

# Reproductive justice in Aotearoa New Zealand—A viewpoint narrative

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The term *reproductive justice* originated in the United States in 1994 (Ross, 2017; Ross & Solinger, 2017; SisterSong, n.d.). It was coined by a group of Black women who organised under the name Women of African Descent for Reproductive Justice (Zavella, 2020). These women recognised that the reproductive rights movement was not only led by wealthy and middle-class white women, but it was also focused *exclusively* on the needs and experiences of wealthy and middle-class white women. The reproductive rights movement did not value or account for the experiences of women of colour, other marginalised women, and trans people—or the unique threats that these people face to their reproductive autonomy. The reproductive rights movement was centred on the idea of “choice”. However, the movement’s leadership failed to acknowledge, or contend with, the barriers to choice that Black women, and other marginalised people, face. It had neither the will, nor the capacity, to address inequities that were not directly experienced by wealthy and middle-class white women. Ross (2006) argued that “the necessary enabling conditions to realize these rights are not just a matter of individual choice and access. Reproductive justice addresses the social reality of inequality, specifically, the inequality of opportunities that we have to control our reproductive destiny” (Ross, 2006, p. 4). In stark contrast, the Women of African Descent for Reproductive Justice called for an intersectional approach—recognising their lived experience and the ways that multiple forms of marginalisation, and oppression interconnect and compound to exacerbate discrimination and

reproductive injustice for specific groups (Collins, 2015; UN Women, n.d.).

Family Planning is Aotearoa’s only national primary care provider specialising in sexual and reproductive health care—including health promotion. We know that equity in access to sexual and reproductive health services, in addition to information and education, is essential to achieving reproductive justice (Ministry of Health, 2023a). We also recognise that the reach of reproductive justice extends well beyond equitable access to health services. To achieve reproductive justice, we believe that the full range of issues and circumstances that impact reproductive decision-making must be recognised and accounted for. One key step towards equitable reproductive autonomy is an all-of-government approach that prioritises reproductive justice in policy and decision-making. In this article, we reflect on the concept of reproductive justice as it relates to Aotearoa, and the issues that fall within our area of work, including the right to have a child, the right to not have a child and the right to parent children in healthy, safe environments. We will also present ways reproductive justice could be furthered in Aotearoa.

## Coloniality and reproductive justice in Aotearoa

Colonisation impacts the sexual and reproductive health and autonomy of Indigenous and diasporic people, (El-Mowafi et al., 2021). Moewaka Barnes and McCreanor asserted that breaches of tino rangatiratanga—

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as ratified in He Whakaputanga and enshrined by Te Tiriti o Waitangi—are “... a central practice of establishing the colonial order in Aotearoa” (Moewaka Barnes & McCreanor, 2019). Colonisation in Aotearoa has had, and continues to have, a profoundly negative effect on Māori with breaches of treaty rights being a mechanism that denies the ongoing intergenerational impacts of colonisation, including impacts on poverty and access to education, health and other social services and the right to self-determination as Indigenous Peoples of Aotearoa.

Racist stereotypes about sexuality, reproduction, and parenting are another feature of colonisation and racism—they contribute to the stigma and shame that marginalised people can feel when they are seeking reproductive health services, social services, or related information (Ministry of Health, 2023; Thompson et al., 2022). Racism limits the reproductive autonomy of Māori (Le Grice et al., 2022) and many other marginalised groups, including Pacific peoples, refugee and migrant communities, and diasporic peoples in Aotearoa.

### Reproductive justice and access to contraception

Before people in Aotearoa can fully express true reproductive and bodily autonomy, they must have ready access to effective and appropriate contraception. One quarter of respondents to a Family Planning contraceptive use survey reported that they were not using their preferred method of contraception (Family Planning, 2020). Despite the critical role of contraception, contraceptive needs in Aotearoa continue to be inadequately and inequitably met (Te Karu et al., 2021).

A body of research has identified many barriers to accessing contraception in Aotearoa, including: cost; a lack of primary care providers trained to provide a comprehensive range of contraceptives; a lack of youth-friendly services; poor referral pathways; and inadequate health literacy

amongst both patients and practitioners (Messenger et al., 2021b.; Health Quality and Safety Commission, 2020; Lawton et al., 2016). Cost and time barriers are exacerbated when women and girls and people using contraception have to make multiple visits to a health practitioner—creating a compounding disadvantage for people poor in one, or both, resources.

Following PHARMAC’s funding of hormonal intrauterine systems (IUS) contraception in 2019, Family Planning researchers observed a significant increase in IUS use (Messenger et al., 2021a). The percentage increase of IUS uptake from 2018/19 to 2020/21 was almost 400% among Pasifika clients, 200% among Māori clients, and about 140% among NZ European/Other. The positive impact that PHARMAC funding had on rates of IUS uptake amongst Māori and Pasifika indicates that cost had been a significant barrier to accessing IUS contraception for those communities. Clearly, financial barriers are not experienced equally.

When women and girls and people using contraception have access to a broad range of contraceptive methods, they are *not only* more likely to self-select the most suitable method—they will frequently continue using contraception, and avoid unintended pregnancy (United Nations, 2015). Unfortunately, in Aotearoa, people do not have access to a complete range of contraceptives. The contraceptive ring (Nuvaring), the contraceptive patch (e.g., Evra), self-injectable Depo Provera (e.g., Sayana Press), ulipristal acetate for emergency contraception, and several modern formulations of oral contraceptive pills (such as Qliara) are not currently available, or are not funded, in Aotearoa. These gaps in funded contraceptive access will impact some populations more than others.

For example, the emergency contraceptive pill that is currently available in Aotearoa has limited effectiveness for people over 70kg.

Ulipristal acetate is an emergency contraceptive that is *not* currently funded—despite the fact that it is known to be very effective with no weight limitations (Lee & Norman, 2022).

Access to self-injectable contraceptives would provide a useful option to people who use, or want to use, Depo Provera. Māori women and girls are more likely to use Depo Provera as their contraceptive (Ministry of Health, 2019). However, people who use Depo Provera are required to visit a health provider every three months to have their injection administered. This is a time and money barrier—in addition to any other barriers that a marginalised client may experience when visiting a clinic. A self-injectable could offer Māori increased contraceptive autonomy, and lower barriers associated with clinic visits. This is just one example of how policy decisions can compromise equitable access to contraceptives. We cannot achieve reproductive justice in Aotearoa without accounting for the experiences and needs of Māori and other marginalised peoples.

To achieve reproductive justice, it is essential that policies and practices do not explicitly, or inadvertently, prioritise one type of contraceptive over another. There is a lot of professional excitement about long-acting reversible contraceptives (LARCs) in Aotearoa and abroad—due to their effectiveness at preventing unintended pregnancy. Many people like using LARCs, and they have high rates of continued use after being inserted. However, we are concerned that prioritising LARCs could impact reproductive justice.

Prioritising one type of contraceptive limits contraceptive options. Limited options can manifest as medical coercion—people end up using contraceptives that they would not freely select, and that do not adequately meet their needs.

There have been some policies in Aotearoa that appear to incentivise LARCs. For example, there are policies that make LARC visits

free for Māori and Pacific people, but do not extend the same support to consultations for other types of contraceptives. There have even been conversations at the national level about making health care consultations for LARCs free—potentially making them more accessible than other types of contraceptives (Ministry of Health, 2023; McGinn et al., 2021). Women and girls and people who need contraception—but cannot afford a consultation—may be pressured into using LARCs by this kind of selective funding policy.

### Reproductive justice and access to abortion

A reproductive-justice-based approach to contraception would ensure that all people have access to the education, information, and services they need to make informed decisions about the contraceptive methods that work best for them. In addition to contraception, ready access to multiple methods of abortion, abortion information, education, and services is crucial praxis for reproductive justice and the right to not have children or have them when the time is right.

Abortion law reform in 2020 codified the autonomy of a pregnant person in Aotearoa to decide whether to have an abortion or not (up to 20 weeks' gestation) (Abortion Legislation Act 2020). Before this law change, every abortion had to be approved by two certifying consultants (doctors). The approval process robbed people of their bodily autonomy—and, in the case of Māori clients, undermined tino rangatiratanga (Laurence, 2019).

The 2020 law change has improved both personal autonomy over, and the provision of, abortion in Aotearoa. There is now a national abortion telehealth service, DECIDE, and, currently, people can self-refer to an abortion provider to have an abortion. However, there is still inequity in access to abortion—particularly for Māori and Pacific people. In the 2022 Abortion Services Annual Report, The Ministry of Health stated: “Māori and Pacific peoples accessed abortion

procedures at later gestations compared with non-Māori, non-Pacific ethnicities. These findings highlight service access barriers continue to exist and disproportionately impact Māori and Pacific peoples” (Ministry of Health, 2022, p. 12).

Under the current system, primary care providers are not funded to offer abortion. With appropriate funding, Family Planning would consider providing early medical abortion (EMA) at more of our clinics, right across the country. With appropriate funding, more general practitioners and nurse practitioners—including Māori and Pacific providers—could provide abortion to people in more local communities.

Ideally, abortion would be another one of the many essential services that primary care providers offer. If abortion were provided as a primary care service, we would see improved access to timely abortion, a reduction in barriers to abortion, and greater de-stigmatisation of abortion services.

The theory and praxis of reproductive justice recognises, protects, and promotes reproductive and bodily autonomy for women and girls and pregnant people. For Māori specifically, *mana motuhake*, *tino rangatiratanga*, and *whakapapa*, must also be recognised and upheld.

The scope of reproductive justice extends beyond equitable access to abortion. However, while there is inequity in access to abortion, we will never manifest true reproductive justice. For true reproductive justice, people must be empowered to express full autonomy when they make fundamental reproductive decisions.

### **Reproductive justice, sexually transmitted infections (STIs), and HPV**

Avoidable, unfair, and unjust differences (Ministry of Health, n.d.) in STI rates result in inequitable health outcomes that impact a person’s ability to become a parent. There are

many situations where STIs can compromise or devastate fertility—as well as create complications during pregnancy, birth, and beyond (Van Gerwen et al., 2022; Tsevat et al., 2017).

We know that 17% of untreated chlamydia infections will progress to pelvic inflammatory disease (PID)—which can cause ectopic pregnancy, and infertility, among other issues (Munari et al., 2022). One of the starkest examples of STIs’ impact on reproductive health is congenital syphilis. Congenital syphilis occurs when syphilis is passed from a pregnant person to a foetus. Congenital syphilis can result in premature birth, foetal harm, and stillbirth (Cooper & Sanchez, 2018).

In Aotearoa, there is significant inequity in STI rates among Māori and Pacific women and girls. Gonorrhoea is contracted by Māori and Pacific women and girls at six times the rate of New Zealand European women. Chlamydia is contracted by Māori and Pacific women and girls at four times the rate of New Zealand European women (ESR, 2022). In 2020, there were eight cases of congenital syphilis. Six of these cases affected Māori women. The other two cases affected Pacific women.

These avoidable, unfair, and unjust differences in STI rates mean inequitable sexual and reproductive health outcomes for Māori and Pacific women and girls. They threaten Māori and Pacific women’s right to parent. If reproductive justice is to be realised in Aotearoa, inequity in STI rates for Māori and Pacific women and girls must be addressed.

The Ministry of Health recently published The Aotearoa New Zealand Sexually Transmitted and Blood Borne Infection Strategy 2023-2030 (Ministry of Health, 2023b). Unfortunately, the strategy fails to clarify how initiatives will be resourced, or how they will meet the specific needs of Māori and Pacific women and girls. In 2004, at the first National Māori Sexual and

Reproductive Health Conference, Dame Tariana Turia said (Turia, 2004):

I often think when I read through the statistics telling me that Māori experience gonorrhoea in higher numbers at a younger age than do non-Māori; Māori and especially rangatahi Māori are at greater risk of sexually transmitted infections; the rate of chlamydia for Māori (at 10.5%) is over two times higher than non-Māori (4.6%); that the tragedy of these statistics is lost when seen only in the context of epidemiological data.

In 2023, Māori and Pacific women and girls remain at a higher risk of STIs. Nothing has changed. The invisibility of Māori and Pacific women and girls in the New Zealand Ministry of Health Sexually Transmitted and Blood Borne Infection Strategy is deeply concerning. Failure to respond to the inequitable rates of STIs among Māori and Pacific women and girls leads to treatable and preventable negative reproductive health outcomes going unaddressed.

Across the total population of Aotearoa, HPV vaccination has led to a decrease in cases of cervical cancer (Innes et al., 2020). However, there is well documented inequity in cervical cancer outcomes for Māori and Pacific women. The relative inaccessibility of cervical screening, as well as treatment, for Māori and Pacific women, has led to inequitable mortality rates amongst cervical cancer outcomes (Lourie, 2020). Furthermore, when cervical cancer develops at an early age, it often compromises subsequent fertility—severely limiting a person’s expression of reproductive autonomy (Somigliana et al., 2020).

Cervical cancer is a preventable condition that *can be eliminated* with readily accessible vaccination, screening, and treatment. Currently, most people must pay a standard fee to visit a health practitioner for a cervical screen. All national screening programmes in Aotearoa are fully funded—with the exception of cervical screening. This

represents a failure, on the part of governing bodies, to realise reproductive justice.

### **Reproductive justice and gynaecological care**

In Aotearoa, it takes approximately eight years to get a diagnosis of endometriosis after the onset of initial symptoms (Ellis et al., 2022). Untreated endometriosis can lead to complications that result in compromised fertility. Poor ovarian and endometrial cancer outcomes are a predictable result of inefficient referral pathways, and long waiting lists, for access to specialist gynaecological care (Ellis et al., 2023).

A lack of resourcing, a lack of providers trained in reproductive health, and the minimisation of women’s health needs has resulted in the marginalisation of reproductive issues within the health care system. University of Auckland Associate Professor Monique Jonas—an expert in healthcare ethics—said the following about gender and access to health care (Venuto, 2023, np).

One example that concerns gender relates to women’s experience of endometriosis, which can be a very painful, prolonged, and seriously debilitating condition for some women. And what women find is when they report their symptoms, they are not always given full weight by doctors. They might not be believed. They might be seen as exaggerating these symptoms.

For reproductive justice to be fully realised, the reproductive health needs of people who are marginalised by misogyny in healthcare must be addressed and resourced. Readily accessible gynaecological care is crucial to reproductive justice in Aotearoa.

### **Reproductive justice and relationships and sexuality education**

Relationships and sexuality education (RSE) aims to equip students with the skills and knowledge to “... develop



healthy relationships, to become positive in their own identities, and to develop competencies for promoting and sustaining their own wellbeing and that of others” (Ministry of Education, 2020). Consent and bodily autonomy are key themes in RSE. Bodily autonomy and the right to give and withdraw consent is applied to various contexts in the RSE curriculum including, but not limited to, non-sexual touch, sexual encounters, medical examination, use of contraception, accessing sexual health services, the establishment and maintenance of healthy interpersonal relationships.

There are policies in place that are intended to support high quality RSE in Aotearoa. RSE is a required area of learning in *The New Zealand Curriculum*, and some excellent RSE programmes are being delivered by committed teachers and schools (Ministry of Education, 2020). The Ministry of Education resource, *Relationships and Sexuality Education: A Guide for Teachers, Leaders, and Boards of Trustees*, focuses strongly on consensual, healthy and respectful relationships as being essential to student wellbeing. It is available in two volumes: one for years 1–8, and one for years 9–13. The guide informs principals, boards and teachers on the requirements of the Education and Training Act 2020. It also assists schools to consult with their community on the ways in which health education should be implemented. Schools have a legal requirement to consult with their community on the health curriculum every two years (Education and Training Act 2020, s. 91).

Despite this, RSE is not *consistently* taught to a high standard. RSE is taught differently in different schools, and delivery frequently varies from teacher to teacher. Schools have the autonomy to include and exclude any part of the RSE curriculum, and their decisions may be impacted by real or perceived opposition from members of their community. The Education Review Office found that many schools struggle to teach this area of the curriculum (Dixon et al., 2022; Education Review Office, 2018). Young

people—particularly Māori and Pacific, and queer young people—have reported that the RSE they received in school did not meet their needs (Education Review Office, 2018; Le Grice & Braun, 2018). Consistent access to high quality RSE education—particularly curriculums that meet the needs of Māori and Pacific, and queer young people—is essential to achieving reproductive justice in Aotearoa.

### **Reproductive justice, sexual violence, and intimate partner violence**

Māori women, trans women, and disabled women are at greater risk of sexual violence and intimate partner violence than other women or genders (Te Puna Aonui, 2022). People who experience sexual and/or intimate partner violence are at an increased risk of unintended pregnancy, abortion, and reproductive coercion.

Reproductive coercion occurs when a person is pressured to continue with—or end—a pregnancy against their wishes. A Women’s Refuge survey on reproductive coercion found that: access to contraception had been controlled by over 80% of the respondents’ intimate partners (Burry et al., 2018). These results highlight reproductive coercion as a common feature of intimate partner abuse. If the results of the Women’s Refuge survey are reflective of a wider trend (which we believe they are) the importance of providing readily accessible reproductive and sexual health services to people who experience sexual and/or intimate partner abuse is self-evident.

Inexplicably, readily accessible reproductive and sexual health services do not feature in Te Aorerekura—the National Strategy and Action Plan to Eliminate Family Violence and Sexual Violence (Te Puna Aonui, 2022).

### **Conclusion**

With a reproductive-justice-informed approach, we can observe the intersections of oppression and disadvantage that limit

free expression of reproductive autonomy in Aotearoa. It is critical that we employ the insights of reproductive justice in the pursuit of reproductive equity, and full bodily and reproductive autonomy. Contending with the function and effects of colonisation is critical to realising reproductive justice in Aotearoa.

Threats to reproductive justice manifest across policy, governance, and between individuals (in the case of sexual violence/ or intimate partner violence). Governance, policy, and individual action are all inextricably linked, and must be addressed with those interrelations in mind. The road to reproductive justice requires us to remove all barriers to reproductive autonomy that exist in, and between, each and every one of those domains.

Necessary changes range from ensuring equity of access to contraception and abortion, to ending intimate partner violence, and sexual violence. Review, development, and deployment of policies and practices in Aotearoa must be informed by the insights and methodologies of reproductive justice—with particular attention paid to the recognition and honouring of tino rangatiratanga for Māori. Family Planning asserts that policies developed with a reproductive justice methodology are crucial to manifesting reproductive autonomy and safety for all people in Aotearoa.

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