“It just adds another layer of stress”:

Rainbow People’s Experiences of Abortion Services in Aotearoa New Zealand Following Abortion Law Reform

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Executive summary

“It just adds another layer of stress”: Rainbow People’s Experiences of Abortion Services in Aotearoa New Zealand Following Abortion Law Reform was undertaken in response to a need for evaluation as to whether abortion services in Aotearoa NZ are serving priority equity groups by providing accessible, timely, and quality abortion care post the implementation of the Abortion Legislation Act 2020.

Prior to this study, minimal information existed about Rainbow people’s experiences of abortion services on a national and international level. This study has addressed this gap by interviewing 10 Rainbow people in Aotearoa NZ who accessed an abortion after the implementation of the Abortion Legislation Act 2020. Interviews explored participants’ experiences of accessing their abortion, having an abortion, and the post-abortion care they received. Qualitative analysis of the semi-structured interviews identified five themes: (1) Coming to abortion services with pre-existing narratives, (2) Initial service engagements create a foundation, (3) Self-determining the abortion pathway, (4) Facing additional layers of exclusion in abortion care, and (5) Towards Rainbow inclusive and affirming abortion care. These themes highlight the importance of Rainbow-inclusive and affirming abortion care that allows for self-determination throughout the entire abortion pathway, in addition to care that is personalised and responsive to each person entering abortion services.

We conclude with recommendations for abortion services on strategies to improve inclusive and affirming abortion care for Rainbow people. The recommendations are based on an inductive analysis and presented using the ‘Te Whare Takatāpui’ framework.

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Contents

Introduction

The passing of the Abortion Legislation Act 2020 was a significant development for reproductive rights and justice in Aotearoa New Zealand, decriminalising abortion and aligning it with other sexual and reproductive health services. Key changes in the legislation included enabling people to self-refer for abortion for the first time, providing opportunities for a wider range of health practitioners to provide abortion services and to do so outside of licenced premises, and removing all clinical or statutory requirements for an abortion before 20 weeks (Ministry of Health, 2021). Additionally, under the new legislation, counselling to support abortion decision making must be offered but would be not mandatory (Ministry of Health, 2021). The Abortion Legislation Act also clarified expectations of health practitioners who conscientiously object to abortion provision. Under the Act, health practitioners can decline to provide or assist with providing contraception, sterilisation or abortion services, but must inform people of their objection and tell people how to access the contact details of the closest provider of the service requested. Conscientious objection does not override health practitioners' professional and legal duties in an emergency.

The new legislative framework for abortion was intended to address enduring challenges in abortion service provision in Aotearoa New Zealand. These challenges included barriers in access to abortion services outside of main centres (Silva & McNeill, 2008), delays in the timeliness of first trimester abortions (Silva et al., 2010), limited choice over abortion methods in some areas (Ministry of Health, 2021), and inequitable and unresponsive service provision for Māori, Pacific, young people, disabled people and other minority communities (Downing, 2020).

People with diverse genders, sexualities, and sex characteristics (Rainbow people) are currently under-recognised as users of abortion services and are frequently not identified as a priority equity group for ensuring accessible, timely, and quality abortion care. Reflecting international trends in abortion care, very little consideration has been given to the experiences of Rainbow people in abortion services in Aotearoa NZ. Abortion services, as a regulatory requirement, collect data related to service users' gender but anecdotal evidence suggests many services continue to assume rather than ask the gender of service users. It remains uncommon practice for services to collect data related to the sexuality of service users. ,. The result is that Rainbow people remain largely invisible as the users of abortion services. Significant disparities in Rainbow people's sexual and reproductive healthcare access and outcomes compared to the heterosexual and cisgender population is hard to address at a policy and service level when they are invisible (Khozah & Nunu, 2023; MacCarthy et al., 2017; Rodriguez-Wallberg et al., 2023; Sbragia & Vottero, 2020). Further, the limited research available on Rainbow people's abortion access suggests that this population group may in fact be over-represented as users of abortion services compared to heterosexual and cisgender populations (Bowler et al., 2022).

Evidence shows that Rainbow people are systematically underserved in healthcare and that this functions as a driver of health inequities for Rainbow populations along with other social determinants including sustained exposure to violence, stigma, and discrimination (Medina-Martínez et al., 2021; Romanelli & Hudson, 2017). Te Pae Tata Interim New Zealand Health Plan 2022 (Te Aka Whai Ora & Te Whatu Ora, 2022) recognises this and commits to improving access to health services that work for Rainbow communities and other priority equity groups including Māori. With both the wider health system and newly reformed abortion services driven towards delivering equity, there is a clear and timely need to understand Rainbow people's access to, experiences of, and outcomes from abortion care in Aotearoa New Zealand.

The following report presents research undertaken as a first step to meet this need. The research presents the findings from a qualitative interview-based study seeking an in-depth insight into Rainbow people's abortion service experiences in Aotearoa New Zealand following the passing of the Abortion Legislation Act 2020. Participants represented a range of genders, sexualities, ethnicities, abilities and ages, and were located around the country with the majority in main or regional centres, affirming the diversity of people who access abortions in Aotearoa NZ. Findings from our reflexive thematic analysis of the interviews are reported and demonstrate both strengths and challenges for the delivery of Rainbow inclusive and equitable abortion services in Aotearoa. Opportunities for abortion services to improve care for Rainbow communities are presented using the mātauranga Māori framework – Te Whare Takatāpui (Kerekere, 2023). Te Whare Takatāpui offers conceptual and practical ways to improve takatāpui/Rainbow communities' health and wellbeing through the enactment of six values: Whakapapa (genealogy), Wairua (spirituality), Mauri (life spark), Mana (authority/self-determination),Tapu (sacredness) and Tikanga (rules and protocols), with each representing a different part of a wharenui (ancestral meeting house). When these values are accounted for abortion services will be resourced to shelter and nurture all people with diverse genders, sexualities, and sex characteristics and their whānau.

Language used in this report

The term ***Rainbow*** is used in this report as "an umbrella term to describe people whose sexuality, gender identity, gender expression or sex characteristics differ from majority, binary norms" (Te Ngākau Kahukura, nd). This includes people with diverse sexualities including queer, bisexual, pansexual, fluid and questioning, and people with diverse gender identities and expressions including trans masculine and non-binary. Used as an umbrella term, 'Rainbow' also includes people who identify as Takatāpui, a traditional Māori term that encompasses Māori of diverse sexualities, genders and sex characteristics, and other culturally diverse ways of understanding gender, sex and sexuality. People who don't use specific words for their identity, people whose identity changes over time, and people who are in the process of understanding their own identity may also come under the Rainbow umbrella if they self-identify as such (Te Ngākau Kahukura, n.d.). It is estimated that people under the Rainbow umbrella make up between 6 and 15% of New Zealand's population (Te Ngākau Kahukura, nd.)

We use cisgender (irapūmau) in this report to describe people who are not transgender and therefore identify more or less with the gender assigned to them at birth (Gender Minorities Aotearoa, 2023).

We use transgender (irawhiti), as an umbrella term to describe people whose gender is different from the sex they were assigned at birth. Transgender people may, or may not, undertake medical treatments to change their sex characteristics and transgender identity is “not dependant on or indicative of medical procedures, sexuality, sex characteristics, physical anatomy, or how one is perceived in daily life” (Gender Minorities Aotearoa, 2023).

We use non-binary (ira tāhūrua-kore) as an umbrella term for all genders other than female/woman/girl or male/man/boy.

We use sex-characteristic diverse (ira tangata) as an umbrella term to describe people who are intersex. People who are intersex have innate natural variations of hormones, chromosomes, and internal and external anatomy which results in atypical traits (Intersex Aotearoa, n.d.).

Self-determination is the key principle in relation to the language used to describe people’s gender, sex, and sexuality. Rainbow people use a range of words and names to talk about their identities and experiences and know the right terms to use for them. Reflecting this principle of self-determination, the language used to describe participants in this report reflects the language they used to describe themselves.

Review of existing literature

The majority of the research that considers experiences of abortion does so from a cis-heteronormative lens (Rosati et al., 2020), meaning that service users are assumed by default to be cisgender and heterosexual and little or no attention is given to the genders or sexualities of service users. Accordingly, research considering the abortion experiences of Rainbow people is severely limited and is focused primarily on the experiences of sexual minority cisgender women (e.g. ciswomen who are lesbian, bisexual, pansexual or queer) (Rodriguez-Wallberg et al., 2023). To date, very little consideration has been given to the abortion experiences of transgender, non-binary, and intersex people (Moseson et al., 2021). The lack of research on Rainbow people’s experiences of abortion is a significant oversight considering that some sexual minority cisgender women may be more likely than heterosexual cisgender women to have pregnancies during their teen years, and/or that are unintended (Charlton et al., 2020). Research shows that bisexual and lesbian cisgender women are more likely than heterosexual cisgender women to have been forced into sex by a cisgender male partner, which resulted in their need for an abortion (Jones et al., 2018). Bisexual cisgender women may also engage in sexual behaviours at a younger age than heterosexual and lesbian cisgender women, and are more likely to have ever used emergency contraception (Tornello et al., 2014). Consequently, bisexual cisgender women were found to be up to three times as likely as heterosexual cisgender women to have had an abortion (Charlton et al., 2020; Tornello et al., 2014).

Abortion care delivered on the assumption that service users are cisgender women results in the invisibility of transgender and non-binary people in abortion services (Bowler et al., 2023; Fix et al., 2020). This is enabled at a structural level when services assume rather than ask the gender of their service users, resulting in a lack of awareness of the proportion of transgender and non-binary people accessing services and contributing to a subsequent lack of service preparedness to provide trans inclusive and affirming care (e.g. Jones et al., 2020). For example, one study estimated approximately 530 transgender abortion patients in the USA in 2017 (Jones et al., 2020), but noted many services did not routinely document the gender of abortion service users. Further, it is estimated that for those services who do collect gender information, gender was likely be under-reported to avoid potential stigma and discrimination (Jung et al., 2023).

Rainbow people face significant barriers to abortion care at structural, provider, and individual levels. Research has demonstrated that when seeking an abortion, Rainbow people tend to experience compounded stigma resulting from the generalised stigma attached to abortion (Biggs et al., 2020; Ingraham & Hann, 2022) intersecting with the stigma attached to gender and sexual minority status (Bowler et al., 2023). At a structural level, this results in Rainbow people being largely invisible and silent in abortion care, compromising abortion services' abilities to provide Rainbow inclusive and affirming care (Carpenter et al., 2020; Fix et al., 2020). These dynamics are compounded for Rainbow people who are also marginalised due to their ethnicity, being disabled, and other forms of exclusion in healthcare (Fix et al., 2020; Pihama et al., 2020). The invisibility of Rainbow people in abortion care manifests in a lack of knowledge and resources that engage Rainbow people, resulting in Rainbow people tending to turn to their peers as a primary source of abortion information (Bowler et al., 2023; Jung et al., 2023; Moseson et al., 2022). This potentially results in disengaging Rainbow people from abortion care altogether, leading to attempts to end a pregnancy without clinical supervision (Bowler et al., 2023; Jung et al., 2023; Moseson et al., 2022)

At a provider level, the dynamics of cis-heteronormativity impact Rainbow people's entire journey throughout abortion services. Cis-heteronormativity is a pervasive system of belief that centres heterosexuality and identification with gender assigned at birth as natural and normal. Cis-heteronormativity underpins the pervasive social construction that Rainbow people are less likely to be fertile and become pregnant (Radi, 2020) which is embedded in the design and delivery of sexual, reproductive, and perinatal health services (Bowler et al., 2023). Cis-heteronormativity in these services expresses itself when service users' gender is assumed and incorrectly recorded in data systems ; the use of gendered language in service names, signage and information resources; the lack of representation of diverse kinds of service users in posters and service imagery; lack of education for providers on Rainbow inclusive and affirming care; and assumptions about peoples' sexuality including the type of sex people are having, who can become pregnant, and who needs access to contraception, abortion and perinatal services (Bowler et al., 2023; Fix et al., 2020; Jung et al., 2023; Mendieta & Vidal-Ortiz, 2021).

From the limited research available, it is clear that cis-heteronormativity results in harm for Rainbow people when engaging in abortion services. Rainbow service users have reported being misgendered and/or assumed to be heterosexual before they even enter an abortion service, and this continues throughout all of their interactions with the service (Jung et al., 2023; Mendieta & Vidal-Ortiz, 2021). Rainbow service users describe assumptions about their own gender, and/or the gender of their sexual partners, the types of sex that they are having, and the incorrect use of names they use for body parts in some cases contributing to gender-related distress (Fix et al., 2020). At an individual level, responsibility is placed onto Rainbow people to self-advocate for affirming and inclusive care throughout their interactions within the abortion service, which is mentally and emotionally taxing (Bowler et al., 2023; Fix et al., 2020). Rainbow abortion service users also report that exposure to cis-heteronormativity resulted in feelings of disrespect, misunderstanding, disempowerment and helplessness, and in some cases mistrust of abortion providers, all of which impeded their abortion outcomes (Bowler et al., 2023). Existing research challenges abortion services to grow their capability for Rainbow inclusive and affirming care at both a structural and interpersonal level (Lowik, 2016; Mendieta & Vidal Ortiz, 2021; Moseson et al., 2021). Strategies may include the adoption of gender-neutral or gender inclusive intake forms, abortion providers who are supported and educated to provide Rainbow affirming care including through the language they use, and a stronger focus on incorporating greater privacy into clinic spaces (Lowik, 2016).

We have not identified any Aotearoa NZ research that provides insights on Rainbow people’s experiences of abortion services or specific guidance to abortion services on Rainbow inclusive and affirming care. This is a concerning oversight considering our specific cultural context and the Te Tiriti o Waitangi obligations of our health system to deliver equitable care for Māori. Takatāpui people are currently underserved in sexual healthcare in Aotearoa (Pihama et al., 2020) and insight is urgently needed on the abortion experiences and outcomes of Takatāpui and MVPFAFF+ (Pacific Rainbow people).

Research aims and objectives

The current research aims to build capability for Rainbow inclusive and affirming care in Aotearoa NZ’s newly reformed abortion services.

Research objectives:

1. To gain insight on the diversity of Rainbow people who access abortion services in Aotearoa NZ.
2. To understand Rainbow people’s experiences of abortion services in Aotearoa NZ following abortion law reform.

3. To understand how Rainbow people's experiences of abortions services are differentiated by other marginalised aspects of who they are such as ethnicity, disability, and neurodiversity.
4. To identify aspects of abortion care that are inclusive and affirming for all Rainbow people.

Research design

Data collection

This research project received ethics approval from the Victoria University of Wellington Human Ethics Committee in May 2023 (#31010). Purposive convenience sampling was utilised to invite Rainbow people who had received an abortion in Aotearoa NZ after the passing of the Abortion Legislation Act in March 2020 to take part in semi-structured interviews about their experiences of abortion services. Prospective participants were recruited through social media posts, trans and intersex Facebook groups and pages, Rainbow and sexual health organisations' social media (e.g., InsideOUT Kōaro, Family Planning), through the Professional Association of Transgender Health Association's (PATHA) email listserv for professionals working in transgender healthcare in Aotearoa, posters on university campuses (see Figure 1), and via word of mouth. Feedback on participant recruitment documents and the interview guide was sought from InsideOUT Kōaro and Gender Minorities Aotearoa.

People were invited to take part in semi-structured interviews if they were aged 16 years or older; self-identified as Rainbow, LGBTQIA+, Takatāpui, MVPFAFF+, or had diverse gender, sexuality, or sex characteristics; and had an abortion in Aotearoa after March 2020. To express their interest, potential participants were directed to a Qualtrics form that asked for their basic demographic information and contact email, or, participants had the option to directly email the research assistant on this project (CD). After expressing their interest, participants were sent further information about the study if they met the eligibility criteria and were asked if they would like to schedule an interview.

Fourteen people initiated contact or expressed interest in participating. Of the 14, four did not respond after a follow-up email, and 10 agreed to take part in an interview. The 10 interviews were conducted by George Parker, a non-binary Pākehā health researcher with a clinical background in midwifery. Of all interviews, six were held over Zoom and four were held face-to-face, two in the participant's home, and two in a public space. Each participant was given a $30 Prezzy card as acknowledgement of their participation.

Figure 1. *Advertising poster for interest in interviews.*

Participate in a study about Rainbow people's experiences of abortion services in Aotearoa

If you:

- Are Rainbow / LGBTQIA+ / Takatāpui / MVPFAFF+
    - E.g., lesbian, gay, bisexual, pansexual, queer, multiple gender attracted, transgender, nonbinary, intersex, asexual, agender, gender fluid
- Are at least 16 years old
- Have had an abortion in Aotearoa NZ since March 2020

We would like to chat about your experience with abortion services. We want to know if abortion services were welcoming and accessible *for you*.

Interviews will be approximately one-hour, in-person or online, and you will receive a $30 Prezzy Card as thanks.

QR Code

Scan me!

Or contact Chelsea *(they/she)* at: [email]

If you have any concerns about the ethical conduct of the research you may contact the Te Herenga Waka —Victoria University of Wellington HEC Convenor by emailing hec@vuw.ac.nz. ref: #0000031010

Participants

Participants represented a diverse sample of the Rainbow community in Aotearoa. Eight participants were cisgender women, one was a transman, and one was non-binary. No participants were intersex. Eight participants were bisexual and/or pansexual, and two were queer. Ages of participants ranged from 19 to 43 years, with an average age of 25.1 years. Ethnicities within the sample consisted of Pākehā/NZ European, Jewish, Māori, Fijian Indian, Tongan, Caribbean, and Indian. Two participants disclosed that they were neurodivergent, and one participant was in the process of figuring out if they were neurodivergent. Participant demographics and pseudonyms can be found in Table 1, however, ethnicity is omitted from this to ensure participant anonymity, and this is consistent with the findings section where we have not identified participants' ages or ethnicities.

Table 1

Participant Demographics

Pseudonym	Pronouns	Gender	Sexuality
Blair	They/he	Transman	Queer/gay
Aubrey	She/her	Woman	Bisexual
Leah	She/her	Woman	Bisexual
Casey	She/her	Woman	Queer/pansexual
Taylor	She/her	Woman	Bisexual
Alexis	She/her	Woman	Bisexual
Cea	They/them	Non-binary	Pansexual
Riley	She/her	Woman	Pansexual
Olivia	She/her	Woman	Bisexual
Cam	She/her	Woman	Bisexual/pansexual

Data analysis

Interviews were audio recorded and one was transcribed by CD, while the other nine were transcribed by a transcriber who had signed a confidentiality agreement prior. CD removed identifying details from the transcripts to ensure participants' confidentiality. Before analysing the data, each participant was sent their de-identified transcript, and were asked if they would like to provide feedback on it. In total, three participants provided feedback on their transcripts: two added further details, and one requested the removal of some details. Transcripts were analysed using reflexive thematic analysis (Braun & Clarke, 2022), led by CD. CD performed complete coding on each transcript independently and met frequently with GP to discuss the codes. Once coding was complete, codes were discussed at a wider team hui to examine the subjectivity in the coding process and account for different perspectives. GP, SM, SB, and CD all coded the same parts of multiple transcripts independently and then discussed their coding and rationale. The coding scheme was finalised and the team grouped these into candidate subthemes and themes. Themes and subthemes were confirmed by the team and a subsequent mapping exercise to align these codes with the six values of Kerekere's (2023) Te Whare Takatāpui health framework was completed, leading to the development of the recommendations in this report (see p. 31).

Key findings

In total, five themes were developed from the data, outlined in Table 2. The themes developed reflect the participants' journeys through the abortion process, starting with the expectations and knowledge participants had before entering the service, to their experiences within the service, and finally, aspects that would have improved their abortion care.

Table 2

Themes and Subthemes

Theme *Subthemes*	**Description**
1. Coming to abortion services with pre-existing narratives	Social narratives, previous healthcare experiences, and access to social support shaped participants approach to abortion services.
1. Healthcare experiences inform expectations	
2. The impact of abortion stigma	
3. Social and cultural scripts about abortions produce assumptions	
4. Social/whānau support mediated the abortion experience	
2. Initial service engagements create a foundation	People's first encounters with abortion providers sets the tone for the rest of their abortion experience.
1. Access and entry point shapes the experience	
2. There is complexity in abortion counselling	
3. Abortions are a vulnerable experience and are emotionally complex	
3. Self-determining the abortion pathway	There is no "one size fits all" abortion process. Choice is fundamental throughout the abortion process to ensure inclusive, accessible abortion care.
1. Abortion method preference	
2. The importance of timeliness and time taken	
3. Importance of agency and choice	
4. Facing additional layers of exclusion in abortion care	Rainbow people face additional barriers to safe abortion care.
1. *Cis-heteronormativity in abortion care*	
2. *Intersectional failure and possibility*	
5. Towards Rainbow affirming and inclusive abortion care	There is room to improve abortion care for Rainbow people, starting with the relationships people develop with staff within abortion services.
1. Relational encounters with abortion providers	
2. Unlearning cis-heteronormativity in abortion care	

Theme 1. Coming to abortion services with pre-existing narratives

1.1. Healthcare experiences inform expectations

Participants expressed that their previous experiences in healthcare informed the expectations they held when entering the abortion service. Participants highlighted that many Rainbow people have a history of negative experiences within healthcare settings, and this resulted in low expectations when approaching abortion services, compounded by the explicitly gendered nature of many abortion services. For example, Cea explained: *"I have maybe generally low expectations about people not assuming my gender."* Moreover, participants expressed that their expectations of the care they would receive in abortion services differed for different roles within the service; people such as nurses and counsellors were expected to provide more emotional or person-centered care, while doctors were expected to be more clinical and to offer less personalised care. Alexis explained this distinction: *"I guess first, their jobs are a little bit different so you would kind of [expect] a difference because a counsellor has to get all the information whereas a doctor's just there to kind of give you information."*

1.2. The impact of abortion stigma

The social stigma attached to abortion was negotiated by all participants in our study. Participants commonly experienced abortion as emotionally complex and some participants described navigating feelings that they were doing something wrong in their decision to have an abortion. For some participants, this feeling manifested as reluctance to seek a referral for an abortion from a known health professional, such as a GP, due to fear of judgement and/or refusal of care, and significantly increased the appeal of self-referral to abortion services. As Casey emphasised, *"Oh my God I would've hated having to go through my GP"*. For some participants, fear of judgement from health professionals was informed by previous negative experiences of sexual and reproductive healthcare where they were subjected to negative reactions or even refused care. Casey, for example, went on to explain:

> *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.*

Within abortion services, participants largely experienced their abortion providers as highly supportive and non-judgmental. However some participants reported fearing judgement during the brief encounters they had with external health providers during the abortion process, for example laboratory staff when getting blood tests to confirm pregnancy, and pharmacists when picking up the medication for a medical abortion. Riley, for example, explained her experience of picking up the medication for her abortion from the pharmacy: *"I just remember sitting there and I felt really nervous, and even if they weren't judging me, I felt judged, and just kind of a bit like, dirty."* Abortion stigma also manifested in how participants navigated their feelings about their abortion more generally. For example, one participant expressed their concern that their decision to have an abortion would be seen as them not being good enough to have another child.

1.3. Social and cultural scripts about abortions produce assumptions

Participants described the weight of normative social and cultural scripts about who needs abortions and why, which they felt they carried with them into their abortion experience. As Aubrey reflected, abortion is not talked about as a normal and common healthcare procedure: "*It doesn't seem like it's just something that everybody accesses, it's something that specific types of people in specific positions access."* One of the scripts about abortion identified by participants was that pregnancy and abortions are only experienced by cisgender women and only result from heterosexual sex, meaning that the need for an abortion automatically infers heterosexuality/being cisgender and disappears or discredits Rainbow identity (the role of abortion services in perpetuating this assumption is detailed further in Theme 4.1: *Cis-heteronormativity in abortion care*). As Riley reflected, *"Well I guess it's [assumed] just heterosexual couples, it's just straight women, that need them [abortions]"*.

Another script identified by participants was that abortion signals immaturity, irresponsibility, promiscuity, and a general lack of proper self-management. Aubrey, for example, explained:

> *I was just always concerned that people would think of me lesser than just because ... I guess I always hear my mum's voice in my head, 'you made like an adult choice and there's adult consequences for this,' all that kind of like rhetoric around being irresponsible.*

The negative connotation that abortion signaled promiscuity was particularly impactful for some bisexual/pansexual/queer participants who reflected how this script about abortion intersected with and compounded similar negative stereotypes attached to their sexuality. As Aubrey reflected: *"I wouldn't share that I'm bisexual because I'm worried that people would judge me, like, 'Oh, you're just…like sexually free, you're probably more likely to take more risks"*. Other participants expressed fear that their abortion decision – scripted as irresponsible and reckless – would be seen as dismissing the difficulty some Rainbow people face getting pregnant and as not appreciating or valuing their own or other Rainbow peoples' ability to have children.

1.4. Social/whānau support mediated the abortion experience

Participants described that having external support when approaching abortion services took some of the emotional weight off the process and made it easier to manage. For some participants, this came in the form of partner support, while for others, support was provided by wider whānau and friends. However, participants also explained that getting support required feeling comfortable and able to tell people about their abortion, which was not always the case. Some younger participants were concerned about their parents finding out about their pregnancy and abortion, resulting in non-disclosure and isolation throughout their abortion experience. Isolation was compounded for participants like Cam who, due to their cultural context, was not out to their parents about their gender/sexuality, meaning that their abortion added another layer of silence:

> *I wasn't gonna tell my parents, they would bloody like, disown me or something, like I wasn't gonna do that. So when you're in that sort of environment, like for a lot of other ethnic kids, especially ethnic kids who are part of the LGBTQI+ community, you can't just open up, like that's like the last thing you sort of- or that's sort of the first thing you think about, like I'm not gonna tell anyone, like if I get this over and done with, I don't need to tell anyone, that's fine.*

Further, participants expressed that even though social support aided them throughout their abortion, this support, especially from a partner, could only do so much. Specifically, that while a partner may be able to be there at every step of the process, the partner was not having the abortion, so would not be able to understand everything. Further, the presence of cisgender male partners commonly contributed to abortion providers' assumptions about participants' gender and sexuality adding layers of complexity to their abortion experience. As Aubrey described, "*there's just a lot of assumptions based on what they see sitting there*".

Theme 2. Initial service engagements create a foundation

2.1. Access and entry point shapes the experience

Participants' experiences of referral and early engagement with abortion services were formative in setting the tone for the rest of their experience. The process of referral into abortion services– either through a primary care provider or through self-referral – was an important factor in determining how participants felt about their abortion service experience overall. Several participants utilized the self-referral telehealth option through DECIDE- National Abortion Telehealth Service and this was seen as greatly improving access and minimizing barriers they would have otherwise experienced. Casey explained that for her, accessing her abortion through DECIDE improved her abortion experience:

> *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.*

However, participants noted that telehealth abortion services have the potential to leave distance between them as the patient, and the abortion service as the provider. Specifically, while the efficiency and streamlining of telehealth services significantly increased access, some participants felt that this came at the cost of personalised care, which resulted in feeling disconnected from the service. Aubrey, for example, explained: *"I didn't feel like not taken care of, but it did feel like it was a phone service, like it* *did feel removed."* Casey elaborated on how this sense of disconnection or 'removal' can make certain conversations throughout the abortion process more difficult: *"I mean there's something about like a face-to-face conversation that's in there, it's different to a voice-to-voice conversation. Especially when you're having those sometimes difficult parts of the conversation."* Participants also explained that there were other barriers to abortion care that telehealth services could not address. Specifically, while telehealth services may address barriers related to physical distance from a service, specific resources are still needed to access the service, like reliable phone reception. As such, telehealth services were seen as an important option, but not something that addressed all existing barriers to abortion care. Further, participants expressed they would like to be given the option of either video-conferencing or phone to give the option of seeing the face of providers when receiving abortion care remotely.

Comparatively, when it came to abortions at a clinic, participants explained that clinic-based care required resources that not everybody has. Specifically, participants described the potential for difficulties to arise regarding travel to and from the clinic, support in their recovery, and childcare for children while they were undergoing the procedure. Participants commonly explained that without the support they had for these aspects of the process, their abortion experience would have been significantly more difficult than it was. An additional concern for participants who visited a clinic was the potential for anti-abortion protesters; participants may not have been worried about facing judgement once they entered the abortion service, but some were worried that just getting into the clinic could be made more difficult if protesters were present. As Riley described: *"There's been a couple anti-abortion protests outside the [main centre] Hospital, I was scared that it'd be just my luck that they'd be there that day".* Overall, participants were adamant that minimizing barriers to, and streamlining abortion access limited the trauma experienced throughout their abortion experience. Specifically, not having to face multiple layers of approval and the opportunity to self-determine the process avoided unnecessary steps and contributed to the reassurance that they would be cared for in abortion services.

2.2. There is complexity in abortion counselling

While the change in abortion legislation should have resulted in pre-abortion counselling being optional, some participants reported that attending a counselling session before they had their abortion continued to be a mandatory step in their process. Olivia, for example, reported: *"You don't have a choice, you have to see a counsellor, no matter what. I don't think they're doing that in any sort of like, malice or negative way."* Some participants found this beneficial; they experienced support they would have otherwise not sought out, while others did not see it as necessary. Other participants reported that pre-abortion counselling was optional, and they did not take up the offer. However, some participants also reported that abortion counselling was inaccessible. Specifically, some participants were not offered counselling support after their abortion when they would have liked some, and others asked for counselling support but did not receive any follow-up.

Overall, participants emphasized that abortion counselling needs to be more accessible, so that it is available for people who need it, but there is no one-size-fits-all need for counselling support and it should not be mandatory. Regardless, participants who accessed counselling (whether as a choice or because it was a requirement) offered insights about what constitutes a positive counselling experience for Rainbow service users. Participants reflected that they appreciated counselling that was not hurried and came with the option of multiple sessions, that their whole self was invited into the room, and that the counsellor made sure they were aware that nothing about them would be surprising. Despite not being given a choice about counselling, Alexis reflected positively on the ways the counsellor affirmed her bisexuality and culture in her pre-abortion counselling sessions and the impact this had on her, *"I felt like I was going through a service that didn't just wanna do the service for me but kind of, cared about what I was feeling and how I was doing."*

2.3. Abortions are a vulnerable experience and are emotionally complex

Participants expressed feeling a range of diverse emotions entering abortion services and explained that having an abortion was not necessarily an easy thing to experience. Participants explained that feelings of isolation and loneliness can result from needing an abortion, especially if they felt like they could not talk to people about their experience. Consequently, participants highlighted that service providers need to take this into consideration when providing abortion care, to really care for the person having the abortion. Like Alexis above, Riley reflected that the experience of care was enhanced when abortion providers took time to invite them as a whole person into the room, genuinely considering who they were as a person and affirming this:

> *Just people caring about me and, like all of me, like my sexuality as well. Like that's not a different part of me, that is me, that is who I am like, caring enough to take the time to like notice and then respect that*.

Participants also expressed that people could experience grief throughout their abortion without having regrets, and that sometimes they felt they just had to do whatever was needed to get through (e.g., dissociate during the procedure). Casey, for example, explained: *"It was a hard emotional experience. Even though I don't regret doing it, like, I don't have regrets about doing it, but I still feel some grief about it, I guess."* One aspect of the process that participants specifically referred to as being distressing was seeing the ultrasound before the abortion, resulting in the suggestion that people should have the choice over whether they want to see this or not.

Participants explained how having abortion providers affirm that all emotional responses throughout the abortion experience are valid was comforting and minimized distress. Alexis, for example, reflected:

> *She [abortion service nurse] just reassured me that, whatever I was feeling at that time was completely okay. If I was feeling, you know, angry, if I was feeling sad, if I was feeling really happy, she reassured me that whatever I was feeling, was valid, I didn't have to be obliged to feel a certain way.*

Overall, it was clear that people can experience vulnerability when having an abortion and this is managed differently by different people. Some participants sought additional support, like counselling from the service. Comparatively, other participants opted to seek support in other ways. Despite this, participants were clear that the normalization and streamlining of abortion care should not come at the expense of providing genuine and individualized care to people having an abortion.

Theme 3. Self-determining the abortion pathway

3.1. Abortion method preference

Participants in our study reported a range of abortion method preferences depending on various factors to do with each individual's social and living context, level of support, priorities, and concerns. Rather than a singular preferred method, participants strongly emphasised the value they placed on being able to self-determine the right abortion pathway for them and the opportunity to make informed decisions. As Taylor reflected, *"I felt like it was a decently informed choice".* For participants who opted for a medical abortion, the process was commonly viewed as easier and more efficient to access than surgical abortions. For some participants, medical abortions were also viewed as providing a level of privacy and comfort through the ability to be at home. As Olivia explained:

> *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].*

Participants who opted for a surgical abortion explained that medical abortions have an aspect of uncertainty due to individual differences in side effects, and expressed concerns that a medical abortion would be more painful and would require more recovery time than a surgical abortion. Some participants also viewed surgical abortions as more complete and final, due to the potential for medical abortions to be unsuccessful. Alexis, for example, reflected:

> *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.*

Regardless, surgical procedures were still viewed as having downsides. For example, one participant expressed that the surgical abortion process lacks space for a support person, and therefore has the potential to add to the isolation and loneliness that can be experienced throughout the abortion process. In sum, participants expressed that choice is vital when deciding on the method of their abortion, and it is the unknown within the abortion process that adds worry. Thus, people must be effectively informed about the different abortion methods to support their decision making.

3.2. The importance of timeliness and time taken

The timeliness of the abortion was viewed as a vital consideration for participants when choosing their abortion method and in shaping how they felt about their abortion experience. First and foremost, participants expressed that a timely process minimizes distress, while waiting for an abortion creates space for mental distress to grow. For example, Aubrey who experienced a significant wait for her abortion, reflected: *"Those three weeks were like absolutely torture, like absolute torture."* Once the decision was made to have an abortion, participants felt strongly that they did not want to wait an extended period for the procedure, which for some, influenced their chosen method. For example, participants expressed that surgical abortions are not timely enough and require a longer wait time for an appointment. Furthermore, surgical abortions require a time commitment to go to the hospital/clinic, and some participants explained that they preferred to do it in their own time, hence opted for a medical abortion. Participants also valued the opportunity for self-referral into the abortion clinic and expressed that one of the benefits of self-referral was that it minimized the wait time to have an abortion.

However, not all participants wanted their abortion to be a swift process. Some participants explained that the streamlining of the process to deliver efficient care has its downsides. Specifically, some participants felt that they were being rushed through the service, which reduced their experience of care. For example, Casey explained her process of seeking an abortion, *"I guess I was expecting to have a more in-depth conversation with somebody then, but they just were like, 'Okay we'll arrange for another phone appointment for you to talk to a nurse.'"* Additionally, some participants explained that the decision for an abortion can take time and is not always a straight-forward process. Consequently, these participants found that slowing the process down minimized their distress and allowed them to process the mental impacts of having their abortion more effectively than if they had not taken this time.

3.3. Importance of agency and choice

Participants expressed how important it was that they had information available to them and were given the opportunity to make decisions about their abortion process throughout all their interactions with the abortion service. This was especially emphasized by participants like Blair who generally had limited access to sexual and reproductive health information:

> *I didn't really know where to go or what to do 'cause I was from a very small town, our high school was very Christian, we didn't really have a lot of information about any kind of sexual reproductive health available to us. So I just looked up like "abortions [provincial city]" and sort of clicked the first link.*

While some participants felt able to make an informed choice about the method of their abortion and the contraception offered after their abortion, not all participants had this experience. Casey expressed that her medical abortion experience was not what she was expecting, as she did not receive enough information about what the process would entail beforehand: *"I definitely didn't feel prepared for that … I kind of thought that it would be like, how I felt after my surgical ones. I mean and they didn't ask me if I'd had an abortion before."* A lack of information and a sense of their abortion care happening to them rather than with them resulted in some participants feeling unprepared, disempowered, and unable to self-advocate during their abortion procedure. Cam, for example, explained:

> *All of the sort of doctors' appointments and visits and stuff because obviously these people, they've seen so many people go through this that they don't- like, 'Okay, like cool, like next one' like it's fine but they don't realise that, you know this might be your first time going through this and they don't like- I didn't know anything. Like I mean obviously I knew that there were options, but I didn't know how this was gonna go, I didn't know that I'd have to have this many appointments or I didn't know I'd have to have like six tubes of blood taken out of me, like I don't know what each tube was for*.

Theme 4. Facing additional layers of exclusion in abortion care

4.1. Cis-heteronormativity in abortion care

Participants described the many and varied ways in which cis-heteronormativity was prevalent in abortion services leaving them feeling unseen, unknown, and in some cases, disengaged and harmed. Cis-heteronormativity was enacted at both a structural and interpersonal level in abortion services with default assumptions that service users would be cisgender women and heterosexual 'built-in' to services. Cea for example, observed, *"I feel like, it's just assumed that I am a cisgender heterosexual, so then I was"*. At a structural level, cis-heteronormativity expressed itself in the use of gendered names of services like 'women's clinic', in referral or intake forms that did not ask people about gender, in information pamphlets and other sources of information about abortion services referring to 'women' as the users of abortion services, and in the physical environment of abortion services such as the lack of all-gender wharepaku/bathrooms. As Blair reflected: *"I don't think there was an option to put your gender down on the referral form, I think it just kind of assumed that automatically."*

Cis-heteronormative assumptions were also embedded and communicated at an interpersonal level in interactions between abortion providers and service users. Very few participants reported an invitation to share their gender and/or pronouns in their interactions with abortion providers, nor abortion providers who proactively shared their own gender and/or pronouns despite most participants confirming this would have been appreciated and affirming for them (regardless of whether they themselves were cisgender). Similarly, very few participants reported an invitation to share information about their sexuality when entering abortion services or during their abortion care. Rather, most participants reported that they felt assumed to be cisgender and/or heterosexual, with participants believing that assumed heterosexuality was particularly likely when being supported by a cisgender male partner. As Leah reflected: *"I think they just assumed that I was straight because I had my boyfriend there."* Participants had a range of views about their assumed heterosexuality, with some participants reporting that their sexuality felt irrelevant to their abortion care and others reporting that the invisibility of this aspect of themselves meant they did not feel fully invited into their abortion care experience and experienced their care as less responsive as a result, as Cea described: *"I feel like I spend a lot of my life with this part of who I am being unseen, so it was just another part of that."* Cea went on to reflect on why they would have like to have been asked about their gender and sexuality during the intake for their abortion:

> *Because I think they just get, I think people get a clearer idea of who I am, when they know about me. Especially in the context of reproductive health, I think there's just so many assumptions, so I do like having as much on the table as possible.*

Most participants agreed that it would be affirming to be asked about their sexuality even if they personally feared making this disclosure due to the stigma attached to bisexuality and pansexuality explored in Theme 1.3 (*Social and cultural scripts about abortions produce assumptions*). Most participants were clear that they would not offer up information about their sexuality nor correct erroneous assumptions by abortion providers about their sexuality in the absence of an invitation to do so. As Cea reflected: "*I would rather people ask, and then I can share. I don't usually correct if someone's wrong, but I would say if someone asks."*

Both structural and interpersonal expressions of cis-heteronormativity in abortion services were particularly impactful for participants who were transgender and non-binary, resulting in little or no space be seen as anything other than a woman in the system. Trans and non-binary participants expressed discomfort due to the gendered language of abortion services, for example service names and information resources that only referred to women as service users. As Blair described: *"I got referred to,* *it was like a part of the [provincial city] hospital that was like the Women's Clinic which I ... struggled with quite a lot, it made me feel really dysphoric"*. Blair further elaborated the connection between the gendered nature of the abortion service and his experience of gender dysphoria:

> *Being pregnant and then having an abortion was already really dysphoria-inducing for me, and then just to have … the language around it to be so focused on women and stuff, like I got mis-gendered a lot, not by like, like most people were pretty good, like once I told them, but it was like at first because everyone assumes if you are getting an abortion you are a woman. And it felt very defined as like, this is a 'female experience' which I struggled with.*

Trans and non-binary participants also reported being misgendered by abortion providers such as being referred to by the wrong name, gender, and/or pronouns. For Cea this was the result of not being invited to self-determine their gender at any point in the abortion journey and not feeling able to correct abortion providers who assumed they were a ciswoman. They reflected:

> *I guess if they had have known about who I am more as a person in terms of my gender and sexuality then y'know they might've used different language which would've then, I dunno just made, I'm still at the stage where I get really happy when people correctly identify me so that would be, that would have been nice – that would've been, made the process easier- y'know more- less unpleasant, 'cos its not a particularly nice thing to go through*.

Blair, on the other hand, took a more active self-advocacy role in seeking to have his gender affirmed by his abortion providers, correcting providers when they misgendered him, sometimes repeatedly. However, while Blair took up this role, they reflected that self-advocacy for gender affirmation during their abortion procedure made an already difficult experience even worse for them: *"It already was one of the most stressful experiences of my entire life, and I think adding to the stress of just constantly having to reaffirm myself, was just like another layer."* Moreover, participants expressed that initial assumptions about their gender and/or sexuality were disengaging, but sustained assumptions once they had advocated for themselves were hurtful and exacerbated the exclusion and invisibility they felt. Alexis explained how these sustained assumptions were impactful*: "I don't mind I guess the initial assumptions, it's more of when people dig into that and just, assume even more."* Overall, participants expressed that cis-heteronormativity within abortion care leading to assumptions and invisibility impedes the safety of Rainbow people going through these services.

4.2. Intersectional failure and possibility

Participants' experiences highlighted that the more minorities a person belongs to, including those related to ethnicity, age and disability, the more barriers in abortion care they are likely to experience. That is, the stigma and exclusion that people experience related to aspects of who they are, has a layering and compounding effect and therefore must be considered as such. Participants reflected that abortion providers could not know who they were, and ensure care was culturally responsive, when care was impersonalized and hurried, a particular challenge for telehealth abortion services because they are delivered at a distance. While appreciating streamlined abortion services, participants expressed their relief and gratitude when encountering diversity and proactive attempts at inclusion in abortion services. Riley, for example, explained the impact that having signs of inclusion has for Rainbow people such as posters, flags, pronoun pins, and Rainbow lanyards, in regards to making them feel safe and accepted within abortion services: *"I think it's just like when you see it, it's kind of like, potential doubts go away, y'know regarding that it's like, 'Oh, like I'm accepted here, like it's safe here for me to be comfortable in my sexuality or gender or whatever.'"* Other participants explained that seeing themselves reflected in the staff at the abortion service provided them with a sense of comfort and safety. For example, Cam explained that as a person of colour, she appreciated the diversity of staff within the abortion service: *"There were a lot of different coloured people there, which was really nice too. I think I felt safe just because the majority of the um people of colour were women also."*

Despite these active attempts at inclusion and diversity within abortion services, some participants questioned whether racism or ableism were part of their abortion experience. Further, participants expressed the desire for more culturally safe care from abortion services related to all aspects of who they are as people, not just gender and sexuality. This included abortion care that showed respect and regard for Te Ao Māori, that provided inclusive environments for disabled and neurodivergent people, and that prioritized the humanising of abortion care. Aubrey reflected that she would have *"loved some more cultural care"* by slowing things down and inviting self-determination of the cultural aspects of care that were important to her. Aubrey reflected:

> *It is a clinic but it was very clinical, which I mean it's a hospital, but I just think some of that just, I guess for them to acknowledge as well that it is also an emotional experience … they offer the counselling and stuff, but just to be like 'Hey yeah you're a human, this is hard, so here's some guidance and some words of well,' you know? Just for you and passing- but I know not everyone will want that acknowledged, but maybe if it's like an option on the form?*

Blair, who is autistic, described where his abortion care fell short in terms of his neurodiversity:

> *I sort of struggle with really bright lights and really harsh noises and stuff, so it was definitely slightly overwhelming and that, just the physical environment, not being necessarily accommodating, to my autism. I think it was mainly that, that in hindsight I would've liked to have been a little more accommodating*.

Altogether, participants expressed that there is even less space for Rainbow identities in abortion care when those identities are complex, nuanced, and diverse. Abortion services aiming to deliver affirming, inclusive, and equitable care therefore need to consider and address all axes of marginality that might be embedded in abortion care including those related to ethnicity and culture, disability, age, and neurodiversity alongside gender and sexuality.

Theme 5. Towards Rainbow inclusive and affirming abortion care

5.1. Relational encounters with abortion providers

The interactions participants had with abortion providers greatly influenced how they felt about their abortion experience and held much potential to humanise abortion care. Participants appreciated abortion providers who took time to listen to them, reassure them, invite them to share aspects of themselves and what was important to them, and who supported their ability to self-determine and make informed choices. For example, Olivia described:

> *A lot of the people that I interacted at the clinic, make it their number one priority that you always know what's happening, and I think that's really important in this process, that you're kind of always clued in as to what's going on, because obviously this is quite a scary thing to go through, especially when you're still quite young and still figuring things out in your life. They always make sure that like, you are their number one priority, and so I think it's like really important that when you have that direct line of contact with them they always just tell you what are the next steps gonna be and how to kind of go through that transition.*

However, participants also described aspects of their interaction with abortion providers that were challenging. For example, some participants explained that a lack of continuity of care meant they had to repeat their story multiple times to different providers which, for some participants, felt retraumatising, especially if repeating their story was paired with the need to self-advocate to have their gender and/or sexuality affirmed. Some participants reported not understanding the roles of the different providers they were interacting with in the service, particularly when receiving care through telehealth, which made participants feel distanced and disconnected from their care.

Some participants also felt that the gender of providers can impact relatability. Specifically, some participants found that having a doctor who was a (presumed cisgender) man conduct their ultrasound and/or abortion resulted in feelings of discomfort. Furthermore, some participants reflected that the surgical abortion process lacked privacy which added to their sense of vulnerability, especially if they had not told people in their life about their abortion. Aubrey, for example, reflected: *"I was just with everybody else when I was waiting for my surgery, I was just sitting in a random chair with other people going for other surgeries and I was like 'oh err'"* . For some participants, their experience would have been enhanced by more follow up care after their abortion, even just a check-up phone call. For example, Cam explained that, *"I thought they'd be like 'Okay like we'll give you a call or we'll see you in like a month's time or two weeks' time, just check up on you.'"*

5.2. Unlearning cis-heteronormativity in abortion care

Participants also offered their reflections on what abortion services and providers can do to ensure Rainbow affirming and inclusive care. As noted in Theme 4.2: *Intersectional failure and possibility,* participants were alert to, and appreciated, any efforts within abortion services to communicate signs of explicit welcome and inclusion of Rainbow people – such as rainbow flags on websites and clinic walls, abortion service staff wearing rainbow pins/lanyards or pronoun badges, and the availbility of information resources specifically tailored to Rainbow people. These signs of inclusion were seen as communicating to participants that they were anticipated and welcome, increasing their comfort and trust within services. For example, Cam emphasized:

> *One of them, [abortion provider] she, was either an ally or part of the LGBTQIA community because I remember I saw her badge and I saw her lanyard and I was like 'Okay this is like a safe space, like I don't feel judged, I don't feel uncomfortable, like this is fine' and she was very, very lovely.*

Similarly, Cea further elaborated on why signs of inclusion felt important: *"If I go places and there's like posters or something that just sort of make it obvious that this is a place where everyone's accepted, then it makes a difference. Yeah just like visibility of allyship or support."*

However, while appreciating signs of inclusion, fundamentally, participants were not able to realise the experience of safety and inclusion in abortion services while encountering cis-heteronormativity at both a structural and interpersonal level (as reported in Theme 4.1: *Cis-heteronormativity in abortion care*). Participants expressed a strong desire for the system to create opportunities for information about their gender and sexuality to be shared rather than assumed, through for example, in intake forms and in initial appointments with the service. Riley reflected on why the invitation to be known in abortion care felt important:

> *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.*

Particpants also reflected on the value of using non-gender specific language and imagery in services to open up the possibility that abortion service users may not be heterosexaul cisgender women. Blair for example reflected: *"I'd just call it like a reproductive clinic instead of a women's one, that would have made me feel more comfortable going there in the first place".*

The importance of educating abortion providers to be able to competently provide Rainbow affirming and inclusive care was also emphasised. For participants this meant supporting abortion providers to critically reflect on where norms and assumptions about gender and sexuality are built into abortion care and equiping them with the skills they need to openly engage with service users about who they are and be able to affirm these aspects of their personhood as they move through services. Participants gave some tangible examples such as abortion providers who took the initiative by introducing themselves using their pronouns, who reflected the language participants used to describe themselves and their bodies consistently in care encounters, and who were open and non-judgemental in the face of difference. As Cea shared: *"I guess some specific steps would have been, even if the people that I was interacting with, if they'd have introduced themselves with their pronouns then that would've been a way for me to then introduce myself with my pronouns."* Importantly, where abortion providers made incorrect assumptions, particularly about service users' gender, it was important to participants that abortion providers had the skills to manage this constructively, such as apologising and upskilling in the use of gender neutral pronouns and language.

Ultimately however, at the heart of Rainbow inclusive and affirming abortion care was the ability for Rainbow service users to be known to abortion providers (if they wish to be) and to receive care that is individualised and responsive. For example, Alexis expressed:

> *By knowing everything about me, she [abortion service counsellor] really took it into consideration as well when she would say things to me. So, when she would ask me certain things it would be I guess more personalised to me, which was not only super helpful, it just made me feel a lot more comfortable. I felt like I was going through a service that didn't just wanna do the service for me, but cared about what I was feeling and how I was doing.*

Participants explained that this kind of regard for them as individuals built their trust in abortion services with the additional positive consequence of raising participants confidence in and/or expectations of healthcare more generally. Alexis, for example, reflected: *"After a positive experience like that you just see the difference, because you can go, 'this is how it should be' and then you just kind of see, just the bare minimum, after that"*. Further, participants emphasized that when all of them was invited into abortion care the quality of abortion care was improved because abortion providers had the information they needed to tailor care, for example in conversations about contraception. Participants described some of the positive impacts of individualized care as increased feelings of safety, confidence, calm and ease which in turn left them feeling supported as they worked through the emotional weight of their abortion and contributed to better post-abortion outcomes overall. As Alexis reflected: *"It helps because it just makes you kind of feel like … people care and people are self-aware and they want to express that to you as well, and it just it [care] opens it up."*

Discussion

This research has been an important first step in addressing the relative invisibility of Rainbow people in abortion services in Aotearoa NZ, and internationally. Insights into Rainbow people's abortion service experiences is vital given that this population has been underserved in sexual and reproductive health services and has poorer sexual and reproductive health outcomes as a result (Pihama et al., 2020). With newly reformed abortion services aiming to deliver equitable access and outcomes to underserved populations (Ministry of Health, 2021), it is vital to understand the diversity of Rainbow people coming through abortion services, whether abortion services are meeting this population's needs, and what constitutes Rainbow inclusive and affirming abortion care. In-depth, semi-structured qualitative interviews were undertaken with 10 Rainbow people with diverse genders, sexualities, ethnicities, abilities, ages, geographical locations, and social contexts, all of whom had accessed abortion services following the passing of the Abortion Legislation Act in March 2020. Interviews were transcribed and analysed using Reflective Thematic Analysis (Braun & Clarke, 2022) and five themes were reported that identify current strengths, challenges, and opportunities in the provision of abortion care that is inclusive and affirming of Rainbow people.

There are several features of newly reformed abortion services that are largely working well for Rainbow people including the ability to self-refer directly into abortion services, the option for home-based abortion care provided through tele-health services, the ability to make an informed choice about abortion method, and for those participants who did not encounter mandatory counselling- the ability to choose to access a counsellor as part of their abortion decision making. These features of abortion services were valued by participants as enabling them to self-determine the abortion pathway which supported their wellbeing during their abortion. Further, for those participants who had had a prior abortion before law reform, abortion services were viewed as significantly more accessible and timelier in comparison. Importantly, participants in this study placed high value on different delivery models of abortion care (e.g., face-to-face or tele-health) and different kinds of abortion methods (e.g., surgical or medical), and there is no one size fits all ideal abortion pathway for Rainbow people. Rather, it is the ability to self-determine the abortion pathway that is appropriate to a person's individual circumstances, values, and contexts that participants associated with positive outcomes.

The ability to self-determine the abortion pathway is particularly important because our participants reported that abortion as a health procedure remains socially stigmatised and embedded with social scripts that can make it an emotionally challenging and isolating experience for Rainbow people. Abortion services that promote flexibility and autonomy by enabling choice about how services are accessed, whether counselling is needed, and how the abortion procedure will be undertaken were reported by participants as promoting wellbeing in the face of stigma, negative social scripts, and for some participants, isolation. These insights emphasise the vital importance of retaining and expanding access to a diversity of abortion service delivery models and abortion methods. This is further supported by the role that resource constraints such as access to transport and social support, and geographical location had on the type of service participants accessed and their method of abortion chosen, meaning that people need multiple pathways into abortion services. Participants also emphasised that most abortion providers they encountered are providing non-judgemental and supportive abortion care and this is highly valued and helps to offset the stigma attached to abortion. Positively, most participants did not encounter anti-abortion protestors or conscientious objectors during their abortion service experiences but we noted that participants continue to fear this, and the implementation and enforcement of safe zones was desired (Ministry of Health, 2023).

There are also aspects of abortion service delivery that are not currently working well for Rainbow people. We were concerned to note that some participants were still reporting pre-abortion counselling as a mandatory part of the abortion pathway in some services despite this no longer being a legislative requirement in abortion services, and others were not accessing counselling post-abortion when they wanted to. While participants largely reported satisfaction with abortion counselling, regardless of whether they had chosen to have it or not, these inconsistencies in the provision of abortion counselling need to be addressed as a system wide level.

Rainbow people enter abortion services with low expectations that healthcare will be safe and affirming and with the additional alertness of entering a service that positions itself as gendered or feminised. Alertness to the gendered nature of abortion services was compounded for Rainbow participants by the dominant social script that it is only cisgender and heterosexual women that need abortions. Some participants reported efforts within abortion services or by individual abortion providers to communicate signs of welcome or inclusion to Rainbow people in their services and participants were alert to and appreciated these signals. However, beyond these signals of inclusion, abortion services were largely encountered as under-resourced and unprepared to provide Rainbow people with an inclusive and affirming health service. This was not the result of overt stigma and discrimination towards Rainbow people in abortion services, with no participants reporting explicit trans/homo/biphobic encounters in their abortion care. Rather, the lack of Rainbow inclusion and affirmation in abortion care stemmed from cis-heteronormative assumptions that are ‘built in’ to abortion services at a structural and interpersonal level from the use of gendered language in service names and information through to being misgendered or assumed heterosexual in interactions with abortion providers, and having limited or no opportunities to disclose gender or sexuality. The combined effects of this were to centre and normalise cisgender heterosexual people as the assumed service user creating the conditions for the invisibility and erasure of Rainbow people in abortion care. Participants described the distancing and disengaging effects of moving through a health service in which core aspects of who they are as a person are invisible and unknown. On a practical level the invisibility of Rainbow people undermined the quality of abortion care leading to uninformed discussions between abortion providers and participants about aspects of their sexual and reproductive health, such as contraceptive choices and sexual health screening. The invisibility of Rainbow people in abortion services also undermined their level of trust, safety and confidence in abortion care which diminished their sense of wellbeing and emotional resiliency during a healthcare encounter that was experienced as stressful for many, and traumatic for some. Importantly, the additional layers of stress experienced when navigating cis-heteronormativity in abortion services were compounded for those participants who were multiply marginalised by abortion care that did not meet their ethnicity and cultural care needs and/or that with access barriers for disabled and neurodiverse people.

It is a key finding of this research that despite appreciating efforts to streamline abortion services, this should not be at the expense of the provision of abortion care that is gently paced, and that provides opportunities for Rainbow people to be known to abortion providers and to receive individualised, inclusive and affirming care as a result. Signs of Rainbow inclusion in abortion services are welcomed but should signal deeper whole of system work to identify and address cis-heteronormativity within abortion services and to educate abortion providers on how to work in inclusive and affirming ways with Rainbow people. This will require abortion providers who can critically reflect on their own norms and assumptions about gender, sexuality, and abortion, and who are skilled in opening up conversations that invite the whole person into abortion care. Additionally, the combined effects of social stigma around abortion, gender and sexuality will mean that some Rainbow people will not feel able, interested or willing to be known to abortion providers and critical reflection is required to deliver care in ways that leave space for not knowing. Crucially, Rainbow inclusive and affirming abortion services cannot be achieved without whole of system commitment to also delivering Te Tiriti informed, equitable and culturally safe care for Māori, care that is explicitly anti-racist and provides space for the meeting of diverse ethnic and cultural needs, and care that is enabling for disabled and neurodiverse people.

To support the implementation of the research findings, the following recommendations provide specific guidance to abortion services and providers for building capability for Rainbow inclusive and affirming abortion care.

Recommendations: A Te Whare Takatāpui informed framework for Rainbow inclusive and affirming abortion care

We were privileged to be gifted the mātauranga Māori framework 'Te Whare Takatāpui'[1] to present our recommendations from this project. The framework is being implemented across the health sector to create the conditions within services for the flourishing of Rainbow people (Parker et al., 2023). Te Whare Takatāpui provides a sheltering conceptual environment within which inclusive and affirming abortion care can be provided. Application of this framework, developed by research team member and leading takatāpui scholar Dr Elizabeth Kerekere, holistically brings to life six core values which honour and provide protection for Rainbow - and indeed *all* - people within their health service encounters (Kerekere, 2023). As previously mentioned in this report, we undertook a secondary analysis of our data by mapping our codes across the value dimensions described within Te Whare Takatāpui. This enabled us to generate specific recommendations for service improvement at all levels which address each of these crucial aspects of personal and whānau well-being. Below, these six core values are each described briefly, accompanied by recommendations for both individual practitioner and service level provision of care which support quality improvement initiatives to enhance Rainbow peoples' experiences of abortion care.

Whakapapa

Whakapapa reminds us that Rainbow people have always been present within our communities and always will be. Whakapapa asks that we remain mindful of all the people and the layers of experience that shape our human existence; it describes who we are in relation to all that has come before us, and what we bring with us into our encounters as service users and service providers.

> *It's not directly, you know, you have to have an abortion, but I know a lot of people, like Tongan and Pacific people who feel obligated to because of the cultural norms. So, that was… a huge key factor… just knowing that in my family I'm one of the only people who have finished college and gone onto study in the university… it's a privilege in my family… and for me it was a guilt thing… my grandparents and my parents had worked so hard for me to have this… and then, like, to fall pregnant… that was like a huge thing as well.*

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[1] For a full understanding of Te Whare Takatāpui, please read Dr Kerekere's chapter in *Honouring Our Ancestors: Takatāpui, Two-Spirit and Indigenous LGBTQI+ Well-being* (Green & Pihama, 2023).

To honour **whakapapa** abortion service providers can:

- Remain mindful that the person's journey to their service has possibly been a difficult one. The people they provide care to, can flourish best when they are recognised as entering the service with their intersecting identities and histories and may be bringing experience from previous negative health encounters with them.
- Hold awareness about their own identities, histories and potentially normative assumptions or preconceptions about people who seek abortion services. Examining and reflecting on their personal values can assist them to provide culturally humble and affirming care.
- Create safe and inclusive spaces for care encounters. Sharing and asking about pronouns when introducing themselves and making space for people to share aspects of their gender and sexuality are ways to begin the development of affirming relationships between service users and clinicians.

Wairua

Wairua is the spiritual dimension to our lives, our essence and interconnectedness with all things. Service providers acknowledge and honour *wairua* by framing gender, sexuality and sex characteristic diversity as a positive and celebratory expression of who people are – enabling them to be at peace with themselves within their abortion experience.

> *For me…having that experience be positive just made it easier to kind of deal with because…all I had to deal with after was just my personal feelings and how I felt about it. If I didn't have, like, a good experience that probably would have made it just a lot worse and probably would have weighed on me a lot more.*

To support **wairua,** abortion service providers can:

- Enable time to build warm and trusting relationships with service users and their whānau and be authentic within their provision of affirming care.
- Recognise that service users may be alert to both implicit and explicit discrimination.
- Display non-judgemental engagement and full acceptance of the person seeking care so they can build trust in this relationship.
- Provide inclusive care that eases peoples' worry and brings a sense of calm to their experience.
- Seek to understand the relationships between the service user and their support people – inclusive care is facilitated when clinicians proactively include the people who come along with the abortion-seeking person.

- Remember that service users who receive inclusive and affirming care report fewer ongoing negative impacts from their abortion experience.

Mauri

Mauri is our individual life spark, what makes us, us, and is the quality that gives us agency to determine our own pathway and be an active decision-maker within our navigation of the world around us. When our mauri is ‘seen’ and respected, we can flourish and be unashamedly who we are, but when our mauri is not respected, it can lead to a more negative sense of self.

> *It’s definitely hard because you never know how someone is going to react like you can never guarantee that, ‘cause there have been times where I have brought up the fact that I’m queer or trans and have not been met with someone being an ally, many many times. It's definitely hard, and it’s more like I never know what exactly to say um how exactly to approach things. My sort of go-to is just introducing myself like with my pronouns and then see like, whether they do the same or how they react to that, it’s just like a, ‘Okay, cool,’ then I’m like ‘Cool, sweet.’ But if it’s like I don’t know, I get the sort of side-eye or something else that makes me go, ‘Oh.’*

To support **mauri,** service providers can:

- Invite people to discuss those aspects of their identity that they are comfortable to disclose and then tailor their care to the whole person.
- Provide a range of options accompanied by relevant Rainbow-affirming resources to enable people to self-determine their abortion pathway.
- Avoid making assumptions that all Rainbow people want the same things.
- Create physical environments that demonstrate commitment to inclusion so that all people can feel welcome within your service. This can include neurodiversity-aware accommodations (e.g. low stimulus waiting rooms) and visual resources that reflect the full diversity of service users.

Mana

Mana is about our authority, dignity, respect, advocacy, and power. Mana gives us the authority to reject discrimination in all its forms, to advocate for Rainbow health and wellbeing, and to have agency and self-determination in the abortion pathway. When the mana of Rainbow people is enhanced it leads to improved overall wellbeing.

> *It’s still hard but, I think in general I’m always like, well what would I rather do in this situation? Like, sit here and not be affirmed, or just jump in and be like, ‘hey, this is who I am, um, deal with it.’*

To support **mana,** abortion service providers can:

- Minimise barriers and streamline abortion access to reduce the potential for abortion to cause distress.
- Withhold judgement regarding experiences of failed or inconsistent use of contraception.
- Provide information about pros and cons of abortion type facilitating informed decisions.
- Leave time and space for the complexity of decision making around abortion.
- Listen actively to individuals to hear their life experience/story.
- Take responsibility for your own learning and challenging those who enable discrimination.

Tapu

Tapu is about those things that are sacred and for Rainbow people, our tapu–our sacredness has often breached physically and mentally –through historical or current violations. Tapu reminds us of the importance of creating safe environments and healing spaces and of providing trauma-informed care that acknowledges the harm done to whānau.

> *She's [abortion provider] like, 'we need to get this blood pressure up ASAP so that these bloods can be done' and she literally took the time out of her day to like make me a sugary drink and get me some cookies so that my bloods would be done successfully, and then when she's like 'Oh my gosh you're afraid of needles' she literally went out to find numbing cream, to put on my arms so that I wouldn't feel the needle going in, and it was such a small thing but honestly it just made me feel so much better to know that there was people out there that, even if it was just such a small thing, like are taking that time to care, and you know tentatively to their patients, and it just made that whole process like, so much better because I just felt so much more at ease.*

To support **tapu,** abortion service providers can:

- Provide trauma informed care, acknowledging that Rainbow people may carry trauma from past experiences in health care and in their daily life.
- Avoid making assumptions and if corrected take this information on board – repeated mistakes are more hurtful.
- Withhold judgement regarding life experiences of Rainbow people – and listen to their needs.
- Facilitate timely processes because waiting can be stressful but be mindful that others need processes to slow down.

- Embrace diversity of peoples' responses to vulnerability. All emotional responses to abortion are valid.
- Ask what is important to Rainbow people.

Tikanga

Tikanga describes the "right way of doing things". Tikanga is about systems, structures and processes that will ensure the safety and flourishing of Rainbow people. Our participants have suggested there are current practices which could be improved, while there are others that could be reinforced. Abortion service providers can take practical steps to meet these needs.

> *Yeah so I was like 'I am bisexual so I'm attracted to both males and females, but I am like, dating a male and am in a straight-presenting relationship' and I think, you know it was very kind of them to ask because you don't really- I feel like what a lot of people assume is that like, abortions are one and the same you know and everyone has had the same experience- which is absolutely not true, like everyone's experience is different as I've said so I think it's very good for them to kind of ask.*

To support **tikanga,** abortion service providers can:

- Explain their role when introducing themselves.
- Build positive interpersonal relationships from first encounter as this shapes the experience.
- Ensure the availability of ***optional*** pre and post abortion counselling.
- Allow time to meet individual "processing" needs (i.e., efficiency is not the primary objective).
- Provide comprehensive and accessible information about abortion options and what to expect.
- Demonstrate competent ethnicity-specific cultural care.
- Address resource-based access barriers to abortion services such as travel, support, and the technology/connectivity required for tele-health services.

Specific recommendations to the Regulation and Monitoring Team, Manatū Hauora

1. Audit abortion services to ensure compliance with the Abortion Legislation Act 2020 relating to the provision of *optional* abortion counselling
2. Clarify abortion service data collection and reporting requirements to ensure that services are collecting and accurately reporting data related to service users' gender. Advise abortion services about how to collect gender-related data inclusively and encourage national standardisation of gender-related data collection in abortion services. Ensure that data capturing gender diversity in abortion services is routinely reported to aid visibility of gender diverse service users.

3. Continue to build capability within national abortion service provision to enhance opportunities for service users to access a range of abortion methods and to make an informed choice about their preferred method.
4. Build system-wide capability for Rainbow inclusive and affirming abortion care by setting standards for minimum education requirements for abortion providers in all service contracts and audit compliance with these requirements. This education should address the principles of Rainbow inclusive and affirming abortion care detailed in this report: A Te Whare Takatāpui informed framework for Rainbow inclusive and affirming abortion care.
5. Continue to model best-practice in Rainbow inclusive abortion care by avoiding gendered assumptions and language in all regulatory, policy and service level documents, and proactively affirm the presence of Rainbow people as abortion service users.

Strengths and limitations

A primary strength of the current research is the diversity of the sample. Participants represented a wide range of genders, sexualities, and ethnicities, and thus provided diverse abortion experiences. Moreover, the interviews were conducted by an insider to the community (Dwyer & Buckle, 2009), which provided a foundation for strong connection with participants and thus resulted in detailed accounts of participants' abortion experiences. This understanding was further strengthened through the insider status within the wider research team, which allowed for analysis to develop depth based on existing insight. Finally, the current research employed an original study in a significantly under-researched population. Thus, the current research has identified clear recommendations for abortion services in Aotearoa NZ, that will work toward improving outcomes for Rainbow people who go through abortion services in Aotearoa NZ.

While the current research engaged a diverse sample, a limitation is the small number of trans and non-binary people who participated in interviews. It is, however, possible that this silence is reflective of the erasure that trans and non-binary people face in sexual and reproductive health services more generally. This erasure could have potentially resulted in trans and non-binary people self-selecting out of the current research, even if they were otherwise eligible and willing to take part. Participants also expressed experiencing various levels of bisexual erasure, and some reported feeling unsure if they were 'Rainbow enough' to take part in this research. Accordingly, it is possible that there were a wide range of people with attraction to multiple genders who self-edited themselves out of the Rainbow community, and thus self-selected themselves out of this research. Lastly, the current research was not able to interview any intersex people who had experience with an abortion in Aotearoa NZ. As such, the current research was not able to highlight any intersex perspectives or experiences, and thus was unable reflect the experience of this important rōpu within Aotearoa NZ's Rainbow community.

Conclusion

This report has presented the findings of a qualitative study to understand the abortion service experiences of Rainbow people in Aotearoa NZ following abortion law reform in March 2020. The study has identified both aspects of abortion service delivery that are working well for Rainbow people and areas for further service development. The ability to self-determine the abortion pathway is a current strength of abortion services for Rainbow people with value placed on being able to decide what kind of service they enter, the ability to self-refer into services, and to make informed choices about abortion counselling and abortion method once inside the service. To improve abortion services for Rainbow people there is a need to identify and address cis-heteronormativity in abortion care to make space for Rainbow people and to pace service delivery to ensure abortion care is relational and personalised and Rainbow people have an opportunity to be known and affirmed during their abortion. Recommendations for Rainbow inclusive and affirming abortion services are presented using the mātauranga Māori framework - Te Whare Takatāpui. If the six values of the framework are implemented abortion services will grow their capability to provide a warm and inclusive environment for rainbow people in which they can flourish.

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