



**DONALD
BEASLEY**
INSTITUTE



**Abortion is a Human Right and Health
Issue: Disabled People's Experiences
of Abortion Services in Aotearoa
New Zealand**

Acknowledgements

This project was generously funded by the Ministry of Health | Manatū Hauora to uncover the stories of disabled people about their experiences of abortion services, stories which have not been told previously in Aotearoa.

We acknowledge that the topic of abortion unearths difficult emotions and carries a complex history. We are deeply grateful to our survey and interview participants for entrusting us with your stories.

We also acknowledge the members of our advisory committee who have guided this project:

- Ms. Cassie Withey-Rila
- Tuifa'asisina Savai'inaea Neta Tomokino
- Ms. Leeann Barnett

This image has been gifted to the project by an advisor who wished to remain anonymous.



Image description: artwork depicting a yellow circle made up of yellow and white intricate flower-like swirls. Within the yellow circle is a collection of pink and white intricate petal shapes coming from one side and blooming in the middle.

Author: Donald Beasley Institute (DBI). The DBI is an independent charitable trust that conducts disability research and education. The DBI is committed to ethical, inclusive, and transformative research and projects that promote the rights of disabled people.

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Trigger warning: This review discusses difficult topics such as eugenics, abortion, ableism and disablism, and forced sterilisation. Please take care when reading.

Disclaimer: The Ministry of Health | Manatū Hauora has made every effort to ensure the information in this report is reliable but does not guarantee its accuracy and does not accept liability for any errors.

Kōrero Whakamārama: Kōrero Whakamārama: We apply the Kāi Tahu dialect when writing in te reo Māori, that includes Kāi Tahu specific words and replacing the ng with a k (for example: whakarongo is changed to whakaroko). We have underlined the k whenever this has been applied.

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Kā Whakamārama / Glossary

Ableism: Discrimination which favours non-disabled people by valuing abled bodies and minds as normal and desirable (Lewis, 2022; Ingham et al., 2022).

Abortion: Intentionally terminating a pregnancy. This can be by any means, such as the use of medication or by surgical processes (Abortion Legislation Act, 2020).

Abortion services: In this project, abortion services have been interpreted broadly and are inclusive of services that facilitate an abortion as well as abortion counselling and post-abortion contraceptive advice and provision.

Cultural responsiveness: The ability to be open, reflective and respond appropriately to diverse cultures which creates cultural safety (The Royal Australian & New Zealand College of Psychiatrists, 2021).

Cultural safety: “A principle that requires service providers and health care and support workers to examine themselves and the potential impact of their own culture in their interactions with people using a service. To practise cultural safety, service providers and health care and support workers acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of service provided” (Ministry of Health, 2021a, p. 5).

Disablism: Discrimination which directly targets disabled people such as exclusion of disabled people from the mainstream education and forced sterilisation of disabled people (Ingham et al., 2022).

Disability: “Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (United Nations, 2006).

Eugenics: A pseudoscience and ideology which "encouraged procreation among favoured groups of people while restricting procreation, including compulsory sterilization, segregation of institutionalized individuals by sex, and prohibition of marriage of those deemed to have 'hereditary defects'" (Powell, 2022, p. 1857).

Intersectionality: A concept and theoretical framework that facilitates the recognition of the complex ways in which social identities overlap and can create compounding experiences of discrimination and concurrent forms of oppression (United Nations Network on Racial Discrimination and Protection of Minorities, 2022).

Learning disability: An alternative term to describe intellectual disability. It is the term preferred by self-advocates with learning disabilities in Aotearoa New Zealand (Ngā Tangata Tuatahi - People First New Zealand, n.d.).

Legal capacity: Legal recognition of "an individual, or other entity, as a legal person and a legal actor ... For example, legal capacity must be recognised in order to vote, marry, contract, inherit, consent to sex, consent to medical treatment, consent to mental health treatment, and any other area of life that requires a legal decision to be made and respected" (Arstein-Kerslake, 2019, p. 4).

Neurodivergence: An umbrella term "which encompasses people whose brain functions differ from the neuro-normative majority. ADHD, Dyslexia, and Autism are all examples of neurodivergent, A person can have an innate (from birth) neurodivergence or acquired (such as in the case of traumatic brain injury.)" (Neff, n.d., p. 9).

Person-centred: An approach which focuses "on the needs of the individual; ensuring that people's preferences, needs, and values guide clinical decisions or disability support; and providing care that is respectful of and responsive to them" (Ministry of Health, 2021a, p. 9).

Reproductive justice: An intersectional approach to reproductive health and child-rearing with three key values: the right to have children when people choose, the right

to parent children in a safe and healthy environment, and the right not to have children (Jarman, 2020).

Sexual and reproductive health services: A broad range of services covering topics such as: sexually transmitted infections, reproductive health and abortion, contraception use, sexuality education, sexual violence prevention and gender-affirming care (Te Whatu Ora, 2024).

Substituted decision-making: The conditions of substituted decision making are ‘(a) legal capacity is removed from a person, even if this in respect of a single decision; (b) a substitute decision maker can be appointed by someone other than the person concerned, and this can be done against his or her will; or (c) any decision made by a substitute decision maker is based on what is believed to be in the objective ‘best interests’ of the person concerned, as opposed to being based on the person’s own will and preferences” (Arstein-Kerslake & Flynn, 2016, pp. 475-476).

Supported decision-making (SDM): An emerging paradigm in which people use friends, family members, and professionals to help them understand and address the situations and choices they encounter in everyday life prioritising people’s ‘will and preference’ rather than what is thought to be in their ‘best interests” (Blanck, 2021, p. 3).

Woman/women: This review uses gender neutral language (such as ‘disabled people’), and is inclusive of the experiences of transgender, gender-fluid, non-binary and gender non-conforming people, all of whom may utilise abortion services. However, the terms ‘woman’ and ‘women’ are used when quotes are referenced from the originally cited literature. This report uses the term ‘woman’ as an adult who identifies as female though they may have been assigned a different sex at birth.

Kupu Rāpoto / Acronyms

ADHD: Attention Deficit Hyperactivity Disorder

DBI: Donald Beasley Institute

DPO: Disabled People's Organisation

DS: Down Syndrome

GP: General Practitioner

IRM: Individually Responsive Methods

NZDS: New Zealand Disability Strategy

NZSL: New Zealand Sign Language

SDM: Supported Decision-Making

SRH: Sexual and Reproductive Health

UNCRPD: United Nations Convention on the Rights of Persons with Disabilities

Whakarāpopototaka Mātua / Executive Summary

This research explores the experiences of disabled people who have accessed the range of abortion-related services available in Aotearoa New Zealand (hereafter referred to as Aotearoa). The findings will help the government and healthcare providers to deliver more equitable and inclusive abortion services. They will also contribute to the government's five-year review of the Abortion Legislation Act 2020, which decriminalised abortion in Aotearoa. The experiences of disabled people were collected through three questionnaires and seven interviews.

Key findings

- **Positive experiences accessing abortion services**

Disabled people's experiences of abortion services after the legislation change were often positive, with participants describing warm and non-judgemental interactions with health professionals, receiving accessible information, in-depth positive discussions about contraception, positive engagement in abortion counselling, and helpful aftercare.

- **Benefits of the legislation change**

The legislation change has had some positive impacts. Participants' gestational duration were decreased (when compared to before the legislation change), indicating fewer barriers to services. Participants also benefited from the ability to self-refer to services and from the changes to counselling services, which are offered but optional.

- **Barriers continue to impact the accessibility of services**

Despite the aforementioned positive findings, some participants described barriers to access such as difficulty finding information in accessible formats, mental access barriers, not receiving accessible and appropriate communication from healthcare providers (including in NZSL), difficulties accessing their preferred form of aftercare, long waiting lists in rural areas and small towns, and challenges associated with travelling from rural areas.

- **Experiences of ableism**

Participants described experiencing ableism both prior to, and after, the legislation change. For example, some participants felt their disability was invisible within the process and that their access needs were not met or were responded to inappropriately. Some experiences of disablism were reported by participants who accessed abortion services prior to the legislation change.

Recommendations

- **A principle-based approach**

Throughout this research participants identified four interlinked principles that are integral to equitable and inclusive abortion services for disability communities.

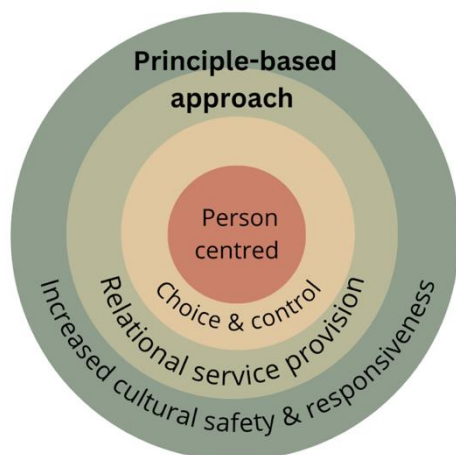


Image description: Four overlapping circles. On the top of the circles, the text says 'Principle-based approach'. The inner circle is orange and the text says 'person-centred', the second circle is tan and the text says 'choice & control', the third circle is light green and the text says 'relational service provision', and the outer circle is dark green and the text says 'increased cultural safety & responsiveness'.

- *A person-centred approach*

Participants wanted services that were person-centred - that is, responsive to their needs and intersectional identities. This included asking people what their access needs are, providing a variety of options at each stage of the abortion pathway, and a range of ways they could access aftercare and post-abortion counselling.

- *Prioritising choice and control*

Participants valued having choice and control throughout the abortion pathway and wanted their autonomy respected when making critical decisions. In particular, participants wanted a variety of options available to them at different points, and for their decisions to be respected and actioned.

- *A relational approach to service provision*

Participants valued a relational approach within healthcare services, highlighting the importance of strong and respectful relationships, including with their general practitioner (GP). Participants spoke highly of health practitioners who provided warm and respectful interactions, and also valued continuity of care.

- *Increased cultural safety and responsiveness*

Individuals experienced trust and safe interactions with healthcare and abortion providers when their intersectional identities were respected. Participants wanted an option to access culturally safe and responsive healthcare services both in regard to ethnic culture and disability culture.

- **Education and training for healthcare providers**

It is critical that healthcare providers receive disabled-led disability rights training that increases their ability to: be critical of the eugenics history of reproductive oppression; realise people's legal capacity; communicate effectively; and provide culturally safe and responsive services in relation to both ethnicity and disability culture.

- **Strategies for increasing the accessibility of services**

Strategies for increasing the accessibility of services for disability communities include: the provision of abortion information in a variety of accessible formats including NZSL; resources that inform individuals of what will take place at each stage of the abortion pathway; the development of a transport service for travel to and from abortion providers; continued investment in and promotion of tele-health services; and the promotion of self-referral pathways.

1. Whakatakika / Introduction

Abortion is both a human right and a health issue. Under Article 25 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), disabled people “have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability,” including “the same range, quality and standard of free or affordable health care ... including in the area of sexual and reproductive health” (United Nations, 2006, p. 18). Importantly, this includes accessible and affordable abortion services.

In July 2022, the Ministry of Health | Manatū Hauora commissioned the Donald Beasley Institute (DBI) to undertake research that included disabled people in a five-year review of the New Zealand Abortion Legislation Act 2020. The New Zealand Abortion Legislation Act 2020¹ amended existing abortion legislation and decriminalised abortion, aiming to modernise the abortion law of Aotearoa and to decrease inequities in access to abortion services (Ministry of Health, 2021b). The main changes resulting from the legislative change were:

- A wider range of registered health practitioners permitted to perform abortions;
- Ability to self-refer to an abortion provider;
- Removal of statutory criteria to access an abortion (a health practitioner may perform an abortion before 20 weeks’ gestation. After 20 weeks an abortion may only be performed if clinically appropriate in the circumstances);
- Removal of premise requirements for providing abortion services, with abortions now occurring in a range of settings, including primary care;
- Non-mandatory counselling available to anyone considering an abortion;
- Added requirement for health practitioners who conscientiously object to abortion provision to tell the person of their objection and how to access details of their closest abortion provider (Ministry of Health, 2021b).

This research was designed to better understand the impact of this critical legislative reform, and to increase understanding about how disabled people experience access

¹ Hereafter referred to as ‘the Legislation’.

to abortion services. The project took a pan-disability approach and utilised the UNCRPD definition of disability, which includes “those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (United Nations, 2006, Art. 1).

The report begins with an overview of relevant conventions, strategies and principles. It then contextualises the project by providing an overview of historical and contemporary forms of eugenics. The findings of an integrative literature review are then summarised, before discussions held during two researcher positioning sessions are explored. Findings from an online questionnaire and interviews with disabled people who had accessed abortion services in Aotearoa New Zealand are then presented, followed by recommendations and concluding comments.



Image description: a flow chart with five arrows. The arrows say: ‘Integrative Literature Review’, ‘Positioning Sessions with Researchers’, ‘Anonymous Questionnaire’, ‘Qualitative Interviews’, and ‘Report and Dissemination of Findings’.

2. Kā Mātāpono / Our Values

The Donald Beasley Institute is an independent charitable trust that conducts disabled-led and inclusive disability research. Kā Mātāpono (DBI Research Values) underpin this important work:

- Whakatinana – Honouring Te Tiriti o Waitangi through our practice
- Whakarakatira – Being Respectful
- Whakawhanaukataka – Being Relational
- Whakamana – Being Ethical
- Whakawhirinaki – Being Accountable
- Whakakotahi – Being Inclusive
- Whānau – Through uplifting whānau, our journey will be one of prosperity.

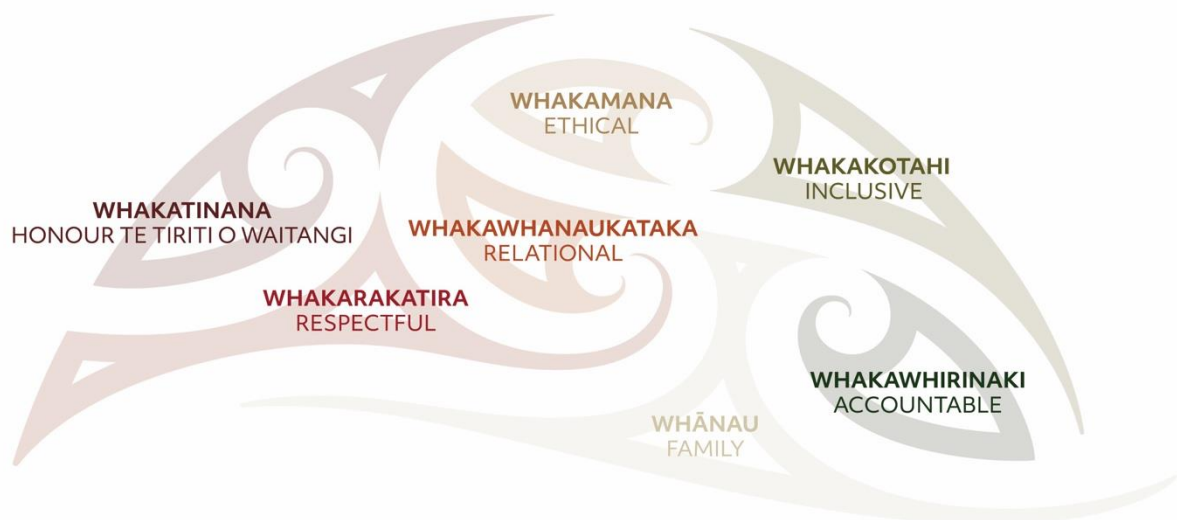


Image description: DBI's tohu. Within the tohu, kōwhaiwhai (shapes) depict patterns representing the DBI's whakapapa (history), mātāpono (values), mahi (work), and commitment to whānau whaikaha (disabled people and their families).

3. Instructive conventions, strategies and principles

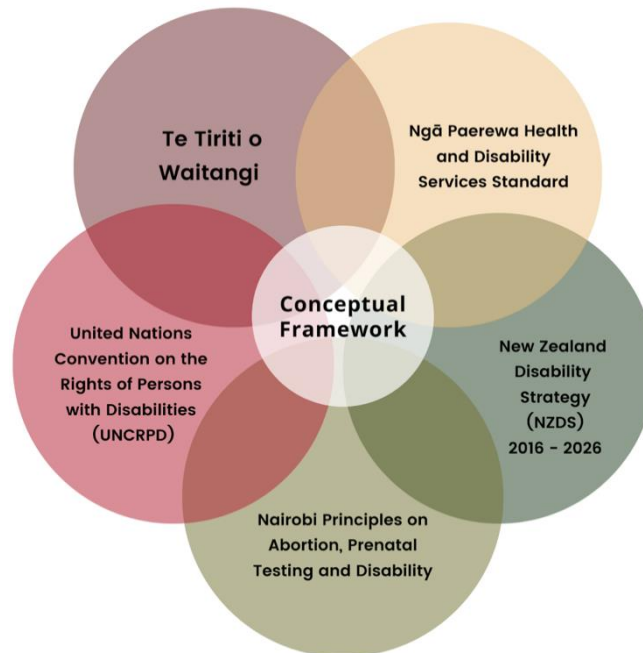


Image description: Five overlapping circles in colours of DBI kā mātāpono and one circle in the middle that says “conceptual framework”. From the top left, it says, Te Tiriti o Waitangi, United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), Nairobi Principles on Abortion, Prenatal Testing and Disability, New Zealand Disability Strategy 2016-2026 (NZDS), and Ngā Paerewa Health and Disability Services Standard.

This project is also underpinned by the five components entwined within the conceptual framework presented above.

Te Tiriti o Waitangi

Te Tiriti o Waitangi sets out the promise between Māori and the Crown, including disabled people, of how to exist together in partnership. One of the principles of Te Tiriti o Waitangi is tino rangatiratanga, often translated as self-determination. Though

Te Tiriti guarantees tāk_ukata whaikaha self-determination and equity in all areas, research shows that tāk_ukata whaikaha experience inequities in health outcomes, including in the area of reproductive health. These inequities reflect a breach of the rights set out under Te Tiriti (Ingham et al., 2022). Huria et al. (2023) have noted that colonisation impacts the reproductive health of Indigenous peoples through, for example, racist stereotypes about reproduction and sexuality.

The Waitangi Tribunal findings of Wai 2575 recommend the use of five principles derived from Te Tiriti to reduce health inequities in Aotearoa and to realise the health care rights of Māori: the Crown providing for Māori self-determination (tino rangatiratanga); the crown committing to achieving equitable outcomes (equity); the Crown acting, to the fullest extent possible, to achieve equitable health outcomes (active protection); the Crown providing for and properly resourcing kaupapa Māori health and disability services (participation); and the Crown working in partnership with Māori in the governance, design and delivery of health and disability services (partnership) (Waitangi Tribunal, 2019).

United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)

The UNCRPD is an international agreement that sets out what governments must do to ensure disabled people have the same rights as everyone else (United Nations 2006). In 2008, the New Zealand Government became one of the first countries to ratify the UNCRPD. Article 25 requires States Parties to provide disabled people with the same range and quality of sexual and reproductive health services as provided to non-disabled people (United Nations, 2006).

New Zealand Disability Strategy 2016-2026 (NZDS)

The New Zealand Disability Strategy 2016-2026 guides the work of government agencies, including the Ministry of Health | Manatū Hauora, on all issues affecting disabled people. The Strategy aims to help realise the rights of disabled people by supporting the implementation of the UNCRPD in Aotearoa (Office for Disability Issues, 2016). Key models informing the Strategy include the social and human rights models of disability. Outcome 3 of the Strategy - health and wellbeing - asserts that “[w]e do not face barriers accessing mainstream health services because of our impairments,

in particular, sexual and reproductive health services for disabled women and girls” (Office for Disability Issues, 2016, p. 28).

Ngā Paerewa Health and Disability Services Standard 2021

Ngā Paerewa Health and Disability Services Standard is a specific guideline for health care and disability service providers. It was developed with the abortion services sector to establish minimum criteria for acceptable care and support. It brings Māori, Pacifica and other New Zealanders to the centre of its focus. It also provides frameworks for service providers to realise their obligations to Māori under Te Tiriti o Waitangi (Ministry of Health, 2021a).

Nairobi Principles on Abortion, Prenatal Testing and Disability

The Nairobi Principles aim to provide a foundational framework for abortion, broader sexual and reproductive health issues, and disability. It was established by disability and reproductive/women’s rights advocates at a CREA convention in 2018². Though the Nairobi principles are not legally binding on Aotearoa, they do provide a relevant framework, with the principles affirming the human rights of disabled people and access to safe abortion practice while renouncing the harmful legacy of eugenics (Preamble). It also calls for “equal access to assisted reproductive technologies and adoption, as well as personal assistance and other parenting support” (Principle 8).

² “A feminist international human rights organisation based in the Global South and led by women from the Global South” ([CREA, n.d.](#)).

4. Historical context

Any examination of disabled people’s experiences of abortion and abortion services must be understood within a complex history of reproductive injustice. As such, it is important to begin with a brief overview of historical and contemporary manifestations of eugenics and its connection to disabled people’s experiences of reproductive autonomy, as it relates to abortion. It will also explore some key concepts that underpin this report.

Historical reproductive oppression

Eugenic theories and practices, which proliferated during the nineteenth and twentieth centuries, supported reproduction among favoured groups of people (positive eugenics) while restricting the reproductive autonomy of groups deemed “unfit for parenthood” and a threat to the advancement of the gene pool (negative eugenics) (Powell, 2022, p. 1857). Disabled people were one of the most common targets of negative eugenic policies, which led to forced sterilisations and abortions, segregation in institutions, and restrictions around marriage (Carlson, 2001; Dunn, 2018; Fletcher et al., 2023; McConnell & Phelan, 2022; Peterson, 2015; Powell, 2022). By the beginning of the twentieth century eugenic ideals were widespread throughout Aotearoa (Office for Disability Issues, 2020; Rollinson, 2020; Stace, n.d.; Wanhalla, 2001). The 1911 Mental Defectives Act, for example, “carefully classified groups of ‘other’ into a hierarchy of idiots, imbeciles and feeble-minded” (Stace, n.d., para. 11).

Contemporary reproductive oppression

While support for explicit eugenics decreased in Aotearoa and internationally, disabled people’s reproductive autonomy continued to be controlled in more subtle ways. For example, while many countries repealed their compulsory sterilisation laws, there is some evidence that disabled women (especially those with a learning disability³) are still more likely to be sterilised than the general population (Dunn, 2018; Li et al., 2018;

³ Learning disability is the preferred term used by self-advocates with learning disability in Aotearoa. Other terms are often used in the literature and legislation, for example, intellectual disability.

Manning, 2021; Servais et al., 2020). Forced sterilisation is often initiated by family members of disabled women, for ‘protection’ from sexual abuse, however the literature identifies such action as a form of violence (Tarzia & Hegarty, 2021).

Disabled people can also experience assumptions about their sexuality. For example, some assumptions construe disabled people as asexual (Hameed et al., 2020) and others as hypersexual (DiMatteo et al., 2022; Powell, 2022). Such assumptions may be reflected in sexual health education programmes, which often lack disability representation and disability-related information (Bollinger & Cook, 2019; Powell, 2022; Wiseman & Ferrie, 2020). It is also often assumed that disabled people are incapable of being parents (Baum, 2014; Boshier, 2020) despite evidence that with sufficient support they can be good parents (Aunos & Pacheco, 2021; Conder et al., 2011; Donald Beasley Institute, 2024; Stefánsdóttir et al., 2023).

Much of the literature focused on current prenatal screening processes for ‘fetal impairment’, the findings of which are often used to justify abortion. Many argue that such processes are a legacy of eugenics (Jarman, 2020), and medical professionals are more likely to recommend prenatal testing to disabled people than non-disabled people (Vaimberg et al., 2021). Hubbard (2010) argues that “normalising these processes of ‘selection’ should be understood within a larger context of biopolitics - of controlling who should and should not be allowed to exist” (Jarman, 2015, p. 49).

Eugenic discourses also continue to shape disabled people’s experiences of accessing contraception and abortion services. There is some evidence to suggest that disabled people (especially people with a learning disability) are sometimes pressured or actively guided toward using contraception (Powell, 2022; McCarthy, 2010; Wiseman & Ferrie, 2020). There is also evidence that certain disability communities (such as the learning disability community) have little choice and control over what type of contraception they take, with long lasting methods (i.e. depo provera) being automatically prescribed rather than daily contraception. This removes disabled people’s choice and control (Lowe & Rowlands, 2022; McCarthy, 2010; Wu et al., 2018). It has also been found that when a disabled person becomes pregnant, it is not uncommon for them to experience attitudes that make them feel they should terminate their pregnancy (Lee, 2020).

Legal capacity

In order for disabled people to have their reproductive decisions respected, they must have their legal capacity recognised. Disabled people have a long history of having their legal capacity limited and removed through institutionalisation, forced treatment, and guardianship regimes (Series & Nilsson, 2018). Legal capacity is “the law’s recognition of an individual, or other entity, as a legal person and a legal actor” who can make legal decisions (Arstein-Kerslake, 2019, p. 3). Disabled people’s legal capacity must be upheld when disabled people make decisions regarding contraception, sterilisation, and whether to have (or not have) an abortion. Article 12 of the UNCRPD affirms that States Parties must recognise a disabled person’s legal capacity (United Nations, 2006).

Critical to the recognition of a person's legal capacity is supported decision-making (SDM). The General Comment on Article 12 has supported a shift away from substituted decision-making models, where a substitute decision-maker makes a disabled person’s decision for them, toward supported decision-making, where the disabled person is supported to make their own decision and their will and preferences are respected (Arstein-Kerslake, 2019; Manning, 2021). When disabled people are denied access to abortion or their views and wishes regarding these services are not respected, this limits their legal capacity (Arstein-Kerslake, 2019).

Reproductive justice

Reproductive justice is a relevant intersectional approach to reproductive health and child-rearing. The term ‘reproductive justice’ was coined by Black feminists in the 1990s in the United States (Daniel, 2021), and recognises that reproductive choice “does not occur in a vacuum, but in the context of all other facets of a [persons]’s life” (Powell, 2022, p. 1885). Reproductive justice has three key values: the right to have children when people choose, the right to parent children in a safe and healthy environment, and the right not to have children (Jarman, 2020). Reproductive justice, therefore, widens the discussion from the typical pro-life versus pro-choice abortion debate, to include disabled people’s choice, control, will and preference (National Partnership for Women & Families & Autistic Self Advocacy Network, 2021).

5. Integrative literature review

This chapter provides a summary of the findings from the integrative literature review⁴. Due to a lack of relevant research within the context of Aotearoa, much of the identified literature is international.

Prevalence and gestational period

There was little to no research regarding the prevalence of abortion amongst disabled people in Aotearoa New Zealand, indicating a critical gap in the literature. Both research from Aotearoa and abroad shows that disabled people are more likely to experience physical and sexual violence, unwanted pregnancy, and maternal and infant mortality than non-disabled people (Abbas, 2020; Deierlein, 2021; Fanslow et al., 2021; Hassan et al., 2023; Malihi et al., 2021). Even so, there is no clear evidence that disabled people access abortion at a higher rate than non-disabled people (Hayward et al., 2017; Horner-Johnson et al., 2017).

Association with disability

Available international research that discusses disabled people's abortions shows that disability type can be a defining factor. A Swiss study found that 62.9% (of 97) of Down Syndrome (DS) people's pregnancies between 1998 - 2009 ended in abortion compared to 22% for people with learning disabilities, and 15.1% for people with no learning disabilities (Orthmann Bless & Hofmann, 2020). The identified literature also showed that disabled people experience contradicting experiences when accessing abortion services. This includes barriers to accessing abortion services, whilst also being encouraged and advised to have an abortion (Daniels, 2022; Guerin et al., 2017; Wołowicz-Ruszkowska, 2016).

⁴ For further detail regarding the methodology of this literature review, please contact the authors.

Barriers to access

Internationally, disabled people experience many barriers to safe abortion services as well as safe sexual and reproductive health (SRH) services (Powell, 2022). Health facilities were often described as being physically inaccessible, too far away, and difficult and expensive to travel to (DiMatteo et al., 2022; Nguyen et al., 2019; Porat et al., 2011). Disabled people also experience attitudinal barriers to accessing abortion services, for example, attitudes from health practitioners that construct disabled people as asexual or incapable of consenting to sex (Fletcher et al., 2023; Mitra et al., 2016). They can also experience information and communication barriers to accessing these vital services. For example, members of the D/deaf community have described struggling to communicate with healthcare workers (Besoain-Saldana, 2023; Nketsia et al., 2022; Rugoho & Maphosa, 2017). Mental barriers were also noted when accessing abortion services, such as a fear of a lack of privacy (Northern Ireland Human Rights Commission, 2021), the impact of historical trauma caused by eugenics ideologies (Miller & Levine, 2013) and the impact of individual medical trauma (Hayes, 2022).

Intersectionality

Disabled people can experience multiple identities, which impact their experiences of accessing abortion services. Critical race theorist Kimberlé Crenshaw coined the term intersectionality (Crenshaw, 1989) to recognise that multiple identities and experiences can intersect, leading to different and layered ways of experiencing discrimination (Office for Disability Issues, 2022). For example, Tākata whaikaha/whānau hauā⁵ (Māori disabled people) have described intersectional experiences of health systems that are ableist, as well as racist and disablist, leading to poor quality services that lack both a disability and kaupapa Māori lens, compounding barriers to health services (Ingham et al., 2022). Disabled women have also experienced compounding

⁵ A Māori model of disability that does not view disability as a defining factor but as one aspect or dimension of a person's life, which is also experienced by their whānau (Hickey & Wilson, 2017).

disadvantages when accessing their reproductive rights due to the intersection of sexism, ableism and disablism (Arstein-Kerslake, 2019).

Counselling services

There was no data in the identified literature that examined disabled people's experiences with abortion-specific counselling services in Aotearoa or similar international services. Data relating to disabled people's engagement with general counselling services indicates they can experience financial barriers to these services, a lack of disability knowledge amongst counsellors, and non-disabled counsellors exhibiting a deficit view of disability (Donald Beasley Institute, 2022; Johnson, 2011; Raffensperger & Miller, 2005). A specific counselling service related to abortion is genetic counselling, which supports people through genetic diagnosis. The literature highlights the eugenic nature of many genetic counselling practices (Luque Bernal & Buitrago Bejarano, 2018), though more recently, genetic counselling has become aware of the implications of eugenics for the profession (Doetz, 2023). However, other research indicates that genetic counselling can still reinforce eugenic discourses (Strnadova et al., 2023).

Recommendations

The literature was not forthcoming as to recommendations for improving abortion services for disabled people. Recommendations that were made include changes to policy and legislation (through, for example, decriminalising abortion) (De Londras & Enright, 2018), increased disability awareness and rights training for health professionals (Nguyen, 2020), and working with the disability community to find strategies for increasing the accessibility of services, for example, through providing SRH information in a variety of accessible formats.

6. Reflecting on researcher positionality

6.1 Researcher positioning sessions

This research project was led by disabled people, with disabled people, and for disabled people. In order to reflect on insider/outsider positioning, the research team participated in two positioning sessions at the outset of the project. These sessions did not explore researchers' personal experiences of abortion services, but were designed to identify and explore the identities, experiences, histories, cultures, and preconceptions the researchers brought to this topic, given its sensitivity and complexity. The research team represented a diverse range of identities. The age of the researchers ranged from late 20s to early 50s. The research team was inclusive of Pacifica, Māori, Asian and Middle Eastern and Pākehā ethnic identities, a variety of gender identities, and represented a diverse range of disabilities including chronic illness, physical disability, neurodivergence, and blindness.

Intentionally exploring positionality enabled members of the research team to be authentic and critical about what they were bringing to the research and how that might shape the approach of the project. It was also a means of ensuring researcher and participant safety. In any research, researchers are an integral part of the research process. Therefore, it is important to understand researcher influence on how the evidence is constructed and presented, how data is analysed and interpreted, and how theories are shaped (Day, 2012). This process, known as reflexivity, is based on the idea that a researcher's status and self-identity play an important role in how data is created and presented (Yeh & Inman, 2007). A reflexive approach to researcher positionality in qualitative research has been widely acknowledged (Mohler & Rudman, 2022) and is particularly important in disabled person-led research.

6.2 Positionality learnings

Outlined below are some of the core learnings from the researcher positioning discussions, which helped shape the study's design, clarify researcher positioning within the research, and inform how the researchers engaged with the research.

The complexity of the topic

Within the positioning sessions, an initial unease with the research topic was identified. Emerging from the history of eugenics, some members of the team felt an initial discomfort with research that had potential to reinforce harmful discourses if conducted insensitively. Other researchers had always understood abortion within the pro-life versus pro-choice debate and as a person's right to choose, and did not have a more holistic understanding of eugenics and its impact on some disabled people's perceptions of abortion. This discussion highlighted the diverse mix of positionalities within our research team and highlighted the importance of understanding the nuanced history of eugenics, and helped to frame the study within this context and complexity. It also assisted the researchers to develop an approach that would be sensitive to potential participant responses. In addition, the insights gained, enabled the researchers to reflect on abortion services as health services for disabled people, while framing the topic as a human right and health issue. Finally, it encouraged the researchers to shift away from the binary nature of the pro-choice versus pro-life debate and to consider the topic more holistically.

Risks and safety

The final key learning came from a discussion about the risks associated with the research and ensuring participant and researcher safety. The researchers explored their responsibility and accountability to the disability community and the potential for disabled people to feel like their experiences were not reflected in the findings. This discussion reinforced the importance of staying true to the voices of the disabled participants, while ensuring the final outputs were accessible and widely disseminated.

Due to the sensitive nature of the topic, another identified risk was the potential for participants to be identified. To mitigate this risk snowball sampling was used, where participants could share the invitation to participate with additional participants who were potentially eligible. This form of sampling is often used when a population is difficult to reach or a particularly sensitive subject is the research topic (Parker et al., 2019). Another strategy was beginning data collection with an anonymous questionnaire, where a participant could choose to share their contact details and

participate in an interview if they chose to. This allowed a soft and sensitive approach to data collection.

The researchers also discussed the need to be responsive to emotional distress that may occur in response to questions about abortion services. The researchers recognised the need to be extra mindful and sensitive to any distress shown in interviews, to provide additional support when needed, and to engage in follow-up meetings with the team lead after any emotionally distressing or difficult interviews to protect their own emotional safety.

7. Qualitative study

7.1 Te Aramahi Mahi / Methodology

7.1.1 Ethics

This research project was reviewed by the Southern Health and Disability Ethics Committee and approved on the 26th of September 2023 (2023 FULL 18681).

7.1.2 Questionnaire

The anonymous questionnaire was made available online (Qualtrics) and in accessible formats. It was shared through the DBI's extensive disability networks and localities with snowballing being used to reach a diverse range of disabled people. To be able to participate, a person had to identify as disabled (or other impairment identity), or as a family, whānau, aiga or close supporter of a disabled person who cannot provide their own consent to participate⁶; be over the age of 18; have accessed, or attempted to access, abortion services since 2020; and be able to provide informed consent to participate. At the end of the questionnaire, participants could either remain anonymous, or give permission for the researchers to contact them for further information, provide further support if needed, or to participate in a qualitative interview. Three completed questionnaires were received.

7.1.3 Qualitative interviews

Participant recruitment

The next phase of data collection engaged seven disabled people and family, whānau, aiga and close supporters of people with a complex disability who took part in the questionnaire, and who provided permission to be contacted again. Of the seven participants, three identified as Māori, one as being from a Pacific Island⁷, and three

⁶ Family, whānau, aiga and close supporters of disabled people who cannot provide consent to participate on their own behalf were asked to contribute their own perspectives, and were not considered a proxy for their disabled family member.

⁷ Island name removed for privacy.

as Pākehā. Six of the participants accessed abortion themselves, while one participant supported a family member to access abortion services⁸. There were a diverse range of disabilities within the participant sample, including D/deaf and hard of hearing, physical disability, neurodivergence, psychosocial disability and learning disability. The age of the participants ranged from late 20s to early 50s. Four participants had accessed abortion services prior to the legislation change in 2020, five participants had accessed abortion services after the legislation change, and two participants had accessed abortion services before and after the legislation change.

Data collection

To enhance the disabled participant's choice and control over how they told their stories, the DBI used an Individually Responsive Methods (IRM) approach. IRM was developed by the DBI as a way of including the voices of disabled people whose experiences and subjectivities are difficult to access using conventional research methods (Milner & Frawley, 2019). IRM offers participants the chance to design and control their research presence by working with a researcher of their choice to tell their story in a way that is both personally meaningful and accessible.

Analysis

All of the interviews were transcribed and de-identified to ensure confidentiality. The transcripts and questionnaire responses were analysed collectively using qualitative analytic thematic analysis (Braun & Clarke, 2022). Thematic analysis is widely used in qualitative research and was appropriate in the current study, where individual experiences were interrogated to identify, analyse and report patterns apparent across the collective body of data.

⁸ This participant provided cultural perspectives about their abortion experience. While the family member could have provided their own informed consent, it was appropriate for their family member to take part in this research as a support person to speak to the collective cultural perspective.

7.1.4 Strengths and Limitations

A key strength of this study was that a diverse team of disabled and non-disabled researchers contributed to all aspects of the research, each bringing their unique lived experience and perspectives. An additional strength was the accessibility of the research - both the questionnaire and interviews were conducted in an accessible manner, meaning all research documents were translated into a variety of alternative formats. Finally, participants had choice and control over key aspects of the research process, including who interviewed them.

The primary challenge of this project was the limited timeframe, which impacted participant recruitment. A broad range of organisations were contacted to assist in recruitment for this study including Disabled People's Organisations (DPOs), disability support and advocacy services, feminist and women's rights organisations, disabled student associations, LGBTQI+ organisations, organisations engaged in abortion law reform advocacy, and abortion providers. Even so, the response rate was lower than expected. Future research in this area would benefit from increased time for building trusted relationships with localities and potential participants, more face-to-face engagement, and further discussions with the disability community about the scope and purpose of the study.

7.2 Kiteka / Findings

The next section of the report examines findings from the questionnaire and qualitative interviews. The findings are framed to reflect how someone might access and navigate abortion services; starting with participants' pre-abortion experiences, any barriers they encountered, and their post-abortion aftercare. The broader social processes at play within disabled people's experiences of abortion services are then explored. Each section ends with a brief discussion about the potential impacts of the legislation change on participants' experiences (when this is relevant), before recommendations are made.

7.2.1 Pre-abortion experiences

The first collection of findings detail participants' pre-abortion experiences. This section begins with a discussion about gestational duration as a general indicator of service

accessibility, before participant's pre-abortion experiences are explored, including referral processes and pre-abortion counselling.

7.2.1.1 Gestational duration

The Ministry of Health identifies gestational duration (the length of the pregnancy at the time of accessing an abortion) as “an important indicator of access to services; earlier gestation at the time of abortion signals fewer barriers to accessing services” (Ministry of Health, 2023, p. 10). Two participants who had accessed abortion services prior to the legislation change had accessed them at a fairly late stage in their pregnancy, at around 14 weeks for one participant (surgical), and at 12 weeks for the other (non-surgical). One of these participants spoke about their age being a barrier, preventing them from accessing abortion services sooner. They described being put on a waiting list because they were young and their healthcare provider thought they would change their mind.

Another participant who accessed abortion services prior to the legislation change found out they were pregnant at four weeks and was able to access abortion services within two weeks, therefore accessing services at a fairly early gestational duration. However, this participant described potentially discriminatory reasons for this ease of access, noting:

I think when you've got a physical disability, health professionals don't view you as someone who should be getting pregnant or should be having sex. So, yeah, so in my second experience, it did resu- it did result in termination. And, and, yeah, I think the process was really quite easy. And I think some of that came down to the fact that, you know, the health professionals were like, “yeah, of course, she's going to have an abortion.”

This participant's experience challenges the assumption that gestational duration indicates fewer barriers. It demonstrates how, for some populations, a shorter gestational duration might indicate problematic attitudes held by health professionals, particularly toward people they think should terminate a pregnancy.

In comparison, the five participants who had accessed abortion services since the 2020 legislation change accessed these at between seven and ten weeks gestational duration. This indicates that the legislation reform may have decreased barriers, as these participants were able to access non-surgical abortion services earlier. Even so,

participants also described various barriers that impacted their gestational duration (discussed further in section 7.2.2).

7.2.1.2 The referral process

As part of the 2020 legislation reform individuals are now able to self-refer to an abortion provider, rather than having to have a referral from a health practitioner such as a GP. Participants appeared to be unaware of this option as the majority were referred to an abortion provider by their GP or Sexual Wellbeing Aotearoa (formerly Family Planning). Only one participant had self-referred to an abortion provider, indicating a need for increased education and information about this specific change to the legislation.

A smooth and timely referral process was highly valued by participants. When the process was stalled, confusing, or unnecessarily lengthened, it created stress and pressure. One participant spoke about their experiences accessing abortion services prior to the legislation change and felt strongly that when the service provider increased the length of the process in order to give her time to decide it made the experience more difficult: “I felt like I was not being listened to. And they're like, 'oh, you're gonna change your mind ... Like, I'm not changing my mind!” In contrast, when the same participant accessed abortion services again after the legislation change they found the referral process quicker and easier:

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

Participants who had been referred noted they were often given clear information and referred directly, which they highly valued. They described the referral process as “really fast”, “quite smooth” and “professional.” One participant spoke about the importance of having a trusted family GP who provided a clear timeline of the process before making a referral, and another participant was grateful Sexual Wellbeing Aotearoa had organised the referral “all on the spot.” Another participant who accessed abortion services following the legislation change spoke of a long wait time at Sexual Wellbeing Aotearoa. They then self-referred to an online telehealth service, which they

described as “really amazing,” showing the benefit of the legislation change regarding self-referrals.

Some participants identified having support from their partner, family or friends from the beginning of the process as important, making the experience less challenging. A participant who supported a family member to access abortion services shared the approach their family took as empowering “them to speak their voice and know that the decision they were making was actually supportive and genuinely supported by us.

7.2.1.3 Pre-abortion counselling

One of the major reforms of abortion legislation in 2020 was ensuring that counselling is optional and always offered, but never mandatory. Some participants talked about their experiences with counselling services prior to having an abortion. Most participants who spoke of pre-abortion counselling had accessed these services prior to the legislation change, and described it as a negative experience. They found it to be “a tick-box kind of process,” and “dehumanising.” One participant said, “...the whole counselling thing for two sessions felt really invasive and cold.” Prior to the legislation change, participants perceived mandatory pre-abortion counselling sessions as a space where they had to justify their decision, which was stressful and upsetting.

A Deaf participant who had received pre-abortion counselling (post-2020) struggled with the service as they chose not to have a sign language interpreter present due to privacy concerns. They also noted they:

found it hard because there was no Deaf culture in that service. So the questions that they were asking weren't quite, I found it hard to relate to those questions.

These experiences speak to the importance of pre-abortion counsellors having training and education in disability and Deaf culture as well as New Zealand Sign Language (NZSL). Having such skills and knowledge would potentially improve patient privacy by decreasing the need for interpreters during counselling sessions.

The legislation change:

- **Gestational duration:** Findings indicate that since the law reform participants are accessing abortion services at an earlier stage in their pregnancy and therefore experience a shorter gestational duration. This may be indicative of fewer barriers when accessing abortion services, although participants still reported experiencing some access barriers.
- **The referral process:** Participants reported positive experiences with the referral process post-legislation change, but there appears to be a lack of information about the ability to self-refer. One participant shared a positive experience of self-referring to a telehealth service, indicating that the ability to self-refer has had a positive impact.
- **Pre-abortion counselling:** Participants found pre-legislation change counselling to be a negative experience. In comparison, participants tended to report positive experiences post-legislation change. They appreciated the optional nature of counselling, and reported that the counselling they received was generally responsive to their needs.

Recommendations:

- **Disability rights training⁹:** The findings suggest a need for healthcare providers, including counsellors, to receive disability rights training in order to avoid perpetuating ableist views, to increase skills in accessible communication (such as NZSL), to better understand disability and Deaf culture, and to increase knowledge as to how disabled people's choice and control can be enabled within services.
- **Accessibility - Information:** Disabled people may benefit from increased accessible information and promotion of the changes in the legislation relating to self-referral. However, participants spoke positively about the referral process and the small participant numbers make it difficult to be conclusive on this point.
- **Enabling choice and control:** A participant spoke about the importance of their health professional respecting their decision to access abortion services and referring them to an abortion provider as soon as possible. This example demonstrates the importance of disabled people having choice and control throughout the abortion pathway.
- **Cultural safety and responsiveness:** Participants need access to culturally safe and responsive abortion services from the outset of the abortion journey, including Deaf and disability culture. This requires health care providers to both acknowledge and address their own biases and assumptions that may impact the quality of the service provided (Ministry of Health, 2021a) as well as valuing the knowledge and perspectives of diverse communities that contribute to health and wellbeing (The Royal Australian & New

⁹ Disability rights training is about understanding disabled people as rights holders and increasing knowledge about how to respond to disabled people in the way that upholds their rights.

Zealand College of Psychiatrists, 2021). Cultural safety also requires health practitioners to critique 'taken for granted' power structures (Curtis et al., 2019). Participants emphasised the importance of Deaf culture having a space in health services. It is also important to recognise the support provided by natural supports, including partner(s) and friends.

7.2.2 Barriers to access

Despite the intention of the law change to bring the legislation in line with the tenets of reproductive justice and to enable access to timely, equitable, and publicly funded abortion services, according to participants, a range of barriers remain. These include travel, rural/small town living, attitudes, information and communication, financial, and mental barriers.

7.2.2.1 Travel

While the 2020 reforms of abortion legislation have resulted in abortion services being available at a greater number of facilities, travel has remained a barrier for disabled people. When travel was needed, a significant amount of planning and resources were required to make it happen. Living rurally or in a small town and needing to travel to healthcare facilities also added time pressure to the process:

Yeah and, and there was a bit of a race against time. So I felt like there's a lot of pressure in terms of trying to get an appointment for the blood [test] and then getting the blood [test], making sure the bloods is going to the hospital in [North Island city], and then arranging with [hospital] to go and meet the person who gives you like a bit of an interview and then you go and get a scan, and then you go back to them and then they give you the drug...

Another participant spoke about the difficulties of transportation as a disabled person:

I mean, it's just, everything's harder to navigate when you've got a physical disability. And I think, you know, having to sit on a train or a bus when you're off to go to an abortion clinic is just trauma in itself, isn't it?

Most participants who lived in urban centres did not describe travel as a barrier, noting how close services were and the simplicity of getting there. To avoid the challenges of taking public transport to a provider, one participant highlighted the importance of being able to afford private transport or having natural/formal supports who could drive them, noting that not all disabled people have such social capital:

I mean, transport wise if, I'm lucky, I've got a car but for those who, who can't get to those places to get bloods and to and then the final kind of pro- final, final part of the process. So you know, you're going to, you're having to like disclosure, you probably might have to disclose your information, you know, disclose why you need the transport and share it with people that you don't want to share with ...

7.2.2.2 Rural/small town living

While living in a small town or a rural area led to travel-related barriers, it also created concerns relating to privacy, decreased choice of services, and longer wait times due to service overload. For example, one rurally-based participant who attended a hospital appointment as part of the abortion process was unexpectedly attended to by a family member working as a nurse in the facility. The participant described feeling both awkward and concerned for their privacy. Though the participant acknowledged they could have asked for a different nurse, this would have increased the time pressure they already felt under due to difficulties around travel.

Two participants also spoke of long waiting lists in small towns or rural areas that made the process more stressful and time pressured as well as having a lack of choice in services:

Definitely, it's, it's a different, it's a different, very, very different experience to urban health services and the options that come with the many, you know, the many opportunities and options that come. And you can select and you know, you can choose if you don't like a part-, you know, you'd, but, whereas you've only got one ... I think it's really hard rurally, like, well, to get the services that you need ... [w]hereas, there's the convenience of, of living in the city. Like it takes, it takes a big toll on you.

One of these participants was able to access an online telehealth service, which improved their ability to access services quickly and increased their options. These participants all accessed abortion services following the changes to the legislation.

7.2.2.3 Attitudes

Participants reported a range of attitudes in their interactions with health professionals. Participants who had accessed abortion services prior to the legislation change appeared to experience more overtly negative attitudes. For example, a participant

spoke about attitudes they experienced about sexual activity and becoming pregnant, stating that “[It] felt like healthcare professionals have the attitude that disabled people shouldn’t have sex and shouldn’t get pregnant.” This participant also engaged with a healthcare provider who, citing personal beliefs, told the participant they could not provide them with advice about accessing an abortion and, therefore, referred them to a different provider. Since the legislation change in 2020, health practitioners who conscientiously object to abortion provision must inform their patient of this objection and share how to access the closest abortion services. The participant recalled how negatively this response impacted them and how it increased the shame they felt accessing these services, noting “It was pretty terrifying. Yeah, I felt very judged.”

Participants who had accessed services after the legislation change also experienced some negative or unhelpful attitudes from healthcare professionals. One participant noted that when they engaged with an abortion provider, they found them to be quite “blase” about the process, telling them to come back in four weeks for an appointment, making them feel stressed about having to wait so long. Another participant shared their family member’s experience of an assumption of incompetency by the abortion providers based on their disability:

[Family member] felt some of the questions were really generic around it, you know, why do they ask us these questions when they can see clearly that I am? Yes, I'm a person with a disability, but I'm not stupid. You know? It was just the questioning, like how they would ask the questions, and sometimes they'd often go really slowly [family member] be like, I understand!

Despite these negative experiences, the majority of participants who had accessed services after the law change reported experiencing positive attitudes when accessing abortion services. Participants highly valued a relational approach, kindness and a lack of judgement from health professionals. One participant noted that the online abortion provider they engaged with “were really like, more, a lot more caring, and empathetic. And like, when they call to make an appointment, or speak to me it felt really caring.” Another participant stated that they did not receive any negative or ableist responses from the variety of healthcare professionals they engaged with and that they were grateful for how they had been treated, noting:

And she treated me, it was fine. It went fine. And the whole process, and in terms of the, the, the, I don't know, the doctor that gave, that talked me through

it, and then I-, and then the lady that gave me the scan, and then that same doctor that gave me the medication. They were, they treated me fine, like there was no, there was no sense of anything.

7.2.2.4 Information and communication

Many participants spoke about the critical role of information and communication in their experience of abortion services. A lack of access to timely and appropriate information created barriers for some participants who felt they needed more information about the process. For instance, one participant said they did not realise the process would occur at multiple healthcare facilities, leading to confusion and frustration. Another participant emphasised the importance of understanding the full process, including what happens before, during, and after the abortion. One participant felt they did not have all of the information they needed to self-administer medication at home and felt stressed by this process and unsure whether they were doing it correctly. Another was surprised by the emotional impact after accessing services and would have liked to have been better prepared for this, noting that “Information, yes, about the person, the process, but also what needs to happen afterwards.”

Participants also spoke about the lack of accessible information and communication. One participant who accessed services prior to the legislation change and who was hard of hearing noted they had had difficulty with reading and writing, which meant they had to bring a support person with them while accessing services. The participant said they would have preferred not to do this as it limited their privacy, and would have preferred the health practitioner to provide information about the process in an accessible format and speak more slowly.

Another participant who had accessed services after the legislation change also struggled to obtain information in an accessible format and would have liked videos in New Zealand Sign Language (NZSL) to explain the process, noting that this would have enabled them to rewatch the video as many times as needed in the privacy of their home. This participant spoke positively about accessing an interpreter throughout the abortion process and valued being able to choose the interpreter. Another participant also spoke positively about accessible communication, noting that their doctor responded immediately when told about their disability:

But I think once I got in, spoke to the doctor, and told him about my disability and the fact that I've got severe anxiety and depression, he was like, okay that's cool. I will be firm and slow. I will try not to use big words, because as a doctor we tend to, and we can take as many breaks as you want.

An identified strategy for improving communication and information is to ask disabled people what their needs are, rather than making assumptions. For example, a family supporter described how health professionals spoke so slowly to the disabled person they were supporting, that it was clear the professional had assumed the person had a significant learning disability when, in fact, their disability was mild and this accommodation was not needed:

just ask like, like, there's no need for them to become the disability specialist. Just ask. That would have really made things more comfortable, like, you know, would have made it a little bit easier for everybody.

Another participant shared they had not disclosed their disability status with the abortion provider. The participant acknowledged that had they shared this information (including their access needs) their experience may have been improved:

I don't think it was even discussed. Like as to whether I had a disability. It wasn't something I told them but I wasn't asked either. Which you would looking back now talking to you now, man, you think that it would be like a screening question.

7.2.2.5 Financial barriers

One participant reported transport costs as being a barrier to abortion services. According to the website of a national abortion telehealth service, there is support for transport-related costs associated with accessing abortion services¹⁰. However, the participant did not appear to know about this support. Another participant recalled how their GP did not charge a consultation fee, which enabled them to attend an appointment and make an informed decision. While financial barriers related to the cost of abortion services were not often highlighted, participants did note that the financial implications of accessing such services extended beyond the cost of the

¹⁰ DECIDE. (n.d.). *Considering abortion*. https://www.decide.org.nz/en/abortion-services/considering-abortion/#section_what-is-abortion

procedure itself and included the costs of child care, travel and taking leave from work. These additional costs became a financial barrier for one participant who lived rurally:

And so it was just- and I was I was working full time at the time as well. And it was just and not necessarily high paid. So it was just, it's in terms of petrol in terms of taking, like, annual leave or whatever, all these kinds of things, and then having a child as well...

7.2.2.6 Mental barriers

Mental barriers (also called mental access) refer to a person's ability to access services "with a sense of mental wellbeing and safety" (Donald Beasley Institute, 2022, p. 21). While mental barriers were not a prominent theme, participants did experience some misgivings about accessing abortion services, which made the process more difficult for them. For some, these misgivings came from previous experiences they had of ableist attitudes and responses. One participant spoke of having their guard up when accessing services, noting "I probably have my barriers up all the time anyway, because I'm disabled and because of the way people treat us and treat my specific disability especially." Other mental barriers related to past medical trauma with one participant feeling worried they would receive the same negative treatment they had received from abortion services when they were younger. Another participant experienced mental barriers due to anxiety and fear of entering new medical spaces where they had a lack of control over who they would interact with.

7.2.2.7 Physical spaces

A positive finding was that participants did not report any physical barriers that impeded their access to services. However, no participants with a physical disability that restricted their movement chose to participate in this study, which may have limited the data relating to this theme. Mental barriers shaped participant's preferences for how physical spaces within abortion providers were organised. For example, one participant preferred abortion counselling services to be located away from the hospital as they felt the physical separation would create greater mental space and safety.

The legislation change:

- **Barriers to access:** The legislation changes have led to an increased number of abortion providers, including online telehealth services. Participants living rurally or in small towns benefited from this change as it increased their ability to choose which service they engaged with and decreased barriers experienced by long waiting lists at in-person health centres. While this is a positive development, barriers to accessing services remain, showing the limitations of legislation change.

Recommendations:

- **Accessibility - transport and online services:** Participants noted that not all disabled people have access to private transport or have a support person who can drive them to abortion services. It was therefore recommended that private accessible transport be made available to disabled people expressly for the purpose of accessing abortion services: “having to sit on a train or a bus when you’re off to go to an abortion clinic is just trauma in itself isn’t it? ... would be nice if they sent out at least, you know, Miss Daisy’s or taxis or something for people?” A participant had positive experiences with online telehealth services, so continuing to invest in online platforms is recommended.
- **Accessibility - information and communication:** Participants struggled to access information and communication in alternative formats. It is therefore recommended that healthcare and abortion providers ensure information is translated into a variety of accessible formats while also asking individuals what support they need. One participant noted they would have appreciated being asked about their disability as a screening question. It is recommended that healthcare and abortion providers find ways to respectfully identify a person’s access needs (and optional disclosure of health and disability conditions) as part of the screening process. Disability rights training focused on communication and social interaction may also help to remove barriers as well as training regarding supported decision-making.
- **Accessibility - information:** Participants valued being provided with information regarding all stages of the abortion pathway. It is recommended that individuals be provided with accessible information about the different types of abortions, what will take place at each stage of the process, how to prepare for self-administering an early medical abortion at home, as well as what steps to take regarding pain management, recovery and aftercare.
- **Accessibility - increased resources in rural and small town areas:** Participants struggled to access services in small towns and rural areas due to long wait lists and a lack of services. It is therefore recommended that more resources are devoted to small towns and rural areas throughout Aotearoa. Furthermore, it would be beneficial to promote the post-legislation increase in abortion providers, including online telehealth services (including in alternative formats).
- **Accessibility - financial barriers:** Participants often required additional support to access abortion services including childcare, petrol costs and leave from work or

school. It is recommended that abortion services provide additional support for disabled people accessing services, including petrol and taxi vouchers, and onsite childcare or information about nearby childcare.

- **Accessibility - mental barriers:** Mental barriers were often ameliorated by relational and accessible interactions with health practitioners. One participant described feeling better about their engagement with services due to their doctor immediately being responsive to their disability, while another felt increased comfort and trust when a nurse was kind and respectful of their right to make a decision about their pregnancy. The availability of online telehealth services also mitigated mental barriers.
- **Choice and control:** Participants emphasised the importance of being able to choose their supports when accessing services. For example, for one participant it was crucial that they were able to choose a NZSL interpreter, while another said it would have been helpful for their health professional to ask what support they wanted and needed. Other participants living in rural areas or small towns also indicated that the lack of choice in services was a barrier.

7.2.3 Post-abortion experiences

After an abortion, people may access follow-up care, which could include follow-up appointments with their abortion provider or GP, discussions about contraception, or accessing external counselling services.

7.2.3.1 Contraception

Contraception is one aspect of post-abortion care. Healthcare providers must offer people several options for future contraception, and these options should consider the person's individual requirements and preferences. Some participants said they were provided with limited options about contraception after their abortion, and some participants' preferences were not considered. One participant with Attention Deficit Hyperactivity Disorder (ADHD) who accessed post-legislation abortion services noted that their abortion provider was unable to offer a suitable way for them to access contraception:

So it's like when I talked to the nurse from the woman's clinic, at the one month follow-up appointment and said that she was 'I'd suggest you either go to your GP or family planning. Because we can't prescribe that over the phone'. But I just thought there would be some sort of, 'we'll pass this information on to whoever', rather than leaving it in my hands, because I have ADHD and there's 50 million things going through my mind. And by the time I actually get around to doing that. It's not straight away. So yeah, just little things like that.

However, other participants, who had all accessed services after the legislation change, reported positive experiences with their healthcare provider offering appropriate information and access to their choice of contraception post abortion. One participant found the process of choosing and accessing contraception smooth and barrier free, describing it as “pretty easy,” while another found that the internet had an overwhelming amount of information and chose contraception based on the advice of their trusted and long-time GP. Another participant said that even though they were not provided with their first preference for contraception (sterilisation, as discussed in the next section), they were happy with how their GP talked them through the options and their eventual decision to use the mirena: “I remember saying to them that this is good enough for now. It’s not what I want but I’ll take it. Anything to stop me getting pregnant again. Remind myself to take a medication or yeah.”

7.2.3.2 Sterilisation

Sterilisation refers to a range of permanent contraception options for people of all genders (Abortion Services in New Zealand, 2020). Throughout history, disabled people have been encouraged or coerced into undergoing sterilisation procedures (Reilly, 2015). This history was touched on by participants, with one participant expressing disgust at such coercion:

I think it is complete and utter [rubbish]. Sterilising, sterilising disabled people, so you can manage them, [bugger] off [laughter]. Sorry, but then women who want to, who are not disabled and want to be sterilised. It's like, it's your body, you should be able to do what you wanna do. If you wanna take your tits off, then take your tits off, you know. It's like 'oh you might change your mind' well that's my problem, that's my problem.

No participants described being coerced into a sterilisation procedure. However, one participant described their wish to be sterilised as they had already had one child, an ectopic pregnancy, and had accessed abortion services twice, and as a result, felt confident they did not want any more children. However, their healthcare provider was reluctant to provide this procedure despite the participant pleading with them to perform it. The participant described this as “devastating” as they felt it should be their choice. The participant questioned whether this decision by the healthcare provider was tied to their disability and an assumption of a lack of competency:

And I don't know if they're taking my disability into account and the fact that I can't think I'm trying to think they don't think I can make the right medical decision on my own regarding having my tubes tied ... but I know what I want and I'm gonna keep pleading until I flippin get it. I reckon like my disability has been like a huge thing that's actually maybe stopping them from doing what they like that for me getting the abortion. But I just don't see how it would make a difference.

7.2.3.3 Aftercare

Aftercare following abortion services can include pain medication, comfort items (hot water bottles), and/or emotional support through wellbeing check-ups. One participant received post-abortion check-up phone calls from their abortion provider and found this to be helpful. However, they also flagged that post-abortion care should not just be a short term support, but that care and counselling should be offered in the months post-abortion in order to support people who take time to process their experience.

A few participants spoke about their feelings post-abortion and how the emotional weight of their decision stayed with them for a long time. These participants felt underprepared for those feelings, which was exacerbated by not having support available during those times.

like three months down the track, you know, you go through the process and they, their follow up was great, the week after type thing, but there's nothing like three months after or six months after to go okay, like so, how are you doing now type of thing?

This same participant described the ways in which they would have liked a personalised approach regarding aftercare:

But yeah, just more, I guess, more questions asked about what people are okay with or how to help them? As far as yeah. Is it going to be easy on the day? Would you like a phone call? Or would you like me to just text and check on you? If you don't reply, I will need to give you a call after an hour just to, you know, make sure you are okay. But there just to have that option for people...

A participant who had an abortion prior to the 2020 legislation change was not offered any follow up care, even when she had an infection from the procedure. While the healthcare provider prescribed medication for the infection, they did not provide support or follow up on physical or mental wellbeing. One participant shared they would have liked to have had the option of sharing their abortion medical notes with their GP

and felt that this would have enabled the continuity of aftercare by the GP. This participant described how a few months after the abortion their mental health declined, but without access to the medical files it was difficult for the GP to provide the necessary support.

Many participants highlighted the ongoing emotional impacts of having an abortion and were often surprised by how affected they were after accessing abortion services. Even though participants often felt secure in their decision to access services, some identified the need for better and more on-going post-abortion care. Abortion after-care also included preventing protests outside abortion providers, with one participant experiencing such protests as they entered and left the abortion clinic prior to the legislation change. This participant experienced protests as deeply traumatising and spoke positively about the recent changes regarding protests, stating “I think the getting rid of those people out the front, has been a good first step. Because if someone in the cognitive space that you’re in”

Additionally, one participant highlighted the need for cultural safety and responsiveness within aftercare services. For example, a participant noted that it was important in Māori culture to bury the product of conception¹¹ but their healthcare professional had not discussed this with them prior to self-administering the abortion at home, which led to anxiety and distress. The participant noted that it was important “to talk to people about the options to bury in your garden, or, you know, so that people aren’t just left to try and create a safe space for themselves in terms of the disposal.”

Another important aspect of aftercare is support participants have from their family, friends and close relations they chose to share the experience with. One person who did not find official abortion services aftercare useful mentioned that their ex-partner was their main source of support. Another participant who supported their family member shared how important it was for the family to wrap around the family member and support the person to heal from the experience: “you're not in isolation, you don't hurt in isolation, you also don't heal in isolation.”

¹¹ A term which refers to placental and/or foetal tissue.

7.2.3.4 Post-abortion counselling

Participants who had abortions before the legislation change highlighted that they were not offered post-abortion counselling, while participants who had accessed abortions more recently, had been offered post-abortion counselling. This reflects the change in legislation, which mandates that abortion counselling must be offered but is not mandatory. When asked whether they had been offered counselling prior to the legislation change, one participant described how dangerous it had been to not be offered this service:

Oh ... no. No. And that's like really dumb because I went and did dumb things straight after the fact and made myself very unsafe. But that's because I was not ok in my head. You need, there needs to be a catch at the other side...

Participants who were offered counselling after the legislation change had different experiences, some opting not to engage in the service while others used it to varying degrees. One participant described how they chose not to do counselling because they felt secure in their decision. However, this participant also felt anxiety about potentially having to justify their decision within counselling sessions, revealing a mental barrier to accessing abortion counselling. Another participant who chose not to access post-abortion counselling immediately after their abortion, noted that in the following months they would have liked to have had the option of accessing counselling:

I think more discussion around like the counselling, or even just if you do decide in three months or six months, you can come back to us type of thing. Because I know mental health wise, like if I go to my GP now and say, I'm struggling, I want to see a counsellor. It's almost impossible to do it through your GP ... But if that option is still available, it would be good to know.

Other participants had various experiences regarding how many counselling sessions they wanted to access. For example, one participant noted that the hospital provided three or four counselling sessions and they had accessed two of them, feeling that was all they needed. One participant who accessed post abortion counselling attended more than ten sessions and was happy to be able to access so many. The participant spoke about these sessions positively, highlighting the importance of being able to discuss their life holistically within them. Another participant drew attention to the variety of spaces in which post-abortion counselling takes place. The person the

participant supported did not access professional counselling but shared their experiences with their GP and family, both of whom they had a long-term and trusting relationship with. This participant also noted that it would have been helpful for the person they supported to have the option of engaging with a culturally specific service after they had accessed abortion services.

The legislation change:

- **Post-abortion counselling:** Participants highlighted how critical abortion counselling services are, and the dangers of not offering these services. Since the legislation change, some participants chose to engage in counselling and some did not, with one participant highlighting the importance of having choice and control. This indicates that the legislation change that requires counselling services to be optional has been a positive one, allowing services to respond to people's individual needs.

Recommendations:

- **Disability rights training:** There is a need for health practitioners to have increased knowledge about disability, disability rights and accessibility needs. Health practitioners require training in how to respond to individuals who have different access needs in terms of post-abortion care as well as how to support their legal capacity. For example, respecting people's decisions regarding contraception.
- **Accessibility - counselling:** Individuals continue to experience mental barriers when accessing counselling due to fears they will have to justify their decision to access abortion services. It is recommended that the benefits and neutrality of abortion counselling be further promoted to allay such fears.
- **Enabling choice and control:** Individuals must be provided with autonomy throughout the abortion pathway. For example, it is recommended that health practitioners respect a person's choice to be sterilised as a form of permanent contraception while being aware of the history of disability eugenics and coercion relating to this procedure.
- **Cultural safety and responsiveness:** Participants emphasised that cultural safety and responsiveness should be made a priority in post-abortion processes. This could be achieved by providing culturally specific and accessible counselling services, and health providers showing knowledge and respect for cultural processes.
- **A person-centred and relational approach:** A participant described person-centred and relational approaches, noting: "it's more just more care taken or more inquiry made into the person rather than it being a process." Strategies for realising these values include offering a variety of accessible ways to engage in aftercare wellbeing checks and such checks being available for longer periods if required. Better coordination between GP and abortion providers is recommended to increase continuity of care based on a person's consent. It is recommended that individuals be provided with options as to the

number of counselling sessions they can access. Another important aspect is honouring the relationships individuals already have with their family, whānau, aiga and supporters. If a disabled person chooses to inform them, natural supports can play an important role in their abortion journey.

8. Kōrerorero / Discussion

The aim of this research was to explore the experiences of disabled people who have accessed the range of abortion-related services in Aotearoa. While participants shared a range of positive abortion service experiences, they also reported negative experiences such as abortion stigma, ableism and disablism. An intersectional approach to the analysis of such experiences, “encourages abortion stigma to be viewed alongside other forms of reproductive stigma” (Millar, 2020, p. 6). The next section of this report discusses the key themes of stigma, ableism and disablism, and intersectionality, as related to participant experiences.

8.1 Stigma

Negative perceptions about abortion can lead to abortion stigma (Astbury-Ward et al., 2012). By decriminalising abortion, the Abortion Legislation Act 2020 took a major step towards addressing this stigma. The impact of this critical change in legislation is made clear when comparing participant experiences prior to, and after, the legislation change. Participants who accessed services prior to the legislation change experienced jarring interactions with healthcare providers. Conversely, all of the experiences shared by the five participants who had accessed abortion services after the legislation change highlighted positive encounters with health professionals.

However, this positive shift within healthcare providers did not appear to be reflected in wider societal attitudes about abortion. Regardless of when the abortion service was accessed, participants did not feel like they could openly share their experience (or learn about the abortion experiences of others) due to stigma, which led to a sense of isolation. One participant shared that their motivation to participate in this project was to break away from this stigma.

I feel like I've been downgraded in society, because that's a decision that I've made, or is it a taboo subject, that's not likely to be that's not going to be shared, you know, that you don't discuss with people. So if more people had awareness, even about abortion, and that it's not an easy decision, you know, and that you've got to sort of think about being in that person's shoes. I think it would make you feel more comfortable, you know, and then you'd have an idea about what it means more and to understand that other person but the situation doesn't allow for that.

As a strategy for reducing stigma, participants suggested there is a need for more open conversations about abortion experiences and increased public visibility. This could include further research in this area to expand upon and continue conversations around equity and accessibility within abortion services.

8.2 Ableism and disablism

Ableism refers to the system of assigning value to people's bodies and minds based on societally constructed ideas of normality, productivity, desirability, intelligence, excellence, and fitness (Lewis, 2022). While ableism refers to the preferential treatment of people who conform to such socially constructed ideas, those who deviate from these standards are considered to be a “diminished state of being human” (Campbell, 2001, p. 44). Disablism, refers to the “discriminatory, oppressive or abusive behaviour arising from the belief that disabled people are inferior to others” (Miller et al., 2004, p. 9). As a direct result of ableism and disablism it is not uncommon for disabled people to internalise the idea that disability should be prevented, with one participant noting, “the fear that he would have [genetic condition] meant that I sought an abortion without knowing kind of health, how long, how far gone I was.”

Another example of disablism was shared by a participant who had an abortion prior to the legislation change. When it was revealed that the foetus had inherited the genetic condition, the participant felt like the health practitioner automatically expected an abortion to take place.

[the doctor said] 'yes, of course, you should have an abortion' here's the paperwork, let's get on with it, so. [...] I s'pose [I felt] relief [about the medical professional's response], but also kind of pissed off, right? I was like 'well that's a bit shit' for um, [...], kind of confirmed what society feels about disabled people.

It is interesting to note that such experiences were not shared by participants who had abortions after the legislation change. Instead, one participant recalled a respectful encounter they had had with a health professional:

the lady who did the scan, she said, 'all the best with whatever decision you make', and it was so lovely, like, it was a really lovely thing to say. 'Cos you do like you kind of have your barriers up and I don't know if that's [...] I'm disabled and because of the way people treat us and treat my specific disability especially. And

so, it was just nice in that time to have that lady say something so simple and nice.

Even so, the fact that this participant felt this was an unexpected response may indicate that such attitudes are not reflective of the wider health sector's, or society's, attitudes towards disability and disabled people's reproductive rights.

While explicit disablism appeared to reduce with the legislation change, some participants experienced an assumption of incompetence (Section 7.2.2.3) and erasure of their disability when their access needs were not considered as part of the screening questions (Section 7.2.2.4). This suggests the continued presence of subtle and more covert forms of ableism and disablism. Therefore, it is recommended that open conversations about a person's access needs to occur at the outset of, and throughout, the abortion pathway. Furthermore, disability and disability rights training should be provided to health professionals to increase understanding of both ableism and disablism, and the impact on disabled people's experiences of abortion services and reproductive justice.

8.3 Intersectionality

Participant characteristics such as age, disability type and ethnicity influenced their perceived or actual experiences of prejudice and discrimination by health professionals and abortion providers. It is not possible to understand participant experiences without considering intersectionality and the interconnected nature of multiple minority identities, which can overlap and lead to discrimination or disadvantage. During the interviews, participants talked about qualities that can improve health practitioners' responsiveness to intersectionality, including the ability to: 1) understand the nuances of a person's identity; 2) conduct respectful and easy communication; and 3) consider the person holistically. For example, one Pacifica participant felt that health practitioners did not have to have the same ethnicity or background as them, as long as they had these skills and were able to build relationships based on trust: "he's not the same culture but that proves to us that it's got nothing to do with ethnicity right? It's actually about, you know, the person and what you find is if they take the time to understand and to and build that trust [...]."

While abortion services appeared to have improved overall, participants shared instances where they felt part of their identity was either made invisible or overly pronounced. It was also noted that cultural safety and responsiveness is still lacking. For example, a Māori participant shared that their disability became the primary focus when interacting with an abortion provider. While they did not feel the immediate need for a culturally-specific approach, they would have appreciated the offer of support from someone who shared their cultural identity:

I always feel, personally, that people don't see my culture as much as they see my disability. In, in, so it's more I feel more, I'm more sensitive to discrimination against, against my appearance or my disability. Because of my disability so yeah, there was obviously no kind of, there was nothing brought up about 'do you need someone from your culture to hold your hand? Or, or, or support you? Or-?' But I never asked for it as well, and I'd, you know. But that would be great.

Similarly, another participant shared they would have liked to have had the option of accessing a Pacific service provider:

I think even just an option, because I think they try and do it, of knowing there is Pacific Health Team available. Because for some families, they'll stay away from it because it's such a small place that everybody will be related then it'll be on the Pacific news, you know, the next hour, but it'll be on radio five MPI, but some families or some people and I wouldn't have minded that because it just shows our rawness around, you know, this, it's life the acceptance that this isn't?

It is recommended to create an option to access specific culturally responsive abortion providers to increase cultural safety and responsiveness within mainstream services throughout the abortion pathway.

9. Tūtohi / Recommendations

The final section of this report draws together the findings from the reviewed literature, researcher positionality focus groups, research findings, discussion themes, and feedback from the advisory group, to summarise three key recommendations for improving disabled people's access to abortion services.

9.1 Education and training

The first key recommendation is to increase education and training for health professionals. Disability rights training, co-developed with, and led by, disabled people should: encourage health practitioners to think critically about the eugenics history of reproductive services (National Partnership for Women & Families & Autistic Self Advocacy Network, 2021); increase practitioners' knowledge about the legal capacity of disabled people and supported decision-making (Davidson et al., 2015); strengthen practitioners' communication skills (Rotenburg et al., 2022; Tracy & McDonald, 2015); and enhance practitioners' knowledge about disability rights, accessibility, inclusion and Universal Design (Havercamp et al., 2021; Craig et al., 2022).¹²

9.2 Accessibility

Participants also described strategies for increasing the accessibility of services for disabled people, including: the provision of abortion information in a variety of accessible and alternative formats including NZSL; the creation of an accessible transport service specifically for travel to and from service providers; further investment in telehealth services; promotion of self-referral services; inclusive and accessible public conversations about abortion services aimed at decreasing stigma; the provision of additional support such as petrol vouchers and information about childcare; and increased promotion of the benefits and neutrality of abortion counselling.

¹² The design of products, environments, programmes, and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialised design (United Nations, 2006, Art. 2).

9.3 Principle-based approach

Throughout the research specific principles were emphasised as being critical to the delivery of disability inclusive and responsive abortion services: person centred, choice and control, relational service provision, cultural safety and responsiveness. The image below provides a graphic representation of these principles, followed by short descriptions of the key elements of each principle.

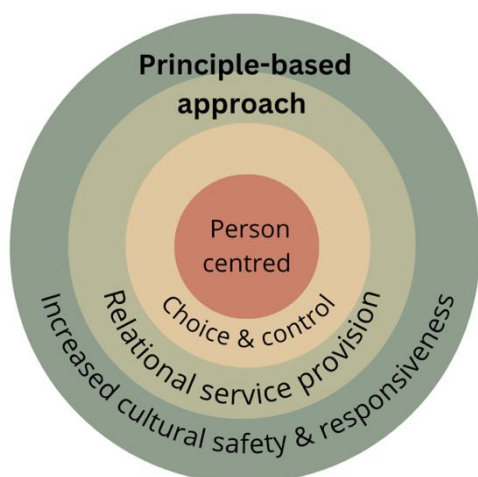


Image description: Four overlapping circles. On the top of the circles, the text says 'Principle-based approach'. The inner circle is orange and the text says 'person-centred', the second circle is tan and the text says 'choice & control', the third circle is light green and the text says 'relational service provision', and the outer circle is dark green and the text says 'increased cultural safety & responsiveness'.

Person-centred: Participants want to engage with person-centred services that are flexible and responsive to their individual needs. For service providers, this could include asking people about their needs; developing processes to respectfully identify a person's disability, condition or access need; and provide a variety of engagement options at each stage of the abortion pathway, especially within aftercare.

Choice and control: Participants valued having choice and control throughout the abortion pathway and wanted their autonomy respected. For example, participants wanted to choose where they accessed abortion services; for their decision to be referred to an abortion provider to be respected and actioned in a timely manner; access to, and choice between, a variety of supports and accommodations such as NZSL interpreters; and to be able to choose from a wide variety of contraceptive options with their contraceptive choices respected.

A relational approach: Participants also valued a relational approach within services, for example, highlighting the importance of having strong and respectful relationships

with GPs as a first point of contact. Participants spoke highly of health practitioners who provided warm and respectful interactions and also noted the challenges of not being able to build relationships with abortion providers, which negatively impacted continuity of care.

Cultural safety and responsiveness: Finally, participants emphasised the importance of cultural safety and responsiveness. Participants came to services with overlapping and intersecting identities, and wanted to be engaged holistically by services that were culturally safe and responsive - both in regard to ethnicity and disability culture. Participants wanted the option of engaging with accessible Māori or Pacifica-specific services as well as mainstream services that provide culturally safe and responsive counselling, culturally holistic aftercare and culturally safe discussions around burial processes.

10. Kupu whakamutuka / Concluding remarks

This study is the first of its kind to be undertaken in Aotearoa New Zealand. It aimed to both deliver a broad picture of disabled people's experiences of accessing abortion services and to increase understanding of the impacts of the change in abortion law in 2020. The literature was limited and focused on eugenics and the tension between the eugenics implications of prenatal testing and feminist discourses regarding a person's right to choose an abortion. This study provided an additional lens through which this context could be understood. It enabled the exploration of disabled people's experiences of these critical health services - services that disabled people have a human right to under Article 25 of the UNCRPD.

Within this study participants described positive experiences when accessing abortion services such as warm and non-judgemental interactions with health professionals, and receiving accessible information and communication. Some of these experiences could be directly linked to the changes in legislation, such as the ability to self-refer and abortion counselling. These findings demonstrate the tangible impacts that can follow from bold legislative reform when it is underpinned by a human rights framework. Despite these positive findings, however, self-selection bias is likely to have had an impact on the study, with people who may have had more challenging experiences choosing not to participate. Participants also described barriers to accessing services such as travel, rural and small town services, attitudes, inaccessible information and communication, financial, mental and physical barriers. To address these issues a variety of recommendations have been provided throughout the report.

This research has created space for starting a conversation about disabled people's access to abortion services in Aotearoa New Zealand. However, it has only begun to scratch the service of this complex topic. Further research is needed to continue this important conversation, particularly in the areas that have been highlighted throughout this report, such as service experiences of disabled people not represented amongst the current participants (for example, people living in residential services) and sterilisation.

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**Whakarakatira te tākata,
ahakoa ko wai, ahakoa nō hea.**

**Respect and treat all with dignity,
irrespective of who they are and
where they come from.**



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