Māori women and abortion: A Kaupapa Māori literature review

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Contents

1 Acknowledgements

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2 Executive summary

Abortion is the intentional act of terminating a pregnancy. It was legalised in New Zealand under certain conditions in 1977, but there are still extensive barriers to Māori women's access to abortion. The aim of the literature review undertaken was to identify barriers to and facilitators of Māori women's access to abortion, in order to inform research proposals. Future research proposals related to this topic will likely aim to lobby for changes to policy and legislation to make abortion more accessible for Māori women.

The scope of the literature review included articles, reports and other literature published between 2010–2018 related to abortion policy and Māori women's experience of abortion. Overall, thirteen pieces of literature were retrieved for review.

The literature review was conducted within a Kaupapa Māori methodological approach. Specifically, selected elements of a Mana Wahine theoretical framework informed the review: the elements were *Te reo Māori me ōna tikanga*, *Te Tiriti o Waitangi*, and *Whānau/whanaungatanga*.

Abortion is a common medical procedure in New Zealand. In 2016, 23.4 percent of all abortions were performed on Māori women. The vast majority of abortions in New Zealand are performed on the grounds that to continue the pregnancy would endanger the woman's mental health; however, there are no statistics available on this specific to Māori women.

Most of the barriers to Māori women accessing abortion are related to policy. Restrictive legislation unduly increases delays in the abortion process. Furthermore, the lack of adequate policy contributes to a lack of cultural competence in the provision of abortion services. Lack of cultural competence diminishes the quality of care that Māori women receive, and can violate their cultural safety.

Policy to implement cultural safety will facilitate Māori women's access to abortion services. Furthermore, supportive legislation will increase Māori women's tino rangatiratanga (self-

determination) when making decisions regarding abortion, reduce delays in the abortion process, and is likely to reduce stigma associated with abortion.

There is no literature on trans men and non-binary people's experience of abortion in New Zealand. Such research is critical to understanding these groups' experiences with regard to abortion. Māori trans men and non-binary people are arguably at more risk than Māori women, as minority gender identities often elicit unique discrimination within the health system.

Research also needs to be conducted into the role of whānau in the abortion processes of young Māori women, particularly the effects of parental involvement. Such research would inform policy and procedures to increase young Māori women's experience of tino rangatiratanga throughout the abortion process.

3 Introduction

Abortion is the intentional act of terminating a pregnancy (Law Commission, 2018). Though it was legalised under certain conditions by the Contraception, Sterilisation, and Abortion Act (1977), there are still extensive barriers to Māori women's access to abortion (Green, 2018; Lee, 2016; Silva & McNeill, 2008). A literature review was undertaken to outline statistics for Māori women's access to abortion; and identify barriers to and facilitators of Māori women's access to abortion services.

4 Rationale

The scope of the literature review, as outlined by Te Whāriki Takapou, included articles, reports and other literature, published between 2010–2018, and related to abortion policy and Māori women's experiences of abortion. As a Kaupapa Māori framework was utilised to shape and tailor the review, specifically, selected elements of Mana Wahine, literature related to Kaupapa Māori and Mana Wahine was also retrieved, including articles, theses, and book chapters. Overall, thirteen pieces of literature were retrieved to be reviewed. Among these was an article from 2008 (Silva & McNeill, 2008), included because it covered important information on geographical barriers that was not available in the more recent literature.

5 Aims

The primary aim of the literature review was to identify barriers and facilitators for Māori women's access to abortion, in order to inform research proposals. Future research proposals related to this topic will likely aim to lobby for changes to policy and legislation, to make abortion more accessible for Māori women.

6 Theoretical perspective

Elements of Mana Wahine provided a framework within a Kaupapa Māori methodological approach to focus and inform the literature review. A Kaupapa Māori approach assumes that the research conducted will be informed by Māori philosophies, centred around Māori people, and be of direct benefit to them (Jackson, 2015; Murphy, 2011; Pihama, 2001). Mana Wahine is a theoretical approach that uses a Kaupapa Māori perspective to analyse social issues that directly impact on Māori women (Pihama, 2001). The theory was selected because its elements centralise Māori women's viewpoints and lived experiences, and allow them to control and define their own understandings. The elements of Mana Wahine selected for the framework were: *Te reo Māori me ōna tikanga*, which ensures that research is grounded within te reo and tikanga Māori (Pihama, 2010); *Te Tiriti o Waitangi*, which outlines the Crown's obligations to Māori (Green, 2018; Jackson, 2015; Pihama, 2001); and *Whānau/whanaungatanga*, which centralises the importance of relationships in Māori culture (Pihama, 2001).

7 Findings

7.1 Abortion in practice: Statistics

One in four women in New Zealand will receive an induced abortion in their lifetime (Lee, 2016). In the year ended December 2017, 13,285 induced abortions were performed in New Zealand, of which Māori women received 23.4 percent (Statistics New Zealand, 2018). In the same year, 89.4 percent of abortions occurred during the first trimester of pregnancy (Law Commission, 2018). Medical abortions, which occur when a woman takes drugs that induce a miscarriage (Law Commission, 2018), accounted for 15.4 percent of total abortions performed in New Zealand in 2016 (Law Commission, 2018). There are no statistics available on the rate of medical abortions for Māori women.

Most abortions in New Zealand are authorised on the grounds that to continue the pregnancy would endanger the women's mental health (Law Commission, 2018). This accounted for 97 percent of abortions performed in 2016. The remaining three percent were performed on the grounds of 'handicapped child', 'seriously handicapped child', danger to life, danger to physical health, or a combination of these (Law Commission, 2018). There are no statistics available that indicate the grounds upon which abortions were authorised for Māori women in 2016.

7.2 Element 1: Te reo Māori me ōna tikanga

This element sought to highlight the role of te reo Māori me ōna tikanga (Māori language and culture) in Māori women's access to abortion. It was selected both because of the elements centrality to Kaupapa Māori research, and also its centrality to the lived realities of Māori people (Pihama, 2001).

7.2.1 Barriers

Lack of cultural competence from healthcare professionals is a major barrier to Māori women's access to abortion (Lee, 2016). This is especially true once the abortion process has started (that is, after referral), as a lack of cultural competence drastically reduces the quality of care for Māori women. Māori may have specific understandings of birth, death, bodies, and illness; furthermore, there are nuances in those understandings between different iwi and hapū (Le Grice & Braun, 2017; Lee, 2016). Lack of knowledge of these understandings, if only in relation to local iwi and hapū understandings, results in prejudice and discrimination against Māori women. At best, the prejudice may make the woman uncomfortable with her treating professionals. At worst, the treating professionals may violate the woman's tikanga, and in turn her cultural safety (Lee, 2016).

Lack of cultural competence is also likely to exacerbate the power imbalances between women seeking abortion and health professionals. People in professional roles have inherent power; as a result, Māori women may be deprived of a voice while seeking abortion services and therefore be unable to speak to her tikanga or wishes (Le Grice & Braun, 2017; Lee, 2016). This is likely to be especially true before referral to an abortion service; if a GP refuses to refer a woman to a service, the power imbalance may result in the woman feeling unable to fight for her right to seek an abortion.

7.2.2 Facilitators

With regard to the Te reo Māori me ōna tikanga element, abortion providers' cultural competence is the most prominent facilitator for Māori women's access to abortion (Law Commission, 2018; Lee, 2016; McCulloch & Weatherall, 2017). In practice, cultural safety for Māori is likely to include a company policy and culture that is congruent with Māori customs or tikanga (Law Commission, 2018; McCulloch & Weatherall, 2017). Specifically, health professionals who work in abortion services should be familiar with the concepts of *tapu* and *noa* and have a plan of action regarding how to practice in relation to those concepts (Law Commission, 2018).

The Law Commission (2018) and Abortion Supervisory Committee (ASC) (2017) reported that providers are required to have access to independent language interpreters for migrant and refugee women. This is because independent interpreters are more likely to reliably facilitate informed consent than a family member or friend of the woman; a friend or family member's translation might undermine the woman's informed consent (ASC, 2017; Law Commission, 2018). This same service, an independent te reo Māori interpreter, should be available to Māori women seeking abortion. Such an interpreter would facilitate Māori women's ability to practice tino rangatiratanga (discussed below in *Element 2: Te Tiriti o Waitangi*) by mitigating language barriers and allowing women the option to make decisions in their indigenous language (Law Commission, 2018).

7.3 Element 2: Te Tiriti o Waitangi

This element sought to highlight the Crown's obligations to Māori people as per Te Tiriti o Waitangi (1840), to illustrate where obligations are not being met, and where policy needs to be changed in order to meet them.

7.3.1 The Crown's obligations

Te Tiriti o Waitangi is a binding agreement between Māori and the Crown (Pihama, 2001). This agreement guarantees that the Crown will nurture Māori people's right to self-determination or tino rangatiratanga, as per the second article; and protect them and their rights of citizenship, as per the third article (Tiriti o Waitangi, 1840). Three specific principles implicit in Te Tiriti o Waitangi - protection, partnership, and participation - inform healthcare policy in New Zealand (Lee, 2016; Ministry of Health, 2014). These principles seek to provide equity for Māori health outcomes and empower Māori to have access to holistic healthcare (Green, 2018; Lee, 2016; Ministry of Health, 2014). As the Crown no longer has any direct power to implement the obligations outlined by Te Tiriti o Waitangi, it is now the State's responsibility to fulfil those obligations.

As per the second article of Te Tiriti o Waitangi (1840), the State is contractually obliged to protect Māori people's tino rangatiratanga. In relation to abortion policy, this means that the State must honour Māori women's right to control their sexual and reproductive health, and to obtain safe, timely, and free abortions (Green, 2018; International Planned Parenthood Foundation [IPPF], 2018; McCulloch & Weatherall, 2017). The IPPF (2018) argues that it is a fundamental human right for people to decide whether or not to have children, and to have the options and means to act on that decision.

7.3.2 Barriers

Political barriers to Māori women's access to abortion are relevant to the Te Tiriti o Waitangi element. This is because the State is responsible for both meeting its obligations to Māori under Te Tiriti o Waitangi, and for writing and maintaining legislation in New Zealand. Legislation ultimately directs policy.

Restrictive policy and outdated legislation are the most prominent barriers to Māori women's access to abortion. Current policy accounts for the majority of delays in accessing abortion services and is also a contributing factor to stigma experienced by women who access those services (IPPF, 2018; Law Commission, 2018; Lee, 2016; McCulloch & Weatherall, 2017). Delays are detrimental to Māori women's access to abortion services. Research suggests that the earlier a pregnant woman seeks an abortion, the longer she tends to wait to receive the service (Lee, 2016). Furthermore, the fact that abortion remains under criminal legislation deters practitioners from referring women to abortion services or providing the services themselves (Law Commission, 2018).

Under current legislation, referrals for abortion must come from a GP; referral from other health professionals, such as nurses or midwives, and self-referral are not permitted (Law Commission, 2018). Currently, no legislation exists to mediate the consequences of a GP's unwillingness to refer women to abortion services. While the ASC recommends that GPs who conscientiously object to referring a woman to abortion services should instead refer her to a GP who will, GPs are not mandated to do so (Law Commission, 2018). This is problematic for women who are unable to navigate the labyrinth that is the healthcare system, and some may stop seeking abortion at this stage of the process. Therefore, current legislation contributes to the undermining of Māori women's tino rangatiratanga (IPPF, 2018; Lee, 2016).

In addition to the requirement of a GP referral, under current legislation an abortion must be authorised by two certifying consultants to be legal (Law Commission, 2018; McCulloch & Weatherall, 2017). A woman seeking an abortion must give a reason for the abortion that satisfies both consultants, to avoid one of them declining authorisation and delaying the process (Law Commission, 2018). The vast majority of abortions are authorised on the grounds of danger to mental health. As outlined above, in order to acquire an abortion women are required to profess that they are 'mad', which also serves to undermine their tino rangatiratanga (Leask, 2013, p. 116; Leask, 2014; Lee, 2016; McCulloch & Weatherall, 2017).

The State is responsible for the geographical and financial barriers that limit Māori women's access to abortion. Location of services has been identified as a major barrier to access, particularly for vulnerable populations such as rural Māori in, for example, Gisborne (Law Commission, 2018; Lee, 2016; Silva & McNeill, 2008). Not all district health boards (DHBs) have abortion services available, and often women must travel great distances to obtain those services (for a full overview, see Law Commission, 2018, pp. 38-40). Geographical barriers in turn create financial barriers; women who have to travel to access abortion services often pay for travel, accommodation, childcare and time off work, as well as paying for the service itself (Lee, 2016). The ASC recommends that DHBs provide funding for transport and accommodation costs to mitigate some financial barriers (Law Commission, 2018). However, at best, these costs are reimbursed rather than paid up front; at worst, women receive no compensation, leaving them financially disadvantaged or unable to access services (Law Commission, 2018).

7.3.3 Facilitators

With regard to the Te Tiriti o Waitangi element, directly addressing restrictive legislation is the most prominent facilitator for Māori women's experience with abortion. Green and Simpson (2013) found that the decriminalisation of sex work increased sex workers' level of safety, particularly in terms of

public harassment, and increased emotional comfort regarding their work. This is likely to be generalisable to the decriminalisation of abortion, as supportive legislation and policy would increase accessibility and decrease stigma associated with abortion.

Although doctors should retain their right to conscientious objection, legislation should exist to mandate that those GPs refer women to another GP who will assist with the abortion process (IPPF, 2018). Women who are refused assistance from their GP may not be able to continue to pursue an abortion and so are effectively barred from services. This is especially true in rural areas where it is notably more difficult to find a GP who will make a referral to abortion services (Law Commission, 2018), and for women who lack the resources to pursue other avenues to obtain an abortion.

Removing abortion from the Crimes Act (1961) and adjusting the referral process for abortion in the Contraception, Sterilisation, and Abortion Act (1977), including only permitting GP referrals and requiring two certifying consultants to authorise an abortion, will drastically reduce delays in the abortion process and may also increase the number of practitioners willing to provide abortion services (Law Commission, 2018). The scope of referral pathways should be expanded to include other health professionals (Law Commission, 2018).

Adjusting the above legislation may also pave the way for policy changes, which would in turn increase the functionality of the abortion process. This would ensure that the healthcare system is less likely to fail people, and so increase Māori women's tino rangatiratanga (Lee, 2016). Adjusting policy may also increase cultural competence in the healthcare system, in relation to abortion. Health professionals' cultural competence supports their provision of client-centred care, which supports Māori women's tino rangatiratanga (Lee, 2016).

Most notably, policy must exist and be enforced regarding the need to tailor healthcare professionals' level of involvement in their care of clients (Lee, 2016). Some Māori women are able to navigate the abortion process well; others are not. Health professionals must gauge which level of involvement – passive or active – will best support the client's tino rangatiratanga (Lee, 2016). Such care will decrease delays for abortion services, increase Māori women's understanding of the process, and also likely assist with accessing other needed services, such as counselling or social welfare (Lee, 2016).

7.4 Element 3: Whānau/whanaungatanga

This element sought to highlight the role of relationships in Māori women's access to abortion, both interpersonally within whānau and between organisations.

Whānau is a broad term that includes immediate family members (such as parents, siblings, children, and intimate partners), wider family members (such as grandparents, aunts, uncles, cousins, and so

on), and members who are whāngai (that is, adopted within an extended family). Whānau relationships are a chief source of support for Māori people, and might also include other relationships, such as with friends (Le Grice & Braun, 2017; Murphy, 2011; Pihama, 2001).

In relation to abortion, relationships within communities are also imperative (IPPF, 2018). This might include physicians co-operating with other health services (such as counselling or social welfare) to extend support for women who seek abortions.

7.4.2 Barriers

Currently, there is little research on the impact of parental involvement on young Māori women who seek abortions. Though the Care of Children Act (2004) protects young women's (under 16 years) privacy, welfare and best interests 'from all persons, including members of [her] … whānau, hapū, and iwi', there is no empirical research on how this is achieved in practice. The risk of whānau involvement (including parents), particularly if there has been an instance of rape or there is risk of domestic violence, is likely to be a barrier for some young Māori women seeking abortion (IPPF, 2018; Law Commission, 2018; Lee, 2016).

Societal stigma within communities is likely to be another barrier for Māori women's access to abortion services (IPPF, 2018; Le Grice & Braun, 2017; Leask, 2013). Demonstrations from anti-abortion groups at abortion clinics are generally distressing for women on the day of the procedure. Furthermore, stigma makes it difficult to talk about abortion with whānau, friends, and professionals, which restricts the sharing of information regarding abortion services (Lee, 2016).

As discussed in *Element 2: Te Tiriti o Waitangi*, practitioners who stigmatise abortion can and do refuse to help women who seek abortion services. These practitioners effectively prevent women from accessing the services they need, particularly when they refuse to refer women to other practitioners who are willing to help (IPPF, 2018; Law Commission, 2018). Where professionals do not adequately collaborate during the abortion process, barriers to services are also created. It is likely that a lack of communication between services – such as GPs and abortion institutions, or institutions and counselling services – delays the abortion process.

7.4.3 Facilitators

Relationships can be nurtured between abortion services (such as counselling, social welfare, and contraception providers) so that patient care is tailored to suit the individual (Lee, 2016). Particular attention needs to be paid to women who attend abortion services on their own; ideally, they should be referred to other services at the level that is appropriate for them (that is, the level of professional participation that best supports their tino rangatiratanga) (Lee, 2016). Furthermore, there should be collaboration between GPs, so that women can be referred to another professional when their GP is

not willing to help with the abortion process. Collaboration between abortion providers, particularly between public and private, should also be integrated into practice (Lee, 2016). Doing so may reduce some pressure on providers, which would decrease delays in the abortion process and on the day of the procedure, and increase the attention to quality of care.

Research shows that whānau support is a prominent facilitator for Māori women's access to abortion (IPPF, 2018; Le Grice & Braun, 2017; Lee, 2016). Le Grice and Braun (2017, p. 156) found that "a woman's … ahua [the way they appear physically and spiritually] is quite different" when she goes through the abortion process alone. Whānau support is also likely to reduce stigma or mitigate the effects of existing stigma (Lee, 2016). Including whānau in the abortion process is more likely to support the woman's holistic wellbeing (Law Commission, 2018). Research is required into how whānau support can be encouraged and nurtured through the abortion process.

8 Conclusions

8.1 Summary

Abortion is a common medical procedure in New Zealand. In 2016, 23.4 percent of all abortions were performed on Māori women. The vast majority of abortions in New Zealand are performed on the grounds that to continue the pregnancy would endanger the woman's mental health; however, there are no statistics available on this specific to Māori women.

Current legislation and policy accounts for the majority of barriers to Māori women's access to abortion. Restrictive legislation unduly increases delays in the abortion process, requiring women to speak to multiple health professionals to have an abortion authorised. Furthermore, GPs who conscientiously object to referring women to abortion services greatly disadvantage Māori women, who may not be able to obtain a referral elsewhere. Lack of adequate policy also accounts for lack of cultural competence in abortion services. This in turn diminishes the quality of care that Māori women receive, and can violate their cultural safety.

Societal stigma affects whānau and communities and may inhibit Māori women's access to abortion. For young Māori women in particular, whānau and parental involvement may be a barrier to accessing an abortion where whānau hold stigmatising views about abortion. Furthermore, stigma makes it difficult to talk about abortion with whānau, friends, and professionals, which restricts the sharing of information regarding abortion services.

Facilitators of Māori women's access to abortion services reflect the barriers identified. Policy to implement cultural safety would be invaluable in improving the quality of care that Māori women receive from abortion services. Furthermore, supportive legislation would increase Māori women's

experience of tino rangatiratanga when making decisions regarding abortion, reduce delays in the abortion process, and would likely reduce the stigma associated with abortion. Particularly for Māori women, the practitioner's level of involvement throughout the abortion process must nurture the woman's tino rangatiratanga. Collaboration between abortion providers and other services will facilitate services that are tailored to individuals; this is especially important for women who attend services on their own. Collaboration between GPs is urgently required to ensure that women whose GPs refuse to provide a referral to abortion services on the grounds of conscientious objection are still able to access the appropriate services.

8.2 Where to from here?

There is no literature on trans men and non-binary people's experience of abortion in New Zealand. Such research is critical to understanding these groups' experiences with regard to abortion. Māori trans men and non-binary people are arguably more at risk than Māori women, as minority gender identities often elicit unique discrimination within the health system. Furthermore, it is possible that rates of refusal for abortion services are higher for these groups. Research that focuses on these population groups would identify the issues and, potentially, strategies to address those issues.

Research needs to be conducted into the practice of cultural safety in abortion services. Empirical evidence is required to understand the consequences of both the presence of cultural safety and the lack of it.

Research also needs to be conducted into the role of whānau in relation to young Māori women's abortion processes. In particular, there is no literature on the effect of parental involvement on the abortion process. Such research would inform policy and procedures to increase young women's tino rangatiratanga throughout the abortion process.

Finally, research needs to be conducted into whether or not current legislation intended to protect women seeking abortion (such as the Care of Children Act, 2004) is effective in doing so.

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