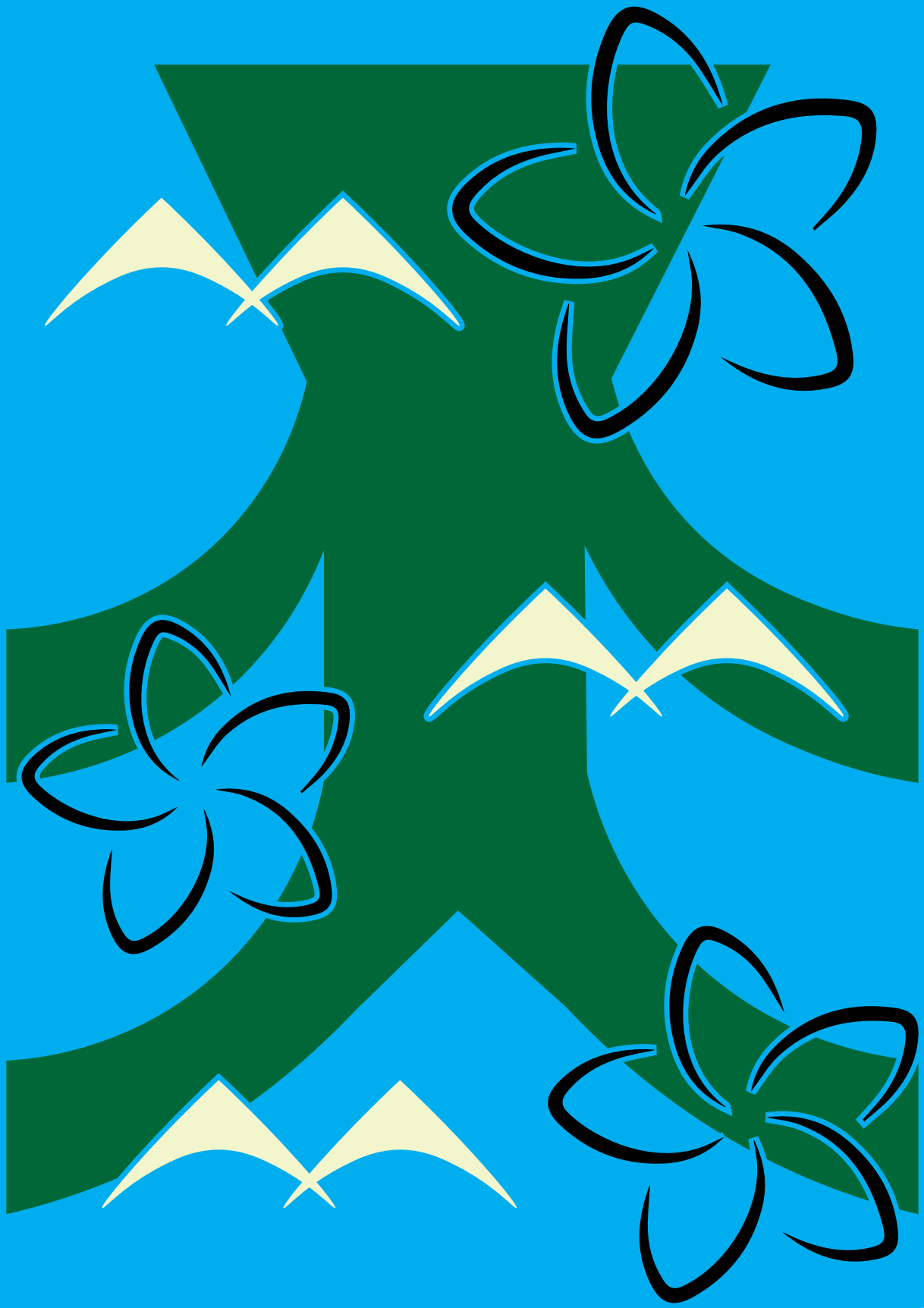
Ora'anga Meitaki no te Vainetini
Cook Islands Women's Wellbeing in the Context of Abortion



CIFWA
Cook Islands Family Welfare Association (Inc.)

Te Puna Vai Marama
Cook Islands Centre for Research

UNSW Kirby Institute

UNSW SYDNEY

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Authors: Kate Burry, Rongo File, Polly Cabia-Tongia, Heather Worth, Kristen Beek, Lisa Vallely, and Bridget Haire

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Cover design: Tamara File

Vaine Toa Motif- Symbolises the strength and honour of the women who took part in this research.

Manutai Motif- Seabird used by our ancestors to navigate, symbolising how this reseach can help us navigate our journey providing services to our people.

Stylised Tipani flower- symbolising life, beauty and growth. The sets of three represent past, present and future, as this research uses past experiences to inform the present situation and to guide the way forward for future generations.

Contents

Introduction

This report is based on conversations with women, advocates, support people, and health workers conducted in Rarotonga in the Cook Islands, and with a health worker in Aotearoa New Zealand, between February and mid-August 2022. The report discusses abortion, including unsafe abortion, in the Pacific islands. The report also details the Cook Islands and how this research was conducted in the Cook Islands. This is followed by key findings from the research organised in three parts: sexual and reproductive health education and services available to women from the Cook Islands; Cook Islands women's experiences accessing abortion services; and navigating and resisting shame, and experiences of support in the Cook Islands. This report concludes with a summary of the report and findings.

Why was the work done?

Unsafe abortions are pregnancy terminations that occur in unsanitary environments using unsafe equipment and practices, and/or with untrained practitioners (1). Unsafe abortions largely occur in contexts were access to legal and safe abortions are restricted by law, meaning pregnant people requiring abortion services must seek these services in unregulated, covert environments, exposing those seeking abortion to injury, trauma, potentially adverse legal consequences, and sometimes death (2). Those with financial resources and support may try to access abortion services by travelling to areas with fewer restrictions, or where abortion is treated as a health, rather than a criminal, matter (3). However, travelling to access abortion services costs people seeking the service financially and emotionally, and takes a toll on their social, family, and spiritual health due to perceived abortion stigma and isolation from their community and associated ongoing distress and anxiety (4).

Those without the financial means to travel to access abortion services may attempt to end their pregnancy themselves through self-harm; by seeking services from practitioners utilising herbal medicines or performing internal abortive procedures that are often dangerous for the individual seeking the abortion; or trying to access medications locally or online to induce abortion (2,5). While the former two methods are particularly risky, medical abortion can be safely and effectively performed outside of a clinic setting, particularly if undertaken early in the pregnancy (up to 13 weeks) (6,7). However, high quality medication, appropriate information, guidance, and support is crucial for safe medical abortion. Where medical abortions occur in countries where abortion is legally restricted, options for support, information, pain management, and follow-up care are limited due to the threat of legal action and poor treatment from hospital staff (5,6).

People require abortion services for a range of reasons and at different stages of their reproductive lives. Pregnancy may occur in the context of financial hardship where a child (or another child) would drive the family further into poverty (8–10). People may perceive that they are not at an appropriate age or stage of life to properly care for and raise a child (8–10). Younger people and/or those pregnant out of wedlock may be fearful of the stigma associated with their pregnancy, and its impact on future spouse options, education, training, and employment (10–12). Coercion and abuse, including rape and incest, may also have caused the pregnancy and a pregnancy could occur in the context of an unstable or abusive relationship (9). Pregnancy and birth could also present significant risks to the life and health of the pregnant person, as well as the possibility of the foetus becoming non-viable or presenting with significant health and developmental issues that would undermine survival.

In addition to legal restrictions, pregnant people seeking abortion services may also have to manage negative socio-cultural attributes ‘ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood’ in particular environments (13). Additionally, the negative characterising of those who require abortions relates to a larger context of sexual and reproductive behaviours that may also be stigmatised, such as adolescent sexuality and pregnancy (14). However, while people seeking abortions may be aware of socio-cultural values and norms that negatively frame those who have abortions, which may complicate their experiences of abortion, they may not accept or may try to resist these values and norms (15). Rocca et al’s (2020) longitudinal study of women who sought abortion services in 30 facilities in the United States found most women reported relief related to undergoing an abortion, and the vast majority (99%) reported decision rightness five years after their abortion (16). On the other hand, these same researchers found that those who are denied services may undertake means that put their health and life at risk or continue with a pregnancy that places them (and their families) in deeper poverty; renders them unable to leave abusive partners; exacerbates mental health issues including suicidality; leaves them with chronic health issues; or even causes their death (16–19).

Abortion in the Pacific islands: Current evidence

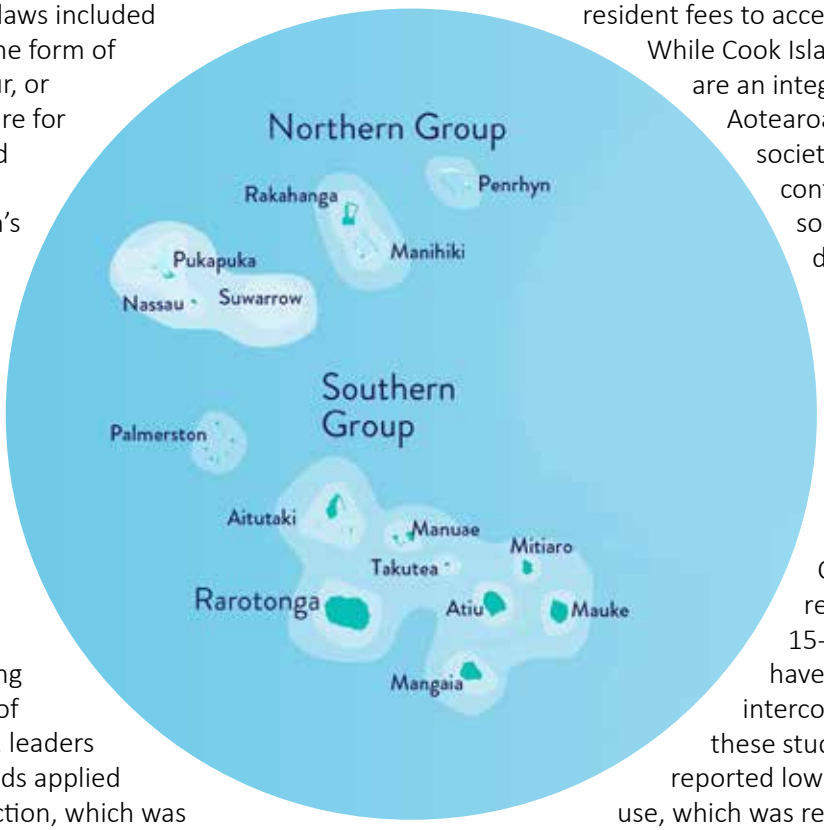
The Pacific island countries of Fiji, the Federated States of Micronesia, Kiribati, Marshall Islands, Nauru, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu all consider abortion a criminal offence, restricting access to the service in most cases except where the pregnant woman's life, and sometimes also her health is at risk (20). Fiji's law pertaining to abortion also specifically allows abortion in cases of rape and incest (21). There is very little research into the experiences of people facing unplanned and unwanted pregnancies in the Pacific region in the face of these significant restrictions (22). However, research from other areas where abortion is restricted by law reveals that making abortion illegal does not stop people from seeking it when faced with a crisis (23). Rather, criminalising abortion is associated with unsafe abortion (24). Therefore, it is important that we understand the experience of abortion-seeking from Pacific perspectives to improve our understanding of this important area of reproductive health in the Pacific islands, and to improve laws and policies governing this area to better protect the health and wellbeing of women and the wider community (2).

Research on abortion in the Pacific region is emerging (22). Research from Tonga, Vanuatu, and the Autonomous Region of Bougainville on adolescent unplanned pregnancy and a study in Goroka, Papua New Guinea, on hospital admissions following unsafe abortions suggests that women often resort to desperate and dangerous measures to end unwanted pregnancies (11,24–27). In line with other research, these studies found that women in these countries may try to end their pregnancies by self-harm, such as jumping from heights, drinking strong alcohol, or applying blunt force to the lower abdomen; seeking out practitioners providing herbal medicines, uterine massage, and/or causing internal trauma by inserting objects into the uterus; paying medically trained practitioners to perform surgical abortions illegally; or illegally accessing and self-administering abortion medications (11,24–27). Vallely, Homiehombo & Kelly-Hanku's (2015) study of women admitted to hospital following unsafe abortions in Goroka in Papua New Guinea is one of the only studies to specifically investigate women's lived experience of abortion in the Pacific. The findings of that study suggest that women in Goroka end their pregnancies primarily due to their young age; their pregnancy affecting their social mobility, including education, marriage prospects and bride price; relationship issues; and the disappointment and shame their pregnancy brought upon their family (11).

We wanted to understand the experiences and journeys of Cook Islands women who have sought abortion services within the Cook Islands or abroad. Importantly, this study includes the stories of women with lived experience accessing abortion services, and the stories of those who supported women to access services, advocates, and health workers. As with other Pacific countries, abortion is considered a criminal offence in the Cook Islands under the Crimes Act 1969, except where the pregnant woman's life is at risk, with penalties for abortion seekers of up to three years of imprisonment; for providers of up to seven years of imprisonment; and for anyone assisting women to access an abortion of up to three years of imprisonment. To our knowledge, no one has been charged or convicted under this law. We wanted to centre the experiences, stories, thoughts, feelings, and insights of Cook Islands women who had sought abortions and their support networks at the interpersonal, health sector, and broader community level in this report.

Background information on the Cook Islands

The Cook Islands is an archipelago nation made up of 15 islands with distinct cultural and linguistic heritage and a total land mass of 240 square kilometres surrounded by nearly two million square kilometres of ocean (28). Following the introduction of Christianity in 1821, missionaries from the London Missionary Society collaborated with some ariki (high chiefs) to implement strict rules governing communities' behaviours, known as the Blue Laws, some of which continued to be enforced under colonial rule (29). These laws included punishment in the form of fines, hard labour, or sometimes torture for real or suspected pre-marital sex, adultery, women's refusal to marry men selected by the mission, and failure to strictly observe the sabbath (29,30). Wary of French invasion as experienced by neighbouring Tahiti, and sensing the inevitability of foreign takeover, leaders in the Cook Islands applied for British protection, which was granted in 1888, before being annexed to Aotearoa New Zealand in 1901 (28). It is probable that the current abortion legislation in the Cook Islands originates from British colonialism and the British Offences Against the Person Act 1861, which was replicated in other British colonies (31). From the 1940s, many Cook Islanders migrated to Aotearoa New Zealand for education and job opportunities, and this outward migration increased with the opening of the airport in 1974 (28). Since 1965, the Cook Islands has been in free association with New Zealand, which means Cook Islanders are New Zealand citizens and use New Zealand currency but govern their own islands and have full responsibility for external affairs.



The population of the Cook Islands in 2021 was 15,040, with over half of the Cook Islands' population, 10,898 people, located in Rarotonga (32). In the 2018 New Zealand Census, 80,532 people identified as Cook Islands Māori, with close to 60 percent located in the Auckland region (28,33). As well as seeking jobs and education, Cook Islanders may enter Aotearoa New Zealand to access health services, although if their usual place of residence is the Cook Islands, they may be required to pay non-resident fees to access care (34). While Cook Islands Māori are an integral part of Aotearoa New Zealand society, they continue to face socioeconomic disparity (33).

Earlier studies on sexual and reproductive health (SRH) and teenage pregnancy from the Cook Islands reported most 15- to 24-year-olds have had sexual intercourse. However, these studies also reported low contraceptive use, which was related to limited reliable SRH education and information; barriers accessing services (including concerns regarding privacy and confidentiality); and a general discomfort with discussing SRH related topics related to social conservatism, particularly associated with young women's sexuality (35–37). The findings of one survey suggested young people are also concerned about the lack of proper understanding and respect for sexual consent, with 71 percent of young women reporting having been pressured into sex (36). Furthermore, one third of ever partnered women in the 2014 Cook Islands Family Health and Safety study reported physical and/or sexual violence from an intimate partner in their lifetime (38).

Women in the Cook Islands Family Health and Safety Study were also more likely to report having had an abortion if they also reported lifetime experience of sexual and/or physical violence from an intimate partner compared to women who did not report abuse (4.7 per cent versus 2.7 percent, respectively) (38).

Pregnancy has been highlighted as a major risk factor for suicide among young Cook Islander women, with pregnant young women potentially facing physical violence or rejection by family, being sent away to mitigate shame on the family, or being made to move in with or marry their sexual partner (36,39,40). Women in the Cook Islands Family Health and Safety Study were also more likely to report having had an abortion if they also reported lifetime experience of sexual and/or physical violence from an intimate partner compared to women who did not report abuse (4.7 per cent versus 2.7 percent, respectively) (38). One study of 10 young women's experiences of unplanned pregnancy in the Cook Islands suggested that young women may seek out abortion services in Aotearoa New Zealand or Australia. However, financial and other restraints mean others may resort to the consumption of plant-based mixtures prepared locally, or may self-harm to end unwanted pregnancies (39).

The findings of this study of young women's experiences of unplanned pregnancy suggest that young, poor, and isolated women are less able to travel to access abortion services available in Aotearoa New Zealand or Australia and, in the context of domestic restrictions in Cook Islands, may have to terminate their pregnancies by dangerous means.

Who conducted the research?

This research was conducted in collaboration with the Cook Islands Family Welfare Association (CIFWA). This research began during COVID-19 lockdowns through video conversations between Kate Burry from the University of New South Wales (UNSW) and CIFWA, who supported the need to gather women's stories of abortion, and the stories of their support people, advocates, and health workers.

The focus groups and one-to-one discussions were conducted by Kate Burry, a papa'a from Aotearoa New Zealand. Established researchers in sexual and reproductive health and rights provided guidance and support throughout the research process. These researchers were Dr Bridget Haire, Dr Kristen Beek, Dr Lisa Vallely, and Professor Heather Worth.

This research was approved by the UNSW Human Research Ethics Committee (HC210407), the Cook Islands Research Committee, the Cook Islands Research Ethics Committee, and the Cook Islands Foundation for National Research. This research also received funding support from the University of the South Pacific Cook Islands Campus Te Puna Vai Mārama | Centre for Research.

Who participated in the research?

This study includes interviews with 12 women who had accessed or tried to access abortion services in the Cook Islands or abroad, including one woman who was in the Cook Islands on a temporary visa, as well as four support people, six health advocates, and three health workers. Focus groups with women from three different age groups: 19-22 years, 27-36 years, and 50+ years were facilitated by the researcher Kate Burry. The inclusion of focus group discussions with women from these age groups was to understand the broader social perceptions and experiences of sexual and reproductive health, including abortion.

Conversation topics covered participants' lived experience of abortion and the experiences of support people, including logistics, decision making and the concept of pregnancy choice, with a focus on their health and wellbeing in a holistic sense, including socio-cultural values and norms related to sexuality, pregnancy, and abortion. Participants also shared their understanding and experiences regarding SRH generally, including access and barriers to SRH education and services.

This report weaves together the stories, insights, and perceptions of these people.

What research participants said

Participants in this research discussed their experiences of accessing, trying to access, or supporting others to access abortion services. Participants also offered broader insights into experiences of SRH education and services, and the concept and experience of shame regarding sexuality and reproduction which interact with women's abortion experiences. Women in this study who had accessed or tried to access abortion services were between the ages of 18 and early 70s, and while some were reflecting on recent experiences, others were recounting experiences from 30 to 50 years ago. The Cook Islands abortion legislation has not changed during this period. However, Aotearoa New Zealand first liberalised its abortion legislation in 1977 to allow abortion where the woman's life, physical or mental health was judged to be at risk by two certifying medical consultants, then decriminalised abortion prior to 20 weeks' gestation in 2020.

On the following page, we summarise the insights reported by participants, starting with their broader discussion of SRH services and education, followed by participants' recounted experiences of abortion, and finally participants' discussions of shame in the context of sex, sexuality, pregnancy, and abortion.

To maintain confidentiality regarding the research participants' identities, we will identify participants by the participant type and identification number (e.g., 'Support Person 1,' 'Advocate 1'). For focus groups, the focus group number and participant age group (e.g., 'Focus Group 1, 27-36 years') is referenced, and different speakers are signalled by P (e.g., P1, P2). Women who accessed or tried to access abortion services are given an identification number (e.g., 'Participant 1'), and their age range, rather than actual age, is referenced (18-24 years, 25-34 years, 35-44 years, and those over 55 years (55+)). Comments and questions from the interviewer (Kate) are in **bold text.**

Sexual and reproductive health education and services

Participants in this research discussed their limited exposure to accurate, reliable, comprehensive, and confidential SRH education and services. SRH education was limited in school and home environments, and the silence on matters related to SRH was related to general perceptions of the taboo nature of SRH. Participants across different age groups noted a lack of comprehensive and ongoing SRH education made them vulnerable to sexual coercion, unsafe sex, and resulted in a limited understanding of their physiological changes throughout puberty.

> *Like, 'cause in my household like me growing up, talking about relationship, puberty, and stuff like that was taboo. Like it was something that my parents was [sic] very uncomfortable. If I ever mentioned about a boy, I would be getting a hiding. Like nothing, nothing like that. I basically learnt it from my friends in school or my friends that are a couple of years older than me that's already got a boyfriend, and they'll be like telling me all these things. […] 'Cause I got my period at a very young age. I think it was like nine going to 10. And I didn't know what was that. I'm like, "Am I dying?" So, my mum came with this rag and, "Just put it in and make sure when it's like, you know, when it's soaking, you go and rinse it. And then we'll wash it, and I'll cut you another one." But no like, "This is part of …" Nothing. No messaging.*
> (FG1, 27-36 years)

Despite the lack of formal SRH education and safe, accurate discussions in the home, participants noted their own and their peers' desire to understand their bodies, relationships, and how to navigate their sexual and reproductive lives safely. Participants described their experiences reading teenage magazines for information or searching for answers to their questions online, including about abortion. Participants also shared that some young people, particularly boys in their pre- or early adolescence, turn to pornography for entertainment, but also to learn about sex. Participants reflected on these magazines and pornography often as sources of misinformation.

Participants highlighted peers as an important source of knowledge and access to SRH services during adolescence. Several participants said that they had received information about contraceptives and had even accessed contraceptive services with or through their peers.

> *What I've found is that, with the young people, it's usually their friends. So, they'll talk to their friends first and, if the friends say, if the friends are on family planning, they're gonna tell their friends if they've asked about it. And I've found it's quite common that a friend who's already on family planning will bring a new one. So, they'll come with them. Yeah. Or, if it's a [sic] older cousin, they'll bring them in. They'll come together, you know.*
> (Advocate 1)

Some participants described their interaction with the work and services of the Cook Islands Family Welfare Association (CIFWA), sometimes through friends or relatives, which enabled them to develop greater insights into SRH, including contraceptives, STI prevention, and sexual consent. Several participants stated that such discussion of SRH topics assisted in normalising dialogue on these issues, as well as assisting access to services. However, some participants also raised concerns about being judged by others should their accessing of CIFWA's services become known, reflecting an ongoing stigma related to accessing SRH information and services. Some participants also commented on the assumption held by some adults that teaching about SRH is a way of encouraging young people to have sex.

P1: It's [education regarding SRH] taboo because they think that exposing kids to that information encourages them. [P2: Yeah, encourages them] But the, that's not the goal. The goal is -

P2: To inform them.

P1: Exactly. So, then like they know if something happens, they know what to do. Not like have to hide it and go around, and they go like really young who get like taken advantage of at young ages. And you'll only have like what? One or two sessions with talking about sex ed and then you won't see it ever again.

(FG2, 19-22 years)

It's easy for the men to go and get it [a vasectomy] done. "Why should I do it, do all this, you know, while you're just enjoying yourself there?" you know? "Don't have to worry about anything." […] Yeah. I got all those [different forms of contraceptives]. All those different methods.

(Participant 10, 55+ years)

I continue to be on the rhythm method[1], and my partners change, and they were unreliable [did not withdraw]. And they, they didn't tell me that I needed to have the morning-after pill[2]. And so that's how I [ended] up in this situation [with an unplanned pregnancy].

(Participant 12, 35-44 years)

Some participants described their experiences accessing contraceptive services in the Cook Islands or Aotearoa New Zealand. Several participants who accessed abortion services overseas described receiving contraceptive services as part of their post-abortion care. Other participants noted a recent wider acceptance of adolescent girls accessing contraception, although barriers remain for young people related partially to concerns over privacy and confidentiality.

Before like the mothers were reluctant to put the girls, when they come to like 13, 14, on contraception. Now, they are more open, and they are using, encouraging the girls. I've noticed that 14, 15, the mothers will bring them to insert an implant, to tell, right? Or they will make effort to get them the Depo [Provera] injection.

(Health Worker 1)

Some participants described trying multiple contraceptive methods, sometimes to try to find one that had more tolerable side effects. Participants also discussed the need for male partners to take more responsibility regarding contraception.

The overall limited capacity to understand and take care of sexual and reproductive health and wellbeing noted by participants is important to consider in the context of unplanned, unwanted pregnancies and women's need for abortion services. Individuals' sexual and reproductive lives are often complex, with state policy, family, and religion all influencing access to information and services, as well as reproductive decision-making (41). Limited access to SRH education and services is also undoubtably influential to individuals' capacities to make informed decisions about their sexual and reproductive health and lives (41).

1 The 'rhythm method' refers to a contraceptive method where women track their ovulation and only have unprotected sex when they are not ovulating. During ovulation, women may abstain from sex, use condoms, or ask their partners to ejaculate outside their vagina ('pull out' or 'withdrawal' method) which is less reliable.

2 The morning after pill is used in the first 72 hours after unprotected sex, where the woman perceives or learns there is a risk of her becoming pregnant. This medication stops pregnancy from occurring by preventing ovulation.

Cook Islands women's accounts of accessing abortion services

Participants in this research described multiple intersecting circumstances that meant the prospect of continuing their pregnancies and having a baby caused significant distress, and their decision to seek an abortion was often clear. These circumstances included a participant's young age; complex, abusive, unstable and/or non-existent relationship with the sexual partner; fear of judgement and punishment from their family and community (including church community) for their pregnancy; financial vulnerability, for example, as a single mother; and a wish to continue with education, or concern over the impact of a pregnancy and motherhood on job, income, or career goals and progression. Some women also described contraceptive failure or dishonesty from sexual partners regarding contraceptive practices, such as failing to withdraw or use a condom, leading to their pregnancies. Several participants discussed their awareness of sexual abuse in their communities, including one focus group participant who described a young woman acquaintance who committed suicide after being made to continue a pregnancy that was the result of incest.

Participants in this research selectively disclosed their pregnancy to people in their networks whom they believed to be supportive and trustworthy and would provide them with information regarding how to access an abortion.

> *My closest friends like growing up with them they're still my closest friends and we have, and I have them on speed dial and stuff. […] But I have not told them that I had an abortion. Like they're the closest things I have to my family but they're the ones that would have judged me [for having an abortion]. Then I have […] my friends who are like, "It's, it's really up to you," who are gonna support me. Like I'm not gonna say that my other friends don't support me, but like they're not gonna judge me. And they're not gonna judge me and they're not gonna throw me under the bus, and they're not gonna go and open their mouths and like spread it.*
> (Participant 1, 35-44 years)

Trusted networks of friends and family are particularly important where, as several participants highlighted, pregnant women wanting abortions who interact with the public health system are likely to face judgement and are usually refused information regarding abortion services. Participants' attempts to manage their pregnancy and abortion quietly was also complicated by their concerns over privacy and confidentiality regarding their medical information. Participants noted that some women avoid accessing services from local public health facilities in the Cook Islands due to concern that their relatives (including those working within the public health system) and, therefore, the broader community would find out about their pregnancy.

> *[Health workers working in women's health] are very 'she wants an abortion. Well, why did she go and have sex if she's just gonna abort the baby?' Like, I have heard midwives talk this way. […] So, the prejudice and the stigmatism is not just from the people but it is also from the healthcare professionals who the people are seeking help and advice from.*
> (Support Person 3)

> *And I think for her [the young woman needing the abortion], because we went to get her blood test or something like that and with, you know, with that information going to them [the health workers] and doing the scan, because we did do the scan … […] I think that is the, yeah, it's just the process of the nurses down here because I think we're just a small community and everybody will just, "Oh, wow, she's pregnant." […] So, what? "Well, it's her fault," you know. All this. "It's her fault she went and opened her legs," and everything like that.*
> (Support Person 2)

Several participants noted that they were required to undergo blood tests and/or dating scans[3] prior to accessing abortion medications online or undergoing an abortion in Aotearoa New Zealand, as well as scans

after the abortion to ensure it was completed. The majority of participants in this study had abortions in Aotearoa New Zealand prior to the decriminalisation of abortion 2020. These participants described compulsory counselling appointments and the requirement to be seen by two certifying consultants who assessed whether their abortion was lawful. Some participants described the added expense and planning required to manage these multiple appointments, sometimes over a number of days, including needing to find transport options for each appointment. One participant booked a motel room closer to the clinic in Auckland, New Zealand, to enable her to attend her appointments more easily.

Support people in participants' networks provided emotional, logistical, financial, and other practical support. This support included researching options, booking appointments, ordering medications online, paying for medications or travel, and accompanying women during the abortion. Even for those who were based in Aotearoa New Zealand or Australia when they needed an abortion, they often had to selectively involve others, usually friends, flatmates, and the sexual partner, for assistance with transportation to and from the clinic; to access information and help to arrange the appointment; and sometimes to book accommodation closer to the clinic. Participant 10 (55+ years) was based in Aotearoa New Zealand in the early 1970s for her tertiary training and had to travel to Australia for an abortion, as access to abortion in Aotearoa New Zealand was severely restricted at the time. Fortunately, she found a supportive doctor who booked her an appointment in Australia and provided her with information on how to get to the clinic. However, she had to pay for her flights and clinic services herself, without support from anyone including her sexual partner, which she described as very stressful.

Although not everyone had adequate support, for those that did, the role of these support people was crucial to their ability to safely access and undergo their abortion.

> *I was still fairly new to the public transport [in Auckland]. So, it took a while to get used to the bus routes and I didn't want to have to worry about that. So, I just quickly asked [a friend], "Hey, can you be, do you think you can take me to this appointment on this day?" She said yes and then another friend said yes to the procedure day. So, I was actually quite lucky to have them available. And then another friend of mine was free for after the procedure to pick me up.*
> (Participant 3, 25-34 years)

> *I said to her, "You make the decision. If you don't want to have a pregnancy and if you find out how far along you are, then I'll start the process." And, so, I went and looked into what the, where I could get one [abortion medication] from, how long it would take - all that sort of stuff - while she went off to find out how far along she was. So, once she came back to me, I actually can't remember how far along she was at that point, it wasn't very far. It was only a couple of weeks. And, so, I got online. I went to the site that I had been given a link to. And, so, I went on that site and then I put through the application and her name. So, you're supposed to actually do it yourself, but it was definitely easier for her for me to do that for her.*
> (Support Person 1)

Those who accessed surgical abortions had to travel usually to Aotearoa New Zealand, and sometimes to Australia specifically for the procedure, however, some women were in these countries for study, work, or to stay with family when faced with their unwanted pregnancy. Advocate 2 described the general awareness in the Cook Islands of women travelling to Aotearoa New Zealand for abortions as contributing to a level of complacency in one of the few public debates on abortion legislation in the Cook Islands she had witnessed. This complacency, however, fails to recognise the financial and practical barriers to many women, and the socio-cultural and emotional isolation this can produce for women. Furthermore, this overlooks the needs of migrant workers who are unable to freely travel to and access New Zealand's public health services, as experienced by one participant in this study who was on a temporary visa.

3 A dating scan is an ultrasound scan done early in the pregnancy to estimate the gestation of the embryo or fetus.

So, I think, so the others … some actually were not as vocal in terms of like, you know, when you put a situation like that … but it was more like, "Well, if it cannot be done here, why don't you just go to New Zealand?" […] Nobody is even talk[ing] about, "What if I can't afford now to go there?" you know… Because you have a problem and that's the only place where it is easier, you don't have to answer a lot of questions. Why don't you just do that? Yeah. So, it's a, so it is in everybody's mind. It's available there and you can access it. So, why make it a big deal?
(Advocate 2)

Support Person 2 also discussed young women relocating to Aotearoa New Zealand for abortion services to avoid being negatively judged for having an abortion which would be 'marked in the, you know, on the island for future'. However, for Participant 4 (55+ years), the experience of isolation from her family and support networks when she became pregnant abroad to a man from a different culture who was not interested in having another child, contributed to her decision to have an abortion. She described the importance of gathering familiar cultural symbols and food after her abortion to reconnect to the warmth of home and her cultural identity.

I just like put little touches, island touches [in the flat] - Cook Island touches - like a sarong. I pinned it on the wall, you know; a picture of the Cook Islands and, you know, that kind of thing. So, I had … and [Cook Island woven] hats, you know. So, there was, I was glad to be back, back in my little space, because, as soon as I got back [from the clinic], I felt that warmth, you know, from, from the sarong, from the, you know, the pictures that I have. And, yeah, so I was okay. Again, coming from that, I would say very sterile and cold environment [of the clinic], even though I was only there for a few hours. […] And they had an Indian grocery store, and they sold taro. I don't know where they got the taro. I guess from Samoa. […] So, I went and got me one, one big one, and just took it and boiled it, and … I guess it's like reconnecting to some kind of warmth, you know. Some kind of island, Polynesian feel, you know.
(Participant 4, 55+ years)

Participants described the journey to access an abortion abroad as expensive, especially for those who had to travel during the COVID-19 pandemic which involved entering and paying for hotel quarantine upon arrival and accessing an abortion under pandemic conditions where services were limited (one participant arrived in Aotearoa New Zealand and subsequently could not access an appointment). Participant 2 (18-24 years) described landing in Aotearoa New Zealand and having to go into hotel quarantine. Participant 2 (18-24 years) described feeling 'pretty scared and nervous' because the abortion was her first experience of a surgical procedure, and because of the uncertainty regarding her access to any healthcare support needed while in the hotel room. She had to stay in the hotel room any time she was not at the clinic, including for post-abortion counselling which, although helpful in normalising her experience, was only available by phone:

I really wanted to go to them and just sit down with them, and talk. And I think it would have been way better than just talking on the phone 'cause you can't really hear them or … And the phone was a bit scratchy. So, I couldn't really hear them. And, plus, [the relative who accompanied her] was around, so I wasn't really comfortable.
(Participant 2, 18-24 years)

Once at the clinic, however, participants who accessed surgical abortions highlighted the ease and painlessness of the procedure, as well as the kindness and professionalism of the staff.

It was a fast process. I remember when I went into the surgical area and there was a little bird. I remember this really clearly. And they just say to you, "Okay, look up there and then just, you know, just keep focus on the bird." And then next minute I was out. I was like, "Oh!" Yeah. So, it was like, it was, it was a quick process.
(Participant 8, 55+ years)

So, I just remember feeling high and then just something a little, like a little pinch on the inside of me but it wasn't enough to hurt or anything. Just feel that it was there. And then just like a minute or two later it was, it was done. […] I was expecting pain, discomfort, and all of that but no. You wouldn't even know that I went through a procedure.
(Participant 3, 25-34 years)

But, yeah, there definitely wasn't much option for pain [management]. I mean, if you're, if you're having an actual miscarriage and you go to the hospital, and they give you something for pain, they're gonna give you the good stuff, alright? Whereas, when you're doing this at home, your options are Nurofen and Panadol [ibuprofen and paracetamol]. There isn't much else you can do.
(Support Person 1)

The embodied experience of surgical abortions, while complicated by the logistics and expense of travel and isolation from one's home and community, was contrasted with participants' experiences ordering and self-administering medical abortion. These medications (misoprostol and mifepristone) are not available to induce abortion in the Cook Islands, so women had to source and import the drugs online using overseas providers. One such online provider reported that their service has provided abortion care information and access to Cook Islanders since 2011 and provided 20 consultations to individuals in the Cook Islands between 2021 and 2023 (pers.comm., August 18, 2023.). Accessing online medical abortion services required that women detected their pregnancies early enough for the drug to arrive before 10 weeks' gestation, with a delivery time of approximately two weeks. Women also need to know about and have the skills needed to navigate the online system, which usually required support. One participant described trying to access these medications before discovering the organisation that ships them had changed their postal service provider which meant they would take too long to arrive.

Participants described receiving a health screening and detailed information on the medication, how to administer it, what to expect, and what to do if they had concerns about how the abortion was progressing, qualifying as a 'safe abortion' under the World Health Organization guidelines (24). One support person reported paying just over NZD $100 for the medications. Participants who managed to access the drugs in time had to find a private location to begin their abortion, such as when parents were at work, or by booking motel accommodation. Participants described their medical abortion as taking between 20 minutes to two hours to complete, and as painful with limited pain relief options and additional support, such as information and support hotlines that are available in countries where abortion is legal.

Those without the financial resources to travel and without support people with knowledge of medical abortion may rely on local services provided by a ta'unga. Ta'unga hold privileged knowledge regarding plant-based medicines for various ailments, including for abortions. Participants in this study who went to see a ta'unga described drinking three 1.5 litre bottles of liquid per day for three days prepared by the ta'unga. Some also received uterine massage and prayer and had to follow other behavioural restrictions such as fasting or sexual abstinence. Participants in this study who reported accessing the services of a ta'unga did not successfully abort their pregnancies, however, one recalled feeling nauseous, and one support person and one advocate described women who were admitted to hospital after their visit to a ta'unga for an abortion. Other participants described women drinking excessive amounts of alcohol in an attempt to have an abortion, and Participant 9 (55+ years) reported successfully causing an abortion by drinking very strong coffee across consecutive days until bleeding began (note that this might have been a spontaneous miscarriage).

Navigating and resisting shame, and experiences of support

All participants noted that abortion, as with other SRH topics, is rarely discussed openly. Participants attributed silence regarding abortion to a widely held belief that abortion is sinful under teachings from church institutions. For some women who had abortions, their awareness of this notion of abortion as sinful and their fear of others' reactions to their abortion, sometimes complicated their recollection of their experience.

> *So, like it's [opposition to abortion] already sort of underlying. Everybody knows that that's sort of the view but then, when you question that, there's like a really aggressive response. Like, "How could you be okay with that. God says this. The Bible says this." […] And then there's also like I know friends who've like, like their families view it as like it's very shameful to have that happen. So, they also think miscarriages are shameful as well, like accidental ones. […] And it was like, yeah, and it's just, it's sad because it really just stops … like it stops all conversation because the immediate response is that.*
> (Advocate 6)

> *I come from a religious family. Yeah. And that's, and that used to be me. I used to be like 'abortion is a sin' like, you know. And like I'm always against it. But, when it happened to me, I was just like, "I can't, I can't do it. I can't go through with this pregnancy because it's wrong." Yeah. […] But, when it [the abortion] actually happened, I just cried. Like I was quite … I don't know how to say it, but it was hard to go through. Yeah. Yeah. 'Cause of my background and my religion, and my family. Like not many of my family know. […] So, that whole experience was, was scary for me, at first.*
> (Participant 5, 25-34 years)

Participants in this research described the role and experience of shame regarding their sexualities, pregnancies, and/or abortions. Many participants explained that judgements related to their decisions and behaviour were not only tied to their value and worthiness as individuals but also to their families' virtue and their families' competence in raising children who present themselves in appropriate and idealised ways, which for young women includes presenting as virginal, humble, and possessing grace (42). Some women in this study described their consideration of others in their decision to have an abortion (such as protecting their family or sexual partner from the shame of the pregnancy and sexual behaviour), alongside their own personal and usually multifaceted reasons.

> *I like to think and integrated into our culture is the sense of selflessness. We are never one person. We are always a community whether it's our family, whether it's your village, your church group, your volunteer group, your fitness group. We are, we are never one person. We are always community. Community first. So, making selfish decisions is always hard for Cook Islands, especially Cook Islands women to do. Our girls are trained and conditioned to put family first. Always put family first. Put church first. Put the village first. Put other people first. So, putting yourself first is almost a betrayal to your cultural values and belief. […] So, it is never just me [who has done wrong]. It is my family, my community. What are they going to think about them? Not, "What are they going to think about me?"*
> (Support Person 3)

> *I knew that news [regarding the pregnancy] would spread around here like coconut wireless, so I didn't want to create a bad name for my family as well as myself. […] They [her parents] would have really looked down on me [for becoming pregnant after a one-night stand]. There would have been a lot of disappointment and, you know, their resentment, maybe.*
> (Participant 3, 25-34 years)

Furthermore, some participants explained that children are not always thought about in nuclear terms, or as belonging solely to their biological parents, but rather to a broader network of family – aunts, uncles, grandparents.

They're all treated the same as our children. And there's no separation of, you know, 'they're his children, they're your children': they're all ours. And the caring and the nurturing is all shared by everybody. Yeah. That's still very strong with many families. […] And you can carry, you, you can carry all the, all the negative things that can happen as a family, you know.
(Advocate 4)

Shame implicates a broader network of people, so protecting oneself from this level of shame was both complex and vital for social survival, particularly given the very small and interconnected population of Rarotonga. For example, participants in this research described pregnant adolescent girls as bringing shame on their families and as targets of bullying in peer groups and at school, as well as complications regarding their continued access to education. Several participants highlighted that for young women faced with an unplanned pregnancy, sometimes their family steps in to make decisions regarding what happens to the pregnancy to manage their collective exposure to shame.

P2: Some families with teenage pregnancies and because of the embarrassment and stigma they would just fly the teenager down to New Zealand, if you've got the money.

If you've got the money.

P2: It's all under the carpet. Fly down. "Oh, she's gone down for a medical check-up." But that's what it is. They're booked into a clinic. Terminate. Spend a month or so down there to recover, recuperate, and then come back. […]

More the, that reputation [of the family] and –

P2: Yeah. The stigma around it [teenage pregnancy].

The stigma, yeah, okay …

P1: Labelling out there in the community.

What kind of labels would, would a family and a young woman get in that kind of situation?

P1: Well, others in the community will always be running down some remarks about whoever is involved and who the parents are.

So, running them down. Like just saying …

P1: Well, they are saying, "Oh …" Sometimes, I hear, "Oh, because they are well-educated parents, why aren't they teaching their children, you know, the right way in …"
(FG3, 50+ years)

Some participants discussed the shame associated with women's sexualities, pregnancies, and abortions as challenging and isolating.

But, yeah, it just felt really cold and very, I felt very alone, you know. […]

Right. So, it was a very, yeah, an experience that was, you didn't necessarily share.

Yeah. I didn't tell anybody. Not even the people at work. He [her sexual partner] tried the best that he could do to help me out, but I don't think he would understand because he's not from here [Cook Islands].
(Participant 4, 55+ years)

What was hard for her at the time was the social stigmatism. It was still a hard … just [others] saying 'it's not right' and a lot of our peers thought and felt the same way. They'd go, "Oh, this is a sin. You shouldn't be doing this," you know. "You're going to hell if you have an abortion." So, it wasn't so much the getting the abortion; it was, I felt like I needed to support her more afterwards, not just from her own … not just from her emotions turning on her but, also, from the stigmatism from our peers around her.
(Support Person 3)

While navigating and negotiating shame, some participants also resisted the narrative of abortion as sinful, and the shame associated with their sexual relationships, pregnancies, and abortions. Participant 10 (55+ years), for example,

reflected on the notion of abortion as sinful that she had learnt from her church:

There actually is room there for things like that where certain things where you can decide between, you know, and something becomes something between you and your god. It doesn't have to be between you and the church.
(Participant 10, 55+ years)

For some participants, resisting the notion of abortion as sinful and the shame attached to their sexualities, pregnancies, and abortions may have been somewhat aided by having supportive and non-judgemental friends and family. Participants also recollected the circumstances that led to their decision, described the clarity of their decision and relief once the abortion was complete, and reiterated that they made the best decision they could at the time.

And I think about it today, and I think I'm, I can honestly say that I made the right decision about it. Yeah. The way that things had turned out to be. Yeah. So, it was something that I, that I had to do but, at the same time, it was quite emotional
(Participant 8, 55+ years)

I went and asked my friend to give me a pregnancy test. We did it at her place. I had a little cry. But for me I won't say it's fortunate but, for me, I did sort of have a plan to just have an abortion, should that occur, because I had it, in my head, a baby's not in the picture until I'm financially set.
(Participant 3, 25-34 years)

It was my decision. Yeah. Well, it was not affecting him [her sexual partner], you know. I mean it was affecting me mostly, you know. […] It's not gonna be him. I worried about with my training, my work, my job, you know?
(Participant 10, 55+ years)

[The abortion was] almost 20 years ago. I think it's probably changed since then but there was, I think I would have preferred a little bit more emotional support, a little bit more … But then I, I think I still would have gone ahead with the decision. And I can't regret the decision 'cause, if I did not carry out the decision, then I wouldn't have my oldest son. And I love my oldest son.
(Participant 12, 35-44 years)

I had no feelings about that I was killing something in my body. I just wanted to, yeah, get rid of it.
(Participant 9, 50+ years)

As well as describing their extensive involvement in the logistical aspects of accessing abortion services, support people in this study also described offering emotional support. Support people recounted providing reassurances; non-judgemental support regarding their friend's or relative's pregnancy decision; and being present during the abortion process for those who accessed medical abortion, or before and after for services provided in Aotearoa New Zealand or by ta'unga. Participants who had abortions described differing levels of social support, with some only disclosing their abortion to one person who was involved in passing on information and logistical support or having more people in their support network who offered support during and after the abortion by way of messages or phone calls.

But, yeah, it's my cousin that helped me through it. Through the whole process, she was actually with me. When I was going through the process of the abortion, she was very supportive. Like she didn't do much. She was just, you know, she was just there. Yeah. […] And I, friends messaging me throughout the day, throughout that time, just giving me encouragement. […] So, there were only certain people that know. They, there have been a little bit more now because I feel like I needed to tell. But only again to certain people that I trust. And that has sort of helped me because I feel like I'm just holding this in. And it's draining me as well. Like I don't want everyone to know. No, I don't want … Just those that I trust. But, yeah, since then, I have told a few more of my friends. And they've been supportive of me as well. Yeah. So, it's been nice.
(Participant 5, 25-34 years)

But, yeah, no-one didn't really know; just my parents, my siblings and my cousin, and just my close friends; that's it.

And how were they in terms of, you know, you going through this experience?

They were really supportive. […] They'll always be here and, and they will always message me every day about how I'm feeling, and after the surgery they would keep messaging me and sending me love, and prayers too. And I would cry sometimes just reading their messages 'cause I know they will always be here for me. When I came back, they were, they were just not talking about it but just asking me if I was okay and things like that. Buying me just little gifts and … yeah.

(Participant 2, 18-24 years)

Participants in this research described a widely held understanding of abortion as sinful in church teachings, and shame associated with their or others' sexualities, pregnancies, and abortions that they had to negotiate. However, participants gave many examples of receiving or providing emotional, financial, practical, and logistical support regarding abortion access. Several participants also discussed abortion as being essential, lifesaving, and personally meaningful reproductive healthcare. Participants' recounting of the social support they provided or received challenges popular associations of abortion with sin and shame, repairing women's personal sense of worth and, more broadly, challenging the universality of these notions in the Cook Islands.

Conclusion

Abortion is a common experience and integral part of reproductive health care. In much of the Pacific, including the Cook Islands, abortion is treated as a criminal rather than health matter. In countries where abortion is restricted by law, those requiring abortion services must attempt to end their pregnancies covertly and outside the health care system, often putting their health, wellbeing, and lives at risk. In this study, we aimed to gain an in-depth understanding of Cook Islands women's experiences, health, and wellbeing in relation to abortion and in the context of these legal restrictions.

This research was undertaken in Rarotonga, home to most of the population of the Cook Islands. Women who had accessed or tried to access abortion services, support people, advocates, and health workers were interviewed, and three focus groups with women from different age groups were conducted. Women described overlapping reasons for accessing abortion services, with clear insight that continuing their pregnancy and giving birth would have brought shame on themselves and their family, and would have caused hardship, distress, and significant disruption to their lives, education, careers, and training. Participants described limited reliable, confidential, and comprehensive SRH education and services due to the shame associated with overt sexuality preventing open discussion of SRH-related topics, such as contraception and sexual consent. Participants reported that young people sometimes turn to other sources of information on SRH which are unreliable or promote misinformation, such as pornography. Some participants did highlight that where education and discussions did occur, such as those facilitated by CIFWA, this assisted in normalising access to SRH services. However, shame and embarrassment reported by participants related to SRH topics, accompanied by concern over privacy and confidentiality when accessing SRH health care in the small, tight-knit community of Rarotonga, continued to hinder access, particularly for young people.

Participants in this research described their own or others' navigation of the legal restrictions on abortion in the Cook Islands and the related logistical complexity. Given significant limitations on abortion access in the Cook Islands, women seeking abortions must resort to dangerous, harmful, and often unproven methods, rather than having the ability to become properly informed and select which option they deem most appropriate, as well as access psycho-social support and adequate pain management. Some participants who had sufficient resources and support (and were not in the Cook Islands on temporary visas) went to Aotearoa New Zealand or Australia and navigated health care in another context and culture, including during the COVID-19 pandemic. Other participants in Rarotonga sought abortion drugs and services but were under considerable time pressure to arrange, order, and find safe and private environments in which to manage their medical abortions. Some participants had to find the right ta'unga who could provide abortions while maintaining privacy and confidentiality, although women who sought support from a ta'unga in this study did not successfully abort their pregnancies. Participants in this study also reported that women may resort to excessive use of alcohol or caffeine in an attempt to induce an abortion by poisoning.

As well as managing the logistics, expense, and sometimes loneliness of accessing abortion services in this restrictive context, participants also reflected on local beliefs of abortion as sinful, and the experience of shame related to women's sexualities, pregnancies, and abortions. Although participants reflected on a general awareness of women making the journey to Aotearoa New Zealand for abortions, as well as the historic use of ta'unga's abortion services, abortion is rarely discussed openly. Participants related this silence to the concept of abortion as sinful under the teachings of church institutions in the Cook Islands. Participants also discussed the function of shame as encompassing the families of individuals who had transgressed local gender norms and norms surrounding sexual and reproductive behaviour. Notions and experiences of sin and shame sometimes complicated women's relationships to their experiences in this study. However, participants also noted the clarity of their decision, the support they received, their

relief once the abortion was over, and recalled the many reasons having an abortion was vital to them and their families.

The treatment of abortion as a criminal rather than a health matter does not prevent abortion, but means women, their families, and support people already facing stressful situations are confronted with expensive, logistically complicated, burdensome, and potentially perilous journeys to get the healthcare services they seek. Abortion is a central part of reproductive health care and should be accessed in a way where people feel whole, where the wellbeing of the person seeking abortion is prioritised, and where they can safely access the method that they choose with appropriate medical, spiritual, psychological, social, and cultural supports in place.

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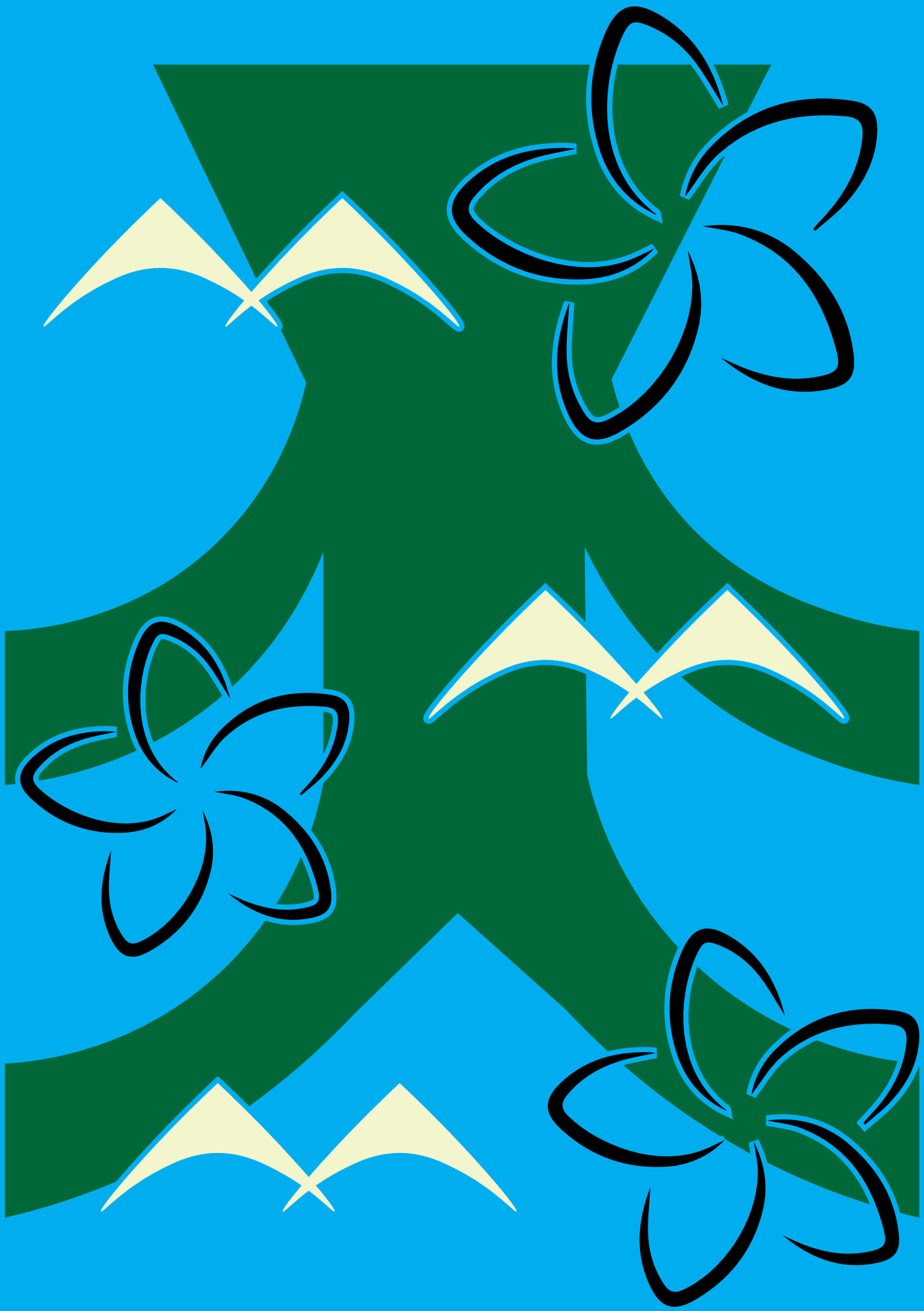

CIFWA
Cook Islands Family Welfare Association (Inc.)

Te Puna Vai Marama
Cook Islands Centre for Research

UNSW
Kirby Institute

UNSW
SYDNEY