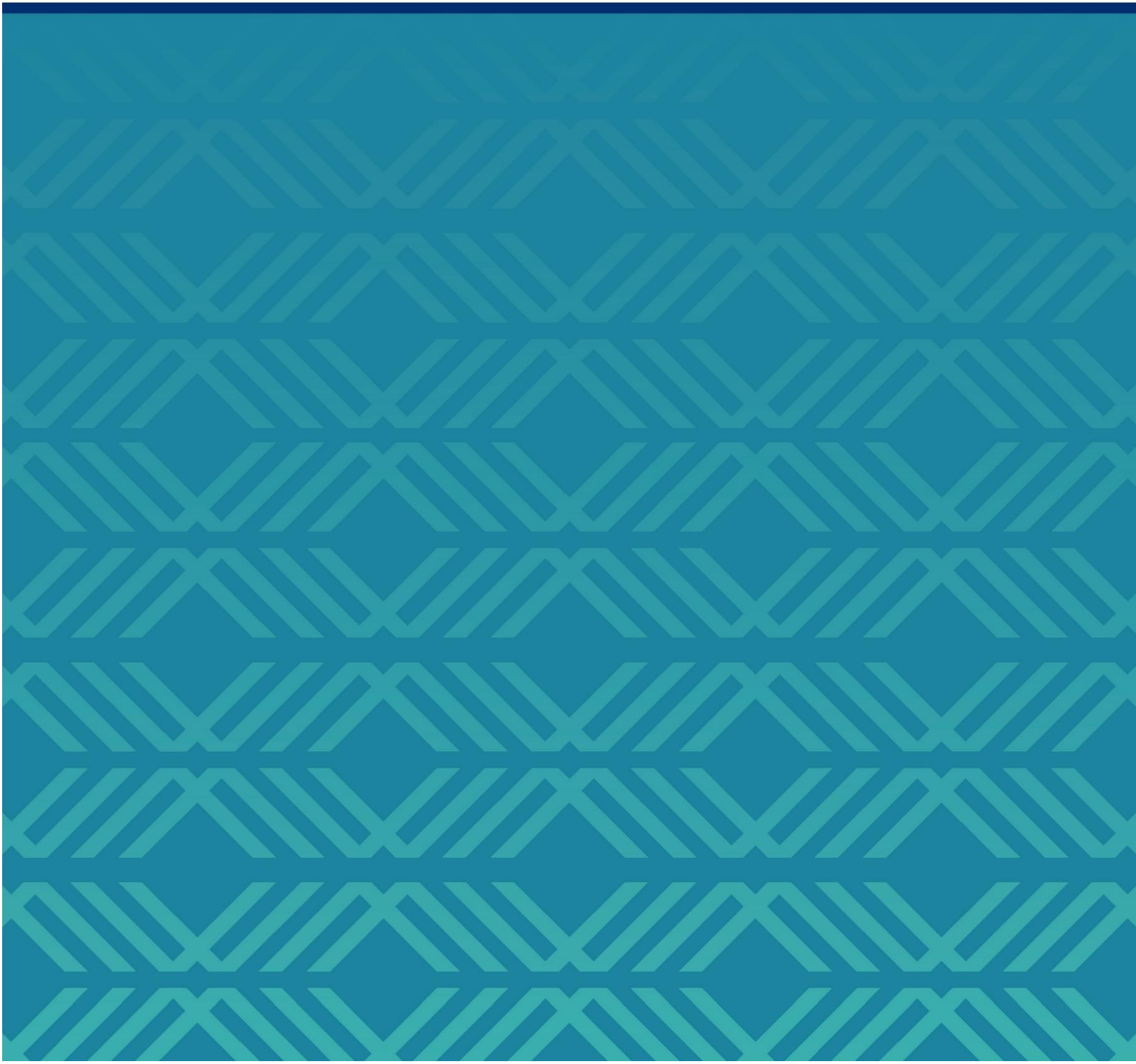




Te Kāwanatanga o Aotearoa
New Zealand Government



Review of Certain Matters under the Contraception, Sterilisation, and Abortion Act 1977



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Presented to the House of Representatives
pursuant to section 22 of the Contraception,
Sterilisation, and Abortion Act 1977

Citation: Ministry of Health. 2025. *Review of Certain Matters under the Contraception, Sterilisation, and Abortion Act 1977*. Wellington: Ministry of Health.

Published in April 2025 by the Ministry of Health
PO Box 5013, Wellington 6140, New Zealand

ISBN 978-1-991324-25-2 (print)
ISBN 978-1-991324-26-9 (online)
HP 9118



This document is available at health.govt.nz



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Contents – Ngā kōrero o roto

Glossary of terms – He kuputaka	1
Background to this report – He whakamārama	3
Executive summary – He whakarāpopoto	4
The legislation – Te ture	8
Contraception – Te ārai hapū	10
Legal requirements for contraception services	10
Contraception services in New Zealand	11
Timely and equitable access	12
Relative costs of contraception throughout New Zealand	14
Sterilisation – Te kokoti-uru	16
Data collection	16
Timely and equitable access	17
Relative costs of sterilisation throughout New Zealand	19
Information and advisory services – Ngā ratonga tuku kōrero	20
Counselling – Te mahi tohuora	22
Timely and equitable access	23
Relative costs of counselling throughout New Zealand	26
Abortion – Te whakatahe	27
Data collection	27
Medicines	28
Improved abortion services choice and access	28
Continued barriers to in-person services, based on district of domicile	31
Early medical abortion	34
Early surgical abortion	35
Later surgical abortion	37
Post 20-week abortion care	39
Self-referral	40

Countering misinformation	42
Workforce	43
Conscientious objection	46
Abortion stigma	48
Funding	49
Abortions for the sole purpose of sex selection – Ngā whakatahe kia whai uri nō ira kē	52
Background	52
Current practice and feedback	53
Research and international practice	53
Recommendations – Ngā tohutohu	54
References – Ngā tohutoro	56
Appendix 1: Data limitations	59

List of Figures

Figure 1: Number of contraceptives provided, by contraception and abortion type, 2020 and 2024	14
Figure 2: Percentage of medical and surgical abortion procedures where women accessed pre-abortion counselling, 2022–2024	24
Figure 3: Number of medical abortions, by gestation and profession, 2020, 2022 and 2024	30
Figure 4: Number of surgical abortions, by week's gestation and profession, 2020, 2022 and 2024	31
Figure 5: Average drive time (in minutes) for females aged 15–44 years to nearest in-person abortion provider, by level of socioeconomic deprivation and GCH urban–rural index, 2023	32
Figure 6: Average drive time (in minutes) for females aged 15–44 years to nearest in-person abortion provider, by district of domicile and GCH urban-rural index, 2023	33
Figure 7: Number of abortion procedures, by procedure type, 2017–2024	34
Figure 8: Practitioners who have completed NZCSRH training as of 30 October 2024, by professional group (percentage)	45
Figure 9: Practitioners who have completed NZCSRH training as of 30 October 2024, by ethnicity (percentage)	45

List of Tables

Table 1: Counselling provision by region of service, 2022	25
Table 2: Counselling provision by region of service, 2023	25
Table 3: Counselling provision by region of service, 2024	26
Table 4: Number of health workers delivering abortion services by profession and region of service, 2021 and 2023	29
Table 5: Number of abortions by provider type and region of service, 2020 and 2024	29
Table 6: Number and percentage of surgical abortions occurring outside of district of domicile, by gestation, 2020, 2022 and 2024	34
Table 7: Number and percentage of surgical and total abortions provided at earlier than 13 weeks' gestation, by district of service, 2020, 2022 and 2024	36
Table 8: Number and percentage of surgical and total abortions provided at 13 to 26 weeks' gestation by prioritised ethnicity, 2020 and 2024	37
Table 9: Number and percentage of surgical and total abortions provided during the second trimester (at 13 to 26 weeks' gestation) by district of service, 2020, 2022 and 2024	38

Glossary of terms – He kuputaka

Term	Meaning
Abortion	Under the Contraception, Sterilisation and Abortion Act 1977, the intentional termination of a woman's pregnancy by any means, including by using: <ul style="list-style-type: none"> • a drug or combination of drugs (medical) • an instrument (surgical).
Conscientious objection	An objection a health practitioner makes, on the ground of personal conscience, to providing contraception, sterilisation or abortion services. This report also describes how conscientious objection is used by organisations and groups (outside of health practitioners).
Contraception	A method, medicine or device to prevent pregnancy.
Decile	A label representing approximately 10% of small areas in New Zealand. Deciles are ordered on a scale of socioeconomic deprivation. For example, 'Decile 1' is the label for the 10% of areas in New Zealand with the lowest level of deprivation on the New Zealand Index of Deprivation, whereas 'Decile 10' is the label for the 10% of areas with the highest level of deprivation.
District of domicile	The Health New Zealand district where a person has a fixed or legal address or permanent residence.
District of service	The Health New Zealand district where a person has accessed the health care service.
Female sterilisation	A permanent type of contraception, where the fallopian tubes are blocked, cut or removed to stop sperm meeting an egg, or where all or part of the uterus is removed.
Health practitioner	A person who is registered with an authority as a practitioner of a particular health profession, under section 5 of the Health Practitioners Competence Assurance Act 2003.
Hysterectomy	An operation that removes the uterus (womb). There are different types of hysterectomy. A 'total hysterectomy' is the most common, involving removal of the uterus and the cervix (neck of the uterus). A 'subtotal' hysterectomy removes the uterus but not the cervix (RANZCOG 2018).
Male sterilisation	A permanent type of contraception involving division or occlusion of both vasa deferentia.
Medsafe	New Zealand Medicines and Medical Devices Safety Authority, the agency that regulates therapeutic products.

New Zealand Index of Deprivation	An index that calculates an area's level of socioeconomic deprivation for the population living there based on the following Census variables: lack of internet access, receiving a means-tested benefit, income below an income threshold, 18–64 years unemployed, 18–64 years without any qualifications, people not living in their own home, people under 65 years living in single-parent families, people living in households below a bedroom occupancy threshold and people with no access to a car.
NHI	National Health Index. A unique identifier assigned to each person who receives health care in New Zealand (Health New Zealand 2024a).
Non-invasive prenatal testing	A test/screen used to detect chromosomal abnormalities such as Down syndrome, Edwards' syndrome and Patau syndrome in the DNA of a fetus. It is not funded in New Zealand (Health New Zealand 2024b).
Rainbow	As used in this report, an umbrella term to describe people whose sexuality, gender identity, gender expression or sex characteristics differ from majority, binary norms.
Salpingectomy	Surgical removal of one or both of the fallopian tubes.
Sex-selective abortion	In reporting requirements under the CSA Act, an abortion requested solely for the purpose of a preference for the fetus to be of a particular sex
Telehealth	Health care services that are typically provided via phone or video consultation. In this report, this term may refer to regionally based or national telehealth services. Telehealth services can coordinate most aspects of care such as testing, prescriptions and counselling services.
Tubal ligation	A permanent form of birth control in which a woman's fallopian tubes are tied or blocked.
Vasectomy	A form of male birth control that cuts the supply of sperm through the division or occlusion of both vasa deferentia.
Women/Woman	In line with the <i>Women's Health Strategy (2023)</i> it is recognised that not everyone who experiences the health issues covered in this report are women. The contraception, sterilisation, and abortion health care needs discussed in this report can be experienced by people with diverse gender identities and expressions and sex characteristics. It is intended that the recommendations within this report will be inclusive of rainbow voices and work to drive services and approaches that respond to rainbow needs and aspirations.

Background to this report – He whakamārama

Section 17(1) of the Contraception, Sterilisation and Abortion Act 1977¹ (the CSA Act) requires the Director-General of Health (Director-General) to undertake a periodic review (the review) not later than five years after the commencement of this section, and then at subsequent intervals of not more than five years. The review must consider whether New Zealanders have timely and equitable access to:

- contraception, sterilisation and abortion services
- information or advisory services about whether to continue or terminate a pregnancy
- counselling services related to abortion services.

The review must also consider the relative costs throughout Aotearoa New Zealand for people accessing those services.

Additionally, section 21 of the CSA Act requires the Director-General to report not later than five years, and then at subsequent intervals of not more than five years, on whether any evidence indicates women are seeking abortions for the sole purpose of selecting the sex of the fetus.

The review must also include recommendations that the Director-General considers appropriate (if any) for making access to those services more timely and equitable.

¹ https://www.legislation.govt.nz/act/public/1977/0112/latest/DLM17680.html?search=ts_act%40bill%40regulation%40deemedreg_abortion_resel_25_a&p=1

Executive summary – He whakarāpopoto

On 24 March 2020, changes were made to the law to decriminalise abortion, better align the regulation of abortion services with other health services, and modernise the legal framework for abortion services in Aotearoa New Zealand.

Since 2020 the Ministry of Health – Manatū Hauora has worked towards achieving these changes through focusing on:

- better reporting for sterilisation and abortion services
- local access for women to first-trimester abortion services within all districts
- improved abortion service choice and access, with barriers and delays removed
- services that are more person-centred and focused on patient needs
- a well-supported abortion workforce, with clear clinical guidance and training as a framework for person-centred and equitable service provision.

The law change is still relatively new, and the Ministry acknowledges that some services are still establishing their provision framework. More work is required to ensure timely and equitable access to abortion services.

The Contraception, Sterilisation and Abortion work programme aligns with the Government Policy Statement on Health (Minister of Health 2024), which outlines the five priority areas for the health system. These priority areas include access and timeliness, which are a specific focus of this report.

In March 2023, the abortion services work programme was divided between the Ministry of Health and Health New Zealand as a part of the health reforms in the Pae Ora Act 2022. Health New Zealand is responsible for abortion and sterilisation service provision and equitable service access. The Ministry regulates and monitors equitable access to abortion and sterilisation services through abortion and sterilisation service reporting and has been engaging with Health New Zealand regularly with the aim of providing timely and equitable access for women seeking abortion health care and sterilisation.

Overall, access to abortion services has increased since the law change. Factors contributing to this improvement have been an increase in the number of abortion providers and in both types and locations of provision available. Improved access is especially evident among those seeking an early medical abortion (EMA) (10 weeks' gestation or earlier). This is a positive sign that those seeking care are experiencing fewer barriers and that the initiatives to improve access, like self-referral and telehealth, are making an impact.

Some key achievements show how service availability, quality of service, and accessibility have improved since the changes in legislation were made. These include:

- an increase in sterilisation provider reporting and a greater awareness of reporting requirements under the CSA Act.
- the introduction of the national abortion telehealth service DECIDE to improve access to information, advice and delivery of EMA
- clinical guidelines for abortion care to support consistent clinical practice in abortion care
- the introduction of data collection and reporting to support better service planning and monitoring of timely and equitable access to abortion and sterilisation services
- improved access to funded EMA medicines for those in community and primary care settings to support patient choice and early abortion access
- clarification of funding opportunities for primary care, which can be accessed through the Primary Maternity Services Notice
- an increase in the number and range of health practitioners providing abortion care
- the development of a primary care education package to enable more providers within primary care to deliver EMA care
- development of the Standard for Abortion Counselling to set the requirements for providing abortion counselling
- proactive engagement with sterilisation and abortion health care providers to understand and engage with their perspectives.

This review identifies that some good progress has occurred. However, some aspects need more work in each of the focus areas, as noted below.

Contraception

Access to contraception is variable for those seeking it, which impacts their ability to have timely access to these services. Funding is available in isolated pockets across the country, but unless a person fits specific criteria, or lives within a certain catchment, they are likely to have to wait for contraception access and will also have to pay for contraception services.

Sterilisation

Accessing a female sterilisation procedure, such as a hysterectomy or tubal ligation (for the purpose of permanent contraception), has unclear health care pathways and involves long wait times through the public health system. Although it is possible to access these sterilisations through private care, the cost is prohibitive and therefore this option is inequitable. Male sterilisation procedures, such as vasectomies, are almost always accessed through private care. While costs are typically lower than for female sterilisation procedures, they too can be prohibitive.

The Ministry does not have a clear picture of the extent of sterilisation services people access. Issues remain over the intention and scope of data collected, as well as provider compliance in reporting.

We note that some issues could prevent equitable access to sterilisation procedures for disabled people. Particular issues are the limited availability of accessible and understandable information and the potential risk that sterilisation may be performed without informed consent, particularly for those with impaired decision-making or communication abilities.

Information and advisory services

Information is available about whether to continue or terminate a pregnancy within several settings, and from a range of people and organisations. However, access to accurate information about abortion services (eg, how to access services) remains a barrier to some women who intend to access abortion care.

A concern is that women may receive biased information and advice and/or misinformation about the risks of abortion, and that this could delay their access to timely abortion care or prevent the abortion altogether.

Counselling

Under the CSA Act, counselling cannot be a condition of service provision. Meaning, providers cannot insist on a woman having counselling services before an abortion procedure, though they must offer it. Regions and facilities appear to vary in their level of provision of abortion counselling. This means that whether or not a provider requires someone to have pre-abortion counselling may depend on the woman's district of domicile, or the standard care procedure that their nearest facility follows.

The Ministry will be undertaking further work to understand the reasons for these variations. It will also continue to monitor counselling provision because having ongoing effective monitoring and regulation of abortion counselling services is critical to ensuring services are accessible, equitable and timely.

Abortion

Gestation is an important factor in access to abortion services. Where women have earlier gestation at the time of abortion, this indicates they have faced fewer barriers to accessing the service. Earlier abortion is also associated with better health outcomes for women accessing these services.

Surgical abortion provision is critical to ensuring timely and accessible care, especially in abortion care at later gestation. Most surgical abortion services are available predominantly in the main centres of New Zealand and typically within hospital facilities. So, while the law change has enabled more timely and equitable access to early medical abortion, large disparities in surgical provision remain, even at early gestations.

The Ministry notes that stigma is still attached to abortion services. As a result, a further barrier to timely and equitable abortion services is 'conscientious objection'. 'Conscientious objection' has been observed to impact patient access to these health services at both individual and organisational levels.

Abortion for the sole purpose of sex selection

In a few isolated cases, practitioners have reported that they believe someone accessed abortion services for the purpose of selecting the sex of the fetus. There is no requirement for a woman seeking abortion services to state their reason for accessing abortion care, except where they are at later than 20 weeks' gestation.

The legislation – Te ture

The Abortion Legislation Act 2020² amended the CSA Act and the Crimes Act 1961, and made minor amendments to several other Acts. The key changes of the law reforms were:

- decriminalising abortion health care (by removing it from the Crimes Act 1961) and allowing a wider range of registered health practitioners to perform abortions
- providing the option to self-refer to an abortion service
- providing regulation that allows qualified health practitioners to 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 within primary care facilities and through accessing telehealth services
- requiring counselling to be available to anyone considering abortion, without making counselling mandatory
- requiring health practitioners who conscientiously object to abortion provision to inform the woman seeking services of their objection as well as how to access details of their closest abortion provider
- requiring employers to accommodate an employee's conscientious objection unless doing so would unreasonably disrupt their provision of health services. Accommodating the employee's objection may include arranging for another existing employee to carry out those duties.

The following year, the Contraception, Sterilisation, and Abortion (Information Collection) Regulations 2021³ (the Information Collection Regulations) were introduced. These regulations outline the information that must be collected from providers of abortion services and introduced annual reporting for abortion and sterilisation providers. Information obtained through the Information Collection Regulations has helped form a view of whether there is timely and equitable access to these services.

The review process

The key information that contributed to the review process was the data collected under the Information Collection Regulations.

Data used within the review includes information that providers submitted to the Ministry of Health – Manatū Hauora, as part of the reporting requirements under the Information Collection Regulations, from 2020 to 2024. Note that data from 2024

² https://www.legislation.govt.nz/act/public/2020/0006/latest/LMS237550.html?search=ts_act%40bill%40regulation%40deemedreg_abortion_resel_25_a&p=1#LMS237556

³ https://www.legislation.govt.nz/regulation/public/2021/0219/latest/LMS532081.html?search=ts_act%40bill%40regulation%40deemedreg_abortion_resel_25_a&p=1

reflects data submitted to the Ministry as of 1 January 2025, and is provisional, pending final review and validation of data from that year.⁴

As the Information Collection Regulations were enacted in 2021, certain data reported here is only available from 2022 onwards. This applies, for instance, to data on access to pre-abortion counselling.

Note that limitations to the data reported in turn limit the interpretations and inferences that can be made. Appendix 1 describes known limitations related to contraception, abortion and sterilisation data. The Information Collection Regulations outline the information that providers must submit for abortion and sterilisation procedures.

In addition to the existing data and reporting process, the Ministry commissioned three research groups to explore the consumer experience of abortion services. These reports focus on Māori and Pacific consumers (National Centre for Women's Health Research 2025); rainbow consumers (Parker et al 2025); and disabled consumers (Donald Beasley Institute 2025). This research was commissioned as, at the time, very little direct research had been undertaken on the experiences of those accessing abortion services. We also recognised that, across the three groups identified, inequity of access and additional barriers to health services persist and that these issues need to be understood within the abortion context.

These qualitative consumer research reports have been used to inform discussion and add further context to issues impacting the timely and equitable access of abortion for these groups, who often experience inequitable health care outcomes. The consumer research reports include valuable insights into and recommendations on the quality of services being delivered. While these findings and recommendations are outside the scope of this review, we encourage abortion health care providers to consider them for improvement in all three research areas.

This review process also involved conducting a survey to abortion providers within the public system and gaining targeted stakeholder feedback to help inform the findings.

Subject matter experts within the Ministry who have legal, academic, policy and clinical backgrounds have considered this review.

⁴ To access previously published reports, go to the Ministry of Health's Publications page (health.govt.nz/publications) and search with the key words **abortion services annual report**

Contraception – Te ārai hapū

Access to timely, equitable and affordable contraception services is important for the health and wellbeing of people of reproductive age. It also gives them autonomy over their own reproductive journey and their decision-making on whether or when to have children. The World Health Organization (WHO) and the United Nations Population Fund (UNFPA) consider access to contraception services to be a fundamental human right (UNFPA 2025; WHO 2025).

Legal requirements for contraception services

The 2020 abortion law reform process did not consider sections 4–6 of the CSA Act. These sections remain as they were originally written into the law in 1977.

As such, some of the language used in section 4 is out of date, is considered not fit for purpose and will not be discussed as a part of this review. The Ministry would, however, welcome opportunities to revisit this section of the CSA Act. Similarly, a medical practitioner enables section 5, which relates to sexual violation, and the Ministry is not obliged to collect information in relation to this.

Section 6 of the CSA Act mandates that where the Minister of Health has gazetted a standard for manufacturing condoms and other contraceptive devices, these devices must meet this standard before they can be sold or supplied. Medsafe (a business unit within the Ministry) is the agency that regulates medicines and medical devices under the Medicines Act 1981 and associated legislation. On its website, it publishes information on the current gazetted standards for contraceptives that are medical devices (Medsafe 2014). Medsafe is currently updating three of the gazetted standards and will consult on a fourth in 2025.

Contraceptives that are medicines must have consent (be approved) before they can be supplied, sold or advertised. Under section 16 of the CSA Act, Health New Zealand must ensure that contraception services are available throughout New Zealand and that any person requesting access to the emergency contraceptive pill can access it anywhere in New Zealand within 48 hours of making their request.

Contraception services in New Zealand

Contraception services available in New Zealand include long-acting reversible contraception (LARC) (eg, implants, injections and intra-uterine devices (IUDs)), oral contraceptive pills, barriers (eg, condoms), vaginal rings and fertility awareness methods. While LARC consists of highly effective contraceptive mechanisms, some forms are also used as treatment for other physical conditions, including pain and heavy menstrual bleeding (Sexual Wellbeing Aotearoa 2025), as well as for menopause symptoms. The Ministry also acknowledges that sterilisation services are a method of permanent contraception. We explore this link further in the sterilisation chapter.

Contraception services are available through several health providers, including general practitioners (GPs), midwives, primary care, and sexual health/youth health clinics. Condoms are available widely through supermarkets, pharmacies and other stockists.

Patients can access emergency contraception through all of the above health providers and pharmacies (pills only), as well as through Health New Zealand urgent care clinics and accident and emergency services. As of December 2024, there were 1,009 pharmacies on Healthpoint⁵ offering the emergency contraceptive pill. This indicates a significant proportion of the population have access to the emergency contraceptive pill, but further analysis is needed to determine whether there is an equitable spread.

In 2020, the Ministry published guidance on contraception after recognising that contraception guidance to that point had been disjointed and spread across a number of documents. The intention behind the updated guidance is to 'improve the quality, consistency and standardisation of contraceptive practice and will support access to suitable contraception for anyone who needs it' (Ministry of Health 2020). This document and work surrounding contraception access now sit with Health New Zealand.

Contraception is part of the Women's Health Strategy, linking to a number of priorities. Feedback received in developing the strategy included:

Access to effective contraception is important for the health and wellbeing of women of reproductive age. Barriers to contraceptive access can lead to unintended pregnancies and sexually transmitted infections. One area where women want change is in access to long-acting reversible contraceptives (LARC). (Minister of Health 2023)

Sexual Wellbeing Aotearoa (formerly New Zealand Family Planning) and Health New Zealand recently funded a collaborative research study on wāhine Māori and contraception. Using a kaupapa Māori methodology, the study identified key areas for improvement, such as destigmatising conversations about sexual and reproductive health and having options that are 'culturally welcoming and safe for wāhine Māori,

⁵ Healthpoint (healthpoint.co.nz) provides up-to-date information about health care providers (especially primary care providers), referral expectations, services offered and common treatments.

including the provision of kaupapa Māori services and contraception options' (Cram et al 2024).

Timely and equitable access

To date, the Ministry's role in the oversight of contraception services has been unclear and lacked centralised ownership (with the exception of Medsafe's role in regulating and publishing information on medicines and medical devices). Additionally, the reporting requirements of the current Act do not enable the Ministry to collect sufficient data to comment in comprehensive detail on timely and equitable access to contraception.

We can provide some information on timely and equitable access to contraception following an abortion. However, this information is variable and relates to contraception received at the time of an abortion procedure. Information on a woman's intent to receive contraception following an abortion is not reliable enough for us to comment on whether this contributes to timely and equitable contraceptive access.

A further, specific concern is that disabled people are at risk of being given contraception (especially LARC) without their free and fully informed consent as the CSA Act does not provide an avenue to monitor issues relating to informed consent for contraception. In addition, some disabled people face unique barriers, where they have impairments that make it difficult to communicate about contraception, and therefore they require specific considerations for using contraception. While these barriers are outside the scope of reporting on contraceptive services within the CSA Act, it is important to note that they, along with potential barriers to understandable information in accessible formats, may disproportionately impact some groups, making it more difficult for them to get timely access to contraceptive services.

For Māori, the Voices of Wāhine report (National Centre for Women's Health Research Aotearoa 2025) made recommendations on contraception access, such as:

- exploring ways to ensure wāhine who access telehealth early medical abortion (EMA) also have access to LARC
- ensuring wāhine have multiple opportunities to have conversations about contraception, where they are offered a choice of contraception, and these conversations are respectful
- fully funding contraception.

National Centre for Women's Health Research Aotearoa (2025) found that almost all surveyed wāhine reported being offered contraception as part of abortion care. Approximately half of the wāhine (particularly Pacific women and young people) surveyed were offered only one type of contraception during their abortion appointment. This finding suggests potentially inequitable and inconsistent approaches to care.

'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."'

Participant reflecting on being asked about contraception before an abortion (National Centre for Women's Health Research Aotearoa 2025)

Importantly, it was reported that although contraception was often discussed at various points in the abortion pathway, some women accessing the service felt that it wasn't the time and place for a discussion about contraception. This is notable, as accurate reporting on contraception provision may be impacted by women choosing to separate contraceptive medical appointments from their abortion medical appointment.

In the Abortion as a Human Right report, the Donald Beasley Institute (2025) describes disabled people's experiences of abortion care. The participants reported inconsistent approaches to contraception during the abortion process. However, overall, participants reported positive experiences about information provided and access to their choice of contraception after an abortion.

'I remember saying to them that this is good enough for now. It's not what I want but I'll take it. Anything to stop me getting pregnant again ...'

Participant (Donald Beasley Institute 2025)

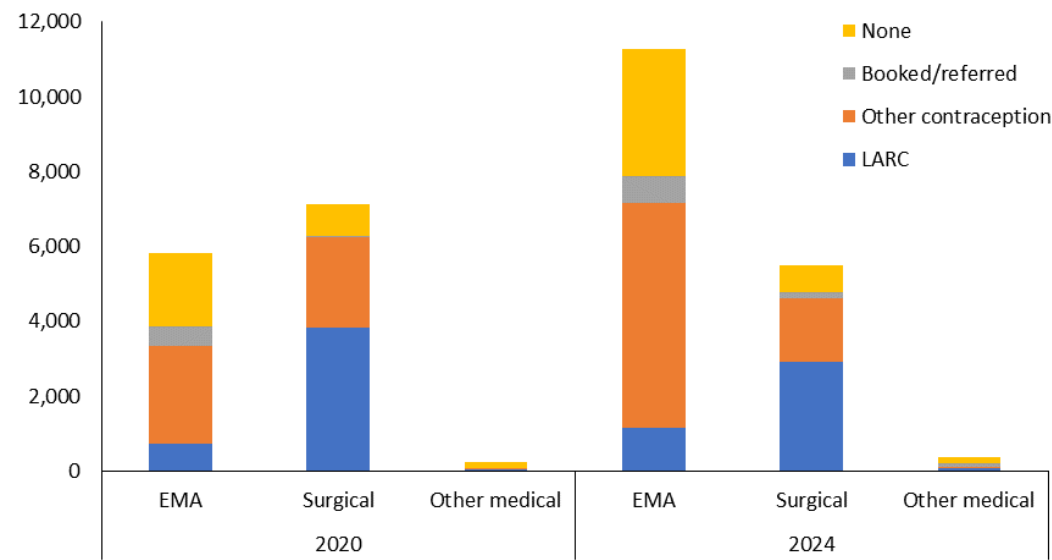
Notably, the type of abortion a woman accesses affects the precision of reporting on the provision of contraception following an abortion. This is because certain contraceptives, such as a LARC IUD, which must be inserted into the uterus, are not generally provided immediately following a medical abortion when it is more likely to be expelled. This form of LARC is therefore generally accessed at a follow-up appointment.

As a result, and due to the reporting requirements to submit a notification of abortion form within one month of an abortion procedure, the Ministry may not receive a full account of contraception provided following abortion. Additionally, the increased use of regional and national telehealth services for EMA, which may require a woman to access a secondary provider for contraception, could limit comprehensive reporting.

Therefore, a key factor following the law reform that may reduce the precision of reporting on contraception provision is the increase in access to EMA. In 2024, EMAs accounted for 66% of all abortions, compared with 38% in 2020. As Figure 1 shows, compared with those using surgical services, a greater proportion of women accessing EMA services are referred to a follow-up appointment, receive a contraception alternative to LARC (eg, condoms or oral contraceptive medication) or receive no contraception at the time of abortion.

In particular, records indicate 10% of women accessing an EMA in 2024 also received LARC at the time of reporting, compared with 53% of those accessing surgical abortions. These findings are comparable with 2020 figures of 13% (EMA) and 54% (surgical). Reported figures may therefore misrepresent the actual uptake of LARC provision, as they exclude a growing proportion of women accessing EMAs who may need to access LARC through follow-up appointments.

Figure 1: Number of contraceptives provided, by contraception and abortion type, 2020 and 2024



Note: 'Other medical' represents medical abortions at later than 10 weeks' gestation.

Relative costs of contraception throughout New Zealand

Assessing the relative costs of contraception throughout New Zealand is challenging as a result of the limited reporting requirements for contraception under the Information Collection Regulations. Contraceptive use and costs in the regulations are only considered through the lens of abortion under the CSA Act, so we have a limited view of costs within the health care system. This issue is further complicated by the availability of commonly used contraceptives for purchase at variable costs from, for example, private providers, pharmacies and supermarkets.

Health New Zealand funds a broad range of sexual and reproductive health services, programmes and initiatives to support high-quality, safe and consistent practice across New Zealand. While it provides funded access to some contraception, this funding is not spread equitably across the country and some people still have to pay (depending on a variety of factors such as their income, age, ethnicity and location) (Sexual Wellbeing Aotearoa 2020).

The Ministry notes that the cost of contraception can also vary depending on the type of contraception the person is using. For example, some contraceptives require

multiple health practitioner appointments throughout the year (such as every 12 weeks for LARC injections) even if the medicine itself is funded or partially funded. Additionally, we are aware that people may need to try several different types of contraceptives before settling on the one best suited to them.

While additional funding for LARC has increased in recent years, access criteria to funded LARC have been inconsistent across the country and access to trained LARC providers varies. As a result, access to LARC has been inequitable and people have faced cost barriers (McGinn et al 2021).

Sexual Wellbeing Aotearoa, Youth One Stop Shops, and the Contraceptive Access Programme (funded by Health New Zealand) have been successful in providing affordable, acceptable care that is culturally safe and youth-friendly to help ameliorate this variation.

Sterilisation – Te kokoti-uru

Sterilisation is an important form of permanent contraception that prevents pregnancy.

The CSA Act covers male and female sterilisation. However, reporting requirements are only for those sterilisations undertaken for the primary purpose of permanent contraception. For this reason, sterilisations undertaken for this purpose will be the focus of this report.

Conversations about sterilisation are often first raised through GPs and primary care. However, sterilisations also occur alongside other medical procedures. For example, sterilisation procedures can be undertaken alongside caesarean sections or as a result of other surgeries (namely for cancer treatment). The most common form of female sterilisation is tubal ligation, although hysterectomies and salpingectomies are used in some cases. The most common form of male sterilisation is vasectomy.

While certain procedures, such as vasectomies, have a clear purpose of permanent contraception, other procedures outside of that scope can occur for the same purpose. For example, LARCs may be used as a permanent measure but are not captured by the sterilisation reporting requirements.⁶ Hysterectomies and salpingectomies used to treat other medical conditions are not included in our data.

The Ministry of Health gathers the data it needs to regulate and monitor equitable access to sterilisation services through providers completing a sterilisation reporting form after every procedure. The amendments made under the Information Collection Regulations introduced annual reporting for sterilisation providers for the first time. The questions focused specifically on types of services, timely access and reasons for refusal, alongside costs of the service.

Data collection

Over the last four years, the Ministry has been engaging with providers about sterilisation reporting and the numbers of providers reporting regularly have increased. However, significant gaps in the data remain.

Resistance from some providers has contributed to the incomplete data. Some practitioners have told us they are unwilling to collect information from their patients as they do not agree with some of the questions, in particular the ones related to relationship status and number of children (see section 8 of the CSA Act).

⁶ See the contraception chapter for further information on LARCs.

In 1977, the Royal Commission into Contraception, Sterilisation and Abortion noted increasing demand for sterilisations in hospitals as permanent contraception. This demand was highest among lower socioeconomic groups, and couples who felt they already had enough children. As a result, the government of the time felt it would help to collect data that was relevant to understanding who was accessing sterilisation services.

We acknowledge that some of the questions set out in the CSA Act are no longer relevant or appropriate, including questions around relationship status, race and number of children of the person seeking a sterilisation. The Ministry is working through changes to the questions for sterilisation services. These changes are yet to be finalised and, if approved, will be implemented later in 2025.

The Ministry intends that these new question sets will enhance the participation of providers in data collection. We also anticipate they will provide better data that we can use to draw firmer conclusions, by the next periodic review, on whether people have timely and equitable access to sterilisation services.

The Ministry has not published data relating to sterilisation services because the data sets are not of a quality that allows any useful analysis. The data does not reflect accurate use. For example, of the 150 providers listed as offering sterilisation services, 62 (around 41.5%) provided an annual report for 2023.

Under the CSA Act, it is possible to issue fines to medical practitioners who do not comply with section 8(1) reporting. However, no fines have been issued to date. To be able to issue fines, the Ministry would need to be aware of individual incidents where providers have not reported on sterilisation procedures, which is difficult to identify given we remain unclear as to the scale of the workforce (ie, who exactly is providing sterilisation services) and the existing or historical data gaps. In addition, a fine of \$100 may not be enough to stimulate reporting, creates an administrative burden (for providers and the Ministry) and potentially could damage relationships within the sector.

Timely and equitable access

Wait times for female sterilisation procedures vary greatly across regions and by type of sterilisation procedure. However, due to incomplete data, the Ministry cannot draw clear conclusions beyond identifying that the range of wait times is anywhere from a few days to over one year between referral and first consultation, and a similar range of times applies between consultation and the procedure. At the upper end of the timeframe, therefore, someone may have a wait time of two years (or longer) to access female sterilisation services.

For male sterilisation procedures, the wait times can be 1 to 31 weeks between referral and consultation, and from the same day to 30 weeks between consultation and the procedure. While these wait times are shorter than for female sterilisation procedures, a person can still wait for just over one year to access a procedure. Additionally, male sterilisation procedures are typically accessed privately and funded options appear to be limited in the public health system. Note that the Ministry only collects data from

the point of referral, and it is unclear what the patient journey looks like prior to and leading up to referral.

In early 2022, the Ministry met with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the Urological Society of Australia and New Zealand (USANZ) about the requirements for sterilisation data collection. Following these meetings, both RANZCOG and USANZ provided written feedback noting that sterilisation procedures and medical practice had changed since the CSA Act was written. Specifically, access to and availability of effective forms of LARC have improved significantly, and female sterilisation procedures are generally no longer a preferred contraceptive approach. Additionally, providers have told us that LARC is more often offered as a first option for those seeking sterilisation.

Disabled people's access

The disability sector has had long-standing concerns about sterilisations performed on disabled people without informed consent, as noted during the Royal Commission of Inquiry into Abuse in Care (2024). The Royal Commission asked the Ministry to provide data on how many disabled people that received sterilisation and whether they had provided informed consent for that. The Ministry was unable to provide this information due to the lack of any coherent or reliable data. While legislative requirements outline practitioners' responsibility to report all cases where a third party gives consent for a woman accessing an abortion, no such legislative requirement applies to sterilisation services.

Following the request from the Royal Commission of Inquiry into Abuse in Care, the Ministry worked internally to strengthen data collection on disabled people's access to sterilisation services. In 2022, it included optional questions on the notification of sterilisation form to collect information on whether the person accessing sterilisation services had a disability and whether a third party provided consent. Additional optional questions focused on whether a court order or capacity assessment was issued in relation to the sterilisation procedure. Following this adjustment to the form, a small number of cases have been reported where a third party provided consent to a sterilisation.

However, although the reporting form now includes questions about disability status and informed consent, under-reporting on disabled people accessing sterilisations may still occur because of poor reporting rates. Additionally, questions relating to disability and consent are included only as an optional addition to the reporting form, and providers are under no legislative requirement to supply this information. As a result, effective oversight is unlikely to be achieved based on this information. Furthermore, the questions do not capture information on informed consent to LARC.

Conscientious objection

We are aware of instances where conscientious objection prevents someone from accessing sterilisation services. Through the annual provider reporting form, the Ministry has been informed that people have been turned away when the health practitioner they approached considered them 'too young' to undergo the procedure,

or refused services on the grounds that the person did not yet have biological children (ie, suggesting they may change their mind later in life).

Ensuring that people seeking a sterilisation are aware of their rights and how to complain if they feel that a health practitioner has refused their request unlawfully will be considered as part of the Ministry's 5 year work plan (referenced in the recommendations chapter).

Relative costs of sterilisation throughout New Zealand

From the information that has been reported to the Ministry, it is clear that costs across the range of sterilisation procedures available vary greatly. While the CSA Act explicitly asks that this review includes only the relative costs for female sterilisation procedures, we have also included costs for vasectomies to provide a more detailed picture of services.

As noted, while female sterilisation procedures are available in public hospitals, wait times are long. Because they are expensive to access through private providers, they are not an equitable option unless some form of subsidy was available.

Price ranges for services are outlined below. These costs are for services that are either provided in private hospitals or not funded by the public health system:

- hysterectomy: \$5,650 to \$25,000
- salpingectomy: \$4,000 to \$22,000
- tubal ligation: \$3,500 to \$15,000
- vasectomy: \$350 to \$8,000.

The Ministry of Health will work closely with Health New Zealand in the future about the cost for these procedures in the public system to enable greater comparison and a better understanding of cost for the next periodic review.

It is evident that costs vary widely between providers and, for female sterilisation in particular (outside of the public system), costs are prohibitive. While some public funding is available for male sterilisations through Work and Income (for those who meet specific criteria), it is not universally available (Work and Income nd). Additionally, the Ministry does not capture which vasectomies were covered under this public funding structure, and therefore does not have accurate information on how many people use this service.

Information and advisory services – Ngā ratonga tuku kōrero

The availability of timely, equitable, unbiased and accurate information and advisory services is critical in supporting women to make an informed decision about their pregnancy options.

The CSA Act considers information and advisory services as distinct from abortion counselling. These services relate specifically to the decision-making process about pregnancy options, including whether to have an abortion (in contrast to counselling, which might provide this information as part of the procedure).

Ensuring that women have accessible, culturally safe information and education on women-specific health issues to reduce stigma and enable more women to access health advice is one of the priorities within the Women's Health Strategy 2023 (Minister of Health 2023). Providing timely and equitable access to information about whether to continue or terminate a pregnancy supports this priority.

A range of people and organisations in several settings provide information about whether to continue or terminate a pregnancy. They include:

- health practitioners (eg, doctors, nurses, midwives)
- social workers and counsellors
- sexual health organisations such as DECIDE (the national abortion telehealth service), Sexual Wellbeing Aotearoa and other local organisations
- charities and religious-based organisations that provide information about pregnancy
- 'crisis' pregnancy centres and pregnancy choice 'opportunity shops' (op-shops that support pregnancy choice information services often provided from the same location), many of which are run by groups with a conscientious objection to abortion.

Most of these organisations provide free information and advice on their website. For women seeking information and advice face to face, there may be a consultation fee.

Health practitioners providing information and advice on pregnancy are bound by their professional codes of practice. Their patients are further protected by the Code of Health and Disability Services Consumers' Rights. Similarly, registered social workers have their own code of conduct that they must follow during practice.

The number of crisis pregnancy centres and opportunity shops linked to pregnancy choice is growing in New Zealand. Several online or over-the-phone 'helpline' services are also available. It appears, based on their publicly available information, that the intent behind these services is to delay or prevent women from seeking an abortion.

In practice, we know that many of the people within these organisations are not health practitioners or registered social workers. Services are often provided by 'volunteers' (who often refer to themselves as counsellors) and they may belong to groups that oppose abortion. They are therefore not bound by the CSA Act or any kind of professional standards or regulations to offer services that are free from bias or coercion and do not spread misinformation.

Based on the consumer research the Ministry commissioned, for some women difficulty in accessing accurate information about abortion services (eg, how to access services) remains a barrier to accessing abortion care. All three research reports noted that once women had accessed abortion services, their experience of the advice and support provided was positive. Getting to the right place for the right information was the barrier.

Women may require a level of health literacy⁷ to identify sources of information that are credible and to detect and avoid disinformation or misinformation. Additionally, some groups, such as those with additional needs in relation to decision-making and communication, may find it harder to access accurate information in understandable formats.

As well as pointing to the need for easy access to information, all three commissioned research projects identified that the kind of language used in sources of information helps to remove barriers within this health service. For instance, rainbow, Māori, Pacific and disabled communities all said inclusive and affirming language was important to them.

Despite the intention of the Select Committee, the CSA Act does not currently provide a basis for monitoring access to information and advisory services (outside of abortion counselling). The Ministry therefore does not have data on areas such as the cost, timeliness and equity of these services, and who provides them.

For this reason, it is unclear whether women have timely access to unbiased, informative and accessible information to support them to make an informed decision about whether to continue or terminate their pregnancy.

⁷ People with a high level of health literacy are able to access and understand essential health information in order to make informed and appropriate health decisions (Ministry of Health 2013).

Counselling – Te mahi tohuora

Abortion counselling is not mandatory. However, the CSA Act is clear that a health practitioner providing abortion services must ensure the woman seeking an abortion is aware that counselling is available.

In describing abortion counselling, the WHO (2015) notes:

Counselling is more than information provision and refers to a focused, interactive process through which the woman voluntarily receives support, information and non-directive guidance from a trained person. It requires a much higher level of specific knowledge than providing general information about safe abortion care.

The Director-General of Health (Director-General) has an obligation under the CSA Act to collect, collate, analyse and publish information about the provision of counselling services in relation to, or in connection with, the provision of abortion services.

The Information Collection Regulations, introduced in September 2021, added annual reporting requirements for facilities providing abortion services. Their reporting must include information on:

- their counselling workforce
- the type of counselling provided, such as pre- or post-abortion counselling
- the cost of the counselling services and the circumstances in which patients are required to pay for the services
- whether these counselling services are offered in virtual or in-person settings.

In August 2022 the Ministry published the first Standard for Abortion Counselling in Aotearoa New Zealand (the Standard) (Ministry of Health 2022). In developing the Standard, the Ministry consulted with experts in counselling and social work, as well as those who provided abortion counselling.

The purpose of abortion counselling is to provide comprehensive support and enhance a woman's ability to assess and understand their situation, evaluate their options and make an informed choice or decision around abortion. It is distinct from the informed consent process that occurs as part of good clinical practice before providing an abortion.

The Standard outlines that abortion counselling provides therapeutic support to women who are considering having, or have had, an abortion. It is grounded in Te Tiriti o Waitangi and health equity practice and sets out what the Ministry expects of those delivering abortion-related counselling.

The principles in the Standard are that abortion counsellors in delivering abortion counselling will:

- give effect to Crown obligations under Te Tiriti o Waitangi, considering interests and needs of Māori
- be objective, impartial and non-judgemental
- ensure counselling services are accessible, equitable and of high quality
- offer timely, person-specific and tailored support
- screen for and acknowledge trauma.

Timely and equitable access

Before 2020, nearly all abortion providers offered counselling as part of their service and had dedicated abortion counselling staff. The law change allowed for different ways of providing abortion care (including in primary care) and the number and diversity of providers in a range of settings has gradually grown.

The introduction of the national abortion telehealth service also allowed for providers in primary care to refer women for abortion counselling to provide an appropriate counselling pathway for those that requested it.

What the research says

All three commissioned research reports commented on consumer experiences of abortion counselling. It is evident that consumer experiences are varied and providers differ in the way they offer counselling. Further training would be beneficial for all providers and counsellors working in this space.

In relation to post-abortion counselling, the Donald Beasley Institute (2025) reports:

one participant described how they chose not to do counselling because they felt secure in their decision. However, this participant also felt anxiety about potentially having to justify their decision within counselling sessions, revealing a mental barrier to accessing abortion counselling. (p 46)

Recommendations from this research highlight that abortion counselling services are critical, that choice is important and that counselling remains optional (but available).

National Centre for Women's Health Research Aotearoa (2025) reiterates that non-judgemental and supportive counselling is important and most of its Māori and Pacific participants were offered counselling. The majority of those who accessed abortion counselling found it useful and informative.

The research on rainbow people's experience (Parker et al 2025) indicates that some providers still treated abortion counselling as a mandatory step in the process. Overall, it found an inconsistency in both abortion counselling provision and the points in the process at which it was offered. This inconsistency was raised as a concern to address for equitable provision of these services.

Data collection

The Ministry began collecting data on pre-abortion counselling for women accessing an abortion within every notification of abortion form in 2022. Between 2022 and 2024, we observed a 35% decrease in women accessing pre-abortion counselling, despite a 21% increase in the total number of abortion procedures provided over this same period.

One reason for the decrease in the rate of pre-abortion counselling may be the effect of the removal of the perception of mandatory counselling in the old regime and promoting the view that women have freedom of choice. Another factor contributing to the decrease in counselling is the increase in medical abortions, and decrease in surgical abortions, over this same period. Specifically, as Figure 2 shows, the proportion of women who had pre-abortion counselling was higher for those accessing surgical abortion services than for those accessing medical abortion services. However, there was an overall decrease in the proportion of patients accessing pre-abortion counselling, regardless of which type of service they accessed.

Figure 2: Percentage of medical and surgical abortion procedures where women accessed pre-abortion counselling, 2022–2024

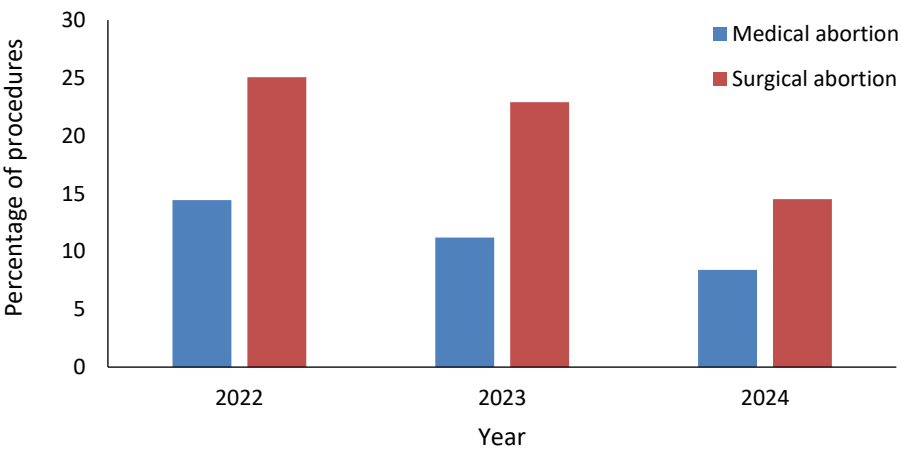


Table 1 to Table 3 show how access to pre-abortion counselling appears to differ between regions. Notably, a higher percentage of women accessed pre-abortion counselling in the Central region, particularly in 2022 (Table 1) and 2023 (Table 2). More analysis is required to understand the reasons for this difference further. It is possible that individual providers are influencing regional rates. For instance, in 2022, two facilities in the Central region accounted for 63% of abortion provision and 92% of pre-abortion counselling access, within that region. The percentage of abortions associated with pre-abortion counselling was 90% in one of those facilities and 98% in the other.

Table 1: Counselling provision by region of service, 2022

Region	Accessed pre-abortion counselling	Counselling from provider ¹	Total abortions	% accessing counselling	% counselling from provider
Te Tai Tokerau (Northern)	526	406	6,090	9	77
Te Manawa Taki (Midland)	243	228	1,888	13	94
Te Ikaroa (Central)	1,775	1,618	2,843	62	91
Te Waipounamu (Southern)	185	140	2,828	7	76
National ²	35	0	515	7	0
Total	2,764	2,392	14,164	20	87

Note: ¹ 'Counselling from provider' refers to instances where a woman accesses pre-abortion counselling at the same facility as they accessed their abortion care. For instance, they accessed both services at the same hospital. ² 'National' refers to the national abortion telehealth service DECIDE.

Table 2: Counselling provision by region of service, 2023

Region	Accessed pre-abortion counselling	Counselling from provider ¹	Total abortions	% accessing counselling	% counselling from provider
Te Tai Tokerau (Northern)	607	481	4,896	12	79
Te Manawa Taki (Midland)	251	227	2,145	12	90
Te Ikaroa (Central)	1,267	1,175	2,720	47	93
Te Waipounamu (Southern)	177	131	2,627	7	74
National ²	207	0	3,889	5	0
Total	2,509	2,014	16,277	15	80

Note: ¹ 'Counselling from provider' refers to instances where a woman accesses pre-abortion counselling at the same facility as they accessed their abortion care. For instance, they accessed both services at the same hospital. ² 'National' refers to the national abortion telehealth service DECIDE.

Table 3: Counselling provision by region of service, 2024

Region	Received pre-abortion counselling	Counselling from provider ¹	Total abortions	% accessing counselling	% counselling from their provider
Te Tai Tokerau (Northern)	540	435	4,664	12	81
Te Manawa Taki (Midland)	146	140	1,902	8	96
Te Ikaroa (Central)	617	525	2,986	21	85
Te Waipounamu (Southern)	170	148	2,463	7	87
National ²	302	0	5,108	6	0
Total	1,775	1,248	17,123	10	70

Note: ¹ 'Counselling from provider' refers to instances where a woman accesses pre-abortion counselling at the same facility as they accessed their abortion care. For instance, they accessed both services at the same hospital. ² 'National' refers to the national abortion telehealth service DECIDE.

These regional variations could therefore be due to inconsistencies in the way services apply the counselling standards or in their practice, or they could be due to data errors.

Variations in counselling also appear associated with a woman's ethnicity, age, and duration of gestation at time of abortion.

The Ministry will undertake further work to understand the reasons for these variations and whether regions differ in timely and equitable access.

Relative costs of counselling throughout New Zealand

Through their annual reporting, providers are asked to submit information on the cost of abortion counselling for their service. Counselling accessed within a publicly funded hospital is free for New Zealand citizens and permanent residents.

Providers in primary care settings can refer women to the national abortion telehealth service if they request counselling. This option means that a woman can still receive free and accessible counselling.

Information that providers submitted through their annual reports shows that when counselling is not free, the reported costs are usually in the range of \$100 to \$200 (per session)⁸. The Ministry does not hold information on the cost of counselling services that a woman accesses privately, outside of the usual referral pathways.

⁸ One provider reported a cost of \$670. However, this has not been verified and may represent a reporting error.

Abortion – Te whakatahe

In its first annual report on abortion services (for the 2020 calendar year) (Ministry of Health 2021), the Ministry's vision was to ensure accessible, equitable and high-quality abortion services. Following implementation of the changes to the CSA Act, it expected to see:

- local access to first-trimester abortion services for all regions of New Zealand
- improved choice and access for abortion services – in particular, those considering abortion services would experience greater choice and timely access, with barriers and delays to care removed
- equitable services that are patient-centred and focused more strongly on the requirements of rangatahi, Māori, Pacific peoples and disabled people considering abortion
- a well-supported abortion workforce that has clear clinical guidance and training as a framework for patient centred and equitable service provision.

The data collected and reported on since 2020 suggests that the changes to the legislation are beginning to have a positive impact on timely and equitable abortion health care. However, there remains considerable room for improvement in each area, as we explore in this chapter.

Data collection

In 2021, the Information Collection Regulations were introduced as secondary legislation. These regulations outline information that practitioners must submit to the Ministry on abortions it provides, within one month of providing each abortion. They also set out annual reporting requirements for facilities offering abortion services.

The data collected, and the range of questions mandated, have allowed the Ministry to report more extensively on aspects of abortion service provision since the law change⁹.

However, the following challenges with the data collected remain.

- Providers see some of the questions required by legislation as irrelevant to service provision (in particular, the questions on the number of previous abortions and the number of children).
- National Health Index (NHI) data is not linked to the notification of abortion form. As a result, collecting demographic information is repetitious and creates an

⁹ To access previously published reports, go to the Ministry of Health's Publications page (health.govt.nz/publications) and search with the key words **abortion services annual report**.

additional burden on health practitioners, particularly those in the public health care system.

- Completing these forms perpetuates the stigma and 'otherness' linked to abortion, because these requirements are outside of normal health care reporting.
- The current structure means information about a woman's abortion care access cannot be placed within their broader health context, such as information on disabilities and care surrounding these disabilities.
- The structure limits the ability to record complications or additional treatment that may occur following an abortion procedure.

Developing a digital platform is part of the Ministry's ongoing programme of work to improve data collection. Development work includes understanding what the system requires, what data is collected, and whether this can be integrated into existing platforms. The data solution may also allow for more detailed review of relevant medical services, including follow-up treatment for complications.

Medicines

There has been progress in removing barriers to access to abortion medicines. In November 2022, Pharmac funding for mifepristone became available. Later, in November 2024, Pharmac announced that from 1 December 2024 it would fund a low-sensitivity urine test kit used after a medical abortion to confirm that a pregnancy has ended (Pharmac 2024). These changes mean that a woman can receive a prescription for abortion medicines and follow-up test kits from their health care provider without needing a blood test. They can pick up prescriptions from a local supporting pharmacy, improving their choice and providing closer-to-home access.

Healthpoint maintains a list of pharmacies that update their information regularly to indicate their willingness and ability to dispense a range of medicines. Coverage of pharmacies is good, with 570 pharmacies around the country indicating they are willing to dispense these abortion medicines.

Improved abortion services choice and access

Following the implementation of the Information Collection Regulations, the Ministry has collected data and reported on the number of professionals and providers delivering abortion services across New Zealand. While the 2024 figures are not yet available, we have observed a marked increase in the number of providers across all regions and professions from 2021 to 2023 (Table 4). Moreover, while 29 unique facilities provided abortion services in 2020, the number has increased to 55 unique facilities in 2024.

Table 4: Number of health workers delivering abortion services by profession and region of service, 2021 and 2023

Region of service	Medical		Nursing		Midwifery	
	2021	2023	2021	2023	2021	2023
Te Ikaroa (Central)	10	36	6	12	0	2
Te Tai Tokerau (Northern)	24	42	60	95	0	30
Te Manawa Taki (Midland)	11	28	13	42	2	4
Te Waipounamu (Southern)	14	26	9	44	0	0
National ¹		4		21		0

Note: ¹ 'National' refers to the national abortion telehealth service, DECIDE.

The availability of different types of facilities offering services has also increased following the changes to the CSA Act. Specifically, fewer abortions were provided in hospital settings across all regions, with an observed increase in community-based provision (Table 5). The increases in the size of the abortion workforce, community-based in-person services, and the availability of national and regional telehealth EMA services demonstrate how services have become more accessible. This greater accessibility is likely to have contributed to the increase in abortions each year following law reform, as well as the decrease in duration of gestation at the time of abortion.

Table 5: Number of abortions by provider type and region of service, 2020 and 2024

Provider type ¹	Te Ikaroa (Central)		Te Tai Tokerau (Northern)		Te Manawa Taki (Midland)		Te Waipounamu (Southern)	
	2020	2024	2020	2024	2020	2024	2020	2024
Hospital	1,683	1,354	4,511	3,275	1,849	1,314	2,584	1,936
Community specialist ²	901	1,584	655	1,247	663	586	400	135
Enrolling general practice	–	8	–	51	–	2	–	22
Community midwife	–	1	–	91	–	–	–	370
Māori health provider ³	–	39	–	–	–	–	–	–

Note: ¹The national abortion telehealth service, DECIDE, also provided 5,108 early medical abortions in 2024.

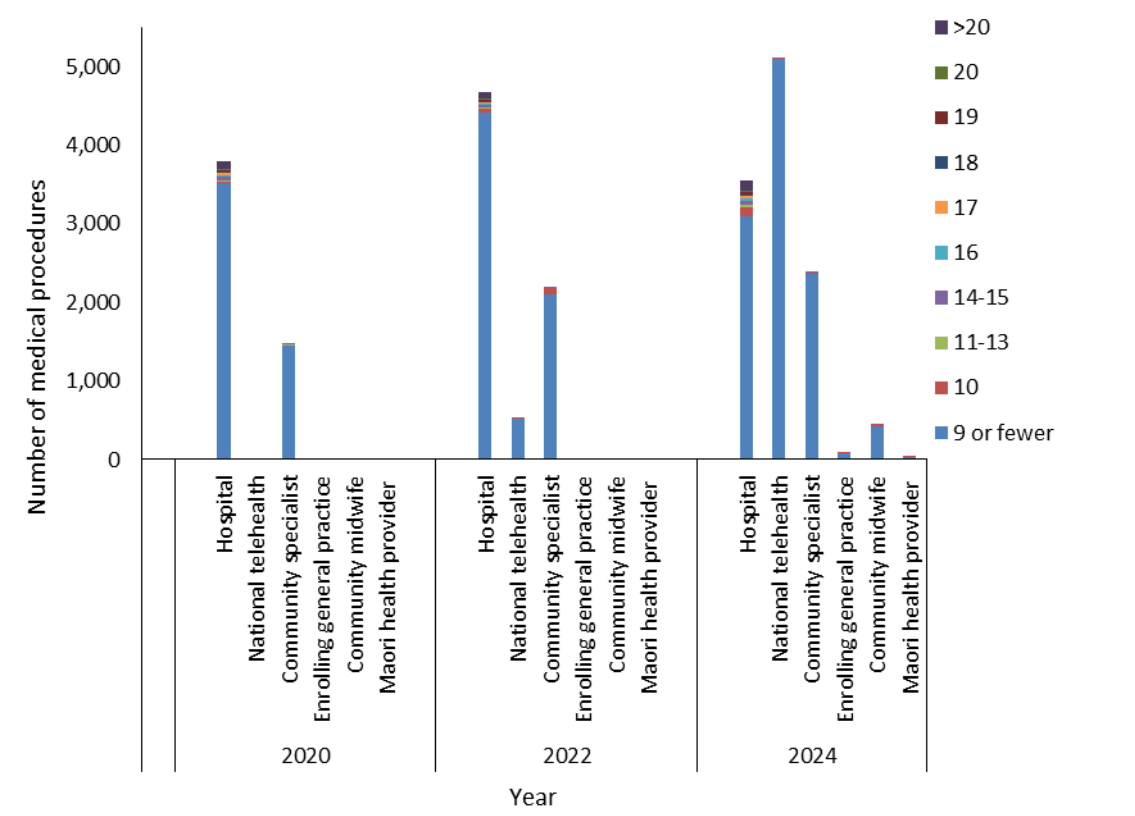
² Community specialists are community-based facilities, such as community-based obstetricians and sexual health clinics, that do not fall under the categories of an enrolling GP practice, or community midwife.

³ The category of Māori health provider represents general practices that have chosen to identify as providing a whānau-focused health care service.

The increased availability of different types of abortion facilities has increased both the volume and range of non-hospital access. As Figure 3 shows, women have accessed medical abortions less frequently within hospital settings following the 2020 law reform. On the other hand, they are accessing medical abortions more frequently within community settings and through the national abortion telehealth service, DECIDE. Specifically, while 73% of all medical abortions were accessed within hospital

settings in 2020, and 63% in 2022, this percentage has dropped to 31% in 2024. This trend gives hospitals the opportunity to upskill and concentrate on abortion service provision at 10 weeks’ gestation or higher (for both medical and surgical procedures).

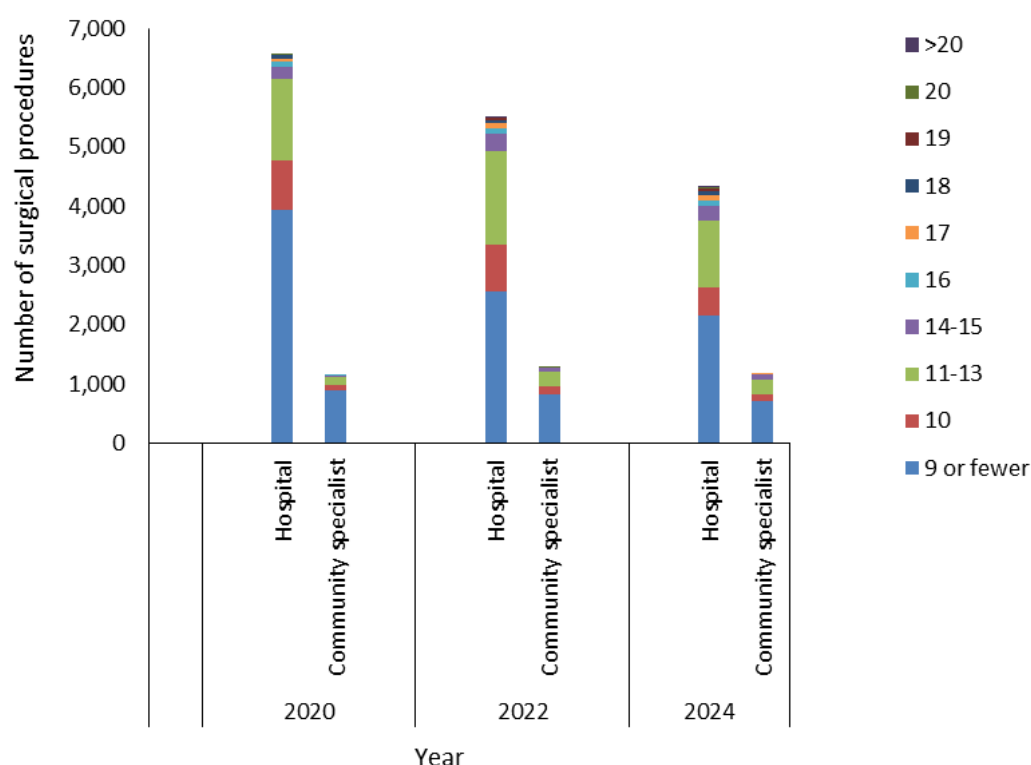
Figure 3: Number of medical abortions, by gestation and profession, 2020, 2022 and 2024



In contrast, while the number of surgical abortions has decreased since 2022 (Figure 4), the percentage of surgical abortions performed within hospital settings has remained relatively stable across 2020 (85%), 2022 (81%) and 2024 (84%). Surgical abortions are also, to a lesser extent, accessed from community specialists at early gestations.

However, surgical abortions occurring at greater than 15 weeks’ gestation were performed almost exclusively in hospitals. This is particularly important to note when considering equitable access to abortion services, as 83% of abortions at greater than 9 weeks’ gestation continue to be provided surgically. Barriers to accessing a hospital or community specialist that is able to provide a surgical abortion near where a woman lives may therefore cause delays in accessing these services.

Figure 4: Number of surgical abortions, by week's gestation and profession, 2020, 2022 and 2024



Note: Across these years, 5 early surgical abortions were performed by either an enrolling general practitioner (3) or a community midwife (2).

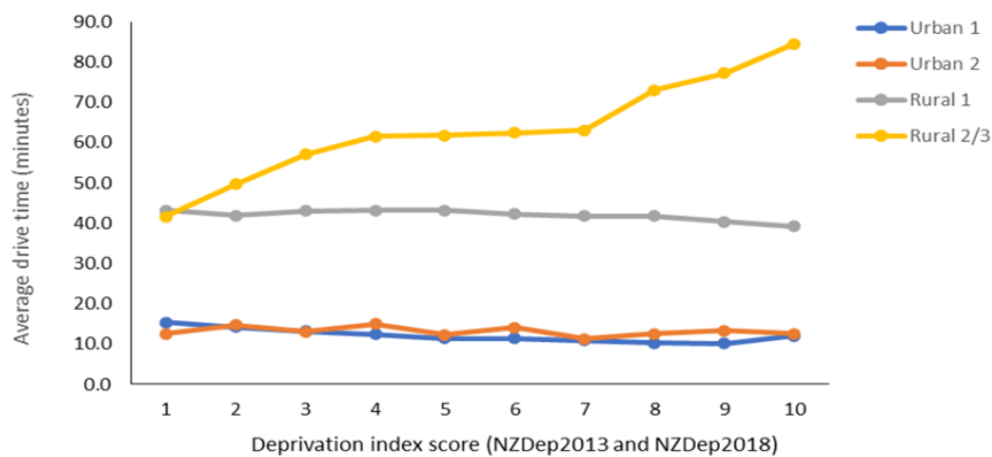
Continued barriers to in-person services, based on district of domicile

As we noted in the previous section, while the increase in providers and access through community-based facilities is encouraging, gaps in service provision remain. As the report for the 2023 calendar year recorded (Ministry of Health 2024a), the majority of in-person services are based within, or near, main urban centres. We therefore considered the impact of living in an urban area (urbanicity) compared with living in a rural area (rurality) on average drive time to an in-person service.

We measure urbanicity/rurality using the Geographical Classification for Health (GCH). The GCH includes two urban categories (Urban 1 and Urban 2) and three rural categories (Rural 1 to Rural 3). To view a map of these classification areas, please visit the Rural Research Network's 'Maps' webpage (<https://rhrn.nz/gch/maps>).

As Figure 5 shows, average drive time to in-person services was greatest for those living rurally, particularly for those living within the most rural areas (Rural 2 and 3). Additionally, for those living most rurally, average drive-time increased as socioeconomic deprivation increased.

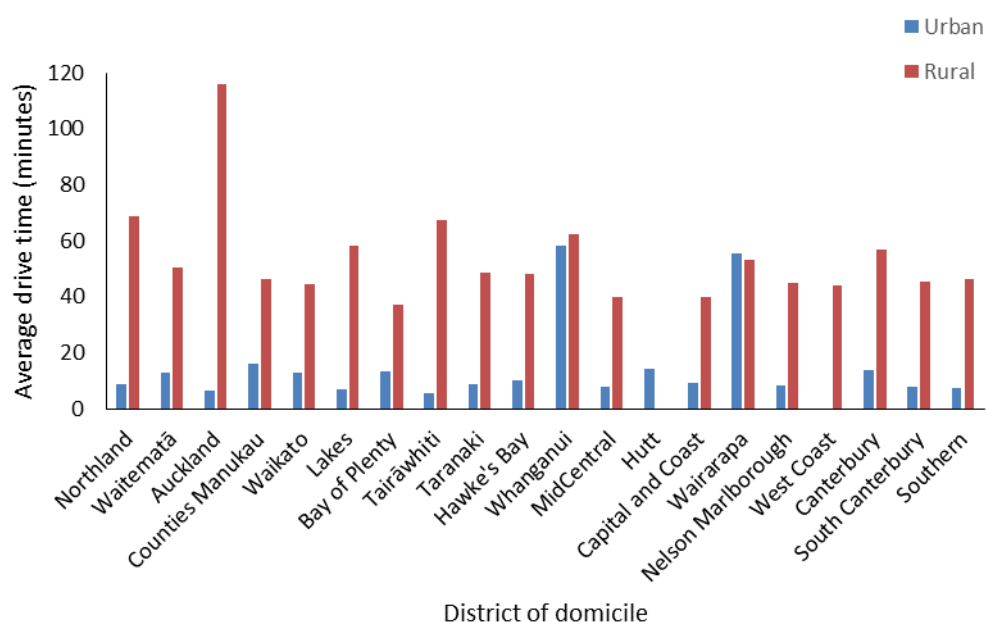
Figure 5: Average drive time (in minutes) for females aged 15–44 years to nearest in-person abortion provider, by level of socioeconomic deprivation and GCH urban–rural index, 2023



Note: 'Females aged 15–44 years' refers to self-reported population-level trends retrieved from national databases. Socioeconomic deciles are measured using the New Zealand Index of Deprivation. Population-level drive time data is not yet available for 2024.

A woman's district of domicile impacts average drive time to an in-person facility. Measures of rurality/urbanicity compound these effects (Figure 6). For instance, while women living in rural areas typically have a longer average drive time to an in-person service, this impact is most pronounced in Auckland. Yet in areas such as Whanganui and Wairarapa, average drive times to an in-person service provider are about the same across the different measures of urbanicity/rurality. These differences reflect inequitable access to services, depending on a woman's district of domicile as well as rurality/urbanicity.

Figure 6: Average drive time (in minutes) for females aged 15–44 years to nearest in-person abortion provider, by district of domicile and GCH urban-rural index, 2023



Note: The entire Hutt Valley district is classified as urban, and the entire West Coast district is classified as rural. 'Females aged 15–44 years' refers to self-reported population-level trends retrieved from national databases.

Importantly, these regional variations are most likely to have their largest impact on access to surgical abortions. As reported above, 83% of abortions at later than 9 weeks' gestation are performed surgically. This presents an additional burden for women, particularly those in rural communities, who may not live near a hospital or community specialist that is able to provide a surgical abortion. In 2024, 43% of women accessing a surgical abortion had to travel out of their district of domicile for service. As Table 6 shows, the percentage of women who have to travel out of their district increases as gestation increases.

Notably, these figures likely do not account for the full burden of travelling for abortion. Women may face additional barriers related to travelling when they would otherwise elect to have a surgical abortion, or an abortion at greater than 10 weeks' gestation. For instance, women with cognitive or physical disabilities may be disadvantaged in accessing timely and affordable transport, particularly if they live rurally or depend on caregivers' support for arranging travel.

Table 6: Number and percentage of surgical abortions occurring outside of district of domicile, by gestation, 2020, 2022 and 2024

Duration of gestation (weeks)	2020	2022	2024
0–5	87 (45%)	13 (22%)	16 (25%)
>5–10	2,083 (38%)	1,594 (38%)	1,282 (38%)
>10–15	784 (45%)	898 (41%)	710 (41%)
>15–20	140 (70%)	189 (67%)	210 (69%)
>20	0 (0%)	0 (0%)	9 (82%)

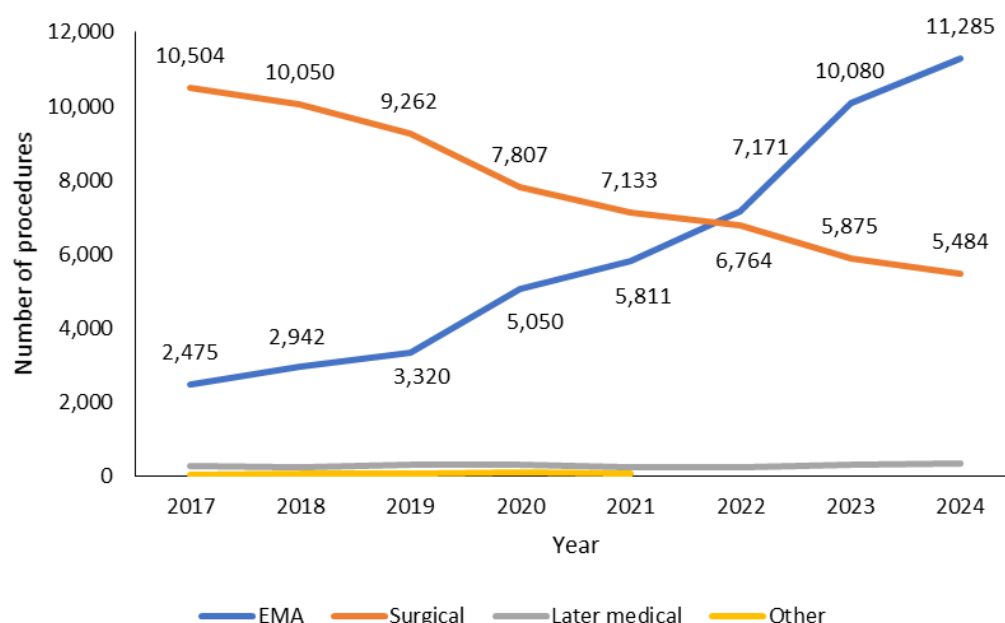
Early medical abortion

Gestation is an important indicator of access to abortion services. Earlier gestation at the time of abortion indicates women have fewer barriers to accessing the services. It is also associated with better health outcomes for women accessing these services.

Since the changes to the legislation, duration of gestation at the time of abortion has decreased across all ethnic groups and socioeconomic deciles. This corresponds to the increase in access to EMA. When the Ministry started collecting data on abortion in 2020, 36% of all abortions provided were EMA. The available figures for abortions accessed in 2024 show 66% of abortions provided were EMA (Figure 7).

In both 2023 and 2024, 86% of all abortions (surgical and medical) were provided at 10 weeks' gestation or earlier, which is an increase of approximately 5% compared with recorded figures in 2020. Together, these figures demonstrate access to abortion care earlier in gestation is increasing, as is accessing early medical, rather than surgical, procedures.

Figure 7: Number of abortion procedures, by procedure type, 2017–2024



This increase in earlier access has a variety of causes. They relate to an increase in the size of the workforce, an increase in the number of services available, the introduction of the national abortion telehealth service and, importantly, the ability for women to self-refer to an abortion service.

In 2021, to improve timely and equitable access to abortion services, the Ministry tendered for a national abortion telehealth service. The outcome of the tender and procurement process was the establishment of DECIDE, a national telehealth service run jointly by Magma Healthcare and Sexual Wellbeing Aotearoa.

The DECIDE service provides information about abortion services that are available across the country and has an 0800 number staffed by trained health practitioners. It provides information, support, referrals, abortion-related counselling, telemedicine consultations and provision of EMA (including by prescribing medicines). It also provides follow-up services, such as providing contraception or referring someone for contraception if their choice is a contraceptive device.

The service is now funded by Health New Zealand.

DECIDE supports providers in primary care by offering after-hours care and access to counselling. It complements other abortion services and does not replace in-person abortion care.

In 2023, among women who used DECIDE services, the rates of use across age groups were comparable with the rates of those using in-person and regional telehealth services. All ethnic groups accessed the service. Notably, those living in rural areas accessed DECIDE at a higher rate than the other services, which corresponds to their longer drive time to in-person support. This suggests that DECIDE is enabling support for women who may find it difficult to access abortion services in-person.

During 2024, DECIDE accounted for approximately 30% of all abortions, and 45% of all EMA.

Early surgical abortion

Early surgical abortion (ESA) is an option for abortion during the first 13 to 15 weeks' gestation. However, the gestation at which it is available depends on the provider. Many practitioners who offer ESA do not offer this service at later than 13 weeks' gestation.

Table 7 outlines the number of abortions provided within each district of service occurring at under 13 weeks' gestation (at or below 12 weeks and 6 days: surgical and total). It also includes the percentage of the total number of abortions provided within each district that these figures represent. These figures demonstrate that, across all districts, the majority of all abortions provided occur at under 13 weeks' gestation. However, consistent with the observed increase in EMA since the law change, there has been a decrease in ESA across almost all districts.

Notably, the proportion of abortions provided as surgical abortions under 13 weeks' gestation varies widely across regions, with higher proportions typically observed in districts with more urban or densely populated areas. As reported above, the proportion of ESA is also impacted by the availability of local facilities providing surgical abortion services, which have been almost exclusively provided within hospitals and, to a lesser extent, by community specialists. So, while the law change has enabled more timely and equitable access to EMA, there are still large disparities in surgical provision even at early gestations.

Table 7: Number and percentage of surgical and total abortions provided at earlier than 13 weeks' gestation, by district of service, 2020, 2022 and 2024

District of service	2020		2022		2024	
	Surgical (%)	Total (%)	Surgical (%)	Total (%)	Surgical (%)	Total (%)
Auckland	2,497 (53.6)	4,071 (87.5)	2,076 (44.2)	4,324 (92)	1,754 (43.9)	3,577 (89.6)
Bay of Plenty	–	246 (100)	2 (0.5)	373 (100)	1 (0.4)	238 (100)
Canterbury	886 (54.9)	1,528 (94.7)	581 (38.3)	1,466 (96.8)	437 (29.6)	1,351 (91.6)
Capital & Coast	855 (67.9)	1,100 (87.4)	797 (59.3)	1,186 (88.2)	515 (53.9)	786 (82.3)
Counties Manukau	–	–	–	–	–	62 (62)
Hawke's Bay	261 (62.1)	398 (94.8)	241 (52.5)	443 (96.5)	225 (52.6)	407 (95.1)
Hutt Valley	0 (0)	0 (0)	–	–	–	8 (88.9)
Lakes	462 (58.2)	738 (92.9)	506 (65.3)	712 (91.9)	373 (64.6)	540 (93.6)
MidCentral	415 (46)	869 (96.3)	357 (34.4)	997 (96.1)	282 (17.7)	1,539 (96.6)
Nelson Marlborough	154 (47)	321 (97.9)	159 (48.3)	321 (97.6)	146 (46.5)	292 (93)
Northland	210 (50.8)	389 (94.2)	150 (29.8)	470 (93.4)	134 (33.8)	389 (98)
South Canterbury	4 (7.3)	55 (100)	7 (6.4)	110 (100)	21 (22.8)	89 (96.7)
Southern	329 (33.3)	914 (92.6)	304 (35.5)	800 (93.3)	267 (47.1)	512 (90.3)
Tairāwhiti	42 (24.4)	170 (98.8)	38 (17.8)	210 (99.1)	14 (7.2)	184 (94.8)
Taranaki	38 (12.5)	286 (94.1)	39 (11.9)	319 (99.4)	56 (24.9)	221 (98.2)
Waikato	806 (80.9)	969 (97.3)	769 (78.9)	969 (16.3)	521 (78)	658 (98.5)
Wairarapa	–	–	–	–	–	–
Waitematā	–	–	3 (3.8)	13 (16.3)	2 (1.1)	99 (56.6)
West Coast	–	–	17 (100)	17 (100.0)	14 (100)	14 (100)
Whanganui	–	–	–	–	–	–
National (DECIDE)	–	–	–	515 (100)	–	5,108 (100)
Total	6,959 (52.5)	12,056 (91.0)	6,046 (42.7)	13,245 (93.5)	4,762 (27.8)	16,074 (93.9)

Note: Figures in parentheses are the percentage of all abortions provided within each district for that year. Percentage reported is a function of total abortions accessed.

Early surgical abortion services can be provided by an appropriately trained GP or midwife. The New Zealand College of Sexual and Reproductive Health (NZCSRH) reports that 44% of the 214 health practitioners who had completed their training (as at 30 October 2024) also completed the ESA module. However, the Ministry has not yet found evidence of an uptake outside of the traditional settings for ESA and recommends that Health New Zealand supports this practice within primary care settings.

Later surgical abortion

Surgical abortion provision is critical to ensuring timely and accessible care, especially for later gestation abortion: 71% of all second-trimester (here referred to as 13 to 26 weeks) abortions were provided surgically in 2024. The current workforce is small and dedicated to ensuring provision. However, it does not have the support it would gain from a nationally consistent approach and direction, along with a clear training pathway.

Health practitioners who offer later gestation surgical abortions are located at some of the main facilities providing abortion care. However, the Ministry is aware of some hospitals declining to provide this service even though willing practitioners are reportedly available.

While the percentage of second-trimester surgical abortions has declined across most ethnic groups since 2020, the number of all second-trimester abortions has increased, and the number of second-trimester surgical abortions has remained generally stable. Table 8 outlines the number of abortions provided at 13 to 26 weeks' gestation (surgical and total) by prioritised ethnicity, along with the percentage of the total number of abortions that these figures represent within each ethnic group.

Additionally, the proportion of all second-trimester (total and surgical) abortions varies widely across districts and to some extent between regions. These services are entirely absent in some districts (Table 9). This creates a high burden both on women who must travel long distances to access services, and on the limited workforce providing second-trimester abortion services to them.

Table 8: Number and percentage of surgical and total abortions provided at 13 to 26 weeks' gestation by prioritised ethnicity, 2020 and 2024

Ethnicity	2020		2024	
	Surgical (%)	Total (%)	Surgical (%)	Total (%)
Māori	253 (8.8)	286 (9.9)	255 (5.6%)	299 (6.6)
Pacific	90 (9.5)	105 (11.1)	99 (6.3%)	121 (7.7)
Asian	79 (2.8)	156 (5.6)	121 (3.2%)	209 (5.6)
Other	308 (4.7)	439 (6.7)	246 (3.4%)	389 (5.4)

Note: Cases with missing ethnicity data are not included. Figures in parentheses are the percentage of all abortions provided in that year by prioritised ethnicity. Percentage reported is a function of total abortions accessed.

Table 9: Number and percentage of surgical and total abortions provided during the second trimester (at 13 to 26 weeks' gestation) by district of service, 2020, 2022 and 2024

District of service	2020		2022		2024	
	Surgical (%)	Total (%)	Surgical (%)	Total (%)	Surgical (%)	Total (%)
Auckland	332 (7.1)	399 (8.6)	346 (7.4)	378 (8)	353 (8.8)	408 (10.2)
Bay of Plenty	–	–	–	–	–	–
Canterbury	36 (2.2)	84 (5.2)	21 (1.4)	48 (3.2)	22 (1.5)	120 (8.1)
Capital & Coast	138 (11.0)	157 (12.5)	142 (10.6)	157 (11.7)	147 (15.4)	162 (17.0)
Counties Manukau	–	47 (88.7)	–	27 (90)	1 (1.0)	34 (34.0)
Hawke's Bay	18 (4.3)	22 (5.2)	13 (2.8)	16 (3.5)	20 (4.9)	21 (4.9)
Hutt Valley	–	3 (100)	–	1 (100)	1 (11.1)	1 (11.1)
Lakes	55 (6.9)	56 (7.1)	60 (7.7)	63 (8.1)	33 (5.7)	37 (6.4)
MidCentral	32 (3.5)	33 (3.7)	37 (3.6)	41 (3.9)	42 (2.6)	54 (3.4)
Nelson Marlborough	4 (1.2)	4 (1.2)	5 (1.5)	8 (2.4)	18 (5.7)	22 (7.0)
Northland	19 (4.6)	24 (5.8)	22 (4.4)	33 (6.6)	8 (2)	8 (2.0)
South Canterbury	–	–	–	–	1 (1.1)	3 (3.3)
Southern	70 (7.1)	73 (7.4)	55 (6.4)	56 (6.5)	42 (7.4)	54 (9.5)
Tairāwhiti	1 (0.6)	1 (0.6)	3 (1.4)	3 (1.4)	7 (3.6)	10 (5.2)
Taranaki	12 (3.9)	18 (5.9)	4 (1.2)	8 (2.4)	3 (1.3)	4 (1.8)
Waikato	17 (1.7)	27 (2.7)	3 (0.3)	6 (0.6)	8 (1.2)	10 (1.5)
Wairarapa	–	–	–	–	1 (100)	1 (100)
Waitematā	–	44 (97.8)	7 (8.8)	64 (80)	14 (8)	68 (38.9)
West Coast	–	–	–	–	–	–
Whanganui	–	–	–	–	–	–
Total	734 (5.5)	992 (7.5)	718 (5.1)	909 (6.4)	721 (4.2)	1,017 (5.9)

Note. Cases with missing district data are not included. Figures in parentheses are the percentage of all abortions provided within these districts in that year. Percentage reported is a function of total abortions accessed.

The Ministry worked with Health New Zealand in 2022 to develop an approach to second-trimester and post 20-week abortion care. This included considering the importance of timely and equitable access to second-trimester care and post 20-week care, the workforce, funding and a national pathway.

Post 20-week abortion care

Across 2020 to 2024, fewer than 1% of all abortions were provided at 20 weeks' gestation or later within each year. Of these procedures, 90% were provided across only five districts.

Services across the country vary in how they understand and manage post 20-week abortion care. There is uncertainty about when to include specialist care and what care can be managed where. This leads to confusion and strained resources, and patients become geographically separated from whānau support.

Access to abortion care specifically after 22 weeks' gestation remains a significant challenge in New Zealand because of the medical specialties that are involved (and their availability) as part of service provision at this gestation or later. Since 2020, abortions at 22 weeks' gestation or later have continued to be a small minority of abortions, representing 0.4% to 0.6% of all abortion procedures in each year from 2020 to 2024.

In practice, this means that most regions that agree to provide post 20-week abortion care have an informal practitioner group to consider requests for abortion at later gestations. The clinical guidelines around post 20-week care should be updated, strengthened and clarified to support national consistency. The revised guidelines should cover robust infrastructure, funding and support to ensure that all patients can access these critical services in a timely and efficient manner.

Given the small number of procedures undertaken at later gestations, the number of appropriately trained health practitioners in New Zealand is low and it may take longer to meet training requirements because training opportunities are so limited. Although a mentorship model is available, access to training is further limited by geographic distance and lack of funding for mentoring and training.

As a result of these workforce issues, some patients have to travel significant distances to access care and experience delay in receiving the service, greatly reducing its accessibility.

To increase the workforce and therefore the availability of services around the country for all second-trimester abortion care, hospitals could:

- manage conscientious objection at an organisational level to ensure that it does not impede timely and equitable access to post 20-week abortion health care
- increase access to training and mentorship
- support service coordination and infrastructure
- clarify and expand service roles
- incentivise workforce growth, such as through funding for training and support for professional development.

Monitoring Health New Zealand's progress in improving access to post 20-week abortion care will continue to be a part of the Ministry's work programme. Please refer to the recommendations chapter for more information.

Self-referral

The consumer research sought participants' feedback about self-referral as well as their knowledge and experience of seeking abortion care. It identified that, overall, women seeking an abortion found the referral process quicker and easier after the legislation changes. However, some participants shared their frustration at not knowing (or not being told) that they could self-refer or at feeling that they had limited choice in which service they accessed due to their location.

'It was like more like instead of like back in 2012 of the waitlist that I had got given prior to 2012. I got seen quite straight away ... and like I was a bit stunned because obviously prior to 2012, but it made a huge difference the fact that I could have access to the abortion clinic without going through a waitlist and checks.' Participant (Donald Beasley Institute 2025)

The Donald Beasley Institute (2025) notes that, overall, 'participants reported positive experiences with the referral process post-legislation change, but there appears to be a lack of information about the ability to self-refer'.

Similarly, National Centre for Women's Health Research Aotearoa (2025) reports 'some participants were unclear about the option of self-referral but noted that their first point of contact gave clear information'.

'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.' Participant (National Centre for Women's Health Research Aotearoa 2025)

The researchers also note:

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. Assumptions about which model of care is best for any group should not be made.

Some participants from the rainbow research expressed the view that having choice over the method of their abortion was vital; what worried them was the unknown within the abortion process. On this basis, Parker et al (2025) concluded 'people must be effectively informed about the different abortion methods to support their decision making'.

Reflections on different abortion methods

EMA: 'I decided to do the medical abortion because I wanted to, obviously have this quite traumatic procedure, I wanted it to be in a place where I was comfortable, and so I chose to do the medical abortion so that I could do that process at home in a place I was comfortable with, surrounded by people I was comfortable [with].'

EMA via telehealth: 'I mean having the home one, really afforded a lot of privacy, which I really appreciated. I didn't even have to go to the pharmacy to collect the medication, you know, it just got delivered to my door. That was quite important to me, the privacy aspect.'

Surgical: 'I chose [surgical] just because, it was like a easy ... once it's done it's done, and it was like a quick little procedure, I'd have to spend like about half a day at the hospital and then that was it. Whereas if I took the medication, she went through a lot of the side effects, and she said that there was also, not a standard timeframe for when it would pass, so it was different for a lot of people and she couldn't exactly tell me exactly how it was gonna go but she kinda gave me an overall.'

Participants (Parker et al 2025)

Some participants felt that living rurally impacted their choice of service, despite being able to self-refer. In addition to travel-related barriers, they had concerns about privacy, decreased choice of services, and longer wait times due to service overload. The Donald Beasley Institute (2025) gives the example of one rural participant who, at a hospital appointment they went to as part of the abortion process:

was unexpectedly attended to by a family member working as a nurse in the facility. The participant described feeling both awkward and concerned for their privacy. Though the participant acknowledged they could have asked for a different nurse, this would have increased the time pressure they already felt under due to difficulties around travel.

'... it's, it's a different, it's a different, very, very different experience to urban health services and the options that come with the many, you know, the many opportunities and options that come. And you can select and you know, you can choose if you don't like a part-, you know, you'd, but, whereas you've only got one ... I think it's really hard rurally, like, well, to get the services that you need.'

Participant (Donald Beasley Institute 2025)

Countering misinformation

Pagoto et al (2023) define misinformation as ‘information that is false and being shared by someone who believes it to be true’. It is distinct from disinformation, where the false information is ‘shared by someone who is aware that it is false but intends to deceive others’.

Misinformation about accessing the abortion service, the procedure itself and how a woman may feel afterwards may impact their decision whether to access an abortion. It could also cause delays in accessing an abortion.

The Ministry is aware of instances where some health practitioners, social workers and other hospital staff are not well informed about the law changes or the processes for an abortion in their local area, with the result that they accidentally spread misinformation. For example, they may perpetuate the belief that abortion counselling is ‘mandatory’ or that patients must go through their doctor for a referral to abortion services.

It is essential that women considering an abortion have access to accurate information and supportive resources on all parts of the abortion process. This enables them to make more timely and informed decisions, and also to go into the procedure prepared, knowing what to expect and being more able to self-advocate. The availability of accessible and inclusive information facilitates equitable service provision.

In some cases, equitable provision means that additional support must be available to address unique barriers that women face. For instance, some disabled people have communication or decision-making impairments and require tailored support to meet their specific needs so they can come to an informed decision. As another example, language barriers may impede access to understandable information and can make services less equitable in locations where translators are not available.

Using inclusive language – such as culturally safe and rainbow-inclusive language – is another important part of providing equitable service, as it supports the safety and wellbeing of those accessing the service. This experience of safety reduces barriers to accessing supportive services.

‘I think it gave me a sense of inclusivity. Like it made me feel as though, anyone was welcome there like ... like it didn’t matter like what the circumstance was like they were gonna welcome you and make you feel as safe as possible which I think is really important especially for the LGBTQ+ community, like, it’s very important that there’s a safe space for them and like, it just made it feel like a very inclusive space.’ Participant, reflecting on why the invitation to be known in abortion care felt important (Parker et al 2025)

The Donald Beasley Institute (2025) observes how a lack of access to timely and appropriate information created barriers for some participants, who felt they needed more information about the process. It describes a participant who:

said they did not realise the process would occur at multiple healthcare facilities, leading to confusion and frustration. Another participant emphasised the importance of understanding the full process, including what happens before, during, and after the abortion.

Reporting on the experiences of wāhine, National Centre for Women's Health Research Aotearoa (2025) found that, overall, wāhine reported that they received useful written and spoken information from abortion services.

'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 really wanted to make sure that I understood what was happening.' Participant (National Centre for Women's Health Research Aotearoa 2025)

'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.' Participant (National Centre for Women's Health Research Aotearoa 2025)

On the other hand, the researchers reported the experience of one wahine whose pathway to abortion care 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'. She finally got an appointment by contacting the abortion clinic directly.

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. (National Centre for Women's Health Research Aotearoa 2025)

In 2024, following feedback from stakeholders, the Ministry published a position statement on abortion reversal. Manatū Hauora does not support or recognise the practice of 'abortion reversal' (Ministry of Health 2024b).

Workforce

Under the CSA Act, Health New Zealand must take reasonable steps to ensure that abortion services (and related services such as counselling) are available throughout New Zealand.

The size of the abortion workforce has increased over the last five years. However, the number of practitioners providing abortion services is still a small proportion of the wider workforce of registered doctors, midwives and nurses.

Among the many reasons why individual health practitioners do not provide abortion services are:

- practical reasons (eg, lack of time or funding)
- concerns about their competence (eg, they feel they do not have the right skills to provide the service)
- lack of knowledge (eg, uncertainty about the law)
- concerns about their reputation (eg, fear of impacting their relationships with other patients or the reputation of their practice)
- personal reasons (eg, the emotional impact that abortion might have on them)
- conscientious objection¹⁰ (see the next section)
- working in a facility that restricts abortion service provision
- working in an area unrelated to sexual health, and where they would be unlikely to be asked to provide abortion services.

The workforce is particularly vulnerable in those areas outside of main centres where there may only be one or two health practitioners willing and able to provide abortion care or sustain an existing abortion service.

To ensure that access to services is timely and equitable and that patients have freedom to choose the type of procedure they prefer, without having to travel out of their district of domicile, it is critical that health practitioners are supported and enabled to provide abortion health care services.

Training

In 2021, the Ministry ran a procurement process to support practitioners in providing abortion in primary care. This included seeking workforce training following the law reform and resulted in a contract with the NZCSRH. This college developed a training programme with the aim of increasing primary care provision of abortion services. Areas it covered included consultation, early medical abortion, early surgical abortion and point-of-care ultrasound.

Health New Zealand now manages and funds this contract. From November 2022 when training was launched until 30 October 2024, 214 health practitioners have completed the modules. The Ministry does not hold data on how many of these practitioners have since provided abortion services.

Notably, Health New Zealand has reported a diverse range of professional groups accessing this training (Figure 8). This trend, if fostered, can promote greater community access to this service, improving equity and accessibility. In addition, practitioners accessing this training come from a diverse range of ethnic groups (Figure

¹⁰ In a landmark case, the High Court ruled that the conscientious objection provisions contained in sections 14 and 15 of the CSA Act did not limit the rights of conscientious objectors under the New Zealand Bill of Rights Act 1990. The decision also gave guidance to employers of abortion service providers, confirming that employers could consider employing only those who were willing to provide abortion services (Chemis et al 2021).

9). Developing a culturally diverse workforce promotes equitable and culturally safe abortion health care.

Figure 8: Practitioners who have completed NZCSRH training as of 30 October 2024, by professional group (percentage)

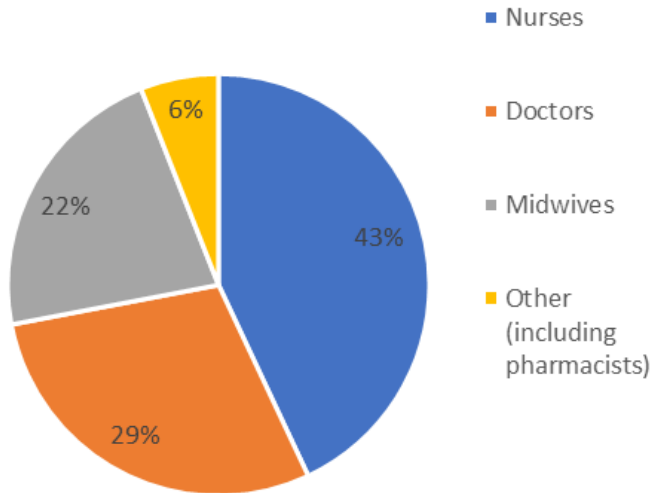
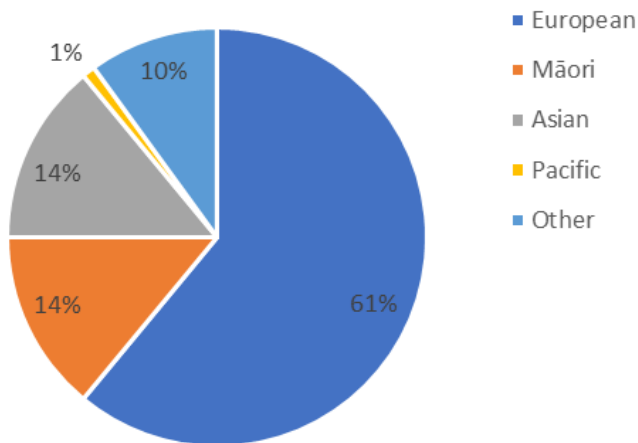


Figure 9: Practitioners who have completed NZCSRH training as of 30 October 2024, by ethnicity (percentage)



Alongside the NZCSRH training, the Midwifery Council has confirmed abortion care has been included in the scope for midwives in July 2023 (Midwifery Council 2023). It has also confirmed that surgical abortion is within the midwifery scope but is yet to approve any education for midwives looking to provide this care.

Overall, both the number of providers who are registered with the Director-General to provide abortion care and the number of those providing abortion in primary care have increased. Alongside the national telehealth abortion service, DECIDE, these changes are providing more options for women seeking abortion care, in particular early medical abortion care.

RANZCOG has established an advanced training module in sexual and reproductive health, which involves practical experience in abortion care, including second-trimester surgical procedures. The curriculum is designed to be undertaken in the final two years of obstetric and gynaecology specialist training, as a special interest. As yet, no funded advanced training module pathway is available at RANZCOG accredited specialist training sites in New Zealand.

Two recent papers (Hudspith et al 2022; Whiting et al 2022) published in the *Australian and New Zealand Journal of Obstetrics and Gynaecology* highlight the challenges of providing safe and effective abortion care for women whose pregnancies are beyond 22 weeks' gestation. Challenges they identify include the limited number of specialists providing such care and the lack of a national referral system.

Conscientious objection

Sections 14 and 15 of the CSA Act allow practitioners to conscientiously object to providing contraception services, sterilisation services, abortion services and information or advisory services about whether to continue or terminate a pregnancy.

In essence, health practitioners who do not provide the service due to their personal beliefs must tell the person of their conscientious objection. They must also tell the person how to access the contact details of another health practitioner (refer to section 14(2) and 14(3) of the CSA Act for more information).

The provisions under the CSA Act do not override a health practitioner's professional and legal duty to provide prompt and appropriate medical assistance to any person in a medical emergency.

The right to conscientiously object is upheld under section 13 of the New Zealand Bill of Rights Act 1990. This section provides that everyone has the right to freedom of thought, conscience, religion and belief, including the right to adopt and to hold opinions without interference.

Conscientious objection at an individual level

Conscientious objection exists on a spectrum. That means health practitioners may have different thresholds for what they object to, depending on their moral, ethical, spiritual and personal views on the subject.

Some examples the Ministry has observed are:

- only providing abortion services up to a certain gestation (despite having the knowledge and skill set to provide abortions at a higher gestation)
- only offering abortion services in the case of fetal abnormality or death
- refusing to provide abortion services unless the woman first seeks counselling.

Findings from the consumer research support these observations. We heard that, overall, the ability to self-refer to services meant that patients were more likely to

access the service in a timely manner as they did not need to go through a health practitioner. However, such constraints are not entirely removed (see the information section for the example of the long and unnecessary pathway to access abortion care for one wahine).

Individuals other than health practitioners who have a conscientious objection to abortion health care may also impact on someone's ability to access abortion health care services. For example, some administration staff within a health care facility may take this position. In contrast to the requirements it imposes on health practitioners, the CSA Act does not require individuals in such groups to direct women elsewhere for abortion services.

Conscientious objection at an organisational level

The Ministry of Health is aware of some reports that conscientious objection plays a part in the decision by some health care providers not to provide abortion care.

The Ministry has engaged with Health New Zealand on these issues. While we acknowledge that they are not easily resolved, the Ministry continues to work with Health New Zealand on ways to resolve them. Failure to reduce the impact of conscientious objection on abortion service provision contributes towards the overall inequity in accessing abortion services around the country.

Impact on timely and equitable care

The Ministry has received some limited feedback on conscientious objection through a survey of abortion service providers in the public system, stakeholder engagement and consumer research. However, it is difficult to assess the overall impact that individual or organisational conscientious objection has on timely and equitable access to abortion care.

Feedback from external stakeholders on the prevalence of conscientious objection varies. One stakeholder explained that, while generally their members did not experience it in their place of work, one member commented 'entire hospitals have claimed to be conscientious objectors, leading to wide disparities in access to care'.

The following feedback from stakeholders gives further insight into how conscientious objection can impact on timely and equitable abortion care and how these issues might be addressed.

'We understand that conscientious objection can create significant challenges for those considering or seeking abortion services. Our clients have shared with us that it is not uncommon for GPs to refuse to accept appointments to discuss termination of pregnancy. Moreover, our clients also report that they are not provided with any additional information for an alternative way to access abortion services. We have also heard reports that a gynaecologist has denied a patient a first trimester abortion in a hospital which required patients to travel to another city to seek care. While these are anecdotal reports, they indicate a significant barrier for women who are seeking abortion.' Stakeholder feedback

'We acknowledge the importance of conscientious objection in allowing healthcare practitioners to act in line with their personal, ethical, and religious beliefs. However, it is essential that conscientious objection does not impede patient access to necessary services. The process of referral to a colleague or institution that can provide the required service should be timely and non-judgmental. We continue to have situations where conscientious objectors are referring patients to other primary healthcare facilities to then be referred on to abortion services rather than providing information that patients can self-refer, creating extra barriers to care. Better public & professional awareness about the ability to self-refer to abortion services would be beneficial.' Stakeholder feedback

Abortion stigma

As noted in the legislation chapter, one of the changes to abortion law in 2020 was to remove abortion care from the Crimes Act 1961 and recognise it instead as a health care service. From the consumer research we commissioned, it appears that while this change has helped to reframe how society views abortion health care, stigma surrounding abortion remains. For some patients, the stigma can still have an impact on their decision-making and their access to abortion care.

While society does seem to be changing and the subject of abortion is becoming less taboo, Parker et al (2025) found that many participants found abortion was 'emotionally complex'. Some felt that in deciding to have an abortion they were doing something wrong. As a result, some preferred to self-refer to abortion services rather than seek a referral from a known health professional, fearing their response might be to judge them and/or refuse care. For some participants, such fears were based on previous negative experiences of sexual and reproductive health care.

'I have had a doctor refuse to give me emergency contraception before, on the grounds of his religious beliefs. This has for sure contributed to anxiety around medical practitioners and disclosing personal histories if I read them as being unsafe in some way.' Participant (Parker et al 2025)

Funding

The Primary Maternity Services Notice outlines what lead maternity carers can claim for service provision. Feedback over time indicates that the notice is unclear about what lead maternity carers can claim for termination of pregnancy services. This uncertainty is likely to have held back the uptake of abortion provision within the primary care sector. Further, those that do provide services may be transferring costs to the patient seeking an abortion.

To clarify the situation for claimants, Health New Zealand has recently provided updated guidance (Health New Zealand 2025).

The Government Policy Statement on Health (Minister of Health 2024) broadly sets out the expectations for service delivery within the health system.

Included in this are the following priorities:

- Access – ensuring all New Zealanders have equitable access to the health care services they need, no matter where they live.
- Timeliness – making sure all New Zealanders can access these services in a prompt and efficient way.
- Quality – ensuring New Zealand's health care and services are safe, easy to navigate, understandable and welcoming to users, and are continuously improving.
- Workforce – having a skilled and culturally capable workforce who are accessible, responsive, and supported to deliver safe and effective health care.
- Infrastructure – ensuring that the health system is resilient and has the digital and physical infrastructure it needs to meet people's needs now and the future.

The Service Coverage Expectations (as part of the Government Policy Statement on Health) link with these priorities and specify how abortion health care services provided by Health New Zealand:

Abortion services are funded for eligible people. This includes pre-abortion assessment (including laboratory tests and imaging as clinically indicated), counselling services and follow up. Early medical abortion services are available via telehealth/telemedicine ...

Where the abortion service is provided outside of the region where the person usually lives, the transport and accommodation costs for the person to access abortion is funded ...

The Ministry is aware of a funding issue for international students who may be seeking abortion care as their health insurance policies may not cover abortion health care and they do not fall under the Health New Zealand eligibility criteria. This means that international students may have to pay for their abortion health care and these costs can be prohibitive for them.

Additional costs

A woman may face additional costs related to an abortion, depending on factors such as where they live, the type of abortion procedure involved and whether they have whānau support.

In its survey of 124 wāhine, National Centre for Women's Health Research Aotearoa (2025) found that three-quarters of respondents (75.0%) reported not needing to pay for any part of their abortion care. The percentage was highest among Pacific women (88.2%), followed by rangatahi – young people (83.7%), wāhine Māori (76.3%) and rural wāhine (70.0%).

The most common part of abortion care that wāhine paid for was ultrasound (as reported by 21.8%). A few paid for a referral to abortion or for contraception after the abortion (3.2% in each case).

Transport costs, travel time, childcare, taking time off work and parking are some of the costs that can add a significant financial burden for a woman seeking an abortion, especially if they live rurally or remotely. In some regions, abortion services are limited or not available at all locally, with the result that women have to travel out of area for the service. Additionally, in instances where the woman consults a GP clinic as a first point of contact, they must often pay the consultation fee.

Other potential costs are for:

- obtaining a pregnancy test kit from a pharmacy or supermarket
- prescription medicines, which may include the two medicines for an EMA and possibly pain relief (as well as a consultation cost to obtain a prescription)
- contraception following the abortion.

These costs can present barriers for someone seeking an abortion and potentially leave them vulnerable to a further pregnancy if contraception is too expensive at the time.

Additional costs are particularly pertinent for women who opt for surgical abortions or seek an abortion at a later gestation as these services are often not available at all in rural or remote locations. Locations that have higher costs associated with an abortion affect women of lower socioeconomic background disproportionately.

Costs may also arise as part of the follow-up appointment with a GP or other health professional.

'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.'

Health care provider (National Centre for Women's Health Research Aotearoa 2025)

Ultrasounds

The clinical guidelines note that ultrasound is one of the options for confirming pregnancy (especially in EMA) but is not required in all cases. Despite this, the Ministry is aware that some providers require women to have an ultrasound before receiving abortion care, even if it is not clinically indicated.

From its research, National Centre for Women's Health Research Aotearoa found that having an ultrasound before the appointment at the abortion service presented a considerable time and cost barrier to wāhine. It confirms that ultrasound is the most common part of abortion care that incurs a cost.

While it can be free for Community Services Card holders in some locations, a first-trimester scan varies in its average expected cost from \$40 to well over \$100. Maternity ultrasounds are funded via the maternity notice and funding has not had any material increase for more than a decade. Providers often include a surcharge. Some districts have arrangements in place to cover the surcharge, but these are variable in nature. In some areas, the hospital services provide the ultrasound scan.

The proportion of cases where a patient is required to pay for an ultrasound to confirm a pregnancy varies significantly across locations. Notably, nationwide 842 patients were reported as paying for an ultrasound before an abortion in 2023. Of these, 68% occurred across two facilities, where the majority (98% and 92%) of patients seeking abortion care paid for ultrasound services. While it is unclear why this discrepancy exists, analysis demonstrates that the observed pattern is unrelated to gestation, or type of abortion. This suggests that the discrepancy may be inequitable, based on where a woman lives: in some areas, women may face pressure to pay for an ultrasound, which those in other areas do not experience.

Abortions for the sole purpose of sex selection – Ngā whakatahe kia whai uri nō ira kē

Background

During the Select Committee process in 2019, committee members were concerned about estimates from the UNFPA about the number of women missing due to gender-biased sex selection through abortion. Members recognised that there was no evidence of this occurring in New Zealand and wanted to reaffirm a strong position for New Zealand on the issue.

While the Select Committee considered options for responding using legislation or other means, most members agreed that setting a restriction through legislation could lead to ethnic profiling, women not disclosing about sex selection or women seeking unlawful abortions.

As a result of Select Committee considerations and feedback on this issue, section 21 of the CSA Act now states that Parliament opposes the performance of abortions being solely sought because of the preference for the fetus to be of a particular sex. Additionally, New Zealand is a signatory of the UNFPA's Programme of Action of the International Conference on Population and Development. This initiative includes the objective of eliminating all forms of discrimination against girls and identifying the root cause of a preference for sons.

A clause in the CSA Act states that a woman seeking an abortion at earlier than 20 weeks' gestation does not need to give a reason. Therefore no data as to reasons for an abortion is collected.

A question in the annual provider reporting asks providers to inform the Ministry about whether they had any approaches for sex-selective abortion in the previous year. A practitioner may also report their concerns to the Ministry. However, neither the CSA Act nor any associated legislation gives any direction on what actions would arise from such a notification, and the Ministry does not have internal processes for responding to one.

Current practice and feedback

Although not intended by the Select Committee in its decision to include the section 21 provision in the legislation, this provision has resulted in confusion among practitioners. Uncertainty has arisen over the appropriate action to take in instances of suspected abortion for the sole purpose of sex selection, whether practitioners should report these abortions directly to the Ministry, or whether they should refuse service in suspected cases.

Within the annual reporting forms, providers have indicated a handful of cases where they suspected that a woman accessing an abortion did so for the sole purpose of sex selection. A small number of providers have contacted the Ministry directly with concerns about an abortion where the sole purpose appeared to be sex selection. They have asked for advice, and whether they need to report such cases formally. New Zealand has no formal mechanisms for dealing with these cases and no clear guidance on what the best form of action should be.

In addition, practitioners are increasingly concerned about the private purchase of non-invasive prenatal diagnosis testing and high-resolution ultrasound to identify sex early. Currently no appropriate methodologies are available to assess if sex selection does occur in direct relation to these technologies.

Research and international practice

Recent research has attempted to address the knowledge gaps in evidence of abortion for sex selection in New Zealand (Simon-Kumar et al 2023). On 8 July 2022, the University of Auckland hosted a symposium to disseminate key findings from this project funded by the Health Research Council, which explores cultural values behind the preference to have a son and practices of sex selection among Asian, ethnic and migrant communities. Analysis from the research project did not find any evidence of sex-selective abortion among Indian and Chinese populations in New Zealand. These findings provide foundational evidence for further research or analysis in this space to build on.

In 2011, the WHO released an interagency statement on preventing gender-biased sex selection (WHO 2011). The reasons for sex-selective abortion are complex. Restricting technology or prohibiting sex detection can limit safe access to abortion and does not address the root cause of the problem.

Many non-legislative responses occur internationally, including commitments by governments to address gender discrimination and bias.

Some countries where sex selection is more prevalent have introduced laws restricting the use of technology for sex-selection purposes and some have criminalised sex-selective abortion. These laws, however, have had little effect in addressing underlying causes and, as noted by the WHO, can unduly restrict access to safe abortion care.

Recommendations – Ngā tohutohu

Improving timely and equitable access

To support timely and equitable access to contraception, sterilisation and abortion services and to prepare for the next periodic review, the Ministry will implement a five-year work plan. This work plan will build on existing regulation and monitoring activities, as well as addressing some of the gaps identified in this report. Some specific areas of focus will be to:

- improve data collection and reporting
- set expectations for service delivery
- improve information for the public and health practitioners
- conduct targeted monitoring into specific areas requiring improvement (eg, abortion counselling, workforce)
- monitor Health New Zealand to ensure that it actions the recommendations outlined below and that abortion health care remains a part of its work plan and service delivery expectations.

The Ministry will report on progress against these matters in the next periodic review. This will include further considering whether abortions occur for the purpose of sex selection in New Zealand.

While not included in the scope of this review and not currently a priority, some parts of the CSA Act are out of date. The Ministry may consider this Act when assessing its legislative review priorities and work programme.

Recommendations

In line with section 17(b)(ii) of the CSA Act, the Ministry has developed a series of recommendations for improving the timely and equitable access to the services identified in this report.

The recommendations outlined below relate to Health New Zealand's responsibilities for service provision and equitable service access, as required under section 16(1) of the CSA Act. They also align with the Government's expectation and priority areas for the health system as outlined in the Government Policy Statement on Health 2024–2027 (Minister of Health 2024).

The Ministry recommends that Health New Zealand:

- identifies and addresses gaps in availability of the services listed in this report throughout New Zealand

- ensures information about how to access these services meets the needs of people accessing them and supports informed decision-making
- engages with the Ministry around the monitoring and oversight of contraception and sterilisation services as part of the broader reproductive health journey
- refreshes the abortion clinical guideline
- addresses workforce issues in abortion health care using training and recruitment
- continues to ensure the abortion pathway is available for women. This includes timely and equitable access to abortion health care, workforce, funding and a national pathway.

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Appendix 1: Data limitations

Contraception

The Information Collection Regulations do not outline reporting requirements specific to contraception. Instead, data on contraception is collected as a part of abortion reporting. Data collected includes the type of contraception used at the time of conception (if any) and the type of contraception provided at the time of the abortion (if any).

Interpretation of this data is therefore limited, as women may not accurately recall the form of contraception they used at time of conception. Additionally, women accessing abortion services may already have access to contraception moving forward or may choose to access contraception at a date later than the day of their abortion. Further, certain contraceptives, such as IUDs, are generally not accessed immediately following an abortion procedure. This data may therefore not be captured in abortion notification reporting.

Sterilisation

Every facility offering sterilisation services must submit an annual report that includes, along with workforce information, data on the types of sterilisation services it offers, the average length of time between consultation and procedure, and reasons for any instance where it refused a request for a sterilisation. In addition, each practitioner must submit data to the Ministry for every sterilisation operation performed within one month of the sterilisation procedure.

Interpretation of this data is limited, as legislative requirements do not include reporting on the form of sterilisation provided, or complications associated with the procedure. Additionally, the Ministry notes concerns about compliance with reporting requirements, which reduces the interpretability of the data.

Abortion

Every facility offering abortion services must submit an annual report that includes, along with workforce information, data on the types of abortion services it offers and reasons for any instance where it refused a request for an abortion. In addition, each practitioner must submit data to the Ministry for every abortion performed within one month of the procedure.

The requirement to submit within one month of service provision limits the interpretability of reporting in that practitioners may observe complications associated with the abortion procedure after they have submitted the notification of abortion form.