Service Users' Experiences of Tele-Health Abortion Services in Aotearoa (New Zealand)

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Charmaine Patricia Sutherland

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Abstract

The Aotearoa (New Zealand) national abortion tele-health service, *Decide*, was launched in 2022, following legal abortion decriminalisation in 2020. The safety, effectiveness, and user satisfaction of tele-health abortion have been reported in a large body of global research. However, service user voices are often overlooked, and little is known about service delivery, especially the extent to which principles of person- and relational-centred care are upheld. This study aims to address this oversight using a qualitative case study design focused on the *Decide* service. An online qualitative survey gathered data from 21 service users, which was analysed thematically alongside relevant textual data (seven national policy, guidance, and training documents on abortion care in Aotearoa, the *Decide* website content and researcher fieldnotes). A reflexive thematic analysis, guided by feminist standpoint, in conjunction with person- and relational-centred care frameworks, generated five themes: (1) the "Everything could be in done in my lunchbreak"; (2) Feeling seen, heard, and supported: Care is relational, supportive, and attentive to emotional wellbeing; (3) Care acknowledges interdependence and honours diverse support needs; (4) Care affirms autonomy and de-medicalises abortion decision-making; and (5) When person- and relational-centred care falls short: Structural strain and cultural stigma. The findings suggest that *Decide* services met the intended aims of being inclusive and emotionally responsive. However, pervasive stigma and structural inequalities undermine service delivery, resulting in fragmented care, erosion of trust in the service, emotional vulnerability, and suppressed autonomy. The findings highlight the importance of centring lived experience in service design and delivery, providing valuable insights for addressing service delivery issues and working toward reproductive justice.

KEYWORDS: Tele-health abortion, abortion, person-centred care, relational-centred care, feminist standpoint theory, abortion stigma, Aotearoa New Zealand

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Approval for this research was obtained from the Massey University Human Ethics Committee. I declare that I used Grammarly for checking punctuation when writing my research proposal in February 2024.

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Chapter 1: Background and Context

As in many nations throughout the world, abortion care in Aotearoa New Zealand (hereafter referred to as Aotearoa excepting organisational names) has historically been shaped by stigma, restrictive laws, and inequitable service access. Until fairly recently, abortion was managed under the *Crimes Act*, with serious punishments, barriers, and multiple consultation requirements (Lawley, 2022; Snelling, 2022). On March 24, 2020, Aotearoa made amendments to the *Contraception, Sterilisation, and Abortion Act* 1977, removing restrictions on abortion seekers prior to 20 weeks' gestation (Hudspith et al., 2022). Abortion is no longer considered a criminal offence and is considered a healthcare procedure by the Ministry of Health (Goodyear-Smith, 2023).

As part of Aotearoa's legal reform process, *Decide*'s national abortion tele-health services were launched on April 26, 2022. At that time, referrals and resources were available, and follow-up care and counselling were added to its services in July 2022. *Decide* became fully operational on November 1, 2022, providing tele-health (digital and telecommunication modes) and telemedicine (a remote dispensary for early medical abortion) (Donovan, 2019; Grossman, 2019; Ministry of Health, 2023). For ease, ongoing, I will refer to *Decide* as a tele-health service with the implicit inclusion of its telemedicine capability.

The *Decide* tele-health service provides abortion information, advice, early medical abortion, after-care, and counselling services. The service can meet the challenges women may face due to geographical remoteness, stigma, and other access obstacles (Seymour et al., 2022). It is also positioned to help create a sense of dignity and empowerment, and reduce stigma (Beddoe & Clarke, 2023; Srinivasulu et al., 2022). *Decide* is a free service operated by trained specialists that offers a convenient alternative service for those living rurally. Mail delivery of early medical abortion medication can be arranged over the phone, live webchat, or by completing an appointment form. Of those engaged with the service, the majority were

urban residents (n = 3,111), and the greatest proportion of rural service users were Māori. Remote residency tends to be associated with lower socioeconomic status, with service users accessing abortion services at a later gestation. Studies show later abortions pose greater health risks and distress (Brennand et al., 2025; Wasser et al., 2024). Overall, Māori access abortion services at a younger age and later gestation dates (Ministry of Health, 2024). Creating equitable abortion access is critical to indigeneity.

For abortion seekers balancing responsibilities such as caregiving and employment, tele-health abortion services provide them a convenient, private, and more autonomous experience (Tressan et al., 2024). However, as with all new healthcare implementations, a thorough examination of its impact on service users is necessary to ensure equitable, inclusive, and quality care is present. Despite literature showing tele-health abortion as a safe and effective health model with positive physical results (Cely-Andrade et al., 2024), examination of its alignment with person- and relational-care frameworks remains a major area of interest in achieving social and reproductive justice (Kerestes et al., 2022; Romanis et al., 2021).

The introduction of a national tele-health abortion service follows international trends in many "developed" countries. Tele-health has emerged as a healthcare model to address persistent access barriers to abortion care, despite law reform in many locations. International studies show that abortion law reform positively impacts access (Mishtal et al., 2022; Ramos et al., 2023) and reduces mortality and morbidity rates (Clarke & Mühlrad, 2021; Ishola et al., 2021; Latt et al., 2019). Despite these positive outcomes, barriers to abortion care access persist, including cultural, geographical, social, and structural barriers. These are particularly salient among Indigenous and minority groups experiencing intersectional marginalisation, as well as those residing in rural or remote areas (Heller et al., 2016; Macfarlane et al., 2024; Monchalin, Jubinville, et al., 2023; Monchalin, Pérez Piñán, et al., 2023; Wood et al., 2024).

Tele-health communication platforms vary throughout the world. Text, social media, email, telephone, and teleconferencing are usable modes. They may be facilitated by independent organisations or affiliated with a provider. Several international organisations have been providing tele-health abortion/medicine services for some years. These include the Alaskan Planned Parenthood clinics, Tabbot Foundation in Australia, Women Help Women and Women on Web (Endler et al., 2019; Shochet et al., 2023). However, it was the COVID-19 pandemic that brought abortion needs to the fore.

Tele-health services have become more acceptable in recent years, largely due to the COVID-19 global pandemic. As the world went into lockdown, women quickly found themselves faced with sexual health challenges (Oyediran et al., 2020; Romanis & Parsons, 2020). With escalating concerns for women's safety, many governments adopted tele-health/medicine services for abortion care (Chong et al., 2021; Ong et al., 2023; Spillane et al., 2021; Stifani et al., 2021), following advice that the services could ameliorate congested hospitals, reduce COVID-19 transmission, and assist rural and poor communities (Aiken, Starling, Gomperts, Scott, et al., 2021; Pleasants et al., 2022; Skuster et al., 2021).

In terms of service users' acceptance of Aotearoa's *Decide* national abortion tele-health service, there has been no detailed investigation. However, engagement with the service can be measured. Statistics reported by the Ministry of Health (2024) show that in the 2022–2023 period, the total recorded abortions performed across all method types (medical and surgical) were 16,277. Of these, 3,889 (24%) were provided through *Decide*. Early medical abortion procedures increased by 11%, while surgical abortions decreased by 12% compared to the 2021–2022 period. These data are collected from service providers. In the absence of any service user research, my research aim is to contribute to an understanding of service users' perspectives of the service, as I explain next.

Research Rationale

Despite reports expressing statistical efficacy of abortion care in Aotearoa, there has been little qualitative data that centres service users' voices about relational or cultural aspects of care. While statistical reports are invaluable in gaining knowledge about service uptake and clinical safety, they fail to capture the full care experience. This study responds to the need for abortion seekers' voices to be part of academic literature and service delivery knowledge in Aotearoa by examining their experiences with the *Decide* abortion tele-health service. I focused on how care was received, perceived, and navigated, drawing on feminist standpoint theory to foreground service users' knowledge, values, and social locations. I did this by analysing particpants' responses that detailed how it feels to be cared for and what those experiences might mean in terms of dignity, support, disconnection, agency, and empowerment. By analysing service users' perspectives and textual guideline data, I offer a critical lens on how tele-health abortion care is delivered in Aotearoa and its relational, emotional, and cultural impact. These insights are particularly urgent within the context of reproductive health, given the historical inequity abortion seekers have experienced.

The rationale for this study is that it can inform abortion care design and delivery by centring on those who are most impacted by policy and practice. Furthermore, my study contributes to the discourse on reproductive autonomy and ethics of care in evolving global and digital health concepts. Thus, my study offers timely insights into both tele-health's opportunities and limitations in abortion care, as well as providing practical recommendations and contributing to feminist health research.

Research Objectives

My study focused specifically on how participants' experiences aligned or diverged from principles of person- and relational-centred care. In doing so, I foregrounded the voices of those who have accessed *Decide* services, acknowledging that they are more than

recipients of care, but experts in their health needs and hold vital knowledge and insight that can inform and improve service delivery.

A significant aspect of this study is to understand what constitutes quality of care from the service users' perspective. By using a feminist lens that centres their voices, I hope to provide relational, cultural, emotional, and practical dimensions of tele-health abortion care in Aotearoa. While tele-health abortion services are promoted as convenient, confidential, and accessible, I considered whether the needs of all service users are met, particularly those experiencing social, cultural, or structural barriers, with a view toward contributing to enhancing service provision so that *all* service users experience trust, autonomy, cultural, and emotional safety. To this end, my study was guided by the following aims:

1. To explore service users' experiences of person- and relational-centred care aspects of *Decide*'s national abortion tele-health service.

2. To identify barriers and facilitators of service users' access to *Decide* services.

3. To examine how care is experienced across diverse social, cultural, and geographical contexts.

4. To produce coherent accounts of care that can inform service improvement, policy, and advocacy of reproductive justice.

These aims were guided by the following research questions:

1. How do service users describe their experiences of care through the *Decide* national abortion tele-health service?

2. In what way do these experiences align or diverge from person- and relational-centred care frameworks?

3. How do service users' social positions, such as daily commitments, culture, and geographical location, shape their care experiences?

4. How do service users' experiences and perspectives reflect broader narratives of gender, power, and marginalisation in abortion care?

Researcher Position and Reflexivity

My study takes a contextualist perspective and is guided by feminist standpoint theory, which, as I explain further below, highlights and locates people's lived experiences within their sociocultural context. My reflexivity is central to the use of the above-mentioned theoretical orientation and research methods, including reflexive thematic analysis. I aimed to show my ethical commitments, assumptions, tone, and line of thought through my field notes, comprising records of personal communications, taken from a diary I kept. These coded field notes incorporate my subjectivity and serve as an integral part of my meaning-making. As part of this, I highlight my own standpoint from the outset of this work and reflect here (and throughout) on how it shaped my rationale and ultimately my knowledge production.

My interest in tele-health abortion stems from my concern for social justice and ethical and equitable care. I have experienced and witnessed healthcare that has empowered service users and alienated them, hampering feelings of trust and emotional safety. These drew my focus to investigating what helps people feel seen, heard, understood, and supported when in sensitive health contexts. I wanted to know how our national abortion tele-health service delivers abortion care and how service users experience this. I was interested in how, and to what extent, dignity and agency are affirmed in vulnerable moments. The research is therefore grounded in my commitment to reproductive and social justice. Thus, I approach my

study with a commitment to augmenting the voices of marginalised and challenging abortion stigma.

Importantly, I am an insider-outsider to my topic of study. Insider-outsider describes a researcher who has some similar experiences to the study's participants (insider), including accessing abortion care, while also being an outsider, yet does not hold similar characteristics to participants (Dwyer & Buckle, 2009). I fit the insider-outsider status in that I did not use the *Decide* services to complete my abortion procedure. Dwyer and Buckle (2009) acknowledge historical arguments that a researcher's position, whether strictly an insider or an outsider, poses risks of biases and limitations. An insider may be too familiar, and an outsider may be too distant from the topic, clouding perceptions of both researcher and participants. However, an insider-outsider position lies in both camps, appreciating the relational aspects involved in study and the spirit of openness, honesty, authenticity, and a deep interest in participants' experiences, coupled with reflexivity. These attributes inspired in me a commitment to adequately represent participants' experiences. Throughout this study, I consistently critically examined my values, assumptions, academic knowledge, and lived experiences, at times sitting with the sometimes confronting literature, social and political abortion stigma, and my personal and participants' experiences of abortion. These reinforced my commitment to social and reproductive justice.

Overview of My Research Approach

My study employed a qualitative case study design guided by a feminist standpoint lens, in conjunction with person- and relationship-centred care frameworks (elaborated on below and explained in full in Chapter 2). The data comprised qualitative survey responses from service users and textual content from the *Decide* website, national organisational documents, and my field notes, which were analysed using reflexive thematic analysis. This research design utilised multiple data sources to provide a comprehensive view of the issue

from various angles, allowing for data crystallisation—to generate meaning through the interpretation of multiple perspectives, thereby enriching the knowledge produced (Ellingson, 2009). This research design also allows researchers to embrace the complexity and nuanced understandings that multiple data sources bring, in line with feminist standpoint theory. Using a case study approach allowed me to generate rich situated knowledge about the functionality of *Decide* services in relation to their impact on service users' experiences of care (Braun & Clarke, 2013).

A qualitative case study also enables a contextualist approach, which grounds the findings and locates service user perspectives (both systemic and social) that support or hamper reproductive agency and power. An important part of this was my intention to use this approach in a way that aligns with reproductive justice principles. First, centring the perspectives of marginalised groups, in this case, women accessing abortion services. This principle informed my decision to use a feminist standpoint lens, which helped ensure that service users' perspectives were foregrounded alongside the textual data. Feminist standpoint theory is an excellent theory for interpreting abortion care experiences, and one strength is its ability to highlight how power and voice are both acknowledged and marginalised, creating reproductive in/justice (Morison, 2023).

The second reproductive justice principle I wanted to uphold was that of health equity. In the context of my research, this meant attention to disparities in care and who may be underserved or excluded from services. This principle informed my decision to draw on the frameworks of person- and relational-centred care as benchmarks for care that promotes health equity. I give an overview of each of these lenses (the care frameworks and feminist standpoint theory) below as background to my study (and explain them further in Chapters 2 and 3).

Person- and Relational-Centred Care Frameworks

Person- and relational-centred care frameworks were developed to improve health equity, women's health-seeking behaviour, and quality of care (Beach et al., 2006; Sudhinaraset et al., 2020). These care frameworks prioritise dignity, trust, shared decision-making, cultural safety, and professional self-awareness. They are attentive to the health seekers' social contexts and emotional needs in treatment planning. Person-centred care focuses on autonomy-enhancing care, which calls for empathetic and effective communication skills (Cabello & Gaitan, 2021; Nelson, 2017; Sudhinaraset et al., 2020).

Relational-centred care extends person-care attributes and skills by emphasising the importance of the interactions between all those involved in a care process, including support persons and communities (Thachuk, 2007). This approach illuminates the social and emotional nature inherent in healthcare, acknowledging the co-construction of care through connection. For example, in a study interviewing 45 women from India and Kenya, findings showed participants most valued being treated with dignity, respect, and kindness (Baum et al., 2021). Studies show that providers who communicate with these attributes help women feel more empowered and report higher satisfaction with the service, resulting in positive health outcomes and service acceptance (Baum et al., 2021; Hoggart et al., 2024; Roncoroni et al., 2023).

These care frameworks challenge traditional care models, which isolate their practice from social and emotional contexts (Dwamena et al., 2012). They provide a standard of care by which to assess service users' experiences. Reports of feeling respected, heard, understood, informed, and generally emotionally supported show an alignment with person- and relational-centred care. Reports of cultural invisibility or ignorance, delayed communication or emotional disconnection show misalignment with care framework principles. These misalignments highlight a fracture between systemic realities and ethical inspirations. Person-

and relational-centred care approaches are therefore central to my research objectives, pointing to the impact of abortion healthcare on women's agency and power, sharing an affinity with feminist standpoint theory.

Feminist Standpoint Theory

While person- and relational-centred care frameworks attend to *how* care is delivered, feminist standpoint theory asks questions about *who*. Whose voices are heard and valued, and whose knowledge is used in shaping health systems? Feminist standpoint theory argues that marginalised groups have valuable insights into institutional practices because of their lived experiences and differing agentic power and social position from dominant groups' narratives (Harding, 2004). In this vein, abortion service users are epistemic agents (having the capacity to reflect on and use knowledge) with crucial understandings of abortion care delivery, equity, and reproductive justice. By applying standpoint theory in my study, I recognise that abortion seekers offer legitimate insight from marginalised groups, especially gendered, cultural, and remote geographic locations, including the stigmatised group of abortion seekers. It is pertinent to understand that their stories relate to power dynamics in healthcare and historical, political and social forms of reproductive control (Morison, 2023). In acknowledging abortion seekers' perspectives as valid, legitimate, and essential knowledge, my study resists institutional measures of quality or a single objective truth (Harding, 1995) and instead prioritises the meanings they draw from their care.

Further relevance in using feminist standpoint theory for exploring abortion care experiences is that tele-health abortion itself intersects with wider feminist scholarship concerned with bodily autonomy, medical gatekeeping, reproductive justice and the navigation of human connection and technological convenience. Using feminist standpoint theory to examine the impact of tele-health highlights logistical functions as well as relational, power, and service values. Moreover, feminist standpoint theory expresses a broader

commitment to social justice that foregrounds service users as experts of their own lives and needs (Hartstock, 2019). In abortion care, injustice can be experienced by not validating service users' pain or emotional needs, minimising and separating cultural identity in care provision, or creating a system that excludes certain persons or groups, resulting in inferior quality of care (Planned Parenthood Advocacy Fund of Massachusetts, 2025; Sorhaindo & Lavelanet, 2022). Feminist standpoint theory challenges these by arguing that a more responsive care system can be created, founded on the knowledge of those who are most affected.

Complementary to these concepts of situated knowledge (Haraway, 1988), feminist standpoint theory embraces reflexivity as an essential methodological and ethical component with the understanding that research is relational. Researchers approach their work from their social locations based on their lived experiences and values, which shape the relationship they build with their research, and their interpretations and conclusions (Braun & Clarke, 2022). This understanding is akin to person- and relational-centred care frameworks in that context, where the relationships between service users and health professionals are central to informing and creating overall outcomes.

Overview of Chapters

In Chapter 2 (Literature Review), I provide an overview of the existing tele-health abortion research and person- and relational-centred care frameworks. This includes studies examining their benefits and limitations and identifying ongoing gaps in service access.

In Chapter 3 (Methodology), I introduce the key tenets of feminist standpoint theory that I used as my theoretical lens, and my qualitative approach using reflexive thematic analysis and case study method. I then describe my specific data collection methods, participant characteristics, and the ethical considerations.

In Chapter 4 (Analysis and Discussion), I expand on five themes I produced from participants' responses, the *Decide* website, textual data, and my field notes. Four themes discuss service users' experiences aligning with person- and relational-centred care, including convenience, sensitivity, support, and autonomy. The fifth theme reveals misalignment with care frameworks, including emotional disconnection, cultural incompetence, stigma, and systemic limitations that hinder timely care and communication. These themes, analysed through a feminist standpoint lens, show how marginalisation and power shape experiences with *Decide.*

In the fifth and closing chapter (Concluding Discussion), I summarise my emergent understandings gained through this study and reflect on their implications for practice and policy. I explore the limitations of this study and future research recommendations. I revisit my research questions and emphasise the important contribution they make by foregrounding service users' voices in the development of ethical, quality, supportive, inclusive, equitable and culturally safe abortion care.

Together, I intend this thesis to present a richly nuanced exploration of how tele-health abortion via *Decide* was experienced by those who engaged with its services and what story these experiences tell about relational, cultural, and political aspects of abortion care in Aotearoa.

Chapter 2: Literature Review

Aotearoa's national abortion tele-health service, *Decide,* is relatively new and therefore, little is known about it. While experiences of tele-health services in other health fields in Aotearoa are available from provider and user perspectives (Officer et al., 2023; Wilson, Bidwell, et al., 2021), there is yet to be any research on *Decide* services. However, international evidence points to the promise of such services. As *Decide* is still in its infancy, the growing international literature around the feasibility, acceptability, and resilience of tele-health abortion services can inform its development.

During the COVID-19 pandemic, in-person abortion services were severely suppressed due to worldwide lockdown restrictions. Calls for tele-health abortion were met around the world (Qaderi et al., 2023). As the services proved largely successful, many countries that had implemented the service temporarily as a COVID-19 response considered extending or permanently extending services following their lockdown periods (Qaderi et al., 2023; Skuster et al., 2021; Sorhaindo et al., 2023). During this time, an expansive body of global research investigating tele-health abortion was produced in different contexts globally.

Research shows that tele-health abortion services gained favour among providers and service users quickly (Gibelin et al., 2021; Peña et al., 2022; Porter Erlank et al., 2021; Reynolds-Wright et al., 2021). The services also proved to have benefits over in-person care. For example, a survey in Canada with providers showed that staff could adapt care protocols quickly for in-person situations, and by adopting complementary tele-health abortion services, they could support more women and mitigate COVID-19 fears (Ennis et al., 2021). Such findings indicate that tele-health abortion services can provide continual healthcare throughout challenging situations, making them viable and resilient.

The research suggests that tele-health abortion services are also promising because they can help address barriers to care and, in turn, help reduce morbidity and mortality rates related to unsafe abortion methods, thus promoting reproductive health, choice, and wellbeing (Adu et al., 2023; Endler et al., 2019). These services can also potentially assist with collecting data about abortion services for monitoring and evaluation purposes, especially in restrictive contexts (Bearak et al., 2020; Endler et al., 2020; Ganatra et al., 2017; Maffi & Tonnessen, 2019; Popinchalk et al., 2022; Rodgers et al., 2021).

While the monitoring of tele-health abortion services is vital to understanding service delivery systems and availability, it is also relevant in understanding care approaches. Services that value and respect abortion seekers' positions help them feel more empowered and trusting of services, which help reduce morbidity rates related to unsafe abortion methods (Cotter et al., 2021; Malek et al., 2024). Tele-health abortion services can offer private, tailored care, which helps improve service users' wellbeing by reducing the stigma sometimes associated with in-person consultations (Becker et al., 2025; Kerestes et al., 2022; Madera et al., 2022). These findings illustrate the importance and advantages of personable abortion care approaches in tele-health abortion services.

In this chapter, I discuss the benefits of tele-health abortion services concerning service users' accessibility and the affordability, acceptability, and quality, drawing on international evidence. As part of this discussion, I consider the challenges vulnerable communities face in accessing abortion care and discuss equity issues. I also examine approaches to abortion care, discussing the benefits of person- and relational-centred care.

Benefits of Tele-Health Abortion

Accessibility

Globally, access to abortion services is a disputed issue influenced by legal, economic, and social factors. These barriers impact those seeking abortion and the healthcare providers offering abortion services. In particular, abortion access is hindered by healthcare infrastructure, with delays caused by requirements for referrals and ultrasounds, despite research suggesting that verbal estimates of gestational age can suffice (Jung, Fiastro, et al., 2023; Porter Erlank et al., 2021). A shortage of trained abortion providers further exacerbates access issues, particularly in rural areas, where legislation and a lack of training programmes limit services (Baier & Behnke, 2024; de Moel-Mandel et al., 2019; Malek et al., 2024). Additionally, providers face challenges interpreting health exceptions to abortion bans, highlighting the complexity of abortion justifications in healthcare systems built around male-centred models (Shai et al., 2021; Shaw et al., 2024).

In contrast, the ability to have an abortion in a private location, such as one's own home, can mitigate in-person deterrents such as provider bias and abortion stigma. Abortion stigma is a significant barrier to accessing abortion services. Such stigma arises from cultural, religious, and political norms, often perpetuated by myths and anti-abortion actors, leading to delays in care, harassment of clinic users, and fears of punishment (Bryant & Swartz, 2018; Cerulli, 2024; Forbes et al., 2021; Getahun et al., 2023; Hoggart, 2017; Piazza & Augustine, 2022; Sorhaindo & Lavelanet, 2022).

This stigma impacts individuals differently based on their intersectional identity, contributing to isolation, anxiety, shame, and infringements on fundamental human rights (Heslin et al., 2024; Killinger et al., 2022; Metzl & Hansen, 2014; Strong et al., 2023). One may question whether a self-managed abortion is an empowered choice or simply an avoidance of stigma. However, tele-health abortion services can assist in normalising societal

attitudes towards abortion over time. For instance, Chilean service users who used the Women Help Women service reported that the service delivery normalised abortion for them (Larrea et al., 2022).

Additionally, tele-health abortion services offer more options for those seeking abortion. Services have allowed a tremendous amount of freedom and choice for women seeking early medical abortion. Tele-health abortion services enable service users to control the location of the abortion at a time that suits them, with the support they need throughout the process (Killinger et al., 2022; Matulich et al., 2022; Shochet et al., 2023). The flexible and tailored approach can offer service users a more autonomous and confidential experience (Porter Erlank et al., 2021). Flexibility is essential for women to choose how and when they access abortion services (Raifman et al., 2024). In this respect, a study in the United States found that service users preferred tele-health appointments due to their convenience, as they fit well with their work and family commitments. Furthermore, the freedom to choose a suitable time and location allowed them to access their preferred self-care activities (Tressan et al., 2024).

Tele-health abortion overcomes many access barriers. Medication can be collected from a pharmacy or mailed to a chosen address. Further options include telephone consultancy (ensuring facial anonymity) or videoconferencing for those wanting a more personal connection. Services offer immediate advice, accurate information, emotional support, and privacy. For instance, a study in Scotland found that tele-health services could offer initial consultations within 24–48 hours (Boydell et al., 2021). Service users interpreted this to mean they would have more flexibility around procedural time limits in relation to gestation dates, which eased anxiety.

Seymour et al. (2023) showed that helplines (free, telephone-based services operating throughout the United States) complemented post-abortion care as well as validated service users' emotions. Helplines also provide neutral perspectives as service users explore whether an abortion is right for them. The rapid response of hotlines (telephone, text, chat platforms) can also assist in reducing morbidity and mortality associated with unsafe abortions (Gill et al., 2021). In the United States, an email helpdesk model supports service users by assigning each service user their own consultant (Johnson et al., 2024). This service provides detailed accounts of physical expectations and possible complications accompanying procedures, giving service users a sense of preparedness and facilitating continuity of care. Service users commonly seek guidance around pain, bleeding, and emotional connection.

To enhance emotional connection, service users in South African and Chilean studies recommended the expansion of websites to include pages that helped with decision-making, tips on sharing their decisions with the important people in their lives, a communal page where other service users could share their experiences, and instant messaging, as a valuable, rapid, and reassuring resource for post-abortion care (Larrea et al., 2022; Somefun et al., 2023). These findings suggest that the immediate availability of tele-health abortion services is well-positioned to support service users' needs.

Affordability

Economic barriers pose significant challenges to access, including lost income due to unpaid leave from work, childcare costs, travel expenses and higher costs associated with in-person procedures (Addante et al., 2021; Aiken, Starling, Gomperts, et al., 2021; Atreya et al., 2024; Ireland et al., 2020; Kimport & Rasidjan, 2023; Middlemiss et al., 2024). These financial burdens, exasperating inequities, disproportionally impact marginalised and low-income communities. As an illustration, those experiencing food insecurity were more likely

to use tele-health abortion services than those who were not affected by factors limiting food access (Koenig et al., 2023).

As previously discussed, a range of studies illustrate the benefits of tele-health abortion services. For example, because travel to clinics is minimised, Pleasants et al. (2022) found that service users could secure an early medical abortion, which reduced the rates of later gestational procedures, thereby decreasing health risk complications and stress. Tele-health abortion services have also facilitated systemic improvements by relieving crowded hospitals and improving communication between agencies (Hunter et al., 2023; Skuster et al., 2021). Additionally, tele-health post-abortion family planning programmes are more economical than in-person programmes, resulting in a higher uptake of long-term contraception methods (Hill et al., 2020).

Acceptability

The successful integration of tele-health abortion services depends on consumer satisfaction. Studies in Europe, the United States, Mexico, and Australia reported minimal complications arising from self-managed abortions, and service users were satisfied with the service they received (Aiken et al., 2022; Comendant et al., 2022; de Tolly & Constant, 2014; Grossman, 2019; Johnson et al., 2023; Koenig et al., 2024; Matulich et al., 2022; Peña et al., 2022; Tsereteli et al., 2024). Service users commonly reported a preference for tele-health due to its confidentiality, the reduced exposure to negative judgment, and the flexibility to complete the procedure at a time and location suited to them (Koenig et al., 2024; Larrea et al., 2022; Somefun et al., 2023). In this vein, an Irish study found that many service users were grateful and relieved to have an at-home option available, with many willing to recommend the service to others (Aiken et al., 2017). Likewise, research conducted in Australia and the United States found that over 96% of respondents reported that the entire

process was convenient, from the initial consultation to post-abortion follow-up, and would recommend the service (Hyland et al., 2018; Munson & Hall, 2024).

There is also significant evidence of service users' satisfaction related to positive experiences with tele-health abortion services. For instance, participants in a United Kingdom study repeatedly referenced receiving compassion, kindness, acceptance, and genuine care throughout their consultations (Hoggart et al., 2024). Service users also appreciated high levels of communication and active listening. Being able to ask questions and be given time to digest information, along with regular and fast responses, eased service users' apprehensions (Boydell et al., 2021; Larrea et al., 2022).

In fact, some service users in a study in the United States believed the communication standard was higher than that of in-person services because they were not subjected to long waiting periods or rushed through consultations (Godfrey et al., 2023). However, because tele-health services lack physical proximity cues, providers must increase their active listening skills and attention to subtle emotional cues, offering a more personalised service user experience. Ultimately, service users trusted tele-health to offer attentive, reliable, and diligent care (Baum et al., 2023).

Quality

One of the most significant factors for service users is choice. Because tele-health abortion services overcome access barriers such as limited abortion providers and remoteness, service users have more control over their family planning (Kerestes et al., 2022; Raymond et al., 2019). Another key consideration is safety. Global studies have shown that tele-health is a safe method for service users to seek and receive help, significantly reducing abortion-related complications (Godfrey et al., 2023; Upadhyay et al., 2024; Zolfaqari et al., 2024). Interestingly, numerous studies report that tele-health abortion services produce more

completed abortions and reduced abortion-related incidences such as haemorrhages, surgical requirements, and deaths than in-person services (Chong et al., 2021; Gill & Norman, 2018; Killinger et al., 2022; Matulich et al., 2022; Raymond et al., 2019; Seymour et al., 2022).

It is clear that tele-health services are an excellent resource for reassuring abortion seekers of procedural safety, dispelling misinformation, and providing ongoing support (Forbes et al., 2021; Karlin & Hodge, 2025; Shahrokhi et al., 2023). In reference to support, numerous studies express the valuable support tele-health staff can provide (Boydell et al., 2021; Larrea et al., 2022; Whitehouse et al., 2021). Service users welcomed clear communication, detailed information and the staff's caring approach. Creating an environment of empathy and understanding alleviates stress and allows for open communication. This connection validates service users' situations, supports their autonomy, and reduces provider-patient power imbalances. For example, a United States study found that service users felt significant trust in the service, citing feelings of safety, security, and autonomy (Koenig et al., 2024). Similarly, an Australian study conducted with rural residents showed that the service users felt valued and empowered by the staff. The information they received enabled them to have confidence in their ability to self-manage their abortion (Ireland et al., 2020).

Equity and Service Access for Marginalised Groups

Tele-health abortion services are also potentially beneficial when service access is affected by social and health inequities and are thus highly relevant for socially marginalised people. Barriers to abortion for those in low-income communities, rural areas, and marginalised groups are significant. The economic costs (discussed previously) present an extra burden for those from low-income communities, who comprise 75% of abortion seekers (Jerman et al., 2017) and those living in rural or remote areas (Addante et al., 2021; Atreya et al., 2024; Ireland et al., 2020; Kimport & Rasidjan, 2023). Abortion seekers in these

communities may have to delay the procedure while funds are raised (Pleasants et al., 2022). Statistics also show that engagement with abortion providers at a later stage in pregnancy is related to low socioeconomic status, which carries increased health risks, as well as additional psychological, emotional, and economic burdens (Kebede et al., 2021; Pack, 2020; Ushie et al., 2018).

Financial burdens associated with abortion services also disadvantage marginalised groups, including those who are sex workers, Indigenous, young adults, and those with chronic health conditions or impairments (Dickey et al., 2022; Monchalin, Pérez Piñán, et al., 2023; Willis et al., 2023; Yokoe et al., 2019). Economic burdens are complicated by added legal constraints, unfamiliar healthcare systems, and differentiated citizenship status (Killinger et al., 2022). People from these marginalised groups are often misunderstood due to differing languages and cultural beliefs about abortion (Napier-Raman et al., 2024). Other challenges specific to female sex workers involve occupational discrimination, stigma, and legal barriers (Birger et al., 2024). Due to this inequitable treatment, many abortion seekers resort to unsafe abortion methods (Napier-Raman et al., 2024).

Indigeneity is another critical factor in service access. Several studies highlight how stigma and discrimination act as barriers to Indigenous people's access (Brown et al., 2023; Burry et al., 2023; Eagen-Torkko & Yanow, 2021; Harris et al., 2006; Sifris & Penovic, 2021; Yokoe et al., 2019). In Aotearoa, Māori and Pacific People's communities experience poorer health outcomes than other ethnicities (Environmental Health Intelligence New Zealand, 2023; Marriott & Alinaghi, 2021). The 2024 *Abortion Services Aotearoa New Zealand Annual Report* revealed that existing barriers to abortion are particularly salient within Māori and Pacific people's communities. Young Māori and Pacific women undergo an abortion at a younger age than other ethnic groups and at later gestational stages (Ministry of Health, 2024).

Another highly stigmatised group are those belonging to the LGBTIQA+ community. Many feel they are disregarded and disrespected, and either avoid health access or refrain from disclosing their identity. However, this can cause extra shame and stress, as subsequently appropriate post-abortion emotional care can be missed (Carpenter, 2021). Numerous studies recommend that care providers tailor information and use appropriate language and interactive delivery methods that meet the needs of gender-diverse individuals and adolescents, helping to alleviate associated feelings of fear, shame, and guilt (Assifi et al., 2020; Fiastro et al., 2023; Jung, Hunter, et al., 2023; Munson & Hall, 2024; Seretlo et al., 2024; van den Dungen & Gomperts, 2024). Services that adopt an inclusive approach can offer care that respects all reproductive and gender identities (Lowick, 2017). Furthermore, a structurally competent health model considers the embedded sociopolitical ideologies, infrastructure, and practices that contribute to barriers and access to healthcare and looks to implement appropriate interventions (Downey & Manchikanti Gómez, 2018; Metzl & Hansen, 2014).

Tele-health can increase access for marginalised groups by building appropriate culturally responsive skills, information, and educational programmes about the impact of stigma in services (Antony et al., 2025; Bhandari et al., 2024; de Moel-Mandel & Shelley, 2017). The fact that tele-health is less economically burdensome, inclusive, and private means service users receive a confidential and empowering experience, allowing greater choice, which reduces unsafe abortion rates and associated morbidity and mortality (Aiken et al., 2023; Ghorashi & Baumle, 2023; Hervey & Sheldon, 2019; Kubuka et al., 2023).

Disadvantages and Negative Experiences

Having examined the positive impacts of tele-health abortion services, exploring the adverse experiences and problems arising from these services is necessary. While a few organisations offering these services have been available for some years internationally, they

have proliferated only within the last 5–10 years. Like any new service, challenges and problems do arise. Here, I will focus on issues relating to technical and emotional connections.

Access to Technology

Technological infrastructure is problematic throughout the world. Poorly invested broadband connectivity leaves some regions without internet availability and others with unreliable or low-speed connections and costly charges, impacting vulnerable groups and communities (Allsworth, 2022; Clare, 2021; Haimi, 2023; Thompson et al., 2022). For instance, a study conducted in Cape Town, South Africa, found that internet connections needed to be more consistent, with outages up to a day at a time, compromising the quality of care. Outages were particularly worrisome for service providers, who also grappled with confidentiality issues. They were forced to use personal phones to maintain contact with service users because the organisation did not provide staff phones. Comparatively, confidentiality and digital access affected service users who did not own a phone. Service users who needed to borrow another's phone were subject to stigma and anxiety.

It is prevalent for people in poorer communities not to own a phone and to struggle with language barriers. For these reasons, some providers prefer to offer in-person services (Somefun et al., 2023). Likewise, a study in England and Wales advocated that in-person consultations should remain an option, arguing that choice constraints impact self-determination (Footman, 2023). Maintaining an in-person option helps overcome language barriers and provides services to those without phone or internet access (Somefun et al., 2023). Additionally, several studies recommend providing language interpreters and cultural brokers to act as bridges between service providers and users (Singh et al., 2023; Thompson et al., 2022; Yang et al., 2024).

An added tension exacerbating access to technology is gender role expectations. For example, despite internet availability in Kenya, Pakistan, and India, women and young girls are less likely to own or use a smartphone because they are preoccupied with domestic care work (Jain et al., 2022; Njagi, 2023; Shaikh et al., 2021). Furthermore, digital access solves only some of the problems. Many providers and potential service users lack digital proficiency, impacting both the quality of care and tele-health uptake (Haimi, 2023; Jain et al., 2022; Ortiz et al., 2022; Parsons & Romanis, 2024; Rebouché, 2022; Shaikh et al., 2021; Somefun et al., 2023). To address proficiency, service users in a study in South Africa suggested additional training to enable providers' smoother dialogue between consultants and service users (Somefun et al., 2023). Further recommendations included implementing speech recognition and voice navigation software to assist impaired users, thereby improving their experience (Kolekar et al., 2024).

Privacy Concerns

It is questionable as to whether tele-health is entirely private. For example, while some service users in a study in the United States were comfortable with tele-health privacy levels, others would have preferred an in-person consultation as they were uncertain that their privacy was assured when they noted that the provider's office door was open during their teleconference (Ruggiero et al., 2022). Concerns about confidentiality have also been expressed by those accessing telemedicine services that mail medications. For example, service users in the United States reported concerns that packaging contents could be identified and delivery could be interrupted (Boydell et al., 2021). Those wanting to be discreet feared their package could be discovered by family or authorities, exposing them to legal sanctions, judgment, and stigma (Madera et al., 2022).

Lack of Emotional Connection with Service Providers

Numerous studies have noted that service users felt a personal connection was missing when using tele-health abortion services. A study in the United States found that 95% of their respondents valued quality of care over costs and insurance coverage, with nearly half valuing face-to-face or in-person consultations (Clure et al., 2023). Further, studies in the United States and the United Kingdom found a similar theme, revealing significant care considerations in implementing tele-health services. For example, some service users felt that videoconference calls could have been more genuine and that they could not establish a personal connection with their consultants. These feelings added to their overall uncertainties about the privacy and legitimacy of the service (Kumsa et al., 2023). These concerns caused many service users to feel isolated and uncertain in their ability to self-manage their procedure, and they preferred an in-person consult where they could be assured of an expert 'hands on' atmosphere that maintained their privacy needs (Baraitser et al., 2022; Lerma et al., 2024).

Uncertainty of Timely Medication Delivery

Service users also report concerns that mail delays would compromise their ability to complete an early medical abortion due to their gestational date. For instance, service users using Aid Access (a United States telemedicine service) feared mail delivery interruptions. This uncertainty led many to consider alternative methods or the continuation of their pregnancy, which carried extra anxiety, stress, and financial hardships. Additionally, concerns over the legitimacy of Aid Access and the medication presented an extra layer of stress for the service users (Madera et al., 2022). As a result of such concerns, Boydell et al. (2021) found that most service users preferred to collect their medication at their convenience, giving them a sense of control and the certainty that they had the means to proceed as suited.

Continued Service Gaps: Rural Populations

Insight into negative experiences with tele-health abortion services and their disadvantages is vital to understanding tele-health effectiveness. While service improvement is foundational and at the heart of providers, inconsistencies remain, especially among rural populations. Information and support for rural and remote communities are lacking despite the presence of abortion services. Furthermore, inadequate roading infrastructure and extreme weather conditions can add to access difficulties (Atreya et al., 2024; Jerin et al., 2024).

These types of barriers also impact providers and their facilities. For example, a study in the United States found that remote facilities struggled to maintain consistent stocks of early medical abortion pills and could not cope with the demand (Summit et al., 2020). Staffing remote services is also challenging due to the limited availability of training placements, and doctors fear they will face stigmatisation for offering services. Similarly, a study in England found that the siloed nature of abortion care further reduced service resources and support, suggesting structural stigma, including societal, institutional, and political (Footman, 2025).

Lack of information compounds access barriers. For example, a study in Australia found that many doctors not only did not know that tele-health abortion services existed, but they also did not understand the early medical abortion procedure or how to provide follow-up care. Unfortunately, the doctors who were aware of the services were reluctant to offer them, fearing negative judgment and assuming that service users were already adequately cared for. Doctors also noted that adding abortion care to their services would be an expensive financial outlay, and their remoteness meant they did not have a nearby hospital to assist with complicated cases (Mazza et al., 2021).

These conditions severely impact the reproductive choices of those living in rural and remote areas. For instance, the geographical expanse of Australia means that some people have up to 16 hours of travel time to their nearest abortion provider (Ireland et al., 2020). Indeed, tele-health abortion services are invaluable to those living rurally; however, if legislation requires service users to travel to obtain an ultrasound scan to prove the gestational date before the procedure, there is no advantage. Costs increase the further the travel is required. Expenses include fuel, accommodation, meals, childcare arrangements, and procedure costs, presenting considerable financial difficulty (Gerdts et al., 2016; Noonan et al., 2023). Saving for these expenses causes delays for some whose gestational date surpasses the early medical abortion cut-off dates, which causes further stress and hardship. As a result of these barriers, rural United States residents have lower abortion rates compared to urban residents (Thompson et al., 2021). This fact impedes the reproductive health and rights of rural service users and undermines their autonomy.

Distance is not the only factor impacting rural residents' sexual health rights. Rural service users also suffer from a lack of available abortion information. This is seen in two Australian studies' findings showing that Google searches offered little access to information, and abortion seekers did not know whom to approach. Seekers relied on a 'who do you know' social tactic, compromising privacy (Ireland et al., 2020; Noonan et al., 2023). It is clear that abortion care delays due to distance-related factors are significantly associated with higher levels of stress, anxiety, depression, and increased risk of health complications and mortality (Wasser et al., 2024).

Comparatively, rural areas with tele-health abortion services have shown positive outcomes. Illustrative of this are three studies in the United States and one Australian study. Firstly, service users valued the reduced distance and work and childcare pressures, resulting in a 64% decrease in in-person consultations. Secondly, a more comprehensive ethnic range

used the services compared to in-person offerings. Thirdly, service users had more options and quicker service. Fourthly, procedural abortion rates dropped significantly, indicating greater user satisfaction with tele-health abortion services. The studies concluded that tele-health abortion services increased access for rural residents as well as addressed stigma-related barriers Indigenous communities face (Colwill et al., 2023; Donovan, 2019; Koenig et al., 2023; Seymour et al., 2024).

Review of Tele-Health Abortion Benefits

In summary, tele-health abortion comes with some challenges, but it also has many advantages. From a feminist perspective, a major advantage is the autonomy and agency that this service promises. The ability to complete a safe self-managed abortion shifts the 'ownership' of the abortion seeker's body from medical experts to themself, shifting the provider-patient power dynamic and increasing the sense of personal empowerment, as reported among service users in a study in the United States (Srinivasulu et al., 2022).

Many countries demonstrate service users' autonomy resulting from tele-health abortion use. Service users feel less scared and more prepared to self-manage, valuing step-by-step procedure instructions. Importantly, confidence in their ability to self-manage arose from the patience and personalised care they received from providers (Baum et al., 2023; Tressan et al., 2024). As such, tele-health abortion services potentially uphold or support a person-centred approach to care. In the following section, I turn to abortion care approaches. Specifically, I explore the principles and benefits of person-centred and relational-centred care that were introduced in Chapter 1.

Person-Centred Abortion Care and Tele-Health

Person-centred care is a flexible approach to care rather than a theory or rigid model. It respects and adapts to service users' preferences, needs, and values, ensuring these guide all

clinical decisions and care processes. Various theories and models can inform person-centred care. However, it is primarily an approach that emphasises the importance of seeing the person as a whole and tailoring care to their unique circumstances. Therefore, this approach recognises that the critical components of successful healthcare lie in the relationship built between the treatment provider and the service user. Providers demonstrating active listening, respect, and care produce quality social connections and a collaborative environment where the service user is an equal and active partner in their care. These attributes help instil self-efficacy and trust in the healthcare provider's guidance.

Reproductive care, from a feminist perspective, involves autonomy and choice (Nelson, 2017). However, changing policies, access, social attitudes, and personal circumstances influence the abortion decision and the availability and quality of care (Coast et al., 2018). These influential micro-level (personal, family, community) and macro-level (socioeconomic policies, cultural, religious) factors were profoundly shown in a study in South Africa, in which gender-related power heavily influenced the choice, even when abortion was not the seeker's preference (Mavuso et al., 2020). By keeping these factors in mind throughout the provider-service user relationship and considering that abortion seekers have expert knowledge about their unique life contexts, power can shift from the traditional view that healthcare professionals are the experts, to one where decision-making is shared with the appropriate support.

In this section, I discuss the person-centred care approach and its benefits. I also explore the principles and benefits of the relational-centred care approach, discussing how its application to abortion care would further enhance service users' experiences.

The Emergence of Person-Centred Care

The early 19th-century approach to patient healthcare focused on disease management to facilitate a functional life (Dwamena et al., 2012). However, this approach did not account for a person's preferences, emotions, support systems, or contextual barriers that can impact healing. This patient-centred approach lacked effective communication between the physician and the service user, and it ignored the patient's lived experience. The overwhelming power imbalance between the professional and the patient under this earlier healthcare approach gave rise to person-centred care. Over time, the creation of abortion quality care frameworks enabled assessments that ensure those seeking abortions receive care that attends to their entire wellbeing (Metrics for Management, 2023; Sudhinaraset et al., 2020).

Principles and Benefits of Person-Centred Care

Contrary to the patient-centred approach, person-centred care focuses on and wraps around the health seeker's values, preferences, and needs (Baum et al., 2023). As such, interpersonal communication and a positive relationship between providers and abortion seekers are essential. Numerous studies discuss the characteristics of person-centred care designed to achieve positive health-seeking outcomes (Baum et al., 2023; Cotter et al., 2021; Monchalin, Jubinville, et al., 2023; Moulton et al., 2025; Rowlands & Wale, 2020). I will now explore these specific characteristics and provide examples of their benefits.

Information Sharing and Transparency

Ethical practice involves service users' right to be fully informed about all available healthcare options so they can choose according to their own needs and preferences (Oberman & Lehmann, 2023). Service users across South America, Asia, and Africa received step-by-step procedural instructions and information about the consequences, including potential pain and complications. Service users valued this honesty, and the open discussion made them feel safe and confident in their decisions (Baum et al., 2023; Cotter et al., 2021).

Respect and Cultural Sensitivity

The Person-Centred Care Framework for Reproductive Health Equity comprises eight evidence-based factors connecting individuals, facilities, and broader communities to produce quality care and positive health outcomes, including dignity and respectful care (Sudhinaraset et al., 2017). To effectively support healthy outcomes, it is critical that providers treat service users with dignity and provide culturally sensitive care (Baum et al., 2021; Cotter et al., 2021; Kerns et al., 2012; Le Grice & Braun, 2017; Monchalin, Jubinville et al., 2023; Roncoroni et al., 2023).

Unfortunately, respect is not always a present component in abortion care, with dire consequences. Service users in a study in Australia reported they were regularly scolded and blamed for their situation and treated coldly (Makleff et al., 2023). Similarly, service users in West Africa were reluctant to access post-abortion care due to the disrespect they received, resulting in three deaths and numerous emergency hysterectomies throughout the study's 3-year duration (Ouedraogo & Juma, 2020). Further, a study in South Africa found health providers sought to alter an abortion decision, disregarding respect and women's autonomy (Macleod et al., 2024).

Social Support, Shared Decision-Making, and Autonomy

Abortion care extends beyond physical care and encompasses service users' emotional, psychological, and spiritual wellbeing. By focusing on consistent empathy, respect, honesty, and transparent information, service users can make decisions free from coercion, reducing the chance of feeling ashamed and stigmatised while increasing their sense of empowerment (Baum et al., 2023).

In conclusion, the person-centred care approach has resulted in many empowering experiences for service users and catered well to varied ages, groups, and preferences (Amoah

et al., 2023; Cotter et al., 2021; Hann & Becker, 2020). Combined with tele-health abortion, service users can receive compassionate, respectful, responsive care that aligns with their values and needs. Relational-centred care offers additional benefits to the person-centred approach because it emphasises and prioritises the relationships between providers, service users, and their support networks. In the next section, I will explore these components and provide examples of their benefits.

Relational-Centred Abortion Care and Tele-Health

While the person-centred care approach has proven to be successful, its focus on autonomy has drawn criticism. Autonomous choice tends to be synonymous with individual choice. McReynolds-Pérez et al. (2023) argue that this individualism derives from a Western, masculine philosophy that irrationally assumes humans can thrive alone. Viewing abortion as an individual action isolates and ignores the supportive network that is influential in an abortion seeker's decisions and wellbeing (Altshuler et al., 2016; van der Waal & van Nistelrooij, 2022). Proper care involves critical attention to how we relate and respond to each other (Beach, 2024; Beach et al., 2006).

Principles and Benefits of Relational-Centred Care

The relational-centred approach carries person-centred characteristics but focuses on the micro and macro networks surrounding service users. In this section, I discuss the principles and benefits of relational-centred care and provider self-reflection as a product of ethical relationships.

Social Networks, Shared Decision-Making, and Holistic Support

Realising the significant impact relationships with health professionals, family and social connections, and societal expectations have on reproductive decisions has emphasised interdependence (Thachuk, 2007). The relational approach considers these networks as

powerful determinants of an abortion decision and of shared care for the abortion seeker. For example, service users in a study in the United States valued having people meaningful to them present during their abortion, from consultation to procedure to post-care. These relationships enabled them to convey their preferences and share their emotions and experiences with those they trusted. Sharing the responsibility for the decision helped them quell their fears and feel strengthened to deal with stigma (Altshuler et al., 2021). A further study in Canada found that abortion doulas reduced structural access barriers often experienced by Indigenous and gender minority groups (Paynter et al., 2025).

A counterargument to the presence of support persons is that they may influence a decision contrary to the service user's preferences. However, ensuring that the service user consents to their support network presence and providing supporting role information can address these uncertainties. The advantages of qualified support persons are that the providers can be more assured that decisions are well-informed, and the abortion seekers have emotional and practical support. For instance, a multi-country study found that support networks were involved in locating services and information, providing transport, cost-sharing, and after-care (Altshuler et al., 2016). Restricting either the presence or the voices of support persons risks maintaining the view that abortion is an individual responsibility, which inflates abortion stigma and stress (Altshuler et al., 2021; Hendrix et al., 2023; Veiga et al., 2011).

Self-Reflection as Ethical Care

An additional component in the relational-centred approach involves providers critically self-evaluating their biases. Regularly reviewing their opinions and beliefs and their impact on service users helps produce more equitable, respectful, and ethical care (Holten et al., 2021). Self-reflection safeguards interrelationships comprising dignity, acceptance, and comprehensive care. An essential facet of self-reflection is that it builds empathetic skills,

which help service users form trust and confidence in sharing their emotions and life contexts, and feeling heard and understood (Nundy & Oswald, 2014).

Self-reflection also impacts the health professional. In Aotearoa, practitioners can decline to offer abortion services (Abortion Legislation Act, 2020). As such, by understanding their values and reasons for choosing to become abortion providers, their wellbeing is improved, and this is reflected in service users' experiences (Merner et al., 2024). For example, a training programme for abortion providers in South Africa that focused on person-centred care and reproductive justice principles, with reflexive components exploring cultural and religious norms, helped them understand and encourage the autonomy of service users (Macleod et al., 2024).

Furthermore, social justice and ethical care are encouraged through self-reflection. For example, providers can share the morality of an abortive decision in an otherwise untenable situation by reframing the procedure as acts of love and responsibility while honouring the spirit of the fetus (Heinsen et al., 2023). These alternative ways of framing situations demonstrate the value of self-reflection and relational-centred care and recognise diverse knowledge sources and spirituality as essential pillars of care and wellbeing (Tresolini & Pew Fetzer Task Force, 1994). These empathetic and ethical practices help reduce abortion stigma and shame and help service users go on to lead self-determined, fulfilling lives.

The responsive nature of tele-health platforms means they can effectively utilise self-reflective practices. For example, a study in Uganda piloted a programme to reduce abortion stigma among providers using various digital platforms (WhatsApp, Zoom, SMS). The project created a space for them to share their challenges, resulting in collaborative and improved abortion care (Kaye et al., 2023).

Conclusion

In this chapter, I have explored the advantages and limitations of tele-health abortion services, highlighting common barriers that affect abortion access worldwide. By situating tele-health abortion within ethical, equitable, and just healthcare, I have also explored the principles and benefits of person- and relational-centred care, emphasising the importance of strengthened provider-service user relationships for positive health outcomes. Research shows that many legal, socioeconomic, structural, and cultural norms present significant hindrances in achieving equitable reproductive justice. However, tele-health abortion services offer a promising solution, providing benefits in terms of accessibility, acceptability, affordability, quality, and equity. International studies indicate that these services deliver outcomes comparable to in-person care, providing timely access, especially for rural residents who face financial and logistical hurdles. The flexibility of services empowers users as they can control the location and time of their procedure, assuring their privacy. Simultaneously, services have reduced numerous travel-related costs, such as fuel and accommodation, and, in many cases, alleviated these extra burdens entirely. Services are well-regarded, and their personalised care has improved medical outcomes and abortion completion rates. Additionally, services ensure culturally responsive care, making abortion care more accessible to diverse groups.

Despite these tremendous benefits, challenges remain. Insufficient internet infrastructure and unreliable connectivity are significant access barriers, especially in low-income areas. Gender-related restrictions are also influencing digital use, and the lack of digital literacy and language barriers are exacerbating access difficulties. In regions where connectivity is not an issue, privacy concerns persist. Service users worry about confidentiality during telephone calls and uncertainty about the legitimacy of the services. Service users also perceive their interactions to be impersonal, contributing to feelings of isolation and distrust. Moreover, many report being anxious about medications arriving past their gestational window, and these insecurities lead some to choose in-person care. Continual

service gaps plague rural populations. Providers lack abortion care knowledge, and their fears about being stigmatised deter them from offering services. Additionally, limited facilities, inconsistent medical supplies, and poor roading undermine access to and for rural and remote communities.

To better understand the success of tele-health abortion services, I delved into the principles that enable good relationships between providers and service users. Both person- and relational-centred abortion care emphasise respectful, supportive, and compassionate communication, but their focus differs. The person-centred approach focuses on individual autonomy, considering their needs, values, dignity, and preferences. The approach requires transparency, ensuring service users are fully briefed about all aspects of the process and are well prepared. It is mindful of cultural contexts and shared decision-making, offering an empowered experience. Person-centred care used with tele-health abortion means service users are emotionally and psychologically supported.

The relational-centred abortion care approach goes beyond person-centred care. It acknowledges the significant role that social networks have in decision-making and support. Thus, the care emphasis is on the relational dynamics between providers and the abortion seeker and their support networks. In practical terms, this means relational-care values shared decision-making and builds support plans with the involvement of abortion seekers' chosen support people. This collaborative approach helps reduce stress and stigma. Another critical difference the relational-centred care approach offers is its attention to self-reflection among providers. By assessing biases and their impact on service users, providers better understand themselves and produce more ethical, empathetic, and equitable care. Tele-health abortion services using the relational-centred approach can facilitate collaborative and reflexive abortion care that improves both the providers' and the service users' experiences.

In conclusion, tele-health abortion services have overcome many access barriers and reduced stigma, morbidity, and mortality. They are a valued and critical alternative to in-person services, capable of meeting ongoing challenges. In reviewing the personable delivery of services, both person- and relational-centred approaches prioritise respectful and empowering care. Additionally, the relational-centred approach recognises the importance and influence of support networks, thus fostering a more holistic care experience. In the following chapter, I explain my methodology, including feminist standpoint theory as the framework of my study, and I describe my study methods.

Chapter 3: Methodology

To answer my research questions outlined in Chapter 1, I used a qualitative case study design guided by a feminist standpoint lens, in conjunction with person- and relational-centred care frameworks. In this chapter, I explain the rationale for using this research design and discuss the various aspects of my methodology. I begin by explicating my theoretical framework of feminist standpoint theory. I detail the theory's three main tenets, specifically, situated knowledge, emphasising marginalised groups, and strong objectivity. I then discuss my case study design, explaining the rationale for using this approach, and describe the data collection and analysis methods used.

Feminist Standpoint Theory

Feminist standpoint theory emerged during the third wave of the feminist movement (Tong & Botts, 2024). Following the failure of previous waves in recognising that women experience oppression differently depending on their backgrounds, this theory asserts that women's positions in the world allow them to perceive and understand various aspects of the world and human activities, challenging male-dominated forms of knowledge production. This theory addresses oppression by highlighting lived experience (Morison, 2023).

I used feminist standpoint theory to specifically explore and analyse service users' experiences. The theory acknowledges that the interpretations drawn from individual experiences shape realities and that social, historical, and cultural contexts influence individual interpretation. Feminist standpoint theory focuses on understanding the multiple meanings that individuals attribute to their experiences, challenges dominant narratives, and invokes self-reflexivity that explores how women make meaning of their experiences within patriarchal contexts (Gilbert & Sewpaul, 2015; Vandamme, 2021).

I applied the following theoretical concepts in the analysis of my survey to capture the complexities of service users' experiences. My survey questions were based on the acknowledgement that societal factors, and the interpretations of these, based on beliefs, values, and personal contexts, shape the realities of my participants. For example, the survey question: "Based on your experience, what do you think about *Decide'*s ability to help people with a range of different life experiences and backgrounds? Is there anything they could do better?" (refer to Appendix A), invited feedback about how well participants felt the service accommodated their social, cultural, and individual contexts, while inviting service recommendations, recognising their positional knowledge.

Key Tenets of Feminist Standpoint Theory

Situated Knowledge

Feminist standpoint theory's origins lie in Marxism, which proposes that the oppressed have access to knowledge that the dominant class does not (Crasnow, 2014). Haraway (1988) proposed that people's knowledge is situated and shaped by our relationships and identities and thus produced within their rich experiences and social, historical, and cultural contexts. For example, Smith (2005) examined women's domestic and caregiving labour, concluding that traditional ideology devalued and made women's experiences invisible, failing to recognise their societal input. The contexts in which people are located limit the experiences they can have and hence what knowledge they can gain. Therefore, people's knowledge or ways of knowing have innate perspectives and biases. Thus, rather than seeing knowledge as an objective fact, feminist standpoint theory acknowledges multiple ways of seeing and understanding the world rooted in situated knowledge (Haraway, 1988).

Feminist standpoint theory allows for the amalgamation of multiple 'situated knowledges' because it values the unique insights each brings in understanding phenomena. By acknowledging the intersection of discriminatory factors such as ethnicity, gender,

sexuality, and socioeconomic status, experiences can be better understood. No single factor can explain the daily challenges for those experiencing multiple forms of discrimination (Collins & Bilge, 2016; Collins et al., 2021; Crenshaw, 1989).

Feminist standpoint theory draws attention to power relations based on how the viewpoints of particular groups, such as the male class, become dominant and are treated as the objective truth. Knowledge disseminated by the dominant group builds societal foundations. Therefore, it is logical to question the accuracy of the so-called truths on which a society is built. The dominant group maintains its dominance by discrediting and silencing any alternative voice through institutional practices, media representation and language use, and funding projects and research that only benefit the dominant group. These practices are infused across institutions, such as churches, education, health, and family, to cement and naturalise dominant narratives (Mouafo, 2024).

Initially, feminist standpoint theory prioritised women's lived experiences as a group, but was later developed by Black feminists to recognise diversity among women (Collins, 2022). The critical need for this is evident when considering historical contexts in which White women, while fighting for abortion rights, omitted the fact that Black women were subject to forced sterilisation when they were not (Ampofo et al., 2015). Building on earlier work, Black feminist scholar Collins (2022) challenged the idea that women as a group shared a single standpoint. Drawing on the notion of intersectionality (Crenshaw, 1989), Collins argued that although women share experiences of living in a male-dominated world, experiences of race, class, and other forms of oppression also shape people's lived experiences. Collins's (2022) work was instrumental in exposing and differentiating African American women's experiences. She asserted that the oppression experienced by these women in relation to both gender and race highlighted power imbalances and inequalities that were neither seen nor felt by White women nor by African American men. Her insights

helped establish that intersectional factors also impact privilege and challenges and developed the notion of situated knowledge (Morison, 2023). I elaborate on this further below.

A critique often asserted is that situated knowledge undermines objectivity, thereby validating all knowledge and hindering the identification and rectification of power imbalances (Haraway, 1988). However, the second tenet of feminist standpoint theory, discussed next, unites each experience to offer a fuller understanding and coherent critique of a social issue.

Epistemological Advantage of Marginalised Groups

Hartstock (2019), inspired by Marxist theory, proposed that based on their unique experiences of oppression, marginalised groups have the potential to develop a unique worldview and a more precise understanding of a controversial issue than the dominant group. For example, early feminist standpoint theorists Smith, Collins, and Rose extolled women's expertise regarding the social and structural impact on daily life, body autonomy, and slavery (Harding, 2004). As Gurung (2020) explains, the oppressed group endures more hardship and therefore develops a global perspective, while the privileged have no opportunities open to them that would provide these specific hardship experiences. Importantly, however, Harding (2004) argues that neither positionality nor oppression automatically signifies a standpoint. Rather, feminist standpoint theory advocates for political equity, which cannot succeed without critical reflection and awareness of how and in what ways power structures shape and limit knowledge and activism to affect change. In this way, epistemological knowledge is seen as more than a perspective but the foundation of a relational achievement (Sweet, 2020).

This tenet has been critiqued for taking an essentialist view, meaning that all members of a particular group share the same experiences and, therefore, have formed the same views. This critique has been addressed by attention to intersectionality, as intimated previously, and

acknowledging that different forms of oppressive conditions shape experiences and perspectives (Ashton, 2023; Collins et al., 2021). Black feminist scholar Crenshaw (1989) noted that racism and sexism were separately categorised discussions that centred solely around privileged members. Crenshaw (1989) reasoned that Black women experience oppression differently in comparison to both Black men and White women, coining the theoretical term "intersectionality" to conceptualise this. Intersectionality represents diverse social identities and experiences resulting from exclusion and silencing (Davis & Lutz, 2023). This privileged knowledge creates accounts of life that enable critical challenges of the status quo (Allen, 1996; Beausoleil, 2021; Bell, 2017; Wilson, Moloney, et al., 2021).

Feminist standpoint theorists argue that through critical evaluation and reflection of intersectional factors and the voices of marginalised people, dominant narratives can be shaken at their core and re-evaluated (Ashton, 2023; Collins et al., 2021). Furthermore, they also propose that those from both socially marginalised and privileged groups have an epistemological advantage from being in two spheres. While they have lived experience and knowledge as a member of a group discriminated against, they also witness dominant ideology in action. This double vision allows a reference for distinguishing their standpoint and avenues for justice iteration (Ashton, 2023). Collins (1999) conceptualises this as an outsider within—due to a relationship with the dominant group, the marginalised person can see and understand both perspectives.

Strong Objectivity

Early feminist standpoint theorist Harding (1995) criticised traditional scientific notions of objectivity. Harding disagreed with the stance that marginalised groups are incapable of impartial judgment and the exclusion of their expertise as biased. She also questioned the morality of detaching human emotion from research used for human benefit. She believed these viewpoints of bias and rationality amounted to poor academic rigour and

carelessness that limited scientific advancements. Harding (1995) did not wish to reject objectivity and risk falling into relativism, but rather to strengthen (or reconceptualise) objectivity to advance social justice. To do so, Harding (1995) advocated for accepting that human nature is always present in any scientific research. Her conceptualisation of "strong objectivity", which I explain next, proposes recognising and including the researcher's and participants' social and historical contexts in the overall understanding of a phenomenon.

Reflexivity

Feminist standpoint theory's premise is that knowledge is situated, partial, and based on a dominant narrative, with the explicit or implicit purpose of maintaining dominant power. This partiality is present throughout the entire process of any research, from conception to data collection, analysis, and presentation of findings. Thus, it is essential for me as the researcher to take moral responsibility for my awareness and contextual knowledge of the project (Linabary et al., 2021). This means that I need to recognise and understand my perspectives and the impact these have on shaping the data that is generated, as well as the power dynamics between me and the participants and my moral duty to build an equitable relationship (Braun & Clarke, 2022).

Braun and Clarke (2013) explain that reflexivity acknowledges that the researcher is a subjective co-creator of findings in that their own interests shape the project's design. Functional and personal qualities influence the project. Functional reflexivity refers to the type of methods used. For example, my study used an online survey, the questions of which would differ from those I might ask using a focus group method. A focus group (whether online or in-person) exploring abortion experiences adds intersectional and interrelational dimensions that may negatively impact participants, which can be overcome by employing an anonymous online survey. Personal reflexivity means that as a researcher, I must define my historical context to understand how it may impact the research, participants, and my position

in the study. Journaling and transparent consultation with colleagues and participants can help achieve quality reflexiveness. Reflexivity ensures ethical treatment of participants and their data and fosters integrity in the scientific community (Field et al., 2024).

Inclusive Research

Feminist standpoint theorists believe that any research should begin with the voice of the marginalised rather than adding it to an established traditional narrative (Harding, 2004). Their knowledge can provide critical insights into oppressive power practices and challenge dominant concepts. Furthermore, creating a space that hears marginalised voices ensures greater social justice. For example, sharing abortion experiences has proven to be validating and empowering for women (Shah, 2020), leading to positive transformations. Alternative standpoints create opportunities for communities to establish supportive initiatives specific to the needs and strengths they have each identified.

In this vein, feminist standpoint theory can make visible factors within broader economic, political, social, and cultural contexts impacting access and experiences with *Decide*. Examining users' experiences can allow for intimate insights into the *Decide* service and its principal foundations. Service users' lived experiences of access challenges, stigma, healthcare inadequacies, and economic, religious and gender constraints and how women navigate them, can help improve abortion healthcare delivery, policy, and community support, and provide insights into broader issues relating to reproductive rights and justice. Moreover, feminist standpoint theory can help the way in which women interpret their experiences. Capturing service users' unique perspectives can also reveal nuances of lived experience, which can inform autonomy and empowerment.

Methodological Rigour

Gurung (2020) points out that the wider vision of feminist standpoint theory is the commitment to moral and political actions to pursue justice. Representing people requires evidence based on notions that will withstand vigorous inspection. Therefore, methodological rigour in feminist standpoint theory requires a systematic procedure to ensure that the groups researchers align with are not exploited, subjected to harm, and are authentic. As strong objectivity advocates, the process of feminist standpoint theory must actively include the voices of marginalised people, recognising their epistemological privilege and expertise. It must value situated knowledge with the understanding that cultural, social, and historical contexts shape our experiences and that these can uncover intersectional barriers. Finally, it must contain a reflexive element that challenges the researcher to uncover biases and power dynamics that may affect the design and outcome of any research. Throughout my study, I carefully attended to participants' anonymity and continually circled back to the data to create deeper connections with the content.

Research Design: Qualitative Case Study

Case study research involves an in-depth examination of a specific case (individual, group, organisation, event, or phenomenon) to explore "how" or "why" something occurs within a particular context, often relying on multiple sources of data (Clarke et al., 2022). In this research, the sources of data included survey responses, guidance and training documents, service user-facing information (a website), and fieldnotes. These were drawn together to provide a rich understanding of a social phenomenon or issue. I used a single case study focused on the organisation, *Decide*. I did not set out to use a case study approach and initially intended to collect data via a qualitative survey using web-based advertising to reach geographically dispersed and often stigmatised abortion seekers (Upadhyay et al., 2020). However, it proved difficult to recruit this hard-to-reach group largely because I could not secure assistance with recruitment through official health agencies, as I had hoped (due to

their internal policies). Stigma also presented a significant challenge to the recruitment of enough survey participants (see discussion on response rate further below), leading me to rethink my research design.

To enrich and maximise the survey data I was able to collect (as described below), I decided to use a case study method. This method is particularly useful when seeking detailed insights into complex situations where context is crucial, such as tele-health abortion service provision. The case study method is ideal for a study such as this, which acknowledges and explores the intersectional lived realities of those seeking abortion. Moreover, a case study approach, especially a single case study, is well suited to generating in-depth data, over the generalisability of findings (Crowe et al., 2011).

Additionally, using a case study approach allows for crystallisation, an approach to using multiple data sources that builds on traditional triangulation (Denzin, 2012). Unlike traditional data triangulation, the aim of this approach is not for a single, unified truth or enhancing validity by attaining a more complete (and therefore accurate) view. Rather, emphasis is on the complexity and multifaceted nature of social phenomena and representing them in a rich, layered way. Examining an issue from several angles helps generate a more nuanced and comprehensive perspective of an issue, and allows for more robust patterns to be identified than from a single data source. Using crystallisation can offer explanations about how or why certain phenomena occur in specific contexts in ways that can deepen understanding and trustworthiness, while being transparent about the researcher's role in shaping the process (Ellingson, 2009).

This approach is ideal for researching service users' experiences of *Decide.* I was able to focus on a smaller dataset with multiple perspectives to gain a nuanced perspective. Given my central aim of understanding service user experience, throughout the research I tried to

keep the participants' perspectives as the focal point of my research and made their voices and my reflections on them the pillar on which I based any other data choice and collection. Moreover, as the researcher, I offer my interpretations and ongoing reflections as a valid co-creator of this critical topic to strengthen participants' voices (Flick, 2023). By using multiple data sources, I endeavoured to produce a deep understanding of participants' experiences, how they navigated and perceived *Decide*, and the meanings they attributed to their interactions with the service, showing the breadth of my study, which can be used to develop further research.

Data Sources

Online Qualitative Survey

Braun and Clarke (2013) refer to qualitative surveys as participant-generated textual data, which describes the act of participants writing (or typing) their perspectives about prompts they are given in real time. Qualitative surveys comprise open-ended, self-administered questions developed by the researcher and centred around their topic of investigation. While there are several formats of surveys (hard copy, email), this study used an online format. Braun et al. (2021) elaborate on some key advantages of using online surveys that informed my choice of method.

Firstly, these surveys are open and flexible, able to accommodate numerous topics and sensitivities. The nature of open-ended questions provides a platform for diverse experiences and perspectives. This was useful in my study as I expected that service users would come from varied backgrounds and life stages, with a myriad of factors influencing their choice to engage with *Decide*. Secondly, this format allowed participants an opportunity to respond with their own thoughts unencumbered, using terminology meaningful to them. Thirdly, and importantly, a qualitative survey is also useful when investigating potentially sensitive subjects, such as abortion experiences, because it can offer anonymity and privacy, allowing

participants to share their own experiences, thoughts, and suggestions with less fear of stigma than face-to-face data collection methods.

Other advantages of online surveys also coincide with the advantages of tele-health previously discussed. Geographical location is less problematic, and the surveys can be completed at a location and time that suits the respondent. The wider scope is also beneficial in that it allows for a larger sample to be reached, as opposed to in-person interviews. In addition, the anonymous nature also offers considerable privacy to respondents, which may give them the confidence to write more detailed responses than those they might give during an in-person or focus group meeting (Braun et al., 2021). Braun et al. (2021) are mindful of this potential and suggest these diverse approaches provide good grounds for challenging dominant practices.

Using an online anonymous survey as part of my qualitative case study approach also allowed me to uphold feminist ethics by offering participants anonymity and thus security and the avoidance of potential stigma that may be associated with disclosure (Becker et al., 2025; Kerestes et al., 2022). This was important given that abortion can be a delicate subject. Although internet access may prove difficult at times (Wi-Fi interruptions), my study is based around a tele-health service that operates through its online presence and by telephone, so I did not see internet access as a necessarily limiting factor.

Recruitment

I created an anonymous online survey using Qualtrics software. Survey questions are available in Appendix A, and the information I shared with organisations about the survey is available in Appendix B. Following the Code of Ethics Review Group (2002), I set the survey's age admission at 16 years and older. I also stipulated that potential participants must have accessed *Decide* between November 1, 2022 and June 30, 2024. I implemented this

timeframe to allow some time to pass to minimise any distress that may be associated with an unintended or undesired pregnancy, and I wanted to be sensitive in giving participants time to process their experiences with *Decide.* To take part, participants did not need to identify as any specific gender or have decided to have an abortion since *Decide* is a resource for those seeking abortion information.

I employed a range of recruitment methods, primarily social media. However, I placed a strong emphasis on establishing rapport with healthcare professionals and organisations through email and the Meta Messenger app to secure their support for participant recruitment. I created digital posters and stories (see Appendices C and D) presenting my research aims and eligibility criteria and shared these on social media pages (Meta, TikTok and Instagram). While social media can attract negative individual comments, and a pseudonym account can protect researcher anonymity (Riggs et al., 2025), I chose to advertise using my personal accounts to assist in the integrity of the study. I also emailed the digital recruitment posters and stories to the Massey University Postgraduate mailing list and every registered pharmacy, psychologist, counsellor, general practitioner, and sexual health clinic and public library in Aotearoa, as well as national organisations (political parties, members of parliament, media outlets, Rainbow communities, national women's institutions, and ethnic community organisations).

I also utilised posters in physical locations, including healthcare premises relevant to my study and public libraries, which are generally supportive of community projects and readily display advertisements. I also envisaged this as a way of reaching a wider range of people. I asked various pharmacies, public libraries, and general practitioner clinics in my town and beyond (using convenience sampling) to display my recruitment poster around their premises. Where appropriate, some clients were informed about my study directly.

Additionally, I supplied (on request) A5-size posters to a far North Island pharmacy to include in clients' abortion medication prescription packs where they deemed it appropriate.

Survey Procedure

On the survey's webpage, I provided pre-survey participation information, which explained who I am, the purpose of my study, how the data would be used, privacy and consent, and participants' rights (see Appendix E). I placed demographic questions at the beginning of my survey, followed by some general questions about the type and location of the services accessed, on the grounds that the topic is emotive, and it gave participants time to ease into the more sensitive areas of the survey, as suggested by Braun et al. (2021). Thereafter, I asked five open-ended questions, with prompts, about (1) the overall experience; (2) how well services met personal needs and concerns; (3) views on the service's ability to help a diverse range of people; (4) experiences of the remote nature of the services; and (5) how the service dealt with external support (e.g., family, friends, or caregivers) and their views on this. A final question invited respondents to share anything else they wished, to allow for insights or issues that I might not have anticipated (see Appendix A).

I also provided prompts to help with question completion, which included their right to discuss questions with any support persons if they wished and that they were under no obligation to complete the survey in its entirety or submit it. Some guidance was provided with survey questions to clarify what type of information I was interested in collecting. Braun and Clarke (2013) explain that it is important to provide clarification on the information required from to fulfil the study's purpose. In this way, I was careful not to waste their time and to collect useful data. The survey took 45–60 minutes in total if completed in one sitting. However, response time was dependent on the amount of information the participant wished to share. Once participants verified their eligibility to participate and their consent, the survey began. Participants could progress through the survey without completing all the questions if

they wished, were invited to say as much or as little as they liked, and were informed that more details would assist in better understanding their experiences.

The information screen advised that a link to enter a prize draw and access to the summary was at the end of the survey. The draw opportunity was one of 30 available Giftpay e-cards valued at $25.00, as a token of appreciation for participating in the survey. The link directed them to two questions inviting them to enter the prize draw and receive a summary of the study's findings. If the participants responded yes to either the draw or summary access, they were taken to a separate screen where they could enter their contact details. This was to ensure that responses in the main survey were not linked to the contact details they provided, and their contact details were not kept. It also allowed those who wished to remain completely anonymous.

Response Rate

Braun and Clarke (2013) suggest that a collection of 50–100 completed surveys produces adequate data from which to formulate reflective observations and sufficient analysis, depending on the depth/length of responses. Based on this advice and my budget, I sought to obtain 50–66 completed surveys. Despite extensive promotion, the survey received only 69 responses, of which 21 were legitimate, prompting the previously discussed research design change. Table 1 summarises the number of responses and how many people responded in full or only partially (i.e., did not answer all questions).

Table 1

Online Survey Responses About Experiences With Decide (N = 21)

Responses	***n***
Responded in full	10
Responded partially	11
Total	21

I used Qualtrics fraud detection tools to ascertain legitimate responses, that is, responses from humans (not bots) who met the inclusion criteria and clicked the consent button. As a quality check, my supervisor performed the task separately from me, and we compared our assessments, which aligned.

This low response rate could be explained by the fact that *Decide* is a relatively new service with a small cohort of users and, as indicated earlier, niche health groups can be difficult to reach (Dobkin et al., 2014). Ongoing abortion stigma could have also deterred participation, even when assured of anonymity. This sociocultural environment also made it difficult to gain public and institutional support. Furthermore, the nature of their experiences and lived realities may also have deterred eligible people from participation.

Participant Characteristics

Based on the demographic data gathered, most participants identified as female (90%) and were in the 26- to 35-year age range, with the majority indicating that they were born and had lived in Aotearoa their entire lives (see Table 2).

Table 2

Age, Birth, Resident, Gender Characteristics of Participants (N = 21)

Characteristic	*n*	%
Age		
16–25	4	19.05
26–35	9	42.86
36–45	7	33.33
46–50	1	4.76
Born in Aotearoa		
Yes	17	80.95
No	3	14.29
Did not say	1	4.76
Length of residence		

Entire life	17	80.95
More than 10 years	3	14.29
Out of the country	1	4.76
Gender		
Female	19	90.47
Prefer not to say	1	4.76
Did not say	1	4.76

Most participants identified as being of European descent. Of those who identified as Māori, all but one identified their iwi (tribe) (see Table 3).

Table 3

Ethnicity Characteristics of Participants (N = 21)

Characteristic	*n*	%
Indigenous		
No	15	71.42
Yes	5	23.80
Did not say	1	4.76
Iwi		
Ngāti Manawa	1	4.76
Tu Wharetoa	1	4.76
Ngāti Tumutumu	1	4.76
Whakatohea	1	4.76
Unknown	1	4.76
Ethnicity		
NZ European	7	33.33
European	4	19.05
Pākehā	3	14.29
Did not say	3	14.29
Māori	2	9.52
Indian	1	4.76
Australian	1	4.76

In terms of education, a considerable number of participants had achieved a university bachelor's degree or above, while occupations were largely cited as student or in the health and social services industry (see Table 4).

Table 4

Occupational and Education Characteristics of Participants (N = 21)

Characteristic	*n*	%
Occupation		
Health and social services	5	23.80
Student	5	23.80
Not employed	3	14.29
Hospitality and tourism	2	9.52
Public administration and government services	2	9.52
Did not say	2	9.52
Agricultural, forestry and farming	1	4.76
Education and training	1	4.76
Education		
University – Bachelor's degree	6	28.57
Graduate or professional degree	5	23.80
Some university – No degree	3	14.29
Vocational or similar	3	14.29
Secondary	2	9.52
Did not say	1	4.76

Table 5 shows that more than half of the respondents considered their residential regions as urban with access to health services such as a general practitioner or hospital. Bay of Plenty and Otago were the most represented regions. A significant number of the participants had accessed *Decide* from their current region.

Table 5

Regional Access Characteristics of Participants (N = 21)

	n	%
Service accessibility		
Urban with health services	12	57.14
Small town, nearby health services	4	19.05
Did not say	3	14.29
Urban area, health services far away/difficult to access	1	4.76
Region of residence		
Bay of Plenty	4	19.05
Otago	4	19.05
Did not say	3	14.29
Auckland	2	9.52
Taranaki	2	9.52
Wellington	2	9.52
Canterbury	1	4.76
Waikato	1	4.76
Northland	1	4.76
Manawatu/Whanganui	1	4.76
Accessed *Decide* from the region of residence		
Yes	16	76.19
No	2	9.52
Did not say	3	14.29

Table 6 shows that while participants accessed the full services that *Decide* offers, information and early medical abortion were utilised the most.

Table 6

Decide Service Type Participants Accessed (N = 21)

Service	***n***	**%**
Information	5	23.80
Early medical abortion	4	19.05
Did not say	4	19.05
Early medical abortion and advice	3	14.29
Information, advice, and counselling	2	9.52
Information and advice	1	4.76
Information, early medical abortion, and advice	1	4.76
Information, early medical abortion, advice, and counselling	1	4.76

While these demographics offer valuable information, I still lacked responses from many regions and rural areas, as well as participants from diverse cultural backgrounds. Although I can only speculate, over-reached and under-heard minority communities may be apprehensive about partaking in surveys without being certain about how their perspectives are portrayed. Furthermore, abortion has culturally diverse understandings that can determine how much, if any, information an individual is willing to share (Le Grice & Braun, 2017). Distrust, caution, silence, and misunderstanding are barriers that may have contributed to the low response rate, and in effect may suppress the full realisation of *Decide* services.

Document and Website Analysis

As mentioned, I collected additional data sources to deepen my understanding of participants' experiences. My process in selecting these sources, guided by my research question, began with me collating a list of government documents and national health websites that discussed tele-health abortion services. I systematically searched for documents that directly addressed the *Decide* abortion tele-health service in nationally recognised organisations. These consisted of the Ministry of Health, Royal Australian and New Zealand

College of Obstetricians and Gynaecologists (RANZCOG) for clinical and counselling guidelines, the Medical Council of New Zealand for specific considerations when consulting and prescribing via tele-health, the New Zealand College of Sexual and Reproductive Health for guidance on communication with service users and early medical abortion support, and the *Decide* website pages for representation of service intention. In total, I used seven separate documents and 13 *Decide* website extracts in my data analysis (see Table 7). I chose reputable national organisations dedicated to abortion guidelines for Aotearoa, each representing their position on abortion care provision.

Table 7

Data Listing Summary

Data source	Title	Type
Ministry of Health (2021)	New Zealand Aotearoa abortion clinical guideline	National guidelines
RANZCOG (2023)	Clinical guideline for abortion care: An evidence-based guideline on abortion care in Australia and Aotearoa New Zealand	Obstetrician, gynaecologist guidelines
Ministry of Health (2022b)	Paerewa mō te tumu kōrero whakatahe i Aotearoa standard for abortion counselling in Aotearoa New Zealand	National guidelines
Medical Council of New Zealand (2023)	Telehealth	Tele-health guidelines
NZ College of Sexual & Reproductive Health (n.d.-a)	MODULE 1: Consultation-communication and decision making	Consultation, communication, decision-making
NZ College of Sexual & Reproductive Health (n.d.-b)	MODULE 2: Early medical abortion	Early medical abortion
Ministry of Health (2022a)	DECIDE-Telehealth webinar	Unpublished transcript
DECIDE National Abortion Telehealth Service (n.d.-f)	A human right	Webpage
DECIDE National Abortion Telehealth Service (n.d.-a)	As a general guide	Webpage
DECIDE National Abortion Telehealth Service (n.d.-d)	Can non-binary, transgender or gender-expansive people have an abortion?	Webpage
DECIDE National Abortion Telehealth Service (n.d.-b)	Can my partner get counselling too, if I'm having an abortion?	Webpage
DECIDE National Abortion Telehealth Service (n.d.-c)	Can my support person stay with me?	Webpage

Data source	Title	Type
DECIDE National Abortion Telehealth Service (n.d.-e)	How to access abortion services	Webpage
DECIDE National Abortion Telehealth Service (n.d.-g)	I'm unsure, scared, nervous about having an abortion. Who can I talk to?	Webpage
DECIDE National Abortion Telehealth Service (n.d.-h)	New Zealand Sign Language video	Webpage
DECIDE National Abortion Telehealth Service (n.d.-i)	What about emotional side effects?	Webpage
DECIDE National Abortion Telehealth Service (n.d.-j)	What about tikanga Māori?	Webpage
DECIDE National Abortion Telehealth Service (n.d.-k)	What to expect	Webpage
DECIDE National Abortion Telehealth Service (n.d.-l)	Will there be protestors standing outside the clinic?	Webpage
DECIDE National Abortion Telehealth Service (n.d.-m)	You decide who knows	Webpage

Data Analysis

I undertook a thematic analysis, taking a largely inductive approach to draw experiential conclusions from the data, but also had a deductive element because I used a feminist standpoint theory lens to interpret the themes I produced. Thematic analysis is flexible in that it can accommodate numerous epistemological or ontological viewpoints (Terry et al., 2017), making it ideal for working with multiple datasets. I followed what Braun and colleagues call a "Big Q" approach to qualitative research, which uses an interpretive framework or paradigm for data coding and theme development (Braun & Clarke, 2013; Terry et al., 2017). This means that I considered my findings to be shaped by the theoretical framework I used as well as the interactions I had with the data, as I, the researcher, played an active role in the study's findings.

Additionally, I did not seek to simply report pre-conceived objective themes, but to understand how the themes related to the broader sociopolitical contexts surrounding abortion (Braun & Clarke, 2022). To analyse the data, I followed the six phases of thematic analysis as described by Braun and Clarke (2012). I explain my analysis process next, discussing each

phase in turn. However, these phases are not always linear, and it is common to shift between phases (Maguire & Delahunt, 2017).

Phase 1. Data familiarisation. In this phase, I became familiar with the data and identified initial patterns that may become codes (Braun & Clarke, 2012). I read the participants' responses numerous times. I sought to become deeply familiar with the content's depth and breadth by immersing myself in the words. As Braun and Clarke (2012) suggest, I posed questions about how participants interpreted their experiences and how I interpreted the textual guidelines. I wrote notes about patterns I noticed. I also spent time reflecting on these and my position in relation to them, recording my reflections in a diary.

Phase 2. Code generation. The aim of this phase was to organise the data in meaningful, manageable codes that comprised data sections. I used the comments function in my word processor to write my interpretations, thoughts, and questions. I then studied my comments and developed patterns and clustered responses under codes (e.g., satisfaction, barriers and recommendations, safety) using a combination of semantic (i.e., face value) and latent (i.e., deeper meaning) coding (Braun & Clarke, 2012). The codes generated contained sections from across the dataset. I then collated the data using a spreadsheet for each code.

Upon completing the coding, I consolidated similar items and reflected on how my understanding of feminist standpoint theory influenced my engagement with the data and the codes I created. Throughout this, I continued to journal my thoughts and observations. I recognised the process as iterative and "messy", particularly once data from different sources were combined, and therefore kept my research questions and, as discussed earlier, the participants' experience at the forefront in my analytical work.

Phase 3. Theme generation. Braun and Clarke (2012) explain that this phase involves sculpting similar codes into significant themes and sub-themes relating to research

questions. Sub-themes are data related to a main theme with a unique perspective. Using spreadsheets helped me organise the relations between these, enabling me to visualise the data in a coherent format, much like a thematic map (Terry et al., 2017). Themes were organised across the entire dataset (i.e., all data combined). Although themes identified in this phase were preliminary, it was important to ensure they were easily distinguishable from other themes. During this theme, I engaged more deeply with the data, revisiting earlier phases to make sense of the codes and highlighting those that resonated with each other. As I created initial themes, I found some codes fitted better in a different category, and their amalgamation began to weave a coherent story. Some codes no longer fitted the overall story, and did not affect the outcome whether they were present, so I decided not to carry them through so I could focus on relevant codes central to my research questions.

Phase 4. Theme review. In this phase, I focused on refining themes and checking that they authentically represented the codes. I followed two steps in this process. The first was to ensure the codes ascribed fitted each theme, and in turn, that the theme fitted the data. This involved ensuring the theme was related to my topic of inquiry and had meaningful, supportive data (Braun & Clarke, 2012, 2022). I reviewed the work of my earlier phases to check that the coding was relevant to my themes. This phase involved discarding, merging, shifting, and consolidating information to ensure that themes were distinct from each other and accurately represented my inquiry. In the second step of this phase, I assessed what I perceived as authentic across the entire dataset. This involved further reading to ensure that the themes accurately represented the story I perceived in the data. In my study, I was checking that the themes accurately portrayed the significant experiences of the participants. Themes were finalised in this phase.

Phase 5. Theme conceptualisation. This phase involves defining theme and sub-theme parameters (Terry et al., 2017) and creating concise descriptions of the story each

theme tells, along with its relation to my research (Braun & Clarke, 2012, 2022). From these conceptualisations, short representative theme and sub-theme names can be assigned. At times, I struggled with defining the parameters of my themes, and I discussed this with my supervisor. In this phase, specific data excerpts from across the dataset were assigned to their appropriate themes or sub-themes with accompanying discussions that highlighted participants' experiences, illustrating their alignment with my study's focus and feminist standpoint theory. Each theme contained at least five data excerpts to qualify theme authenticity and explicate participants' experiences (Braun & Clarke, 2013).

Phase 6. Writing up findings. In this phase, I constructed a narrative that explained the value of each theme and the insights they offered in relation to my research questions. Themes were systematically addressed and illustrated by data excerpts, explaining how they supported the theme and how they related to the focus of my study. Braun and Clarke (2012) explain that each excerpt must be interpreted and connected to the framework used. In my study, I discussed ways in which the participants' experiences could be understood from a feminist standpoint perspective. I also discussed how the findings challenged and supported current knowledge of care approaches, tele-health, and reproductive health from micro and macro views. Any spelling or grammatical errors found within respondent surveys were left in if I deemed that they did not confuse the essence of the text. Any changes made to assist in clarifying the meaning were presented within parentheses and bold font. To further ensure the quality of my analysis, I maintained constructive meetings with my supervisor. These meetings involved directions and reflections on the expectations of individual phases (Braun & Clarke, 2013). This ensured I remained loyal to thematic analysis methodology and feminist standpoint theory to provide meaningful feedback to *Decide* and the study participants.

Ethical Considerations

In the following sections, I discuss specific pragmatic points of conducting ethical research built on a foundation of researcher reflexivity. An elevated level of self-awareness is necessary to co-create an ethical response to experiences happening in the moment (Reid et al., 2018). Reid et al. (2018) refer to procedural, situational, and relational aspects, as well as the dissemination of findings, as key ethical areas. These areas cover the ethical approval process, the study's context, researcher influence, and issues arising during and after dissemination of findings.

In terms of procedural ethics, Reid et al. (2018) direct us to look beyond the codes that bind our research design and behaviour, questioning our motivations for conducting the research. Balancing personal gain with altruism is an important consideration, which is fortunately managed by an ethics committee's thorough examination. Nevertheless, it is also a reflexive question that the researcher must pose to ensure a project's foundations are built on the commitment to beneficent, non-maleficent, just, and equitable treatment of participants. I followed the ethics set out in *Te Ara Tika, Massey University Research Policy*, and the *New Zealand Psychological Society's Code of Ethics* (Code of Ethics Review Group, 2002; Hudson et al., 2010; Massey University, 2015). The following ethical considerations applied to my study.

Benefits to the Participant

By sharing their experiences and reading what others shared, participants could feel empowered and heard, as well as having an opportunity to provide feedback to *Decide*, contributing to service improvement.

Informed Consent

Consent is necessary due to the vulnerability and private nature of the participants (Roberts, 2015). Massey University's (2017) *Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants* contains elements pertaining to consent, which I considered in my study design. These include ensuring potential participants have adequate information about the purpose, aims, risks, and benefits to make an informed, voluntary, and non-coerced decision about participation, and that they are aware of where and with whom the findings may be shared.

The participant information and consent (see Appendix E) explained the study's purpose, data use, consent, rights, outcomes, and that participation was on the understanding that no personal identification information would be collected. This information screen appeared first, followed by a check box to verify consent and check eligibility requirements (see Appendix A). Eligibility was based on the responses to these questions. Those who were not eligible were phased out at that point, and the survey screen loaded for those who were eligible.

Anonymity and Confidentiality

Although an ethical consideration in any research, Braun and Clarke (2013) suggest that sensitive topics may be better suited to anonymous online surveys to preserve participants' privacy. Confidentiality and privacy were a priority in my study. The information screen also explained that all participant responses within the survey would be anonymous and anonymised before analysis, assuring them that nothing would link them to their responses. All research material would be stored securely on a password-protected computer, and no paper copies would be made. Any information the participant provided would only be used for this research and kept confidential, with access only available to my supervisor and me. Finally, as per Massey University policy, after my study is completed, the

participant's information will be held for 5 years in the Massey University School of Psychology archive and then destroyed. As previously mentioned, the link to the draw entry and summary request was provided at the end of the survey. However, participants were able to click through the survey to this secondary survey. Their contact information was not linked to their responses, nor stored following the study's completion. This method ensured anonymity.

Protection From Harm

The principle of 'do no harm' is a mainstay in research and care of subjects (Braun & Clarke, 2013). It includes actively minimising potential risks to participants and advising them of any risks that accompany the research being undertaken. Information advised participants of their right to withdraw from the research at any time, receive any necessary debriefing, and have the research's findings available to them (see Appendix E). I recognised that there may be difficult and distressing circumstances associated with an unintended, unwanted, or unsupportable pregnancy and seeking abortion care. However, similar studies to have found positive outcomes in participating (Seymour et al., 2023). I hoped that, by being invited to share their experiences, participants would find the opportunity empowering and validating. I hoped that in reading the findings, the stories of others would help to produce a sense of normalisation and relief. I also hoped that they might appreciate the opportunity to help others both in the present study and in the future.

To minimise any associated stressors, the information screen provided several pointers on survey responses. These pointers included the right not to answer any questions they did not wish to, and that they did not have to disclose any details they were uncomfortable sharing. While completing the survey, they could choose to stop participating at any time, and they were not obligated to submit their responses. By way of debriefing, as suggested by

Braun and Clarke (2013), the last question posed in my survey invited respondents to add any additional information they would like to add about their experience.

To assist in stress minimisation, I also included contact information for support services at the end of the survey (Buchanan & Williams, 2010). I also included contact details for myself and my supervisor, should they have any queries about my study, and the option to opt in to receive summary findings. Participants were informed that, upon survey submission, I would not be able to retract their responses from my analysis process because responses were anonymous, and that there would be no identifying data to connect them to their completed survey.

To mitigate any distress I might encounter from the study's content, I maintained a reflexive diary and decided that if needed, I would inform my supervisor and seek appropriate emotional support. To ensure the reputation of *Decide* staff, all survey content was anonymised, and no references were made to any individual staff member or person. Additionally, I approached the report writing from a strengths-based manner to uphold the integrity of the *Decide* service, participants, Massey University, and my study's aims.

Cultural Responsiveness

As Aotearoa is a bi-cultural nation, Te Tiriti o Waitangi forms the basis of all practices throughout the country. *Te Ara Tika Guidelines for Maori Research Ethics* outlines the Māori ethical framework for research in Aotearoa (Hudson et al., 2010). Although my study did not specifically focus on Māori, it was anticipated that I would have a diverse range of participants, including Māori, and members of other ethnicities and cultures. It was important to me that I design my study with integrity and cultural awareness.

Four tikanga (values) based principles make up *Te Ara Tiki*: whakapapa (relationships), tika (correct research design), manaakitanga (cultural and social

responsibility), and mana (justice and equity). To adhere to these principles, on the information screen, I introduced myself and referred to my personal and professional experiences with abortion. Although *Decide* provides services to under-16-year-olds, by restricting participation eligibility to 16 years and over, I demonstrated kaitiaki (care) and whakahaumaru (protection) of minors. Furthermore, the same kaitiaki and whakahaumaru were shown by providing psychological and emotional support contacts.

I understand that abortion is a sensitive topic. Through my cultural supervision and earnest research in te ao Māori (Māori worldview), my study shared an empowered voice from situated places of knowledge that are often unheard. In honouring manaakitanga, within my survey questions, if relevant, I invited respondents to share how their support people (e.g., whānau/family members, friends, caregivers) were included or accommodated during their use of *Decide* services. Finally, mana was upheld by adhering to ethical principles, ensuring the survey questions only reflected the study's aims (Markham & Buchanan, 2012), and making the findings available to inform further research in the realisation of equitable healthcare for all Aotearoa residents.

I also underwent a cultural consultation through Massey University with an expert in Māori sexual health. We discussed design and appropriate language use and tone in forming my questions, and te ao Māori views of abortion. Finally, I consulted with organisational representatives of gender minority and Asian community groups to ensure my survey was culturally appropriate.

Reflexivity

Our subjectivity (assumptions, values, experiences, ideas) affects our choices and shapes our interactions and how we interpret these. In qualitative research, it is accepted that our subjectivity will shape research, adding to the richness of the findings (Braun & Clarke,

2013). Reflexivity is the critical process that addresses our impact on the knowledge we produce, a vital component of feminist standpoint theory. My position, lived experience and understanding of abortion impact every aspect of my study. From the decision to engage in this topic of interest, the methodology and analysis choices and the implications I drew (Linabary et al., 2021).

I noted that I was both an insider and outsider (Braun & Clarke, 2022) with the study participants, and this not only affected my relationship with the data but also with previous studies I reported on throughout my literature review. I consistently questioned how this impacted my study and participants. I acknowledged the weight of power I brought as a researcher, as a woman, and the co-creation of findings impacting society. I developed a more nuanced understanding that abortion is wrapped in contentious lived realities for individuals, and multiple societal aspects and ideologies, recognising the position of situated knowledge and challenging notions of objective truth, as espoused by Harding (1995).

Through this, I endeavoured to critically analyse my own position in relation to the context of my culture, lived experience, and personal perspectives, along with the evolving nature of reproductive health and abortion care both nationally and internationally. Throughout my study, I kept a reflexive diary to help me record and manage the varied emotions and vulnerabilities that I experienced—distress, incompetence, fear, along with discussing these with trusted colleagues. The more familiar I became with other abortion stories, the more I realised the need for public openness in achieving social and reproductive justice.

These understandings enabled me to press on despite the unpopularity of abortion as a topic and the personal and professional vulnerability I face. Adhering to feminist standpoint theory assertions, I acknowledge that my study findings are but one interpretation of many

possibilities. My lived experiences provided me with a lens to explore my data and create themes; therefore, the conclusions and implications I present are reflective of my own understanding of abortion in Aotearoa. Finally, in terms of choosing a qualitative design, the attention to context and the open-ended nature of qualitative research can help generate further research (Ahmad et al., 2019). Hence, since *Decide* is a new initiative, my study could contribute to further research on service delivery, care approaches, and reflection of existing service assumptions.

Conclusion

The first part of this chapter outlined the methodological framework I used in this study, emphasising my choice to use a qualitative research design guided by feminist standpoint theory and thematic analysis to explore service users' experiences with the *Decide* abortion tele-health service in Aotearoa and national documents (textual data). I explored the benefits of using a qualitative approach along with crystallisation and collective case study methods. Benefits include flexibility and their ability to provide focused and nuanced understandings, as well as emphasising lived experience. These align well with feminist standpoint theory. I positioned feminist standpoint theory as my study's framework, which informed my survey questions and data interpretations, and presented an overview of its key tenets: situated knowledge, epistemological advantage, and strong objectivity.

The flexibility of qualitative research allows for the potential to reveal sociocultural or political aspects and practices that may shape access to, and experiences of, *Decide*'s services. As part of this, qualitative methods prioritise lived experience and participants' voices (Braun & Clarke, 2013). Focusing on lived experience helps capture information about diverse backgrounds, contexts, and identities, which can influence service use and experiences. Our experiences, history, and contexts of our lives create our knowledge. This situated knowledge provides a valuable aspect of a phenomenon. Marginalised groups have expert knowledge

about their situations and intersectional factors impacting their lives, offering a perspective that dominant groups may lack. Furthermore, their ability to understand their contexts as well as experience the effects of societies' dominant ideologies gives them a double vision, providing relevant insights for challenging structural inequalities. Strong objectivity argues that traditional narrative analysis offers only a partial view of a phenomenon. By examining our position, acknowledging the power of our interactions and positions, and being inclusive in our research practices, we can provide more nuanced and valid understandings.

The second part of this chapter provided the detailed steps I undertook in this study. Using a qualitative online survey provided a private and anonymous environment that overcame geographical barriers. This enabled participants to share their lived experiences and insights regarding *Decide*, while the textual data provided me with the means to magnify the story the voices told. The six phases of thematic analysis described the process and application in my study, detailing my code and theme development. Finally, I discussed the ethical considerations bound to the nature of my study, which included informed consent, anonymity, protection from harm, cultural responsiveness, and reflexivity. The next chapter explores the five themes I developed through my analysis, tying them together with previous abortion literature. The themes are supported by participants, national and organisational abortion documentation, guidelines, the *Decide* website, and my field notes. Together, my findings share a layered story of care, contradiction, and the ongoing challenges for equity in Aotearoa abortion services.

Chapter 4: Analysis and Discussion

Alignment with person- and relational-centred care approaches, as outlined in Chapter 2, contributes to positive service user experiences (Baum et al., 2023; Ireland et al., 2020; Koenig et al., 2024). Care that conflicts with the ethos of these care models elicits more negative user responses (Makleff et al., 2023; Ouedraogo & Juma, 2020). The provider's understanding of these care models and their effective delivery were central to how the participants perceived their interactions and overall impressions of the service and their care. Therefore, analysis of participant experiences in relation to care approaches is central to my study.

As shown in Table 8, my first theme details how participants found accessing the service convenient, informative, and inclusive, which culminated in their sense of feeling rational and capable. The second theme shows how participants were positively impacted by an emotionally responsive, empathetic, respectful, and mana-enhancing service that valued kindness and understanding. Theme 3 discusses the nuances of needs and preferences surrounding the inclusion of support networks and showcases the complexities and diverse contexts shaping an abortion journey. Theme 4 highlights the value of autonomous agency, where choice was central to participants' sense of control and wellbeing. In contrast, Theme 5 details instances which I interpret as misalignments with person- and relational-centred care. While textual data envisions supportive care, participant feedback reflects tension in service delivery. This theme contains two sub-themes; the first explores staffing shortages, timing delays, and fragmented care, compromising continuity and emotional support. The second sub-theme reflects the presence of abortion stigma, shaping individual and community experiences, pointing to a structural reassessment of abortion care.

Using reflexive thematic analysis allowed an openness to the often contradictory and messy codes that were inductively produced from the data (Braun & Clarke, 2022). These codes reflected the experiences of service users and textual data guidelines, while highlighting broader social and institutional dynamics. In line with subjective engagement, this study grounds the person- and relational-centred care principles throughout the data collection and how service users' voices were treated during analysis.

Table 8

Overview of Themes

Theme	Alignment with person- and relational-centred care	Not aligned with person- and relational-centred care
1	"Everything could be done in my lunchbreak"	
2	Feeling seen, heard, and supported: Care is relational, supportive, and attentive to emotional wellbeing	
3	Care acknowledges interdependence and honours diverse support needs	
4	Care affirms autonomy and de-medicalises abortion decision-making	
5		When person- and relational-centred care falls short: Structural strain and cultural stigma
5.1		Structural strain and fragmented care
5.2		Secrecy as safety: Navigating stigma through invisibility

Theme 1: "Everything Could be Done in My Lunchbreak"

This theme focuses on how the design and delivery of the *Decide* service reflected key principles of person- and relational-centred care, including respect, inclusivity, and responsiveness to service users' everyday lives. First, I examine how the *Decide* service is positioned through guidance documents and website materials as inclusive, responsive, and designed to reduce structural barriers. I then turn to participants' accounts to show how these values were experienced in practice, particularly in how the service acknowledged and

accommodated users' social roles, responsibilities, and emotional needs, which contributed to users feeling respected, prepared, and in control (Baum et al., 2023; Cotter et al., 2021; Kerestes et al., 2022; Roncoroni et al., 2023).

Inclusive Care

The textual data highlight that the *Decide* service is underpinned by a commitment to person- and relational-centred care, as reflected in both Ministry of Health guidance and the user-facing materials on the *Decide* website. These resources promote a model of care that is respectful, inclusive, and responsive to the lived realities of abortion seekers. The service vision is framed as addressing the cumulative burdens of women's multiple roles, their gendered labour, and the marginalisation often seen in traditional healthcare models (Klann & Golabi, 2024; Larrea et al., 2022; Shenkin, 2023). Attention to inclusive practice is visible throughout the textual data. For example, the national training materials stress that tele-health services can "increase patient access to, and choice of, healthcare services", especially for those who struggle to attend face-to-face appointments (Ministry of Health, 2022b, p. 10). Similarly, the clinical guideline of RANZCOG (2023) emphasises equitable, inclusive access (especially for Indigenous, gender minorities, and those with access challenges due to remote living or disabilities). These texts also highlight the values of person- and whānau-centred care.

Regarding user-facing material, the *Decide* website reflects inclusivity in its practical and identity-affirming design. Messages such as those shown in Figures 1 and 2 include a New Zealand Sign Language video for Deaf and hearing-impaired users (DECIDE, n.d.-h), and content is explicitly inclusive of "transgender, non-binary, and gender-expansive people" with guidance on affirming pronouns and inclusive language (DECIDE, n.d.-d). The platform also features symbols such as the Rainbow flag and refers to accessibility services such as New Zealand Relay. These design features reflect a relational model of care that recognises

users' diverse social locations and the structural barriers they may face (Donald Beasley Institute, 2025; Parker et al., 2023). They validate the experiential realities of those who have been historically excluded from safe, affirming reproductive care (Carpenter, 2021; Davis, 2013).

Figure 1

Screenshot of "New Zealand Sign Language Video"

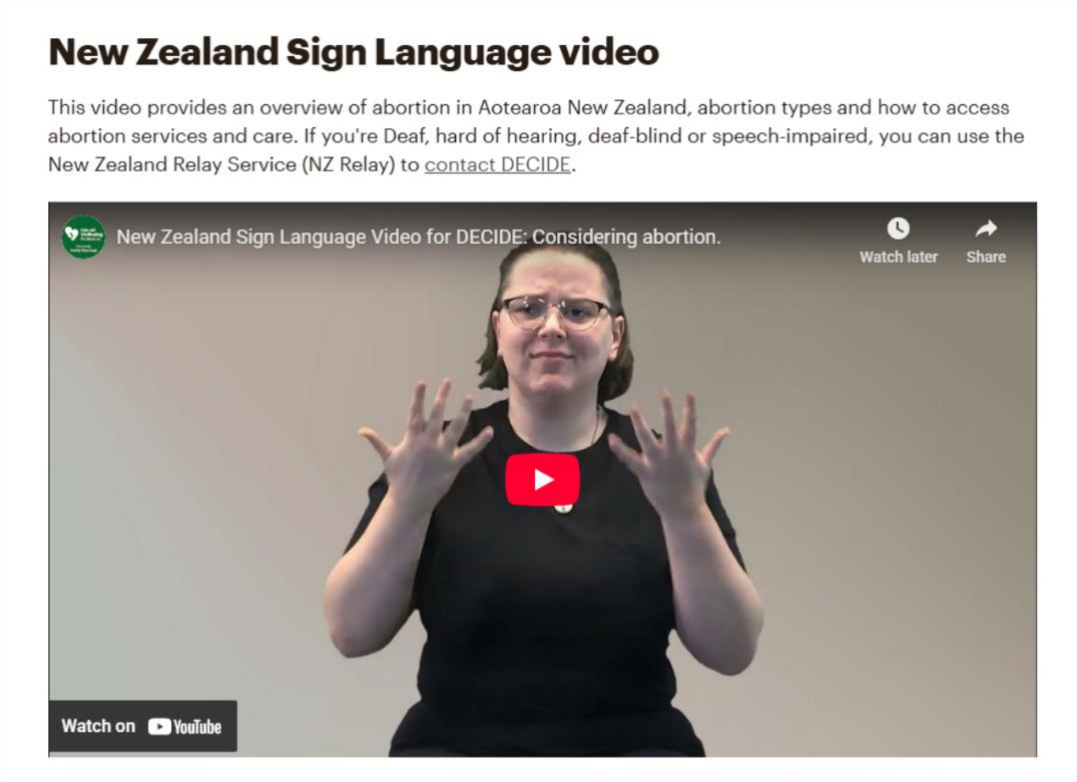
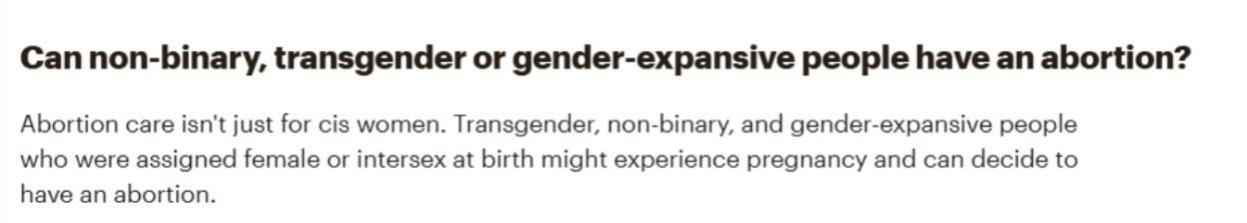


Figure 2

Screenshot of "Can Non-Binary, Transgender or Gender-Expansive People Have an Abortion?"

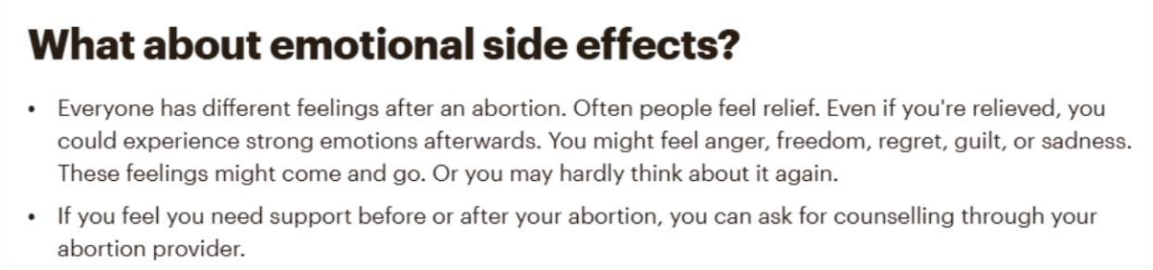


Emotional and Physical Guidance

An important feature of enhancing accessibility is the attention to emotional safety across the textual data, which reflects a person-centred ethos in which clients are understood not simply as medical subjects but as relational beings with complex needs and moral agency (Johnson et al., 2024; Porter Erlank et al., 2021; Seymour et al., 2023)**.** The website normalises a wide range of emotional responses to abortion as shown in Figures 3 and 4, stating: "You might feel anger, freedom, regret, guilt, or sadness. These feelings might come and go. Or you may hardly think about it again" (DECIDE, n.d.-i). It also states, "If you feel you need support before or after your abortion, you can ask for counselling through your abortion provider" (DECIDE, n.d.-i), placing emotional care on equal footing with physical care. This framing is further supported by detailed guidance on what to expect physically (e.g., "expected" vs "unexpected" symptoms), how to assess complications, and when to seek help, all communicated in accessible, non-judgemental language (DECIDE, n.d.-a). This material goes beyond merely informing but enables preparedness, a core feature of agency, which is central to person- and relational-centred care (Baum et al., 2023; Cotter et al., 2021; Johnson et al., 2024)**.**

Figure 3

Screenshot of "What About Emotional Side Effects?"

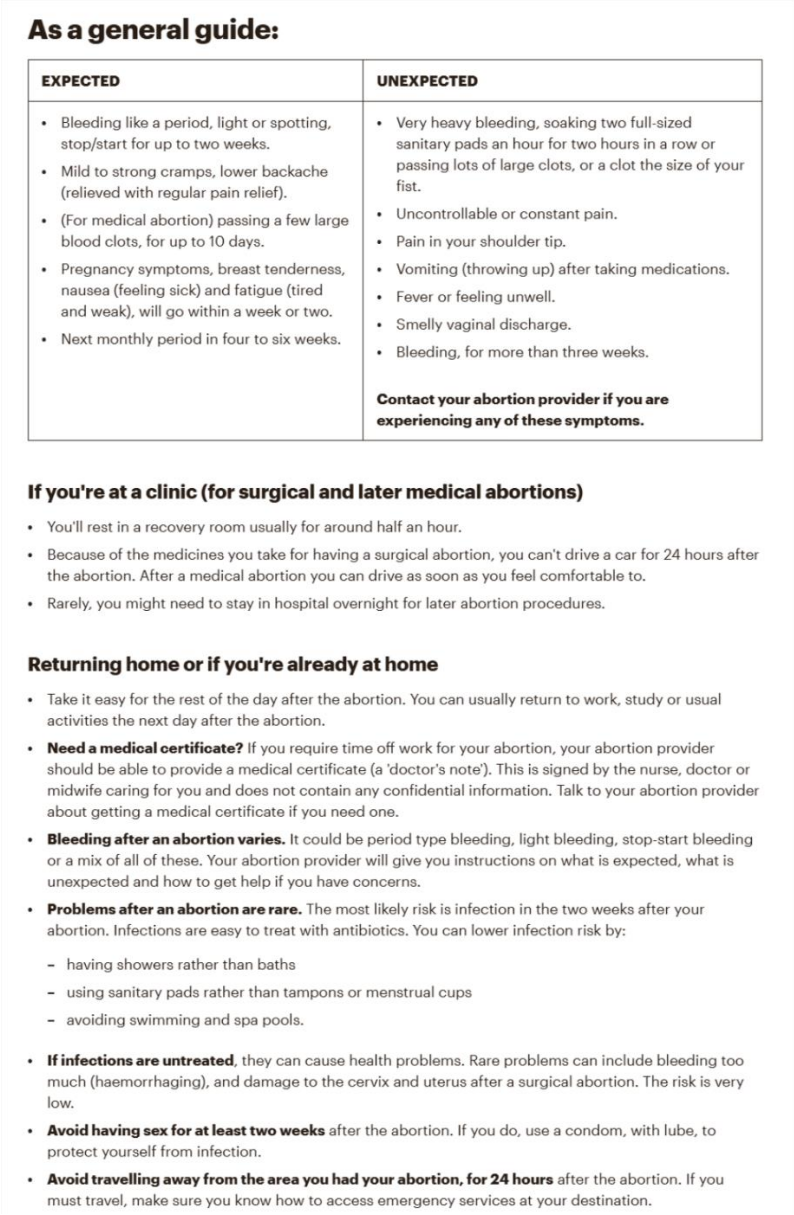


What about emotional side effects?

- Everyone has different feelings after an abortion. Often people feel relief. Even if you're relieved, you could experience strong emotions afterwards. You might feel anger, freedom, regret, guilt, or sadness. These feelings might come and go. Or you may hardly think about it again.
- If you feel you need support before or after your abortion, you can ask for counselling through your abortion provider.

Figure 4

Screenshot of "As a General Guide"



As a general guide:

EXPECTED	UNEXPECTED
• Bleeding like a period, light or spotting, stop/start for up to two weeks. • Mild to strong cramps, lower backache (relieved with regular pain relief). • (For medical abortion) passing a few large blood clots, for up to 10 days. • Pregnancy symptoms, breast tenderness, nausea (feeling sick) and fatigue (tired and weak), will go within a week or two. • Next monthly period in four to six weeks.	• Very heavy bleeding, soaking two full-sized sanitary pads an hour for two hours in a row or passing lots of large clots, or a clot the size of your fist. • Uncontrollable or constant pain. • Pain in your shoulder tip. • Vomiting (throwing up) after taking medications. • Fever or feeling unwell. • Smelly vaginal discharge. • Bleeding, for more than three weeks. **Contact your abortion provider if you are experiencing any of these symptoms.**

If you're at a clinic (for surgical and later medical abortions)

- You'll rest in a recovery room usually for around half an hour.
- Because of the medicines you take for having a surgical abortion, you can't drive a car for 24 hours after the abortion. After a medical abortion you can drive as soon as you feel comfortable to.
- Rarely, you might need to stay in hospital overnight for later abortion procedures.

Returning home or if you're already at home

- Take it easy for the rest of the day after the abortion. You can usually return to work, study or usual activities the next day after the abortion.
- **Need a medical certificate?** If you require time off work for your abortion, your abortion provider should be able to provide a medical certificate (a 'doctor's note'). This is signed by the nurse, doctor or midwife caring for you and does not contain any confidential information. Talk to your abortion provider about getting a medical certificate if you need one.
- **Bleeding after an abortion varies.** It could be period type bleeding, light bleeding, stop-start bleeding or a mix of all of these. Your abortion provider will give you instructions on what is expected, what is unexpected and how to get help if you have concerns.
- **Problems after an abortion are rare.** The most likely risk is infection in the two weeks after your abortion. Infections are easy to treat with antibiotics. You can lower infection risk by:
  - having showers rather than baths
  - using sanitary pads rather than tampons or menstrual cups
  - avoiding swimming and spa pools.
- **If infections are untreated**, they can cause health problems. Rare problems can include bleeding too much (haemorrhaging), and damage to the cervix and uterus after a surgical abortion. The risk is very low.
- **Avoid having sex for at least two weeks** after the abortion. If you do, use a condom, with lube, to protect yourself from infection.
- **Avoid travelling away from the area you had your abortion, for 24 hours** after the abortion. If you must travel, make sure you know how to access emergency services at your destination.

Overall, the textual data reflects a clear commitment to inclusivity and structural accessibility. These features indicate a strong alignment with relational and culturally responsive care, as they anticipate user diversity and actively work to reduce barriers to access and understanding. Taken together, these data reflect a service model that theoretically aligns well with person-centred care values, and especially accessibility, informed choice, inclusivity, and relational safety (Engle, 2025; Ireland et al., 2020; Johnson et al., 2024; Larrea et al., 2022; Lowick, 2017; Raifman et al., 2024; Srinivasulu et al., 2022; Tressan et al., 2024).

Turning to the service user experiences, the participants' comments aligned well with the envisioned service implementation that I identified across the textual sources, attending to equitable access to services. Many described *Decide* as a convenient service that fitted into their lives with minimal disruption. This convenience was often framed as "easy" and "fast", but more importantly, rather than requiring users to adapt to rigid models of care, *Decide* accommodated their lived realities, including women's multiple and overlapping social roles. Many participants described *Decide* as a service that fitted around their lives, enabling them to manage childcare, work, and geographic challenges without compromising their autonomy or privacy. For example:

> **Extract 1:** I liked it — busy mum, lots of kids, studying. [Participant 13, 37 years, Ngāti Tumutumu iwi, accessed information, early medical abortion by phone, advice]

> **Extract 2:** I loved I could call up and everything could be done in my lunch break… Whole thing was fast. [Participant 1, 34, NZ European, accessed early medical abortion by phone]

Extract 3: …actually I needed everything to move fast because I was getting close to the cut-off. So I was grateful I could access this service without having to faf about and organise hui around my studies and whānau life. [Participant 1, 34, NZ European, accessed early medical abortion by phone]

Extract 4: [I appreciated] How easy it was. Lovely people helping me. My situation was hard as I was moving towns as it was happening and didn't have anywhere to do the abortion. They sent it to me by mail which is amazing. [Participant 11, 22 years, NZ European, accessed early medical abortion by phone]

These quotes illustrate how participants were able to integrate abortion care into complex daily responsibilities, including work, parenting, study, geographic movement, and health challenges. They highlight the importance of service flexibility, a core principle of person-centred care that promotes responsiveness to individuals' social realities (Baum et al., 2023). Rather than requiring women to reorganise their lives around the service, *Decide* enabled care to be integrated into their routines—an example of system design that supports autonomy and dignity. The service model showed an awareness and inherent responsiveness to women who can experience multiple daily responsibilities, such as caregiving and career (Kerestes et al., 2022). As part of this, the service's flexibility and remote delivery enabled women to exercise control and autonomy, which are qualities often restricted in traditional healthcare settings. The following participant responses highlight these benefits:

Extract 5: Love the option of remote access cause it breaks down barriers of access. [Participant 4, 42 years, Māori, Ngāti Manawa iwi, accessed information]

Extract 6: Remote nature was exactly what I needed — I would have struggled to make an in-person appointment due to severe nausea + would have needed to arrange childcare. [Participant 7, 36 years, Pākehā, accessed early medical abortion by phone]

These quotations highlight appreciation for ease and flexibility. Participants' accounts suggest that the model's flexibility enabled them to navigate structural constraints such as barriers created by rurality, transience, and transport costs. Similarly, in Pleasants et al.'s (2022) study in the United States, findings highlighted how the reduction of travel distance to abortion facilities reduced health risk and curtailed added distress. The ability to receive care without unnecessary travel or scheduling burden aligns with person-centred principles of minimising disruption, reducing stress, and supporting informed self-management as found in a similar study by Srinivasulu et al. (2022) in the United States.

However, one participant who had accessed information and advice reported a mixed experience in this regard, stating, "*it was actually good and bad. I was away from my usual location, so was easy to call… but also, they were hard to get hold of*" (Participant 20, 32 years, NZ European). This experience points perhaps to the challenges that technological constraints can pose. For the most part, however, participants expressed appreciation and reflected responsiveness to the context in which service users' needs arose, which is integral to relational-centred care (Larrea et al., 2022; Malek et al., 2024). As such, the responses reflect a high level of communicative respect. Staff members were reported to have listened without judgment, provided clear information, and respected participants' emotional needs. They also reflected emotional safety, where service users reported feeling seen, understood, and in control. These are key indicators of trauma-informed, relational-centred service that is mindful in attending to safety as stated by the Ministry of Health (2022b) and in the *Decide* webpages, as evident in the following participant responses:

> **Extract 7:** I absolutely loved the care from the staff, I felt seen and understood without being victimised or "poor you". […] They provided all the info I needed and more, and checked in with my health regularly. They heard my emotional needs and responded with professionalism and care [Participant 5, 32 years, Pākehā, accessed full range of services]

> **Extract 8:** They understood the need for a medical abortion with zero judgement, and while they made me aware of the counselling services they were also not pushy... [Participant 7, 36 years, Pākehā, accessed early medical abortion by phone]

The staff are described here as refraining from imposing meaning on service users' experiences, including pity or moral judgements. Reserving judgment is significant in abortion care, where stigma can otherwise impede women's sense of self-worth and confidence (Makleff et al., 2023; Ouedraogo & Juma, 2020). Likewise, in extract 7, Participant 5 suggested feeling "understood" and highlighted the staff's acceptance of her rationale for terminating a pregnancy and, perhaps, not wishing to access counselling. This account of her experience reflects epistemic respect, in contrast to traditional models of care that position patients as passive recipients rather than experts in their own lives (Beach, 2024). These quotations highlight how responsive and respectful services can amplify women's agency in emotionally charged situations (Becker et al., 2025).

Finally, clear, accessible information was central to participants' experiences of quality care. Several women described feeling informed, prepared, and emotionally supported by how information was communicated to them throughout the process. For example, one participant noted, "*They provided all the info I needed and more, and checked in with my health regularly*" and "**[they]** *made me feel like there was a plan that'd work when it seemed chaos*" (Participant 5, 32 years, Pākehā, accessed information, counselling, early medical abortion advice). Another reflected, "*They were great to provide information as requested*

without any other unnecessary information" and "*I liked that it* **[*Decide*]** *was easy to navigate and the information was easy to read and understand*" (Participant 14, 28 years, Pākehā, accessed information). These accounts highlight how information is not just a matter of clinical clarity, but a relational act that shapes users' sense of safety, control, and legitimacy. Providing timely, clear, and respectful information aligns closely with person- and relational-centred care, where service users are understood as whole persons navigating complex emotional and social contexts.

In summary, this theme affirms that a service that is inclusive, informative, and responsive to service users' contexts (as described by the *Decide* service and documented texts), are essential components of person- and relational-centred practices. These practices, as described by participants, illustrate how they created experiences of being respected, prepared, and in control. The next theme builds on this by discussing care principles and practices that value the importance of whole-person wellbeing.

Theme 2: Feeling Seen, Heard, and Supported: Care is Relational, Supportive, and Attentive to Emotional Wellbeing

This theme covers how the relational qualities of care, including empathy, kindness, patience, non-judgment, and emotional responsiveness, shaped service users' experiences of the *Decide* service. Drawing on both the textual data and participants' accounts, it shows that these interpersonal dimensions are not simply "nice to have", but fundamental to person- and relational-centred care. When users feel seen, heard, and emotionally safe, they are better able to navigate what can be a vulnerable and morally charged experience (i.e., an unwanted/unsupportable pregnancy) with confidence and dignity. This theme complements Theme 1, which foregrounds the logistical and informational accessibility of care, by highlighting that structural access alone is not enough, and that meaningful, emotionally

supportive relationships are also vital. Together, these features contribute to a model of abortion care that centres users' lived realities and affirms their moral agency.

The textual data reflected a service model that takes emotional wellbeing seriously. Both the Ministry of Health guidance and national training modules emphasised that abortion services must be empathic, respectful, and mana-enhancing, delivered in a way that promotes dignity and autonomy (Ministry of Health, 2021, 2022b). This ethos is echoed in the user-facing language on the *Decide* website. For instance, messages such as "Know that you're not alone" and "You can talk to us" signal not only availability, but care, as shown in Figures 5, 6 and 7 (DECIDE, n.d.-e, n.d.-g, n.d.-k).

Figure 5

Screenshot: "How to Access Abortion Services"

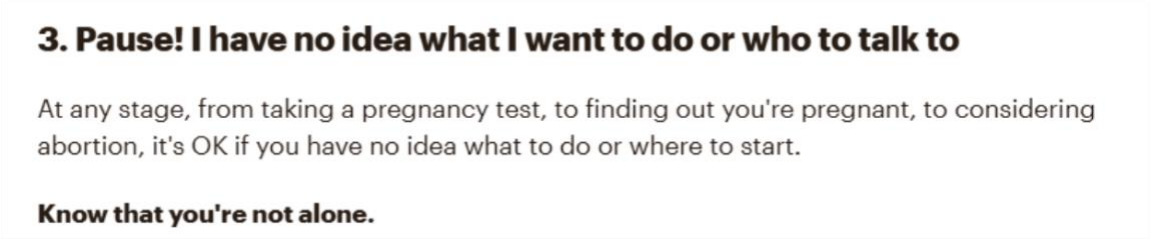


Figure 6

Screenshot of "I'm Unsure/Scared/Nervous About Having an Abortion. Who Can I Talk To?"

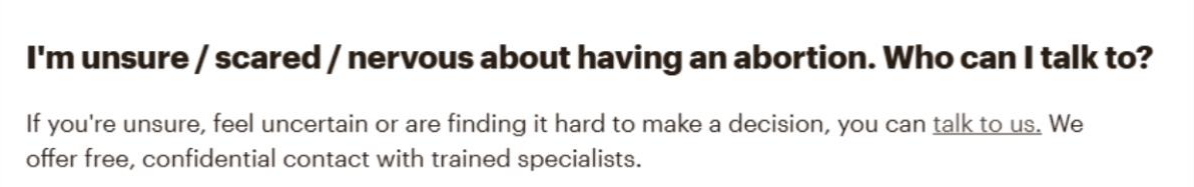
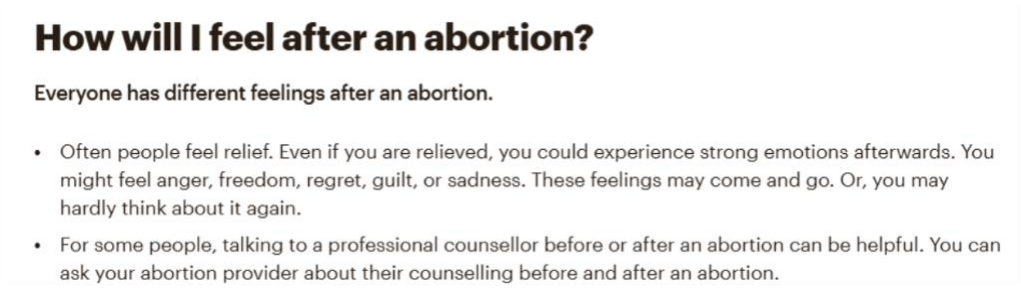


Figure 7

Screenshot of "What to Expect"



This commitment to emotional care is further reflected in counselling guidelines, which describe abortion counselling as a space where people can explore their thoughts and feelings safely, supported by therapeutic, non-directive approaches with "empathetic staff, gentle technique, music and verbal reassurance" (Ministry of Health, 2022b; NZ College of Sexual & Reproductive Health, n.d.-b, p. 10). Such framing validates emotional responses as legitimate and positions service users as agents with emotional and moral authority. Participants' accounts show that many experienced this promise of emotional care as being fulfilled. They describe staff as "*kind, understanding and empathetic*" (Participant 7, 36 years, Pākehā, accessed early medical abortion by phone), "non-judgemental", and often refer to feeling "seen", "heard", and "cared for". For example:

> **Extract 9:** Being a young female and confused, I found this service to be great. What i liked about this service is they gave me assurance and the ability to understand and cope with what was happening with my body physically and emotionally. To know that there was a service to reach out too whenever I needed. The biggest challenge I found was making an informed choice. … Decide services went above my expectations. They were patient, kind, compassionate and understanding. …At first it was a bit daunting to open up at first but they were very patient and waited till I was ready. There was no pressure at any given time. They were great and I highly

recommend their services. [Participant 10, 25 years, European, accessed full range of services]

This extended reflection captures the layered nature of person- and relational-centred care. The participant highlights not only the emotional responsiveness of staff but also the value of patience, respect for readiness, and the reassurance of ongoing support. These elements demonstrate that emotional care is not an "add-on" but fundamental to an experience of safety, validation, and autonomy. A person-centred care approach in which service users are encouraged to share their needs and providers are engaged in continual reflexivity forms the basis of a high-quality abortion experience (Moulton et al., 2025; Rowlands & Wale, 2020). This sense of connection appears to have been fostered even without face-to-face contact, as the following excerpts show:

Extract 10: The staff showed more kindness over the phone than many in-person medical services I have accessed. [Participant 7, 36 years, Pākehā, accessed early medical abortion by phone]

Extract 11: I was glad it was distance/by phone and pick up meds wherever was convenient... They heard my emotional needs and responded with professionalism and care. [Participant 5, 32 years, Pākehā, accessed full range of services]

These accounts suggest that relational qualities of care, such as kindness, patience, and attentiveness, can be powerfully conveyed in remote formats. When care is responsive and validating, it can transform what might otherwise be a clinical or even stigmatising encounter into one marked by dignity and affirmation. These findings challenge assumptions that remote care is inherently less personal or relational and instead suggest that what matters most is *how* care is enacted, not just where it takes place. Similarly, international research findings have also challenged the assumption of remote care as inferior, demonstrating tele-health services'

ability to provide quality user experiences (Boydell et al., 2021; Godfrey et al., 2023; Hoggart et al., 2024; Ruggiero et al., 2022).

In summary, this theme underscores that emotional and relational dimensions of care are central to person- and relational-centred practice. The *Decide* service, both as described in institutional guidance and experienced by participants, demonstrated that respectful and emotionally attuned care is achievable even at a distance, and that such care is essential for supporting safe, affirming abortion experiences (Ireland et al., 2020; Whitehouse et al., 2021). Building on these findings, the following theme concerns the relational ecosystem of care, focusing on service user support networks as opposed to provider support.

Theme 3: Care Acknowledges Interdependence and Honours Diverse Support Needs

Abortion care is not only experienced individually but also often in relation to others. Person-centred care must account for this interdependence and support user autonomy in choosing who (if anyone) is involved. This theme deals with support persons beyond the provider-user dyad (i.e., whānau, partners, friends) and how such support is experienced in varied and nuanced ways. While Theme 2 highlights the importance of relational qualities within provider-client interactions, this theme expands the focus to examine how participants navigated the role of social support in their abortion experiences and how *Decide* made space for this relational complexity. Drawing on textual data and participant reflections, it shows that choice about relationality is an ethically, culturally safe, emotionally supportive, and empowering option (Altshuler et al., 2021; Hendrix et al., 2023; Veiga et al., 2011).

The textual data reflect an understanding of the nuanced influence support persons can have on service users. Numerous documents refer to the right to have support throughout the entire abortion process. This is also recognised as a culturally safe practice (Ministry of Health, 2021, 2022b; NZ College of Sexual & Reproductive Health, n.d.-a). Training

materials also highlight external support as helpful in reducing any anxiety a service user may be experiencing (NZ College of Sexual & Reproductive Health, n.d.-b). This is echoed through the *Decide* website pages. For instance, messages encouraging service users to "bring your partner" and making "joint counselling" available explicitly demonstrate holistic care, as shown in Figures 8 and 9 (DECIDE, n.d.-b, n.d.-c). These textual and user-facing messages validate cultural and individual preferences as fundamental principles of person-centred care (Le Grice & Braun, 2017; Monchalin, Jubinville, et al., 2023).

Figure 8

Screenshot of "Can My Partner, Parent, Friend or Whānau Member Stay With me?"

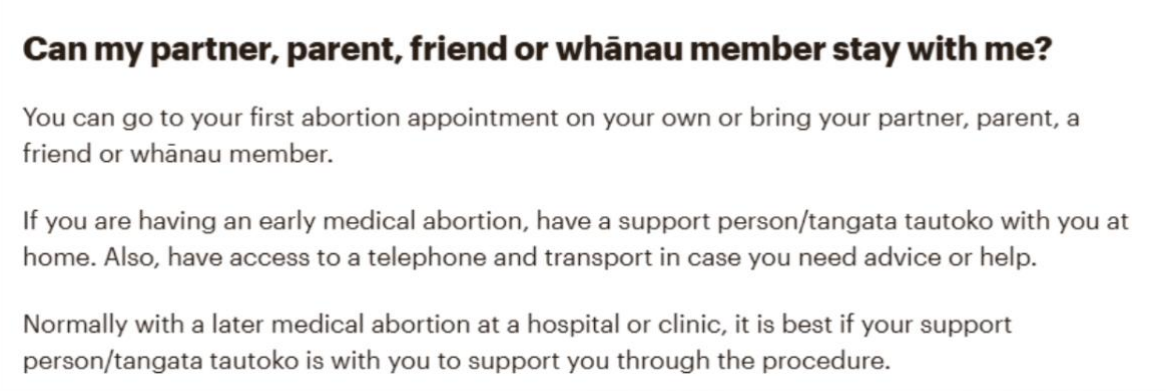


Figure 9

Screenshot of "Can My Partner Get Counselling Too, if I'm Having an Abortion?"

Conferring with this relational understanding, textual documents reflected a trauma-informed approach, ensuring users felt comfortable with their support persons and were free of coercion in their decision (NZ College of Sexual & Reproductive Health, n.d.-a). This consideration validates and honours the multiple ways service users navigate their abortion journey. Participants' accounts reflect the services' attention to their support networks. All

stated that they were asked about their support network, which many described as “great” and “helpful”. For example:

> **Extract 12:** Yes, great. They also showed care in asking what kind of network I could lean on, if I felt safe with people around me, etc. [Participant 5, 32 years, Pākehā, accessed full range of services]

> **Extract 13:** Yes, they did ask about the support I had at home. This made me feel that they were ensuring my safety (both emotionally and physically). [Participant 7, 36 years, Pākehā, accessed early medical abortion by phone]

> **Extract 14:** Yes, they did ask. Luckily for me I had a great support network outside of decide services. [Participant 10, 25 years, European, accessed full range of services]

These extracts show a service with a deep understanding of the value of inter-relational dependence. Inquiring about the ‘kind of support’ users have access to reflects a relational-care model that invites participants to self-determine how support and safety are represented in their lives—emotionally, psychologically, spiritually, and physically (Altshuler et al., 2016, 2021). Furthermore, this enquiry reflects a whole-person approach service model, acknowledging that support networks can also help mitigate abortion stigma and related stress (Altshuler et al., 2021; Hendrix et al., 2023). However, support can be experienced differently, as demonstrated in the following extracts:

> **Extract 15:** Yes they told me to seek support but i was not in a mentally right place to talk to anyone around me yet. [Participant 2, 21 years, NZ European, accessed information]

> **Extract 16:** No I think it was helpful not having alot of support. [Participant 9, 40 years old, European, accessed information]

Extract 17: They **[*Decide*]** did **[ask about support]** but I didn't realise how important that was at the time. I felt like I couldn't tell any family which they still don't know and only could tell friends. I wish it was encouraged to be more open about it with siblings and friends (doesn't have to be parents) because the more people you tell the more I realised how common it was to have an abortion. [Participant 11, 22 years, NZ European, accessed early medical abortion by phone]

These extracts suggest that meaningful abortion care contains explicitly relational and contextual dimensions. They reveal that abortion can be experienced in isolation, whether through distress or choice, and that privacy and self-reliance can also be experienced as positive or protective factors. A service model that is respectful of service users' context and position enables epistemic agency; their goals and needs influence how care is delivered and experienced (Beach et al., 2006).

However, these reflections also connect to broader abortion stigma, experienced as navigating silence and social disconnection (discussed further in Theme 5). For example, Participant 11 "...*couldn't tell any family*" wishing "... *it was encouraged to be more open about it*". This statement signals a desire for the public normalisation of abortion, because, as the participant stated, it is "*common.... to have an abortion*". The normalisation of abortion directly challenges traditional narratives and reframes care as a holistic service, one that supports alternative viewpoints and honours both individual needs (Heinsen et al., 2023; Paynter et al., 2025).

In summary, this theme shows that *Decide* acknowledges the nuanced value of support persons' presence in abortion care while recognising service users' knowledge about what is right for them. A respect for and attention to service users' support networks shown throughout textual documents and the *Decide* website express critical, emotional, and ethical supportive aspects of personal- and relational-centred care. Participants not only felt grateful

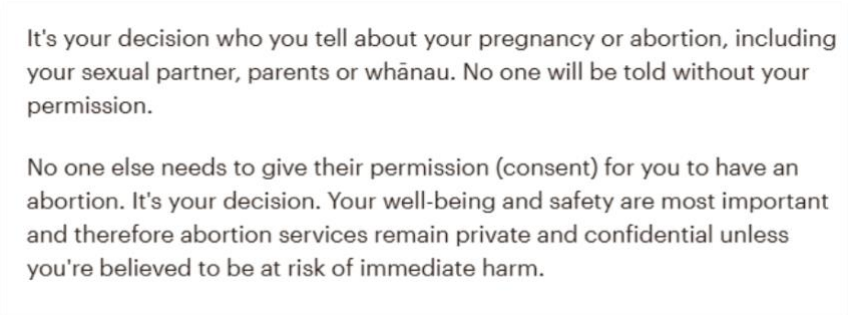
for this inclusion, but they also had the flexibility to choose what support looked like for them, although elements of stigma and an associated desire for isolation were implicit in some participants' experiences. The following theme builds on the concept of user choice and agency as key components of patient-centred care.

Theme 4: Care Affirms Autonomy and De-Medicalises Abortion Decision-Making

In this theme, I explore how the person-centred qualities of care, including informed choice and autonomy, facilitated a sense of self-determination and control among participants. Drawing on their accounts and textual documents, I show how choice is not only an imperative component of care but also a fundamental right. The textual data showed that autonomy is a core principle underpinning the *Decide* service, embedded in rights-based framing and its practical implementation. Across the website and policy documents, users are repeatedly assured of their right to make their own decisions—including choice of abortion method, consultation modality, and who is involved in their care. For example, in Figure 10, the website affirms, "Your Safety First" (DECIDE, n.d.-m) and details service users' rights to private, secure communication, refusal of treatment, and access to information that supports informed choice.

Figure 10

Screenshot of "You Decide Who Knows"



Other documents also referenced the importance of choice, for instance, regarding the method used, considering individual circumstances and preferences, and informed consent

(e.g., explaining the risks and benefits of different procedures) (Ministry of Health, 2021). Complementary to choice are service users' rights. Figure 11's messaging expresses choice as a "Right to make own decisions" (DECIDE, n.d.-f) while the Ministry of Health (2021, p. v) emphasises service users' ability to self-refer.

Figure 11

Screenshot of "A Human Right"

Similarly, documents centre users in the decision-making process (Ministry of Health, 202b), for example, ensuring they have time and the right to consider their options. In a similar vein, user independence is a focus of the Ministry of Health (2022a) and training materials (NZ College of Sexual & Reproductive Health, n.d.-a), reflecting on the importance of 'accepting' users' decisions and to safeguard their right to make non-coerced decisions. These messages reflect an effort to shift away from paternalistic healthcare and toward a person-centred model that positions service users as moral agents with full decision-making authority (Baum et al., 2023; Nelson, 2017). The service's commitment to autonomy was also evident in participants' accounts. For example, one participant wrote: "*it was helpful and made me think more rational*" (Participant 2, 21 years, NZ European, accessed information) while another noted, "*The biggest challenge I found was making an informed choice*" (Participant 10, 25 years, European, accessed full range of services). These comments reflect the gravity of the decision and the emotional labour involved, but also highlight the supportive role of the service in facilitating empowered, values-aligned decision-making.

Accounts of participants exercising autonomy and its positive impact are illustrated in the following extracts:

> **Extract 18:** I had a great experience. The person who supported me was surprised I didn't want or need counselling. But I knew what was right for me and have the abortion was what I needed and wanted. [Participant 1, 34 years, NZ European, accessed early medical abortion by phone]

> **Extract 19:** I think decide has a very high ability to help a range of people. To me, an abortion was a medical decision that I needed to do due to existing health reasons - the service made sure I was aware of the counselling support but were not pushy. They were accepting of not wanting to discuss options/emotions etc but I still felt they would be there if I did need this support... I can't quite put into words just how valuable the decide service was to me. They made a really difficult time a lot easier - it's been nearly 2 years now but I still think about the kind nurses every time abortion comes up in the media, and I'm extremely grateful that there was such an easy service to access. [Participant 7, 36 years, Pākehā, accessed EMA by phone]

In these extracts, there is a shift from the paternalistic assumption that abortion care must be uniformly experienced, thereby requiring emotional support, to one that radically expresses the uniqueness of situated knowledge. Participant 1's comment about the provider being "surprised" she did not want counselling reflects the assumption of abortion as necessarily traumatic, and possibly paternalism on the part of the service provider. Her response of knowing what she wanted represented a shift in power in the provider-user relationship, which is advocated by the person-centred care model, offering agency that has previously not always been afforded to women service users. Not only did the participant know what was 'right' for her and what she 'wanted', the service honoured this, indicating shared decision-making and respect. Likewise, Participant 7 reported that providers "were not

pushy" about engaging her in counselling. Such respect for a service user's determination of her own needs and desires reflects person-centred principles. The ability to make autonomous decisions, such as those seen in these extracts, as well as having access to clear information, further counters traditional stigmatising views of abortion.

As the extracts show, care was experienced as affirming and transformative, countering dominant narratives that construct abortion as morally suspect or requiring justification (Kerestes et al., 2022; Maffi & Tonnessen, 2019). Other participants explicitly valued the emphasis on privacy, calling the service "discreet" and praising its confidentiality protections. Together, these accounts and documents point to an approach that treats abortion as a normal and legitimate healthcare decision—one that belongs to the person seeking it. In this way, *Decide*'s design and implementation embodied core person-centred care values: respect for autonomy, informed choice, and the provision of care that aligns with individuals' preferences, values, and needs. Having examined alignments with person- and relational-centred care, I now explore misaligning incidents. The following theme explores occasions where user experiences did not match service intentions, exposing the impact of fragmented care.

Theme 5: When Person- and Relational-Centred Care Falls Short: Structural Strain and Cultural Stigma

While most of the survey data highlighted a flexible and responsive approach to service users' lived realities, needs, and preferences, a few participants described negative experiences. These appeared to be exacerbated by the pervasive stigma surrounding abortion in Aotearoa and beyond. As previously highlighted, abortion stigma is influenced by cultural, religious, and male-dominant ideologies. These influences shape abortion decision-making and care quality (Gilbert & Sewpaul, 2015; Morison, 2023; Sorhaindo & Lavelanet, 2022). However, fewer participants reported negative experiences, potentially due to fewer

respondents willing to share these, a downside to self-selection surveys or perhaps an unwillingness to expand in detail, a possible consequence of survey fatigue (Braun et al., 2021). Similar issues were raised in conversations with some service providers working in the sector during recruitment, indicating that the challenges described here may be more widespread.

This final theme addresses reports of where person- and relational-centred care fell short due to delays, fragmentation, provider disengagement, or stigma. International studies have shown that these gaps in care impact users' wellbeing (Jung, Fiastro, et al., 2023; Mazza et al., 2021; Strong et al., 2023). I explore care misalignments that arose when lived realities were not adequately supported by the systems and contexts in which abortion care was delivered, highlighting how sociostructural barriers and persistent abortion stigma erode care quality, autonomy, and trust. I attend to both the structural design of the service and the sociocultural climate surrounding abortion in Aotearoa.

The theme is presented in two interrelated sub-themes. In the first, "Structural strain and fragmented care", I examine how staffing shortages, delays, and disjointed care pathways compromised continuity, emotional support, and timely responsiveness, all core tenets of relational-centred care. In the second sub-theme, "Secrecy as safety: navigating stigma through invisibility", I explore how abortion stigma continues to shape service users' experiences, creating emotional risk and compelling them to manage care through strategies of secrecy and silence. Together, these sub-themes show how even a well-intentioned, values-driven service such as *Decide* can fall short when it operates within systems that remain structurally and culturally inhospitable to abortion care.

In each sub-theme, as before, I examine the related *Decide* service and textual data before turning to participants' accounts offering insight about how experiences that fall short

of service vision impact not only users' agency but their sense of safety. These gaps of care are direct contradictions of the tele-health model's potential to provide adaptable, acceptable, and safe care, thereby compromising user confidence and autonomy (Chong et al., 2021; Gibelin et al., 2021; Ireland et al., 2020; Koenig et al., 2024; Raymond et al., 2019; Seymour et al., 2022).

Structural Strain and Fragmented Care

The Ministry of Health (2021) emphasises that tele-health can reduce access barriers by providing "timely abortion care" (p. v) and more efficient care pathways, founded on the concept of consistent and quality care (see also Ministry of Health, 2022b, pp. 3, 10). However, the following extracts reveal how systemic constraints can undermine these intended outcomes:

> **Extract 20:** Timing was a challenge, I know there's only so many staff for so many of us. This meant having to wait and go through very difficult situations and emotions while weeks went by waiting for my turn. [Participant 5, 32 years, Pākehā, accessed full range of services]

> **Extract 21:** Problems and challenges– the waiting time for the appointment (over Easter which also made it worse). [Participant 7, 36 years, Pākehā, accessed early medical abortion by phone]

These extracts point to systemic barriers that sit in tension with person- and relational-centred care principles. Participant 5 sympathetically notes the limited availability of staff, with "only so many staff for so many of us". Her account illustrates how staffing shortages led to long waits, during which she endured hardship and strain, including "very difficult situations and emotions" without clarity about when care would be provided. Similarly, Participant 7 points to how the timing of public holidays (in this case, Easter) further delayed

access, worsening her experience. In both cases, delayed care undermined timely responsiveness, an essential tenet of person-centred care (Footman, 2025; Mazza et al., 2021; Sudhinaraset et al., 2020; Summit et al., 2020).

Even when *Decide*'s design promotes person-centred values, failures in implementation due to under-resourcing, staff shortages, lack of integration with local services, or provider disengagement, can reproduce the very forms of marginalisation it seeks to remedy. Participants described limited control over communication and unpredictable contact, which undermined their sense of preparedness and autonomy. These findings echo international research demonstrating the emotional toll of abortion-related delays and the need for follow-up care that affirms women's experiences (Gerdts et al., 2016; Kerestes et al., 2022; Noonan et al., 2023; Wasser et al., 2024). This picture of systemic strain was corroborated by a service provider I spoke to during recruitment. She responded to my request to recruit through her clinic by detailing several concerns about service delivery through the national abortion tele-health service:

> **Extract 22:** We have only seen a few women who had contact with The National Service, less than 12 in the 2 years of the National Service's operations. Of these seven did not complete their abortions with The National Service mostly because of the delays involved in communicating with them, we took them on. For the first four of these women, we wrote to the National Service to convey the level of distress we had had to deal with. The replies were less than satisfactory. […]

> Another woman came to us in a distressed state to discuss her care and have counselling and then proceeded with the National Services medications only to return for follow-up and contraception with us. Two women were delayed by the National Service process and then referred to us to organise a surgical abortion. These situations are really difficult for us as we have very limited access to surgical TOP because of the shortage of seditionists and anaesthetists. One woman who had been on holiday out of Gisborne had engaged with the National Service and then presented to us with retained products. Finally one woman had an okay experience and then presented to us for an IUS **[intrauterine system]** at 2 weeks post-procedure so we had to do a workup to ensure that the process was complete before we could fit the device. [Service provider A, personal communication, October 1, 2024]

This testimony provides a sobering account of the emotional and clinical consequences when access is delayed or follow-up care is fragmented. It also highlights the strain placed on local providers who, despite limited resources, often step in to fill service gaps. These accounts are symptomatic of broader structural constraints. Labour shortages, lack of ring-fenced funding, and limited clinical capacity for procedures such as surgical abortion all appear to compromise the ability of the service to provide timely, person-centred care.

According to the annual report produced by the Ministry of Health (2024), just 25 *Decide* staff members serviced 3,899 abortion seekers in the 2023–24 period. Of those who identified as Māori, 53% did not receive follow-up abortion care. These figures suggest that misalignments in care may be less about service values and more about the larger health system design and resourcing. A lack of political will and marginalisation of abortion care within health funding structures may be contributing factors. Similarly, international abortion research findings indicate a culmination of funding priorities and policies that undermine

abortion care resources (Baier & Behnke, 2024; de Moel-Mandel et al., 2019). Delays in care can result in fragmentation, which compromises continuity and weakens relational aspects of care. This was evident in the experience of one survey participant, who reflected:

> **Extract 23:** I was super affected by the pill and was in a bad mental state for a couple months after. Counselling I didn't enjoy. As I didn't trust the person I was seeing. A check up from one of your ladies would've been appreciated to see how I was going emotionally not just physically. [Participant 11, 22 years, NZ European, accessed early medical abortion by phone]

Here, the participant's unmet emotional needs reflect a breakdown in person- and relational-centred care. The absence of follow-up and the impersonal nature of counselling left her feeling unsupported and exposed. This experience illustrates how fragmented care can erode rapport, leaving women concerned that providers are neither emotionally present nor attentive to their unique circumstances. As suggested in earlier extracts (Participants 5 and 7), delays further compounded distress in already emotionally charged situations. This sentiment was also echoed by the service provider quoted earlier, who subsequently attempted to support my recruitment by contacting eligible participants directly. She reported:

> **Extract 24:** I can remember the names of five women who used tele abortion. I made contact with four, three of whom agreed to consider the survey. I drove round town and delivered the flyers to each of them (not so far). The fourth woman got upset just mentioning tele abortion so I withdrew gently and the fifth I couldn't contact. [Service provider A, personal communication, February 23, 2025]

Her comment illustrates not only the emotional toll of participants' experiences but also the lingering distrust and distress that discouraged some from participating in the research at all. It is possible that those who felt poorly supported by *Decide* were among those

least likely to engage with my survey, suggesting that the experiences captured here may under-represent the full extent of service user dissatisfaction. These accounts also point to how service users' distress and other negative feelings can be exacerbated within a cultural climate where abortion stigma persists.

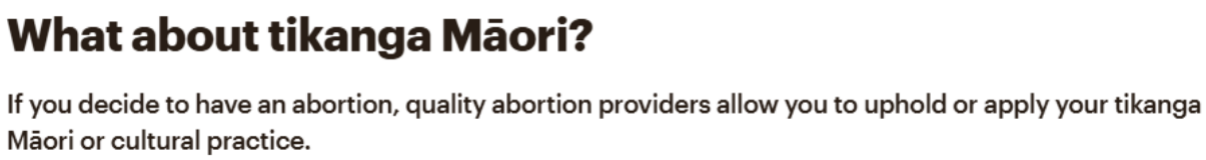
These accounts show that care fragmentation, delays, and provider disengagement are not merely operational issues, but expressions of deeper structural constraints, including underfunding, workforce shortages, and lack of integration with local services. However, participants' experiences were not shaped by systemic design alone. The emotional and relational costs of care were also shaped by persistent stigma, which continued to structure how abortion was accessed, discussed, and felt. In addition to structural constraints, participants described how stigma (both overt and ambient) shaped their experiences of abortion care. Even in a post-decriminalisation context, abortion remains morally and socially contested, producing emotional labour, silence, and a need for self-protection, as I discuss next.

Secrecy as Safety: Navigating Stigma Through Invisibility

The *Decide* service and national documents acknowledge abortion stigma and have integrated safety factors within their systems. Cultural safety is interwoven throughout to ensure equitable service access, adherence to Te Tiriti o Waitangi, the support of cultural practices, and the opportunity to include cultural advocates (Ministry of Health, 2021, 2022b; NZ College of Sexual & Reproductive Health, n.d.-a, n.d.-b; RANZCOG, 2023). These principles are affirmed by *Decide*'s communication in Figure 12 (DECIDE, n.d.-j).

Figure 12

Screenshot of "What About Tikanga Māori"



In terms of physical safety, the Ministry of Health (2022a, pp. 2–3) emphasise non-judgment and legal protection from harassment, as illustrated by the *Decide* message in Figure 13 (DECIDE, n.d.-i). Furthermore, the Abortion Services National Telehealth webinar transcript (Ministry of Health, 2022b, pp. 3, 6) expresses the importance of collaboration with local providers to minimise any forms of stigma.

Figure 13

Screenshot of "Will There Be Protestors Standing Outside the Clinic?"

However, the structural context of abortion stigma is less often addressed. In this sub-theme, I explore how service users navigated that cultural terrain, often relying on secrecy and invisibility as strategies for safety. Stigma remains a significant barrier to relational and person-centred abortion care. Although abortion is broadly legal and widely accepted in Aotearoa, this acceptance is often conditional and dependent on circumstances such as age, relationship status, or perceived responsibility (Addante et al., 2021; Cerulli, 2024; Getahun et al., 2023; Larrea et al., 2022; Maffi & Tonnessen, 2019; Sorhaindo & Lavelanet, 2022).

These societal conditions create a climate where stigma continues to operate subtly and overtly, shaping women's emotional experiences and their perceptions of care. As a researcher, I encountered this stigma directly. Throughout the recruitment process, I faced reluctance from some organisations to support the study, often due to anti-abortion views. I received personal attacks claiming that the *Decide* service and my research were "scams" and I encountered people who refused to engage with the topic unless the word "abortion" was replaced with euphemisms such as "termination" Even when the university's communications team reached out to national media outlets to promote the study, there was no response. These examples reflect the wider cultural silencing and discomfort that continue to surround abortion, even in a post-decriminalisation context (Footman, 2025).

This wider climate of stigma can exacerbate personal ambivalence and emotional distress, as indicated by one of the participants, "*The only challenges I faced was my own with my decision*" (Participant 6, 24 years, NZ European, Tu Wharetoa iwi, accessed information, counselling, advice). The comment highlights how internal conflict shaped by societal norms can weigh heavily on people making decisions about pregnancy. Those who choose to terminate must often navigate not only personal circumstances but also the moral judgements of others. As the following quotations show, stigma can manifest even in peripheral interactions with the healthcare system, compounding the difficulty of seeking and receiving care:

> **Extract 25:** The lab test place I went to saw the south island address of decide and started asking questions about what the place was and what it was for (I did not feel comfortable sharing this while just trying to get a blood test). I also had to provide the names of a few local pharmacies before we could send the script to one that would supply the medication. None of these were the services fault, but did provide challenges. [Participant 7, 36 years, Pākehā, accessed early medical abortion by phone]

Here, logistical barriers overlap with a lack of discretion from third-party providers, making the participant feel scrutinised in an already vulnerable context. While the participant was careful not to blame *Decide* directly, these experiences reflect a deeper misalignment with person-centred principles of privacy, dignity, and emotional safety. The participant was effectively made to justify the existence of the service and act as a conduit between disconnected parts of the healthcare system, all while navigating a potentially distressing pregnancy/abortion experience. This requirement reflects an inadequate system and the gendered burden of navigating fragmented care systems, where collaboration is assumed but

not reliably enacted. This directly contradicts the vision of tele-health abortion services as working smoothly with local providers (Ministry of Health, 2022a).

This added burden of self-explaining, coordinating, and managing stigma contributes to emotional exhaustion. It underscores how abortion stigma is not merely interpersonal but structurally embedded in healthcare processes that leave women vulnerable, unseen, and unsupported. One participant raised this structural dilemma, stating that "*The only downside from my perspective is it* **[siloed abortion services]** *adds to the perceived stigma of abortions being something done in the dark*" [Participant 1, 34, NZ European, accessed early medical abortion by phone]. Both this comment and extract 25, while differing in their challenges, are based on inherent stigmatised foundations. Similarly, another participant reflected on the impact of perceived judgment and exclusion:

> **Extract 26:** I was pushed away. It was utter crap. I needed support and help. And it felt like those who were careless got more support than someone who was in my situation. [Participant 20, 32 years, NZ European, accessed information and advice]

The participant draws on dominant moral narratives that frame abortion as justifiable only in certain circumstances, highlighting how stigma can produce hierarchies of worthiness—a sense that some people deserve support more than others. In this way, stigma not only affects service delivery but also shapes how care is experienced and remembered. These responses point to the emotional labour involved in managing abortion in a society where it is simultaneously legal and stigmatised. Consequently, many participants described a need for secrecy or invisibility as central to feeling safe (Røseth et al., 2024). While *Decide*'s commitment to confidentiality was appreciated, participants' comments reveal how secrecy was not simply a preference but a protective strategy, one shaped by cultural norms that continue to construct abortion as morally suspect or socially unacceptable. In the following extracts, the ability to retain secrecy is equated with safety:

Extract: 27: I loved how the person and place on the other end had a database of "safe" places to pick medication needed up from. [Participant 1, 34 years, NZ European, accessed early medical abortion by phone]

Extract 28: Loved also that I was asked every time if it'd be safe to call/email, etc. shame that's necessary, thanks for that tho. [Participant 5, 32 years, Pākehā, accessed full range of services]

Extract 29: Not really I found that decide could be more advertised. [Participant 14, 28 years, NZ European, accessed information]

These responses reflect how stigma operates at multiple levels—internalised, interpersonal, and institutional, reinforcing silence, shame, and avoidance (Footman, 2025). While *Decide*'s confidentiality protocols were clearly experienced as supportive, they also signal that abortion care remains marginalised and distinct from "normal" healthcare. In this way, safety assurances, while essential, may inadvertently reinforce the idea that abortion is taboo or dangerous, contributing to a broader cultural climate of stigma (Crasnow, 2014).

Even when participants felt empowered in their decision, they were often limited in their social freedoms, needing to carefully manage when and how they could communicate, where they could pick up medications, and with whom they could share their experiences. One participant noted the emotional burden this creates, stating "*they* **[service providers]** *told me to seek support but i was not in a mentally right place to talk to anyone around me yet*" (Participant 2, 21 years, NZ European, accessed information). This quote exemplifies how stigma shapes not only access but also emotional wellbeing and self-expression. Being "not in the right place" suggests a heavy burden of self-surveillance, which requires confidence not only in one's own decision but also in how others may respond. International abortion studies found similar accounts in which abortion seekers felt vulnerable and uncertain about their

social and professional connections (Kumsa et al., 2023; Noonan et al., 2023; Ruggiero et al., 2022).

Added to this, one participant expressed her need for providers to "*Pronounce Māori names better*" (Participant 4, 42 years, Māori, Ngāti Manawa iwi, accessed information). This quote challenges Māori understanding of abortion and demonstrates how stigma operates differently across cultural contexts. Language is one way of expressing cultural beliefs; a disconnection in comprehension risks a failure in providing adequate tailored support (Le Grice & Braun, 2017; Napier-Raman et al., 2024).

While *Decide* aspires to person- and relational-centred care, these qualities can be undermined when abortion must be managed through limited cultural understanding or secrecy. The broader cultural silence around abortion, where even the name of the service was unknown to some healthcare professionals, reinforces this marginalisation. During the research, I received emails from clinicians unaware of *Decide*'s existence, and I encountered pharmacies that had either never heard of the service or were reluctant to be publicly associated with it, citing concern for staff and reputation, similar to what was found among Australian doctors (Noonan et al., 2023). This supports Participant 14's observation that *Decide* "could be more advertised". In fact, their comment epitomises an international study finding structural mechanisms intentionally stifling abortion providers' advertising abilities (Piazza & Augustine, 2022).

When a service remains invisible, people may struggle to access it, particularly those who do not already have knowledge of or confidence in navigating the health system. Cultural stigma cannot be resolved through service-level protections alone. A structurally competent health model would acknowledge how broader systems (legal, cultural, and institutional) shape experiences of both safety and silence (Downey & Manchikanti; Metzl & Hansen,

2014). Ultimately, secrecy can serve as a form of self-protection in a stigmatising environment. But it can also isolate users, undermine support networks, and compromise the relational qualities that are essential to holistic, person-centred abortion care (Heslin et al., 2024). Stigma disrupts relational safety and undermines person-centred care by constraining openness, eroding trust, and creating distance between service users and providers. Even when the service model itself aspires to inclusivity and compassion, the surrounding cultural context can undermine those intentions. A truly relational-centred model must account for these broader forces, recognising that emotional support and affirmation are not just clinical add-ons, but essential components of care.

The accounts presented in this theme show how person- and relational-centred care can falter when it fails to engage with the full complexity of peoples' lived realities, and especially so in moments of vulnerability, uncertainty, and stigma. When delays, fragmentation, or lack of responsiveness occur, participants described feeling isolated, disrespected, and emotionally unsupported. These experiences undermine the service's aim of offering inclusive, equitable, and affirming care, and highlight the persistent gap between system intent and practice. Importantly, these misalignments are not merely individual failures but reflect broader systemic neglect. They show how marginalised knowledge such as women's lived experiences, situated emotions, and social contexts, are often sidelined in favour of institutional logics (de Moel-Mandel et al., 2019; Dwamena et al., 2012; Shai et al., 2021; Shaw et al., 2024). Structural fragmentation and silences entrench stigma and contribute to feelings of invisibility and shame. Indeed, the operation of stigma can be seen across multiple levels in the findings: individual, interpersonal, and institutional. Participants expressed anxiety about being judged, described silence in personal and professional networks, and even reported that some healthcare professionals were unaware of *Decide*'s existence. These findings mirror international literature showing that abortion stigma silences disclosure, limits support, and obstructs access to care (Addante et al., 2021; Antony et al.,

2025; Bhandari et al., 2024; Hoggart, 2017; Mazza et al., 2021; Middlemiss et al., 2024; Sudhinaraset et al., 2020; Summit et al., 2020).

Although *Decide* offers a promising model of accessible and inclusive care, its success relies on adequate resources, workforce preparedness, and integration with broader healthcare systems. Relational-centred care is not just about kindness. It demands structural competence**,** possessing awareness of the dynamic shifts in the economic, physical, sociopolitical, cultural and historical influences on health outcomes (Metzl & Hansen, 2014), and a responsive system with deliberate effort to counteract stigma. Without these conditions, abortion seekers risk navigating their decision in isolation, with autonomy compromised rather than supported (Altshuler et al., 2016; van der Waal & van Nistelrooij, 2022).

Conclusion

In this chapter, I analysed participants' accounts of their experiences with the *Decide* national abortion tele-health service, along with textual data supporting service implementational guidelines. I have specifically focused on person- and relational-centred care approaches, and how participant experiences align (or do not align) with these health models. In this way, I have foregrounded participant insights, thus meeting a feminist standpoint theorist lens. In using a case study methodology, the numerous textual documents I have analysed magnify participant voice and contribute to the understanding of how abortion care is experienced in Aotearoa.

The textual data showed a tele-health model of care that values a respectful, inclusive, empathetic, culturally and emotionally responsive, non-judgmental and informative approach that envisions emotional safety, equitable, and timely access. While autonomy and a focus on individual preferences are evident, which are person-centred care qualities, both the national documents and *Decide* embrace the presence of wider support networks, which are a strong

relational-care component. The flexibility of the service and attention to lived realities, acknowledging the often multiple and overlapping social roles service users experienced, meant that many participants found the service "fast" and "easy" to navigate with minimal interference in their daily lives. Furthermore, the inherent nature of a tele-health service to overcome geographical barriers meant that participants could maintain their confidentiality needs with reduced access barriers.

In their accounts, participants explained their understandings of how a successfully implemented health model impacted their sense of feeling capable, in control, and well-prepared in making choices about their reproductive journey. This was further validated by participants determining who, if anyone, would walk alongside them in their abortion journey. Throughout the themes aligning with person- and relational-centred care, the service maintained high levels of emotional care, and this attentive, tailored approach helped participants feel "seen" and "heard", which are both crucial validating experiences. I reflected throughout these themes that a strong autonomous choice was felt by the participants and encouraged by the service.

However, in Theme 5, my analysis explored occasions depicting the overarching constraints of abortion care operating within structural, societal, and internalised abortion stigma contexts. Staff shortages, timing delays, cultural tensions, lack of interagency cohesion and service awareness, and moral ambivalence caused fragmented care. Weighing heavily on users, these prominent gaps in care culminated in compressed autonomy and emotional vulnerability. The continued persuasiveness of abortion stigma was relayed in discussions about how an abortion seeker should be treated, who is more deserving of empathy, and how a siloed abortion service can contribute to ongoing stigmatising attitudes. While participants were grateful for the service, it was also described as a "shame" that so much safety and privacy were sought at every interaction.

Chapter 5: Concluding Discussion

This study was driven by four research questions:

1. How do service users describe their experiences of care through the *Decide* national abortion tele-health service?

2. In what way do these experiences align or diverge from person- and relational-centred care frameworks?

3. How do service users' social positions, such as daily commitments, culture, and geographical location, shape their care experiences?

4. How do service users' experiences and perspectives reflect broader narratives of gender, power, and marginalisation in abortion care?

Using a qualitative case study design guided by a feminist standpoint lens and, in conjunction with person- and relational-centred care frameworks, I foregrounded service users' perspectives alongside textual data from the *Decide* website, national organisational documents, and my field notes. This design allowed for crystallisation of the data (Ellingson, 2009), offering an approach that centres women's experiences, locating them within the contextual factors (systemic and societal) that support or hamper reproductive agency and power. Feminist standpoint theory is an excellent theory for interpreting abortion care experiences. Its advantage is the ability to highlight how power and voice are both acknowledged and marginalised, creating reproductive in/justice (Morison, 2023).

In this chapter, I present a summary of my findings—alignments and lapses with person- and relational-centred care approaches, discussing how findings relate to feminist

standpoint theory and previous abortion research literature. I then present my reflections on the study, including methodological choice, recruitment strategy, participant characteristics and my positionality. Finally, I discuss implications and potential future research directions.

Key Findings

The qualitative survey data capture largely positive service user experiences, but also challenges to service access. Analysed thematically alongside the textual data (7 relevant documents, 13 *Decide* website extracts, and my field notes), I generated five themes that highlighted alignment with person- and relational-centred care frameworks (Themes 1–4) as well as failures to deliver such care (Theme 5). The findings reveal the strengths of the *Decide* service, as well as ways that its goal of delivering equitable person-centred care can be undermined, in particular by healthcare system issues and ongoing, pervasive abortion stigma. In this section, I describe how person- and relational-centred care was reflected in service design and how the tele-health service itself was perceived positively by many participants. In addition to this, I describe the positive impact of an emotionally responsive and inclusive service model.

Overall Alignment Between Decide's Service Model and User Experiences

The *Decide* service was experienced by many as convenient, accessible, and supportive of autonomy. The inherent flexible and private nature of tele-health meant participants could access services on their own terms (Porter Erlank et al., 2021). Textual data and the *Decide* website showed attention to inclusive, equitable access, centring the service user's preferences and illustrating ethical practice (Baum et al., 2023; Nelson, 2017; Oberman & Lehmann, 2023). Participants' experiences highlighted the value of a health model that reflects the situated knowledge of those navigating the service, disclosing the contrast in traditional models that do not often recognise their realities (Crenshaw, 1989). In turn, this understanding of user situated knowledge (Haraway, 1988) is foundational to the person- and

relational-centred care approaches reflected in the service's design. In practice, emotionally responsive, respectful communication, and transparent information reflect key user empowering principles (Baum et al., 2023).

The Importance of Emotional/ Relational Care. Feeling "seen", heard, and emotionally supported contributed to participants' sense of safety and confidence during their abortion process. The service's detailed empathy, understanding, and moral support reflect the ways in which the service values users' dignity, wellbeing, and positive provider-user interaction (Cotter et al., 2021). Moreover, participants expressed appreciation of compassionate, non-judgmental interactions. Relational aspects such as empathy, patience, and non-judgment were described as more than just "nice to have"; they were essential to quality care. This reflects *Decide*'s understanding that care is more than a clinical process (Sudhinaraset et al., 2020); rather it is embodied in relational, cultural, and emotionally integrated care (Moulton et al., 2025; Rowlands & Wale, 2020). This attuned care mirrors similar abortion research, finding caring and validating approaches fundamental to positive and safe user experiences (Ireland et al., 2020; Whitehouse et al., 2021), and are important tools in grounding traditionally marginalised groups as privileged experts (Harding, 1995).

Inclusion of Others in Care (External Support). While person-centred care qualities such as autonomy and a focus on individual preferences were evident, both the national documents and *Decide* embrace the presence of wider support networks, which is a strong relational-care component. As found in international abortion research (Altshuler et al., 2016, 2021; Paynter et al., 2025), participants appreciated both being asked about their support networks (seeing this as ensuring their "emotional and physical" safety) and having the option to include others, although experiences varied. While some participants welcomed external support, others preferred privacy, and yet others longed to share their experiences with loved ones. Choice and agency regarding who (if anyone) to involve were important and reflected

the relational nature of decision-making. By supporting this contextual nature of the abortion process (DECIDE, n.d.-b, n.d.-c; Ministry of Health, 2021, 2022a; NZ College of Sexual & Reproductive Health, n.d.-a). *Decide* fundamentally challenges traditional conceptualisations of whose knowledge shapes care, acknowledging users' epistemological advantage (Hartstock, 2019).

These findings align with person- and relational-centred care approaches, highlighting the value of a care model that looks beyond medical need, integrating empathy, contextual and cultural awareness, and shared power and in turn, promoting autonomy, facilitating empowered decision-making, and reducing harm (Baum et al., 2023). The findings suggest that tele-health services can deliver compassionate abortion care despite non-personal contact by attending to care principles. Tele-health abortion care in Aotearoa is founded on concepts that promote and value women's social position and agency, positioning it as a relational service.

Lapses in Person- and Relational-Centred Care

Despite the overall positive findings, lapses in care were reported by some participants, which hampered rapport and contributed to distrust and emotional distress, mirroring international findings (Kerestes et al., 2022; Wasser et al., 2024). This reveals a tension between the service model's inclusive and person-centred intentions and structural factors such as funding, labour resources, policy, and societal views, impacting service delivery and undermining their autonomy. It was apparent that systemic issues and structural inefficiencies played a role, including pervasive abortion stigma. Each of these will be discussed in turn.

Gaps in Service Delivery Reflect Structural Disconnection, Not Just Operational Delay. Participants' accounts show that care fragmentation, delays, and poor follow-up are

not merely service-level hiccups, but structural failures rooted in underfunding, staff shortages, and a lack of integration with local health systems. These gaps produce emotional and relational consequences, with women describing feeling forgotten, unsupported, or even forced to seek care elsewhere. Some had to manage burdens that should belong to providers (e.g., coordinating pharmacies, chasing follow-up), which not only compromised care but eroded trust and safety. Findings showed that when care fell short, participants struggled with emotional distress, with a call for abortion to be integrated as a normalised reality.

Person- and relational-care approaches are important foundational factors in effective and equitable abortion care. However, these care approaches are bound by broader systemic support where low funding affects the labour force and service facilities (Footman, 2025). The gendered labour, lack of agency collaboration, staff shortages, and hesitancy in garnering support described by some participants and myself reflects systemic underfunding, and distinct cultural blindness, which challenges national guidelines emphasising cultural and physical safety and collaboration (Ministry of Health, 2021, 2022a, 2022b; NZ College of Sexual & Reproductive Health, n.d.-a, n.d.-b, p. 4; RANZCOG, 2023). These misalignments do not reflect a collaborative or agentic-friendly user experience, mirroring international findings pointing to systemic devaluation of abortion care (Piazza & Augustine, 2022; Shai et al., 2021; Shaw et al., 2024). In terms of feminist standpoint theory, this amounts to epistemic injustice, in which marginalised groups are inappropriately cared for and further silenced (Ampofo et al., 2015; Collins, 2022).

Stigma is Embedded and Multifaceted, Compromising Care at All Levels. While affirming interactions were described, a persistent underlying internalised stigma prevailed, and a significantly prominent structural abortion stigmatisation emerged. Stigma was not limited to isolated incidents of judgment but operated at multiple levels: internal (self-doubt or shame), interpersonal (avoidance, silencing, suspicion), and institutional (lack of

professional awareness, poor public visibility of *Decide*). Even where individual staff were respectful, stigma in the broader social and professional environment undermined the service's promise of relational safety. Participants described expecting judgment, withholding disclosure, and feeling they had to protect themselves, all of which undercut the relational goals of the service. As one respondent reported, "*I didn't trust the person I was seeing*" (Participant 11, 22 years, NZ European, accessed early medical abortion by phone), underscoring how stigma fractures the emotional foundations of care.

Occasions arose where knowledge of *Decide*'s existence was lacking among agencies and health professionals. The lack of collaboration risks the maintenance of abortion stigma, as does its siloed existence (Footman, 2025). These realities hinder quality care and proliferate burdening silence and vulnerability, adversely impacting service users' sense of dignity, which is essential to person-centred care (Sudhinaraset et al., 2017). In effect, the disconnection between agencies diminishes relational-centred care by invisibilising provider self-reflexive practice (Holten et al., 2021; Merner et al., 2024), an important relational-care component, and instead emphasises dominant abortion narratives (Mouafo, 2024).

The impact of abortion stigma is dispersed throughout service funding resources, delivery, and public attitudes, creating power imbalances between those seeking help and those dictating worthiness, perpetuating vulnerable situations for service users, driving ambiguous decision-making, and marginalising minority groups. From a political perspective, the awareness of the influence stigma has in shaping equitable access is paramount in affecting change (Harding, 2004). It is important to contextualise these findings, especially their largely positive leaning, by reflecting on some aspects of the research design and how this shaped the survey data.

Reflection on the Data

While my study offers valuable insights into participants experiences with and perceptions of *Decide* abortion tele-health services, it is also worth considering how the data were shaped in particular ways by my design choices, specifically in relation to: (1) the survey method I used, which had both advantages and drawbacks; (2) recruitment strategies and the difficulties of locating participants from a "hard-to-reach" group; and (3) the participant characteristics in terms of capturing diverse perspectives. I discuss each of these aspects, as well as how my own identity and personal experience of abortion shaped how I approached the research and data analysis.

Use of Survey Methodology

While an anonymous online survey's strengths lie in assuring anonymity or confidentiality and having a wider geographical reach, it can lack substantial opportunities to delve deeper into participant experiences, especially in comparison to focus groups or one-to-one interviews (Braun et al., 2021). The lack of interactional depth and anonymity meant I could not invite further reflections on their responses, nor provide nuances that might better define the relational experiences participants had with *Decide*, including those communicated through physical expressions. Online surveys also risk excluding marginalised groups (Braun & Clarke, 2013), as previous research exploring digital division has shown (Haimi, 2023; Ortiz et al., 2022; Somefun et al., 2023).

I took care in designing an empathetic survey acknowledging participants' autonomy and safety. Participants were able to answer as little or as much as they chose and were under no obligation to submit their responses if they did not wish to. My reflections on conducting this study via an online survey revealed that I was unable to convey or receive non-verbal cues, which often communicate a story. Nor was I able to interact with participants to verify my understanding of their intended meanings or explore their responses in-depth with them. A

drawback of online surveys is that they risk excluding marginalised groups (Braun & Clarke, 2013), such as individuals who lack access to digital devices or experience intermittent connectivity (Clare, 2021). However, the strength of my design was that it was accessible, anonymous, and honoured principles of autonomy and relational ethics.

Online surveys are ideal for exploring sensitive topics and capturing diverse perspectives from a range of backgrounds, utilising open-ended questions (Braun & Clarke, 2013). These types of questions elicited responses of varied length and depth; some provided rich content, while others were brief. Although I worked diligently throughout my coding phase, the ratios of participant responses to textual codes were uneven in some themes. In particular, while a great deal of textual data focuses on cultural and mana-enhancing practices, the ratio of participants identifying as Indigenous was exceptionally low compared to Europeans. This has the potential to influence analysis by presenting an unbalanced cultural perspective (discussed further below).

Recruitment Strategy and Challenges

Participation in my survey was voluntary and self-selected. The inherent risk in surveys inviting people's perspectives is that responses may not reflect a full range of experiences. The sensitivity and vulnerability of abortion likely impacted willing participants. Certainly, my field notes revealed that those who had particularly negative experiences were reluctant to participate. A further point about self-selection is that an online survey collection method requires participants to possess some digital literacy (mentioned previously), as well as comfort in written personal expression, particularly in this context. This study may lack representation from individuals who lack digital literacy, have limited internet access, or face challenges that affect their writing ability, or those who are uncomfortable producing a written record of their experiences (Braun & Clarke, 2013).

Participant Characteristics and Capturing Diverse Perspectives

Participant demographics encompassed a wide age range and primarily represented individuals born and raised in Aotearoa. Although the survey explicitly asked participants whether their specific needs and circumstances (including cultural needs) were acknowledged, very few responses addressed this dimension of care. This silence is analytically significant, especially given that abortion service guidance in Aotearoa strongly emphasises Te Tiriti o Waitangi as a framework for delivering equitable, mana-enhancing, and protective care (Ministry of Health, 2021). National standards expect providers to engage with cultural competence, work in partnership with Māori, and centre te ao Māori worldviews (Ministry of Health, 2022a; NZ College of Sexual & Reproductive Health, n.d.-a). The lack of participant commentary on these aspects may reflect an absence of cultural engagement within the care experience itself, or it may reflect the limitations of the sample.

Most participants were of NZ European or Pākehā descent, and it is possible that those who felt culturally unsafe, marginalised, or alienated by the system chose not to participate. As others have argued, language and cultural barriers can erode trust and disrupt relational care (Fiastro et al., 2023; Munson & Hall, 2024). The absence of such accounts here may point not to a lack of concern, but to a form of structural exclusion. From a feminist standpoint perspective, recognising this silence is critical: it reminds us that the voices heard in this research do not necessarily represent all experiences, and that those most affected by cultural inequities may also be the least likely to be visible in research. Attending to these absences helps avoid reinforcing assumptions of neutrality or inclusiveness in tele-health abortion care and points to the urgent need to centre Indigenous perspectives in abortion research and practice (Mouafo, 2024). In relation to participant characteristics, my study was limited by the small number of participants. In total, 21 responses were received.

Although my analysis approach allowed for crystallisation, providing data that enabled me to accentuate the participant's voice, ideally, I would have preferred a greater number of respondents to bolster my interpretations. Nevertheless, this study does present strengths critical to abortion care in Aotearoa. It reflects lived experience, bridging the gap between theory and human realities, thereby displaying voices both missing and benefiting from abortion care. This study is socially relevant given the globally diverse approaches to abortion care and the more recent law reform in Aotearoa (Goodyear-Smith, 2023; Mayall et al., 2025). By choosing to frame this study through a feminist standpoint theory lens, it offers further insight into gender, relational, and systemic inequities, contributing meaningfully to feminist and health literature. Furthermore, this theory grounds the value of a reflective, inclusive, and relational approach as a foundational practice in abortion care provision, strengthening its findings and trustworthiness.

Researcher Identity

Finally, as a feminist researcher using feminist standpoint theory with lived experience of abortion and values that align with reproductive justice, these factors influenced the focus and interpretations of my study, and relational-centred care piqued my interest. While I have regularly shared my position, illustrating my continual commitment to critical reflexivity, it is essential to note that another researcher of a different background may have highlighted aspects that I did not and framed the analysis quite differently. Although this is a limitation, it is also a strength, as feminist standpoint theory acknowledges that one’s situated knowledge can offer insights that are overlooked by dominant narratives. In the next section, I discuss the implications of my study.

Future Research

These study findings offer both systemic and service-level opportunities to strengthen aspects of care. I will begin with those relevant to research and follow with service and systemic recommendations.

Implications and Takeaways for Researchers and the Service

Similar to previous research, this study showed that attention at the service level in promoting a respectful, emotionally, and contextually supportive environment throughout the entire abortion journey was crucial to women's sense of emotional and mental wellbeing (Boydell et al., 2021; Hoggart et al., 2024; Larrea et al., 2022). However, this study also shows how values of empathy, inclusion, and responsiveness can be undermined by systemic constraints and stigma. Relational-centred care must be analysed alongside structural conditions. Future research should explore how *intentions and frameworks* interact with *contextual realities* in service delivery.

Foregrounding user experience is vital. A variety of research designs and methodologies, such as participatory and arts-based methods, as well as one-to-one interviews, can create environments that illustrate the realities of abortion care as a relational experience, providing public education. Research and service evaluation based on the lived experiences of those at the centre of service, such as this study, can help identify practices that strengthen autonomous and relational interactions (Braun & Clarke, 2013). From a feminist perspective, this builds socially and structurally just abortion care. Using feminist standpoint theory helped illuminate how marginalised knowledge, such as lived experience, emotional needs, and relational contexts, are often sidelined in institutional settings (Morison, 2023). This approach offers a powerful tool for reforming not just practice, but the systems shaping that practice.

Stigma remains a central mechanism of exclusion. Even after legal reform, abortion stigma persists in subtle and overt forms. To better understand how a siloed abortion service impacts service users' and public perceptions of abortion stigma and to gain a nuanced perspective of how voice, cultural safety, and equity are present in Aotearoa abortion care, researchers should continue to examine how abortion stigma operates across levels. This can be informed by policy and discourse, as well as micro-interactions, and how it can be resisted through relational, culturally safe, and rights-affirming care (Collins, 2022). Suggested communities include: LGBTQIA+, Indigenous, migrants, people living with disabilities, and rural regions.

Recommendations for the Service and System

Structural investment is critical for delivering relational-centred care. Responsive, inclusive, and affirming care cannot be achieved solely through values statements. *Decide* must be adequately resourced and integrated into the broader healthcare system to prevent delays, disjointed care, and over-reliance on users to coordinate their own treatment (Ireland et al., 2020; Mazza et al., 2021; Noonan et al., 2023). Cultural and structural stigma must be explicitly addressed. Stigma is not just an attitudinal problem; it permeates systems, interactions, and policy silences. Staff training should incorporate structural competence (Metzl & Hansen, 2014) and abortion-specific stigma awareness to ensure care environments support emotional openness and safety.

Further investments in relational training and reflective practice can help improve cultural and rapport gaps, while enhancing shared care planning with chosen support networks, thereby facilitating positive outcomes. Additionally, these initiatives allow awareness and flexibility to flourish when considering the diversity of service users' needs that align with person- and relational-centred care. Furthermore, engaging with provider views involves exploring how *Decide* staff perceive their roles in providing relational care,

how they perceive the constraints of their service implementation, and how they manage the accompanying stigma and heightened emotional context of their work.

Care must attend to both autonomy and relational connection. Respecting decision-making is vital, but when services do not follow up or are emotionally disengaged, women may feel *abandoned in autonomy*. Check-ins, affirming interactions, and trauma-informed practices are crucial for supporting users in vulnerable moments. Structured follow-up calls built into every completed abortion experience have the potential to counter isolating and disconnecting emotions often associated with abortion, redressing the lack of confidence some participants experienced with *Decide* services. This means designing protocols and check systems that ensure staff are meeting their planned appointments and have systems in place to update service users of any delays. These simple communication acts can help women feel 'seen,' which is a self-validating and principal factor in wellbeing (Boydell et al., 2021; Larrea et al., 2022).

Support networks should be included in a flexible and safe manner. While some participants valued relational support, others preferred privacy or feared judgment. Services should continue to ask about users' networks, but in ways that respect autonomy, trauma histories, and stigma-related silencing (Altshuler et al., 2016; Veiga et al., 2011). Addressing the ways in which social support affects decision-making, emotional wellbeing pre-, during, and post-abortion would facilitate a better understanding of relational-centred care principles

Visibility and legitimacy of abortion care must be normalised (Larrea et al., 2022). The relative invisibility of *Decide* (e.g., providers unaware of the service and media silence) reinforces abortion's marginal status. Greater public education, inter-provider communication, and policy recognition are needed to bring abortion care into the mainstream of health services. Participant feedback points to a greater need for coordination between

abortion-related services and a more integrated approach within primary and community health settings. Although unintentional, the delays, shortage of providers, and fragmentation in care fuel a disempowered and continued abortion stigma. Relevant investment in abortion services to facilitate equitable access across both urban and rural areas, and policy-level action that normalises abortion as a routine healthcare appendage, can address structural gaps. Moreover, the evident societal-wide abortion stigma shining through this study, a distinct barrier contributing to secretive, morally ambiguous, and dehumanising views, can be addressed through public and health education and further workforce development.

Conclusion

My study was underpinned by a commitment to reproductive and social justice. I wanted to know how abortion care was received and delivered. I acknowledged that often those most impacted by healthcare provision are not heard, and I wanted to address this imbalance. The gaps and tensions I explored revealed how people's experiences are shaped by their position and the systems of power to which they are subject. My study intersects psychology, feminist research, and reproductive justice by prioritising minimised voices, therefore disrupting and adding to dominant narratives of abortion care. Through crystallisation, I was able to demonstrate how structural, inter-relational, and cultural factors shape experiences. This is an invaluable multi-textured view of abortion care representing the complexity of abortion decision-making as well as resisting reductionism, honouring co-creation of meanings, relational dynamics, and reflexivity as typical feminist methodological components.

In highlighting the importance of a care model that is culturally safe, timely, and emotionally responsive, this study contributes to reproductive justice action. The impact of digital exclusion, stigma, gender, and cultural constraints is embodied in the realities shaping experiences of care. In this way, my findings provide a call to reframe abortion access and

care as normalised, holistic, and equity-focused, and care that affirms identity, dignity, positionality, and autonomy. In terms of wider social power, my study provides realistic and practical insights that ground care systems in relational and inclusive design.

Abortion care is about addressing the needs of people. It is a relational and politically ethical practice that must at its heart carry meaningful connection, dignity, agency, and justice for and with abortion seekers. Tele-health abortion care is a service with fantastic potential. I am mindful that the themes I have developed highlight the importance of grounding policy and service delivery in the voices of those affected by it throughout the design, delivery, and service evaluation processes. While my study offers an observational snippet and cannot be generalised, I do hope that it offers some contextual depth and appeals to social discourse around the care and normalisation of abortion in Aotearoa.

References

Abortion Legislation Act 2020. https://www.legislation.govt.nz/act/public/2020/0006/latest/LMS237600.html

Addante, A. N., Paul, R., Dorsey, M., McNicholas, C., & Madden, T. (2021). Differences in financial and social burdens experienced by patients traveling for abortion care. *Women's Health Issues*, *31*(5), 426–431. https://doi.org/10.1016/j.whi.2021.06.002

Adu, J., Roemer, M., Page, G., Dekonor, E., Akanlu, G., Fofie, C., Teye, M. D., Afriyie, P. O., Affram, A. A., Ohemeng, F., Tabong, P. T.-N., & Dwomoh, D. (2023). Expanding access to early medical abortion services in Ghana with telemedicine: Findings from a pilot evaluation. *Sexual and Reproductive Health Matters*, *31*(4). https://doi.org/10.1080/26410397.2023.2250621

Ahmad, S., Wasim, S., Irfan, S., Gogoi, S., Srivastava, A., & Farheen, Z. (2019). Qualitative v/s. quantitative research: A summarized review. *Journal of Evidence Based Medicine and Healthcare*, *6*(43), 2828–2832. https://doi.org/10.18410/jebmh/2019/587

Aiken, A. R. A., Gomperts, R., & Trussell, J. (2017). Experiences and characteristics of women seeking and completing at-home medical termination of pregnancy through online telemedicine in Ireland and Northern Ireland: A population-based analysis. *BJOG: An International Journal of Obstetrics & Gynaecology*, *124*(8), 1208–1215. https://doi.org/10.1111/1471-0528.14401

Aiken, A. R. A., Romanova, E. P., Morber, J. R., & Gomperts, R. (2022). Safety and effectiveness of self-managed medication abortion provided using online telemedicine in the United States: A population based study. *The Lancet Regional Health – Americas*, *10*, 100200. https://doi.org/10.1016/j.lana.2022.100200

Aiken, A. R. A., Starling, J. E., & Gomperts, R. (2021). Factors associated with use of an online telemedicine service to access self-managed medical abortion in the US. *Journal of the American Medical Association Network Open*, *4*(5). https://doi.org/10.1001/jamanetworkopen.2021.11852

Aiken, A. R. A., Starling, J. E., Gomperts, R., Scott, J. G., & Aiken, C. E. (2021). Demand for self-managed online telemedicine abortion in eight European countries during the COVID-19 pandemic: A regression discontinuity analysis. *BMJ Sexual & Reproductive Health*, *47*(4), 238–245. https://doi.org/10.1136/bmjsrh-2020-200880

Aiken, A. R. A., Tello-Pérez, L. A., Madera, M., Starling, J. E., Johnson, D. M., Broussard, K., Padron, E., Ze-Noah, C. A., Baldwin, A., & Scott, J. G. (2023). Factors associated with knowledge and experience of self-managed abortion among patients seeking care at 49 US abortion clinics. *Journal of the American Medical Association Network Open*, *6*(4), e238701. https://doi.org/10.1001/jamanetworkopen.2023.8701

Allen, B. J. (1996). Feminist standpoint theory: A black woman's (re)view of organizational socialization. *Communication Studies*, *47*(4), 257–271. https://doi.org/10.1080/10510979609368482

Allsworth, J. E. (2022). Telemedicine, medication abortion, and access after Roe v. Wade. *American Journal of Public Health*, *112*(8), 1086–1088. https://doi.org/10.2105/AJPH.2022.306948

Altshuler, A. L., Nguyen, B. T., Riley, H. E. M., Tinsley, M. L., & Tuncalp, Ö. (2016). Male partners' involvement in abortion care: A mixed-methods systematic review. *Perspectives on Sexual and Reproductive Health*, *48*(4), 209–219. https://doi.org/10.1363/psrh.12000

Altshuler, A. L., Ojanen-Goldsmith, A., Blumenthal, P. D., & Freedman, L. R. (2021). "Going through it together": Being accompanied by loved ones during birth and abortion. *Social Science and Medicine*, *284*. https://doi.org/10.1016/j.socscimed.2021.114234

Amoah, E., Enos, J. Y., Ganle, J., & Maya, E. T. (2023). Adolescents' satisfaction with abortion services received and factors associated with satisfaction at reproductive health centres. *Journal of Advanced Nursing*, *79*(12), 4828–4841. https://doi.org/10.1111/jan.15823

Ampofo, A. A., Asa Adjei, E., & Kyerewaa Brobbey, M. (2015). Feminisms and acculturation around the globe. In J. D. Wright (Ed.), *International encyclopedia of the social & behavioral sciences* (2nd ed., pp. 905–911). Elsevier. https://doi.org/10.1016/B978-0-08-097086-8.64021-7

Antony, M. R., Umali, S. E., & Hanna, F. (2025). The impact of socioeconomic barriers on access to telehealth services for medical abortion in Australia during the COVID-19 pandemic. In R. Kai-Yu Tong & B. Ganesan (Eds.), *Digital technology in public health and rehabilitation care* (pp. 331–352). Elsevier. https://doi.org/10.1016/b978-0-443-22270-2.00022-8

Ashton, N. A. (2023). Evidence, relativism and progress in feminist standpoint theory. In M. Lasonen-Aarnio & C. Littlejohn (Eds.), *The Routledge Handbook of the Philosophy of Evidence* (pp. 209–220). Routledge. https://doi.org/10.4324/9781315672687-20

Assifi, A. R., Kang, M., Sullivan, E. A., & Dawson, A. J. (2020). Abortion care pathways and service provision for adolescents in high-income countries: A qualitative synthesis of the evidence. *PLOS One*, *15*(11), e0242015. https://doi.org/10.1371/journal.pone.0242015

Atreya, A., Adhikari, K., Nepal, S., Bhusal, M., Menezes, R. G., Shrestha, D. B., & Shrestha, D. (2024). Striving toward safe abortion services in Nepal: A review of barriers and facilitators. *Health Science Reports*, *7*(2), e1877. https://doi.org/10.1002/hsr2.1877

Baier, A., & Behnke, A. L. (2024). Barriers to abortion provision: A qualitative study among medical students and gynecologists in Berlin, Germany. *Contraception*, *130*. https://doi.org/10.1016/j.contraception.2023.110325

Baraitser, P., Free, C., Norman, W. V., Lewandowska, M., Meiksin, R., Palmer, M. J., Scott, R., French, R., Wellings, K., Ivory, A., & Wong, G. (2022). Improving experience of medical abortion at home in a changing therapeutic, technological and regulatory landscape: A realist review. *BMJ Open*, *12*(11), e066650. https://doi.org/10.1136/bmjopen-2022-066650

Baum, S. E., Jacobson, L., Ramirez, A. M., Katz, A., Grosso, B., Bercu, C., Pearson, E., Gebrehanna, E., Chakraborty, N. M., Dirisu, O., Chowdhury, R., Zurbriggen, R., Filippa, S., Tabassum, T., & Gerdts, C. (2023). Quality of care from the perspective of people obtaining abortion: A qualitative study in four countries. *BMJ Open*, *13*(9), e067513. https://doi.org/10.1136/bmjopen-2022-067513

Baum, S. E., Wilkins, R., Wachira, M., Gupta, D., Dupte, S., Ngugi, P., & Makleff, S. (2021). Abortion quality of care from the client perspective: A qualitative study in India and Kenya. *Health Policy and Planning*, *36*(9), 1362–1370. https://doi.org/10.1093/heapol/czab065

Beach, M. C. (2024). Disrespect in health care: An epistemic injustice. *Journal of Health Services Research & Policy*, *29*(1), 1–2. https://doi.org/10.1177/13558196231212851

Beach, M. C., Inui, T., Frankel, R., Hall, J., Haidet, P., Roter, D., Beckman, H., Cooper, L. A., Miller, W., Mossbarger, D., Safran, D., Sluyter, D., Stein, H., & Williamson, P. (2006). Relationship-centered care: A constructive reframing. *Journal of General Internal Medicine*, *21*(Suppl. 1). https://doi.org/10.1111/j.1525-1497.2006.00302.x

Bearak, J., Popinchalk, A., Ganatra, B., Moller, A. B., Tunçalp, Ö., Beavin, C., Kwok, L., & Alkema, L. (2020). Unintended pregnancy and abortion by income, region, and the legal status of abortion: Estimates from a comprehensive model for 1990–2019. *The Lancet Global Health*, *8*(9), e1152–e1161. https://doi.org/10.1016/S2214-109X(20)30315-6

Beausoleil, E. (2021). Calling in to cut back: Settlers learning to listen for a decolonial future. *Ethnicities, 22*(5), 705–720. https://doi.org/10.1177/14687968211062918

Becker, A., Doria, C., Koenig, L. R., Ko, J., & Upadhyay, U. (2025). "It was so easy in a situation that's so hard": Structural stigma and telehealth abortion. *Journal of Health and Social Behavior*. https://doi.org/10.1177/00221465241303873

Beddoe, L., & Clarke, E. V. (2023). A critical commentary: Abortion stigma standing in the way of reproductive justice. *Aotearoa New Zealand Social Work*, *35*(4), 125–135. https://anzswjournal.nz/anzsw/article/view/1127

Bell, A. (2017). Co-existing indigenous and settler worlds: Ontological styles and possibilities. *Journal of New Zealand Studies*, *24*, 15–24. https://doi.org/10.26686/jnzs.v0i24.4054

Bhandari, P., Narasimhan, S., & Newton-Levinson, A. (2024). "We just need to create as many avenues for access as we possibly can": Clinician and administrator attitudes toward telehealth medication abortion in the U.S. South. *Contraception: X*, 6, 100112. https://doi.org/10.1016/j.conx.2024.100112

Birger, L., Peled, E., & Benyamini, Y. (2024). Stigmatizing and inaccessible: The perspectives of female sex workers on barriers to reproductive healthcare utilization: A scoping review. *Journal of Advanced Nursing, 80*(6), 2273–2289. http://dx.doi.org/10.1111/jan.16010

Boydell, N., Reynolds-Wright, J. J., Cameron, S. T., & Harden, J. (2021). Women's experiences of a telemedicine abortion service (Up to 12 weeks) implemented during the coronavirus (COVID-19) pandemic: A qualitative evaluation. *BJOG: An International Journal of Obstetrics & Gynaecology*, *128*(11), 1752–1761. https://doi.org/10.1111/1471-0528.16813

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol 2: Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 57–71). American Psychological Association. https://doi.org/10.1037/13620-004

Braun, V., & Clarke, V. (2013). *Successful qualitative research*. SAGE.

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. SAGE.

Braun, V., Clarke, V., Boulton, E., Davey, L., & McEvoy, C. (2021). The online survey as a qualitative research tool. *International Journal of Social Research Methodology*, *24*(6), 641–654. https://doi.org/10.1080/13645579.2020.1805550

Brennand, E. A., Huang, B., Scime, N. V., Paw, J., & Nelson, E. L. (2025). Abortion care in Alberta, Canada, from 2012 to 2023: A population-based, cross-sectional analysis of use and geographical access. *The Lancet Public Health*, *10*(3), e246–e256. https://doi.org/10.1016/S2468-2667(25)00010-6

Brown, C., Neerland, C. E., Weinfurter, E. V., & Saftner, M. A. (2023). The provision of abortion care via telehealth in the United States: A rapid review. *Journal of Midwifery and Women's Health*, *68*(6), 744–758. https://doi.org/10.1111/jmwh.13586

Bryant, A. G., & Swartz, J. J. (2018). Why crisis pregnancy centers are legal but unethical. *American Medical Association Journal of Ethics*, *20*, 269–277. https://doi.org/10.1001/journalofethics.2018.20.3.pfor1-1803

Buchanan, T., & Williams, J. E. (2010). Ethical issues in psychological research on the internet. In S. Gosling & J. A. Johnson (Eds.), *Advanced methods for conducting online behavioral research* (pp. 255–271). American Psychological Association. https://doi.org/10.1037/12076-016

Burry, K., Beek, K., Vallely, L., Worth, H., & Haire, B. (2023). Illegal abortion and reproductive injustice in the Pacific Islands: A qualitative analysis of court data. *Developing World Bioethics*, *23*(2), 166–175. https://doi.org/10.1111/dewb.12352

Cabello, A. L., & Gaitan, A. C. (2021). Safe abortion in women's hands: Autonomy and a human rights approach to COVID-19 and beyond. *Health and Human Rights Journal*, *23*(1), 191–197. https://www.jstor.org/stable/27040046

Carpenter. (2021). "The health system just wasn't built for us": Queer cisgender women and gender expansive individuals' strategies for navigating reproductive health care. *Women's Health Issues*, *31*(5), 478–484. https://doi.org/10.1016/j.whi.2021.06.004

Cely-Andrade, L., Cárdenas-Garzón, K., Enríquez-Santander, L. C., Saavedra-Avendano, B., & Avendaño, G. A. O. (2024). Telemedicine for the provision of medication abortion to pregnant people at up to twelve weeks of pregnancy: A systematic literature review and meta-analysis. *Reproductive Health*, *21*(1), 136. https://doi.org/10.1186/s12978-024-01864-4

Cerulli, F. (2024). Access to abortion for rape victims in armed conflicts: A feminist perspective. *Israel Law Review*, 1–31. https://doi.org/10.1017/s0021223724000013

Chong, E., Shochet, T., Raymond, E., Platais, I., Anger, H. A., Raidoo, S., Soon, R., Grant, M. S., Haskell, S., Tocce, K., Baldwin, M. K., Boraas, C. M., Bednarek, P. H., Banks, J., Coplon, L., Thompson, F., Priegue, E., & Winikoff, B. (2021). Expansion of a direct-to-patient telemedicine abortion service in the United States and experience during the COVID-19 pandemic. *Contraception*, *104*(1), 43–48. https://doi.org/10.1016/j.contraception.2021.03.019

Clare, C. A. (2021). Telehealth and the digital divide as a social determinant of health during the COVID-19 pandemic. *Network Modeling Analysis in Health Informatics and Bioinformatics*, *10*, 26. https://doi.org/10.1007/s13721-021-00300-y

Clarke, D., & Mühlrad, H. (2021). Abortion laws and women's health. *Journal of Health Economics*, *76*, 102413. https://doi.org/10.1016/j.jhealeco.2020.102413

Clarke, L. P., Walton, J. B., & Foote, L. A. (2022). Designing for integration in mixed methods case studies. In J. H. Hitchcock & A. J. Onwuegbuzie (Eds.), *The Routledge handbook for advancing integration in mixed methods research* (pp. 213–228). Routledge.

Clure, C., Sheeder, J., Teal, S., & Cohen, R. (2023). Telemedicine to improve reproductive health care for rural Coloradans: Perceptions of interest and access. *The Journal of Rural Health*, *39*(1), 172–178. https://doi.org/10.1111/jrh.12697

Coast, E., Norris, A. H., Moore, A. M., & Freeman, E. (2018). Trajectories of women's abortion-related care: A conceptual framework. *Social Science & Medicine*, *200*, 199–210. https://doi.org/10.1016/j.socscimed.2018.01.035

Code of Ethics Review Group. (2002). *Code of ethics: For psychologists working in Aotearoa/New Zealand.* New Zealand Psychological Society. https://www.psychology.org.nz/journal-archive/code-of-ethics.pdf

Collins, P., & Bilge, S. (2016). *Intersectionality*. Polity Press.

Collins, P. H. (1999). Reflections on the outsider within. *Journal of Career Development*, *26*(1), 85–88. https://doi.org/10.1177/089484539902600107

Collins, P. H. (2022). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. Routledge. https://doi.org/10.4324/9780203900055

Collins, P. H., da Silva, E. C. G., Ergun, E., Furseth, I., Bond, K. D., & Martínez-Palacios, J. (2021). Intersectionality as critical social theory. *Contemporary Political Theory*, *20*(3), 690–725. https://doi.org/10.1057/s41296-021-00490-0

Colwill, A. C., Ingeno, L., & Edelman, A. B. (2023). Have we expanded access? The impact of abortion telehealth in a state with extensive reproductive health deserts. *Contraception*, *127*, 110202. https://doi.org/10.1016/j.contraception.2023.110203

Comendant, R., Cook, C., Hodorogea, S., Sagaidac, I., Bubulici, C., & Platais, I. (2022). Medical abortion via telemedicine for women and adolescents: Experience from Moldova. *Reproductive, Female and Child Health*, *1*(1), 80–87. https://doi.org/10.1002/rfc2.3

Cotter, S. Y., Sudhinaraset, M., Phillips, B., Seefeld, C. A., Mugwanga, Z., Golub, G., & Ikiugu, E. (2021). Person-centred care for abortion services in private facilities to improve women's experiences in Kenya. *Culture, Health and Sexuality*, *23*(2), 224–239. https://doi.org/10.1080/13691058.2019.1701083

Crasnow, S. (2014). Feminist standpoint theory. In N. Cartwright & E. Montuschi (Eds.), *Philosophy of social science*: *A new introduction* (pp. 145–161). Oxford University Press.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, *1*(8). https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. (2011). The case study approach. *BioMed Central Medical Research Methodology*, *11*(1), https://doi.org/10.1186/1471-2288-11-100

Davis, K., & Lutz, H. (2023). Intersectionality as travelling theory: Possibilities for dialogues. In K. Davis & H. Lutz (Ed.), *The Routledge international handbook of intersectionality studies* (pp. 3–13). Routledge. https://doi.org/10.4324/9781003089520-2

Davis, L. J. (Ed.). (2013). *The disability studies reader* (4th ed.). Routledge. https://doi.org/10.4324/9780203077887

DECIDE National Abortion Telehealth Service. (n.d.-a). *As a general guide*. Retrieved April 14, 2025, https://www.decide.org.nz/en/abortion-services/what-to-expect/what-to-expect-after-an-abortion/

DECIDE National Abortion Telehealth Service. (n.d.-b). *Can my partner get counselling too, if I'm having an abortion?* Retrieved June 18, 2025, from https://www.decide.org.nz/en/faqs

DECIDE National Abortion Telehealth Service. (n.d.-c). *Can my support person stay with me*? Retrieved June 18, 2025, from https://www.decide.org.nz/en/faqs

DECIDE National Abortion Telehealth Service. (n.d.-d). *Can non-binary, transgender or gender-expansive people have an abortion?* Retrieved April 15, 2025, from https://www.decide.org.nz/en/faqs

DECIDE National Abortion Telehealth Service. (n.d.-e). *How to access abortion services*. Retrieved April 13, 2025, from https://www.decide.org.nz/en/abortion-services/how-to-access-abortion-services/

DECIDE National Abortion Telehealth Service. (n.d.-f). *A human right*. Retrieved April 13, 2025, from https://www.decide.org.nz/en/abortion-services/abortion-and-your-rights/

DECIDE National Abortion Telehealth Service. (n.d.-g). *I'm unsure, scared, nervous about having an abortion. Who can I talk to?* Retrieved April 14, 2025, from https://decide.org.nz/en/faqs

DECIDE National Abortion Telehealth Service. (n.d.-h). *New Zealand sign language video*. Retrieved April 15, 2025, from https://www.decide.org.nz/en/abortion-services/considering-abortion/#section_new-zealand-sign-language-video

DECIDE National Abortion Telehealth Service. (n.d.-i). *What about emotional side effects?* Retrieved April 14, 2025, from https://decide.org.nz/en/abortion-services/what-to-expect/what-to-expect-after-an-abortion/

DECIDE National Abortion Telehealth Service. (n.d.-j). *What about tikanga Māori?* Retrieved April 23, 2025, from https://www.decide.org.nz/en/abortion-services/what-to-expect

DECIDE National Abortion Telehealth Service. (n.d.-k). *What to expect*. Retrieved April 13, 2025, from https://www.decide.org.nz/en/abortion-services/what-to-expect/

DECIDE National Abortion Telehealth Service. (n.d.-l). *Will there be protestors standing outside the clinic?* Retrieved April 27, 2025, from https://www.decide.org.nz/en/faqs/

DECIDE National Abortion Telehealth Service. (n.d.-m). *You decide who knows*. Retrieved April 14, 2025, from https://www.decide.org.nz/en/abortion-services/abortion-and-your-rights/

de Moel-Mandel, C., Graham, M., & Taket, A. (2019). Snapshot of medication abortion provision in the primary health care setting of regional and rural Victoria. *Australian Journal of Rural Health*, *27*(3), 237–244. https://doi.org/10.1111/ajr.12510

de Moel-Mandel, C., & Shelley, J. M. (2017). The legal and non-legal barriers to abortion access in Australia: A review of the evidence. *The European Journal of Contraception and Reproductive Health Care*, *22*(2), 114–122. https://doi.org/10.1080/13625187.2016.1276162

Denzin, N. K. (2012). Triangulation 2.0. *Journal of Mixed Methods Research*, *6*(2), 80–88. https://doi.org/10.1177/1558689812437186

de Tolly, K. M., & Constant, D. (2014). Integrating mobile phones into medical abortion provision: Intervention development, use, and lessons learned from a randomized controlled trial. *JMIR mHealth and uHealth*, *2*(1). https://doi.org/10.2196/mhealth.3165

Dickey, M. S., Mosley, E. A., Clark, E. A., Cordes, S., Lathrop, E., & Haddad, L. B. (2022). "They're forcing people to have children that they can't afford": A qualitative study of social support and capital among individuals receiving an abortion in Georgia. *Social Science & Medicine*, *315*. 115547. https://doi.org/10.1016/j.socscimed.2022.115547

Dobkin, L. M., Gould, H., Barar, R. E., Ferrari, M., Weiss, E. I., & Foster, D. G. (2014). Implementing a prospective study of women seeking abortion in the United States: Understanding and overcoming barriers to recruitment. *Women's Health Issues*, *24*(1), e115–e123. https://doi.org/10.1016/j.whi.2013.10.004

Donald Beasley Institute. (2025). *Abortion is a human right and health issue: Disabled people's experiences of abortion services in Aotearoa New Zealand*. The Ministry of Health.

Donovan, M. K. (2019). Improving access to abortion via telehealth. *Guttmacher Policy Review*, *22,* 23–28. https://www.guttmacher.org/gpr/2019/05/improving-access-abortion-telehealth

Downey, M. M., & Manchikanti Gómez, A. (2018). Structural competency and reproductive health. *American Medical Association Journal of Ethics*, *20*(3), 211–223. https://doi.org/10.1001/journalofethics.2018.20.3.peer1-1803

Dwamena, F., Holmes-Rovner, M., Gaulden, C. M., Jorgenson, S., Sadigh, G., Sikorskii, A., Lewin, S., Smith, R. C., Coffey, J., Olomu, A., & Beasley, M. (2012). Interventions for providers to promote a patient-centred approach in clinical consultations. *Cochrane Database of Systematic Reviews*, *12*. https://doi.org/10.1002/14651858.CD003267.pub2

Dwyer, S. C., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods*, *8*(1), 54–63. https://doi.org/10.1177/160940690900800105

Eagen-Torkko, M., & Yanow, S. (2021). The critical role of midwives in safe self-managed abortion. *Journal of Midwifery and Women's Health*, *66*(6), 795–800. https://doi.org/10.1111/jmwh.13289

Ellingson, L. L. (2009). *Engaging crystallization in qualitative research*. SAGE. https://doi.org/10.4135/9781412991476

Endler, M., Cleeve, A., & Gemzell-Danielsson, K. (2020). Online access to abortion medications: A review of utilization and clinical outcomes. *Best Practice & Research: Clinical Obstetrics and Gynaecology*, *63*, 74–86. https://doi.org/10.1016/j.bpobgyn.2019.06.009

Endler, M., Lavelanet, A., Cleeve, A., Ganatra, B., Gomperts, R., & Gemzell-Danielsson, K. (2019). Telemedicine for medical abortion: A systematic review. *BJOG: An International Journal of Obstetrics & Gynaecology*, *126*(9), 1094–1102. https://doi.org/10.1111/1471-0528.15684

Engle, O. (2025). 'Everything I can do at home, I will do it at home': The materialities, temporalities, and spatialities of telemedicine abortion care. *Social and Cultural Geography, 26*(5), 607–624. https://doi.org/10.1080/14649365.2024.2441774

Ennis, M., Wahl, K., Jeong, D., Knight, K., Renner, R., Munro, S., Dunn, S., Guilbert, E., & Norman, W. V. (2021). The perspective of Canadian health care professionals on abortion service during the COVID-19 pandemic. *Family Practice*, *38*(Suppl. 1), 30–36. https://doi.org/10.1093/fampra/cmab083

Environmental Health Intelligence New Zealand. (2023). *Ethnic profile*. Retrieved July 17, 2024, from https://www.ehinz.ac.nz/indicators/population-vulnerability/ethnic-profile

Fiastro, A., Zheng, Z., Ruben, M., Jessica, G., & Godfrey, E. (2023). Patient characteristics associated with choosing telehealth vs. in-clinic medication abortion care. *Contraception*, *121*, 110019. https://doi.org/10.1016/j.contraception.2023.110019

Field, S. M., Thompson, J., De Rijcke, S., Penders, B., & Munafò, M. R. (2024). Exploring the dimensions of responsible research systems and cultures: A scoping review. *Royal Society Open Science*, *11*(1), 1–21. https://doi.org/10.1098/rsos.230624

Flick, U. (2023). *An introduction to qualitative research* (7th ed.). SAGE.

Footman, K. (2023). Revolution in abortion care? Perspectives of key informants on the importance of abortion method choice in the era of telemedicine. *Sexual and Reproductive Health Matters*, *31*(1). https://doi.org/10.1080/26410397.2022.2149379

Footman, K. (2025). Structural stigmatisation of abortion in the health system: Perspectives of abortion care-seekers, providers, managers, and funders in England and Wales. *Social Science & Medicine*, *365,* 117566. https://doi.org/10.1016/j.socscimed.2024.117566

Forbes, M., Darney, B. G., Ramanadhan, S., Earp, M., Waldner-James, L., & Han, L. (2021). How do women interpret abortion information they find online? *Contraception*, *103*(4), 276–281. https://doi.org/10.1016/j.contraception.2021.01.005

Ganatra, B., Gerdts, C., Rossier, C., Johnson, B. R., Tunçalp, Ö., Assifi, A., Sedgh, G., Singh, S., Bankole, A., Popinchalk, A., Bearak, J., Kang, Z., & Alkema, L. (2017). Global, regional, and subregional classification of abortions by safety, 2010–14: Estimates from a Bayesian hierarchical model. *The Lancet*, *390*(10110), 2372–2381. https://doi.org/10.1016/S0140-6736(17)31794-4

Gerdts, C., Fuentes, L., Grossman, D., White, K., Keefe-Oates, B., Baum, S. E., Hopkins, K., Stolp, C. W., & Potter, J. E. (2016). Impact of clinic closures on women obtaining abortion services after implementation of a restrictive law in Texas. *American Journal of Public Health*, *106*(5), 857–864. https://doi.org/10.2105/AJPH.2016.303134

Getahun, G. K., Kidane, M., Fekade, W., Shitemaw, T., & Negash, Z. (2023). Exploring the reasons for unsafe abortion among women in the reproductive age group in western Ethiopia. *Clinical Epidemiology and Global Health*, *22,* 101301. https://doi.org/10.1016/j.cegh.2023.101301

Ghorashi, A. R., & Baumle, D. (2023). Legal and health risks of abortion criminalization: State policy responses in the immediate aftermath of Dobbs. *Journal of Law and Health*, *37*(1). https://engagedscholarship.csuohio.edu/jlh/vol37/iss1/5

Gibelin, K., Agostini, A., Marcot, M., Piclet, H., Bretelle, F., & Miquel, L. (2021). COVID-19 impact in abortions' practice, a regional French evaluation. *Journal of Gynecology Obstetrics and Human Reproduction*, *50*(5), 102038. https://doi.org/10.1016/j.jogoh.2020.102038

Gilbert, I., & Sewpaul, V. (2015). Challenging dominant discourses on abortion from a radical feminist standpoint. *Affilia: Feminist Inquiry in Social Work*, *30*(1), 83–95. https://doi.org/10.1177/0886109914549232

Gill, R., & Norman, W. V. (2018). Telemedicine and medical abortion: Dispelling safety myths, with facts. *mHealth*, *4*, 3. https://doi.org/10.21037/mhealth.2018.01.01

Gill, R. K., Cleeve, A., & Lavelanet, A. F. (2021). Abortion hotlines around the world: A mixed-methods systematic and descriptive review. *Sexual and Reproductive Health Matters*, *29*(1), 75–89. https://doi.org/10.1080/26410397.2021.1907027

Godfrey, E. M., Fiastro, A. E., Ruben, M. R., Young, E. V., Bennett, I. M., & Jacob-Files, E. (2023). Patient perspectives regarding clinician communication during telemedicine compared with in-clinic abortion. *Obstetrics & Gynecology*, *141*(6), 1139–1153. https://doi.org/10.1097/AOG.0000000000005192

Goodyear-Smith, F. (2023). Abortion law in Aotearoa New Zealand. *The New Zealand Medical Journal*, *136*(1580), 72–77. https://doi.org/10.26635/6965.6197

Grossman, D. (2019). Telemedicine for medical abortion – Time to move towards broad implementation . *BJOG: An International Journal of Obstetrics & Gynaecology*, *126*(9), 1103. https://doi.org/10.1111/1471-0528.15802

Gurung, L. (2020). Feminist standpoint theory: Conceptualization and utility. *Dhaulagiri Journal of Sociology & Anthropology*, *14*, 106–115. https://doi.org/10.3126/dsaj.v14i0.27357

Haimi, M. (2023). The tragic paradoxical effect of telemedicine on healthcare disparities – A time for redemption: A narrative review. *BMC Medical Informatics and Decision Making*, *23*, 95. https://doi.org/10.1186/s12911-023-02194-4

Hann, L. R., & Becker, A. (2020). The option to look: Patient-centred pregnancy tissue viewing at independent abortion clinics in the United States. *Sexual and Reproductive Health Matters*, *28*(1), 1730122. https://doi.org/10.1080/26410397.2020.1730122

Haraway, D. (1988). Situated knowledges: The science question in feminism and the privilege of partial perspective. *Feminist Studies*, *14*(3), 575–599. https://doi.org/10.2307/3178066

Harding, S. (1995). "Strong objectivity": A response to the new objectivity question. *Synthese*, *104*(3), 331–349. https://doi.org/10.1007/BF01064504

Harding, S. (2004). *The feminist standpoint theory reader: Intellectual and political controversies.* Routledge.

Harris, R., Tobias, M., Jeffreys, M., Waldegrave, K., Karlsen, S., & Nazroo, J. (2006). Effects of self-reported racial discrimination and deprivation on Māori health and inequalities in New Zealand: Cross-sectional study. *The Lancet*, *367*(9527), 2005–2009. https://doi.org/10.1016/S0140-6736(06)68890-9

Hartstock, N. C. (2019). *The feminist standpoint revisited, and other essays*. Routledge. https://doi.org/10.4324/9780429310881

Heinsen, L. L., Bruheim, C., & Adrian, S. W. (2023). Orchestrating moral bearability in the clinical management of second-trimester selective abortion. *Social Science & Medicine*, *338*, 116306. https://doi.org/10.1016/j.socscimed.2023.116306

Heller, R., Purcell, C., Mackay, L., Caird, L., & Cameron, S. T. (2016). Barriers to accessing termination of pregnancy in a remote and rural setting: A qualitative study. *BJOG: An International Journal of Obstetrics & Gynaecology*, 123(10), 1684–1691. https://doi.org/10.1111/1471-0528.14117

Hendrix, T., Roncoroni, J., Magdamo, B., Whitaker, S., Zareba, K., & Grieco, N. (2023). Stigma, social support, and decision satisfaction in terminations of pregnancy for medical reasons. *Women's Health Reports*, *4*(1), 271–279. https://doi.org/10.1089/whr.2022.0092

Hervey, T., & Sheldon, S. (2019). Abortion by telemedicine in the European Union. *International Journal of Gynecology & Obstetrics*, *145*(1), 125–128. https://doi.org/10.1002/ijgo.12738

Heslin, R. A., O'Higgins, S., & O'Donnell, A. T. (2024). "We were cast aside": An interpretative phenomenological analysis of abortion journeys from Ireland. *Feminism & Psychology*, *34*(4), 555–575. https://doi.org/10.1177/09593535241265899

Hill, J., McGinn, J., Cairns, J., Free, C., & Smith, C. (2020). A mobile phone-based support intervention to increase use of postabortion family planning in Cambodia: Cost-effectiveness evaluation. *Journal of Medical Internet Research MHealth and UHealth*, *8*(2), e16276. https://doi.org/10.2196/16276

Hoggart, L. (2017). Internalised abortion stigma: Young women's strategies of resistance and rejection. *Feminism & Psychology*, *27*(2), 186–202. https://doi.org/10.1177/0959353517698997

Hoggart, L., Purcell, C., Bloomer, F., Newton, V., & Oluseye, A. (2024). Social connectedness and supported self-management of early medication abortion in the UK: Experiences from the COVID-19 pandemic and learning for the future. *Culture, Health & Sexuality*, *26*(7), 855–870. https://doi.org/10.1080/13691058.2023.2258189

Holten, L., de Goeij, E., & Kleiverda, G. (2021). Permeability of abortion care in the Netherlands: A qualitative analysis of women's experiences, health professional perspectives, and the internet resource of Women on Web. *Sexual and Reproductive Health Matters*, *29*(1), 162–179. https://doi.org/10.1080/26410397.2021.1917042

Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). *Te ara tika: Guidelines for Māori research ethics: A framework for researchers and ethics committee members*. Health Research Council of New Zealand on behalf of the Pūtaiora Writing Group.

Hudspith, A., Paterson, H., Caldwell, C., & Whiting, R. (2022). Leaps ahead in law but not in practice: Why we need to train in second trimester abortion care. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, *62*(1), 140–146. https://doi.org/10.1111/ajo.13454

Hunter, I., Thomas, A. W., Green, N., & Large, R. (2023). *Telehealth use in public hospitals stocktake 2022–23*. https://www.telehealth.org.nz/assets/2024/Telehealth-Use-in-Public-Hospitals-Stocktake-Report-2022-2023/Telehealth-22-23-Hospital-Report-V2.pdf

Hyland, P., Raymond, E. G., & Chong, E. (2018). A direct-to-patient telemedicine abortion service in Australia: Retrospective analysis of the first 18 months. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, *58*(3), 335–340. https://doi.org/10.1111/ajo.12800

Ireland, S., Belton, S., & Doran, F. (2020). 'I didn't feel judged': Exploring women's access to telemedicine abortion in rural Australia. *Journal of Primary Health Care*, *12*(1), 49–56. https://doi.org/10.1071/HC19050

Ishola, F., Ukah, U. V., Alli, B. Y., & Nandi, A. (2021). Impact of abortion law reforms on health services and health outcomes in low- and middle-income countries: A systematic review. *Health Policy and Planning*, *36*(9), 1483–1498. https://doi.org/10.1093/heapol/czab069

Jain, D., Rastogi, A., Kartik, K., Diwan, A., & Saha, O. (2022). Medical abortion through telehealth in India: A critical perspective. *Sexual and Reproductive Health Matters*, *29*(2), 2107090. https://doi.org/10.1080/26410397.2022.2107090

Jerin, T., Chowdhury, M. A., Azad, M. A. K., Zaman, S., Mahmood, S., Islam, S. L. U., & Mohammad Jobayer, H. (2024). Extreme weather events (EWEs)-related health complications in Bangladesh: A gender-based analysis on the 2017 catastrophic floods. *Natural Hazards Research*, *4*(3), 434–447. https://doi.org/10.1016/j.nhres.2023.10.006

Jerman, J., Frohwirth, L., Kavanaugh, M. L., & Blades, N. (2017). Barriers to abortion care and their consequences for patients traveling for services: Qualitative findings from two states. *Perspectives on Sexual and Reproductive Health*, *49*(2), 95–102. https://doi.org/10.1363/psrh.12024

Johnson, D. M., Michels-Gualtieri, M., Gomperts, R., & Aiken, A. R. A. (2023). Safety and effectiveness of self-managed abortion using misoprostol alone acquired from an online telemedicine service in the United States. *Perspectives on Sexual and Reproductive Health*, *55*(1), 4–11. https://doi.org/10.1363/psrh.12219

Johnson, D. M., Ramaswamy, S., & Gomperts, R. (2024). Experiences with misoprostol-only used for self-managed abortion and acquired from an online or retail pharmacy in the United States. *Contraception*, *131*, 110345. https://doi.org/10.1016/j.contraception.2023.110345

Jung, C., Fiastro, A., Cornell, A., Steward, R., Rible, R., & Gipson, J. D. (2023). Patient perspectives on barriers in obtaining timely abortion care in Los Angeles, California. *Contraception*, *117*, 50–54. https://doi.org/10.1016/j.contraception.2022.08.003

Jung, C., Hunter, A., Saleh, M., Quinn, G. P., & Nippita, S. (2023). Breaking the binary: How clinicians can ensure everyone receives high quality reproductive health services. *Open Access Journal of Contraception*, *14,* 23–39. https://doi.org/10.2147/OAJC.S368621

Karlin, J., & Hodge, C. C. (2025). Intimacy, anonymity, and "care with nothing in the way" on an abortion hotline. *Culture, Medicine, and Psychiatry*, *49*, 127–153. https://doi.org/10.1007/s11013-022-09810-4

Kaye, D. K., Kayondo, S. P., Nabatanzi, S. L., Nassuuna, S., Musana, O., Namagembe, I., Nsanja, J. P., Kakaire, O., Ssebadduka, P., & Ssekimpi, C. (2023). Using digital platforms to promote a healthcare provider community of practice for abortion care in Uganda. *Reproductive Health*, *20*(1), 180. https://doi.org/10.1186/s12978-023-01721-w

Kebede, K., Gashawbeza, B., Gebremedhin, S., & Tolu, L. B. (2021). Magnitude and determinants of the late request for safe abortion care among women seeking abortion care at a tertiary referral hospital in Ethiopia: A cross-sectional study. *International Journal of Women's Health*, *12*, 1223–1231. https://doi.org/10.2147/IJWH.S285282

Kerestes, C., Delafield, R., Elia, J., Shochet, T., Kaneshiro, B., & Soon, R. (2022). Person-centered, high-quality care from a distance: A qualitative study of patient experiences of TelAbortion, a model for direct-to-patient medication abortion by mail in the United States. *Perspectives on Sexual and Reproductive Health*, *54*(4), 177–187. https://doi.org/10.1363/psrh.12210

Kerns, J., Vanjani, R., Freedman, L., Meckstroth, K., Drey, E. A., & Steinauer, J. (2012). Women's decision making regarding choice of second trimester termination method for pregnancy complications. *International Journal of Gynecology & Obstetrics*, *116*(3), 244–248. https://doi.org/10.1016/j.ijgo.2011.10.016

Killinger, K., Günther, S., Gomperts, R., Atay, H., & Endler, M. (2022). Why women choose abortion through telemedicine outside the formal health sector in Germany: A mixed-methods study. *BMJ Sexual & Reproductive Health*, *48*, E6–E12. https://doi.org/10.1136/bmjsrh-2020-200789

Kimport, K., & Rasidjan, M. P. (2023). Exploring the emotional costs of abortion travel in the United States due to legal restriction. *Contraception*, *120*, 109956. https://doi.org/10.1016/j.contraception.2023.109956

Klann, E., & Golabi, N. (2024). Abortion, reproductive justice, and intersectional inequity. In J. Bindeman (Ed.), *The mental health clinician's handbook for abortion care* (pp. 171–192). Springer Nature Switzerland. https://doi.org/10.1007/978-3-031-61453-8

Koenig, L. R., Becker, A., Ko, J., & Upadhyay, U. D. (2023). The role of telehealth in promoting equitable abortion access in the United States: Spatial analysis. *JMIR Public Health and Surveillance*, *9*, e45671. https://doi.org/10.2196/45671

Koenig, L. R., Ko, J., Valladares, E. S., Coeytaux, F. M., Wells, E., Lyles, C. R., & Upadhyay, U. D. (2024). Patient acceptability of telehealth medication abortion care in the United States, 2021–2022: A cohort study. *American Journal of Public Health*, *114*(2), 241–250. https://doi.org/10.2105/AJPH.2023.307437

Kolekar, S. V., Agnihotri, S., & Rao, D. (2024). Enhancing the experience and accessibility of users with disability by integrating voice navigation into a telemedicine website. *International Journal of Mathematical, Engineering and Management Sciences*, *9*(4), 801–820. https://doi.org/10.33889/IJMEMS.2024.9.4.041

Kubuka, A. E., Abdulrahman, H. M., Soa, A. H., & Kivishe, P. W. (2023). Unsafe abortion; The hidden cause of maternal death. *International Journal of Family & Community Medicine*, *7*(5), 157–158. https://doi.org/10.15406/ijfcm.2023.07.00331

Kumsa, F. A., Prasad, R., & Shaban-Nejad, A. (2023). Medication abortion via digital health in the United States: A systematic scoping review. *npj Digital Medicine*, *6*(1), 128. https://doi.org/10.1038/s41746-023-00871-2

Larrea, S., Hidalgo, C., Jacques-Aviñó, C., Borrell, C., & Palència, L. (2022). "No one should be alone in living this process": Trajectories, experiences and user's perceptions about quality of abortion care in a telehealth service in Chile. *Sexual and Reproductive Health Matters*, *29*(3). https://doi.org/10.1080/26410397.2021.1948953

Latt, S. M., Milner, A., & Kavanagh, A. (2019). Abortion laws reform may reduce maternal mortality: An ecological study in 162 countries. *BMC Women's Health*, *19*(1), https://doi.org/10.1186/s12905-018-0705-y

Lawley, A. (2022). Women behaving badly: Problematisation and biopolitical governance of gender in the New Zealand abortion debate. *New Zealand Sociology*, *27*(2), 81–93. https://search.informit.org/doi/10.3316/informit.822677278962703

Le Grice, J. S., & Braun, V. (2017). Indigenous (Māori) perspectives on abortion in New Zealand. *Feminism & Psychology*, *27*(2), 144–162. https://doi.org/10.1177/0959353517701491

Lerma, K., Arey, W., Strelitz-Block, E., Nathan, S., & White, K. (2024). Abortion clients' perceptions of alternative medication abortion service delivery options in Mississippi. *Women's Health Issues*, *34*(2), 156–163. https://doi.org/10.1016/j.whi.2023.11.009

Linabary, J. R., Corple, D. J., & Cooky, C. (2021). Of wine and whiteboards: Enacting feminist reflexivity in collaborative research. *Qualitative Research*, *21*(5), 719–735. https://doi.org/10.1177/1468794120946988

Lowick, A. J. (2017). *Trans-inclusive abortion services: A manual for providers on operationalizing trans-inclusive policies and practices in an abortion setting*. Retrieved August 17, 2025, from https://www.rainbowhealthontario.ca/resource-library/trans-inclusive-abortion-services/

Macfarlane, E., Dawson, P., Stitely, M., & Paterson, H. (2024). The first trimester abortion journey Aotearoa: Health practitioners' perspectives. *The New Zealand Medical Journal*, *137*(1607), 67–74. https://doi.org/10.26635/6965.6647

Macleod, C., Kalyanaraman, Y., & Mogonong, L. (2024). Enacting reproductive justice. *International Perspectives in Psychology*, *13*(3), 153–163. https://doi.org/10.1027/2157-3891/a000105

Madera, M., Johnson, D. M., Broussard, K., Tello-Pérez, L. A., Ze-Noah, C. A., Baldwin, A., Gomperts, R., & Aiken, A. R. A. (2022). Experiences seeking, sourcing, and using abortion pills at home in the United States through an online telemedicine service. *SSM – Qualitative Research in Health*, *2*, 100075. https://doi.org/10.1016/j.ssmqr.2022.100075

Maffi, I., & Tonnessen, L. (2019). The limits of the law: Abortion in the Middle East and North Africa. *Health and Human Rights Journal*, *21*(2), 1–6. https://www.jstor.org/stable/26915371

Maguire, M., & Delahunt, B. (2017). Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars. *All Ireland Journal of Higher Education*, *9*(3), 3351. http://ojs.aishe.org/index.php/aishe-j/article/view/335

Makleff, S., Belfrage, M., Wickramasinghe, S., Fisher, J., Bateson, D., & Black, K. I. (2023). Typologies of interactions between abortion seekers and healthcare workers in Australia: A qualitative study exploring the impact of stigma on quality of care. *BMC Pregnancy and Childbirth*, *23*(1), 646. https://doi.org/10.1186/s12884-023-05902-0

Malek, M., Homer, C. S. E., McDonald, C., Hannon, C. M., Moore, P., & Wilson, A. N. (2024). Abortion care at 20 weeks and over in Victoria: A thematic analysis of healthcare providers' experiences. *BMC Pregnancy and Childbirth*, *24*(1), 112. https://doi.org/10.1186/s12884-024-06299-0

Markham, A., & Buchanan, E. (2012). *Ethical decision-making and internet research: Recommendations from the AoIR ethics working committee*. AoIR. http://www.aoir.org/reports/ethics.pdf

Marriott, L., & Alinaghi, N. (2021). Closing the gaps: An update on indicators of inequality for Māori and Pacific people. *The Journal of New Zealand Studies*, *2021*(NS32), 2–39. https://doi.org/10.26686/jnzs.iNS32.6863

Massey University. (2015). *Code of reasonable research conduct*. Retrieved August 17, 2025, from https://www.massey.ac.nz/documents/1589/Code_of_Responsible_Research_Conduct.pdf

Massey University. (2017). *Code of ethical conduct for research, teaching and evaluations involving human participants.* Retrieved August 17, 2025, from https://www.massey.ac.nz/research/ethics/human-ethics/#Usingparticipantsinresearch

Matulich, M. C., Hou, M. Y., Chen, M. J., Uhm, S., & Creinin, M. D. (2022). Implementation of telemedicine preoperative visits for abortion procedures through 18 weeks gestation at a Northern California hospital-based center. *Contraception*, *114*, 74–78. https://doi.org/10.1016/j.contraception.2022.06.001

Mavuso, J. M. J., Chiweshe, M. T., & Macleod, C. I. (2020). 'Choice' in women's abortion decision-making narratives: Introducing a supportability approach. *PINS–Psychology in Society*, *59*, 20–40. https://doi.org/10.57157/pins2020Vol59iss1a5605

Mayall, K., Ajayi, L., & Gruer, C. (2025). Global progress in abortion law reform: A comparative legal analysis since the International Conference on Population and Development (1994–2023). *Sexual and Reproductive Health Matters*, *33*(1), 2499324. https://doi.org/10.1080/26410397.2025.2499324

Mazza, D., Seymour, J. W., Sandhu, M. V., Melville, C., O'Brien, J., & Thompson, T. A. (2021). General practitioner knowledge of and engagement with telehealth-at-home medical abortion provision. *Australian Journal of Primary Health*, *27*(6), 456–461. https://doi.org/10.1071/PY20297

McReynolds-Pérez, J., Kimport, K., Bercu, C., Cisternas, C., Wilkinson Salamea, E., Zurbriggen, R., & Moseson, H. (2023). Ethics of care born in intersectional praxis: A feminist abortion accompaniment model. *Signs: Journal of Women in Culture and Society, 49*(1), 63–87. https://doi.org/10.1086/725843

Medical Council of New Zealand. (2023). *Telehealth*. Retrieved August 27, 2025, from https://www.mcnz.org.nz/our-standards/current-standards/telehealth/

Merner, B., Haining, C. M., Willmott, L., Savulescu, J., & Keogh, L. A. (2024). Health providers' reasons for participating in abortion care: A scoping review. *Women's Health*, *20*. https://doi.org/10.1177/17455057241233124

Metrics for Management. (2023). *ACQ tool: Abortion care quality indicators*. Metrics for Management. Retrieved August 17, 2025, from https://www.acqtool.org/metric/indicators/

Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine*, *103*, 126–133. https://doi.org/10.1016/j.socscimed.2013.06.032

Middlemiss, A. L., Boncori, I., Brewis, J., Davies, J., & Newton, V. L. (2024). Employment leave for early pregnancy endings: A biopolitical reproductive governance analysis in England and Wales. *Gender, Work & Organization*, *31*(1), 75–91. https://doi.org/10.1111/gwao.13055

Ministry of Health. (2021). *New Zealand Aotearoa abortion clinical guideline.* Retrieved August 17, 2025, from https://www.health.govt.nz/publication/new-zealand-aotearoa-abortion-clinical-guideline

Ministry of Health. (2022a). DECIDE-Telehealth webinar [Unpublished transcript]. Ministry of Health.

Ministry of Health. (2022b). *Paerewa mō te tumu kōrero whakatahe i Aotearoa standard for abortion counselling in Aotearoa New Zealand*. Retrieved August 17, 2025, from https://www.health.govt.nz/system/files/2022-08/final_standard_for_abortion_counselling_28_july_v3.pdf

Ministry of Health. (2023). *Ratonga whakatahe i Aotearoa: Abortion services Aotearoa New Zealand: Annual report*: *Pūrongo ā-tau.* Retrieved August 17, 2025, from https://www.health.govt.nz/system/files/2023-10/abortion-services-aotearoa-new-zealand-annual-report-2023-v2.pdf

Ministry of Health. (2024). *Abortion services Aotearoa New Zealand: Ratonga whakatahe i Aotearoa: Annual report: Pūrongo ā-tau*. Retrieved August 17, 2025, from https://www.health.govt.nz/publications/abortion-services-aotearoa-new-zealand-annual-report-2024

Mishtal, J., Reeves, K., Chakravarty, D., Grimes, L., Stifani, B., Chavkin, W., Duffy, D., Favier, M., Horgan, P., Murphy, M., & Lavelanet, A. F. (2022). Abortion policy implementation in Ireland: Lessons from the community model of care. *PLOS One*, *17*(5), e0264494. https://doi.org/10.1371/journal.pone.0264494

Monchalin, R., Jubinville, D., Pérez Piñán, A. V., Paul, W., Wells, M., Ross, A., Law, K., Chaffey, M., & Pruder, H. (2023). “I would love for there not to be so many hoops … ”: Recommendations to improve abortion service access and experiences made by indigenous women and 2SLGTBQIA+ people in Canada. *Sexual and Reproductive Health Matters*, *31*(1). https://doi.org/10.1080/26410397.2023.2247667

Monchalin, R., Pérez Piñán, A. V., Wells, M., Paul, W., Jubinville, D., Law, K., Chaffey, M., Pruder, H., & Ross, A. (2023). A qualitative study exploring access barriers to abortion services among Indigenous peoples in Canada. *Contraception*, *124*, 110056 .https://doi.org/10.1016/j.contraception.2023.110056

Morison, T. (2023). Using reproductive justice as a theoretical lens in qualitative research in psychology. *Qualitative Research in Psychology*, *20*(1), 172–192. https://doi.org/10.1080/14780887.2022.2121236

Mouafo, A. V. D. (2024). Representations of feminism and strategies for defending male hegemony in a patriarchal context: The moderating effect of sociodemographic and attitudinal variables. *International Journal of Psychological Science*, *4*(1), 9–20. https://doi.org/10.11648/j.ijps.20240401.12

Moulton, J. E., Arefadib, N., Botfield, J. R., Freilich, K., Tomnay, J., Bateson, D., Black, K. I., Norman, W. V., & Mazza, D. (2025). A nurse-led model of care to improve access to contraception and abortion in rural general practice: Co-design with consumers and providers. *Journal of Advanced Nursing 81*(2), 1019–1037. https://doi.org/10.1111/jan.16299

Munson, E., & Hall, K. S. (2024). Opportunities for increasing access to person-centered abortion care through telehealth. *American Journal of Public Health*, *114*(2), 152–154. https://doi.org/10.2105/AJPH.2023.307541

Napier-Raman, S., Hossain, S. Z., Mpofu, E., Lee, M.-J., Liamputtong, P., & Dune, T. (2024). Abortion experiences and perspectives amongst migrants and refugees: A systematic review. *International Journal of Environmental Research and Public Health*, *21*(3), 312. https://doi.org/10.3390/ijerph21030312

Nelson, E. (2017). Autonomy, equality, and access to sexual and reproductive health care. *Alberta Law Review*, *54*(3). https://doi.org/10.29173/alr771

Njagi, J. (2023). A qualitative approach to interrogating the age and gender divide in digital SRHR platforms in Kenya. *Sexual and Reproductive Health Matters*, *31*(4), 2291908. https://doi.org/10.1080/26410397.2023.2291908

Noonan, A., Black, K. I., Luscombe, G. M., & Tomnay, J. (2023). "Almost like it was really underground": A qualitative study of women's experiences locating services for unintended pregnancy in a rural Australian health system. *Sexual and Reproductive Health Matters*, *31*(1), 2213899. https://doi.org/10.1080/26410397.2023.2213899

Nundy, S., & Oswald, J. (2014). Relationship-centered care: A new paradigm for population health management. *Healthcare*, *2*(4), 216–219. https://doi.org/10.1016/j.hjdsi.2014.09.003

NZ College of Sexual & Reproductive Health. (n.d.-a). *MODULE 1: Consultation-communication and decision making*. Retrieved February 26, 2025, from https://bpac.org.nz/ema/docs/Module1.pdf

NZ College of Sexual & Reproductive Health. (n.d.-b). *MODULE 2: Early medical abortion*. Retrieved February 27, 2025, from https://bpac.org.nz/ema/docs/EMAModule2.pdf

Oberman, M., & Lehmann, L. S. (2023). Doctors' duty to provide abortion information. *Journal of Law and the Biosciences*, *10*(2). https://doi.org/10.1093/jlb/lsad024

Officer, T. N., Tait, M., McBride-Henry, K., Burnet, L., & Werkmeister, B. J. (2023). Mental health client experiences of telehealth in Aotearoa New Zealand during the COVID-19 pandemic: Lessons and implications. *JMIR Formative Research*, *7*, e47008. https://doi.org/10.2196/47008

Ong, I., Zulkarnain, A. D. M., Lim, K. Z. Q., Teh, D. B. L., Tam, W., & Huang, Z. (2023). The global impact of COVID-19 on abortion care. *Heliyon*, *9*(5), e16094. https://doi.org/10.1016/j.heliyon.2023.e16094

Ortiz, J., Salazar, S., Lesmes, T., Marulanda, E., & Vivas, M. M. (2022). Regulatory authorities are limiting telemedicine's potential to deliver legal abortion care to everyone in Colombia. *Sexual and Reproductive Health Matters*, *29*(3). https://doi.org/10.1080/26410397.2022.2034366

Ouedraogo, R., & Juma, K. (2020). From the shadows to light. Perceptions of women and healthcare providers of post-abortion care in Burkina Faso. *Social Science & Medicine*, *260*, 113154. https://doi.org/10.1016/j.socscimed.2020.113154

Oyediran, K. A., Makinde, O. A., & Adelakin, O. (2020). The role of telemedicine in addressing access to sexual and reproductive health services in sub-Saharan Africa during the COVID-19 pandemic. *African Journal of Reproductive Health*, *24*(2), 49–55. https://hdl.handle.net/10520/ejc-ajrh-v24-n2-a8

Pack, M. (2020). Women's grief in induced abortion (IA) and later loss of pregnancy: Themes from a narrative literature review with implications for counselling. *New Zealand Journal of Counselling*, *40(*2), 69–80. https://doi.org/10.24135/nzjc.v40i2.249

Parker, G., Kerekere, E., Millar, S., Baddock, S., & D'Cruz, C. (2023). *"It just adds another layer of stress": Rainbow people's experiences of abortion services in Aotearoa New Zealand following abortion law reform.* Ministry of Health. Retrieved August 17, 2025, from https://www.health.govt.nz/publications/it-just-adds-another-layer-of-stress-rainbow-peoples-experiences-of-abortion-services-in-aotearoa

Parsons, J. A., & Romanis, E. C. (2024). "All hands on deck": A qualitative study of safeguarding and the transition to telemedical abortion care in England and Wales. *Social Science & Medicine*, *348*, 116835. https://doi.org/10.1016/j.socscimed.2024.116835

Paynter, M., Heggie, C., McLeod, A., Castonguay, M., Fuller, M., & Norman, W. V. (2025). The role of doulas in abortion care in Canada: A qualitative study. *PLOS One*, *20*(3), e0313918. https://doi.org/10.1371/journal.pone.0313918

Peña, M., Figueroa Flores, K., Muñoz Ponce, M., Facio Serafín, D., Camarillo Zavala, A. M., Ruiz Cruz, C., Ortiz Salgado, I. G., Ochoa Rosado, Y., Socarras, T., Pacheco López, A., & Bousiéguez, M. (2022). Telemedicine for medical abortion service provision in Mexico: A safety, feasibility, and acceptability study. *Contraception*, *114*, 67–73. https://doi.org/10.1016/j.contraception.2022.06.009

Piazza, A., & Augustine, G. L. (2022). Nevertheless, they persisted: How patterns of opposition and support shaped the survival of U.S. abortion clinics. *Journal of Management Studies*, *59*(8), 2124–2153. https://doi.org/10.1111/joms.12865

Planned Parenthood Advocacy Fund of Massachusetts. (2025). *Abortion stigma.* Retrieved August 17, 2025, from https://www.plannedparenthoodaction.org/planned-parenthood-advocacy-fund-massachusetts-inc/abortion-stigma

Pleasants, E. A., Cartwright, A. F., & Upadhyay, U. D. (2022). Association between distance to an abortion facility and abortion or pregnancy outcome among a prospective cohort of people seeking abortion online. *JAMA Network Open*, *5*(5), e2212065. https://doi.org/10.1001/jamanetworkopen.2022.12065

Popinchalk, A., Beavin, C., & Bearak, J. (2022). The state of global abortion data: An overview and call to action. *BMJ Sexual & Reproductive Health*, *48*(1), 3–6. https://doi.org/10.1136/bmjsrh-2021-201109

Porter Erlank, C., Lord, J., & Church, K. (2021). Acceptability of no-test medical abortion provided via telemedicine during Covid-19: Analysis of patient-reported outcomes. *BMJ Sexual & Reproductive Health*, *47*(4), 261–268. https://doi.org/10.1136/bmjsrh-2020-200954

Qaderi, K., Khodavirdilou, R., Kalhor, M., Behbahani, B. M., Keshavarz, M., Bashtian, M. H., Dabir, M., Irani, M., Manouchehri, E., Farahani, M. F., Mallah, M. A., & Shamsabadi, A. (2023). Abortion services during the COVID-19 pandemic: A systematic review. *Reproductive Health, 20,* 61. https://doi.org/10.1186/s12978-023-01582-3

Raifman, S., Gurazada, T., Beaman, J., Biggs, M. A., Schwarz, E. B., Gold, M., & Grossman, D. (2024). Primary care and abortion provider perspectives on mail-order medication abortion: A qualitative study. *BMC Women's Health*, *24*(1), 382. https://doi.org/10.1186/s12905-024-03202-z

Ramos, S., Keefe-Oates, B., Romero, M., Ramon Michel, A. R., Krause, M., Gerdts, C., & Yamin, A. E. (2023). Step by step in Argentina: Putting abortion rights into practice. *International Journal of Women's Health*, *15*, 1003–1015. https://doi.org/10.2147/IJWH.S412975

RANZCOG. (2023). *Clinical guideline for abortion care: An evidence-based guideline on abortion care in Australia and Aotearoa New Zealand*. Retrieved August 17, 2025, from https://www.racgp.org.au/getmedia/a5c4f797-9b8c-4b0f-a9db-c41a0486bb97/Clinical-Guideline-for-Abortion-Care.pdf.aspx

Raymond, E., Chong, E., Winikoff, B., Platais, I., Mary, M., Lotarevich, T., Castillo, P. W., Kaneshiro, B., Tschann, M., Fontanilla, T., Baldwin, M., Schnyer, A., Coplon, L., Mathieu, N., Bednarek, P., Keady, M., & Priegue, E. (2019). TelAbortion: Evaluation of a direct to patient telemedicine abortion service in the United States. *Contraception*, *100*(3), 173–177. https://doi.org/10.1016/j.contraception.2019.05.013

Rebouché, R. (2022). Remote reproductive rights. *American Journal of Law & Medicine*, *48*(2–3), 244–255. https://doi.org/10.1017/amj.2022.29

Reid, A. M., Brown, J. M., Smith, J. M., Cope, A. C., & Jamieson, S. (2018). Ethical dilemmas and reflexivity in qualitative research. *Perspectives on Medical Education*, *7*(2), 69–75. https://doi.org/10.1007/s40037-018-0412-2

Reynolds-Wright, J. J., Johnstone, A., McCabe, K., Evans, E., & Cameron, S. (2021). Telemedicine medical abortion at home under 12 weeks' gestation: A prospective observational cohort study during the COVID-19 pandemic. *BMJ Sexual & Reproductive Health*, *47*(4), 246–251. https://doi.org/10.1136/bmjsrh-2020-200976

Riggs, D. W., Ciccarello, C., & Cations, M. (2025). The challenges of using social media to recruit participants for research on LGBTQ people and animal companionship. *Feminist Media Studies*, 1–7. https://doi.org/10.1080/14680777.2025.2483426

Roberts, L. D. (2015). Ethical issues in conducting qualitative research in online communities. *Qualitative Research in Psychology*, *12*(3), 314–325. https://doi.org/10.1080/14780887.2015.1008909

Rodgers, Y. van der M., Coast, E., Lattof, S. R., Poss, C., & Moore, B. (2021). The macroeconomics of abortion: A scoping review and analysis of the costs and outcomes. *PLOS One*, *16*(5), 1–18. https://doi.org/10.1371/journal.pone.0250692

Romanis, E. C., & Parsons, J. A. (2020). Legal and policy responses to the delivery of abortion care during COVID-19. *International Journal of Gynecology & Obstetrics*, *151*(3), 479–486. https://doi.org/10.1002/ijgo.13377

Romanis, E. C., Parsons, J. A., Salter, I., & Hampton, T. (2021). Safeguarding and teleconsultation for abortion. *The Lancet*, *398*(10299), 555–558. https://doi.org/10.1016/S0140-6736(21)01062-X

Roncoroni, J., Whitaker, S., Magdamo, B., Hendrix, T., Zaręba, K., & Yohannes, R. (2023). Perceptions of patient-centered care and their association with patient satisfaction in abortions for medical reasons. *Women's Health Issues*, *33*(4), 374–381. https://doi.org/10.1016/j.whi.2023.03.001

Røseth, I., Sommerseth, E., Lyberg, A., Sandvik, B. M., & Dahl, B. (2024). No one needs to know! Medical abortion: Secrecy, shame, and emotional distancing. *Health Care for Women International*, *45*(1), 67–85. https://doi.org/10.1080/07399332.2022.2090565

Rowlands, S., & Wale, J. (2020). A constructivist vision of the first-trimester abortion experience. *Health and Human Rights*, *22*(1), 237–250. https://www.hhrjournal.org/2020/06/18/a-constructivist-vision-of-the-first-trimester-abortion-experience/

Ruggiero, S. P., Seymour, J. W., Thompson, T. A., Kohn, J. E., Snow, J. L., Grossman, D., & Fix, L. (2022). Patient and provider experiences using a site-to-site telehealth model for medication abortion. *mHealth*, *8*, 32. https://doi.org/10.21037/MHEALTH-22-12

Seretlo, R. J., Smuts, H., & Mokgatle, M. M. (2024). Development of an mHealth app by experts for queer individuals' sexual-reproductive health care services and needs: Nominal group technique study. *JMIR Formative Research*, *8*, e59963. https://doi.org/10.2196/59963

Seymour, J. W., Goode, B. A., Guerrero, P., Campos, A. M., Kyles, K., Dreyfus-Pai, P., & Baum, S. E. (2023). Emotional, informational, and decision-making support needs among people seeking abortion in the US: Perspectives from all-options talkline callers. *Sexual and Reproductive Health Matters*, *31*(1). https://doi.org/10.1080/26410397.2023.2248742

Seymour, J. W., Melville, C., Grossman, D., & Thompson, T. A. (2024). Examining service delivery patterns before and after implementation of a direct-to-patient telehealth service providing medication abortion in Australia. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 64*(6), 647–650. https://doi.org/10.1111/ajo.13846

Seymour, J. W., Melville, C., Thompson, T. A., & Grossman, D. (2022). Effectiveness and safety of a direct-to-patient telehealth service providing medication abortion targeted at rural and remote populations: Cross-sectional findings from Marie Stopes Australia. *Contraception*, *115*, 67–68. https://doi.org/10.1016/j.contraception.2022.06.010

Shah, M. (2020). *You're the only one I've told: The stories behind abortion.* Chicago Review Press.

Shahrokhi, S. N., Salmani, H., & Ahmadi, M. (2023). The role of electronic health tools in unwanted pregnancy prevention, abortion and post-abortion follow-up: A systematic review. *Iranian Journal of Nursing and Midwifery Research*, *28*(5), 487–503. https://doi.org/10.4103/ijnmr.ijnmr_312_20

Shai, A., Koffler, S., & Hashiloni-Dolev, Y. (2021). Feminism, gender medicine and beyond: A feminist analysis of "gender medicine". *International Journal for Equity in Health*, *20*(1). https://doi.org/10.1186/s12939-021-01511-5

Shaikh, I., Küng, S. A., Aziz, H., Sabir, S., Shabbir, G., Ahmed, M., & Dabash, R. (2021). Telehealth for addressing sexual and reproductive health and rights needs during the COVID-19 pandemic and beyond: A hybrid telemedicine-community accompaniment model for abortion and contraception services in Pakistan. *Frontiers in Global Women's Health*, *2*. https://doi.org/10.3389/fgwh.2021.705262

Shaw, D., Awoonor-Williams, K., Brauer, A., Gil, L., Morales, J. P., & Chavkin, W. (2024). Perils and possibilities of health exception laws: A narrative review. *International Journal of Gynecology & Obstetrics*, *164*(Suppl. 1), 67–80. https://doi.org/10.1002/ijgo.15337

Shenkin, E. N. (2023). Gender equity for sustainable development: Barriers and telehealth opportunities during the pandemic. In W. L. Filho, N. Aguilar-Rivera, B. Borsari, P. R. B. de Brito, & B. A. Guerra (Eds.), *SDGs in the Americas and Caribbean region* (pp. 381–404). Springer. https://doi.org/10.1007/978-3-031-16017-2_38

Shochet, T., Berro Pizzarossa, L., Larrea, S., Blum, J., Jelinska, K., Comendant, R., & Sagaidac, I. (2023). Self-managed abortion via the internet: Analysis of one year of service delivery data from women help women. *Gates Open Research*, *7,* 41. https://doi.org/10.12688/gatesopenres.14369.1

Sifris, R., & Penovic, T. (2021). Barriers to abortion access in Australia before and during the COVID-19 pandemic. *Women's Studies International Forum*, *86*, 102470. https://doi.org/10.1016/j.wsif.2021.102470

Singh, R., Mazza, D., Moloney, L., Shankar, M., & Subasinghe, A. K. (2023). General practitioner experiences in delivering early medical abortion services to women from culturally and linguistically diverse backgrounds: A qualitative-descriptive study. *Australian Journal of General Practice*, *52*(8), 557–564. https://search.informit.org/doi/10.3316/informit.314680897825923

Skuster, P., Dhillon, J., & Li, J. (2021). Easing of regulatory barriers to telemedicine abortion in response to COVID-19. *Frontiers in Global Women's Health*, *2*. https://doi.org/10.3389/fgwh.2021.705611

Smith, D. (2005). *Institutional ethnography: A sociology for people.* AltaMira Press.

Snelling, J. M. (2022). Beyond criminalisation: Abortion law reform in Aotearoa New Zealand. *Medical Law Review*, *30*(2), 216–242. https://doi.org/10.1093/medlaw/fwab051

Somefun, O. D., Constant, D., & Endler, M. (2023). The acceptability of implementing telemedicine for early medical abortion in South Africa: A substudy to a randomized controlled trial. *SSM – Qualitative Research in Health*, *3*, 100241. https://doi.org/10.1016/j.ssmqr.2023.100241

Sorhaindo, A. M., Castle, S., Flomen, L., Lathrop, E., Mohagheghpour, S., Dabash, R., Toedtli, F. K., Wilkins, R., Läser, L., Titulaer, P., Nyamato, E., Dakouo, M. L., Awadallah, A., Shrestha, R., Morales, M., & Rehnström Loi, U. (2023). Adaptations to comprehensive abortion care during the COVID-19 pandemic: Case studies of provision in Bolivia, Mali, Nepal, and the occupied Palestinian territory. *Sexual and Reproductive Health Matters*, *31*(1). https://doi.org/10.1080/26410397.2023.2249694

Sorhaindo, A. M., & Lavelanet, A. F. (2022). Why does abortion stigma matter? A scoping review and hybrid analysis of qualitative evidence illustrating the role of stigma in the quality of abortion care. *Social Science & Medicine*, *311*, 115271. https://doi.org/10.1016/j.socscimed.2022.115271

Spillane, A., Taylor, M., Henchion, C., Venables, R., & Conlon, C. (2021). Early abortion care during the COVID-19 public health emergency in Ireland: Implications for law, policy, and service delivery. *International Journal of Gynecology & Obstetrics*, *154*(2), 379–384. https://doi.org/10.1002/ijgo.13720

Srinivasulu, S., Nyandak, D., Fiastro, A., MacNaughton, H., Tressa, A., & Godfrey, E. (2022). P052 "I feel like I had the best team": Patients' experiences with telehealth abortion in primary care. *Contraception*, *116*, 85. https://doi.org/10.1016/j.contraception.2022.09.076

Stifani, B. M., Avila, K., & Levi, E. E. (2021). Telemedicine for contraceptive counseling: An exploratory survey of US family planning providers following rapid adoption of services during the COVID-19 pandemic. *Contraception*, *103*(3), 157–162. https://doi.org/10.1016/j.contraception.2020.11.006

Strong, J., Coast, E., & Nandagiri, R. (2023). Abortion, stigma, and intersectionality. In P. Liamputtong (Ed.), *Handbook of social sciences and global public health* (pp. 1579–1600). Springer International. https://doi.org/10.1007/978-3-031-25110-8_103

Sudhinaraset, M., Afulani, P., Diamond-Smith, N., Bhattacharyya, S., Donnay, F., & Montagu, D. (2017). Advancing a conceptual model to improve maternal health quality: The person-centered care framework for reproductive health equity. *Gates Open Research*, *1*. https://doi.org/10.12688/gatesopenres.12756.1

Sudhinaraset, M., Landrian, A., Afulani, P. A., Phillips, B., Diamond-Smith, N., & Cotter, S. (2020). Development and validation of a person-centered abortion scale: The experiences of care in private facilities in Kenya. *BMC Women's Health*, *20*(1). https://doi.org/10.1186/s12905-020-01071-w

Summit, A. K., Lague, I., Dettmann, M., & Gold, M. (2020). Barriers to and enablers of abortion provision for family physicians trained in abortion during residency. *Perspectives on Sexual and Reproductive Health*, *52*(3), 151–159. https://doi.org/10.1363/psrh.12154

Sweet, P. L. (2020). Who knows? Reflexivity in feminist standpoint theory and Bourdieu. *Gender & Society*, *34*(6), 922–950. https://doi.org/10.1177/0891243220966600

Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic analysis. In C. Willig & W. Stainton Rogers (Eds.), *The SAGE handbook of qualitative research in psychology* (2nd ed., pp. 17–37). SAGE. https://doi.org/10.4135/9781526405555.n2

Thachuk, A. (2007). Midwifery, informed choice, and reproductive autonomy: A relational approach. *Feminism & Psychology*, *17*(1), 39–56. https://doi.org/10.1177/0959353507072911

Thompson, K. M., Sturrock, H. J., Foster, D. G., & Upadhyay, U. D. (2021). Association of travel distance to nearest abortion facility with rates of abortion. *JAMA Network Open*, *4*(7), e2115530. https://doi.org/10.1001/jamanetworkopen.2021.15530

Thompson, T. A., Northcraft, D., & Carrión, F. (2022). Addressing structural inequities, a necessary step toward ensuring equitable access to telehealth for medication abortion care during and post COVID-19. *Frontiers in Global Women's Health*, *3*. https://doi.org/10.3389/fgwh.2022.805767

Tong, R., & Botts, T. F. (2024). *Feminist thought: A more comprehensive introduction* (6th ed.). Routledge. https://doi.org/10.4324/9781003016939

Tresolini, C. P., & Pew Fetzer Task Force. (1994). *Health professions education and relationship-centered care*. University of California San Francisco. Retrieved August 27, 2025, from https://healthforce.ucsf.edu/publications/health-professions-education-and-relationship-centered-care

Tressan, A., Nyandak, D., Srinivasulu, S., Fiastro, A. E., MacNaughton, H., & Godfrey, E. M. (2024). Telemedicine abortion in primary care: An exploration of patient experiences. *Annals of Family Medicine*, *22*(1), 19–25. https://doi.org/10.1370/afm.3058

Tsereteli, T., Platais, I., Maru, M., Maystruk, G., Kurbanbekova, D., Rzayeva, G., & Winikoff, B. (2024). Evaluation of telemedicine medical abortion using a no-test protocol in the Eastern Europe and Central Asian region: Evidence from Ukraine, Uzbekistan, and Azerbaijan. *International Journal of Gynecology & Obstetrics, 167*(2), 804–809. https://doi.org/10.1002/ijgo.15708

Upadhyay, U. D., Jovel, I. J., McCuaig, K. D., & Cartwright, A. F. (2020). Using Google Ads to recruit and retain a cohort considering abortion in the United States. *Contraception: X*, *2*, 100017. https://doi.org/10.1016/j.conx.2019.100017

Upadhyay, U. D., Koenig, L. R., Meckstroth, K., Ko, J., Valladares, E. S., & Biggs, M. A. (2024). Effectiveness and safety of telehealth medication abortion in the USA. *Nature Medicine, 30*(4), 1191–1198. https://doi.org/10.1038/s41591-024-02834-w

Ushie, B. A., Izugbara, C. O., Mutua, M. M., & Kabiru, C. W. (2018). Timing of abortion among adolescent and young women presenting for post-abortion care in Kenya: A cross-sectional analysis of nationally-representative data. *BMC Women's Health*, *18*(1). https://doi.org/10.1186/s12905-018-0521-4

Vandamme, D. (2021). Bringing researchers back in: Debating the role of interpretive epistemology in global IR. *International Studies Review*, *23*(2), 370–390. https://doi.org/10.1093/isr/viaa099

van den Dungen, R. F., & Gomperts, R. (2024). 'The abortion gave me my life back': The long-term impact of access to self-managed medication abortion through telemedicine on women's lives in legally restricted countries. *Culture, Health & Sexuality,* 1–12. https://doi.org/10.1080/13691058.2024.2408337

van der Waal, R., & van Nistelrooij, I. (2022). Reimagining relationality for reproductive care: Understanding obstetric violence as "separation". *Nursing Ethics*, *29*(5), 1186–1197. https://doi.org/10.1177/09697330211051000

Veiga, M. B., Lam, M., Gemeinhardt, C., Houlihan, E., Fitzsimmons, B. P., & Hodgson, Z. G. (2011). Social support in the post-abortion recovery room: Evidence from patients, support persons and nurses in a Vancouver clinic. *Contraception*, *83*(3), 268–273. https://doi.org/10.1016/j.contraception.2010.07.019

Wasser, O., Ralph, L. J., Kaller, S., & Biggs, M. A. (2024). Experiences of delay-causing obstacles and mental health at the time of abortion seeking. *Contraception: X*, *6*, 100105. https://doi.org/10.1016/j.conx.2024.100105

Whitehouse, K. C., Blaylock, R., Makleff, S., & Lohr, P. A. (2021). It's a small bit of advice, but actually on the day, made such a difference…: Perceptions of quality in abortion care in England and Wales. *Reproductive Health*, *18*(1). https://doi.org/10.1186/s12978-021-01270-0

Willis, B., Church, K., Perttu, E., Thompson, H., Weerasinghe, S., & Macias-Konstantopoulos, W. (2023). The preventable burden of mortality from unsafe abortion among female sex workers: A community knowledge approach survey among peer networks in eight countries. *Sexual and Reproductive Health Matters*, *31*(1). https://doi.org/10.1080/26410397.2023.2250618

Wilson, D., Moloney, E., Parr, J. M., Aspinall, C., & Slark, J. (2021). Creating an indigenous Māori-centred model of relational health: A literature review of Māori models of health. *Journal of Clinical Nursing*, *30*(23–24), 3539–3555. https://doi.org/10.1111/jocn.15859

Wilson, G., Bidwell, S., Toop, L., & Savage, R. L. (2021). Empty waiting rooms: The New Zealand general practice experience with telehealth during the COVID-19 pandemic. *New Zealand Medical Journal*, *134*(1538).

Wood, S. M., Alston, L., Chapman, A., Lenehan, J., & Versace, V. L. (2024). Barriers and facilitators to women's access to sexual and reproductive health services in rural Australia: A systematic review. *BMC Health Services Research*, *24*(1), 1221. https://doi.org/10.1186/s12913-024-11710-9

Yang, S., Barwise, A., Perrucci, A., & Bartz, D. (2024). Equitable abortion care for patients with non-English language preference. *Contraception*, *133*, 110389. https://doi.org/10.1016/j.contraception.2024.110389

Yokoe, R., Rowe, R., Choudhury, S. S., Rani, A., Zahir, F., & Nair, M. (2019). Unsafe abortion and abortion-related death among 1.8 million women in India. *BMJ Global Health*, *4*(3), e001491. https://doi.org/10.1136/bmjgh-2019-001491

Zolfaqari, Z., Ayatollahi, H., Ranjbar, F., & Abasi, A. (2024). Motivating and inhibiting factors influencing the application of mhealth technology in post-abortion care: A review study. *BMC Pregnancy and Childbirth*, *24*(1). https://doi.org/10.1186/s12884-024-06253-0

Appendix A: Survey Questions

EXPERIENCES OF DECIDE SERVICES: A QUALITATIVE SURVEY

Screening questions

1. When were you born? – *not eligible if younger than 16 years-old*
2. When did you access Decide services? [month/year] – not eligible if after 30 June 2024
3. Are you human? [Capture to identify bots]

Survey Questions

Please write as much or as little as you like; there are no right or wrong answers. The more detailed your answers, the more helpful it is to understand your experiences.

Section 1: About you

Please provide us with the following information about you. Answering these questions helps us ensure that our survey results accurately represent the diverse perspectives and experiences of all participants.

1. Age (in years):
2. Gender
3. Ethnicity
4. Iwi (if known)
5. Birthplace (if other than New Zealand)
6. If you were born elsewhere, how long have you lived in New Zealand? >> Less than 5 years | 5 – 10 years I More than 10 years
7. What is your occupation?
8. What is the highest level of education you have attained?
    a. Primary school
    b. Highschool
    c. Some tertiary but no qualification
    d. Tertiary / University diploma/bachelor's degree
    e. Postgraduate degree (i.e., honors, master, doctoral degree)
    f. Professional qualification (e.g., medical doctor)

Section 2: About the services

Please provide some details to help us provide feedback to DECIDE.

1. Region living in at the time of accessing DECIDE services [drop down]
2. What DECIDE services did you use? (e.g., information, counselling, advice, medication)

Section 3: Open-ended questions

1. Please tell us about your overall experience of using DECIDE services.
   - What did you like the most, and why?
   - Were there any problems or challenges you faced?
2. How well did DECIDE services meet your personal needs and concerns?

   (For this answer, you can think about your spiritual or cultural needs if that's important to you.)
3. Based on your experience, what do you think about DECIDE's ability to help people with a range of different life experiences and backgrounds?

   Is there anything they could do better?
4. Some people prefer using tele-health because it's private, while others might find it harder without in-person support. How did you feel about the remote nature of the DECIDE services?
5. Did the DECIDE service providers ask about your support network (e.g., family, friends, or caregivers) or encourage you to seek support during your care?
   - If yes, how did this make you feel? Was it helpful or not?
   - If no, do you think this would have been helpful for you?
6. Is there anything else about your experience that you'd like to share?

Appendix B: Organisation Information Sheet

ORGANISATION INFORMATION SHEET

About the Study: The aim of the research is to understand service users' experience with DECIDE services. I wish to invite those who have used DECIDE services between 1st November 2022 and 30th June 2024 to share their experiences via an anonymous online survey. I would like to receive up to 100 responses as research suggests that 50-100 responses are an adequate number to extract rich content. The survey will consist of open-ended questions to allow respondents to share their experiences in their own words and to include whatever information they feel is most important or relevant. The responses will be analysed thematically from a relational care perspective.

Eligibility criteria: To be eligible to take part in the survey, respondents must (1) be 16 years and older (i.e., able to legally consent to participate) and (2) have accessed services between 1st November 2022 and 30th June 2024 (the cut-off date ensures that some time has passed to minimise any distress associated with a pregnancy that was unintended, undesired, or not able to be supported emotionally, physically, or financially).

Research Procedures

- After clicking the survey link, respondents will be presented with an information sheet and required to check the consent box and answer eligibility questions regarding their age and the date they accessed DECIDE services.
- Those eligible will be directed to the survey, which will capture demographic information, type of service they accessed, and contain six open-ended questions about their experiences of care throughout their service use.

- The survey will be anonymous and can be completed at a time that suits the respondent. Respondents may take as long as they wish to complete the survey (saving their responses), but I expect it to take approximately 45 - 60 minutes.
- To recognise and honour participants' time and contribution to the study, participants can opt in on a draw to win one of 30 x $25.00 Giftpay ecards.

Privacy

- All information provided within the survey is anonymous and anonymised. This means nothing will link the participants to their responses.
- All research material will be stored securely on a password-protected computer, Massey OneDrive platform. No paper copies will be made. Any information the participant provides will only be used for this research and kept confidential, with access only provided to my supervisor and me.
- Per Massey University policy, after research is completed, the participant's information is held for five years in the Massey University School of Psychology archive and then destroyed.

Participants Rights: Recruitment materials will clarify that there is no obligation to accept the invitation to participate and assure them of their anonymity and confidentiality should they opt in. Potential participants will also be fully informed of the purpose of the study, how the information will be used, and their rights, which include the right to:

- Decline to answer any question.
- Provide information on the understanding that there is no personal identifier information such as name.
- Access a summary of research findings.

Benefits and risks of participation: We recognise that there may be difficult and distressing circumstances associated with an unintended, unwanted, or unsupportable pregnancy and

seeking abortion care. However, based on similar research conducted elsewhere, we hope that being invited to share their experiences will be validating and cathartic. Nevertheless, participants will be advised that they do not have to answer any questions they do not wish to or disclose any information they are uncomfortable sharing. Contact information for support services will also be provided at the end of the survey.

Benefits to DECIDE: The findings will provide DECIDE with valuable feedback for service improvement and provide quality, equitable services, especially to Māori and other socially marginalised groups who experience worse health outcomes and service barriers.

Researcher Charmaine Sutherland
Master of Arts in Psychology Candidate,
Massey University
Email: charmaine.sutherland.1@massey.ac.nz

Supervisor Tracy Morison
Associate Professor, School of Psychology
Massey University, Palmerston North
Email: t.morison@massey.ac.nz
Tel: [redacted]

Appendix C: Participant Recruitment Advertising

Appendix D: Participant Recruitment Social Media Story

https://youtube.com/shorts/-0mMJcLlOA4?feature=share

Appendix E: Survey Information Sheet

WHAT WAS YOUR EXPERIENCE OF DECIDE SERVICES?

Nau Mai, Haere mai! You are invited to take part in this anonymous survey.

As part of my degree at *Massey University*, I am conducting research on experiences with DECIDE, the national tele-health abortion service. I am inviting those who have used this service to complete an online survey about their experiences to help improve care for all users.

About the researcher: I'm Charmaine Sutherland, and I'm studying for a master's in psychology. I was born and raised in Taranaki, and I have Irish and Scottish heritage. My personal and professional experience with abortion services drives my interest in this research issue.

Anonymity: This survey is completely confidential. No identifying information (such as your name or birthdate) or contact information will be collected.

Who can take part? | Ko wai ka whai waahi?

You can take part if you:

(2) are 16 years or older, and

(2) used the DECIDE services between 1 November 2022 and 30 June 2024.

What will I have to do? | Ka aha ahau ina whai waahi ahau?

This anonymous survey asks about your experiences with DECIDE services, including what worked, what didn't, and what could be improved. Your story is important, and there are no right or wrong answers.

The survey should take about 45-60 minutes in total.

- You can save your answers and complete the survey in your own time.
- You can write as much or as little as you feel is appropriate (but more detailed responses will be helpful!).

- You can skip any question you don't want to answer.
- Please find a quiet time to focus on the survey and your self-care.
- You can discuss the questions with any support people (like your whānau or partner) if you want to, but it's not required.
- You can enter a draw to win one of thirty Giftpay ecards valued at $25.00 each.
- You can access the summary of the findings via a secure link.

What will happen to my data? | Ka ahatia aku raraunga?

All the information shared will be anonymized. The study aims to improve services for all users, so once the answers are analysed, they will be shared with DECIDE and presented in academic articles. A summary of the study will be available on the survey website for you to read.

During the study, all research materials will be stored securely in a password-protected computer or locked cabinet that only my supervisor and I can access. They will be stored for five years after the study is completed and then destroyed.

Do I have to take part? | Me whai waahi ahau?

You're not obliged to participate, and you have the right to ask any questions about the study. If you change your mind while completing the survey, you don't have to submit your responses. Please be aware that once you click submit, your answers cannot be removed because they are anonymous.

What are the benefits and risks to me? | He aha ngā painga me ngā raru ki ahau?

We don't foresee any risks from your participation, but:

- If any question makes you feel uncomfortable or upset, you don't have to answer it.
- If you feel you need to talk about your experiences at any time, there is a list of support services at the end.

We believe there may be some benefits to taking part, including:

- You may feel empowered by sharing your experience and reading what others shared.
- Your feedback can contribute to improving DECIDE services.

Questions? | Patai?

If you have any questions or queries regarding this study, please don't hesitate to contact me, Charmaine Sutherland or my supervisor Tracy Morison.

If you need to talk

Free services:

- Lifeline – 0800 543 354
- Rape Crisis – 0800 883 300
- Women's refuge crisis line – 0800 733 843
- HELPline - (following sexual assault) 0800 623 1700
- Whatsup - (for children and teenagers) 0800 9428787
- Māori health provider directory https://www.teakawhaiora.nz/en-NZ/find-health-services
- Shakti – 0800 742 584 (migrant and refugees only) https://en.shakti-international.org/
- National counselling - free call or text 1737
- Sexual and reproductive health - https://sexualwellbeing.org.nz/
- Victim Support - https://www.victimsupport.org.nz/

To locate psychologists in your area (not free):

- New Zealand Psychological Society - www.psychology.org.nz
- New Zealand College of Clinical Psychologists - https://www.nzccp.co.nz/

CONSENT

By clicking the consent box, I AGREE to participate in this research and CONFIRM that I understand the following.

- The researcher is interested in my experiences of DECIDE services. By participating, I can share my story and help improve services.
- Participation involves completing a survey taking about 45-60 minutes of my time.
- I can change my mind about taking part. I don't have to submit my responses after giving consent.
- I can choose not to answer any question and have access to support contacts if needed.
- I can contact the researcher with any concerns about my participation.
- All research material will be kept confidential and destroyed 5 years post-study.
- A summary of the findings and draw entry will be available via a link at the end of the survey.

"*This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 1, Application OM1 24/33. If you have any concerns about the conduct of this research, please contact the Chairperson, Massey University Human Ethics Ohu Matatika 1, email* humanethics1@massey.ac.nz*."*