Time for Change: Quantitative & Qualitative Analyses of Women's Desires to Improve Access to Abortion Services on Prince Edward Island

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Acknowledgments

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Abstract

Prince Edward Island is the only province in Canada lacking local, surgical abortions and Island citizens must travel across provincial borders in order to obtain an abortion. Many barriers exist that impede women's access to abortion services making it difficult for many women to access this constitutionally protected, medically necessary service. This three-phase study examines the ICD-9 codes of recorded pregnancies with abortive outcomes on PEI within the first phase, and the desired changes of Prince Edward Island women regarding access to abortion in the second and third phases. The Pregnancy with Abortive Outcome ICD-9 codes between 1996-2013 obtained from Health PEI indicate that physicians bill for illegal and failed attempted abortions on PEI. Using Interpretive Phenomenological Analysis, 22 individual interviews were analysed to identify the changes women wanted who had previously accessed abortion services. The main themes that emerged from the individual interviews included access to abortion services, counselling, judgment/stigmatization, education, support, and privacy. A focus group consisting of 6 participants was also conducted to gain further insight to necessary changes surrounding abortion access, and methodological hermeneutics were used to analyse the focus group discussion. The main themes that emerged from the focus group included a local, publicly funded health clinic, information, and support. The findings of the study emphasize the lack of abortion access and the necessity of various changes to occur in order to attain reproductive justice on Prince Edward Island. Recommended changes that will assist in improving abortion access and reproductive justice are central to ameliorating the reproductive health of Island women.

Literature Review

The striving towards reproductive justice has been a continuous struggle for women across Canada. Reproductive choice and reproductive justice stress the importance of reproductive options available to women and girls, so that they have the power to make decisions about their sexuality, reproduction, and bodies. Reproductive justice also emphasizes the ability for women to choose when they become pregnant, give birth, and raise children (Sethna, Palmer, Ackerman, & Janovicek, 2013). From the late nineteenth century until 1969, in Canada, reproductive justice was hindered as a result of restrictive abortion laws. Abortion was illegal and abortion providers faced life imprisonment for performing the procedure. Women undergoing the procedure could face up to seven years imprisonment, and abortions could only be performed if the life of the pregnant woman was deemed to be in jeopardy. Strict prohibition of abortion services caused many women to self-induce or seek illegal abortions, and many women died from acquired infections (Sabourin & Burnett, 2012).

In 1969, illegal abortions were identified as a serious public health issue and motivated changes to the Canadian Criminal Code. The longstanding desire for change stemming from many women losing their lives to botched abortions led to the legalization of abortion, but only under limited conditions. Abortions had to be approved by a Therapeutic Abortion Committee (TAC), and would only be permitted if the life or health of the pregnant woman was in danger. Therapeutic Abortion Committees were only established in a select few hospitals and were found mainly in urban areas. The liberalization of the Canadian Criminal Code did not eliminate illegal abortions, and for many women did not lead to greater reproductive justice. Many women were denied abortion services and were required to travel great distances, within and outside Canada, in order to obtain timely abortion services (Sethna, et al., 2013).

In 1988, the Supreme Court of Canada struck down the law from 1969, which limited abortions to women whose life would be endangered without the procedure, because it was in violation of the Canadian Charter of Rights and Freedoms. Since 1988, abortion was deemed a medically necessary service under the Canada Health Act. This Act requires provinces and territories, in return for federal financing, to provide equal access to medically necessary services through provincial health insurance (Palley, 2006). While the decriminalization of abortion has made a significant contribution to the reproductive rights of women, it has created an illusionary sense of equitable access to abortion. In actuality, abortion access remains out of reach for many women in Canada. The Vancouver's Women's Caucus indicated in 1969 that abortion services were only made available to wealthier women (Sethna, et al., 2013), and in many ways, this remains true today. Provinces continue to limit abortion access directly through public policies, or indirectly by allowing local health systems to limit access (Palley, 2006). This indicates that despite extensive changes with regard to abortion access through its decriminalization, it remains unattainable for many women.

The women who are most negatively affected by the constraints of barricading policies and financial constraints, are the women who are most vulnerable. Women who are poor, isolated, young, addicted, disabled, or somehow compromised will be less likely to conquer the barriers than their more privileged counterparts (Kaposy, 2010; Sethna, et al., 2013). The majority of women who access abortion services are women in their twenties and have low income. Having to access abortion exacerbates their financial stress as they may be required to pay for the abortion and associated costs, which include travel costs, money lost from their absence at work, child care, etc. (Sethna & Doull, 2013). This is problematic because women who must travel in order to obtain an abortion are not only subject to increased travel expenses, their absence may jeopardize their confidentiality by having to explain themselves to others. Women are thereby subject to an anti-choice climate and culture, which may create further barriers.

Travelling to access abortion services, and its consequential costs and repercussions, are significant barriers for many women. Fewer rural women were found to access abortion services than urban women as they were underrepresented among abortion patients. This may be attributed to the disproportionate difficulties rural women may encounter when trying to obtain an abortion, and may have to find abortion providers who are a greater distance from their place of residence (Jones & Jerman, 2013). Research has shown that the farther women must travel to obtain abortion services, the less likely they will be able to obtain one. In addition, women who reported increased travel times, increased costs, and difficulty in arrangements, were more likely to report experiencing a difficult journey (Sethna & Doull, 2007). Not only did women who were required to travel greater distances report more difficulties, women who were required to travel more than 100 km were also more likely to report they would have preferred to have obtained the abortion sooner. An inability to access timely abortions was not reported among women who lived closer to the abortion clinic. This discrepancy indicates possible delays and hardships as a result of being required to travel (Sethna & Doull, 2013).

Possible delays that may result from a requirement to travel presents significant barriers for women seeking abortion services. It was found by Wiebe & Sandahu (2008) that having timely access to an abortion was the most important aspect of abortion services. Women indicated that the most important issue was the time that they had to wait in order to obtain an abortion, and the time they had to wait in order to make an appointment. Women also preferred to speak to someone in person when making an appointment. Many women had difficulty making, or getting an appointment because they were required to leave a message on an answering machine as opposed to talking with someone directly, or were put on hold. It is very common in Canada to have complicated appointment systems, which are related to lengthy waiting times in order to access abortion services and increased anxiety among women attempting to book an appointment (Wiebe & Sandahu, 2008).

Not only are lengthy wait times a barrier for many women when seeking abortion services, simply finding a physician to perform the abortion or provide a referral may be challenging. Kaposy (2010) indicates that additional barriers with respect to accessing abortion services include: physicians refusing to provide referrals, or refusing to refer patients to a doctor who will refer them, physicians providing false information, or using tactics to stall the abortion beyond the local gestational limits (Kaposy, 2010, MacQuarrie, Macdonald, & Chambers, 2014). Wiebe & Sandahu (2008) indicated that most patients sought information about abortion access from their physicians, and many indicated it was distressing as many physicians refused to give information or counselled them against the abortion. An insufficient number of abortion providers also creates an impediment to access to abortion services for women; and fewer hospitals now provide the service. Furthermore, fewer doctors are trained and willing to provide abortions, as many doctors are unwilling to endure harassment and violence of anti-choice groups (Kaposy, 2010).

Harassment and violence from anti-choice groups create barriers for women attempting to access abortion and changes are required to address this barrier. Although cited less often than the reputation of the clinic, participants in a survey conducted in the Toronto Morgentaler Clinic by Sethna and Doull (2007), indicated that they were comforted by the clinic's safeguards against protestors as a reason for contacting this clinic first. Women also indicated that they chose this particular clinic for confidentiality reasons, indicating that confidentiality may be an important component to have in an abortion clinic, something that may be jeopardized with the presence of protestors. People who contacted other clinics first, as indicated in the survey by Sethna and Doull (2007) indicated that they ended up choosing the Morgentaler clinic in Toronto because their first place of contact did not have any appointments available within the time frame that they needed (33.5%), the fees were too expensive (18.2%), they were concerned about their safety as a result of anti-abortion protestors (15.3%), the staff were rude (12.5%), or the hospital or clinic was too far from their place of residence (10.2%). These concerns regarding abortion services exist across Canada, particularly in places with severely restricted access.

Restricted access to abortion services does not terminate the existence of abortions, rather it creates an environment where unsafe abortions are more likely to occur (Sabourin & Burnett, 2012). Abortions can be performed with very few complications when legally performed. Infections, haemorrhaging, or injury to the cervix or uterus are uncommon following an abortion, with the risk of complications estimated to be less than 1-3% (Dobkin, Perrucci, & Dehlendorf, 2013). However, a lack of access to safe abortion services may drive some women towards unsafe methods of inducing an abortion, increasing the risks associated with abortions. Many women may self-induce or seek illegal abortion services when barriers prevent them from accessing safe abortions. Unsafe abortions or illegal abortions are those that are performed by people lacking the necessary medical skills to perform an abortion, or are performed in an environment lacking the necessary medical standards for abortion service. They account for between 12% and 30% of maternal deaths worldwide, with the majority occurring in places with restrictive abortion laws (Sabourin & Burnett, 2012).

Although self-induced and/or illegal abortions are more likely to occur in locations where performing abortions is illegal, restrictions continue to exist in Canada that may drive women to have illegal abortions. Self-induced abortions and/or illegal abortions are often believed to be only a relic of history, particularly in Canada; however, women continue to induce abortions, and may continue to be harmed by these abortions. According to Hayden (2011) the reduction of the accessibility of abortion services is likely the main reason as to why there is an increase in self-induced procedures, though little research in the area is available. In addition, women may be unable to take enough time off work, or may not be able to afford the costs associated with an abortion, particularly when traveling is required. Another factor may be that the significant stigma surrounding abortion may deter women from clinic and other medical spaces. The practice of self-induced and illegal abortions is a response to the economic, geographic, social, and political constraints that surround abortion services (Hayden, 2011). These constraints are transformed into obstacles, making abortion access difficult for many Canadian women.

Abortion services for Prince Edward Island (PEI) women continue to be available to only those that can afford to leave the province, making abortion access unequal across Canada (MacQuarrie, MacDonald, & Chambers, 2014; Kaposy 2010). PEI, Canada's smallest province, is situated in eastern Canada in the Gulf of St. Lawrence. It is the only province in Canada that does not offer surgical abortions within the province. Women in PEI are forced to travel to neighbouring provinces to access surgical abortions as a result of the unavailability of local abortion services (Sethna & Doull, 2013). The Provincial Abortion Funding Policy for PEI indicates that the province will pay for abortions in which patients are referred by their PEI doctor to the Queen Elizabeth II (QEII) hospital in Halifax, Nova Scotia, as long as the abortion is deemed to be of medical necessity by the Department of Health and Social Services. As of

2005, only this hospital in Halifax will accept referrals from women in PEI who require abortion services (Sethna & Doull, 2007).

PEI also does not currently cover the costs of abortions performed in free-standing clinics (Eggertson, 2001). This can be considered to be in direct violation of the Canada Health Act because of the lack of funding for abortions within the province (Sethna & Doull, 2013; Sabourin & Burnett, 2012). There have been numerous violations of the Canada Health Act by the province of PEI by not only failing to provide abortion services in hospitals, but by including abortions on the excluded list of reciprocal billing agreements between provinces, and generally refusing to reimburse women who obtain abortions from private clinics (Sabourin & Burnett, 2012). The Canada Health Act indicates that all medically necessary services, including abortion, are to be paid by the provinces, regardless of whether or not they are performed in a hospital or clinic (Palley, 2006). These barricading policies limit reproductive justice and choice by increasing the economic cost of abortion for women, and by requiring increased effort in order to obtain an abortion. By not publicly funding all abortions, this service becomes unattainable for some women, and may cause other women to be economically impaired in order to terminate the pregnancy (Kaposy, 2010). “The availability of abortions in Canada now depends on a woman’s location and the size of her pocketbook” (Eggertson, 2001, p.847).

In addition to policies that have restricted PEI women’s access to abortion services, the Island government has taken an anti-choice stance against abortion services. In response to the 1988 Morgentaler decision, the PEI government issued Resolution 17, on March 29, 1988, which is PEI’s only legislative response to abortion:

> WHEREAS the Parliament of Canada must now legislate a new law concerning abortion;

> AND WHEREAS the great majority of the people of PEI believe that life begins at conception and any policy that permits abortion is unacceptable;
>
> AND WHEREAS the great majority of Islanders demand that their elected officials show leadership on the very important issue and demonstrate the political will to protect the unborn fetus;
>
> THEREFORE BE IT RESOLVED that the Legislative Assembly of PEI oppose the performing of abortions;
>
> AND BE IT FURTHER RESOLVED that this Resolution be forwarded to the Leaders of all three Federal political parties requesting the passage of legislation consistent with the intent of this Resolution.

Resolution 17 indicates that PEI opposes the performing of abortions and it therefore supports in restricting access to these services.

Despite the fact that abortion access is hindered by these policies, the current premier of PEI, Robert Ghiz, has indicated that no change will occur to the policies surrounding abortion services on PEI. Ghiz indicated that the government will stick to the "status quo" and that requiring women to travel to the mainland to access abortion service is a "good compromise". Though the Ghiz government does not believe changes are necessary to the current system many barriers are currently in place that restrict this medically necessary service. Travel costs, social and political barriers, a lack of information, as well as time restrictions, make it very difficult for many women to access this procedure (CBC News, 2011, MacQuarrie et al, 2014).

Although abortion is a common procedure with approximately one third of Canadian women accessing abortion services during their reproductive years (Norman, 2012), and can be performed in any hospital (Kaposy, 2010), the CEO of Health PEI indicates that due to PEI's small size and population, abortions cannot occur on the Island (CBC News, 2014). As a result of the many barriers that continue to exist following the decriminalization of abortion services, abortion access is not equal for women. PEI women continue to have significant difficulties in accessing this service and therefore, many changes are necessary surrounding abortion access. The aim of this three-phase project will be to determine the incidence of recorded abortions that may occur on PEI, and to analyze the narratives of Island women's desires for changes surrounding abortion access. This study will investigate the many changes that are essential to changing abortion accessibility in PEI and provide recommendations regarding how to execute change so that optimal accessibility is obtained for Island women. As a result of the many barriers that exist surrounding a constitutionally protected and medically necessary procedure, changes to improve abortion access in PEI will be analyzed.

Phase 1: Quantitative Methods

Procedure

The Privacy and Information Access coordinator within the Health and Information Management division of Health PEI was contacted in September 2013 to inquire about a request to access information about abortions performed on PEI. A general information request was made to Health PEI where the data regarding the ICD codes that are used by physicians and hospitals on PEI in the billing process were requested. The ICD codes for Pregnancy with Abortive Outcome, particularly ICD-10: 000-008 (inclusive), and ICD-9: 634-639 (inclusive), were requested. It was also requested that the data be provided for as early as is available, and a required specific time frame from January 1980-Present was given.

The claim was processed in October 2013, and the following month the ICD-9 codes (634-639 inclusive), from January 1996 to the present (November 2013), were obtained. ICD codes for illegal abortions (code 636) and failed attempted abortions (code 638) were drawn from the data for each year in which the procedure was billed.

Reflexivity

When trying to obtain the data from Health PEI, it was indicated that the request could not be submitted because there would be no data on Pregnancies with Abortive Outcome as abortions do not occur on PEI. Knowing that there would be data regarding spontaneous abortions, or abortions resulting from ectopic pregnancies at the very least, the claim was submitted despite pressure to do otherwise. The denial surrounding the performing of abortions on PEI from the government and civil servants is astonishing.

Phase 1: Results

It was found that in 1996 two illegal abortions (code 636) were recorded; one specifically was indicated as not having any complications (code 6369) and another illegal, uncomplicated abortion in 2000 was recorded. In 2003, a failed attempted abortion with hemorrhage (code 6381) was recorded and in 2004, a failed attempted abortion with a resulting pelvic infection (code 3680) was recorded. In 2005, an illegal abortion with complications (code 6368) was recorded and in 2006 an uncomplicated, illegal abortion was recorded. The following year, a failed attempted abortion with no complications (code 6389) was recorded. Two illegal abortions, one with a resulting pelvic infection (code 6360) and the other with renal failure (code 6363) were recorded in 2009. In 2011 an illegal abortion with complications and a failed attempted abortion with pelvic damage (code 6382) were recorded. In 2012, an illegal abortion with a pelvic infection and a failed attempted abortion (code 638) were recorded; an illegal abortion with metabolic disorder (code 6364) in 2013 was recorded (Health PEI, 2013).

Up to two illegal and/or failed attempted abortions were recorded each year since 1996 (Figure 1), however, complications followed many illegal or failed attempted abortions that were reported. The data indicate that 8 out of a total of 14 recorded failed attempted and illegal abortions resulted in complications, indicating that more than half of recorded unsafe abortions resulted in complications. In addition, between 6 and 80 unspecified abortions were recorded each year as a result of specific codes not being known or a lack of information. The forms and types of abortions to which some women were resorting have been illustrated clearly.

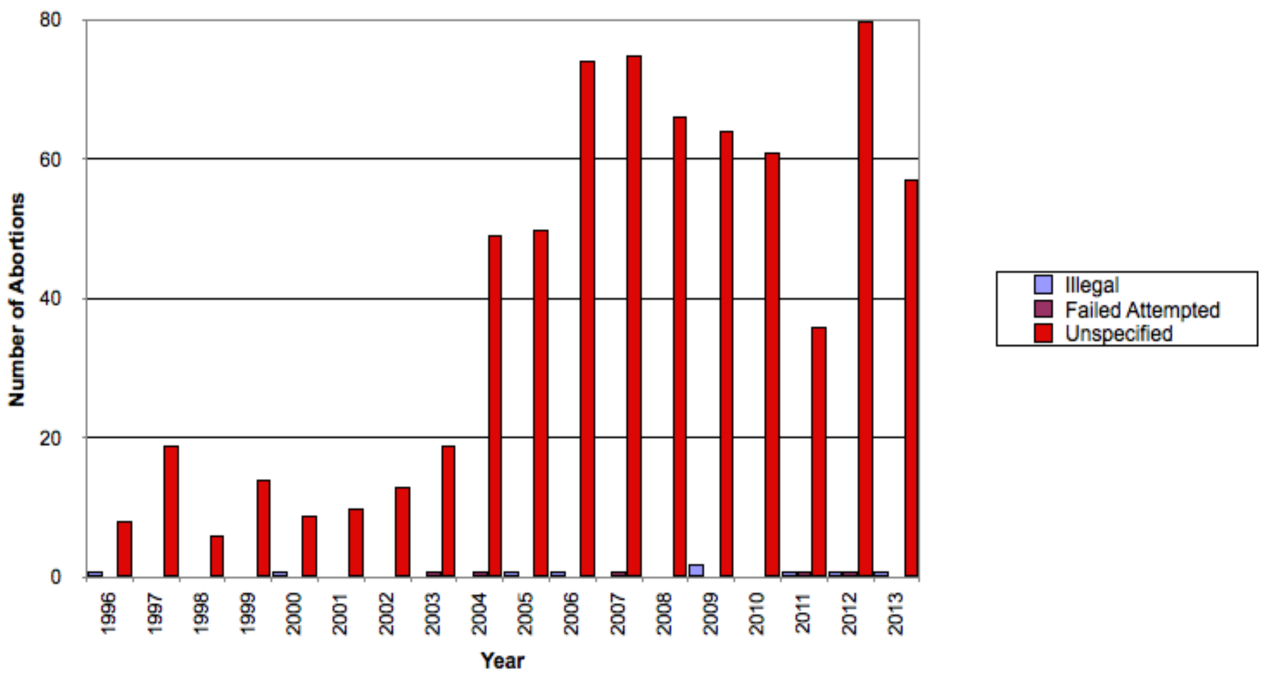

Figure 1. Recorded abortions in Prince Edward Island hospitals from 1996-2013.

Phase 2 &3: Qualitative Methods

Participants

Participants with the *Understanding for a Change* research project, conducted by Dr. Colleen MacQuarrie at the University of Prince Edward Island, were recruited for the purposes of better understanding the experiences of Island women surrounding obtaining abortion services.

Ethical approval from Research Ethics Board at the University of Prince Edward Island signalled the authorization to recruit participants on July 13, 2011, and this recruitment ended October 13, 2013. Of the 45 participants that were interviewed during the *Understanding for a Change* project, 22 had a personal experience obtaining an abortion (MacQuarrie, MacDonald, & Chambers, 2014). Of these participants with experience obtaining an abortion, 6 chose to further participate in a focus group to discuss the changes that they would like to see surrounding abortion access in PEI. This study focuses on the ideas for change expressed by participants from the individual interviews and the focus group. To protect the anonymity of the participants, pseudonyms were used to refer to the women who participated in the project.

Instruments

The interviews with participants and the conversation during the focus group were taped using Olympus audio recorders. Audio recordings for the interviews were transferred to Express Scribe software to create transcriptions. Transcripts were imported into Nvivo9, a qualitative data software analysis program, where the transcripts were coded for analysis. The audio recording for the focus group was transferred onto the Olympus DDS Player® Version 7 software for transcription and the single focus group transcript was hand coded.

Analytical Approaches

Interpretive phenomenological analysis (IPA, Willig, 2008) was used to examine the experience of women who have had an abortion, to gain further insight to their interpretation and opinion regarding the lack of abortion access in PEI, and their insight to the changes they felt were necessary. IPA satisfies both a phenomenological and interpretive requirement of qualitative data. It aims to comprehend participants' emotions, opinion, or point of view, and also contextualizes their assertions and discontent with a particular topic by positioning their comments within a larger social frame of reference. A study using IPA typically involves a relatively small number of participants and involves a highly detailed and substantial analysis of the data (Larkin, Watts, & Clifton, 2006). Methodological hermeneutics (Rennie, 2007) was used to interpret the focus group conversation into thematic areas.

Procedure

Recruitment for the project began with a vast array of media ranging from local print to CBC broadcasts on television and radio, to broad calls for participation through social media using blogs, Twitter, Facebook, and placing posters throughout PEI in high foot traffic locations. In addition to the study's research advisory team, prominent feminist organizations' communications networks assisted with the recruitment. All conversations were preceded with an informed consent process where any questions or concerns were addressed, the purpose of the study was discussed, and the participant's rights, which included confidentiality and anonymity, were foremost. Though anonymity is compromised within a focus group, participants were asked to respect the confidentiality of others and a conversation with the group explained the boundaries of how to share focus group experiences while respecting anonymity. With the consent of the participants for the interviews and the focus group (Appendix A), the conversations were recorded. Interviews were transcribed, coded, and analyzed to determine the changes the participants felt were necessary surrounding abortion access. These research conversations were conducted in 2011, at a time and location that was convenient for the participant. The interviews lasted for an average of 64 minutes and were coded manually using IPA. The interpretations of the interviews were coded using one-worded codes that were used to deconstruct and categorize segments of data. Codes that were specific to ideas about change were organized into themes and major themes based on their resemblance to other codes.

The focus group conversation was held at the UPEI Faculty Lounge, on May 1, 2013, at 7pm, and lasted for 2 hours. The transcribed conversation was coded using Methodological Hermeneutics (Rennie, 2007) whereby the researcher who facilitated the focus group also transcribed the conversation, and was fully immersed in the context and meanings of the conversation prior to creating the smaller meaning units for thematic analysis. Through the broad context, interpretations of the data using salient one-worded codes were used to segment and organize the data. The codes were reorganized into themes and major themes based on their similarity to other codes, the pervasiveness and the potency of meaning within the broader context of the transcription. All information that could jeopardize the anonymity of the participants was removed from the transcript. Notes about the necessary changes surrounding abortion access and notes from the focus group were documented in a research journal.

Phase 2 & 3: Results

Individual Interview Analysis

Six major themes of the individual interviews were described and are shown in Table 1: 1) Access to abortion services, 2) Counselling, 3) Judgement/stigmatization, 4) Education/information, 5) Support, and 6) Privacy. Theme 1, improved access to abortion in Halifax, Fredericton, or a local clinic, was indicated as a necessary change to the health care system, as well as access to funds that would help cover the travel expenses associated with being required to leave the province for abortion services. Theme 2 included varied responses with respect to necessary changes regarding counselling services desired by participants with some participants reflecting the need for increased peer counselling services available to women prior to obtaining an abortion from women who may have more experience with the procedure. Other participants indicated that counselling was not necessary. Theme 3 embraced social change for all aspects of the systems surrounding abortion provision as well as in the broader culture to shift our understanding of abortion and to end stigma. This change included health care professionals whose duty was to care for women all the way through to anti-choice picketers who target women and attempt to infringe on their autonomy through harassment. Theme 4 included the desire for more sexual health education and information surrounding abortion access, including where, and how to access abortion services as well as counselling services. Theme 5 focused on increased formal systemic supports including health care and financial support as well as better informal supports from our communities, family and friends. Finally, Theme 6 illustrated increased privacy and confidentiality were necessary changes, with a desired change for health care professionals to be held accountable for the breeching of patient privacy (Table 1).

Table 1

Themes Obtained from the Analysis of the Individual Interviews

Theme	Description	Example
Access	Includes access to a clinic on PEI, better access to the clinic in Fredericton and the hospital in Halifax, and access to funds for travel expenses.	"I don't know but they definitely need to be changed. I don't think that's - that's more than the stigma was the fact that I didn't have access. I think I could have braved the stigma of it if I had access. Like I would have said, "you know what? " it was secret. If it comes out it comes but, at least I can do this. But the access wasn't even there. I think access is the first step that's really gonna make a huge difference. I think that it would be great for people to not be judgmental. It would be great to have support. But none of that's worth anything if you don't have access." P6

Counselling	Varied opinions regarding the necessity of discussing the abortion with others. Pre-abortion counselling services may have been beneficial for some, but not others.	"Well, also like a counselling centre would be nice, like, I mean we have a rape crisis centre and we have a pregnancy centre that counsels for the other option. So, it would be nice for people you know who do want an abortion, or maybe help deciding. It's not just to have a facility to provide the abortions, but to have a place where you could go before hand to out if, you know, information about it, and 'cause some people I'm sure want to know exactly what happens, and exactly how it is, and what the process is and all that stuff." P3
Judgment/ Stigmatization	Change surrounding stigma and judgement from others was found to be a necessary social change, including the judgement from doctors, and picketers. Participants felt abortion should be normalized, and that people should not have to feel bad about getting an abortion. Referrals should be obtainable without fear of judgement.	"I would say more awareness of where you could go for information and help, counselling. And not be ashamed of calling. Being ashamed of what situation you're in. It was a bad choice, it was a bad choice. You know. Nobody knows your circumstances. Nobody knows your circumstances and nobody should judge you because of your circumstances". P15
Education/ Information	More information about abortion access is needed, including more awareness about where to access abortion, information, and/or counselling services. Increased sexual education, and information from doctors are necessary changes.	"And I just think people need to be more educated about it. Maybe if there were pamphlets at the pharmacy or something". P9

Support	Increased support from family, friends, other women, and doctors were mentioned as necessary changes, as well as more financial support.	"I probably could have used [a support group] when it happened to me, or someone to talk, you know. Someone to follow-up with me, because I probably wouldn't have gone and reached out." P15
Privacy	Privacy and confidentiality are major issues discussed by participants that need to be changed.	"Yeah, but it's just going to be picket lines and picket lines and fights, just like it is in other places. Except here you're going to know everyone on the picket line, and they're going to see you walking in that clinic, and they're going to know. 'Oh that's my co-worker' - "Oh that's my neighbour' - you know." P23

With PEI being the only province in Canada without access to safe surgical abortion within the province, it is clear from this research that changes are necessary. During the individual interviews with participants from the *Understanding for a Change* project, who had previously obtained an abortion, many participants expressed their desired changes regarding access to abortion, and other related services. The major themes reflect the most commonly desired changes by participants.

Although most participants highlighted better access to safe abortion as a crucial change to occur on PEI, there was some divide regarding the best way to provide better access to abortion. Some participants felt a clinic on PEI was necessary, with one participant stating:

> A clinic, I want a clinic... Um, ideally I want a clinic. And it should be within, it should be paid for and covered, and you should walk in and receive excellent treatment and care, and counselling services and it should be. Everything should be at your finger tips that second you decide okay, I think, I could possibly, I don't

> want to carry this to term. I don't want to have a child then, okay well here's counselling, here is, um, free tests and services and everything, and it should just be there... (P25).

Others felt that abortion services should be available within Island hospitals. Another participant felt that better access to off-Island abortions was a more feasible solution, where costs associated with traveling would be covered.

Issues of privacy arose when discussing access to abortion being available on PEI, where some participants felt privacy issues that accompany living in a small province needed to be addressed prior to in-province access. There was one participant who mentioned fear from potentially knowing the picketers who would likely be outside a clinic and stated:

> I mean we were talking about if we could have an abortion clinic here - I said, "Yes. You know, we need that access here. It's already a tremendous experience, and then to have to go off-Island - you know what it’s like, Mom! We went through this!" She said, "Yeah, but it's just going to be picket lines and picket lines and fights, just like it is in other places. Except here you're going to know everyone on the picket line, and they're going to see you walking in that clinic, and they're going to know. 'Oh that's my co-worker' - "Oh that's my neighbour' - you know." So I think views need to be changed first, before a clinic comes (P23).

Another participant mentioned she would not go to the Queen Elizabeth Hospital in Charlottetown, even if abortion services were available because of the lack of privacy and confidentiality granted by hospital staff. While some participants expressed concerns about the lack of privacy, one participant articulated that while concerns about privacy may exist, it is not an excuse for not providing abortion services.

Many participants also expressed counselling services as necessary changes. Having a counselling centre and providing more compassionate, empathic counselling services were suggested.

> Well, also like a counselling centre would be nice, like, I mean we have a rape crisis centre and we have a pregnancy centre that counsels for the other option. So, it would be nice for people you know who do want an abortion, or maybe help deciding. It's not just to have a facility to provide the abortions, but to have a place where you could go before hand to out if, you know, information about it, and 'cause some people I'm sure want to known exactly what happens, and exactly how it is, and what the process is and all that stuff (P 3).

One participant, however, did not feel counselling was necessary as she did not feel as though a counsellor would be able to provide her with services that her friends could not.

Although some participants felt ample support, many expressed the desire for more support from friends, family, and doctors. They felt that doctors should be providing more and better information, and that more education and information about abortion services should be available.

> I mean I would love to see it be accessible on PEI, first of all. Without all the trouble that girls have to go through to get one. I think, just in my own experiences, through my work and things like that, that young girls need to know that they can in some way access it, but they need to know where to go to and who to talk to and "who can set this up for me and who can set this up for me and who can help me figure this out: - or "is there anybody who can help me pay for this" or is there any-you know, like, all those kinds of things, like even pay for

> travel, or pay, you know, like is there someone that does that? Is there someone that helps them to do that. So, like, messages in the high schools, I think. And maybe there are, you know, campaigns and things like that, but I don't know if it. I haven't seen anything (P 10).

It was suggested that more information be provided in high schools, and that abortion should be discussed more frequently to help normalize it. A support group was also mentioned as something that could be beneficial to women as some participants felt alone in the process, and some mentioned that talking about it afterwards would have been helpful.

> I probably could have used one when it happened to me, or someone to talk, you know. Someone to follow-up with me, because I probably wouldn't have gone and reached out (P15).

Support was essential for many women as a result of the judgement and stigmatization surrounding abortion. Many participants indicated that abortion should be normalized so that the fear of judgement from others may be reduced and that women may not feel inferior for having obtained an abortion. The judgement given by doctors was also stated as something that needed to change, and that referrals from doctors should be given without judgement. Participants also expressed that doctors could speak out about abortion to help normalize it. It was also stated by participants that people need to talk about abortion more, and by talking about it more, the term 'abortion' may not be as difficult for people to use.

Focus Group Analysis

Three major themes of the focus group are briefly described in Table 2: Theme 1) Access to a Local Health Clinic, Theme 2) Information, and Theme 3) Support. Theme 1, Access to a local, publicly funded health clinic that provides abortion services and other sexual health services was indicated as an essential change to the healthcare provided on Prince Edward Island, and was a central topic of the focus group. They also indicated in Theme 2, that more information was necessary for Islanders about abortion and sexuality during early school years. Lastly in Theme 3, participants indicated that more support for and from doctors and other people who may be affected by abortion should be available.

Table 2

Themes Obtained from the Analysis of the Focus Group

Theme	Description	Example
Access to a Local Health Clinic	A local, comprehensive, publicly funded health clinic	"I think that the, the publicly funded like sexual and reproductive health clinic for lots of different stuff is really important…"
Information	Participants mentioned different areas in which more information is needed, as misinformation is common and used as a tool to limit access to services. More objective sexual health education early in school, information about healthy relationships, and information for parents about finances were necessary changes.	"The little amount that's in the school is catching people too late anyway."
Support	More support for women accessing abortion, more support for doctors performing abortions, more support from doctors, more support for mother, partners, and grandparents, and an age-independent support group, were found to be important changes that could be made on PEI.	"I would have appreciated having someone to talk to about making the decision to have an abortion. I would have appreciated someone to go with me to talk to my parents, someone to talk to my boyfriend who broke up with me…"

During the focus group, the conversation focused around having a local, publicly funded health clinic that provided abortion services, as well as other sexual health services. As obtaining an ultrasound for some women proved to be challenging, the women in the focus group suggested that the clinic have ultrasound services available within the clinic. Participants indicated that the clinic should provide services such as STI testing, contraception, family planning information, information about healthy relationships, as well as information regarding menstruation and menopause. The clinic, as desired by the participants, would have non-judgemental staff, and a feminist doctor who were professional in that they respect patient privacy and confidentiality. It was also desired that the clinic be gender/sex neutral, have a comfortable environment, and have counselling services, including pre- and post-abortion counselling, counselling for partners and grandparents, a support group, and a life coach who would be available to discuss concerns and to support them through various aspects of their lives. Other than to make sure the patient was not being pressured into the abortion, participants indicated that all counselling services should be optional.

Support for women accessing abortion was found to be necessary by participants, not only through counselling services, but by doctors, nurses, and other professionals. Medical professionals were often found to be judgmental, did not provide adequate information, and did not respect their privacy. They also expressed the desire for more support for the doctors themselves who are providing abortions. Support for people regardless of their age or experience with abortion, whether they were partners, parents, or grandparents of those who have obtained an abortion should be present. The participants also expressed that increased supports for mothers raising their children should be present, including financial information and support.

Increased information surrounding abortion and abortion services were mentioned as well as more holistic information about parenting were indicated as necessary changes. Improved, more objective, sexual education to youth was seen as essential. As well, education about healthy and abusive relationships were important to have incorporated as early as possible into the school curriculum. The current misinformation about sex and abortion services was seen as a tool to limit the access available to the public.

Discussion

The obtained from Health PEI show that women continue to attempt abortions and receive illegal abortions indicating that sufficient access to abortion services or the knowledge of how to obtain a safe, legal abortion is unavailable. The “status quo” embraced by the government on Prince Edward Island is harming women as adequate access to abortion services are not available, turning some women to illegal abortions that could result in complications. With more than half of reported illegal or failed attempted abortions resulting in complications, this suggests that illegal or attempted abortions that did not have complications may have gone unreported as the woman may not have felt the need to go to the hospital afterwards. In addition, there is the potential that within the category of unspecified abortions there may have been illegal or failed attempted abortions that took place.

Although it has been indicated that abortions do not occur on PEI, particularly illegal abortions, (CBC News, 2014), the data from Health PEI is able to confirm the performance of abortions on PEI, whether they are legal or otherwise (Health PEI, 2013). To deprive women of access to safe abortion services does not limit abortions from happening, but rather increases the likelihood that illegal abortions will take place, and increases the risk of complications following an abortion. In light of these data, it has become increasingly apparent that change is necessary surrounding access to abortion services on PEI, as well as information concerning the attainment of the procedure.

The results from the individual interviews, most of which were conducted 1 to 2 years before the focus group, differ from those of focus group as a number of political and community shifts have occurred. Since the individual interviews a number of abortion rights activist groups including the Abortion Rights Network (ARN) and the PEI Reproductive Rights Organization (PRRO) were formed. Add to this a number of community and media events, including the Reproductive Rights Rally and the Rally for Responsible Government in 2012, all of which have increased awareness about the lack of abortion access in PEI. As a direct result of this activism, more information is now available for people seeking an abortion, and importantly, after decades of feminist lobbying, the PEI government provided information regarding abortion access on the government website in December 2011. During the interviews, participants indicated that gaining information about where PEI women could access abortion was next to impossible as there was no information online and doctors were providing incorrect information. With the addition of information on the government website, this information became more readily accessible. Although increased access to information was also mentioned as a necessity during the focus group, it was centred on increasing sexual health education in schools and increased information for parents, as opposed to where or how to access safe abortion services.

During the individual interviews some participants were unsure as to what was the best method for delivering abortion services. Some people thought abortion services should be available at a local clinic within Island hospitals and others thought that we should focus on improving access to these services off Island. Within the focus group however, it was unanimously decided that a local, publicly funded clinic that provided abortion services and other sexual health services was essential for the citizens of PEI. This shift indicates how the political and community change surrounding abortion services have allowed people to think further about the best delivery method for abortion services. Since the interviews, participants were able to reflect on their research conversations and determine what changes they felt were necessary to improve abortion access in PEI. Upon joining the focus group, there was no doubt to the participants that a publicly funded clinic was essential in PEI, as there was no wavering on this idea throughout the conversation. Participants shared and elaborated on their pre-existing ideas for a clinic and solidified their visualizations with the other participants.

During the individual interviews and the focus group, support from doctors as well as financial support for women were indicated as essential. In the individual interviews, participants indicated not having support from family, friends, and medical professionals. Support from family and friends were not as prominently discussed during the focus group as were other forms of support, such as financial support, or support for other people, particularly doctors performing abortions, or support for other family members. This indicates a shift from personal desires for support from others to greater supports for the community. With the increased awareness about a lack of abortion services, participants who previously felt alone were better able to connect with other members of the community and became more aware of the necessarily for abortion services for other women. This shift from individual to structural thinking is a key component of resistance present in liberation psychology (Todd, 2011) and has implications for reproductive justice.

The themes expressed throughout the individual interviews and focus group were centred on a desire for reproductive justice, which involves women and girls having the power to make decisions about their bodies, reproduction, and sexuality. Participants expressed a desire for reproductive justice when discussing the need for a local abortion and sexual health clinic that would be supportive of their decisions regarding their bodies, reproduction, and sexuality.

Participants expressed a desire for reproductive justice when indicating the need for more information regarding abortion and sexuality because they felt it was their right to be more informed about the options regarding their bodies. Reproductive justice requires systemic changes, which can be led by a government.

It is recommended that the PEI government take a pro-choice stance regarding abortion access and provide abortion services that are in agreement with the Canada Health Act. Though some provinces pay for abortions in both hospitals and clinics, PEI continues to fund just abortions performed in the QEII hospital in Halifax, which limits options for women trying to obtain abortion services. MacQuarrie et al. (2014) revealed that wait times were never less than 15 weeks for ultrasounds necessary to confirm the gestation of the pregnancy prior to obtaining an abortion at the QEII. Therefore all ultrasounds had to be flagged as emergency and physicians warned participants this made it clear they were getting an abortion. This indicates that not only are wait times for ultrasounds extensive, they also limit the confidentiality for pregnant women.

It is recommended that until the province of PEI has a fully operational, publicly funded abortion clinic, or provides abortions within hospitals on the Island, the province will, at the very least, pay for abortions performed in clinics when the wait times for ultrasounds or the abortion procedure itself are too long within the hospital, or any available appointments exceed the gestational time limit. If the PEI government is looking for leadership, they can follow the example of the province of Manitoba. In 2004, Manitoba declared the province would pay for abortions performed in clinics if the wait times in the public sector were too long. This decision was based on the fact that abortions are considered medically necessary under the Canada Health Act and to not publicly fund this service would be in violation of the Canadian Charter of Rights and Freedoms (Sethna & Doull, 2007). It is also recommended that women should no longer require a referral from an Island doctor in order to receive coverage for an abortion, as a referral is not needed for women who obtain abortions in private clinics. The requirement to obtain a referral in order to receive coverage, according to Kaposy (2010), is arguably in violation of the Canadian Charter of Rights and Freedoms "security of the person". PEI should improve abortion access by changing the policy requiring women to obtain a physician referral before obtaining an abortion (Kaposy, 2010). This would reduce the amount of time women had to wait in order to be able to access provincially covered abortions.

In a study by Sethna and Doull (2007), many patients indicated they ended up choosing the particular clinic that was being studied because the first place of contact did not have available appointments within the time frame they required. Although travelling presents significant barriers for women seeking abortion services, particularly on PEI where women must travel across provincial borders and pay tolls for bridges or ferries to access the service, having timely access to an abortion was the most important aspect of abortion services (Wiebe & Sandahu, 2008). Women indicated that the most important issue was the time that they had to wait in order to obtain an abortion and the time they had to wait in order to make an appointment. Women also preferred to speak to someone in person. Many women had difficulty making or getting an appointment because they were required to leave a message on an answering machine as opposed to talking with someone directly, or they were put on hold. Being able to talk to someone directly is not currently available at the Termination of Pregnancy Unit at the Queen Elizabeth II Health Sciences Centre in Halifax, where PEI women may access publicly funded abortions. The lengthy waiting times for accessing abortion services in Canada are common within Canada's complicated appointment systems. This may lead to increased anxiety among women attempting to book an appointment (Wiebe & Sandahu, 2008). The literature indicates wait times for abortion services need to decrease and booking an appointment should be convenient and done with ease. Sethna and Doull (2007) also found that participants chose a different clinic because the fees were too expensive or were concerned about their safety as a result of the anti-abortion protestors, the staff were rude, or the hospital and clinic were too far from their location of residence. This indicates that services available to Island women need to be performed in a timely manner, and all abortions, regardless of whether or not they were performed in a hospital or clinic should be free of fees and should be covered by the provincial government. Local access to all these services should be available with professional staff who are friendly and compassionate. In addition, the clinic should be free of protestors to protect the women seeking abortions from harassment and potential violence from protestors.

As fewer doctors are trained and willing to provide abortions and doctors on PEI are not willing to endure possible harassment and violence from anti-choice groups (Kaposy, 2010) that may result from performing surgical abortions, it is important for the provincial government to voice their support for any doctors who may be willing to provide abortion services. Focus group participants mentioned that more support for doctors who would be willing to provide abortions is necessary. The government of PEI should replace the anti-choice stance of Resolution 17 with pro-choice position, as this anti-choice resolution contributes to the culture of anti-choice frames for women (MacQuarrie et al., 2014) and physicians. Replacing this legislation may help protect physicians and patients alike who access abortion services, including a buffer zone around hospitals and clinics that may provide abortions and around the homes and offices of doctors, so that to protest in those locations is against the law. These policies have already been adopted by British Columbia in 1994, under the Access to Abortion Services Act, and in Ontario in 1995, so that the area around places providing abortions services (Kaposy, 2010), as well as the homes of doctors performing abortions, (Sethna, et al., 2013) are protected by restricting the protesting of abortion, making it illegal to protest abortion in those areas. Having a buffer zone around the home and work environment of doctors performing abortions will not only protect doctors, but will show support for their services through the implementation of the above policy. It is the job of the provincial government to protect and to support doctors who engage in the legal provision of the medically necessary service of abortion that is currently present in all other provinces in Canada. It is time for the PEI government to stand up for the rights of women and doctors, and to finally oppose the pressure from anti-choice groups to continue to violate the Canada Health Act.

Not only should patients seeking abortion services and the doctors providing those services be protected from anti-choice picketers and groups, anti-choice doctors who block women's access to abortion services should be held accountable for their unethical practices. Anti-choice doctors who provide women with incorrect information, or refuse to provide information about abortion access with the intention of preventing women from accessing abortion should be penalized. Although doctors have the right, for moral or religious beliefs, to refuse to provide a referral, under the Canadian Medical Association's Code of Ethics, the doctor must provide women with the information of someone who will give a referral; to do otherwise would be medical malpractice. Kaposy (2010), suggests that if refusing to provide a referral to a patient for an abortion would mean that she will be denied the ability to access abortion, this should be punished as well. It is the responsibility of the PEI government in collaboration with the Medical Society of PEI to ensure that this medical malpractice of physicians not providing accurate information be penalized.

It was commonly mentioned by participants that confidentiality in PEI is an issue and to have a clinic here may jeopardize women's confidentiality of the process given that staff may breech confidentiality and any local protestors may recognize them. Though these are valid concerns and should be addressed, Kaposy (2010) indicates that to not have a local clinic may threaten confidentiality as people leaving the province may be required to justify their absence. In a small location like PEI, it is especially important to ensure patient confidentiality and necessary measures are required to uphold the patient's right to privacy.

Privacy is particularly important in small rural communities, but access to abortion services are increasingly limited in these small areas. As PEI has a large portion of its population residing in rural communities and it may be more difficult to access abortions and abortion providers, it is recommended that telemedicine be used for medical abortions. This may reduce the distance patients are required to travel, and may reduce the need for second trimester abortions (Jones & Jerman, 2013). Having access to abortions in rural hospitals may also be beneficial for rural residents. It has, however, been indicated that due to the Island's size and population that it is not possible to provide every medical procedure within the province and therefore, abortion cannot be provided in the hospitals here (CBC News, 2014). Though it is true that it would be challenging to provide every service, Jones and Jerman (2013) indicate that hospitals have the necessary equipment to perform abortions, and most abortion procedures are not complicated. In addition, data collected from Health PEI indicates that abortions do occur in PEI already and they used to provide them until 1986 (MacQuarrie et al., 2014).

Although abortions do occur in PEI, it is likely that they are often forced upon the system as a result of desperate circumstances as opposed to being carefully planned. They could also occur as a result of the harms incurred as a result of self-induced or illegal abortions. From a public policy management perspective, creating the space to provide this care in an ambulatory setting within the hospital may be much more efficient than the current high end use of abortion services. In addition, operating rooms could be left available for other procedures or for abortions that result from unforeseeable circumstances and not the result of barriers to access.

Although access to abortion services in hospitals may help increase availability to abortion services, and may be able to provide women with increased safety from protestors, the women in the focus group unanimously agreed that a clinic in PEI would be preferred to abortions performed within the hospital. This desire is consistent with other research by Sethna and Doull (2013) who found that women bypassed abortion services in hospitals in, or near, their place of residence in favour of free-standing abortion clinics. Women may avoid abortions performed in hospitals for a number of reasons, including confidentiality issues, particularly in smaller areas, multiple appointments, the use of general anesthesia, and/or insufficient counselling services. Wait times are often greater in hospital based setting, and priority may be given to other surgical procedures that need to be performed in the hospital. Clinics tend to have shorter wait times, use less invasive procedures, and sympathetic staff. They also provide counselling and contraceptive information (Sethna & Doull, 2013).

During the interviews, participants expressed varied opinions on counselling services provided to women who access abortion services. Some indicated that counselling would not be able to provide them with anything a friend could not, while others found it to be, or could be, beneficial. During the focus group, the participants indicated that counselling services should be available, other than to ensure a woman was not being coerced into the abortion, all counselling services should be optional. When counselling does occur, it should be patient centred. Physicians should refrain from offering prescriptive advice and engage in collaborative decision-making with patients. It is important to support patient autonomy and promote both comprehension and satisfaction. Medical professionals have often been a source of the weakening of reproductive choice, and their counselling may be biased by race, economics, or other oppressive considerations. It is important for counselling providers to be aware of their biases so that they may take the necessary precautions to reduce the negative effects their biases may have on the patient (Dobkin, et al., 2013).

Not only do the biases of health care professionals delivering counselling services to women seeking abortion services or providing post-abortion care need to be examined, but the biases and judgments made about women who access abortion services need to be addressed as well. The social barrier of judgment and stigmatization surrounding abortion negatively affect those who may need to access this service, or those who underwent the procedure. Women in the individual interviews and in the focus group both expressed a desire for women accessing abortions to be supported. Supportive staff and the elimination of anti-abortion protestors at the clinic were indicated as making the journey easier for women who accessed abortion services (Sethna & Doull, 2013). It is therefore important for staff to be supportive and non-judgmental, and for the government to tangibly and visibly support abortion services. In addition, decision makers in the health, political, and education fields can contribute to an enhanced public perception of abortions (Norman, 2012), making it especially important for these groups to support women seeking, or who have sought, abortions.

Both the federal and provincial governments need to ensure that publicly funded reproductive healthcare, including the constitutionally protected, medically necessary abortion services, be accessible to all in both clinics and hospitals (Rodgers & Downie, 2006). Changes to the current health care system must be implemented so that women in PEI are not required to leave the province to access abortion services. Restricting abortion access does not eliminate abortions from happening but it assuredly increases the probability of unsafe conditions for abortions (Hayden, 2011), as well as increases the likelihood that complications will follow from the unsafe abortions. Given that restricting access to abortion is detrimental to the heath of women seeking this service and that the law restricting abortion access was struck down by the Supreme Court of Canada more than 26 years ago, change needs to happen in PEI so that women can better access this medically necessary service.

Limitations of the project

The limitations to the research might appear to be the restricted set of participants who became involved in the research, as the people who were interested in the interviews were people who were interested in improving abortion access in PEI. Many of the people who came to the focus groups became activists in the community since their individual interviews and they were highly knowledgeable with respect to abortion access in PEI. Therefore, people who do not share the same concerns did not choose to participate in a project geared towards change. Nevertheless, it was also a strength of the research to have many participants who were very knowledgeable about abortion and abortion access as they were able to provide educated and thorough responses.

Future Directions

The next initiative for research would involve the investigation of the necessary steps in order to have a local, publicly funded sexual health clinic by researching other sexual health and abortion clinics. It would be beneficial to compare PEI to other locations with sexual health and abortion clinics, to determine how the services here can be improved to better serve the community and to determine which options are feasible in PEI. It is important to research the effects of travelling on rural Islanders in particular, and to find better, more effective ways to serve this portion of the population. It is also necessary to hear from people who have obtained abortions who are less active in the greater social change so we can be as inclusive as possible in the provision of services.

Reflexivity

As a woman born and raised in Prince Edward Island, in an anti-choice household, I have always been aware of the judgment and stigmatization surrounding abortion access. After the adoption of my youngest sister from China, I became increasingly aware of the damaging effects of reproductive injustice. In a country where women have few reproductive rights, with most women being unable to determine how many children they will have, the importance of reproductive justice has became apparent to me. It is often believed that reproductive injustice occurs elsewhere, in less developed countries, but reproductive injustice is present on Prince Edward Island, where Island women do not have local access to fundamental reproductive health services.

Negative attitudes regarding abortion access that surround me have only contributed to my perception and affirmation of the necessity for reproductive justice. Abortion access is unnecessarily difficult for Prince Edward Island women, and being a woman of childbearing age, with goals and aspirations outside of motherhood, it is important that reproductive autonomy be attained for all Island women. Reproductive autonomy can only be done through the promotion of reproductive justice.

Since this research, the reproductive injustice on Prince Edward Island has become increasingly evident, and it is time for change, and to listen to the voices of the women who have experienced this injustice. The difficulties other women have experienced have inspired me to seek change, so that no woman will be judged for her decision to access an abortion, or have to travel elsewhere for access to safe abortion services.

Conclusion

The current system and policies are not a "good compromise", but rather compromise the health of many Island women. The "status quo" cannot be accepted and positive change that will improve the health of Islanders is a necessity. It has been 26 years since abortion has been decriminalized and it is time for the government to pay for this legal, medically necessary service. The PEI government must prioritize the guarantee of abortion access for Island women by implementing the recommended changes; to do otherwise would be reproductive injustice. Not providing adequate information to patients, or not condemning doctors for not providing enough information to patients is reproductive injustice. Not supporting doctors willing to provide abortion, not adhering to a patient's right to privacy and confidentiality, and not helping women feel safe from harassment and violence when accessing abortion services is reproductive injustice. Not supporting women in their decision to have an abortion, and not providing local, publicly funded abortion services is reproductive injustice. It is time for change so that the province of PEI is no longer a place of reproductive injustice. It is time for the government of PEI to be held accountable for denying reproductive justice to Island women. It is time for change.

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Appendix A **DISCUSSION GROUPS CONSENT FORM**

Understanding for a change: Interrogating effects from twenty years of denying women's access to an abortion in PEI.

You participated in an interview in our project. As promised, we removed any identifying information and analysed our interviews across many participants. We have analysed the interviews and now want to get your feedback on what we understood from those interviews.

The lead researcher is Dr. Colleen MacQuarrie, Department of Psychology, UPEI. If you have any questions about this research, you can contact Dr. Colleen MacQuarrie at 902-566-0617 (cmacquarrie@upei.ca). We want to share the findings with you to see how those findings fit with your experiences. Your opinions and your ideas are important to change reproductive justice for women in PEI.

The discussion group will be facilitated by Dr. Colleen MacQuarrie. An Honours student working with Dr. MacQuarrie may also be present. The meeting will take place on the UPEI campus.

If you choose to participate in the research you will join a group discussion along with approximately 10 other people who also participated in our interviews.

Four separate discussion groups are held for women who:

- have secured an abortion while living in PEI
- have tried to obtain an abortion but were blocked from doing so,
- tried home remedies for abortion and either were or were not successful in terminating the pregnancy
- have accessed the morning after pill for themselves in PEI.

Two separate discussion groups are held for allies. If you were in our family/friends allies group, this group may include people who supported women by obtaining morning after pills at drugstores or who accompanied women to an abortion. If you were in our activist and medical professionals allies group, it may include people who have worked as abortion rights activists and medical personnel interested in securing women's reproductive rights in PEI.

- The discussion will be about
  - your opinions on the ideas coming from the research
  - your ideas about other ways to work for reproductive justice in PEI
- discussions will last about 2 hours
- you will not be identified in the research findings
- your ideas will be combined with others to improve the research

- All discussion group participants are requested to hold the information confidential to the group.

- This means that after the discussions you may discuss ideas you have with people outside the group, but that the other participant's names and identities should not be shared. It is unethical to share people's names outside this group. Of course, we as researchers can not guarantee that all discussion group participants will adhere to this requirement and so neither confidentiality nor anonymity can be guaranteed from group discussions.

It is possible that participating in this group conversation may be difficult for you, and you may wish to talk to someone about your experiences. For your convenience, we have attached a list of services that you can choose to access if you would like to. Cathrine Chambers (M.Ed, CCC), who is a trained counsellor has also agreed to be contacted by phone (902-830-3084) should you have any personal concerns that arise following the group discussion and can assist you with a referral for assistance to other community supports.

The discussion will be audio-taped and the facilitators will be the only ones who have access to the audio tapes. Notes will be taken from the discussion. All of the information collected will be kept confidential. The group conversations will be analyzed to determine what needs to be added to the findings from the interviews. You personally will not be identifiable in the research reports.

The information from the group discussion will be kept in a locked cabinet at the University of Prince Edward Island. Only the facilitators will have access to the audio tapes. Any notes made from the tapes will not contain any identifying information. You will remain anonymous in all reports and presentations that result from this study. This means that your personal information, such as your name or anything else that could identify you, will be removed from any notes from the discussion group. No one outside the facilitators will be able to see or hear any personal information that will let them know who has been interviewed. The data collected will be destroyed 5 years after the completion of the study.

I hereby consent to be a participant in a research study led by Colleen MacQuarrie, PhD of the University of Prince Edward Island. I have read the information and understand that the purpose of this research is to understand my ideas and opinions about women's reproductive justice in PEI.

I acknowledge that:

1) I understand my participation is voluntary

2) I have the freedom to withdraw from the research at any time without penalty or prejudice

3) I have the freedom not to answer questions I am not comfortable with

4) I understand the information I share will be confidential within the limits of the law

5) I understand I can keep a copy of the signed and dated consent form

6) I understand that I can contact the UPEI Research Ethics Board at 902-620-5104, or by e-mail at lmacphee@upei.ca if I have any concerns about the ethical conduct of this study.

Furthermore, I agree to keep all the information discussed in the context of the focus group confidential and anonymous. I can only share my ideas outside the group; I cannot share other's identities.

Participant's Signature_________________________________ Date_________________

Researcher's Signature_________________________________ Date_________________

If you would like to receive a summary of the results of this study, please provide either your mailing address or e-mail address below: