Abortion unit's over there." I was like, "Oh shit. Sorry." So that was a bit whakamā for me. Wahine 5

Interviewed wāhine were aware of anti-abortion demonstrations in their towns and of the potential for anti-abortion protesters outside the abortion service.

I was expecting to be judged and stuff. Wahine 1

Most of the abortion services involved in this research now have Safe Areas in place (Ministry of Health). Healthcare providers highlighted the importance of ensuring adequate security and Safe Areas for all abortion services.

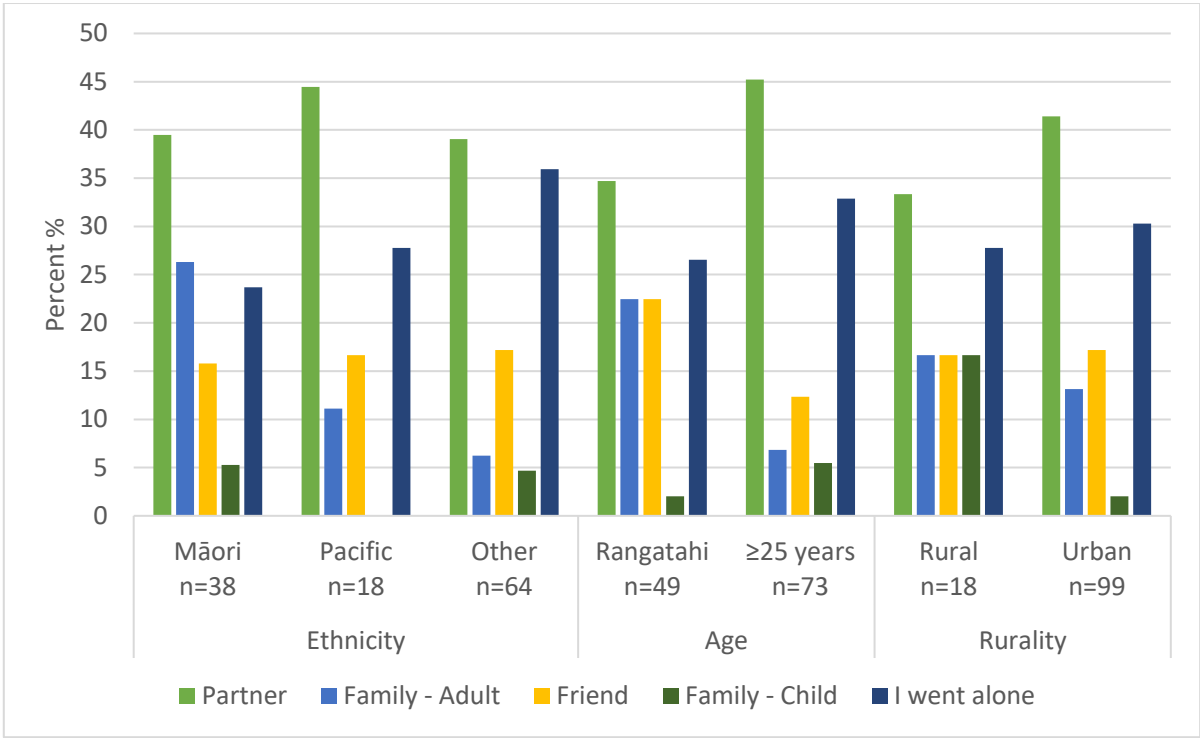
They used to stand outside with their banners outside because when you came into the hospital to park, they would be there. So that was quite off-putting ... It's fantastic that they just can't do it now [with the introduction of Safe Areas]. And we have an amazing security team so that the minute if someone turned up...they will be over within five minutes and to escort him off the building and have him arrested. Healthcare provider 5

These measures are likely to have contributed to our finding that only three survey participants reported seeing protesters at the abortion service and none reported being approached or spoken to by protesters. This finding emphasises how important this additional legislation has been.

The role of whānau

Whānau included people connected by whakapapa such as partners, parents, siblings, and kaupapa whānau such as friends. More than two thirds of survey participants (70.2%, 85/121) attended the abortion service with whānau or support people, most commonly their partners (41.3%, 50/121). Adult family members and friends also commonly accompanied Māori and rangatahi (Figure 5). A small but notable number of wāhine (5% overall, 6/116 and 9% rangatahi, 4/44) felt that having more support people with them would have made having an abortion easier.

Figure 5: Whānau/support people attending the abortion service.



Interviewed wāhine reflected on the vital role of whānau. Whānau helped find information for decision-making and seeking care. They also provided practical support such as transport, accompanied wāhine at the clinic, provided reassurance, and a private space for EMA at home and recovery.

My friend went through this just last year, so I think that helped me a lot knowing that someone else in my friend group had been through it, or someone else my age had been

through it, and I could talk to her about what's going on and what to do. It was quite helpful to have someone who's done it knowing that they won't judge you kind of thing. Wahine 4

And then he went home to get me some clothes, came all the way back to [suburb] to get me some different clothes and stuff. Wahine 5

The whānau member interviewed valued being able to support her daughter at the abortion service, by being present and providing reassurance.

We were allowed to come through on her room...She would have freaked being on her own and she would have withdrawn from it, so just having us there. Same with not been able to go through to the operation room with her, that would have been scary for her, but we went through, she was just, "Okay baby, this is all you, you've got this. We're just down the hall babe. We're just down the hall. We'll see you when you come back." Whānau 1

Interviewed wāhine expressed empathy for people without strong emotional and practical support from whānau, and how they would need additional support from the health system.

Specifically, Pasifika women have – because I know in very strict Pasifika whānau, they are quite religious, and this procedure obviously goes against their religious beliefs. I don't know, extra wraparound support for women in those positions because I can just imagine – I've got many friends who come from strict religious whānau. I can only imagine how hard it would be for them to go through something like this. Wahine 5

For the most part, interviewed wāhine felt that their whānau/aiga were well looked after by staff at the abortion service. They were welcomed, provided with seating, and important tikanga such as being offered refreshments happened for many of the interviewed wāhine. The interviewed healthcare providers also highlighted the importance of whānau inclusiveness, support, and engagement.

Worry about the wellbeing of their partner was a strong theme in the wāhine interviews. Although partners were in a support role, wāhine described their partners sometimes feeling 'freaked out' or confused by elements of their abortion experience.

Yeah. My partner was kind of freaked out after my procedure because of everything that happened. But yeah, I think they made him feel comfortable, waiting for me, offered him lunch too. And... first thing in the morning and the nurse took his number in case anything had happened or would happen overnight, which I found was quite nice. Wahine 5

One wāhine did not think her partner was supported well enough and took on this role herself.

Include? Yes. Support? I'm not sure to be fair. No-one really asked if [name] was okay or anything. If anything, I was doing that. I kept asking, "Is this okay? What are you feeling about this?" No-one really asked him, but he was brought to everything. He was brought to when we got the first dose. He was brought to the scan and stuff. Wahine 2

Tests and costs

Both the survey and the interviews suggested having an ultrasound prior to the appointment at the abortion service presented a considerable barrier to wāhine in terms of time and financial costs. A potential way to address this is to have portable ultrasound scanners at all abortion services and staff trained in their use. This would allow point-of-care ultrasound scanning, with a potential reduction in time and cost barriers to wāhine and reduction in pressure on community ultrasound services. Almost all survey participants reported needing a blood test before the appointment at the abortion service (92.0%, 115/125), 74.4% reported having an ultrasound (93/125), and 13.6% had swabs (17/125). Fewer rural wāhine reported needing ultrasounds (70%, 14/20) and swabs (5.0%, 1/20) before the appointment at the abortion service, suggesting regional variation in availability of community ultrasound services and variation in opportunistic sexually transmitted infection testing by abortion services.

Information about the tests needed prior to an abortion was a common topic wāhine wanted more information about: 11% overall (12/109), 12.5% Māori (4/32), 20.0% Pacific (3/15), 14.0% rangatahi (6/43).

Overall, three-quarters of surveyed wāhine (75.0%, 93/124) reported not needing to pay for any part of the abortion care: 76.3% Māori (29/38), 88.2% Pacific (15/17), 83.7% rangatahi (41/49), 70.0% rural wāhine (14/20). Ultrasound was the most common part of abortion care that wāhine reported paying for (21.8%, 27/125), with a small number paying for a referral for the abortion (3.2%, 4/125), and contraception after the abortion (3.2%, 4/125).

The interviews also identified other costs incurred by wāhine such as time off work (themselves and whānau), transport or travel, and parking.

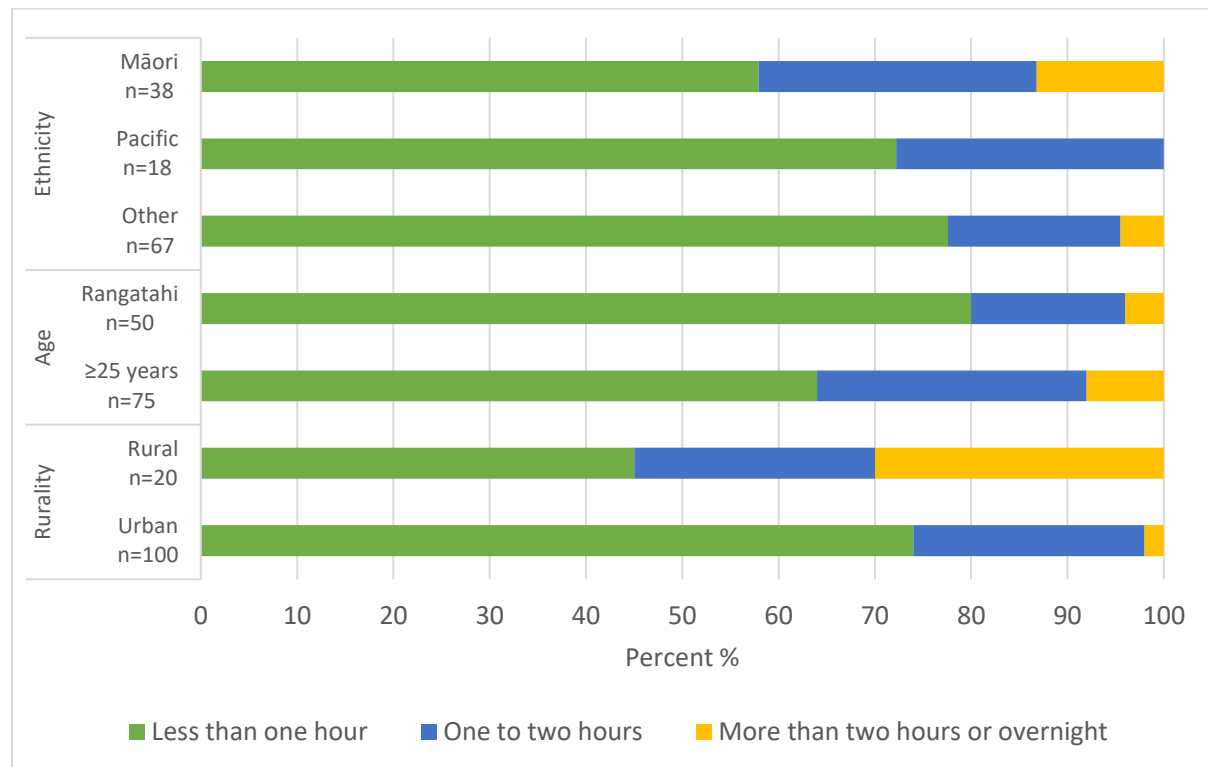
The only thing that I was worried about being off work was paying rent. Wahine 1

Our car parking makes it hard for any patient to come into. It's just not ideal. But also, where we are in [region], travel is a massive thing. [Clinician] on the odd occasion will take a patient [to their clinic] to avoid that issue for some people. We will hunt down petrol vouchers for people who need it...when really required. Healthcare provider 9

We live in a geographically isolated area so the transport is huge for women, huge...[if] a woman that has three kids or two kids or a child to then ask them to go somewhere else and then somewhere else again; bloods somewhere else, a scan somewhere else and then come back, it's unreasonable. It really is unreasonable, it's unfair. We're talking about equity, and there's no equity. Healthcare provider 6

Travel time to the abortion service was two hours or less for most surveyed wāhine (93.6%, 117/125), although 13.2% of Māori (5/38) and 30.0% of rural wāhine (6/20) had to travel for more than two hours or stay overnight on the way there or back (Figure 6).

Figure 6: Travel time to abortion service.



Private transport was the most common way to travel to the abortion service (91%, 111/122), however more rangatahi used multiple forms of transport or a wider range of transport options (87.8%, 43/49 solely used private transport). Transport or travel to the abortion service was an area for improvement for some surveyed wāhine, with 15.7% (18/115) reporting having an abortion could have been made easier if it was easier to get to the abortion service (11.4-36.8% across priority groups) or if no travel was required for any appointment: 10.4% overall (12/115) and 21.1% rural wāhine (4/19).

The interviews suggested there were also costs incurred by wāhine in terms of impact on their employment. Abortion is acute healthcare that cannot be planned around the needs of the workplace. Work with other areas of government is needed to protect and support wāhine with paid leave for time-sensitive healthcare. All interviewed wāhine had to take time off work to access abortion care and there were different levels of support from workplaces. One wāhine applied for annual leave but

had her application declined. She then obtained a medical certificate from the hospital to secure recovery time at home. At least one used flexi-hours so had to make up extra time at work on her return. Another had just started in a new job and lost income because of an insufficient sick leave balance.

Mainly my work was hard to get out of. Wahine 6

Transparency about taking leave from work to have an abortion was an added complexity. Wāhine are under no legal obligation to share their personal reasons for taking leave with employers. However, asking for time off without giving a reason had different responses from employers; for some this was an obstacle to leave being approved.

One healthcare provider shared their experience of supporting a wahine to access care for post-surgical complications and maintain confidentiality within their workplace.

[An example] where somebody was bleeding that wanted to keep it confidential... We picked them up from work and ended up taking them to [hospital] and saying it was bad period pains to give her some options about what to use [with employer]. Healthcare provider 10

The whānau interview stood out from others in the experience of taking time off work to support her whānau member accessing abortion care.

Where my job was concerned, my boss has actually been through it herself. My boss is all about family. If you're sick, you take that time off. You still get paid. I work for beautiful people. Whānau 1

The recovery time needed away from work varied but interviewed wāhine wanted more guidance on the amount of time required off work for abortion and recovery. Wāhine reported a range of different needs; for example, a wahine Māori described needing time to heal their wairua.

Another thing that could be improved is the expectation that you're okay to return to work the next day, or the day after. Like physically you might be, but mentally you might not be... Especially for Māori that feel things, our wairua differently; so have that connection with their baby. Wahine 3

Counselling

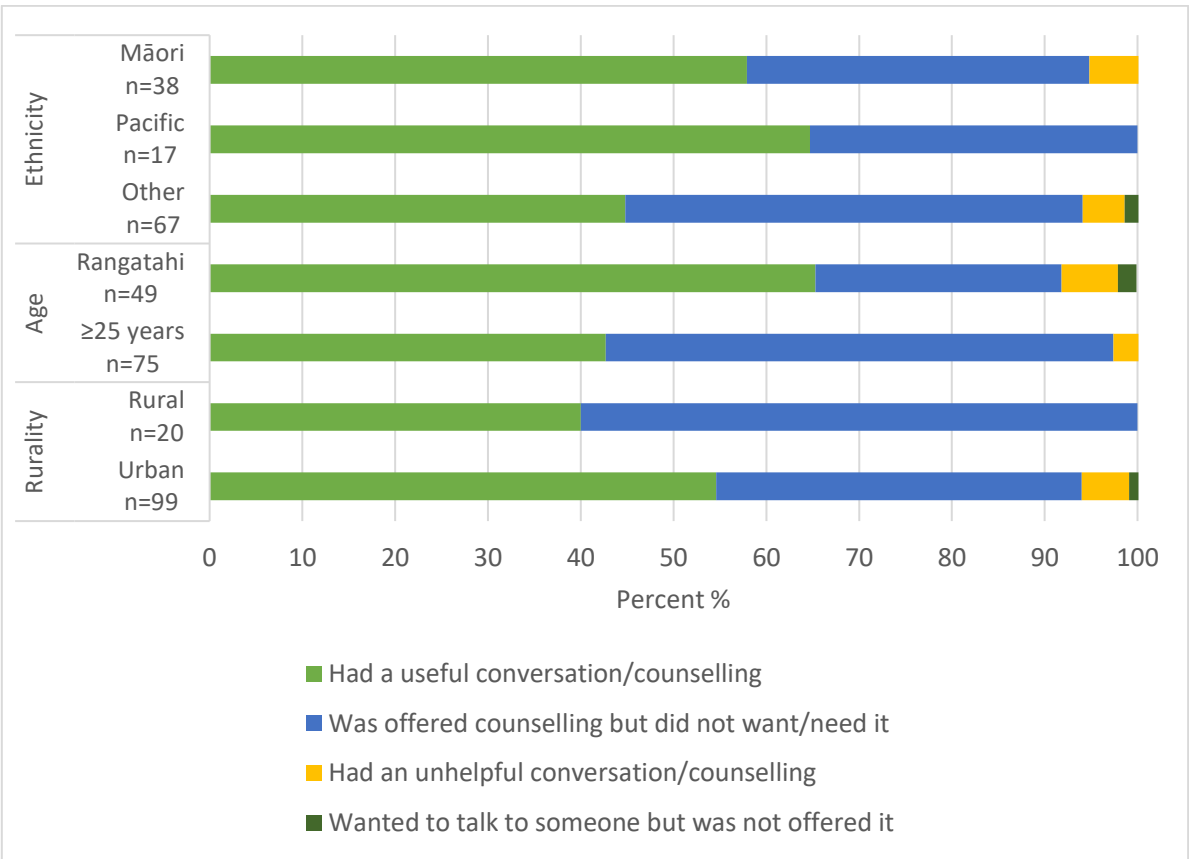
Both parts of the research suggested that non-judgemental and supportive counselling with someone relatable was valued by wāhine as both a source of information and emotional support. Interviewed wāhine who received counselling described learning more about what to expect during the abortion procedure.

Yeah, the counsellor was actually the most informative; she was very, very thorough, and very knowledgeable not just in her practice but with the medical side of things, so I probably got the most out of her. I hope all their counsellors are like her. Wahine 3

The nurse or the doctor she offered it [counselling]. Because I really had a good support system, I didn't need it. Wahine 6

Almost all surveyed wāhine (95.2%, 118/124) reported either a) having a helpful conversation or counselling about the abortion with a healthcare provider or b) being offered counselling but not wanting to talk about the abortion (**Figure 7**). Ensuring that counselling is offered to rangatahi at multiple points in the pathway is important, as a small but notable 8.2% of surveyed rangatahi (4/49) reported having an unhelpful conversation or wanting to talk to someone but not being offered it (**Figure 7**).

Figure 7: Counselling or a conversation about the abortion with a healthcare provider.



Information provision

Information and reassurance about what to expect was very important to wāhine. Overall, wāhine reported receiving useful information from abortion services. This included both written and spoken material. Of surveyed wāhine having an abortion before 10 completed weeks gestation, 89.4% (84/94)

remembered being offered a choice of medical and surgical abortion. Almost all reported being encouraged to ask questions at the first appointment with the abortion service (97.6%, 122/125). Almost all also reported being satisfied with the answers given or did not have any questions (97.5%, 119/122). These findings were supported by the interviews.

They had papers, they put out posters and information sheets. I remember walking away with a whole booklet of information sheets and papers. Yeah, it was good. They asked me a lot of questions if I understood. I mean I knew the process. I didn't ask any question, but they really wanted to make sure that I understood what was happening. Wahine 5

Despite these high levels of satisfaction, some surveyed wāhine wanted more information about:

- the different types of abortion: 18.8% Māori (6/32), 20.0% Pacific (3/15) and 11.6% rangatahi (5/43)
- potential side effects of different abortion options: 15.6% Māori (5/32) and 14.0% rangatahi (6/43)
- pain management: 9.4% Māori (3/32) and 20.9% rangatahi (9/43)

Information needs identified by the interviews included what to expect during an EMA, when to take the second set of medication, and how to prepare the physical space for an at-home EMA.

I didn't really realise how painful it was going to be until I watched a TikTok... I think they do kind of play down how painful it can be. I guess because like for some people it's not that painful, but it was probably the worst pain I've been in.... They kind of tell you to take the Codeine when you get pain, so that took like about 40 minutes; that's 40 minutes of me being in pain before the Codeine kind of kicked in, and it was really bad. Wahine 4

There wasn't a full-on, "This is the process. This is what is going to happen. This is how long it will take." Wahine 2

Based on their experiences delivering abortion care, healthcare providers shared several ways information could be improved for wāhine and whānau/aiga. Healthcare providers noted a need to:

- Ensure wāhine know they can self-refer.
- Ensure that there is clear clinical pathway information adapted to the local circumstances available online for primary care. This should include pathways for access to medical, surgical and later abortion services. This information should be made available with urgency and kept up to date.
- Provide more information/resources about what it is like to have an abortion (including the potential pain), and how to cope and manage after an abortion.

- Further information and education for GPs, midwives, nurses, and other first points of contact about current abortion care and pathways, so they can provide wāhine with accurate and timely information.
- Provide all information and resources in multiple languages.

Routine follow-up care and care for concerns or symptoms

For the most part, wāhine in both parts of the study thought the information given at the abortion service about what to expect and how to look after yourself after both surgical and medical abortion was good.

Surprisingly the booklet about aftercare and stuff made a really big difference. There was stories from people that had experienced situations worse than mine, but feeling the exact same way I felt. I think for me that was really important. Wahine 2

Most surveyed wāhine were satisfied with the information provided about follow-up after the abortion (94.4%, 117/124); however, 10.2% of rangatahi (5/49) reported not receiving information, understanding the information, or being able to act on the information. Consistent with this, 16.3% rangatahi (7/43) and 15.8% rural wāhine (3/19) would have liked more or better information about follow-up care.

The interviews identified that clinical follow up available to wāhine after they left the clinic varied and some wāhine encountered barriers to contacting health services for follow-up care. Some wāhine had an expectation that the abortion service would contact them once they were home to check if they were okay, but this had not happened. Wāhine did not feel they could reach out to general practice for information or support after their abortion for a variety of reasons. Wāhine needed reassurance they would not be a nuisance if they called their GP after an abortion.

I haven't had a follow-up to see if everything's going okay...Thinking about it now, I think follow-up call to see how things go but nah, there hasn't been. Wahine 5

I've been trying to get a hold of the [abortion provider] to see if it's okay if it's taken [the blood test] outside of those seven days. They just haven't got back to me yet, so that's another thing that was a bit stressful. Wahine 4

Most surveyed wāhine felt they knew what to do or who to contact if they had problems, complications or worrying symptoms after the abortion (90.3%, 112/124); however, 14.0% of rangatahi (6/43) and 15.8% of rural wāhine (3/19) would have like more or better information about what to do if these happened. This need was consistent with the interviews, in which some wāhine

found availability of after-hours care was poorly organised and inconsistent, and encountered barriers to accessing after-hours care.

Probably like a direct line to someone rather than going through a call centre that you have to explain your situation to every nurse until it gets to a doctor. Which is kind of where my reluctance was because I belong to a medical centre, and you don't always get your same doctor. So yeah, probably, or even if it's with the [redacted] clinic, if that's the right channel to use if anything goes wrong. I actually can't remember; I just remember seeing the GP. So maybe yeah, just being really clear on who your post care is with. Wahine 3

The [the after hours gynaecology clinic registrar] was kind of like, "Have you tried calling the day surgery because we don't really offer advice for the abortion?" I was like, "Well, you're the number on the wee pamphlet they gave me." She eventually gave me the information anyway, and gave me advice ... but yeah, it would have been a lot better if I think she was made aware they're the afterhours number. Because I feel like a lot of people are probably doing it, in the weekend, when their partners are home from work and stuff. Wahine 4

Contraception

Almost all surveyed wāhine reported being offered contraception as part of abortion care (97.5%, 117/120). The most commonly offered contraception was an intra-uterine device or implant (74.2%, 89/120), followed by the oral contraceptive pill (47.5%, 57/120), Other (e.g. condoms, 42.5%, 51/120), and an injection (e.g. Depo Provera, 36.7%, 44/120). Overall, 15% were offered permanent contraception (18/120). Approximately half (55.0%, 66/120) of wāhine were offered only one type of contraception, with high numbers of Pacific women (64.7.6%, 11/17) and rangatahi (62.5%, 30/48) reporting this. Most wāhine (85.0%, 68/80) who chose contraception were given it straight away.

The interviews indicated that contraception was discussed at multiple points in the abortion care pathway, by a range of healthcare providers. Wāhine decisions about whether to use contraception and what type were based on previous experience, availability, and timing.

Once I'd made the decision she [counsellor] talked me through all of those things, and gave me suggestions of what contraceptives are available, and some of the benefits, and just was very informative about what I could get. Wahine 3

Although interviewed wāhine felt that staff asked about contraception in an acceptable and safe way, there was an element of sensitivity in the context of contraception being discussed as part of abortion care. One participant felt that it 'wasn't the kind of time and place' for this discussion:

I understood why. It makes sense, but I was already feeling overwhelmed. I was feeling upset and stuff. It's like when you lose something and someone tells you, "You should have put it here". Wahine 2

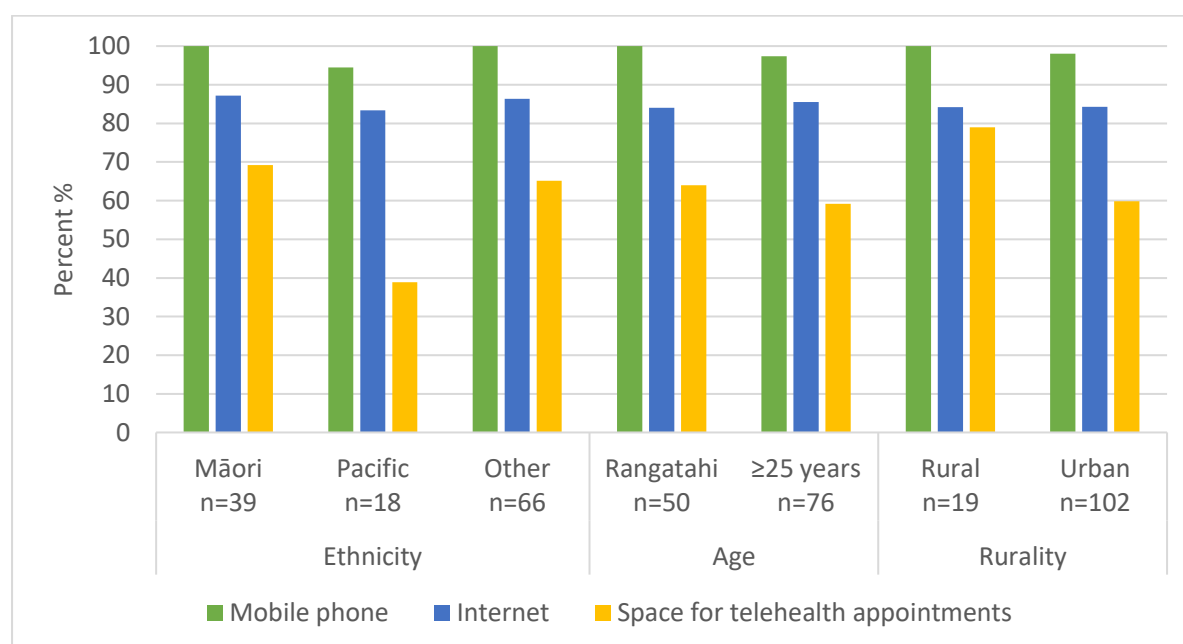
Healthcare providers noted the need to consider the social and wellbeing context when discussing options for contraception with wāhine. This is particularly important for wāhine who may be homeless or reside in emergency/transitional housing.

If they're homeless, or if they're, you know, halfway if their lifestyle is so busy that they haven't made it in [we'll discuss] a surgical where they can get contraception immediately...a long acting one. Healthcare provider 10

Telehealth and EMA at home

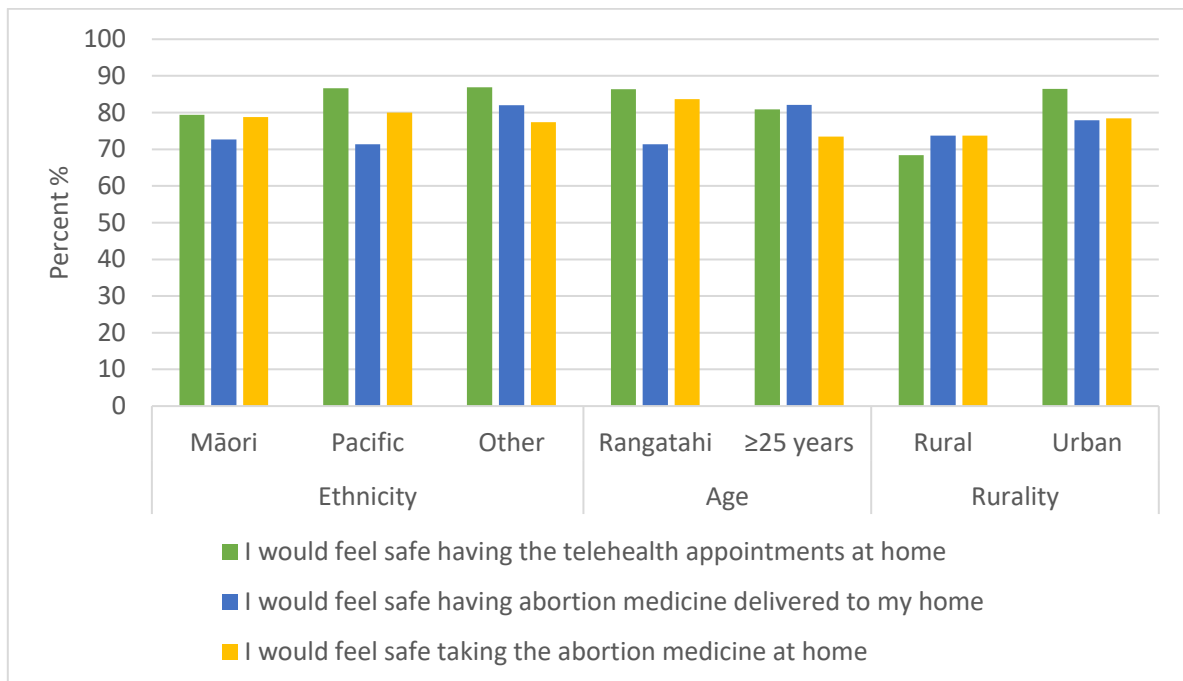
The survey explored wāhine views on safety and privacy aspects of telehealth in general and for abortion care specifically. We found that it cannot be assumed that telehealth and EMA at home will work for a certain group of wāhine, or all wāhine in a certain group. A considerable number of wāhine in each group had concerns about privacy and safety. Almost all wāhine had private and safe access to a mobile phone, but up to 13-18% did not have private and safe access to internet, and up to 61% did not have private and safe access to a room or space to have telehealth appointments (**Figure 8**).

Figure 8: Private and safe access for general telehealth.



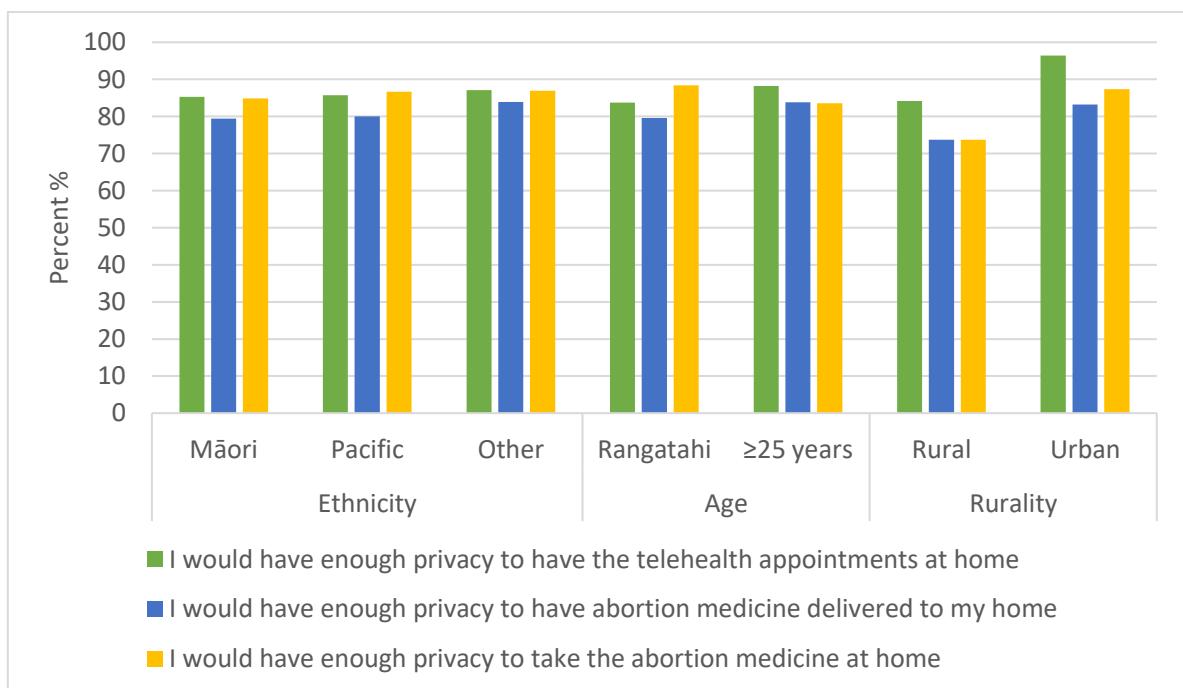
When explored further, the majority of wāhine would feel safe having abortion medicine delivered to their home (78.0%, 85/109) or taking abortion medicine at home (77.5%, 86/111), but around one in four women in the priority groups had safety concerns. Rural wāhine in particular were concerned about these options (**Figure 9**).

Figure 9: Safe to have abortion telehealth appointments and EMA at home.



The findings related to privacy were similar (**Figure 10**).

Figure 10: Private enough to have abortion telehealth appointments and EMA at home.



Consistent with the survey findings, having access to a private space was considered essential for EMA by interviewed wāhine. Wāhine described a private space as essential given the sensitive nature of the procedure, and the amount of bleeding and pain they endured.

It was mortifying... , seeing how often I went to the bathroom and how much blood was left between... yeah, I was quite glad to have my own space. Wahine 2

Some interviewed wāhine lived with other people, including whānau and flatmates, and did not feel that they had enough privacy. One wahine shared how she opted to have the medication in the clinic instead:

The doctor, or the nurse, one of them had spoke to me and they said, “Oh well, you can do this with the pill.” And I just didn’t have the space here at home to go through it. So I was like, ‘I’ll come in and do it.’ Wahine 5

Having EMA at the clinic is not an option available to all wāhine, with at least one healthcare provider reporting their service does not have enough beds to allow for that choice. Healthcare providers discussed advantages and disadvantages to telehealth abortion services, and most noted that despite limitations they would recommend this service.

Healthcare providers felt that telehealth EMA services can offer to wāhine:

- Improved access to abortion information and assessment
- Reduced barriers such as taking time off work and transport and parking costs
- Reduced disruption to, and flexibility to work with, wāhine daily life/routine (especially for those with small children and/or busy schedules)
- Non-confrontational engagement and provision of a level of anonymity

Healthcare providers felt that telehealth EMA services can limit opportunities to:

- Exclude potential coercion
- Build meaningful relationships, observe non-verbal behaviour/cues, probe beyond surface level conversations about wāhine support needs
- Engage meaningfully and converse with wāhine who have limited English or require an interpreter
- Ensure accurate gestational dating and appropriate use of medication
- Follow-up and monitor use of required medication
- Provide all contraception options

Some healthcare providers also highlighted that while 0800 DECIDE was a useful source of information and support for some wāhine, disconnect between telehealth and in-person services presented challenges that for some wāhine increased anxiety and stress.

...If [0800 DECIDE are] doing their [blood] tests we can't access them, which is really not helpful. One woman came in... "I've got a picture of [my blood test]"... It was a beta-hcg hormone level... She started crying, I said, "Why are you crying?" And she says, "Oh don't tell me I have to wait even more." Healthcare provider 1

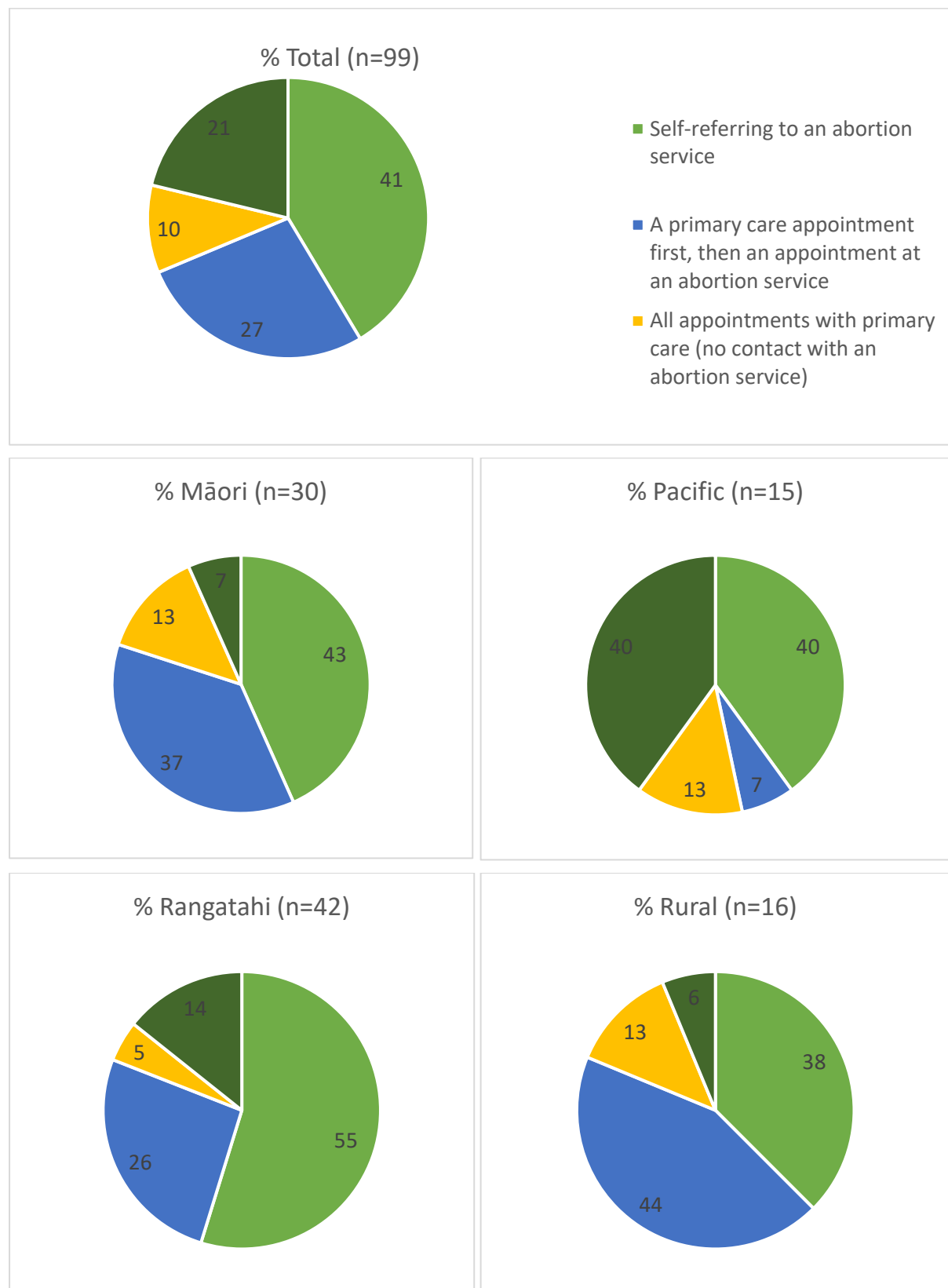
A need to understand any unintended consequences of telehealth services on availability of in-person abortion services in smaller regions was also raised by healthcare providers. A reduction in local clinical workforce skills, theatre space etc may reduce choice for wāhine.

A telehealth EMA service is one access point for wāhine, but our findings suggest there would be negative impacts on equity, safety, and accessibility if it was the only way of delivering abortion services in Aotearoa. Wāhine need to continue to have the option of undertaking EMA at abortion clinics.

Preferences for accessing abortion services

There is a need for practical support and information for wāhine wanting to self-refer. When asked which way to access abortion would have suited them best, the most common preference overall among survey participants (41.4%, 41/99), and in all but one group, was “making my own appointment with the abortion clinic, without having an appointment with someone else first” (**Figure 11**). This was followed by a preference for a GP appointment first (telehealth or in-person) and a subsequent appointment with an abortion clinic. Delivering abortion services in a range of ways, and protecting a choice of services, is most equitable, as wāhine within the same population have different preferences, and wāhine between populations have different preferences (**Figure 11**). Assumptions about which model of care is best for any group should not be made. A good example of this is “all appointments by telehealth” which was preferred by 40.0% Pacific (6/15), but only by 6.7% Māori (2/30), 14.3% rangatahi (6/42) and 6.3% rural wāhine (1/16).

Figure 11: Preferred ways to access abortion services.

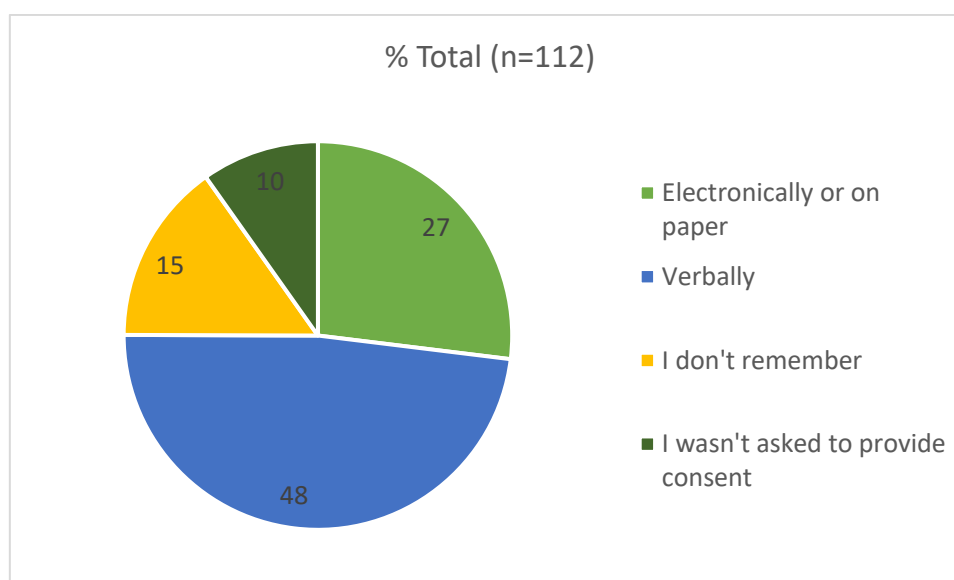


Use of information about abortion care

People's health information, including information about abortion care, is used by health services and the organisations to make decisions about an individual's current and future healthcare, about improving health services and the health system, and to better understand the health and needs of populations.

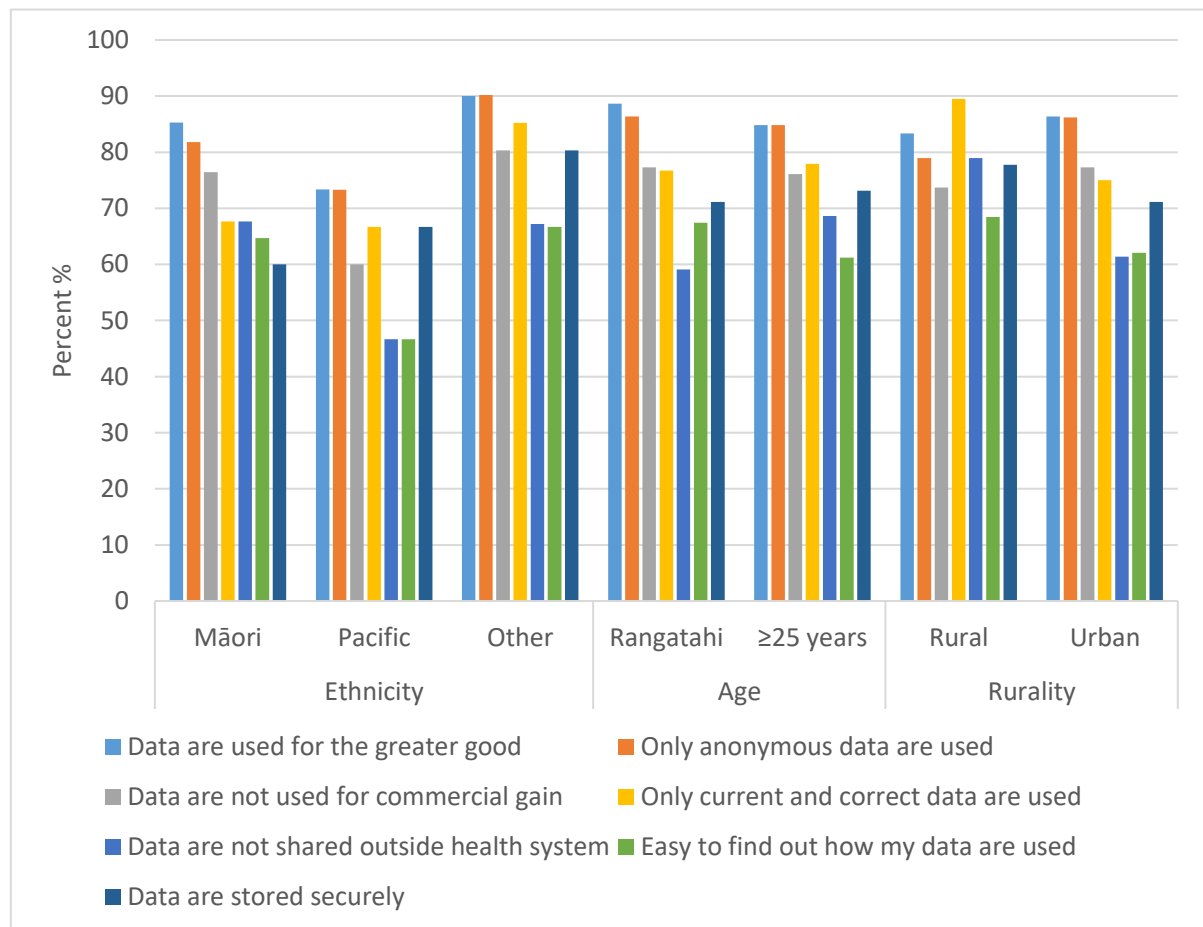
There is a need to strengthen processes for asking wāhine for consent for their abortion data to be used. Overall, 75.0% (84/112) of surveyed wāhine reported being asked to provide consent for information about their abortion care to be used (**Figure 12**); however, fewer wāhine Māori (70.6%, 24/34) and Pacific (66.7%, 10/15) reported this.

Figure 12: How were you asked to provide consent for data about your abortion care to be used?



A need for strict and transparent governance of abortion care data was also indicated. When asked what is important about how people's abortion information is used, the majority of surveyed wāhine felt it is important that abortion care data are used for the greater good (to benefit others) (86.4%, 95/110) and only anonymous data are used (85.5%, 94/110). Three-quarters of wāhine felt it is important that abortion care data are not used for commercial gain (76.6%, 85/111) and that only current and accurate data are used (77.5%, 86/111). Two-thirds (or more) of wāhine felt it is important that data are stored securely (72.3% 81/112), data are not shared outside the health system (64.9% 72/111), and that they can find out how their information is being used (63.6%, 70/110) . Findings for each group are presented in **Figure 13**.

Figure 13: What is important about how people's abortion information is used?



Strengths and limitations

Strengths

The mixed methods approach generated rich data about a complex and sensitive healthcare event. Māori, Pacific Peoples and rangatahi were well represented in the survey responses. Both interview and survey participants valued the opportunity to be heard. The support of clinical champions in each region was crucial in facilitating data collection. The research team's engagement approach and ethnically matched female interviewers created a safe space for wāhine to actively participate in interview discussions.

Limitations

Only three survey participants had all appointments with the abortion service by telehealth and the experiences of wāhine having telehealth EMA at home are not represented at all in the interviews.

Future research is needed to fully understand the impact of a national telehealth EMA service. The experiences of wāhine having an abortion after 20 weeks' gestation are not represented in this report and is an area for further research. Wāhine with disabilities, and people of diverse sexual orientation, gender identity and expression, and sex characteristics may not be well represented in this report, and we look forward to the two forthcoming reports by other research teams focussing on these populations. While some wāhine initially provided contact details and indicated willingness and enthusiasm to talk about their experiences, only a small final number took part in an interview. However, those interviewed had a lot of kōrero to share, providing rich and nuanced information.

Conclusions

The findings from this study suggest the first few years after the Abortion Legislation Act changes have seen many steps towards the Manatū Hauora vision of accessible, equitable and high-quality abortion services.

An overarching finding is abortion care does not begin or end with the abortion procedure itself. For wāhine, the procedure itself is only one part of the abortion care pathway.

The decriminalisation of abortion is a first step to incorporating this care as a normal part of reproductive health care but that is not yet the reality. Abortion care takes place in a societal context of considerable stigma and judgement. This impacts access to care, how care is provided, and how we have interpreted the data from this research. The research team acknowledges the people who work in abortion care, and their dedication to providing wāhine with the best rights-based care they can.

From this research, we conclude that elements of equitable, timely, safe, and accessible abortion services include:

- Culturally safe staff at all steps of the abortion care pathway: from reception and switchboard staff, through to staff providing after-hours and follow-up care.
- Clear and accurate information at all steps: wāhine seek information and rely on it to seek the care that will best meet their needs, and to feel safe and prepared.
- Self-referral: wāhine do take up the option to self-refer, many prefer this option, and many would have self-referred had they known about it.
- Delivering abortion care in a range of ways to support the different needs of wāhine. Ensuring availability and provision of in-person abortion services and telehealth EMA services, and protecting a choice of services, is essential to equitable and safe access.

- Offering counselling and ensuring that wāhine know that it can be a source of both information and emotional support and that it can be accessed after the abortion as well.
- Removing time and financial barriers for wāhine, both of which are distressing and impede access to care.
- Offering choices for post-abortion contraception and facilitating its fully funded provision.
- Whānau inclusiveness: recognising and supporting the vital role of whānau support for wāhine accessing abortion services.
- Ensuring no contact with protesters.

“Violence against women comes in many different forms and is any pattern of behaviour that is used to gain or maintain power and control over women. It can be physical, sexual, emotional, economic, and psychological actions, or threats of actions, that influence and potentially harm another person.”

– Manatū Wāhine, <https://women.govt.nz/womens-safety>

Based on the findings contained in this report, we conclude that to remove safeguards enshrined in the new legislation (including the Safe Areas Amendment Act 2022), or to remove any identified elements of equitable, safe, and accessible abortion services that are currently in place, would be violence against women.

This report provides a platform for the further actions needed to fully realise that vision. It identifies some of the actions required for dissemination, translation, and implementation of abortion law reform to fully comply with the intent of equitable, timely, safe, and accessible abortion services. Recommendations based on this research are described in the recommendations section at the beginning of this report.

Te Tātai Hauora o Hine welcomes any opportunities to partner with organisations to support education for their members. We note that many national professional organisations and councils confirm that abortion care is within their scope of practice (Te Tatau o te Whare Kahu | Midwifery Council, Te Kaunihera Tapuhi o Aotearoa | Nursing Council of New Zealand, Te Pou Whakamana Kaimatū o Aotearoa | Pharmacy Council Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand, Te Whare Tohu Rata o Aotearoa | The Royal New Zealand College of General Practitioners, The Royal Australian and New Zealand College of Obstetricians and Gynaecologists) (Ministry of Health 2022).

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